THE UNIVERSITY OF MANITOBA

SOCIAL CONTROL IN MEDICINE:
ON THE MEDICALIZATION OF PREGNANCY AND CHILDBIRTH

by

KAREN R. GRANT

A THESIS

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The task of social science now is to raise self-consciousness to the second degree, to find out the causes, the mode of functioning and the consequences of the adoption of ideologies, so as to submit them to rational criticism.

J. Robinson, Freedom and Necessity

ABSTRACT

The purpose of this exploratory study is to examine the multi-dimensional character of medical social control, specifically in terms of the medicalization of pregnancy and childbirth. In particular, this thesis focuses upon those events which have resulted in the medicalization of birth and its subsequent technologization, as well as factors which have shifted birth management in recent history from women to men and from midwives to physicians (i.e., professionally trained experts). In addition, the implications of these changes for birthing women are explored.

As a guide for this analysis, Conrad's typology of medical social control is utilized (1979). According to Conrad, the medical profession exercises social control through three mechanisms, namely, (1) the creation and dissemination of medical ideology; (2) the monopolization of technique; and (3) the control of "illness managers" within the health care hierarchy.

Based on available data sources, it is concluded that, with respect to medical ideology, the medical profession has effectively transformed social understanding and perceptions regarding the reproductive process. By defining birth as pathophysiological, the profession of medicine has transferred the place of birth from the home environment to the hospital. Whereas previously, most births were considered non-problematical, increasingly birth has become a medical problem in need of technical management. Several obstetrical procedures originally designed to deal with the extraordinary case (eg., Caesarean section, episiotomy, forceps delivery, vacuum extraction, and surgical induction or augmentation of labour), have become routine

forms of intervention in a great many deliveries. It is noteworthy that, with the exception of vacuum extraction, all other aforementioned obstetrical procedures have been used with increasing frequency in Canada and Manitoba during the period of 1969-1976. Finally, whereas history has discerned that birth was "women's business" (i.e., within the purview of empirically experienced, rather than professionally trained, midwives), there has been a shift in focus, away from traditional birth attendants to "men of science".

Recent developments such as certified nurse-midwifery and the home birth movement suggest that childbirth may be de-medicalized. That is, by altering definitions of the reproductive process, it is possible that birth may once again become a normal aspect of adult life. However, before normalization takes place, considerably more rigorous research will have to be undertaken as a way to understand more fully the relationship between medicine and society, medicine's social control functions, and the implications of medical social control for patients and their maladies.

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Finally, I thank my family and it is to them that I dedicate this thesis. Most especially, I wish to thank my parents for their support, interest and understanding in this and all endeavors. I am eternally grateful for all that they have taught me and all the happiness they have brought into my life.

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INTRODUCTION

In recent years, mankind has witnessed tremendous technological diversification -- a sign taken of the progress of human civilization. As a result, members of society have come to believe that what is new is better, or at least better than what was in the past. Once members of society are convinced that these phenomena are more advanced, more efficient, more rational, or will allow them to deal more effectively with the exigencies of daily life, these innovations become a part of the terms of reference of our everyday reality. One gauge commonly used for assessing the merit of these phenomena is science, because science has come to assume a position of extreme importance in modern society. The belief system which reflects the key part played by scientific principles in daily life is called "scientism" (cf. Ellul, 1964; Hayek, 1952).

In the area of health care, scientism is of vital significance. As a result of the marriage of science and medicine in the fourteenth century (Bullough, 1966), new products, techniques, and ideas are always being introduced, in the hope that such advances will perhaps enhance the quality, if not the quantity, of life. In fact, one cannot help but wonder where mankind would be today were it not for Pasteur's work, the invention of the microscope, the discovery of the circulation of the blood, and countless other scientific discoveries which help the medical profession offer treatment and care for the sick.

However, increasingly it is being recognized by some health

care practitioners and some consumers, as in other spheres of life, that "new" is not always "better"; and that sometimes "primitive", "archaic", or outdated practices and methods may have served mankind as well or better than those currently in vogue. Evidence of this skepticism of new things is provided in a number of cases, such as the popular desire for back-to-nature nutrition, lifestyles, birth practices, and the return of many forms of caring and curing from the hospital to the home environment.

Reasons for this return to basics and increasing skepticism regarding the efficacy of scientific medicine are many. The proliferation of iatrogenic diseases (Greenfield, 1976; Illich, 1977; Mendelsohn, 1979; Weiss, 1975) and the almost epidemic proportions of unnecessary surgery (Barker-Benfield, 1976a; Cohen and Backhouse, 1979; Larned, 1977; 1978; Rodriguez-Trias, 1978; Scully, 1980) have fueled the current disenchantment among health care consumers. Consumer groups (such as the National Women's Health Network and the Reproductive Rights National Network, to name but a few) and government agencies (such as the U.S. Food and Drug Administration and the Consumer Protection Agency), alike, have noted that certain treatment modalities, and the extent to which they have been used are of questionable value and cause for concern. Although the medical profession justifies the use of certain drugs and technological solutions as being utilized "in the name of health", health care consumers continue to question the validity of some medical practices and priorities. Even some members of the medical profession today are beginning to

question the goals and priorities of their profession (eg.Mendelsohn, 1979; Szasz, 1970; 1977). Some have even gone so far as to divorce themselves entirely from the medical model because of their concern over whether medicine is actually serving the needs of its patients as Hippocrates and other early physicians had implored them to do. In other words, there is reason to believe that devout faith in the efficacy of scientific medicine can no longer be taken-for-granted. No longer can one assume that doctors will use treatments that help rather than harm the patient. Nor can one assume that the priorities of the medical profession will always be directed towards humanitarianism, and the service of mankind through technical expertise. Rather, the techniques and service orientation of the medical profession must be viewed as problematical, worthy of -- in fact necessitating -- empirical investigation which can clarify the objectives and actions of the medical profesion for its sometimes skeptical audience. There is, in sum, reason to believe that what is new is not always better, and that perhaps a return to old or alternate ways may be in order in some areas.

In contemporary society, medicine has come to assume a position of dominance (Freidson, 1970b). Evidence suggests, moreover, that medicine operates as an institution of social control (Conrad, 1978a; 1978b; 1979; Conrad and Schneider, 1980a; 1980b; Ehrenreich and Ehrenreich, 1978; Illich, 1977; Strong, 1979; Zola, 1978). In this sense, anything having to do with health and illness falls within the purview of the practice of modern medicine, irrespective of the profession's capacity to deal with it effectively (Freidson,

1970a; 1970b). As a consequence of the profession's ability to define what constitutes health and illness, and compounded by society's belief in the efficacy of medicine, western society has observed what Illich has called "the medicalization of life" (1977). Steps are taken by the medical profession to medicalize conditions and behaviors it defines as illnesses. Previously, other experts handled some of these conditions or behaviors. However, now that the medical profession is equipped with a well-organized ideology, a diversified and advanced technology, and the assistance of other experts who collaborate in the medicalization process (Conrad,1979), once an entity is defined as illness, the medical profession exerts its control over the individuals so "afflicted".

Examples of medicalization of various conditions are widespread because in many cases, the medical profession has pre-empted other so-called experts.* For example, historically, the church played a dominant role in handling moral issues such as abortion, euthanasia, and suicide; now however medicine controls these "medically defined problems" (Charmaz, 1980; Szasz, 1977). Whereas the legal profession handled the question of moral responsibility and criminal culpability in cases involving the "mentally ill", now

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* One should not be misled into believing that medicine was and is systematically engaged in an empire-building endeavor. While it is apparent that the profession eagerly sought to manage some conditions it defined as illnesses, the medicalization process has been described as largely an insidious one, where either the public encourages the profession to offer medical solutions to their problems or other disciplines abdicated or failed in their responsibility for handling the problems experienced by individuals in society (cf. Conrad and Schneider, 1980b; Strong, 1979).

the medical and legal professions work hand-in-hand in the courtroom (Melick, et al.,1979; Szasz, 1970; 1977). The school teacher typically exercised discipline in the classroom in dealing with unruly children; now these same children are called "hyperkinetic", and treated medicinally (Conrad, 1978a; 1978b). These are but a few of the ways in which medicine has come to dominate many of the social, moral and legal problems confronting mankind today. By calling something an illness, the medical profession gains control over those who are labeled ill. In this capacity, the medical profession operates as an institution of social control, and increasingly expands its boundaries of professional jurisdiction.

The examples of the medicalization process noted previously are evidence of "the medicalization of deviance". Now, however, medicine is medicalizing quite normal and natural phenomena or conditions. While it is true in many cases that the medical profession is perhaps more competent than some others in handling the biophysical events of our lives, there is concern that the medical profession may be going too far in expanding its jurisdictional domain.

What is of interest in the present discussion is the medicalization of birth, an inherently normal, natural event in most women's lives. In times past in a number of societies, and in some societies today, birth was viewed as just another in a series of processes experienced during one's lifetime. So unproblematical was birth for women in "primitive" and "underdeveloped" societies that some would stop only long enough to give birth -- most times without the assistance of anyone or only with the assistance of a midwife or

family member -- and then would almost immediately resume work, whether in the agricultural fields or in the home (Jordan, 1980). This somewhat quaint scenario is diametrically opposed to the picture of birth today in a number of western societies, including Canada. In North America and some European countries, the birthing woman, with the aid of professional personnel inside the hospital, is delivered, with her feet up in stirrups, in a supine position, with the manufactured comfort produced by a wide array of drugs and techniques, and often without the support of family and friends. Everything, she is told, is being done with the safety of her child and herself in mind. Notwithstanding the fact that most, if not all, medications can be potentially lethal to an unborn child; that the supine position may cause a reduction in the amount of oxygen reaching the child (Caldeyro-Barcia, 1977) -- these hospital procedures and several others dictate that the modern form of handling birth is in the best interests of both mother and child.

Indeed, there is no question that in some -- but not all -- cases, many of these medical measures may be needed. The fact of the matter is, though, that pregnancy and childbirth are fundamentally uncomplicated processes. In most cases, the medical paraphernalia are unwarranted. However, because birth is no longer viewed as normal or natural (by doctors and laymen), and instead is now viewed as a crisis necessitating medical intervention, such management is justified on medical grounds. In a word, birth has been medicalized.

How birth has been medicalized is the focus of this thesis.

It is suggested that doctors are not totally responsible for the medicalization of birth and other conditions. Rather, the push by health care consumers, who are relinquishing ever greater amounts of responsibility for their beings, together with the pull by professionals to control more and more aspects of life has led to our society being medicalized. The extent to which various aspects of life are being medicalized is problematical. Hence, the medicalization process must be subject to rigorous scientific investigation.

The purpose of this thesis is to explore the reasons for and consequences of medical social control in the area of pregnancy and childbirth, and to propose a theory of medical social control. Using a socio-historical method (cf. Denzin, 1970; Schwartz and Jacobs, 1979; Webb, et al.,1966), as well as secondary data analysis (cf. Babbie, 1975; Webb, et al.,1966), the focus will be upon those events which have resulted in the medicalization of birth, and which have shifted birth management in recent history from women to men, and from midwives to physicians; as well as the implications of these changes for birthing women.

The objectives of this study may be broadly stated as follows:

(1) to trace historically the transition in the definition of childbirth from a normal process of the healthy female reproductive system to a disease-like medical problem;

(2) to examine the social and political factors which have contributed to professional (i.e., medical) control of women's reproductive health and the simultaneous displacement of midwives by professionally trained (and primarily male) experts;

(3) to examine the effects of various ideologies (specifically, the ideology of professional medicine, and the competing ideologies of self-help, feminist, and natural childbirth groups) on the definition of childbirth and its management;

(4) to examine factors essential for de-medicalizing birth (i.e., normalization) such that women can regain control over reproductive health care; and finally

(5) to suggest relevant research issues in this field of inquiry.

Given the pervasiveness of various controlling mechanisms in society today, and specifically the dominance of the medical profession in matters of health and illness (and increasingly, social, political, and economic matters) it is essential that members of society, including academics, not be lulled into a false sense of security concerning the efficacy of medicine in resolving our most pressing problems. In order, then, to generate a more lucid understanding of the relationship between medicine and society, and in a sense, to de-mystify the nature of medical social control "in a world that lives on myth" (Berger, 1963), this thesis may be seen as one step among many in achieving a broader understanding of our taken-for-granted reality.

Chapter One
Social Control: The Concept and Its Special Meaning in the Profession of Medicine

THE CONCEPT OF SOCIAL CONTROL

Social control has long been a major focus of sociologists, as well as philosophers, political scientists and others in the social sciences and humanities (Schwendinger and Schwendinger, 1974). The significance of the concept of social control was aptly articulated by Robert E. Park, who believed that social control was "the central fact and the central problem of society" (cited in Coser, 1971:358). Growing out of the Hobbesian notion of "a war of all against all" (Hobbes, 1969), as well as the problems associated with the transition from traditional to industrial societies, a number of European and North American sociologists directed their attention to explaining the complex dialectic between individuals and society, believing that the concept of social control lay at the heart of the problems in the social order.*

Although there is evidence of differences in the conceptualization and operationalization of the meaning of social control (Schwendinger and Schwendinger, 1974: 188-221, 388-409, 561-574),

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* This evolutionary trend has been variously labeled by scholars as the difference between "community" and "society" (Tonnies, 1963), "mechanical" and "organic solidarity" (Durkheim, 1933), "nondifferentiated" and "differentiated" (Ross, 1901), "primary" and "secondary" (Cooley, 1909), "familistic" and "contractual" (Sorokin, 1947), "folk" and "urban" (Redfield, 1947), "sacred" and "secular" (Becker, 1950), and "precapitalist" or "natural" and "capitalist" or "social" (Marx, 1978). In each, however, essentially the same concern has been addressed -- that being to differentiate historical epochs in terms of interpersonal (i.e., social) relationships.

for all intents and purposes, the concept has been used within the context of reconciling the contradictions between social order and social disorder, harmony and disharmony, social statics and social change, or functional and dysfunctional tendencies within society. On the level of the individual actor, social control refers to those mechanisms created so as to regulate or restrain deviance or aberrations. As an expression of the "interests of society", an amorphous notion at best, social control mechanisms were created for the purpose of promoting some semblance of stability or equilibrium in a world inhabited by egotistical individuals with insatiable needs and desires. "Social control always operates so as to regulate competition, to compromise conflict, or to harness individuals to the necessary requirements of the social order" (Park and Burgess, 1921:42).

The concept of social control can be understood from a number of diverse sociological perspectives; for example, structural-functionalism (cf. Durkheim, 1951; Parsons, 1951), critical conflict theory (cf. Greenaway and Brickey, 1978; Chambliss and Seidman, 1971), symbolic-interactionism (cf. Becker, 1963; 1973; Lemert, 1967), and social constructionism or phenomenological sociology (cf. Berger and Luckmann, 1966; Berger and Pullberg, 1965). An alternative approach to studying the nature of social control (i.e., the question of social order) is to conceptualize it in terms of a normative, as opposed to an interpretive, paradigm (Hawkins and Tiedeman, 1975; Wilson, 1970).

The normative paradigm is predicated on the assumption that

one can best understand human behavior as "a product of adherence to normative standards or institutionalized expectations of behavior in various situations" (Hawkins and Tiedeman, 1975:3). According to this paradigm, social order is taken-for-granted and imposed via socialization into a common culture. Individuals' desires to optimize gratification and avoid negative sanctions are believed to account for conformity to institutionalized behavioral expectations.

However, because some members of society do not effectively internalize the institutionalized expectations (according to functionalists) or because they may not regard the expectations as either legitimate or representative of the "common will" (according to conflict theorists), acts of deviation do occur. In order to re-establish equilibrium or the status quo, social control mechanisms are created.

Parsons, representative of a structural-functionalist orientation, defines the relationship between deviance and social control as follows:

> Deviance . . . is defined by its tendency to result either in change in the state of the interactive system, or in re-equilibration by counteracting forces, the latter being the mechanisms of social control. It is presumed . . . that such an equilibrium always implies integration of action with a system of normative patterns which are more or less institutionalized (1951:250).

Through social control mechanisms, society is able to exist in a more or less stable manner because social control keeps the various actors' behavior in check. On the one hand, that deviance exists suggests that social control has failed to some extent (i.e., a

dysfunction of deviance). On the other hand, deviance defines the boundaries of permissable behavior and thus strengthens social control. By controlling deviants, society through social control restrains others from deviating (i.e., positive functions of deviance). In all, the functionalist perspective posits that the primary purpose of social control mechanisms is to ensure that a particular status quo is maintained.

For conflict theorists, who also operate within the normative paradigm, to the extent that both the behavioral expectations and status quo represent only a fraction of the interests of members of society (the ruling classes or elite, as opposed to all classes), social control must be considered problematical (Schwendinger and Schwendinger, 1974). According to this perspective, mechanisms consist of those institutions and individuals commissioned by the elites of society to maintain the status quo which permits the ruling classes various privileges (Alford, 1975; Domhoff, 1978; Mills, 1956). Social control mechanisms are defined primarily in terms of the interests of the bourgeoisie (i.e., controllers of the mode of production), who are intent on keeping the proletariat in its subordinate status (Marx, 1978; Sallach, 1974). Since their control is legitimated through ideological hegemony, the bourgeoisie is in a position to define what is and is not deviance; as well as the various sanctions that will be applied to deviants should they depart from the status quo. The alarming aspect of social control, according to Schwendinger and Schwendinger, is that when one penetrates the surface of the controlling mechanisms

to the roots (i.e., ideology), one becomes cognizant of "the degree to which fallacious ideological views of social reality maintain outstanding social inequalities at any given time" (1974: 195-196/emphasis in original).

As in the functionalist explanation, social control facilitates the restoration of equilibrium. However, the equilibrium which is restored is neither consensually arrived at, nor non-repressive (as functionalists would have us believe). On the contrary, the status quo is an ideological creation which ensures the superordination of elite interests at the expense of mass (proletarian) interests. The reality which emerges, and which becomes reified and fixated, is not characterized by harmony, unity or a brotherhood of man -- it is rather an oppressive and repressive order effectively disguised as representative of the "common interests of society".

In contrast to the positions advocated within the normative paradigm, adherents of the interpretive paradigm suggest that "social order emerges from within interaction, it is not imposed from without" (Hawkins and Tiedeman, 1975: 4/emphasis in original). Because the social order is considered precarious, problematical, and always in the process of "becoming" (as opposed to already "being"), it is essential that one understand the manner in which reality is constructed (Berger and Luckman, 1966). As such, interpretive sociology focuses upon the interaction between individuals in order to comprehend both the genesis and nature of social order. Within this framework, human behavior is shaped not so much

by strict role expectations, but rather by situational contingencies and a negotiation of role expectations and behaviors within various contexts. "Out of a mutual process of defining and redefining the relevant or 'meaningful' elements of situations, something like a social order . . . gradually emerges" (Dreitzel, 1970: 18).

Within the interpretive paradigm, and specifically from a sociology of knowledge perspective, "the reality of everyday life is taken for granted as reality" (Berger and Luckman, 1966:23) over the course of time. Once activities and processes become typical and/or habitualized, one witnesses the genesis of institutions. The various institutions tend to acquire objectivity such that the possibility of significantly altering the institutional world is diminished. "The institutions, as historical and objective facticities, confront the individual as undeniable facts. The institutions are there, external to him, persistent in their reality, whether he likes it or not" (Berger and Luckman, 1966: 60/emphasis in original).

By their very nature institutions control human behavior, by channelling patterns of conduct within a historical and social milieu. In contrast to explanations within the normative paradigm however, no action, nor any mechanisms for sanctioning any action, is immutable. Rather, deviance from a predefined institutional imperative must be situated within a particular time and space, and the system of social control likewise must be contextualized in order to be seen as a legitimate control.

Although sociologists of knowledge forcefully stress the

dynamic and negotiable quality of reality, with time certain institutional arrangements tend to be typified in the consciousnesses of individuals. In general, certain definitions of reality take precedence over and dominate others (i.e., they acquire legitimacy), and when this occurs an "official" definition of the situation emerges within the institutional framework. Alternative definitions of reality (i.e., deviance) must be kept at bay, and therefore social control will be exerted upon the challengers of the official (i.e., legitimate) reality.

Although it would appear that the philosophical foundations of the normative and interpretive paradigms are quite disparate, in actuality neither is mutually exclusive. Social order may be at one and the same time normative and dynamic. Institutions, although generally fixed in nature, can and occasionally do undergo changes in response to external requirements. The behaviours of individuals, although subject to routinization, are modifiable. Finally, as noted previously no mechanism of social control is immutable. Owing to the complexity and changeability of social reality, both structural stability and flexibility appear to be necessary and complementary requisites for the maintenance of the social world.

Notwithstanding the fundamental differences between the normative and interpretive paradigms, the meaning of social control is essentially the same. Social control is intended to regulate deviance -- regardless of the form this takes -- in order to allow society to function in an efficacious and rational

manner. Whether the sanctions are formal or informal, positive or negative, repressive or liberating, the aim is to maintain some semblance of order in society.

MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL

There are a number of institutions in society which function as mechanisms of social control; for example, the family, educational institutions, the State, the economy, religion, and the law. Although certain groups can and do exert control, and thus channel human behavior (eg., in small communities, where anonymity is virtually impossible, gossip can be used effectively to promote conformity to the values espoused by the group), the concept of social control is generally analyzed at the institutional level.

Typically, when one thinks of mechanisms of social control, the legal system comes to mind. It is through the combined efforts of the police and the criminal justice system (including the courts, prisons, parole and probation services, and the law itself) that human behavior is channelled in the direction of conformity to legal imperatives. By apprehending and sanctioning those who deviate from established behavioral expectations, the legal system functions ostensibly to ensure that citizens do not break laws which supposedly have been enacted for the betterment of society. However, the voluminous works of conflict theorists (cf. Chambliss, 1973; Graham, 1972; Griffin, 1971; Gusfield, 1963; Hepburn, 1978; and Pilivian and Briar, 1964) reveal that only certain interests are protected by the law. The definitions of conformity and deviance

typically reflect the dominant ideology of the ruling class. As a result,

> the substantive content of the legal system inevitably reflects some value systems, to the exclusion of others. What is one man's pleasure is another man's vice. If the man who sees the act as a vice is in a position to define what is right or wrong and the other man is defenseless to keep that definition from being imposed upon him, then in a complex society, partaking of that pleasure may have to be weighed against the possibility of state imposed sanctions (Chambliss and Seidman, 1971: 189).

The preceding statements on the legal system, in sum, confirm what has already been noted regarding the functions of social control. The one-sidedness of definitions of conformity and deviance tend to secure the established social order and foster the perpetuation of the existing social relations (most notably, structured inequality).

Parsons indicated in his general theory of social action (1951) that medicine operates not unlike the law in securing conformity to health "norms", and thus may be viewed as a mechanism of social control. Specifically, medical practice controls who enters the sick role, as well as when and why the sick role is adopted. According to the Parsonian model, the sick role involves clearly defined obligations and expectations. The sick person is exempt from his/her normal social role obligations, as well as responsibility for his/her condition; and it is understood that s/he will seek technically competent help (i.e., doctors) in the curing process so as to be able to resume normal role obligations (Parsons, 1951: 436-437). Although Parsons' analysis of the

sick role is repleat with both methodological and conceptual problems (cf. Freidson, 1970a; 1970b; Mc Kinlay, 1972; Segall, 1976), his contribution is still regarded as extremely significant in the literature on medicine as an institution of social control, and patient-physician relationships in the health care system.

Since illness is ubiquitous in society, and since in accordance with Parson's orientation, illness is inherently "dysfunctional" with respect to the maintenance of the social system, entrance into the sick role must be controlled in order to protect against malingerers. This control function is performed by physicians whose aim it is to restore the individual to a health state (i.e., re-equilibration of the individual's status quo).

Historically, doctors gained legitimacy in controlling biological deviance (illness) by virtue of a "license and mandate" (Hughes, 1958) granted to them by society. Accordingly, members of society believed that doctors would utilize their expertise in the service of mankind, and would do so in a responsible manner. Since the medical profession exhibited specialized training and scientific expertise, as well as an orientation towards service (as illustrated in their aim to serve others before serving themselves), society granted the medical profession self-regulatory autonomy (Freidson, 1970a: 83).

Owing to their specialized training and expertise as it pertains to the human body and biophysical processes, and fortified by a professional ideology (Dibble, 1962; Blishen, 1969), physicians became "status definers" in the truest sense, regarding illness. In the realm of health and illness, doctors acquired "power", which permitted

them to impose their "will" (i.e., definitions of health and illness) on others despite resistance from the consumers of health care (Weber, 1968). Moreover, by virtue of their ideology, persuasive tactics, and political efforts, the power of organized medicine has been legitimated within society, thus rendering medical decisions authoritative. Not unlike other elite segments in society, physicians have assumed a position of dominance and therefore censor heterodox views and practitioners who fail to conform to the medical model and "weltanschauung" (Sallach, 1974).

Part of the armamentarium of medical practice (i.e., its social control function) is to locate the source of illness in the individual so afflicted. Following this logic, "the medical perspective focuses on the individual diagnosing and treating the illness, generally ignoring the social situation" (Conrad, 1978a: 77).* Paradoxically, the individual is presumed to be incapable of treating him/herself, and therefore is obliged to consult the experts. Under such circumstances, one finds evidence that not only do physicians rely on their ideology to convince potential patients of their expertise in handling the problems of biological life, but also that this ideology has been sufficiently disseminated to the public so that patients willingly, if not eagerly, invite the aid of the experts. Illich has referred to this process as "disabling dependence" on the

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* This is analogous to "blaming the victim" (Ryan, 1976), where "bandaid remedies" are provided to the individual, which typically fail to correct the pathogenic social environment.

experts (1977). Increasingly, patients are divesting themselves of responsibility for their conditions, leaving all to the experts. Unfortunately, in so doing, patients become vulnerable to direct manipulation by physicians by virtue of the power (or authority) imbalance which exists between any patient and physician. Because of the "push" by patients, and the "pull" by the medical profession, doctors have become agents of social control; and the public remains subject to their control.

> In essence, the process of treatment and care may be seen as a process which attempts to lead the patient to behave in a way considered appropriate to the illness which has been diagnosed, a process often called "management" by professionals . . . Professional management generally functions to remove from the patient his identity as an adult, self-determining person, and to press him to serve the moral and social identity implied by the illness which is diagnosed (Freidson, 1970a: 329-330).

In terms of the social control function of medicine, it is not that the medical profession "manages" illness that is problematical, but rather that physicians are in a position to <u>define</u> what conditions will be considered legitimate forms of illness. Since illness embodies both social as well as physical dimensions (Freidson, 1970a), the physicians' work is, by definition, evaluational if not moral. In this sense, the physician can be referred to as a "moral entrepreneur" (Becker, 1963) in that s/he plays a major role in the assignment of the label "illness" to various conditions, and additionally in terms of the creation of illness as an official social role which human beings periodically occupy. As the sole gatekeeper in matters of health and illness, the medical profession is "the agent

who is absolutely central in determining at the most general level what is to count as illness" (Watkins, 1975: 115/emphasis in original).

In recent years, the definitional role of the medical profession has expanded increasingly, to the point where illness has come to embrace more and more forms of social life, replacing some institutions, and superseding others. The trend which seems to be taking place in contemporary western society is one in which the boundaries of medical practice are changing continually because, in its definitional capacity, the profession of medicine has -- legitimately or illegitimately -- defined more conditions and behaviors as illnesses. This process is referred to as "medicalization". It is interesting to note that medicalization, according to Pitts, "is one of the most effective means of social control and that it is destined to become the main mode of formal social control" (1968: 391/emphasis in original). As medicalization becomes more pervasive,

> the picture of the medical system that emerges . . . is that of some vast, expansionist, and itself uncontrolled regulatory apparatus -- forever advancing the frontiers of its jurisdiction and enfolding more and more citizens into its (always benevolent) supervision. Medical theory aggressively claims new territory as "sickness" (Ehrenreich and Ehrenreich, 1978: 47).

The discussion thus far would seem to suggest that the social control function of medicine is essentially one that is expansionary. However, Ehrenreich and Ehrenreich (1978) contend that the social control function of the medical profession does, in addition, have an exclusionary dimension. Just as the profession may eagerly

crusade to manage certain groups and their "maladies", so too, it crusades to avoid certain other groups and their "maladies" (most notably those persons in the lower echelons of society, and various other persons with stigmata). By excluding individuals from entering into a relationship with a medical professional, social control is exercised: the behavior or person is diverted away from professional management. In sum, Ehrenreich and Ehrenreich have discerned that the two major forms of social control exercised by the medical profession are disciplinary control and cooptative control (1978).

Disciplinary control, or that which is exclusionary by nature, occurs when people are encouraged to maintain their normal role responsibilities, and thus refrain from adopting the sick role. Irrespective of their conditions, people are informed that their condition, regardless of the discomfort and dis-ease they may experience is not an illness or not worthy of medical treatment. Thus, for example, company doctors may refuse to provide sick leave to people in order that they continue their work in industry (Ehrenreich and Ehrenreich, 1978). A more unscrupulous example of disciplinary control is the way in which the medical profession denies the existence of problems of selected groups. Through sheer neglect, and perhaps to a certain extent through intimidation, the lower echelons of society are informed, formally or informally, that their problems are not serious enough to warrant professional assistance. For example, it has been noted that during the 19th and early 20th centuries, while middle and upper class women were virtually under

constant care by physicians because of their inherent frailty, the lower class women were considered to be "robust" enough to work long hours in dangerous environments, needing neither physicians' care nor expertise (Ehrenreich and English, 1973a, 1978; Fidell, 1980).

More recently, the provision of mental health services is influenced largely by the patients' perceived social status. Whereas upper and middle class patients are likely to receive psychoanalysis, group or family therapy, the lower classes tend to be treated with psychotechnologies (Hollingshead and Redlich, 1958). The treatment of persons in emergency wards as well, demonstrates how selective the medical and anciliary health professions can be in the provision of life-saving services (cf. Sudnow, 1970). In general, "low status (patients) will be responded to more severely both in terms of diagnosis and treatment by middle class . . . staff than will middle class patients" (Wilkinson, 1975: 29). That the lower classes and minority groups (especially where socialized medicine is not available) fail to have at their disposal preventive health services,* or services which allow them to maintain some semblance of dignity (Ryan, 1976), is evidence enough to illustrate that the medical profession excludes and discourages people from seeking professional assistance in some matters of health and illness.

Cooptative control, on the other hand, is exercised when individuals are encouraged to seek professional aid, and adopt the sick

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* In general, medicine does not have a health prevention philosophy (cf. Martin, 1978).

(and patient) roles which will facilitate medical management. This encouragement is extended in both sick and nonsick situations. "In so doing they bring large numbers of people into the fold of professional management of various aspects of their lives. It is this situation of professional management -- whether all-inclusive,. . . or partial -- which allows for the exercise of cooptative control" Ehrenreich and Ehrenreich, 1978: 49/emphasis in original).

In exercising cooptative control, the medical profession defines what constitutes disease (i.e., health norms and values), and vis-a-vis their theological (Szasz, 1977) or ecumenical (Dibble, 1962) orientation, influences and ultimately defines the shape of societal values with respect to health and illness. In effect, what cooptative control leads to is an ever greater dependency on the medical profession, its knowledge of health and illness, and its technology (Bush, et al.,1978; Dewar, 1976; 1978; Illich, 1977; McKnight, 1977; Zola, 1977).

Although the existence of disciplinary social control is recognized as a serious social problem in that certain groups in society are effectively excluded from receiving quality care, in the present discussion the scope will be limited to an analysis of cooptative control, its forms and consequences. It is duly noted, however, that disciplinary control is fundamental to the maintenance of the "preferred" medical status quo, as well as the maintenance of structural inequality in society.

Medical cooptative control takes three forms: medical ideology, medical technology, and medical collaboration (Conrad, 1979: 3).

Perhaps the most important aspect of medical control, is the notion of medical ideology. Medical ideology

> involves defining a behavior or condition as an illness primarily because of the social and ideological benefits accrued by conceptualizing it in medical terms. It includes adopting medical or quasi-medical imagery or vocabulary in conceptualizing and treating the problem. Medical ideology uses medical authority by way of language. The latent functions of medical ideology may benefit the individual or the dominant interests of society or both, but are quite separate from any organic basis for illness or any available treatment (Conrad, 1979: 6).

According to this definition, it is through medical language, and only through medical language, that the concept of illness is understood. Only those duly knowledgeable and equipped with the medical vernacular know "what counts as illness". Lay or other declarations of sickness lack authority. As stated by McKnight,

> there is no greater power than the right to define the question . . . When the capacity to define the problem becomes a professional prerogative, citizens no longer exist. The prerogative removes the citizen as problem-definer, much less problem-solver. It translates political functions into technical and technological problems (1977: 85).

Once a condition is located within this medical frame of reference, it is removed from the realm of public discussion, and placed within the hands of a group of certified experts. In the current system of health care, "the medical profession has first claim to jurisdiction over the label illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively" (Freidson, 1970a: 251).

There are a number of components of the medical ideology

which, combined, allow the profession to function as an institution of social control. At its most basic level, the ideology contains certain ideas, beliefs and values regarding the patient role and professional role, the interrelations between patient and physician, between the profession and other groups (e.g., government), and between the profession and society. Clearly, one of the most effective aspects of the medical ideology is to frame notions of health and illness in such a way as to eliminate or significantly reduce the role of the average citizen in handling his/her own affairs. "The language of modernized professional services mystifies both problem and solution so that . . . only people 'competent' to decide whether the servicing process has any merit are professional peers . . . " (McKnight, 1977: 86). Problems are defined in technical terms, thus mandating only those technicians (i.e., doctors) who are capable of handling them to provide solutions. The effect of defining problems in this way is to reduce the individual to a passive and dependent recipient of technical solutions, which s/he can neither understand nor question.

Another important dimension of the medical ideology, which fuels the profession's dominance and control is to locate the source of all problems in the individual (Ryan, 1976). In so doing, the cause and solution of problems are focussed on the individual, virtually neglecting the complex social environment (which may have been a significant predisposing factor in etiology). The combination of the medicalization and individualization processes leads to the depoliticization (Conrad, 1978a) of health problems.

Depoliticization of health problems refers to the process whereby the predisposing social, political or environmental causes of problems are neutralized, precluding the possibility of locating essential etiological factors. For example, the institutionalization of Soviet dissidents in mental hospitals neutralizes the meaning of political protest, thus indicating that dissent from the official world view of the Soviet state is symptomatic to mental illness (Conrad, 1977). Similarly, by medicating hyperactive children, the problematic school environment is relieved of any culpability as a negative or ineffective institution. In a world whose problems are overwhelmingly political in nature, the depoliticization of health (and social) problems functions effectively to maintain the existing social relations (Gerson, 1976). In sum, the depoliticization process limits public discussion, and fortifies medicine's position of dominance. Some have even suggested that framing problems in this way is more "humanitarian", less condemning, and less stigmatizing for the patient (Conrad, 1978b; Zola, 1978). Ultimately, however, depoliticization enhances medical social control.

Dibble (1962) has suggested that professional ideologies contain two types of ideas: those which are "parochial" (i.e., relevant to the particular occupational group itself); and those which are "ecumenical" (i.e., congruent with generally accepted social values). In effect, what the medical profession has done is to disseminate ideas and images of illness and the role of professionals as technical managers which it wishes others to hold. This ideology, in turn, facilitates public sanction for the profession

to perform in whatever capacity it deems appropriate in the interest of "good health". The profession achieves credibility through its ideology because it is portrayed as a group of technically superior experts, who are ethical and moral servants of mankind.

However, since the functions of ideology are to contain strain and establish inter-group boundaries, as well as to justify actions and beliefs, or power (Geertz, 1964), it is not clear that the profession and its ideology are as benign as one would care to believe. In fact, medical ideology is used as a means of social control, developed so that the profession's dominant status may be retained, whatever the cost (social, political or economic). The manifest function of this professional ideology is that a health care system is developed, the aim of which is to provide caring and curing to the sick. The latent functions are that the system controls individuals' lives, reducing them to objects of technical manipulation by an always benevolent group of experts, and moreover that this system operates as a vehicle for the entrenchment and reinforcement of social values -- values which reflect the interests of some groups to the exclusion of others.

Medical technology includes those methods and practices utilized by the medical profession to contain illness. The most notable examples of medical technology include psychotechnologies (e.g., drugs and behavior modification techniques used in handling any array of "deviant" conditions), drugs of various sorts used in general treatment and therapy, equipment (including such simple devices as the stethoscope and such complex instruments as the electro-

cardiograph which monitors contractions of the heart), and a wide assortment of surgical procedures. In all cases, this technology is intended to supplement and complement the physician's theoretical base of knowledge in managing illness. In a subtle manner, this medical technology or technique (to use Ellul's terminology, 1964) equips the medical profession with the means for achieving a desirable end: the enforcement of a medical status quo through technology.

That a specialized technology or technique has been developed (by the scientific research community -- and not medical practitioners, the principal users of the technology) is important in a number of respects. Most notably, this immense technology has become the sole "property" of medical practitioners. Informed by a very specialized training program, grounded in the university setting, the medical profession produced a situation in which only those appropriately trained were deemed competent in the use of these tools. Therefore, a condition of dependency among the entire patient population was produced. Keeping the tools under the control of the profession resulted in a situation in which anyone in need of treatment was obliged to seek the aid of only those who were seen as technically competent in operating this technology and managing illness; i.e., the medical profession. As such, medical technology furnished the profession with an important mechanism for controlling illness and maintaining a medical status quo. This technology, moreover, limited individuals' autonomy in dealing with the problems experienced in daily life: "having come to demand what institutions can produce,

we soon believe that we cannot do without it" (Illich, 1973: 19). Patients no longer (or minimally) consider themselves capable of dealing with the problems associated with daily life.

Finally, medical collaboration involves the association of medical experts with other agents of social control in the location and custody of the ill. For example, in contemporary society, both the professions of medicine and the law deal with mental illness (Melick, et al.,1979); both educational authorities and the medical profession handle problem children in the classroom (i.e., hyperkinetics) (Conrad, 1978a; 1978b); both social workers and the medical profession deal with violence in the family and other forms of social deviation (Kempe,et al.,1962; Pfohl, 1977; Wiseman, 1970); and so on. As stated by Conrad,

> medicine acts not only as an independent agent of social control, but frequently medical collaboration with other authorities serves social control functions. Such collaboration includes roles as information provider, gatekeeper, institutional agent and technician. These interdependent medical control functions highlight the interwoven position of medicine in the fabric of society (1979: 4-5).

There are two aspects of medical collaboration which are of interest in the present discussion. The first, primarily a "gatekeeping" function of medicine, concerns the definition of illness and the accompanying sick role. The second dimension involves interprofessional relationships in the management of those conditions defined as illnesses. Although Conrad discusses medical collaboration exclusively in terms of the cooperative efforts of medicine and other agents of social control, in the present context, it is contended

that a more comprehensive and inclusive articulation of the concept of medical collaboration is required. In some cases, it became possible for the medical profession to exert control in matters of health and illness only after other potential agents of social control or illness managers had been denied authority to handle legitimately specific conditions.

Therefore, while collaboration is indeed a significant dimension of medicine's social control function, it is vital that one recognizes that conflict between competing managers be considered in any discussion of the social control of illness. Such a broad conceptualization offers a more all-encompassing perspective on this aspect of social control. As well, adopting the notion of "interprofessional relationships" in illness management allows one to trace historically the manner in which medicine ultimately arrived at its current position of dominance in the health care system. It is suggested that medicine's current independence must be analyzed in terms of its previous interdependence and conflicts with other practitioners.

For the purpose of clarification, the notions of medical ideology, medical technology, and medical collaboration (hereafter referred to as interprofessional relationships) have been analytically separated. In reality, all of these types of social control work in concert so as to reinforce professional dominance in health care. Through the primary process called "medicalization" (which involves not only the definition of problems in medical terms, but as well,

the nature of technical solutions, the role of the patient as passive recipient, and the profession as the only competent advisor and therapeutic agent), medicine has become a major institution of social control. By relying on scientific explanations and justifications, medicine has become "the new repository of truth" (Zola, 1978: 80). Moreover, as a major institution of social control, "medicine becomes a de facto agent of the status quo" (Conrad, 1978b: 88).

CONCLUDING REMARKS: PROPOSING A THEORY OF MEDICAL SOCIAL CONTROL

To return to the opening theme of this thesis, medicalization, in particular, and medical social control, in general, are evidence of the desire on the part of laymen and professionals to depend on science to solve human problems. Contemporary mankind has been socialized according to "scientistic" values: "the worship of science in general and technology in particular" (Charmaz, 1980: 104). Once an issue is shrouded in the "objective" and "morally neutral" language of science, it is elevated to a position beyond public scrutiny (cf. Hayek, 1952).

This process is relatively new, and is becoming more pervasive. Western society has become a most fertile ground for medicalization. Western society has a "fetish" for new, innovative, scientific, and pragmatic solutions to human problems (Conrad and Schneider, 1980a). As such, it is in this society that the predominant values have facilitated medicalization to an extent unheard of elsewhere. The unanticipated consequences of this trend have been the creation of

passivity and dependence among health care consumers, and a growing distance between consumers and producers of health care.

In the ensuing discussion, an attempt will be made to explore the many faces of medical social control, the role of scientism as a dominant force in society, and the implications of not only the medicalization of deviance, but also the medicalization of conditions which are inherently normal and natural. What follows is an inquiry into the expanding boundaries of medical expertise, using childbirth as the example.

As a guide for this inquiry, the following propositions are offered:

1. A characteristic feature of all societies is the creation of social control mechanisms. Regardless of the context within which social control mechanisms emerge, their function is to channel human activity and thought in accordance with specifiable behaviorial expectations, thus maintaining the prevailing status quo. The primary force utilized to legitimize both the mechanisms of social control, as well as the status quo, is ideology.

2. Medicine, in western industrialized nations such as Canada and the United States, is an institution of social control which is mandated to secure conformity to health "norms". As such, the profession controls entrance into the sick role, as well as the determination of what constitutes health and illness.

3. In recent years, more and more forms of life have been subsumed under the heading of "illness". This process is referred to as medicalization, and represents the most effective strategy used by the medical profession to ensure its dominance in health care as well as the maintenance of the status quo.

    3.1 A number of behaviors and conditions having non-biophysical origins have been medicalized recently and increasingly normal and natural conditions such as pregnancy and childbirth have been medicalized

as well. As such, all stages of the childbearing process are considered, if not pathological, potentially disease-like medical problems. (Chapter 2)

4. Once a behavior or condition is situated within the medical framework, it is removed from the realm of public discussion. Moreover, the designation of a condition or behavior as a technical (i.e., medical) problem in turn mandates the utilization of technical solutions to effect resolution of the condition. Through the monopolization of technique, the profession of medicine exercises social control.

   4.1 Pregnancy and childbirth, having been medicalized, also have been technologized to a greater or lesser extent by the medical profession. As such, these conditions tend to be "diagnosed" and "treated" by the medical profession and are managed in the hospital, where technicians and technical solutions are easily accessible. (Chapter 3)

5. Through its control over medical language and technology, as well as through its political lobbying and persuasion, the profession of medicine has risen to the apex of the medical division of labour. As such, it has been afforded the authority to determine who will be considered a legitimate practitioner in health care.

   5.1 Because pregnancy and childbirth have been medicalized and technologized, the medical profession has determined that the most competent technicians are obstetricians. As a result, there is no place for midwives, traditional birth attendants. (Chapter 4)

In the following chapter, medical ideology will be examined. Subsequent chapters will center on medical technology and interprofessional relationships. Following the theoretical and socio-historical discussions of each of the types of medical social control, empirical data will be presented documenting the extent to which the profession of medicine exercises social control as it pertains to pregnancy and childbirth.

Chapter Two
Medical Ideology:
Pregnancy as Pathology -- The Transformation of Birth Through Language and Technique

In the discussion which follows, medical ideology will be analyzed. However, before discussing the medicalization process which has transformed perceptions of pregnancy and childbirth, it is essential that one first situate the prevailing medical ideology within the broader context of ideology in society. Following a brief review of the concept of ideology, the ideology of medical care will be reviewed and evaluated. Finally, the chapter will conclude with a discussion of medicalization as a form of social control and the medicalization of birth in particular. As implied in the title of this chapter, the aim is to demonstrate that medical ideology, even in the face of competing paradigms, has effectively altered the way birth is defined both by professionals and laymen.

THE CONCEPT OF IDEOLOGY

As has been noted previously, the major purpose of institutions of social control is to ensure the maintenance of a particular status quo. In western industrialized societies such as Canada and the United States, the State (i.e., political institutions), the economy, the law, religion, educational institutions, and the family all function, directly or indirectly, to ensure the channelling of human behavior and thought in accordance with normative expectations. Individuals are permitted various freedoms in daily life, however only insofar as their freedom of action does not infringe upon the

freedoms and rights of others. Ultimately, the system is believed to accrue certain benefits, in that some semblance of "order" is maintained. Whose order, however, is maintained? The answer to this query is that the order of those in positions of power is maintained. The persons in power are the ruling classes, and by using ideology, their control is maintained, as is the status quo (Alford, 1975; Domhoff, 1978; Marx, 1978; Sallach, 1974).

Ideology may be defined as a belief system that is created and used by a group of persons to advance beliefs which they wish others to hold with regard to a particular order or aspect of it. Marx has referred to ideology as the rule by ideas or abstractions (Marx, 1973: 164-165).

> The ideas of the ruling class are in every epoch the ruling ideas: i.e., the class which is the ruling material force of society, is at the same time its ruling intellectual force. The class which has the means of material production at its disposal, has control at the same time over the means of mental production, so that thereby, generally speaking, the ideas of those who lack the means of mental production are subject to it. The ruling ideas are nothing more than the ideal expression of the dominant material relationships, the dominant material relationships grasped as ideas; hence of the relationships which make the one class the ruling one, therefore, the ideas of its dominance. The individuals composing the ruling class possess among other things consciousness, and therefore think. Insofar, therefore, as they rule as a class and determine the extent and compass of an epoch, it is self-evident that they do this in its whole range, hence among other things rule also as thinkers, as producers of ideas, and regulate the production and distribution of ideas of their age: thus their ideas are the ruling ideas of the epoch (Marx, 1978: 172-173/emphasis in original).

Gouldner refers to ideology as "rhetoric of rational discourse" (1976: 197). He suggests that the concept of ideology is only comprehensible in terms of the bourgeois order, because it is in the

bourgeois order that ideologies were first created. For Gouldner, as for the present discussion, "those who want to talk 'ideology' must also talk 'property'" (1976; 197).

The history of ideology dates back to the French Revolution (circa 1789 - 1848). This period of time, an era of great transition and change, was when the reason and pure thinking of man were glorified by liberal ideologues. By disseminating the notions of freedom, liberty, utilitarianism, the independence of the State as an arbiter between adversaries and so on, the bourgeoisie was able to mobilize the masses via a rhetoric which was intended to be publicly persuasive (Gouldner, 1976; Lichtheim, 1967). The public was effectively convinced that "equality for all", for example, meant just that, and furthermore that an end to the sanctioned privilege of nobility had been achieved.

This, however,is not to suggest that the problem of domination by the elite segments of society had been obliterated. Rather, one finds that the ideology that was developed tended to blur or conceal the perpetuation of a system of domination. As Gouldner suggests, subordinates tend to internalize the beliefs and definitions of reality espoused in ideologies, and unwittingly and spontaneously submit to the hierarchies of domination. Although they believe they are free, masses are still in chains.

This brief historical review of the genesis of ideology functions as a preface to the ensuing discussion, because the power of ideologies in general, and more specifically within the field of health, has changed little over time. Today, as in yesteryear, "ideologies

facilitate the production or maintenance of some power hierarchies" (Gouldner, 1976: 206). Those in control of the political economy, retain control over all other forms of production, including mental production and ideology. By generalizing their particularistic interests into a universalistic framework the elite exercises and justifies its power (i.e., the elite exercises social control).

> The dominant class uses its privileged access to ideological institutions to propagate values which reinforce its structural position. Such propagation involves not only the inculcation of its values and the censorship of heterodox views, but also and especially the ability to define the parameters of legitimate views . . . The most effective aspect of (their ideological) hegemony is found in the suppression of alternative views through the establishment of parameters which define what is legitimate, reasonable, sane, practical, good, true, and beautiful (Sallach, 1974: 165-166/emphasis in original).

For any elite group, the creation of an ideology only serves as "a mask and a weapon . . . (in) a universal struggle for advantage" (Geertz, 1964: 52). In modern society, the professions, for the most part, form a segment of the elite, and as such create ideologies to sustain their advantage in the social division of labour and in society in general. In the discussion which follows, the ideology of organized medicine will be examined as a particular form of bourgeois ideology. The purpose of this analysis will be to ascertain what the basic components of the medical ideology are, how this ideology is manifested, and the implications for the health care system and the wider society. Moreover, an attempt will be made to illustrate that this medical ideology has been used to promote the idea that certain conditions (pathophysiological or otherwise) need to be defined within the medical frame of reference, therefore providing

the profession with a mandate to operate as an institution of social control. More pointedly, medical ideology is utilized to "medicalize" certain aspects of social life. First, however, some preliminary remarks are in order on the genesis and functions of ideology in general, and specifically for the profession of medicine.

There are a number of reasons for the genesis of ideologies, whether social, political, or economic. Most commonly, ideology emerges as a response to strain; i.e., as a coping mechanism. "Ideology is a patterned reaction to the patterned strains of a social role. It provides a 'symbolic outlet' for emotional disturbances generated by social disequilibrium" (Geertz, 1964: 54). As such, it may provide specific actors within certain situations or relationships with the means by which to establish symbolic boundaries (as in the "we-they" dichotomy), in turn, giving rise to cohesive and solidary units of reference (cf. Dunkerley, 1975: 36-38). Through such strategies, the ideology serves to legitimate (or at least lends support to) one group, while discrediting the opposition. At the same time, the ideology provides the major protagonists with a frame of reference which is all-encompassing and doctrinaire.

THE IDEOLOGY OF MEDICAL CARE

In discussing the ideology of professional medicine, Blishen has noted that this ideology,

> consisting of a set of ideas, values, and beliefs concerning the nature of the professional role, its relationship to other roles, and to the society, attempts to resolve the conflicting demands and strains facing the professional in a changing society (1969: 22).

The ideas contained in the ideology of the medical profession are of two types. The first are parochial ideas, relevant to the particular occupational group itself. Coupled with these parochial ideas, there are ecumenic ideas tailored to social values and sensitive to laymen's concerns (Dibble, 1962). Where professions have highly developed ideologies (as in medicine), the ideas included will be less parochial, and if parochial ideas do exist, chances are that these ideas will be almost indistinguishable from ecumenic ideas. That is, the medical profession has "generalized parochial ideas so as to make them applicable throughout an entire society" (Dibble, 1962: 234).

The overall effect of creating an ideology which is congruent with generally accepted social values (e.g., the sanctity of health, humanitarianism, etc.) is the easy dissemination of the profession's ideas throughout the ranks of society. As such, the ideology facilitates public sanction for medical practitioners to perform in whatever capacity is deemed appropriate in the interest of mankind. Furthermore, the profession creates the means by which to eliminate and discredit other practitioners who fail to conform to the requirements and/or standards espoused by the profession. The profession, thus, enhances its credibility from the perspective of its audience. By successfully "propagating images of themselves which they wish others to hold" (Dibble, 1962: 240), the medical profession in North America raised itself to the apex of the occupational hierarchy in society, and has achieved a special position in terms of wealth, status, and power in everyday life. The profession gained a "license and mandate"

(Hughes, 1958) to control its work, and was supported in this respect by members of society who believe in the superior technical skill and ethicality of members of the profession of medicine.

The ideology of the medical profession is not all that different from the ideologies of other professional groups. There are basically two elements of the ideology which give all others meaning. The first concerns the claim to expertise based on a body of abstract, esoteric knowledge. It is asserted that such expertise rests on a solid scientific foundation (which in society today is sanctified and beyond scrutiny -- cf. Hayek, 1952). The second component of the ideology is the claim that doctors utilize their expert knowledge in the service of mankind. Accordingly, modern scientific medicine claims to be a humane, effective and desirable means by which to achieve health in society (Freidson, 1970a; 1970b).

These two aspects of the professional ideology of medicine find expression in a number of forms. Blishen, as a result of a survey of the official statements of the Canadian Medical Association from 1943 through to 1965, determined that there are at least eight major themes in the ideology of organized medicine. These include: professional control and self-government, freedom, quality of medical care, public responsibility, privacy, personal responsibility, voluntary participation, and universal availability (Blishen, 1969: 150-163). Although many of these themes operate simultaneously, for the sake of clarity, each theme will be discussed separately.

Professional Control and Self-Government

The substance of this theme is summarized in the following statement: "The competence and ability of any doctor is determined only by professional self-government" (The Canadian Medical Association Statement on Medical Services Insurance, 1960 cited in Blishen, 1969: 187). According to this proposition, only those appropriately trained to evaluate medical services (i.e., doctors) shall be in a position to do so legitimately. Therefore, neither third parties, government, insurance companies, nor laymen are considered to be equipped with the knowledge to criticize or scrutinize medical practice. The tone of urgency regarding professional independence is made clear in the following statement by the Canadian Medical Association: "it is not in the patient's interest that the State invade the professional aspects of the patient-doctor relationship" (Principles Relating to Health Insurance Approved by the General Council of the Canadian Medical Association, 1944 cited in Blishen, 1969: 180/emphasis mine).

Only members of the profession are considered sufficiently competent to define the terms and conditions of professional work, as well as the method and amount of remuneration they will receive for professional services. Regarding the former, the profession reserves the right to define its authority within the health care hierarchy as a function of its superiority in skill and technical know-how. As such, all other paramedical personnel work under the direction of the medical profession. Regarding the method and amount of payment for services rendered, the profession contends that the

salience of their services are such as to justify "rewards for achievement" (Blishen, 1969: 154) such as income and status.

In essence, the professional control and self-government theme represents the profession's claim to self-governing autonomy (Freidson, 1970a). Autonomy is obtained via a political process in which the profession makes certain claims (for example that their technical expertise is superior to that of other would-be health professionals and that this expertise will be utilized to deal with the most intense crises faced by mankind) which the political elite considers sufficient to warrant professional self-regulation.

Intuitively, the notion that only those knowledgeable in a specific field should be able to evaluate legitimately their colleagues' work would seem to be reasonable. However, in an area so vital as the health services, it seems equally plausible that recipients of health care services should be able to evaluate the care they receive, at least so that they can avoid the possibility of manipulation by professionals. In light of the fact that physicians have a vested interest in the evaluation of the terms and conditions of their work, it would seem reasonable that external evaluation should be welcomed as a countervailing mechanism against physicians' innate "conflicts of interests".

To allay any fears among the populace as to the validity of the profession's autonomy, a number of mechanisms for internal control of practitioners have been established by the profession (Freidson, 1970a). Perhaps the most critical is the creation of codes of ethics and standards of good practice. These are intended to be evidence of the profession's desire to ensure quality services and technical

efficiency among practitioners, and furthermore to promote trust and confidence among the laity. Although such regulations and standards are codified, the extent to which they are enforced is unclear. When these standards are enforced, their impact is questionable (cf. Freidson, 1970a: 185-201). However, that they do exist appears to be reason enough in the minds of some members of society to grant the profession autonomy.

Another example of the profession's determination to internally control its members is the creation of standards for recruitment and selection of prospective practitioners in medical schools. Only the "best" students are admitted and once in the system, they are expected to perform at a level well above average. As well, during medical training, medical students are socialized into the role and responsibilities of a physician (cf. Becker, et al., 1961; Merton, et al., 1957). Upon completion of this education experience, the profession determines who will be granted a license to practice. Each of these internal control mechanisms exercised by the profession serves to persuade the public that only qualified personnel will practice medicine, and that the profession has an array of internal controls to ensure technical competence in the provision of health services.

Furthermore, the profession promotes the idea that it offers a unique service. It is, therefore, "likely to proclaim openly that its rivals are either charlatans, that is, not properly trained, or encroachers, that is, illegal competitors" (Goode, 1960: 904). In this way, it defines who should be recognized as a legitimate prac-

titioner, and thereby secures a monopoly within the medical division of labour.

All of the factors noted previously, as well as various others, are instrumental in securing legal sanction for the profession in the form of technical autonomy. Insofar as the medical profession has convinced the leaders of society that it offers a unique service to humanity,and that moreover the profession actively regulates itself, the state creates mechanisms to ensure that the profession maintains a monopoly in health care, and is a self-governing, autonomous body.

Freedom

The idea of freedom in the ideology of medical care suggests that both patients and doctors should be able to exercise free will and choice as consumers and providers of health care. Therefore, patients are free to choose the kinds of services best suited to their needs as well as from whom they will obtain services. In addition, presumably patients are free to refuse treatment. The medical profession also is at liberty to decide who will receive treatment as well as the kinds of services to be provided

The emphasis on freedom -- an ecumenic idea -- in the professional ideology functions as an effective means of legitimation because freedom is one of the most widely cherished values in a democratic society. "By emphasizing freedom as a value -- the medical profession once again legitimizes its status as a free, autonomous, self-governing profession" (Blishen, 1969: 155).

It is important to note that the freedom of patients is deter-

mined in large measure by the profession of medicine itself. After all, the ideology of medical care suggests that patients are, by their very nature, ignorant when it comes to understanding the many dimensions of illness and etiology, as well as alternative treatment modalities (McKinlay, 1975). Notwithstanding the many conceptual and methodological problems common to research on patient understanding of medical phraseology, there is ample evidence from past and recent research (cf. Pratt, et al., 1957; Segall and Roberts, 1980) to suggest that physicians generally underestimate patients' levels of comprehension of medical information. Assuming that the findings reported by Segall and Roberts (1980) are valid and reliable, there is reason to believe that today's patient community is in a position to make more informed decisions in the patient-doctor relationship than in times past.*

On the other hand, the literature on ideology presents a forceful argument suggesting that even when individuals (i.e., subordinates)

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* Presumably, an increased level of comprehension of medical language and heightened awareness of medical conditions among patients has occurred as a result of numerous factors. It is doubtful, in light of the findings presented by McKinlay (1975) and Segall and Roberts (1980), that physicians are responsible -- even remotely -- for an increase in patients' level of understanding with respect to medical language. The proliferation of self-help groups and manuals in recent years (cf. Boston Women's Health Book Collective, 1979; Kleiber and Light, 1978; National Women's Health Collective, 1980a; 1980b; 1980c; 1980d; 1980e; 1980f; 1980g; 1980h; 1980i; Ruzek, 1978), as well as increased formal education (Haug, 1975; 1976; 1977), however, may help account for heightened medical sophistication among patient populations. Since freedom to make decisions in any therapeutic relationship is influenced by what patients know, it is necessary to comment on the role of the self-help movement as a competing ideology in health care. Following the discussion on medical ideology, the self-help movement and its ideology will be considered at length.

believe that they are free,it is questionable that this is so. For example, Laing, in discussing the bourgeoisie's tendency to "mystify" the nature of exploitation in capitalist society, has noted that

> by representing forms of exploitation as forms of benevolence the exploiters bemuse the exploited into feeling at one with their exploiters, or into feeling gratitude for what (unrealized by them) is their exploitation, and, not least, into feeling bad or even mad to think of rebellion. (cited in Mehl, 1979: 26).

Thus, there is reason to believe that, by emphasizing freedom in the doctor-patient relationship, the profession of medicine, perhaps as much or more than patients is the beneficiary. It is the profession of medicine which attains credibility as a humane service organization. Although some -- but not all -- patients may participate more actively in the therapeutic relationship, it is still the doctor who is in control. The incorporation of "freedom" in the medical ideology serves to justify the exercise of power by medical personnel (Gouldner, 1976: 207).

Quality of Medical Care

Quality of medical care is significantly affected by the supply, availability, knowledge, and skills of physicians. While the profession is in agreement with the idea that "the highest standards of medical care should be available to every resident" (The Canadian Medical Association Statement on Medical Services Insurance, 1960 cited in Blishen, 1969: 187), it is equally cognizant of the fact that quality can only be assured if the profession is free to determine the conditions and terms of its work, or the social organiza-

tion of medical practice. Again, in an attempt to gain support for their ideological claims to autonomy, physicians proclaim that "the profession's control over working conditions is in the public interest" (Blishen, 1969: 158/emphasis in original), and furthermore that quality will be maintained only through the various internal controls established by the profession.

The issue of quality of care, despite claims by the medical profession, is problematic. There is a growing body of literature (cf. Ehrenreich, 1978; Kotelchuck, 1976; Waitzkin and Waterman, 1974) which suggests that it is questionable whether any significant improvements in the standards of health of the United States (and inevitably in most other countries) are attributable to personal medical care. On the contrary, improved nutrition and housing, as well as a "safer" environment have been more instrumental in reducing mortality and morbidity (Dubos, 1979).

This rather dismal evidence regarding the efficacy of medical care has led a number of health care analysts to conclude that "modern medical care was and is, at best, much less effective at reducing morbidity and mortality than the doctors have claimed and most people have believed" (Ehrenreich, 1978: 12). Nonetheless, the inclusion of the theme concerning quality of medical care in the medical ideology demonstrates the good intentions of the profession. Furthermore, the emphasis on quality of care represents another example of the attempt by the profession to gain public support for its ideological claims (Blishen, 1969: 159).

Universal Availability

> To suggest that health is a privilege is also to suggest that sickness is also an individual matter. An effective socially oriented health system must challenge the "privilege" of the individual to be sick and regard that sickness as a detraction from the total society. A social concept of health requires we move past the atavistic concept that health is a privilege, beyond the reformist concept that health is a right, to the socially determined concept that health is an obligation (Levin, 1974: 43-44).

Social inequality is a ubiquitous feature of capitalist societies (Bottomore, 1966; Domhoff, 1978; Forcese, 1975; Marx, 1964; 1978; Marx and Engels, 1979; Sallach; 1974). Nonetheless, the notion that medical services ought to be available on an equitable basis irrespective of one's ability to purchase such services would seem to be an inoffensive notion to most persons. The medical profession, least of all, would dispute the virtues of universal availability. Blishen's review of statements by the Canadian Medical Association substantiates the profession's belief in the concept of universal availability (1969: 179-191). For example, in 1960 The Canadian Medical Association Statement on Medical Services Insurance proposed that "the highest standard of medical services should be available to every resident of Canada . . . regardless of age, state of health or financial status" (cited in Blishen, 1969: 187).

"Universal availability" is another example of the incorporation of an ecumenic idea into the professional ideology of medical care. The inclusion, however of the concept of universal availability should not be taken as evidence that all persons receive medical care in an equitable and unbiased manner.

Even in Canada, where medical services are publicly funded, social class influences the distribution of health services. Facilities, in general, do not provide for equality in either the distribution or quality of medical services. "Class in Canada is . . . a matter of . . . some people having too much, and others insufficient . . . Medical care may be guaranteed all Canadians, but the ease and promptness of treatment and the expertise, are not equally distributed" (Forcese, 1975: 83-87). In discussing the American health care system, Ryan makes a compelling indictment of health care services:

> Like good cars, good homes, and good education, good health is a commodity in the American marketplace -- for sale to the highest bidder. The poor are less healthy for the same reason they have less of everything else; they can't afford to buy health (1976: 166).

Berkanovic and Reeder (1974); Sudnow (1970) and various others (cf. Britt, 1975; Duff and Hollingshead, 1968; Hollingshead and Redlich, 1958; Rowden et al., 1970) have commented on the extent to which the concept of universal availability (and/or treatment) in health care is a fallacy. Nevertheless, the profession's inclusion of this concept apparently satisfies both officials and the public, who would like to believe that the profession will direct its efforts toward improving the availability of services. Having granted the profession autonomy, the public is persuaded through medical ideology that this idea will be realized in medical practice.

Voluntary Participation

Like most other themes in the ideology of medical care, voluntary participation represents a value shared by most Canadians.

Repeatedly, the Canadian Medical Association has stressed the desirability of physicians having the right to choose whether or not they will participate in government-sponsored medical care (see, for example, The Canadian Medical Association Statement of Policy on Medical Services Insurance, 1965 cited in Blishen, 1969: 190). The profession also supports a patient's choice of physicians within and outside the publicly-funded medical system. From the standpoint of the profession, independence from restrictions on both patients' and physicians' freedom to participate in publicly funded health insurance is essential so as to avoid compromising the quality of care.

Public Responsibility and Private Responsibility

Depending on the society under discussion, the emphasis on public, as opposed to private, responsibility in medical care will vary. In Canada, where there is a long historical tradition of active government support of certain institutions, public responsibility is stressed more frequently than private responsibility (Blishen, 1969: 142). In the United States, by comparison, "health is a private entrepreneurial matter between physician and patient" (Levin, 1974: 3). Presumably, the notions of private and public responsibility are included in the ideology of medical care in both countries, however the emphasis on one as opposed to the other varies. Regardless, these themes represent basic societal values in both countries. By affirming these ideas, the profession again demonstrates its predisposition toward upholding coveted values espoused by the citizenry of a country. Moreover, it justifies the desirability of professional autonomy.

Privacy

The doctor-patient relationship is a very special one in which the patient is obliged to reveal any details (physiological or otherwise) which are perceived by the "objective", "morally neutral" professional as being relevant to the condition (Ehrenreich and Ehrenreich, 1978; Parsons, 1951). (The converse is of course not true.) Confidence and privacy are the mainstays to the stability of professional-client relationships. To ensure that the sanctity of this relationship is not preempted, the profession emphasizes the importance of privacy (another societal value), and likewise considers external interference or control inappropriate. For example, in 1944 in Principles Relating to Health Insurance Approved by the General Council of The Canadian Medical Association, the profession cogently stated that "it is not in the patient's interest that the State invade the professional aspects of the patient-doctor relationship . . . this relationship . . . implies also maintenance of the confidential nature of medical practice" (cited in Blishen, 1969: 180). These themes, although presented some 37 years ago, are still very current in the modern health care system. As in all of the aforementioned themes, the ideology of professional medicine repeatedly reaffirms the salience of autonomy to guarantee that the maximum caliber service will be given to all who request it.

Recapitulation of the Ideology of Medical Care

As demonstrated in this review of the themes of medical ideology, in the final analysis, the crux of the matter is professional autonomy.

Through its ideology, the medical profession has isolated the practice of medicine from other would-be practitioners and has insulated itself from external control or criticism simply because the profession maintains that its autonomy is restrained by responsibility. Through a complex of various ideas -- some ecumenic and others parochial -- the profession portrays itself as a group of humanitarian practitioners using technical expertise in the most efficacious manner.

However, as has been noted, the effectiveness of the profession's internal control mechanisms remains unclear (cf. Freidson, 1970a: 359-382). Insofar as the profession has secured an autonomous position which frees it from lay evaluation and control, it can be said that the professional ideology of medicine is based on "professional fictions" (cf. Smith, 1962). While these fictions help the practitioner in his day-to-day functioning both with clients and colleagues, these fictions may similarly sensitize the layman to the problem of professionalism. There is a danger, Freidson contends,

> when outsiders may no longer evaluate the work by rules of logic and the knowledge available to all educated men and when the only legitimate spokesman on an issue relevant to all men must be someone who is officially certified (1970b: 160).

Upon critical reflection, it is apparent that the problem of professionalism is a natural outgrowth of a system which permits certain groups to be elevated to a position beyond recrimination. The problem of professionalism must, therefore, be analyzed within the context of capitalism, as it is the general social milieu and the prevailing social values which give any system of beliefs, including the ideology of organized medicine, any meaning (Mannheim, 1936).

It is asserted that professionalism, the belief in technical superiority, and professional privilege represent variants of the capitalist bourgeois ideology and the concomitant status this ideology permits.

Professionalism

> serves a legitimating function and contributes to the perpetuation of existing social arrangements. It . . . combines in characteristic form diverse elements which are either acquired or confirmed in the passage through academic systems. With specific variations, these elements constitute an ideological complex which may well be the most significant common trait shared by the diverse and otherwise incomparable occupations that claim professional status (Larson, 1979: 613).

In health care, some of the consequences of professionalism include: the commodification of health needs and the subsequent fetishization of health as a commodity (McKinlay, 1977; Marx, 1978; Navarro, 1976)*; maldistribution of health services such that economic and social barriers are created thus reinforcing a system of social inequality (Ryan, 1976); expansion of the boundaries of professional expertise to the point where medical definitions transcend the social, political, and economic spheres of life as well as those directly relevant to classical medical expertise (i.e., reference here is to the medicalization of social life and the

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* Marshall's point is well-taken when he asserts that "all this insistence on service and on ethical obligations is a mere camouflage to diguise the purely selfish desire to create an artificial scarcity and to win the material and immaterial advantages which scarcity can confer" (1939: 327).

"moral entrepreneurial" role that the medical profession has come to assume in recent years -- cf. Ehrenreich and Ehrenreich, 1978; Illich, 1977; Zola, 1977; 1978); and the increasing institutionalization of medicine as an agent of social control (Conrad, 1978a; 1978b; 1979). Like Mills' "power elite" (1956), the medical profession today assumes a position of power in society. Moreover, the power of the medical profession is legitimated via state and public sanction (cf. Weber, 1968).

Through the creation of medical ideology, the profession ensures that its definitions of reality relative to health and illness are retained. Moreover, by presenting its particularistic ideas as universal values, the ideology of medical care is easily disseminated.

> Given the ability to influence general information-processing rules, and specific definitions of reality, the dominant group (in this case, medicine) can now get others to do as it wishes without being compelled either to resort to force or to issue direct orders. Once someone complies with the rules of behavior and accepts the conception of reality favoured by others, then he will willingly and "spontaneously" behave in ways that the latter wishes, without having to be forced or ordered to do so . . . "Ideology helps support an elite and to justify the exercise of power" . . . (Gouldner, 1976: 206-207/emphasis in original).

As a result of ideological hegemony, the profession of medicine attains and maintains control over the organization and delivery of health services. "The presumably benevolent purposes of the medical endeavor provide an unusually opaque disguise for the sometimes antagonistic social relations built into it" (Ehrenreich, 1978: 17).

Furthermore, through its ideology, the medical profession secures

a "monopoly of credibility" (Larson, 1977: 17). The autonomy of the profession is thus explained in terms of its technical-scientific superiority and service orientation, and allows the profession to emerge as the dominant profession in the health care system. In turn, the profession (was and) is afforded the opportunity to define situations relevant to its practice. Through the use of language, then, the profession operates as a social control institution.

Freidson has discussed the ideological component of medical language as follows:

> In the case of medicine, a strategic facet of its authority is its delineation of pathology, the definitions of health and illness that guide the application of knowledge to human ills. The physician is the ultimate expert on what is health and what is illness and on how to attain the former and cure the latter. Indeed, his perspective leads him to see the world in terms of health and illness, and the world is presently inclined to turn to him for advice on all matters related to health and illness regardless of his competence . . . The public has even been inclined to ask the profession to deal with problems that are not of the biophysical character for which success was gained from past efforts. What were once recognized as economic, religious, and personal problems have been defined as illness and have therefore become medical problems (1970b: 147).

Clearly, the medical profession has become the most authoritative status-designation group in society concerning matters of health and illness. It is the sole agent with the capacity to determine what constitutes illness.

As noted in the above quotation from Freidson's work, medical definitions have come to embrace more and more forms of social life. It is worthwhile, then, to review the forces of "medicalization" in contemporary society, and to this end, the remainder of this discussion

will be devoted to the medicalization process (in general, and with respect to pregnancy and childbirth, in particular) operated and controlled by the profession of medicine.

MEDICALIZATION AS A FORM OF SOCIAL CONTROL

Pitts has suggested that "medicalization is one of the most effective means of social control and that it is destined to become the main mode of formal social control" (1968: 391/emphasis in original). By defining conditions within the medical frame of reference, these problems are elevated to a level beyond public discussion, and thus are reserved solely for professional management. As a result, solutions are similarly defined (see Chapter 3), as well as the relevant service-providers (see Chapter 4).*

Both presently and in the past, the labels "healthy" and "ill" have been effectively attached to an array of "deviant" conditions. As such, problems previously imbued with legal, moral or social values have been redefined in medical terms. For example, whereas criminal culpability was previously determined within the courts, today, this becomes a matter to be decided by the medical and legal professions. Deviants are no longer necessarily "criminal", rather they are "sick" (Melick, et al., 1977; Szasz, 1970). Similarly, disruptive children in the classroom are redefined as "hyperkinetics"

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* As will become apparent in the ensuing chapters, the effectiveness of medicine as an institution of social control ultimately rests on the successful dissemination of its ideology.

(Conrad,1978a) in need of medical rather than disciplinary attention. Drug addicts and alcoholics are also defined as sick rather than social deviants (Szasz, 1977). Violent parents and others who abuse children are similarly handled by medical experts, as well as social service and legal authorities in contemporary society (Kempe, et al., 1962; Pfohl, 1977). Welfare recipients and those who do not want to work in a very achievement-oriented society, rather than seeing themselves as failures define their behavior -- or lack of behavior -- as a sickness (Cole and LeJeune, 1972).

Because western society has become secularized, the church no longer can exert the control it once did. As within the legal-social questions previously considered, moral questions have been redefined as medical problems. Abortion, suicide (Szasz, 1977) and euthanasia (Charmaz, 1980) have ceased to be questions for spiritual leaders to resolve. The profession of medicine now decides when life begins and ends.

Each of the above examples points to the profession's success in medicalizing deviance. Wittingly or unwittingly, the boundaries of medical jurisdiction have expanded to the point where "medicine and the labels 'healthy' and 'ill' (have been made) relevant to an ever increasing part of human existence" (Zola, 1977: 47/emphasis in original).

The success of medicine in medicalizing deviance, and the overwhelming acceptance of the medical model or "weltanschauung" in diagnosing and treating various conditions has become so pervasive in society that this medical language has been applied, as well, to

quite normal and natural conditions. From the womb to the tomb, medical experts intervene and control the normal biophysical events of men and women. Thus, childbirth is defined as an illness, or a potential illness (Pritchard and MacDonald, 1976), and doctors are always on the look-out for pathology (Arms, 1977). Pregnant women are categorized as high-risk and low-risk,* and hospitalized accordingly. Moreover, because of woman's presumed inherent frailty (Ehrenreich and English, 1973a) and low threshhold for pain, it is possible that she will be drugged and thus rendered a passive recipient rather than an active participant in perhaps one of the most exhilarating experiences she is likely to encounter in her lifetime. As a result of the immense technology deemed "necessary" for safe birth most women will be immobilized, which may be potentially lethal to the unborn child (Caldeyro-Barcia, 1977). Finally, childbirth is often defined as a surgical event -- episiotomies, caesarean sections and other surgical procedures are more common today than ever before (Larned, 1978). (Statistical evidence confirming the extent to which birth has become a surgical event will be provided in Chapter 5.) To be sure, doctors have no malintent -- their interventions are believed to be in the best interests of both mother and child.

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* It is interesting to note that pregnant women are customarily categorized as low, high, or extremely high risk patients, but never are they considered at no risk. Such a classificatory scheme would seem to provide evidence of the profession's predisposition toward viewing the reproductive process , at the very least, as a potential illness or illness-like condition (cf. Hobel, 1976).

At the other end of the life process, death is defined as necessitating medical intervention. Death today is technologized to the extent that life-support (or death-prevention) systems may be utilized to deter, if not prevent, the inevitability of death (Charmaz, 1980). Again, there is no malice intended -- doctors as much as anyone fear death and wish to prevent it. Death is the "enemy", and is to be avoided whenever possible. In both birth and death, the profession of medicine appears to be reluctant to allow Nature to take its own course. In effect,

> birth and death, the two most natural and "normal" biological occurrences, have become preempted by the medical profession. Thus pregnancy and senility are regarded as diseases whose management requires expert medical assistance (Szasz, 1964: 126).

It appears that in contemporary society, virtually nothing escapes the doctor's scalpel and technique. But as stated earlier, doctors are not totally responsible -- individuals play an extremely important role in shaping this situation. The result of the push by individuals who forfeit responsibilities for great parts of their lives (cf. Illich, 1973; 1977) and the pull by professionals eager to increase their jurisdictional control, has led to our society being medicalized (cf. Zola, 1977; 1978).

In order to appreciate the consequences of the medicalization process, and the ideology which informs the redefinition of normal aspects of social life, the following discussion will attempt to illustrate how birth has become defined as a pathological event. It will be shown that by redefining birth in medical -- or "illness" --

terms, the profession of medicine, first, located the appropriate birth managers of this condition and the solutions to be employed; secondly, the profession defined the proper location of birth, and thirdly, the profession defined the role appropriate for those experiencing pregnancy (i.e., the sick and/or patient role). Moreover, once problems are defined as in need of expert solutions, the patient and significant others are excluded from active participation in this experience. Responsibility for all key decisions is shifted to those who are the "experts" rather than to those who are actually involved. It is through the illustration of the medicalization of birth that it will be shown that medicine, today, operates as an institution of social control.

THE MEDICALIZATION OF BIRTH

In times past and even in some societies today (e.g., Holland, Sweden and Yucatan, Mexico), the manner in which childbirth has been experienced and managed has undergone little change. Women are involved in their normal daily activities up to and including the onset of labour. When the child is about to be born, the woman goes to a prearranged locale (typically the home or other familiar territory), and with or without the assistance of a midwife or family members, gives birth. Her attendants' responsibilities are two-fold: to catch the child (as opposed to delivering the child) and to provide emotional and moral support to the birthing woman. After the child is born, the umbilical cord is severed, the placenta is disposed of, and the child is placed on the mother's breast for the first feeding.

Shortly after the delivery, the mother resumes her normal routines of daily life (Jordan, 1980).

Diametrically opposed to this view is that of modern, industrialized societies, such as Canada, the United States, and to a lesser extent some European countries (e.g., Britain). Today, childbirth is medicalized and technologized. The woman ceases to engage in her normal role obligations prior to and following birth (the time period is quite variable ranging from the point of conception for some women to only days prior to delivery for others). With the onset of labour, she is generally hospitalized. There, she is closely monitored throughout labour and delivery. Her birth attendants are strangers (until only recently when husband-coached pregnancy was sanctioned by medical and hospital administrative authorities). Birth is commonly a surgical event (see Chapter 5), thus, in the event of surgery, the mother is often separated from her child.* When she leaves the hospital, she is advised to refrain from anything strenuous until she has fully recuperated from the birthing experience.

Although there exist various intercultural and intracultural differences in conceptions and experiences of pregnancy, clearly

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* In the case of a Caesarean delivery, for example, mothers are generally physically segregated from their newborns, although in many cases today hospitals try to minimize the amount of physical separation. In some instances, in order to promote and/or preserve the maternal-infant bond, mothers and newborns are housed together within sight and sound of one another.

western physicians have defined birth as pathology -- congruent with the medical model. Logically, the perspective guiding the physician's orientation regarding pregnancy as pathology is derived from conceptions of women and sickness in the Victorian Era (Ehrenreich and English, 1973a; 1973b; 1978). During that time, especially among the upper strata, normalcy was equated with sickness among women. Upper-class women were viewed as inherently weak and fragile, and always, actually or potentially sick. Women were encouraged to preserve their strength by refraining from anything strenuous (which, at that time, might have constituted merely getting out of bed!). Since all ailments were traced to their reproductive organs, women were implored to withhold involvement in activities which might deprive the reproductive organs of necessary energy. Rest and relaxation were prescribed, and the medical prognosis was nothing short of chronic illness and a future of bed rest and idleness.

It is interesting to note that while upper-class women tended to receive preferential treatment from medical practitioners, lower class women seldom, if ever, received comparable services (Ehrenreich and English, 1973a; 1978; Fidell, 1980). In part, this pattern of inequitable availability of health services is explained in terms of perceived differences in the health and social statuses of women throughout the stratification spectrum. For example, while upper-class women were viewed as frail and sickly, lower-class women (and in particular, black women in the United States) were seen as "sickening", "congenitally dirty", and "possibly contagious"

(Ehrenreich and English, 1973a: 18).

Many doctors concentrated on the "sicknesses" (real or imagined) of upper-class women to the exclusion of the infirmities of many working and lower-class women. One prominent physician, Dr. Augustus K. Gardner (who was instrumental in ushering in widespread public acceptance of gynecological surgery), reportedly ignored the poor entirely contending that "the quality of their lives made the incidence of . . . female diseases infrequent" (Barker-Benfield, 1976b: 241).

When the lower-classes did receive medical attention, services tended to be inadequate, unsafe, or delayed such that their chances for survival were severely diminished. The only other time that the poor and black populations received medical attention was when they served as teaching or experimental subjects for novel gynecological operations. Dr. Marion Sims, the father of American gynecology, is noted for having bought several slaves for the sole purpose of experimentation (Barker-Benfield, 1976b). After subjecting many of these women to brutal, dangerous, and sometimes lethal operative procedures, Sims was able to refine his methods, which subsequently were performed on upper-class women for substantial fees.

Although doctors uniformly discriminated according to one's social class, the ideology of medical care found one common thread which crossed all classes: female physiology was inherently pathological. "Women were'sick', and their sickness was totally determined by their anatomy" (Ehrenreich and English, 1973b: 48).

By propagating this sexist ideology, medical practitioners effectively shaped public consciousness as to the need for obstetricians and gynecologists to "save" women from their defective bodies.

Because the reproductive organs were the fundamental source of their problems, it was no wonder that 19th century women subjected themselves to the paternalistic and always benevolent doctor to cure common ailments. Normal ovariectomies, the surgical removal of the ovaries for non-ovarian malaise, became common practice (cf. Ehrenreich and English, 1973a; 1973b; 1978). Since they were incapable of self-help (it might drain their energies to pursue such endeavors), and since doctors (males only) were the only legitimate practitioners, the onset of pregnancy permitted upper-class women to enter the "sick role" (Parsons, 1951) -- which, in fact, was probably not all that different from their daily experiences. Their conditions required medical diagnoses and "treatment". With the physician's diagnosis, pregnancy became an illness. To maintain the definition of pregnancy as illness, doctors treated women <u>as if they were sick</u>.

Since the 19th century, the physician's orientation regarding pregnancy has remained stable, and in some cases has been fortified. With the birth of obstetrics around 1908 (Kobrin, 1966) as a specialty of medicine, it became readily apparent that women's reproductive functions were so inherently pathological as to require special experts -- obstetricians. Obstetricians convinced the public that "normal" pregnancy was the exception to the rule.

To illustrate the significance of medical ideology in the medicalization of birth, one may note three major vehicles utilized by the profession to ensure physician management of this "pathology". These are: the diagnosis of pregnancy as illness, the designation of the hospital as the appropriate place for birth, and relatedly, the suitability of adopting the sick role during pregnancy.

Because the ideology of medical care suggests that only certified experts (i.e., doctors) are equipped with the technical skill and scientific knowledge necessary to recognize disease, the definition of pregnancy becomes a matter of professional responsibility. In western industrialized society, an official diagnosis of pregnancy has become a prerequisite for women in terms of their adaptation to new or altered roles. It is no longer sufficient for a woman to make a self-diagnosis (cf. Pritchard and MacDonald, 1976). As Illich has noted, "people have lost the right to declare themselves sick; society now accepts their claims to sickness only after certification by medical bureaucrats" (1973: 6).

Kolker's review of the mass literature available to prospective parents (1980: 4) makes this point abundantly clear:

> Pregnant women are constantly exhorted to submit to medical supervision. "The most important thing you can do for your unborn child during pregnancy is to put yourself under a physician's care as soon as possible." (Guide to Expectant Parents, 1979: 10) "Prenatal care really begins when your doctor confirms the fact that you are pregnant. Once he knows you are going to have a baby, he starts preparing you for the event. He examines you, runs tests . . ." (Getting Ready for Your Baby, 1973: 3).

Oakley, as well, has noted the importance of an official diagnosis of pregnancy (1975: 640).

Having the authority of their office to define (diagnose) pregnancy, doctors subsequently ensure that they control pregnancy. To this end, pregnancy is defined as patholological.* Notwithstanding the fact that, to some at least, pregnancy is seen as the epitome of the feminine role, doctors repeatedly stress the pathology of this condition. For example, in Williams Obstetrics, this "disease orientation" is evident in the following passage:

> From a biologic point of view pregnancy and labour represent the highest function of the female reproductive system and a priori should be considered a normal process. But when we recall the manifold changes which occur in the maternal organism it is apparent that the borderline between health and disease is less distinctly marked during gestation than at other times, and derangement so slight as to be of but little consequence under ordinary circumstances may readily be the precursor of pathologic conditions which may seriously threaten the life of the mother or the child or both. It accordingly becomes necessary to keep pregnant patients under strict supervision and to be constantly on the alert for appearance of untoward symptoms . . . Indeed, antepartum care is an absolute necessity if a substantial number of women are to avoid disaster . . . (Eastman and Hellman, 1961: 337/emphasis mine).

Despite a presumed "liberalization" of medical thought in recent years regarding perceptions of pregnancy, there is persistent emphasis in the technical literature on the potential for disease during reproduction. In the fifteenth edition of Williams

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* Given that pregnancy is statistically normal, is normal in the sense that reproduction is vital to the preservation of the species, and that pregnancy is a desirable state for most women (with the exception of unwanted pregnancies), there is some merit in viewing pregnancy as normal. There is some question as to the validity of the abnormal view advocated by the medical profession (McKinlay, 1972).

Obstetrics, the authors describe pregnancy as follows:

> A prior pregnancy should be considered normal. Unfortunately, the complexity of functional and anatomic changes induced by gestation tends in the minds of some to stigmatize normal pregnancy as a disease . . . At times, pregnancy imposes . . . changes that when modest in degree are normal, but when more intense are decidedly abnormal . . . Therefore, it is essential for the physician . . . to be familiar with the changes in normalities as well as the abnormalities imposed by pregnancy (Pritchard and MacDonald, 1976: 245/emphasis mine).

Nature apparently cannot be trusted. Only medical intervention, properly administered by physicians, can ensure success in this process and as such prevent catastrophe from taking place.

Given that a medical diagnosis of pathology is made, pregnant women are implored to avoid all risks which might preclude safety and success in birth. Safety and success are considered possible only if birth is situated in the hospital. It is in the hospital that all the necessary equipment and technology are easily accessible to the doctor to contain or reduce the risks associated with pregnancy and parturition. That some women require the facilities and personnel available at hospitals is not being disputed. What is a matter of contention is whether all mothers must be confined to a hospital for delivery (cf. Richards, 1978: 84; Mehl, 1979).

According to the medical community, not only is the home lacking potentially necessary equipment and staff, but in addition, it is not sterile. Unfortunately, there is little evidence to suggest that the hospital is any less of a breeding ground for disease or that a hospital delivery guarantees success in birth (Devitt, 1977; Stewart, 1976: 1).

Nevertheless, the medical profession, having defined childbirth within a medical frame of reference, as a condition requiring medical attention, has also defined the proper place of birth as the hospital, the place otherwise reserved for the sick and dying (Oakley, 1977: 19). This, of course, is logically consistent with medical ideology because of the profession's disease orientation. (Evidence regarding the benefits and risks of hospital, as opposed to home, deliveries will be discussed at length in chapter 5.)

Finally, women are encouraged to submit to the authority of their doctors. This, in part, reflects the fact that doctors consider it appropriate for pregnant women to adopt the sick role (Parsons, 1951). The latent function or secondary gain (cf. Waitzkin and Waterman, 1974) of defining pregnant women as legitimate incumbents of the sick role is that it invests the physician with ultimate control over a woman's parturition. With pregnancy defined within the framework of the sick role, women are obliged to seek "technically competent help" (Parsons, 1951; Rosengren, 1961; 1962-3; 1966; 1980; McKinlay, 1972). McKinlay, however, has strongly argued that the remaining rights and duties outlined in the Parsonian sick role are inappropriate for pregnant women, because pregnancy is normal rather than a form of illness (1972). Rosengren's work in this area has failed to yield clear conclusions regarding the sick role during pregnancy. In light of the paucity of research demonstrating a definitive link between the sick role and the pregnant role, future research should address this problem

in order to clarify the ambiguity surrounding pregnancy and the sick role (see, for example, Martindale, 1977).

Oakley has suggested that "to say that someone is ill is one of the most effective ways of robbing them of autonomy and authority (1976: 57). Because it is essential that physicians maintain an upper hand in the therapeutic relationship, they have created the various mechanisms previously noted to ensure their dominance. It is through these mechanisms -- the definition of pregnancy and childbirth as pathological and pregnancy as sick role, as well as the location of birth in the hospital -- doctor's turf -- coupled with an immense technology, and the preemption of midwives and other lay birth attendants, that medical social control is exercised.

Whether the medical control of birth is a benefit or a hazard has yet to be determined conclusively (Chard and Richards, 1977). There is evidence to suggest that in many cases, the medical management of birth has failed to reduce mortality and morbidity (Devitt, 1977), and in fact may be a major source of clinical, social and cultural iatrogenesis (Illich, 1977) (see chapter 5). Most importantly, medical social control has apparently preempted women and their families from their own birthing experiences.

CAN POPULAR IDEOLOGY REVERSE OR ALTER THE MEDICALIZATION PROCESS?

Despite the fact that an overwhelming majority of the population actively continues to seek professional advice and treatment for maladies, there has been growing suspicion and concern about the efficacy of medical care among health care consumers. Because

alternative forms of care are sharply limited by institutionalized medical authority (Freidson, 1968; Ruzek, 1978), many health care consumers want to ensure that the care they receive be the best possible. Many individuals evidently are dissatisfied with the kind of care they have received from physicians. Rather than being cared for or cured, they feel that doctors are controlling their lives (Lear, 1978). Out of indignation and perhaps resentment of professional authority has emerged the revolt of the client in the form of the self-help movement (Haug and Sussman, 1969; Ruzek, 1978). No longer intent on blind acceptance and faith in medical care, the self-help movement functions as an external accountability structure organized to promote and/or ensure quality health care (Ruzek, 1978: 235).

Although numerous individuals throughout history have questioned the expertise and altruism of organized medicine (Gordon, 1978), these visionaries were often unable to significantly alter the organization and delivery of care. While some, such as Margaret Sanger (who was instrumental in promoting women's rights in birth control -- Gordon, 1978), were able to effect incremental improvements in health care, in general the power of organized medicine (and its supporters in the political economy) typically was such as to be able to annihilate its adversaries, thus perpetuating the existing social relations.

However, in the mid - 1960's in North America, as a result of growing dissatisfaction regarding the quality and kinds of care given by the medical profession, combined with a heightened awareness

that health is more than simply the absence of disease, health care consumers joined forces to challenge the sanctity of professional privilege (Bird, et al., 1979). The realization that medicine might be hazardous to one's health was fundamental in the genesis of the self-help movement (Illich, 1977; Ruzek, 1978). Concerned with the public interest, the self-help movement (and various consumer advocacy groups such as "Nader's Raiders") sought to generate the seeds of social change by challenging the ideology of organized medicine.

Various segments of the self-help movement have organized to alter the existing status quo in health care and other service sectors, for example, in education (Haug and Sussman, 1969). It is in health care in particular, where the popular movement has adamantly sought to challenge institutionalized medical authority. Determined to "take their bodies back" (Dreifus, 1977), members of the popular health movement are resolved to "sharply (reduce) the medical profession's ability to insulate itself from public observation and avoid accountability" (Ruzek, 1978: 2).

Troubled by the blatant sexism of organized medicine (cf. Burns, 1978; Howell, 1978; Scully and Bart, 1978), as well as physicians' misuse and overdependence on technology (cf. Anderson, 1979; Arms, 1977; Mendelsohn, 1979; Ratner, 1978), and consumer passivity in face-to-face interaction with professionals (Bell, 1979; Ruzek, 1977), the self-help movement encourages recipients of health care to participate actively in making decisions about the care they receive from physicians. In particular, the kind and quality of

gynecological and obstetrical care given women has been sharply criticized. "Self-help advocates . . . aim to re-establish women's ability and inclination to care for themselves and make their own decisions about their bodies" (Ruzek, 1977: 1).

A number of self-help groups and clinics have been established throughout the United States, Canada, Mexico, England, France, Belgium, Denmark, Italy, North Ireland, West Germany, and New Zealand (Ruzek, 1977). These groups promote active participation among health care consumers, providing literature and instruction which will expand individuals' capacity to care for themselves. Rather than reinforcing "disabling dependence" (Illich, 1977) on experts, these groups promote what Illich has referred to as "conviviality" (1973), the values of individual freedom and autonomy, and personal interdependence in dealing with the exigencies of daily life. While proponents of self-help recognize that medical expertise is necessary at times, they actively encourage women to learn more about their bodies and to utilize their own resources so that when expert medical care is needed, they will be able to maximize their participation in the doctor-patient relationship.

The self-help movement is primarily an urban, white, middle-class phenomenon (Ruzek, 1977). Initiated primarily by women in their twenties and early thirties, the movement has sought to alter the nature of all consumer-provider relationships in the health care system. Most self-help advocates are staunch feminists who believe that "controlling their bodies is <u>essential</u> to controlling their lives" (Ruzek, 1977: 2). Although attempts at introducing a self-help

philosophy to the lower-class minority groups have been largely unsuccessful, this is not to suggest that the movement is prepared to ignore these groups (Ruzek, 1977). On the contrary, the self-help movement is determined to institute a radical restructuring of routine reproductive health care for all women, irrespective of age, social class, and race. Self-help challenges the "license and mandate" (Hughes, 1958) of organized medicine, as well as typical preconceived notions regarding the efficacy of medical care and professional dominance. For the self-help movement, it is clear that "the doctor is not necessarily the 'best agent' of the patient when making choices on his(/her) behalf" (Tsalikis, 1972).

What has been the effect of the self-help movement, and in particular how has the movement changed the system with respect to reproductive health care? First of all, through the dissemination of literature and increased instruction regarding human physiology and anatomy, the movement has tried to foster greater independence and responsibility among health care consumers. Patients who have a greater understanding of their bodies will be equipped to make informed decisions in therapeutic settings. Ultimately, this movement aims to pressure physicians into responding to patient demands in a tangible manner, rather than merely paying lip-service to their patients (Ruzek, 1978). Ideally, the goal is to transform the therapeutic relationship from one based on physician dominance and patient submission to one based on equality and mutual interdependence (Szasz and Hollender, 1978: 102).

On the institutional level, several changes have been noted, although longitudinal research projects have not been undertaken as of yet to determine whether there is a causal relationship between the rise of self-help and the changes which have taken place. Procedures once performed with impunity (e.g., shaving the birth area, pelvic examinations, elective induction of labour, and to a lesser extent, elective Caesarean section) presumably tend to be performed less often or after consultation with clients (Malone, 1980). Physicians reportedly are more accountable for their actions because clients are asking more questions and demanding more answers from their physicians. Professional authority, it seems, is not the "sacred cow" it once was (Ruzek, 1978), although again, one must regard such claims with caution because of the scarcity of verification of such propositions.

Hospital policies in many locales have also responded to patient demands. Fathers or partners are generally welcomed to accompany mothers throughout labour and delivery. Whereas most hospitals enforced a four-hour feeding schedule in the not too distant past, women are now encouraged to breastfeed on demand (Haire 1978a; Haire 1978b). In recognition of the desire for home (or home-like) births (or perhaps to prevent the proliferation of home births), many hospitals have instituted "family-centered maternity care" programs (Ruzek, 1978). There have been attempts to humanize the "factory-like" atmosphere of most hospitals, thus making it more like home, flexible and responsive to consumer

demands (Woods, 1979). Adamant in their claims that domiciliary deliveries are unsafe (i.e., the incidence of maternal and infant mortality is presumably higher), physicians have determined that "in Canada (as elsewhere) the demand for home delivery can be interpreted as a plea to make childbirth as far as possible a human rather than a medical experience" (Woods, 1979: 1444). Some hospitals have also instituted 24-hour release programs for women who have had uncomplicated deliveries (Jager, 1980), and there is a growing trend toward encouraging sibling visitation following birth (Woods, 1979).

The impact of the self-help movement on the direction of reproductive health care remains somewhat unclear at present. However,

> mothers have made it clear in childbirth that control of important human events must not be surrendered to those who bear badges of expertise. When decisions are turned over to experts, independence and a measure of humanity are lost as well (Malone, 1980: 6E).

So, to answer the question posed at the outset of this discussion, that is "can popular ideology reverse or alter the medicalization process?", it is difficult to draw any definitive conclusions at this time. Indeed, based on what has been noted by adovocates of self-help, the time is ripe to rigorously investigate what, if any, impact this movement has had on the organization and delivery of maternity care. Ruzek suggests that there have been broad attitudinal changes in <u>both</u> patients <u>and</u> practitioners, changes in health care delivery, a reduction in discrimination and overt

sexism in medicine (in medical schools and in the delivery of health care), reappraisals regarding the use of hazardous drugs and devices, and government recognition of women's health issues (1978: 218-232). Although an overwhelming majority of women still rely on conventional medicine for their health care, and as many delivery their children in hospitals, many observers suspect that the self-help movement is at least partially responsible for women "taking their bodies back" (Dreifus, 1977) and trying to redirect reproductive health care in contemporary society (Ruzek, 1978: 218). The efforts of the self-help movement indicate that a major battle against the "impurity of professional authority" (Freidson, 1968) may have been won. On a less happy note, the war against professional dominance rages on, as women (and patients in general) challenge the existing status quo in order to obtain quality health care without having personal freedom and dignity compromised.

The foregoing discussion has centered on medical ideology, which for all practical purposes, is fundamental to the exercise of social control. The centrality of medical ideology is revealed in that the way in which conditions are designated by medical practitioners determines the form of solutions to be employed, as well as the personnel who will be charged with the management process. In the following chapter, a second type of medical social control -- medical technology -- will be discussed.

Chapter Three
Medical Technology:
The Technologization of Birth by the Medical Profession

TECHNOLOGY IN MODERN SOCIETY

> (Technique) is not a kind of neutral matter, with no direction, quality or structure. It is a power endowed with its own peculiar force. It refracts in its own specific sense the wills which make use of it and the ends proposed for it. Indeed, independently of the objectives that man pretends to assign to any given technical means, that means always conceals in itself a finality which cannot be evaded. And if there is a competition between this intrinsic finality and an extrinsic end proposed by man, it is always the extrinsic finality which carries the day (Ellul, 1964: 141).

As indicated in the above quotation from Jacques Ellul's seminal analysis of our technological civilization, technique, or "the totality of methods rationally arrived at and having absolute efficiency (for a given stage of development) in every field of human activity" (Ellul, 1964: xxv) has become a force to be reckoned with in modern industrialized society. Unlike previous stages of development, today's society has come to rely on technical solutions for even the most mundane problems facing mankind, so much so that it appears that man has lost control of his own tools (Illich, 1973; Marx, 1978):

> . . . though technology is merely a product of our activity, it has not only become independent of us its producers, but has actually become our master. Technology is running wild. It is like a machine gone out of control which is terrorizing every body. It dominates us rather than we it. We are helpless in the face of its development and are forced to accept whatever impact it has on us (Gendron, 1977: 148).

By utilizing the contributions of Ellul (1964); Illich (1973; 1977); Marx (1978); and Novek (n.d.), the groundwork will be laid to

facilitate an analysis of medical technology as a mechanism of social control. Specifically, the focus of the ensuing discussion will revolve around the following key issues: the role of technology in contemporary society in satisfying fundamental needs (i.e., the role of technology as a key problem-defining and solving mechanism); the emergence of scientific-medicine, and its expansion through technology; technology and the division of labour (specifically, who controls what technology and on what basis is this control determined); and the implications of technology for the birth process. The aim of this discussion will be to demonstrate that as a result of the medical profession's overwhelming reliance on science and technological interventions, an inherently normal process (i.e., birth) has been distorted, dehumanized, and rendered (medically-speaking) a pathological crisis.

The relationship between technology and society has long interested scholars from various disciplines. For many, technology in its early days was seen as a liberating force, in that it would allow society to evolve towards a more rational and advanced stage of development. However, as quickly as supporters rallied around the virtues of technology, a growing sense of disillusionment emerged among sociologists. For example, some believe that the increasing rationalization of life will lead to mankind's demise; i.e., inevitably we will all become mere cogs in the great machinery of rational life (Weber, 1968).

In his paper entitled "A Critique of Technological Pessimism",

Novek has outlined the major assumptions of "technological malevolence" (pp. 4-19). According to his perspective, which is strongly influenced by Weberian technological pessimism (1949), Novek argues that technology results in the domination of man by machines, that technology survives on the basis of its own self-perpetuating ideology, and that technology is self-producing and reproduces society in its own image, i.e., technology is unidimensional.

"Technology as domination" has two major variants. In the first case, technology is seen as an instrument which serves to perpetuate existing social, economic and political relations. It is claimed that within an industrial complex such as that in the United States and Canada, those forces controlling the political economy create technology and in time, this technology is used to reinforce the existing status quo. According to this perspective, the capitalist social order and the system of social, economic and political relations within that order produce technological forms which serve as forces of domination. Advocates of this perspective, many of whom are Marxists, are cautiously optimistic that revolution will bring an end to the domination that is facilitated by technology (cf. Marcuse, 1964; Marx, 1978).

According to advocates of the second variant, technology is seen as "the principal cause of the growing domination of man and nature" (Novek, p. 5). It is contended that technology is less an instrument of domination, and increasingly becomes the principal focus in not only the domination of man by man, but as well the

domination of man by machines. Unlike the "soft" determinists of the first variant, "hard" determinists claim that it is doubtful that a society organized on the basis of socialistic principles will reverse the influence of technique. Rather, technique has become so pervasive as to preclude a radical reorganization of society along lines that would be less dominating and alienating (cf. Ellul, 1964).

As Novek points out, whether technology is a derivative of the existing social relations or a cause of these relations is still a matter of contention among critics of modern technology (Novek, p. 10). What is clear, at least in the present context, is that in modern industrialized society, technology has often failed to solve the problems it was intended to correct. While it is true that mechanization has reduced work time and increased leisure time, notwithstanding these benefits, technology has created social evils such as alienation and dehumanization. Furthermore, technology has clarified power imbalances: those who already have, have even more; those who had little to start with have even less (cf. Domhoff, 1978; Gendron, 1977). In contemporary western society, technology has given rise to the possibility for domination and manipulation which far exceed the likelihood of freedom and liberation. In effect, "technology serves to institute new, more effective and more pleasant* forms of social control. . . the technological society is

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* Implicit in Marcuse's discussion is the interrelation between bourgeois ideology and technology, the former serving as a legitimation of the latter. In view of the previous discussion on the concept of ideology, it is apparent that the system created and sustained by

(continued on next page)

a system of domination . . . " (Marcuse, 1964: xv-xvi/emphasis mine).

The notion of "technology as ideology" refers to the fact that not only does technology function as a system of domination, but additionally, it is self-legitimating. Technology develops an entire system of values and rationalizations which facilitate the sustained growth and domination of the political-economic social order.

> Technique elicits and conditions social, political and economic change. It is the prime mover of all the rest, in spite of any appearance to the contrary, and in spite of human pride, which pretends that man's philosophical theories are still determining influences and man's political regimes decisive factors in technical evolution. External necessities no longer determine technique. Technique's own internal necessities are determinative. Technique has become a reality in itself, self-sufficient, with its special laws and its own determinations (Ellul, 1964: 133-134).

Technological domination and ideology, in turn, create "technological unidimensionality", or the reproduction of society in the image of technology (Novek, p. 16). In essence, society becomes subordinated to the push and drive of technology. Technology defines choices and demands. "It poses primarily technical problems which consequently can be resolved only by technique" (Ellul, 1964: 92). Inevitably, the predominance of technology leads to the subordination of human creativity and input, and hence, the autonomy of technique.

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capitalist ideology is more than meets the eye. Technology serves as a mechanism of social control, which is seldom understood in its entirety by the common man, as a result of ideological hegemony of the ruling classes.

This somewhat brief review of the significance of technology in society leads one to conclude that technology is the primum mobile of history. Moreoever, it is apparent that technology is fundamental in terms of the perpetuation of the status quo in contemporary society in that it defines the nature of society's problems as well as the solutions that will be introduced to alleviate society's problems.

Technology qua technology, however, is not sufficient to function as a driving force in the progression of human civilization. Rather technology has united with science to generate and implement technical solutions. In fact, science and technique have become one: without science, there is no technique and without technique, there is no science.

The importance of the mutual interdependence of science and technology is that "technocracy (can) bask in the more lofty, indeed sacred, aura of science's Promethean struggle for truth, against superstition, for enlightenment; technocracy (can) now define itself as the modern embodiment of human rationality" (Gouldner, 1976: 251). It is, therefore not fitting to denigrate technologies nor their creators with respect to the alienation and dehumanization which accompanies the domination of technique. To the contrary, the unity of science and technique represents the systemization and institutionalization of rationality geared towards resolving the most intense problems of mankind, the benefits of which are shared by all members of the social order. Although some contend that

technology has coopted science in an attempt to achieve legitimacy (e.g., Gouldner, 1976: 251), it is clear that by associating with science, technology is considered potentially as a morally neutral, nonpartisan enterprise predisposed to discovering and implementing the most efficacious technical solutions to the crises faced by individuals in society.

Any further elaboration oftechnology and its relationship to science, in particular, and to society, in general, is beyond the scope of this discussion. However, it is important to note that the intimacy of science and technology has profoundly influenced what individuals believe to be true in a technologically-oriented society such as Canada. Technique, resting on scientific principles, has emerged as a key problem-defining mechanism in society. For technical problems, technical solutions must be sought. Although a problem may reside in the moral, political, economic, or social order, once it is defined as "technical", "it has been moved from the realm of values . . . to the realm of usefulness, effectiveness, and expediency" (Charmaz, 1980: 104). The implications of this shift will be discussed at length at a later point. First however, it is essential that one clarify the significance of technique and science in terms of the division of labour. For this, Marx provides some valuable insights.

Although technology is essential to Marx's theory, unlike Ellul (1964), he declined to view it as the sole motivating force in human history. Instead, Marx saw the mode of production as the key

to understanding the nature of historical development (1978). The mode of production is a complex dialectic between the productive forces (i.e., the relationship between man and nature) on the one hand, and the relations of production (i.e., the interrelations between individuals) on the other. The productive forces are represented in the various tools utilized by man in different stages of development.

The mode of production is seen as the economic foundation of society (technology being a mere manifestation of economic relations) on which an entire superstructure is created. The essential dimension of Marx's theory in the present discussion is that the controllers of the mode of production -- which include those who control technology -- are but a small segment of the population (i.e., the bourgeoisie). Equipped with control of material production, the bourgeoisie are able to influence the structure, form and content of society. They are in a position, moreover, to define who does what and how, that is, the division of labour.

Marcuse has suggested that in advanced industrialized societies, the controllers of the productive forces, in essence, define "the socially needed occupations, skills, and attitudes" (1964: xv), not to mention both the needs and desires of individuals. In essence, the specialization of skills and division of occupations are inseparable from technological progress and economic growth. Various roles in the division of labour, very simply, are defined in terms of the use and elaboration of a specific technology.

The close ties between science, technology and the division of labour have been discussed at length by Larson (1977). In her analysis of the professional project (i.e., the professionalization of service producers committed to marketing their expertise), Larson demonstrates that when groups appeal to the logic of technique and science, or that body of thought resting on the principles of rationality, standardization, objectivity, functional specificity, universalism, etc. (cf. Parsons, 1954), the likelihood of legitimation explained in terms of technical superiority is great. In fact, Larson's historical analysis of the "professional project" demonstrates definitively that the professionalization of any occupational group is inseparable from a monopolization of technical expertise. It is through a monopoly of expertise in the market that certain occupational groups attain and maintain technical autonomy. In turn, autonomy insulates the profession to the extent that the professional group constructs an ideology which is presented as the most valid definition of specific spheres of social reality (Larson, 1977: xiii).

To illustrate the mutual interdependence of science, technology and the division of labour, the remainder of this discussion will focus on the medical profession, its rise to the apex of the occupational hierarchy, and its subsequent expansion through technology.

SCIENCE, TECHNOLOGY AND THE PROFESSION OF MEDICINE

Human labour has long interested sociologists. In the last three decades in particular, several sociologists have devoted considerable time and attention to understanding the realm of work and occupations. In the 1950's and 1960's, Goode (1957; 1960), Greenwood (1962), and others (e.g., Carr-Saunders and Wilson, 1962; Wilensky, 1964) were instrumental in noting the differences between work forms, particularly those which are considered "occupations", and those which are considered "professions".

More recently, it has been suggested that the label "professional" and work performed by professionals may not necessarily be all that unique. That is, previously noted distinctions between work types may have been somewhat artificial. Indeed, there remains little consensus among analysts as to the appropriateness of the label "professional" for certain forms of work, and heuristic value of making distinctions between work types (Haug, 1975; 1976; 1977; Roth, 1974; Rueschmeyer, 1964).

Despite this somewhat ambiguous situation, it is generally acknowledged within the sociology of work and occupations that medicine is a profession. In fact, along with the clergy and the legal profesions, medicine is considered to be a prototype of all professions -- a yardstick by which to evaluate all other "would-be" professions.

Given the salience of the medical profession both in social life and as an analytic tool in the sociology of occupations and professions, it is understandable that a considerable amount of

attention has been paid to this group of workers. Following the lead provided by authors such as Freidson (1970a; 1970b) and numerous others such as Blishen (1969), Carr-Saunders and Wilson (1962), Goode (1957; 1960), Haug (1975; 1976; 1977), Hughes (1958; 1971), Larson (1977), Marshall (1939), Parsons (1951; 1954), Roth (1974), and Vollmer and Mills (1966), the purpose of the following discussion will be to comment on the historical development of the medical profession, as well as the position of dominance this profession has achieved since its emergence as the leader among healing practitioners, most notably in terms of its dominance vis-a-vis technology.

This discussion is divided into three major sections. First, an historical perspective on the rise of medicine as a profession will be provided, tracing its origins from ancient times through to the modern-day era, noting in particular its transition from a "learned" profession to an "organized consulting" profession (Freidson, 1970a). The second section will focus on the criteria of professionalism. Although many sociologists of work have utilized the attribute theory (Greenwood, 1962) in analyzing various occupational groups in the past, there is increasing evidence to suggest that this framework is less than adequate as an analytical tool (Haug, 1975; 1976; 1977; Roth, 1974; Rueschemeyer, 1964). Therefore, the second section will offer a critical assessment of the attribute theory of professions, as well as insights into more recent developments in the sociology of work and occupations. In the final section, the role of technology in medicine will be elaborated as a way of demon-

strating that technical autonomy facilitates medical social control. For illustrative purposes the medicalization and technologization of birth will be analyzed.

A Brief History of the Profession of Medicine

The professionalization of medicine can best be understood by reference to its progression through time from primitive, preliterate societies to modern, rationally-based "scientific" society (Bullough, 1966; Bullough and Bullough, 1972). Accordingly, this historical account covers two major eras -- the first spanning a number of centuries where there was a strong alliance between religion and medicine, and the second in which medicine emerged as a distinct discipline resting on the foundations of rational, scientific principles.

In primitive society, medicine was not practiced by a specialized group of practitioners in the modern sense of the term. Rather, treatment of illness and disease was performed by shamans, who in addition, were responsible for religious guidance and various other spiritual and intellectual functions (Bullough, 1966; Moore, 1970). It is important to note that owing to the intimate relationship between religion and medicine,the shaman was able to establish himself as a credible intermediary between the gods and man. Because of the "divine backing" of his remedies, he was granted authority and a monopoly over the healing arts by the public.

At this time in history, the occurrence of disease was attributed to evil spirits or angry gods, and since the shaman was able to communicate with the gods, patients deferred to the shaman and

complied with his supernatural methods of healing, which included such techniques as exorcism and magic. Unlike modern medical practitioners, the shaman was able to win public approval and was granted legitimacy in his endeavors, because of the strong spiritual overtones in his treatment modalities. Although the circumstances are vastly different today, the common thread binding ancient and contemporary medicine is that there existed a "competence gap" (Haug, 1975; 1976; 1977; Parsons, 1970) between patients and practitioners.

In ancient times, the significant attribute of shamans was their ability to communicate with the gods -- an ability far removed from the common man. In deference to the gods, members of preliterate and ancient societies complied with the treatment and instructions offered by the shaman (Bloom, 1963). In contrast, the modern physician relies on scientific knowledge to direct his/her treatment modalities. George Bernard Shaw once commented that today "we have not lost faith, but we have transferred it from God to the medical profession". Whereas previously the shaman functioned as an intermediary between the gods and mankind, today "science" has become god-like (i.e., omniscient), and the physician is the intermediary between science and mankind (Szasz, 1977). In both cases, healing practitioners were awarded authority and autonomy over their work (Bullough, 1966; Freidson, 1970a).

Methods of healing in preliterate societies were closely guarded secrets which were preserved by oral tradition. With the passage of time, men began to document medical remedies and techniques

so as to ensure their retrievability for future generations of practitioners. Although a number of extant medical documents are available from Egyptian and Mesopotamian societies, the first comprehensive documents on medicine are those embodied in the Hippocratic corpus (ca. third century B.C.) (Cartwright, 1977; Coe, 1970). Hippocrates, the legendary physician at Cos, promoted the idea that medicine was an observational science and relied on empirical rather than philosophical principles. He advanced the notion that the best way to learn the basics of medicine was through apprenticeship (Bullough, 1966).

Hippocrates was responsible for two major advancements in medical practice. First, although religion was still important in shaping man's conceptions of health, illness and various other aspects of social life, Hippocrates postulated that a natural (as opposed to a supernatural) explanation of illness was to be found in an equilibrium model. That is, Hippocrates maintained that the human body was composed of four humors: blood, phlegm, black bile and yellow bile. So long as these humors were in balance, the body remained healthy. In the event of excessive or inadequate amounts of these humors, disease ensued (Coe, 1970). Diagnostic procedures were relied upon extensively and treatment was aimed at re-establishing equilibrium.

Although the techniques used by these medical practitioners seem primitive and archaic according to modern standards, they were quite sophisticated, relatively speaking. In fact, much of the work of Hippocrates and his disciples in the areas of diagnostic and

prognostic principles have only been slightly altered since the fifth and fourth centuries B.C. It may be justifiably claimed that the foundations of modern medicine can be traced to the doctrines promoted at the medical school on the island of Cos.

The second achievement -- and surely the most widely recognized achievement -- attributed to Hippocrates, was the creation of the Hippocratic Oath. Very basically, the Oath was intended to promote the notion of medical ethics among practitioners, and additionally functioned in such a way as to solidify the bonds between students and their teachers. Moreover, the Oath was instrumental as an exclusionary device in that it impressed upon prospective practitioners that their knowledge was intended to be shared only with qualified persons (i.e., other practitioners).

In general, Hippocrates fostered the beliefs that, firstly, medicine was a very special and specialized skill to be learned and practiced only by a very select group. Secondly, Hippocrates claimed that the success of medicine rested to a great extent on a cohesive and solidary community of practitioners. Finally, and most significantly, he fostered the notion that the prestige of the profession would be enhanced if its practitioners were ethical, responsible, and put the interests of their patients above their own personal interests (Coe, 1970: 165-166). The philosophy embodied in the Hippocratic Oath persists to this day, promoting the integrity of medicine and instilling a sense of "calling" (Weber, 1958; 1963) among its practitioners.

As noted previously, it was during this time that man began to document medical knowledge in order to ensure its preservation.

While documentation facilitated easier transmittance of necessary medical doctrines, these written records could be obtained by the average layman. With the availability of these documents, especially among the educated upper-classes, the development of medicine as a profession was impeded. In addition, with the breakdown of Greek society and the simultaneous birth and expansion of Roman civilization, medicine came to be regarded as a liberal art: "every educated man was expected to have a knowledge of medicine" (Bullough, 1966: 29). As a result, the medical practitioner was basically on equal footing with the layman in terms of his level of knowledge of medicine. In order to be elevated above the educated layman (and thus promote professionalization) medicine had to be institutionalized. The rise of the university (ca. tenth century A.D.) paved the way for the institutionalization of medicine and the birth of the profession (Bullough, 1966; Larson, 1977).

The first university in which medicine was taught was at Salerno, Italy, although monastic institutions continued to instruct the clergy in the theoretical knowledge of medicine. During this medieval era, instruction was altered in form from the previous exchanges exemplified in Socratic dialogues to medical commentaries fortified by theoretical and empirical doctrines. The title "doctor" was introduced to recognize practitioners who did not teach, and the distinction between physicians (intellectuals) and surgeons (artisans) was made explicit. While the church continued to play a major role in medicine and in life in general, its supremacy began to falter as the world moved into the period of the Renaissance

and Reformation (Bullough, 1966).

One important advancement which followed the organization and institutionalization of medical schools was the enactment of laws providing for structured curricula, state examinations, licensing, and further restrictions on who could legitimately claim the title "doctor", and the concomitant status and privileges associated with the title. During this time, medical practitioners were beginning to achieve and maintain state sanction and support. Increasingly, with "scientific" achievements, legal sanction and the institutionalization of medical education, medical practitioners were moving ever closer to professional status.

Of the various scientific advancements made during the Renaissance, Vesalius' theory of anatomy and Harvey's discovery of the circulation of the blood are most notable, although countless other scientific innovations were incorporated into medical practice (Coe, 1970: 172-174). It is noteworthy that many (if not all) of these discoveries occurred outside of medicine, but eventually came under the control of the medical profession. Furthermore, this relationship between scientific innovations and the practice of medicine has remained unchanged. As in times past, it is the scientific community (including, for example, biochemists, microbiologists, physicists and geneticists) which is responsible for the many "breakthroughs" in medicine (see, for example, Watson, 1968). As will be noted in the final section of this chapter, technology developed primarily by the scientific community furnishes the profession of medicine with the means for resolving "medical" (i.e., biophysical) problems

(Gouldner, 1976).

Another important milestone in the history of medicine during the Renaissance was the separation of religion and medicine. No longer did individuals seek the aid of clerics. On the contrary, the "scholastic grip of the church was broken -- dogma gave way to observation and experiment, faith to logic and reasoning" (Coe, 1970: 173). The birth of science was imminent; the birth of the profession had occurred. Freidson has noted that the break from the Church, and the ability of physicians to determine the etiology of various diseases (as a result of the contributions of Pasteur and Koch in bacteriology) created "a qualitative break from the past, making possible for the first time the predictable and reliable control of a wide spectrum of human ills by virtually any well-trained practitioner of the occupation" (1970a: 16).

Over the course of time, a specialization of functions occurred within health care. Consequently, various practitioners began to lobby in society in order to "sell" their product (i.e., technical knowledge and skill). The competition between practitioners (both within medicine and between medicine and other healing practitioners) resulted in active campaigns to achieve boundary maintenance between practitioners from various schools of thought (i.e., generalists vs. specialists and orthodox medicine vs. other healers). For example, Kronus (1976) has analyzed the relations between pharmacists (apothecaries) and physicians, noting that physicians ultimately obtained sufficient power to control their work as well as that of their adversaries. Through state sanction, the physicians were able to define

and defend their occupational tasks and prevent encroachment on the part of pharmacists. This pattern of boundary maintenance has more or less become institutionalized over time, with the medical profession determining who, in the medical division of labour, will perform specific tasks. In essence, medicine has monopolized occupational power, and uses its power to retain its position at the apex of the medical division of labour (Freidson, 1970a; 1970b; Kronus, 1976).

To reiterate, one finds that since the emergence of medicine, medical practitioners acquired expert knowledge and/or technical competence; that a monopoly in health care ensued due to this expertise; that this monopoly was sanctioned by legal authorities (and in turn, the layman); and finally that with the break with the church and the simultaneous birth of science, medicine became institutionalized (Bullough, 1966). Each of these milestones in the history of medicine promoted the professionalization of medicine. With the passage of time, medicine moved further away from its ancient and medieval counterparts, to the ultimate status "profession".

Medicine became a well-organized discipline supported by professional organizations such as the College of Physicians and national Medical Associations. It was and is no longer a "learned" profession, but an "organized consulting" profession (cf. Freidson, 1970a). By this is meant that the continued growth and development of the professional group are largely dependent on those whom it serves. The medical profession apparently utilizes its expert knowledge in the service of others, and would lead a somewhat questionable existence

without the support and consumption of its services by the layman.

It is this very fact -- that laymen utilize the expertise of medical practitioners -- that gives medicine its justification for being, its raison d'etre. The learned professions exist for the benefit of their colleagues and students, and while there is a service being provided in the truest sense of the word, the overall losses to society would not be all that devastating were the learned professions to terminate (Hughes, 1960; Larson, 1977). In contrast, it is believed that medicine promises to provide society and its members with a valuable commodity -- health* -- which must be maintained because it is in the vital interests of all members of society (cf. Larson, 1977: 24-25). In describing the medical profession, Sigerist has noted that:

> the characteristic features of the medical profession are determined to a large extent by the attitude of society towards the human body and by the valuation of health and disease. The scope of medicine has always been the same: to cure disease and eventually to prevent it . . . However, the medical ideal was a very different one in different periods of history, determined by the structure of the society of the time and by its general conception of the world (1960: 3).

Through persuasion of lay clientele, medicine gained public sanction. Through their persuasion of political and legal officials,

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* This aspect of medicine's success in professionalization is well stated by Larson:

> in a secularized society, medicine serves most directly the "sacred" (sic) value of life. Of all the professions, it appears to have the strongest claims to an ideal of service and devotion to human welfare (1977: 39).

medicine gained state sanction. In distinguishing between learned and consulting professions, Freidson clearly articulated the importance of public support when he stated that

> scholarly or scientific professions may obtain and maintain a fairly secure status by virtue of winning solely the support of a political, economic or social elite, but . . . such a consulting profession as medicine must, in order to win a secure status, make itself attractive to the general public which must support its members by consulting them. The contingency of the lay public was thus critical to the development of medicine as a profession (1970a: 188).

In sum, one finds that the monopoly attained in health care by the medical profession was possible as a result of its ability to secure both lay and official sanction. Together, both of these types of assurance literally provided the medical profession with a "carte blanche" in shaping the organization and delivery of health care in society. Increasingly, the medical profession has become an institution of social control and has expanded its boundaries of expertise. Apparently, this trend is partially explained in terms of the profession's ability to convince target groups (i.e., laymen and/or elites) of the merits of introducing a medical perspective as a means for resolving the problems of contemporary society.

The Professions in Society

The professions have come to play a major role in society, not only recently, but for a number of centuries. Traditionally, the title "professional" was used to refer to those persons whose life-work centered in the divinty, law and medicine (cf. Carr-Saunders and Wilson, 1962; Freidson, 1970a; Goode, 1957; 1960; Greenwood, 1962;

Haug, 1975; 1976; 1977; Hughes, 1960; Parsons, 1954; Vollmer and Mills, 1966). However, increasingly today, more and more occupational groups are making claims to professional status, so much so that it is becoming difficult to determine who is or is not a professional in the truest sense of the word. There are professional dancers, musicians, hair stylists, mechanics, and so on, in addition to the more conventional professional occcupations of the clergy, law and medicine. Haug poses the following rhetorical question:

> What . . . is the difference between a plumber and a urologist? Both require training, both deal with pipes. Neither works for nothing. It could be said that one deals with life and death matters and the other does not, but that evaluation depends on the nature of one's emergencies and one's sex . . . Both are experts in their own fields. One might well ask, why should one be considered a professional and the other not? (1975: 211)

Given this apparent ambiguity regarding what type of work legitimately may be regarded as professional, the aims of the following discussion will be first, to review and critically evaluate the relevant literature dealing with the attributes of professions in the sociology of work and occupations; and secondly, to discuss directly the "prototype" of professions -- the profession of medicine.

It is useful, at the outset, to view professional work as that involving individuals in social roles bound within a set of social relationships, and intimately linked to the broader social structure. According to this definition, all work -- whether professional or not -- is socially defined. In addition to viewing professionals and their work within a social context, a number of researchers have classified occupations in terms of a continuum of professionalism,

with "professions" and "nonprofessions" at the polar extremes (cf. Greenwood, 1962). According to this framework, otherwise referred to as the attribute theory, virtually all occupations exhibit some aspects of "professional" and "nonprofessional" work -- the differences between occupations emerge as a matter of degree. Accordingly, one can view "professional" and "nonprofessional" as ideal types (Weber, 1949), and in this way it is possible to classify various occupations according to the extent to which they manifest the various elements of professionalism. Finally, while the specification and classification of work types along a continuum provides the analyst with a useful conceptual model, it is not always easily discernable when an occupation stops being an occupation and becomes a profession. In this respect, it is recognized that the label "professional" is largely evaluative as well as descriptive (cf. Freidson, 1970a: 3) and as such, the appropriateness of claims to professional status may at times be somewhat questionable.

In recent years, some sociologists of work and occupations have questioned the heuristic value and appropriateness of the attribute theory of professions (eg., Haug, 1975; 1976; 1977; Roth, 1974; Rueschemeyer, 1964). Roth, in particular, has called professionalism "the sociologist's decoy" (1974). Haug, in response to a 1964 paper by Wilensky, has suggested that the "professionalization of everyone" thesis is no longer an accurate description of the work world. Instead, she contends that there is a trend toward the "deprofessionalization of everyone" (1975; 1976; 1977).

In addition, Haug has commented on the ethnocentrism which inheres in the concept of the professions (1975). For example, the French include most clerical white collar occupations and non-manual work roles under the heading of "metier" -- a close translation of the Anglo-Saxon word "profession". West Germans equate "professions" with the word "beruf" or "calling", with the accompanying emphasis on commitment and dedication derived from occupational socialization and academic training. In East Germany, all skilled occupations are subsumed under the heading of professions. It has been reported that in the German Democratic Republic, there are some 389 professions to which 95 percent of the youth in that country aspire (Bohring cited in Haug, 1975: 200). In Russia, professions ("intelligentsia") tend to be defined as non-manual occupations. Apparently, as Haug has discerned, western scholars have generalized a concept basically unique to British-American industrial capitalism to the remainder of the world, regardless of cultural and socio-economic differences between systems (1975; 1976; 1977). As a result, a number of problems emerge in analyses of workers and work forms.

Notwithstanding cross-cultural differences, western societies such as Canada and the United States have somehow determined that professionals are extra-ordinary in some respects. Cogan's definition of a profession is widely shared: a profession is

> a vocation whose practice is founded upon an understanding of the theoretical structure of some department of learning or science, and upon the abilities accompanying such understanding. This understanding and these abilities are applied to the vital practical affairs of man. The practices of the profession are modified by the accumulated wisdom and experience of mankind, which serve to correct the errors of specialism. The profession,

> serving the vital needs of man, considers its first ethical imperative to be altruistic to the client (cited in Vollmer and Mills, 1966: vii).

According to this definition, then, a profession is comprised of individuals who profess training and expertise which is scientifically or technically based, and who rely on universalistic knowledge within a functionally-specific sphere to assist others in dealing with the exigiencies of daily life (Parsons, 1954).

Another way to conceptualize the professions is to distinguish between those characteristics of the professions which are "core" and those which are "derived" in nature (Goode, 1960). The core characteristics include " a prolonged specialized training in a body of abstract knowledge, and a collectivity or service orientation" (Goode, 1960: 903). The derived characteristics of a profession include the following: professional self-control in the areas of education and training (including strict control of socialization processes), recruitment and selection, licensure and standards of practice; the representation of professional interests in official legislation; official recognition and sanction as manifested in licensure by legal authorities; freedom from lay evaluation and control; the establishment of a collegial network or community (Goode, 1957) serving as a reference group and support system; and finally, monetary and social rewards such as wealth and prestige. Following a brief review of the attribute theory, a critical assessment of this framework will be presented.

Professionals,in general, are presumed to work on the basis of a body of systematic theory and/or esoteric, abstract knowledge. Their training is very specialized,spanning a number of years and is complex in character. On the basis of their specialized training and knowledge,

the professional claims expertise in his/her field, thereby serving to discredit other practitioners who have not acquired like training and/or the attendant abstract theory and intellectual technique (Goode, 1957; 1960; Greenwood, 1962).

The fundamental aspect of professional expertise is that it is grounded in science. This knowledge, resting on the laurels of "objectivism" and "rationalism", is authoritative (as compared with "traditionalism" which is not). In addition, scientific expertise is seen as universally valid (Parsons, 1954).

> A scientific basis stamps the professional himself with the legitimacy of a general body of knowledge and mode of cognition, the epistemological superiority of which is taken for granted in our society. The connection with superior cognitive rationality appears to establish the superiority of one professional "commodity" independently of the interests and specific power of the group or coalition which advocates this definition. The monopolistic professional project is legitimated, therefore, by the appearance of neutrality (Larson, 1977: 41).

Although some nonprofessional occupations operate on the basis of a body of "scientific" thought, the distinguishing feature of professional groups is that they claim their knowledge is more uniform and standardized, more esoteric and more abstract. The sheer complexity of this cognitive basis requires an often prolonged period of study, sometimes requiring a life-long education in order to keep up-to-date in terms of the continual progress and changes which are being made in the field (Larson, 1977).

Another related feature of professionalism is that the training duly obtained is situated in the university. This, in and of itself, "brings in a built-in legitimation of monopoly in terms of cognitive superiority" (Larson, 1977:48). As Bullough has noted (1966),

medicine's grounding in the university was fundamental in the professionalization process. Finally, the expertise of the professional is also functionally specific (Parsons, 1954). In being limited to the particular field of his/her expertise, boundaries are established and the professional is deemed an authoritative expert in his/her sphere.

Regarding the service orientation, it is suggested that professionals customarily utilize their expertise in solving the problems of those unequipped to do so themselves. That is, "work at the professional end of the continuum is regarded as that which has the greatest applicability to the most intense crises that persons face" (Pavalko, 1971:19). In the service of his/her clients, ideally, the professional defers satisfying his/her own personal interests for the sake of the client's best interests. The service orientation, perhaps more than anything else is what separates many occupations from professions, and is a critical factor in the professionalization process.

The service orientation of both modern and classical professions (here, referring to medicine) has a long history, dating as far back as ancient times. The Hippocratic Oath is the exemplar of medicine's orientation towards service:

> I will use treatment to help the sick according to my ability and judgement, but never with the view to injury and wrong-doing . . . Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm . . . (Coe, 1970: 164).

Professional work is pursued as a calling (Weber, 1958), a life-long task, the aim of which is to help others. Pecuniary interests are secondary. Service is rendered to humanity for the good of the public. The salience of the service orientation in professions is highlighted, therefore, by altruism and a general subordination of self-interests.

Conversely, nonprofessions presumably exhibit egoism and acquisitiveness common to a capitalist social structure (Parsons, 1954).

By virtue of these characteristics of professions, society grants to the professional autonomy in his/her work. However, it is expected that this autonomy will be restrained by responsibility (Moore, 1970). Society

> will concede autonomy to the professional only if its members are able and willing to police themselves; will grant higher fees or prestige only when both its competence and its area of competence seem to merit them; or will grant an effective monopoly to the profession through licensure boards only when it has persuasively shown that it is the sole master of its special craft and that its decisions are not to be reviewed by other professions (Goode, 1960: 903).

Therefore, in order that its autonomy remain stable and intact, the profession takes the necessary measures in monitoring its members' practices, ensuring that only those with appropriate credentials be awarded license, and so on (i.e., the derived characteristics of the profession).

In sum, the profession creates an ideology (see chapter 2) which serves as a justification for its claims to autonomy and which institutionalizes various role relationships supporting the professional and professional group (eg., practitioner--client, practitioner--practitioner, practitioner--professional community, practitioner--society, professional group--society, etc.). In addition, professions like medicine tend to emphasize the importance of the service orientation as a counterbalance to professional autonomy, and as an element of public persuasion in the attainment of self-regulatory autonomy (Freidson, 1970a).

Although Greenwood (1962), for instance, would have us believe

that the differences between professions and nonprofessions are quantitative (i.e., a matter of degree), rather than qualitative, it appears that what <u>really</u> distinguishes professions from nonprofessions, or would-be professions is <u>not</u> the amount, scope or content of training, <u>nor</u> the extent to which service and altruism are manifested as opposed to pecuniary interests, <u>nor</u> any of the previously mentioned "derived characteristics" of a profession. Rather, what separates professions from other work groups in society is a matter of <u>autonomy</u> -- autonomy for the individual practitioner, and autonomy for the collectivity of which the individual professional is a part. This autonomy is evidenced in the ability of the profession to define the terms and content of its work, and the method and amount of remuneration for services rendered. For most professions (eg., medicine), this autonomy is organized and legitimate, providing the occupational group with the means by which to control and monopolize those aspects of life within the boundaries of its professional expertise. Freidson's comments on the instrumentality of autonomy are noteworthy:

> . . . the possibilities for functional autonomy and the relation of the work of an occupation to that of dominant professions seem critical. And the process determining the outcome is essentially political and social rather than technical in character -- a process in which power and persuasive rhetoric are of greater importance than the objective character of knowledge, training, and work (1970a: 79).

Autonomy for certain occupations permits them to dominate other workers in the division of labour. Owing to its position of dominance, the medical profession, for example, is free to define which other professional groups will operate within the health care system, and in what capacity (cf. Kronus, 1976). Strategies for controlling these

other workers include defining who shall be considered as a professional, their terms and content of work, and often the method and amount of remuneration these workers will receive. Most importantly, dominant professions lay claims to ultimate responsibility in health care, thus locating themselves at the apex of the hierarchy in health care -- holding the reins of power and assuming a solid position of dominance. The fact of medicine's autonomy and authority in health care, in addition, facilitates medical social control. Medicine directs the stage play: it determines the plot (i.e., the definitions regarding health and illness) as well as the actors and their respective scripts (i.e., doctors are the major protagonists, while all others remain subordinate).

In sum, when one speaks of professionalism and professionalization, implicitly or explicitly, the discussion centers on technical autonomy and monopolization (cf. Freidson, 1970a; 1970b; Larson, 1977) -- autonomy and monopoly of educational programs, curricula, facilities and recruitment policies, work settings, clientele, other groups of workers, social definitions relevant to professional expertise, and perhaps even input into major policy questions in some of the basic institutions in society (Larson, 1979), as well as the freedom to control and dictate functional aspects of those institutions.*

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* For example, doctors and lawyers often have direct input into public policy questions related to their fields of expertise. Increasingly, however, their expert advice has been sought in other spheres, which may only be tangentially related to their areas of competence (eg., environmental protection, consumer product safety, etc.). The participation of professional groups in public policy has been praised by some, and lamented by others. For example, Carr-Saunders and Wilson (1962) suggest that expert involvement is an asset in contemporary society. As they state, "entrance of professional associations into
(continued on next page)

Despite the apparent heuristic value of the attribute theory of professions (i.e., as an analytic tool), there is a growing suspicion that the attribute theory of professions is obsolete (Haug, 1977). Becker declared that the concept of professions was a "folk concept" -- a word used as a semantic tool to garner status, income, increased privileges and reduced constraints (cited in Haug, 1975: 198). Roth has suggested that the concept of professions is "the sociologist's decoy". He contends that the professionalization of various occupational groups represents a process designed to secure certain rewards not necessarily commensurate with achievements. As an object of study of sociologists, professionalism has been analyzed as a product, rather than a process (Roth, 1974). More pointedly, he claims that

> sociologists who focus on lists of attributes . . . become the dupe of established professions (helping them justify their dominant position and its payoff) and arbiters of occupations on the make, keeping score instead of observing and interpreting the behavior involved in the process of scoring . . . The listing of attributes and the rating of occupations on a professionalism scale are objectionable not only because they have proved a theoretical dead-end, but also because they have deflected concern from more crucial problems created by professionalization, such as the avoidance of accountability to the public, the manipulation of political power to promote monopoly control, and the restriction of services to create scarcities and increase costs (Roth, 1974: 17-18).

Furthermore, there is a growing body of evidence to suggest that

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questions of public policy . . . is one of the most hopeful means of bringing the expert into the service of democracy" (1962: 204). On the other hand, such involvement of professionals in public policy has been seen as just another way for these groups to exert social control. It is suggested that although "a professional . . . (should be) held to be an 'authority' only in his(/her) own field"(Parsons, 1954: 38), in contemporary society, professional jurisdictions have become quite elastic. Because professional advice is accepted as "expert" and "altruistic", society has become more amenable to accepting such involvement on the basis of its inherent credibility and ethicality (irrespective of whether these professions are competent to deal with questions outside their jurisdictions).

the autonomy of professions is withering away. Haug (1975; 1976; 1977) presents cross-cultural evidence to suggest that the increased education of the masses has demystified professional knowledge. Moreover, the new consumerism ("client consciousness") has resulted in a demand for greater accountability to the public. As was noted previously, the self-help movement has been instrument in debunking professional power (Haug and Sussman, 1969). Finally, the age of the computer has increased accessibility of knowledge to both professionals and clients. Just as before when the printing press threatened the professionalization of medicine (Bullough, 1966), so too, the computer may be instrumental in shattering the monopoly of knowledge within the professions. In effect, the "competence gap" between professionals and clients may be narrowing (Parsons, 1970). Eventually, one may see a time when it becomes not <u>what</u> you know, but instead, <u>whether you know how and where to locate stored knowledge</u> (Haug, 1977: 29).

Another point deserves critical comment. Doctors have long claimed that their discipline has a scientific basis (cf. Freidson, 1970a), and they use this contention as a means of securing autonomy. Contrary to medical opinion, McKinlay has suggested that most of medicine remains as a body of primarily unexamined techniques and information (1977: 471). A large part of medical practice, indeed, is fraught with serious gaps in available knowledge (eg., physicians have been unable to determine the etiological basis of certain diseases such as leukemia, forms of muscular dystrophy, etc.) which cause immeasurable uncertainty for practitioners and clients (Fox, 1957; Light, 1979). Nonetheless, by claiming (sic) a special relationship

with science, the medical profession achieves a public mandate which raises it to a special position in society.

Finally, it is important to comment on the service orientation of professions, and particularly that of the medical profession. The autonomy of professions is partially explained in terms of the public's belief in the ethicality and non-pecuniary interests of professions. In essence, the profession's success in obtaining a public mandate is predicated on its claims of ethicality and selflessness. It seems reasonable to suggest that such a mandate ought to be granted on the basis of practical experiences rather than simply on the basis of claims. Until such time as it can be documented that the medical profession is unquestionably ethical and altruistic -- there is compelling evidence to suggest that the opposite is the case (cf. Ehrenreich and Ehrenreich, 1978; McKinlay, 1977; Ryan, 1976; Sudnow, 1970) -- it is difficult (and perhaps fallacious) to argue that there is, in fact, a correspondence between physicians' claims and social realities.

In light of the possible gaps which exist between idealistic claims and empirical realities, one must exercise caution in suggesting that professional autonomy and immunity are desirable. There may be a danger in permitting porfessionals to act on the basis of supposition. Faith in medicine, in particular, may be a risky endeavor given some recent developments (e. unnecessary surgery, clinical iatrogenesis, etc.)

Yet, it appears that modern medical practice continues to retain a measure of autonomy and dominance in health care. To a greater or lesser extent, the technical autonomy of medicine still pervades the

health care system. The coupling of medical ideology and a monopolization of technique continue to facilitate medical social control, and it is to this subject that the discussion now turns.

THE TECHNOLOGIZATION OF BIRTH

On the basis of the preceding discussion of the nature of technology in society and professionalism, what follows will be an attempt to illustrate how technical autonomy, the key defining characteristic of the professions, has been utilized by the medical profession as a means of social control. Professional practice is defined primarily in terms of the monopolization of techniques (Larson, 1977). The example of birth can be used to demonstrate the extent to which social control is exercised by the medical profession.

In the preceding chapter on ideology, it was noted that through the use of medical or quasi-medical language, the profession of medicine redefines the nature of selected problems, i.e., the conditions are medicalized. Moreover, it was noted that by removing conditions from the social, political, economic or physical orders and placing them on the technical level, technical solutions are designated by the profession. The literature presented in the previous chapter illustrated that through defining pregnancy as a legitimate time to assume the sick role (Parsons, 1951), through the location of birth in the hospital (cf. Oakley, 1975), and the necessity of a physician's diagnosis (cf. Kolker, 1980; Oakley, 1975), birth has been medicalized.

In addition, there is evidence to suggest that birth has been "technologized". That is, physicians have demonstrated their

reluctance to let Nature handle itself, and have instead introduced a wide array of technologies into the management of birth. Haire has referred to the technologization of birth as "the cultural warping of childbirth" (1978a). Various others have referred to the transformation of birth by medicine as the distortion of childbirth (Anderson, 1979), "the trap of medicalised motherhood" (Oakley, 1975), and the dehumanization of childbirth (Ratner, 1978). Each of these critical assessments of the management of childbirth suggests that the medical profession has signfficantly altered the birth process, the result having been perceived as somewhat undesirable.

In spite of recent changes in obstetrical practice (Ruzek, 1978), childbirth is generally thought of by the medical profession as an illness (or illness-like condition) rather than a natural process of the female reproductive system. Technical interventions, therefore, are commonly introduced into the management process, and are always utilized with the best of intentions (i.e., to shorten labour and delivery, to reduce pain and anxiety, and to curb neonatal and maternal morbidity and mortality).

It is important to note that the technologization of birth (like the medicalization of birth) has occurred not only as a result of the medical profession's desire to implement technological interventions, but additionally because laymen have encouraged the utilization of technologies in the treatment of medical and/or medicalized conditions. For example, Haug has documented the demands by patients for prescriptions for barbituates and tranquilizers to relieve anxiety and depression (1976: 93). Leavitt, as well, has documented women's demands for

"twilight sleep" (an anesthesia composed of scopolamine and morphine) during delivery around the turn of the century (1980: 147-164).

Historically, and even today, the layman's reverance for medical science and its potential (derived from a belief in scientism) has resulted in the technologization of various conditions. It is evident that health care systems act as socializing agents (cf. Jordan, 1980; Kloosterman, 1978; Mead and Newton, 1967; Oakley, 1977), and as such define the terms of reference regarding matters of health and illness. It follows, then, that the ideology of medical care which suggests the pathological nature of birth has been successfully disseminated to the public so as to facilitate medical intervention. Consequently, childbirth has been transformed from a normal and natural process into a socially constructed medical (i.e., technical) event (Graham, 1976).

The medicalization of childbirth is a relatively recent phenomenon. Most historical accounts reveal that the transition in the conceptualization of childbirth from a natural, physiological event to a pathological medical crisis began in the late 1800's. With time, and as a consequence of the increasing professionalization of medicine, changing socio-cultural values, and the joining of medical and industrial forces, childbirth "lost its character as a taken-for-granted aspect of adult life" (Oakley, 1975: 640). Whereas previously, women accepted birth as normal and unproblematical, today's prospective mother shares an intimacy with the medical profession in recognizing the pathology of pregnancy and childbirth. Her condition requires medical diagnosis and "treatment". Moreover, in order to "maintain

the definition of pregnancy and childbirth as medical phenomena, the doctor must treat the patient as if she were ill" (Oakley, 1975: 640/ emphasis in original).

Since the 19th century, the physician's orientations regarding pregnancy and childbirth have remained stable, and in some senses, have been fortified. With the birth of obstetrics around 1908 (Kobrin, 1966) as a legitimate specialty in medicine, it became readily apparent that women's reproductive functions were inherently pathological and must be handled by qualified medical practitioners. Furthermore, obstetricians convinced the public that "normal" pregnancy was the exception to the rule. In order to discredit the midwife, obstetricians claimed that the midwife's success stemmed from the fact that she only dealt with "normal" pregnancy. To bolster support for their interests, obstetricians

> argued again and again that normal pregnancy and parturition are exceptions and that to consider them to be normal physiologic conditions was a fallacy . . . Combatting the "fallacy" of normal pregnancy and delivery was necessary not only to enhance the value of obstetric skills but also to make the American mother not merely respect, but fear, possible danger and so consider no precaution excessive (Kobrin, 1966: 353, 359).

Having attained a "carte blanche" in this area, and with the aid of a massive technology, the medical specialists gained exclusive control in the management of this "medically recognized illness". Women were encouraged to adopt the sick and patient roles (although it is questionable whether pregnancy conforms to Parsons' conceptualization -- cf. McKinlay, 1972: 567-570).

> It was seen as appropriate for the women to cede control over the process to medical experts, to adopt a relatively passive role of acquiescence in medical instructions, and

> to remain relatively ignorant of the basis of professional decisions. Childbearing is regarded as highly hazardous, with medical assistance and intervention being uniformly necessary. The physical experiences of childbirth are perceived negatively and therefore to be alleviated, or removed from consciousness, when possible (Macintyre, 1977: 482).

Accordingly, the "normal" view of pregnancy and childbirth was replaced by the "illness" view. The illness paradigm is most prevalent in North America today. To understand the extent to which the medicalization of pregnancy and childbirth (as opposed to the normalization of these procedures) has occurred in contemporary society, one need look no further than the technology utilized by the medical profession. (Comprehensive statistics on the prevalence of various birth technologies utilized in modern obstetrical practice in Canada will be presented in chapter 5.)

First of all, Oakley notes that the most striking evidence of the medicalization of pregnancy and childbirth is the trend toward hospital delivery. In Britain, for example, 15% of all births took place in hospitals in 1927, whereas 91% of all births in 1972 were hospital births (1975: 640). According to the "logic" of hospitals, the birthing mother is a "patient". However, it is questionable that she is "sick". Nonetheless by ensuring that birth is situated in the hospital, physicians can reaffirm the pathophysiological nature of reproduction.

As a patient, the birthing woman and her condition are subject to management by the experts (Freidson, 1970a). To assist them, doctors utilize various "preventive" techniques designed to reduce risk. However, given that childbirth is natural, the physician must utilize medical ideology to justify intervention and the adoption of

various technologies. Arms provides the following description of the doctor's rationale for interventions:

> . . . preventive interferences are the doctor's way of turning sloppy old nature into a clean, safe science. He may explain that obstetrical science is simply a "just-in-case" game of playing the odds in her favour: just in case you hemorrhage, we'll give you simulated hormones before you expell the placenta; just in case your perineum tears, we'll make a nice clean incision before delivery; just in case labor tires you out, we'll give you an early sedative; just in case you need a general anesthesia (for an emergency Caesarean), we'll keep a vein open and stop you from eating and drinking throughout labor, even if it takes twenty-four hours; and just in case you totally lose control, we'll anesthetize you out of all sensation . . . The result is that birthing mothers have given up their responsibility in birth to obstetricians, who have then turned the normal into the abnormal for the sake of preventive procedures, which in turn have caused greater (but more predictable) risk, and this in turn has required even more preventive technology to interfere further with what was once a natural and uncomplicated process requiring no interference at all (1977: 65-66/emphasis in original).

The woman is caught in the vicious circle of medical ideology and technology. The ideology transforms the natural event of childbirth into a physician-centered operation (Corea, 1977: 209); and the technology transforms a simple, uncomplicated process into a surgical event. As Corea asserts, physicians claim that "if every woman has natural childbirth, we (doctors) wouldn't be able to practice techniques" (1977: 232). Therefore, since natural childbirth is "taboo" in medical circles,"we're (doctors) going to make it so unnatural that you won't be able to (have natural childbirth)" (Corea, 1977: 261).

Unfortunately, we have reached a point in history, as a consequence of the professionalization of obstetrical medicine, the divestment of personal responsibility among patients, and a medical-industrial complex (to paraphrase Mills, 1956), where "normal",

"natural" childbirth is the exception to the rule. Few births are natural today, although this situation is gradually changing with the move towards normalization of childbirth (cf. Macintyre, 1977: 482). Most births, however, are in one way or another interfered with and managed by the experts. The types of intervention common to the North American way of birth include the following: induction of labour, fetal heart monitoring, drugs, forceps and vacuum extraction, episiotomies, lithotomy (or supine) position for delivery, and Caesarean sections.

Elective induction of labour, done by puncturing the woman's bag of waters and/or by the administration of hormones, although convenient for the doctor (i.e., s/he can plan deliveries according to a desired schedule) often leads to dire consequences for both mother and child (Cartwright, 1979). For the mother, it exaggerates pain in labour, invariably necessitating the administration of more drugs. For the infant, it may lead to deformities of the head, sluggishness of the respiratory system, acid-base imbalance, dis-alignment of the parietal bones, perinatal mortality or future impairment of learning ability. Since induction is usually unnecessary and potentially harmful, it remains questionable as to why this practice occurs so frequently (see chapter 5).

The fetal heart monitor, designed originally to detect abnormalities in birth, is one of the most common preventive procedures utilized in North American births. However, like most machinery (and especially when in the hands of inadequately trained personnel), it is subject to errors which may lead to further intervention, especially Caesarean

sections (Placek and Taffel, 1980). Aside from this effect, the utilization of the monitor has the secondary effect of immobilizing the mother and may result in "supine hypotension", which reduces the blood (oxygen) flow to the baby. Again, "the very interference used to 'help' the natural process only provides further complications that hinder the process as well" (Arms, 1977: 77).

Drugs of all sorts, but especially analgesics, anesthetics, barbituates, and narcotics,are in common use during labour and delivery. Generally, women are uninformed of the disadvantages of obstetrical medication. While physicians believe that obstetrical medication will ease the mother through an "uncomfortable" and "painful" labour and delivery, it is common knowledge in obstetrical science that virtually everything crosses the placenta and can cause significant drug concentrations in the fetus, which can hardly tolerate the adverse pharmacological effects of these drugs. It is clear that "a major danger may now be medication itself" (Arms, 1977:87).

Forceps extraction is practiced in over 65% of all births in most North American hospitals (Haire, 1978a: 193; see chapter 5 for Canadian statistics). In some cases, forceps extraction is necessary (eg., maternal exhaustion, premature separation of the placenta, etc.), however, increasingly, the obstetrical forceps has become a procedure used for convenience. As Arms asserts,

> since most doctors believe more fully in their scientific expertise and technological skill than in the natural process of birth, and since the obstetrician's job in birth is often to prevent problems from occurring, the doctor is more likely to reach for forceps than wait for the process to correct itself in good time (1977: 96).

Similarly, the vacuum extractor is utilized to "suck" the baby's head

down the birth canal. It is generally a less traumatic technique than forceps extraction (although there remains some uncertainty on this point -- cf. Pritchard and MacDonald, 1976), but if used for the doctor's convenience without regard for the child's safety or the woman's choice, it remains a questionable practice. Moreover, in both forceps and vacuum extraction, "there is no scientific justification for the routine application of (these procedures) for delivery" (Haire, 1978a: 193).

Episiotomies -- the surgical incision to enlarge the vaginal orifice -- are performed in over 70% of all births in North America (Arms, 1977: 101; see chapter 5 for Canadian rates). The justification for this intervention is that it will reduce the amount of tear in the perineal tissue and will ease the birth process. In Williams Obstetrics, the bible of obstetrical medicine, it is claimed that the episiotomy should be performed "more for the sake of the baby . . . (since) . . . it spares the baby's head the necessity of serving as a battering ram against perineal obstruction" (in Arms, 1977: 100). Unfortunately, there is little scientific evidence to affirm that episiotomies are necessary or better (i.e., less traumatic) than a slight perineal tear (Haire, 1978a: 194).

The supine or lithotomy position is "inherently harmful for every mother and child" (Arms, 1977: 102/emphasis in original). Aside from the fact that the lithotomy position works against natural forces of gravity, it "tends to alter the normal fetal environment and obstruct the normal process of childbearing, making spontaneous birth more difficult or impossible" (Haire, 1978a: 192). The lithotomy position

generally increases the need for more intervention (eg., forceps or vacuum extraction, drug stimulation, episiotomy, etc.) and severely endangers the life of the infant because of the potential acid-base imbalance, reduced oxygen, and so on that this position creates. Indeed, the available evidence points to the fact that the only one to benefit from the lithotomy position is the doctor (Arms, 1977; Haire, 1978a; Rich, 1977). As stated by Dr. Caldeyro-Barcia, himself an obstetrician, "except for being hanged by the feet, the supine position is the worst conceivable position for labor and delivery" (cited in Arms, 1977: 102). History has shown that a semi-sitting position or a birthing stool are more amenable to safe and easy birth. However, "the chief objection to the use of the obstetrical stool or chair seems to be that obstetricians believe it would be inconvenient for them in attending births" (Rich, 1977: 156).

The ultimate medical intervention is the Caesarean section birth. The operation consists of making an incision through the abdominal wall and through the uterus in order to remove the fetus manually. In some cases, the procedure is necessary to save either mother, child or both (eg., diabetic mothers, elderly (over 35 years) primigravidae, breech births, etc.), however, with increasing frequency C-sections are being performed by doctors without just cause or medical evidence of the procedure's benefits. In some American hospitals, C-sections are performed in as many as 50% of all live births (Arms, 1977: 115; see chapter 5 for Canadian data).

> The Caesarean places the natural process totally within the specialist's domain and relieves the birthing woman of any effort, indeed any responsibility, in her own birth. With an elective C-section there is no need for doctor and patient to "quibble"

> about the value of induction, oxytocics, monitors, drugs, forceps, or episiotomies. The mother herself, after enduring the trauma and pain of recovery following major abdominal surgery, may find the Caesarean so quick and easy that she will tell her friends that it was as simple as having tonsils or an appendix removed . . . (However) mother and child pay a price (as measured in socio-emotional, rather than economic, terms; i.e., bonding) for this ultimate intervention that may far outweigh the value of Caesarean in the long run, but from the doctor's viewpoint, if it takes a Caesarean to ensure safety, what else is there to worry about? (Arms, 1977: 115-116/ emphasis in original)

Each of the above medical interventions, as well as numerous others (including separation of mother from familial support, mandatory hospital birth, confinement to bed for labour, shaving the birth area, delaying birth until the physician arrives, early clamping or "milking" of the umbilical cord, delaying the first breast feeding, withholding nighttime feedings, restricting feeding to a four-hour schedule, preventing early father-child contact, restricting sibling visitation and restricting intermittent rooming-in* -- cf. Haire, 1978a: 189-197) provide ample and strong evidence of the extent to which medical interventions occur in North American births. As Haire asserts, these obstetrical practices have only served to "warp and distort the childbearing experience" (1978a: 188). Moreover, the above account points to the extent to which obstetrical medicine functions as an agent of social control, via the routine and over-dependence on medical technology.

Although 90% of all births are normal (Arms, 1977: 122), the

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* It should be noted that the frequency of occurrence of these interventions is believed to be on the decline as a result of, for example, the women's health movement (Ruzek, 1978). Lacking empirical investigations in this respect, one can only speculate as to why there have been reductions in certain interventionist obstetrical practices.

medical profession has created a situation where few births do in fact occur naturally and without medical intervention. Doctors always claim that their interventions are in the best interests of the mother and child, but such assertions must be critically evaluated in light of the fact that a substantial amount of intervention is unnecessary and iatrogenic (Illich, 1977). Using an ideology which exaggerates their superiority in technique, ability and benevolence, medical practitioners have medicalized birth. After all, "how could a woman . . . know more about oxytocics or forceps than her doctor? Why would a mother want to challenge a doctor's expertise when he obviously has her safety and the safety of her child in mind?" (Arms, 1977: 122-123) Birth, according to physicians, is doctor's business. It is defined as a medical "problem", and is widely accepted as such by the lay population. However, until such time as it can be demonstrated that risk is reduced by medical intervention, it remains a matter of contention whether the medicalization (and technologization) of birth serves the interests of anyone, except the medical profession itself.

THE DOMINATION OF BIRTH THROUGH TECHNOLOGY

To return to the opening theme of this discussion regarding the role of technology in society, it appears as though technology has become a paramount factor in the management of the birth process. In terms of "technology as dominance" (Novek, n.d.), the various technological interventions adopted by the medical profession are signfficant in ensuring (or at least promoting) patient acquiescence

and professional control. In fact, because these interventions are introduced with the best interests of the mother and child in mind, and because birthing women want least of all to jeopardize the lives of their offspring, "uncritical acceptance of (the doctor's) expertise is frequent: a patient wants to believe that somebody can help" (Larson, 1977: 22).

Through technology, wittingly or unwittingly, the medical profession is able to perpetuate existing social relations, and in the case of birth, the subordination of women to the "kindly","always benevolent" (and often male) obstetrician. That technology functions as a self-legitimating ideology is also evidenced by the fact that inherent in the various technological interventions is a built-in rationalization system. This ideological component of technology is illustrated by Anderson (1979: 24-25) and Ettner (1977: 17-23). One intervention gives rise to another, and another,and so on. All are justified as responsible management of an "inherently abnormal" process. Technology preempts women's freedom of choice(i.e., it actually defines choices) and furthermore "demonstrates the 'technical' impossibility of being autonomous, of determining one's life" (Marcuse, 1964: 158).

Finally, that technology is unidimensional is evidenced by the fact that members of society have assimilated notions regarding birth and the necessity of intervention and professional management (i.e., the scientific rationality regarding birth as advocated by the medical profession). "The dialectic interplay between technology and social structure has been lost and the latter has collapsed into the former" (Novek, p. 16).

The autonomy of technique is best summarized by Ellul:

> . . . technique pursues its own course more and more independently of man. This means that man participates less and less actively in technical creation, which by the automatic combination of prior elements, becomes a kind of fate. Man is reduced to the level of catalyst. Better still, he resembles a slug inserted into a slot machine: he starts the operation without participating in it (1964: 135).

In the sphere of medicine, the unquestionable salience of technique and science furnish the technicians -- doctors -- with the means to exercise cooptative social control.

At the same time, the recent emergence of a "patient consciousness" as a result of the consumer movement, as well as higher levels of education among the public in general may be able to erode professional authority and autonomy somewhat (Haug, 1975; 1976; 1977; Haug and Sussman, 1969). Patients' demands for greater accountability on the part of their physicians, as well as sound evidence on the need and efficacy of treatment modalities eventually may lead to reduced intervention in the birth process. However, the demedicalization (i.e., normalization) of birth is not yet at hand. To a greater or lesser extent, physicians continue to intervene in the birth process, and thus exercise medical social control.

The preceding discussion of the centrality of medical ideology and technology in the exercise of social control may now be utilized to understand <u>who</u> controls the birth process. The succeeding chapter will examine the nature of interprofessional relationships. In essence, because birth has been medicalized and technologized, the medical profession has determined that expert (i.e., medical) management is critical.

Chapter Four
Interprofessional Relationships: Midwives and Medical Men -- A Socio-Historical Analysis of Rivalries in the Management of Birth in America and Britain

THE MANAGEMENT OF CHILDBIRTH

> . . . the giving birth to a child is a manifestation of nature pure and simple. And nature in this, at least, is considered practically, if not entirely, self-sufficient. Nature requiring but a minimum of assistance to complete her work in her obstetric undertakings, obviously such a minimum assistance should merit but a minimum of regard with the little that entails. This minimum assistance has been rendered from time immemorial and in it we can see the obvious development of the midwife (Paine, 1915: 761).

Historically, birth has seldom gone unattended. For centuries, the responsibility for assisting women at birth resided with the midwife. Although the practice of midwifery by male physicians was common as far back as the second century A.D. (Donnison, 1977), typically attending births was "women's business" (Oakley, 1976). The traditional orientation prevalent in early America and Europe (and that which is still operative in selected western European nations today such as Norway, Denmark, and Sweden)viewed reproduction as inherently normal and valued the empirical experience of the female midwife.

By contrast, the modern orientation of scientific-technical medicine considers birth to be a medical condition, which is potentially dangerous and which requires professional assistance. The emphasis today, which originated around the beginning of the twentieth century, is on the need for professionally trained male obstetricians (cf. Barker-Benfield, 1976b; Devitt, 1979; Donegan, 1978; Ehrenreich and English, 1973b; 1978; Kobrin, 1966; Lorber, 1975; Oakley, 1976; Rich, 1976; Wertz, 1980; Wertz and Wertz, 1979). The conflict between

perceptions of reproduction as normal versus pathological, between the need for experience versus professional training, and attendance by women versus men is the subject of the discussion which follows.

It was suggested in the introduction to this thesis that Conrad's concept of "medical collaboration" (1979), as a type of medical social control offered too narrow a perspective on the nature of inter-professional relationships. That medical authorities cooperate with other agents of social control to facilitate the provision of information, gatekeeping, and other functions is not being contested. However, it is important to note that medicine's relations with other groups have not always been harmonious. In fact, competition between medicine and other health care practitioners (and even within the various factions of the profession itself) have been common throughout medicine's history (cf. Bullough, 1966; Bullough and Bullough, 1972; Kronus, 1976). It would seem that one of the ways in which the profession of medicine is able to exercise independent social control today can be understood by analyzing the nature of competition between medicine and its adversaries in the past. To this end, the purpose of the following discussion is to examine the historical relations between the medical profession (primarily obstetrician-gynecologists) and midwives (i.e., lay or empirically trained, rather than professionally trained midwives), the profession's primary rivals in the management of birth.

The rivalries between midwives and medical men have been most heated in Britain and the United States *, and center on the emergence

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* There is reason to believe that the debate between midwives and physicians in Canada also occurred at this time (cf. Hurlburt, 1981). However, lacking substantial evidence in this respect, one can only
(continued on next page)

of obstetrics and gynecology as a specialty in medicine. Accordingly, the major issues to be dealt with in this chapter are: the rise of obstetrics and gynecology; the preemption of midwives by the medical profession in America through control over technology, ideological claims of superiority and legislative means; and in Britain, the control of midwives through national legislation and registration programs.

To the extent that the debate over control of childbirth today is an expression of past concerns, this socio-historical review will be utilized to inform the current interprofessional rivalries in birth management -- a topic to be considered in the ensuing chapter.

THE RISE OF OBSTETRICS AND GYNECOLOGY

The development of various medical specialties has been primarily contingent on technological diversification within the profession, as well as patient demand for physicians with specialized knowledge in parts of the human anatomy (Kobrin, 1966: 350). One specialty which emerged as a result of the elaboration and institutionalization of scientific knowledge and technological discoveries was obstetrics and gynecology.* However, its acceptance in medical and non-medical circles

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suggest that it is likely that the campaign against midwifery was blind to national differences in North America. Indeed the absence of midwifery in Canada today would seem to indicate that early and sustained opposition to this group of practitioners was typical in Canada (see chapter 5).

* Obstetrics and gynecology was also referred to as midwifery in earlier times, and the two terms were often used synonymously. However, for the sake of clarity, "obstetrics and gynecology" will be used to refer to the profession of medicine's management of birth; while "midwifery" will be used in the context of the discussion of primarily female, lay practitioners.

depended largely on attitudes toward reproduction. Despite the fact that most laymen considered birth to be a normal physiological process prior to the twentieth century, after this time many believed that treatment and management by certified experts was necessary to ensure successful outcomes in birth. Indeed, it appears that the transition in laymen's perceptions regarding birth and its management were determined largely by professional perceptions. It is conceivable that changes in the birth rate (i.e., individuals were opting for fewer children) also led the layman to alter his/her perceptions regarding the management of birth -- that is, there was an inclination towards professional management (cf. Chamberlain, et al., 1980; McKeown, 1965; 1979; McKeown and Lowe, 1974).

One of the most significant precursors to the rise of obstetrics and gynecology was traced to the medical profession's perspective on women. During the late nineteenth century, there was a common belief among medical practitioners that the female physiology was inherently pathological (Ehrenreich and English, 1973a; Scully, 1980). Not only were there serious risks associated with childbearing, but more importantly, all female functions were perceived to be pathogenic. "Moreover, since women were held to be creatures at the mercy of their physiology, the problem required a body of experts to deal with them"(Barker-Benfield, 1976b: 88).

The ideology prevalent during this time resulted in the development of numerous theories and technical interventions designed to explain and resolve the problems associated with the female anatomy. One popular theory used to account for the sicknesses of upper class

women -- the conservation of energy theory (Ehrenreich and English, 1973a: 31) -- postulated that since the female reproductive organs were the center of a woman's body, women should be advised to refrain from activities which might deprive their vital organs of much needed energy.* Involvement in political, intellectual, or other similar activities might result in untoward physical symptoms or mental illness. Such an ideology was an effective weapon of social control in two respects.

First, it functioned so as to keep upper class women away from jobs and in their homes minding their houses, husbands, and children. But more importantly, established doctors began to develop surgical techniques which they would use (or threaten to use) in the event that women deviated from their accepted social roles (Barker-Benfield, 1976b).

In 1809, the first ovariectomy (female castration) was performed and by 1872, the "normal ovariectomy" was a common surgical procedure (Litoff, 1978: 18). The removal of ovaries was, by 1900, being done as a matter of course for a number of non-ovarian diseases or maladies, such as "insanity" and "sexual perversion". Other indications for ovariectomies included: "troublesomeness, eating like a ploughman, masturbation, attempted suicide, erotic tendencies, persecution mania, simple 'cussedness', and dysmenorrhea" (Barker-Benfield cited in Ehrenreich and English, 1973a: 40). Barker-Benfield has noted that

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* The "conservation of energy" theory was used primarily to control upper class women's health. Lower class women, on the other hand, were faced with an exclusionary system -- "doctors were not interested in serving people who could not pay" (Ehrenreich and Ehrenreich, 1978: 50). Barker-Benfield presents telling evidence regarding the use of the lower classes as teaching material (1976b), and the fact that seldom did the lower classes receive the extensive care that the upper classes were afforded.

some physicians at this time boasted that they had performed as many as 2000 ovariectomies each. In 1906, a prominent gynecological surgeon estimated that approximately 150,000 American women had been castrated by their physicians (Barker-Benfield, 1976b: 121-124).

Another surgical technique developed to keep women in their places was the clitoridectomy (excision of the clitoris). Along with the ovariectomy, the clitoridectomy was used to keep women under male control (their husbands and doctors). These surgical procedures, in addition, raised the status of obstetrics and gynecology. The frequency with which various operative procedures were performed in America led international observers to remark that American gynecology was characterized by "flamboyant, drastic, risky, and instant use of the knife" (Barker-Benfield, 1976b: 90). Unfortunately, available accounts on birth technologies at the turn of the century fail to include exact figures on the number or proportion of cases where such procedures were utilized. Nonetheless, several observers have been led to conclude that obstetricians and gynecologists did perform certain operative procedures frequently (eg., Ehrenreich and English, 1973a; 1978; Litoff, 1978; Sablosky, 1976).

In addition, other scientific discoveries were taking place to advance not only obstetrical science, but medicine in general. In the 1840's, anesthesia was introduced, and significantly altered the birth process (Litoff, 1978: 19). Pasteur's bacteriological discoveries were also incorporated into obstetrical medicine at this time. The occurrence of childbed (puerperal) fever had almost reached epidemic proportions in some hospitals (Slaughter, 1950), but the introduction

of antiseptic measures allayed women's fears of death in lying-in chambers, and thus enhanced the specialty.

Ergot was used to induce uterine contractions. The stethoscope was used to monitor the fetal heartbeat. Instruments were developed to dilate the cervix, thus permitting doctors to insert other instruments into the uterus which would monitor the fetus. The forceps, which had been developed by the Chamberlen family in the late 1600's, had been improved and made more functional for difficult births. By employing forceps, obstetricians claimed that they could reduce neonatal mortality and maternal morbidity and mortality rates. Whether reductions in morbidity and mortality can be linked to the use of forceps (and other medical techniques) still remains a matter of contention (see chapter 5) (Donegan, 1978: 49-59). Neonatal blindness was determined to be preventable through the application of silver nitrate to the eyes of the newborn. Finally, the twentieth century ushered in radiology (X-ray technology), which allowed doctors to measure more precisely the pelvis. Each of these improvements led to the advancement of obstetrical medicine as a specialty (Litoff, 1978: 18-20).

Concurrently, clinical instruction in "demonstrable midwifery" (Barker-Benfield, 1976b) was introduced in the curricula of various medical schools. Physicians were able, therefore, to emphasize not only their superiority in the theoretical aspects of female reproduction, but also now claimed clinical -- empirical -- superiority as well (Litoff, 1978). In addition, the rise of hospitals facilitated clinical instruction, and therefore, enhanced the credibility of

obstetrics and other specialties in medicine (Bullough and Bullough, 1972: 95).

In the latter half of the nineteenth century, the American Medical Association recognized obstetrics as a core area of the profession. Soon thereafter, journals were founded dealing with the diseases of women specifically. In 1876 and 1888 respectively, the American Gynecological Society and the American Association of Obstetricians and Gynecologists were founded. Each of these milestones contributed to the belief that obstetrics was a specialty worthy of pursuit by specially trained physicians.

In 1919, in his presidential address to the American Gynecological Society, Dr. Franklin Martin posed this rhetorical question to his colleagues: "What justifies a specialty, and what maintains it if it is justifiable?" (1919: 252). The answer:

> A specialty is justifiable when a portion of the human body, physical or functional, is sufficiently distinct and important to warrant a group of practitioners devoting their entire time to the consideration of its diseases, if by devoting their exclusive time to such special subject they make it apparent beyond a doubt that such exclusive attention is justified by the improved results (Martin, 1919: 252).

In the minds of the specialists, the practice of obstetrics and gynecology was indeed justified, although many outside observers doubted whether actual improvements in women's health care were traceable to the genesis of this specialty (cf. Brack, 1976; Sablosky, 1976).

As all of these developments were occurring, public attitudes were changing. The profession had effectively convinced the public that childbirth was a disease, which needed both the surgical skill * as

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* Obstetrics is a branch of surgery,ergo, the claim for the need for surgical skills (Donnison, 1977; Emmons and Huntington, 1911; Graham, 1951; Martin, 1919; Ziegler, 1922).

well as drugs and instruments which obstetrician-gynecologists had monopolized. For a good many middle and upper class women, what the physician could offer in childbirth, the midwife lacked.

> The pregnant woman, vulnerable in her understandable wish for a shorter and safer delivery, permitted the (obstetrician-gynecologist) to be called because she believed he always offered the best chance for both (Donegan, 1978: 143).

For the lower classes and most of the immigrant population, midwives continued to serve women in birth. However, the entrenchment of obstetrics and gynecology soon led to the demise of the midwife. In the United States (and presumably, Canada), she was virtually eliminated. In western European nations such as England, Germany, Italy, Holland and others, the midwife continued to attend births, but was regulated by the State.

INTERPROFESSIONAL RELATIONSHIPS IN AMERICA: THE PRE-EMPTION OF MIDWIVES

In order for organized obstetrical medicine to establish itself and eliminate the lay midwife, it had to first, medicalize childbirth (i.e., redefine reproduction as pathological), second, convince the public that only specially trained obstetrician-gynecologists were sufficiently trained in the manipulation of various technological devices and the implementation of essential surgical techniques, which would result in successful outcomes at birth, and finally, discredit the midwife in terms of her abilities and record. In other words, the pre-emption of the midwife rested on the various ideological claims of the profession, as well as its monopolization of techniques. Although obstetrical skills were primitive in the late 1800's and

early 1900's, and physicians' ability to deliver quality care had yet to be proved superior, established medicine began a vehement campaign to ensure physician-control over women's reproductive health care and the effective subordination (in Europe) and elimination (in America) of the lay midwife (cf. Anisef and Basson, 1979; Barker-Benfield, 1976b; Devitt, 1979; Donegan, 1978; Donnison, 1977; Dye, 1980; Ehrenreich and English, 1973b; Litoff, 1978; Wertz and Wertz, 1979).

Takeover Through Redefinition

As stated earlier, one of the determining factors in the success of obstetrical medicine was public acceptance of the specialty's practice. Therefore, the profession had to prove that its perspective on the nature of reproduction was valid, or at least quell opposing perspectives. The official medical perspective on birth is best summarized as follows: "normal pregnancy and parturition are exceptions . . . to consider them to be normal physiologic conditions (is) a fallacy" (Kobrin, 1966: 353).

Further evidence of the medicalization of birth by obstetricians is noted in the review of articles appearing in prominent obstetrics journals during the period of 1910-1920, when the debate on the status of midwives was so heated. For example, Dr. Pomeroy of the Medical Society of the County of Kings (Brooklyn, New York) did not believe that "the midwife (could) classify her cases as normal or abnormal" (cited in Mabbott, 1907: 521).

In 1911, Emmons and Huntington quoted an anonymous Boston physician as having said:

> "No one can thoroughly understand the nature and treatment of labor who does not understand thoroughly the profession of medicine as a whole. He must look upon it with the eye of a physiologist and a physician before he can comprehend its nature, its relations, or its objects"(1911: 255/emphasis mine).

In another passage, they offer the following question for consideration:

> Shall we who enjoy the many improvements in medical science, who are "better educated and fitted for its duties", and who enjoy "the advances in learning and knowledge", and who realize . . . the responsibilities of the more intricate, the more complex and the more difficult methods required by modern obstetrics, and who look forward to far greater advances in preventive obstetrics, whereby skill and judgement of the obstetrician shall be trained to foresee and forestall the many dangers to the coming mother; shall we, I say, let down the bars, shall we take the weaker course and compromise the birthright bequeathed to us by such worthies? (Emmons and Huntington, 1911: 256/ emphasis mine)

Later in the same article, they offer a response:

> We believe it to be the duty and privilege of the medical profession of America to safeguard the health of the people; we believe it to be the duty and privilege of the obstetricians of our country to safeguard the mother and child in the dangers (sic) of childbirth. The obstetricians are the final authority to set the standard and lead the way to safety. They alone can properly educate the medical profession, the legislators and the public (Emmons and Huntington, 1911: 261/ emphasis mine).

Dr. Edgar of New York suggested as a remedy for the midwife problem that

> there should be repeated drill in the physiology of (asepsis or antefactum, labour or intrafactum, and postfactum instruction), with at the same time a clear understanding of the borderline of the pathological (1911: 883/ emphasis mine).

Dr. Cody of Massachusetts stated the situation as follows:

> We are agreed that the expectant mother should be safeguarded through her pregnancy by all that scientific medicine can guarantee; that her delivery and convalescence should be under

> the strictest surgical aseptic precautions, aided by skilled nursing; and at all times she should receive the fullest measure of sympathy. We further wish this could be the lot of every parturient woman. This is the obstetric ideal (1913: 416/ emphasis mine).

Drs. Emmons and Huntington in 1912 similarly emphasized the need for one standard of care -- that is, obstetrical care to ensure "the best possible, immediate, attention for the welfare of all women in the perils of childbirth" (1912: 404/ emphasis mine). In 1913, Dr. Huntington noted the grave ignorance among the laity regarding reproduction:

> There is probably no other branch of medicine about which so much ignorance exists in the lay mind as the subject of obstetrics. The average American, and immigrant, too, for that matter, realizes where to seek and how to find competent medical skills for the illnesses and emergencies that beset his path, but has no idea of the importance of adequate medical attention during pregnancy, labor, and the pueperium. Since the child comes into existence and later into the world by natural processes in the vast majority of cases, the need of any intelligent supervision is not recognized. The deaths and invalidism resulting from incompetent care are not traced to their source (1913: 419/ emphasis mine).

He later suggested that normal birth was only normal in retrospect.

> At any moment complications are liable to arise capable of taxing the skill of the obstetrician to the utmost. . . unless a trained man is within reach the resulting delay means certain death for infant or mother, or sometimes both . . . The obstetrician, by his care of pregnancy, tends to prevent miscarriage, premature delivery and toxemia, and by his preliminary examination selects the operation that he may have to perform, to give the surest chance for a strong living infant and a healthy mother. This the midwife obviously cannot do (Huntington, 1913: 419/ emphasis mine).

Dr. Moran, in the Journal of the American Medical Association, urged his colleagues to sensitize the public to the "clinical fact that normal pregnancy and parturition are the exception" (1915: 125-126).

Implicitly or explicitly, each of the above commentaries suggests that to view the potential for anything short of imminent danger in childbirth would be fallacious. Moreover, that certified experts were required to forestall or prevent possible death or debilitation should be understood as a matter of course.

To substantiate further their perceived "right" and "duty" to pregnant women, and moreover to present evidence of the lay midwife's inadequacy in obstetrics, the profession began a monopolistic campaign in terms of birth technology.

Control of Technology

As has been noted in the previous chapter, the key defining characteristic of professions is technical autonomy (Freidson, 1970a) -- which includes not only the control of the terms and conditions of professional practice, but as well, the definition and control, as well as monopolization of techniques common to professional practice. By designating who can legitimately utilize selected techniques, the profession defines the principles of "exclusion and inclusion" (Larson, 1977) relative to professional practice.* Moreover, by establishing control in this manner, the profession not only discredits its

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* The principles of "exclusion" and "inclusion" are analogous to the concepts of "disciplinary" and "cooptative" control noted by Ehrenreich and Ehrenreich (1978). The monopolization of techniques by the medical profession resulted in the exclusion of midwives, i.e., disciplinary control. At the same time, monopolization of techniques afforded the medical profession with an opportunity to exercise cooptative control over women's reproductive health care.

opposition, but labels them as "charlatans" or "quacks" (i.e., improperly trained) or "encroachers" (i.e., illegal competitors) (Goode, 1960: 904; see also Wardwell, 1972).

The rise and institutionalization of obstetrics took place during and after the development of a number of drugs, instruments, and procedures. Many of the advancements occurred outside of medicine (bacteriological discoveries of the need for antiseptics, the invention of the stethoscope and X-ray technology, to name but a few), but were soon taken over by the medical profession. What is more is that the midwife was denied access to these techniques because it was believed that she was incompetent and ignorant, and had even admitted that training was of little or no practical value to her (Litoff, 1978: 91).

The control of technology in American obstetrics became entrenched in law between 1914-1916 in a number of states in the union, although some others outlawed the midwife entirely (Baker, 1912; Foote, 1919). Failure to comply with legislation led to criminal prosecution and fines of up to $200.00 and/or imprisonment for up to six months (Foote, 1919: 542-543). Midwives were permitted to attend only uncomplicated births and were obliged to notify a qualified physician in the event of any untoward signs or symptoms (eg., excessive vomiting, persistent headache, fits, convulsions, irregular discharge, repeated bleeding or staining, venereal diseases, prolonged labour, irregular fetal heart rate or disappearance of the fetal heart sound, breech presentations, prolapse of the umbilical cord, maternal exhaustion or collapse, or failure of the placenta to be expelled) (Foote, 1919: 543-549).

The only equipment the midwife was licensed to carry included a nail brush, wooden or bone nail cleaner, castile or green soap, vaseline, clinical thermometer, douche reservoir and vaginal douche nozzles (to be used only on a physician's orders), rubber catheter, blunt scissors for cutting the umbilical cord, lysol, boric acid powder, silver nitrate solution and medicine dropper to be used to prevent neonatal blindness, tape or cord, sterile gauze, and absorbent cotton. "No other instruments shall be used or owned by the midwife or kept in her possession. (Possession of these instruments will be taken to indicate their use.)" (Foote, 1919: 544-545). If a diagnosis of fetal presentation revealed a breech position, the midwife could not do an inversion. No episiotomies were to be performed. No surgical equipment was to be in her possession, and therefore she could not perform Caesarean sections when indicated. As few vaginal examinations as necessary were to be made. Forceps could not be used, nor any other instruments introduced into the vaginal cavity to extract the fetus. No drugs or procedures could be used to induce labour or the expulsion of the placenta.

In the event of miscarriage (spontaneous abortion), stillbirth, maternal or infant mortality or morbidity, the midwife was obliged to consult a local physician. By law, the midwife was required to report all deaths to the local registrar of Vital Statistics.

In addition to each of these regulative measures, attempts were made to educate the midwife. Some doctors believed that the lay midwife was an "unnecessary evil" (Cody, 1913: 418-420), whose time of elimination was unpredictable -- although inevitable. Therefore,

she ought to be educated in the meantime. One doctor summarized the anti-midwife sentiments as follows:

> Since the evil cannot be eradicated, the danger to the public can be minimized by some provision for the proper regulation, supervision, and control of the midwife by the state. If these provisions (are) properly carried out, (we can be) hopeful that they would lead to her ultimate elimination (Litoff, 1978: 75).

Special schools and courses of instruction to train the midwife in the essentials of aseptic midwifery were developed in a number of American cities, as a result of the fear of their inferiority promulgated by the medical profession (Baker, 1912; Noyes, 1912; Williams, 1912).

It would seem on the surface that the education of midwives would serve to strengthen, rather than undermine the midwife's claims to legitimacy. Keeping in mind that physicians claimed the right to determine the curriculum of midwifery schools, as well as retention of a strong monopoly over birth technology, it is apparent that educating midwives was merely a camouflage for physician control of midwives. It is also important to note that physicians believed it to be their right and duty to protect the public welfare (Barker-Benfield, 1976b). If appeasing part of the community through the development of midwifery programs would allow the profession to maintain strict control over women's reproductive health care, the profession temporarily favoured the introduction of midwifery programs. It should be recalled, nonetheless, that physicians foresaw the eventual elimination of the lay midwife, despite any education she might receive. As one physician noted regarding necessary reforms, there should be a "gradual abolition of midwives in large cities . . . If midwives are to be educated, it should be done in a broad sense, and not in a makeshift way. Even then disappointment will probably follow" (Williams, 1912: 501-502).

It is interesting to note that the skills and training of both doctors and midwives in the early twentieth century were less than adequate. After conducting a survey concerning obstetric education and the midwife problem in America, Dr. J.W. Williams discovered that nearly 20% of the respondents to his questionnaire (n=43) presented evidence of the deplorable state of affairs in obstetric programs. Most schools were inadequately equipped for teaching purposes. Most professors of obstetrics were improperly trained as instructors, not to mention their general incompetence to perform obstetrical surgery. Few had any confidence that graduates of the obstetrics programs were adequately trained to practice obstetrics, nor would they receive adequate training following graduation (Williams, 1912: 501).

Both midwives and obstetricians were responsible for unnecessary intervention and misjudgement in the handling of birth. There is evidence, however, to suggest that doctors were more negligent than lay midwives (Kobrin, 1966; Litoff, 1978; Ziegler, 1922). By their own admission, the obstetricians who responded to Williams' survey in 1912 stated that "ordinary practitioners lose proportionately as many women from puerperal infection as do midwives, and over three-quarters . . . more deaths occur each year from operations improperly performed by practitioners than from infection in the hands of midwives" (Williams, 1912: 501/ emphasis mine).

Levy reported that midwives in New Jersey in 1921 had better performance ratings than did physicians. In terms of maternal mortality, physicians had a rate of 71 per 10,000 live births, while midwives only lost 22 mothers per 10,000 live births. Midwives' performance with

respect to neonatal mortality (a reflection of the skill of the birth attendant) was also superior. While physicians had a rate of 40.6 deaths per 1000 live births, midwives had a rate of 32.3 deaths per 1000 live births. Even when the greater proportion of difficult births (i.e., primiparous or firstborns) was taken into account, midwives reported better outcomes than doctors. However, physicians were intent on biasing the statistical methodology to create the appearance of midwife inferiority (cited in Devitt, 1979: 170-172). Despite the incriminating evidence against doctors, midwives were never credited with having superior skills. Few doctors acknowledged the importance of environmental factors upon health. Instead, "they laid the blame for the nation's poor obstetric health upon the midwives" (Devitt, 1979: 169).

In 1922, Dr. Charles E. Ziegler, professor of Obstetrics at the University of Pittsburgh, appealed to his colleagues to improve the standards and quality of obstetrical care in the nation. He suggested that the elimination of lay midwives would only partially improve the appalling infant, neonatal, and maternal mortality statistics. He emphasized the need for the improvement of all accoucheurs -- men and women, midwives and obstetrician-gynecologists: "It will not get us anywhere to say that midwives do just as good work as the average doctor, which may be true. It should not be a question of the lesser of two evils. Neither is fit" (Ziegler, 1922: 412). Only after radical reforms were introduced in maternal and child health care would it be possible to effect a significant change in the quality of care (Williams, 1912; Ziegler, 1922).

Despite strong evidence regarding the competence of lay midwives (i.e., their services went beyond strict medical care, and included emotional support as well as public health services), the power and technical autonomy of physicians were sufficient to ensure medical control of childbirth (Devitt, 1979). The profession convinced the public that no intervention was excessive, and in fact, that only physicians were competent to forestall or prevent danger from ensuing in the birth process. Combined, the prevailing medical ideology, and monopolization of techniques furnished the profession of medicine with the means by which to exclude midwives from practicing in America, even in the face of competing evidence. "Every time obstetricians applied the forceps or performed a Cesarean delivery they proved to themselves that they, the obstetricians, were necessary" (Devitt, 1979: 184).

Non-Technical Criticisms of the Midwife

Aside from the medicalized perspective on birth, and technical exclusion of the lay midwife, the medical profession relied on anecdotal and unsubstantiated opinions, as well as sexism and racism to argue against the institutionalization of midwives in America. As Devitt discovered, "most of the medical men had too great a contempt for the midwife and thus too little respect for fact" (1979: 89) to be able to evaluate objectively the quality of care given by midwives. Obstetric skill on the part of physicians was not self-evident, yet the midwife was never credited with having any skills whatsoever. Devitt's review of the literature between 1890-1930 demonstrates this explicitly (1979). Prejudice more than fact was instrumental in the

elimination of the American midwife.

First, there were sexist "slurs" on the midwife's character and potential. Anti-midwife physicians repeatedly stressed that "women were biologically and intellectually inferior to men" (Litoff, 1978: 78; cf. Ziegler cited in Cody, 1913).* Next, there were racial prejudices which biased the medical community's perspective on the midwife. The opinion of Dr. Underwood, director of the Bureau of Child Hygiene of Mississippi in the 1920's, is typical of the anti-Negro sentiment during this time:

> What could be a more pitiable picture than that of a prospective mother housed in an unsanitary home and attended in this most critical period by an accoucheur, filthy and ignorant, and not far removed from the jungles of Africa, laden with its atmosphere of weird superstition and voodooism? (cited in Litoff, 1978: 78)

Anti-immigrant prejudices were also rampant. In the late 1800's and early 1900's, a good majority of midwives and women predisposed to using the services of the midwife were immigrants. Immigrants were seen as ignorant and beyond education. Emmons and Huntington's remarks were similar to others fearful of the "foreign element":

> With the stream, or, better, the mighty river of emigration which has swept this country within the last half century, has come very naturally the midwife habit and the midwife. In all large cities or centers of foreign population these midwives have quietly plied their trade, commonly unrestricted, unsupervised and unmolested (1911: 256).

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* This attitude, no doubt, originated during Victorian times, when women were encouraged to refrain from intellectual pursuits for the sake of their reproductive organs (Ehrenreich and English, 1973a; 1973b; 1978). Moreover, intellectual training was seen as un-feminine. This perhaps accounted for the restrictive policies of higher educational institutions (cf. Blackwell, 1977; Campbell, 1973; Walsh, 1977).

The "midwife problem" in America, in fact, was attributed to the foreign midwives, who apparently were attempting to institute an "old" custom in a "new" nation. The only resolution of the "midwife problem" was, according to some, to stop the flow of immigrants into America. As obstetricians believed their cries for a moratorium on immigration to resolve the "midwife problem" were falling on deaf legislative ears, they resorted to slanderous defamations of all midwives, but particularly the foreign-born midwife.

> The obstetricians thought of her as "the typical, old, gin-fingering, guzzling midwife with her pockets full of forcing drops, her mouth full of snuff, her fingers full of dirt and her brains full of arrogance and superstition" (Gewen, 1960); . . ."a relic of barbarism" (deLee, 1915); "pestiliferous" (Garrigues, 1898); "vicious" (Titus cited in Emmons and Huntington, 1913); "often malicious" (Emmons and Huntington, 1911); "(with) the overconfidence of half-knowledge . . . unprincipled and callous of the feelings and welfare of her patients and anxious only for her fee" (Emmons and Huntington, 1912); "(earning) $5,000,000 (sic) . . . which should be paid to physicians and nurses for doing the work properly"(Ziegler, 1913); and lastly, "un-American" (Mabbott, 1907). (Devitt, 1979: 89)

The midwife was seen as a social, political, and economic threat and problem (cf. Cody, 1913; Emmons and Huntington, 1911, Huntington, 1915; Mabbott, 1907; Paine, 1915; Ziegler, 1922). (Earlier she was seen as a witch -- Ehrenreich and English, 1973b; 1978; Oakley, 1976.) Moreover, she was a health hazard (Litoff, 1978). As noted by Devitt, "these invectives suggest that obstetricians were engaged in something more than a public-spirited campaign to lower infant and maternal mortality" (1979: 89).

The obstetrician-gynecologists attained ideological hegemony in their anti-midwife campaign. Soon after articles appeared in technical and medical journals, the anti-midwife propaganda appeared in many of

the mass periodicals, such as The Ladies' Home Journal and Good Housekeeping. The message conveyed: obstetricians were the "best" birth attendants. Midwives were incompetent, unskilled and dangerous.

Subsequent to this vociferous campaign, the midwife all but disappeared from American society. With the midwife no longer a threat to established medicine, obstetrician-gynecologists were able to assume near complete control of women's reproductive health.

INTERPROFESSIONAL RELATIONSHIPS IN BRITAIN: THE CONTROL OF MIDWIVES

The campaign against midwifery was not nearly as successful in Britain and other European nations (eg., Italy, France, Germany, Austria, and Holland), and in fact midwives (lay and professional) continue to serve women at birth even to this day. This is not to suggest that obstetrician-gynecologists did not wage an aggressive crusade against the midwife, but rather that because the midwife had become integrated into the social fabric of these societies, her elimination was not seen as either advantageous or inevitable.

The history of the English midwife dates back to medieval times. From then on, until 1512, the major qualifications the midwife had to meet were that she be supportive of the birthing woman, that she serve an educational function to the public and thus foster greater knowledge of the processes of childbirth, that she witness either birth or death in childbirth, whichever the case may have been, and finally that she refrain from employing surgical instruments which had been monopolized by the surgeons' guilds (Donnison, 1977: 2-3). Periodically, throughout British history, the Church attempted to control

the midwife, but it was not until the Act of 1512 in Tudor England that formal control mechanisms were established to provide for a system of licensing laws. (This Act was designed to regulate lay midwives as well as a host of other practitioners, specifically those who were unskilled and relied on witchcraft.)

In the 1600's, men began practicing midwifery and were generally summoned in difficult cases (these men were the predecessors of modern obstetrician-gynecologists). There was some concern over the morality and decency of man-midwives, so "out of deference to the woman's modesty, the man-midwife commonly worked blind, with his hands under a sheet, a practice which sometimes led to serious error" (Donnison, 1977: 11). However, women were predominant in this field throughout the seventeenth century, many pursuing midwifery as an occupation.

During the 1700's, more men entered midwifery and soon began to displace female midwives. The decline of the female midwife was started by the consolidation of the surgeons' guilds, and their monopoly of, for example, the forceps. In addition, lying-in hospitals (maternity wards) began to flourish, which man-midwives used as a source of clinical teaching material. Moreover, as a way of enhancing their status in the eyes of the laity, man-midwives exaggerated the imminent dangers associated with childbirth, which they claimed could only be avoided by having a male birth attendant.*

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* Little definitive evidence exists as to why men entered the field of women's health care during this period, given that female healers were predominant and had performed quite adequately previously. One possible explanation for the infiltration of men into the field of reproductive health care is that as health becomes a "commodity", to be bought and sold in an open market, it also becomes a "male enterprise" (Ehrenreich and English, 1978: 41).

By the middle of the 18th century, man-midwives were coming under attack for their negligence and over-zealous tendency to intervene in birth, with the aid of various instruments. The man-midwife was accused of using instruments unnecessarily to hasten births, causing damage or death to mothers, children or both -- all for the sake of justifying higher fees commensurate with their apparent manual dexterity (Donnison, 1977: 32-33).

Notwithstanding the allegations condemning man-midwives, during the eighteenth century, male practitioners succeeded in elevating midwifery to the status of a branch of medicine. There was some resentment on the part of established physicians, who continued to argue that childbirth was both normal and "women's business", and that man-midwives were merely transforming birth into a surgical operation for financial reasons.

By the mid-1800's, licensing laws were enacted by Parliament as a way of registering practtitioners -- men and women alike -- who met the qualifications of various degree- and diploma-granting bodies. This registration campaign was carried out under the auspices of the General Council fo Medical Education and Registration.

Although women were excluded from universities and the medical profession for much of this period, a growing number of women were entering the nursing field. Florence Nightingale's remarkable achievements during the Crimean War led to the acceptance of women in health care, even though as nurses, they were subordinate to medical doctors. Midwifery-nurse programs were initiated in order to provide women with an alternative to conventional medical services (see chapter 5)

(Ehrenreich and English, 1978; Donnison, 1977; Donegan, 1978; Litoff, 1978), but with the epidemic of puerperal fever in many lying-in chambers and teaching hospitals (where midwife-nurses were trained in the clinical aspects of their work), many of the programs were closed down. Nevertheless, the belief that women were the appropriate attendants at birth resulted in women being permitted to attend normal labour and delivery. The lobbying efforts of various women's medical societies were vital in the reinstatement of midwifery in English society in the late 1800's and into the twentieth century (Donnison, 1977; Litoff, 1978).

In the 1870's, the General Medical Council favoured legislation to regulate practicing midwives. Practicing lay midwives were admitted to the Register, and any other midwives after this time were permitted to register only after they had completed the approved training programs and passed the necessary qualifying examinations. The regulation of lay midwives was placed in the hands of established physicians (Donnison, 1977: 96).

Between 1874 and 1890, a number of midwives' societies developed. Their aims were multifaceted and included the desire not only to improve and advance midwives' skills, but also to work in harmony with the medical profession in order to achieve legitimacy (Donnison, 1977: 100). The midwives recognized their own limitations, and agreed to attend only normal labour and births, leaving the complicated cases to obstetricians.

For a number of years, the debate over state registration and licensing of midwives continued without tangible results. Doctors

continued to argue that childbirth was pathological (or at least prone to be) and that it needed the attention of someone trained in surgery and medicine. The midwives, in contrast, continued to present views favourable to midwife registration. History was repeating itself -- medical men were again intervening too much and too soon to the detriment of women and children. The midwives argued, as before, that action needed to be taken to "alleviate the sufferings and minimise the dangers of poor lying-in women" (Donnison, 1977: 111).

In 1902, The Midwives' Act was passed. Midwives were regulated through state registration. Registration was possible only after a minimum of three months' training. Other requirements included competence in obstetrical examinations (external and internal), no less than twenty deliveries and follow-ups of these cases, completion of training and success on the qualifying examination (Donnison, 1978; Emmons and Huntington, 1911: 255). Although the Act of 1902 was intended to elevate the midwife to a "respected and worthy status" (Donnison, 1977: 174), the midwife remained subordinate to and under the control of the medical profession. However, persistent agitation by women, midwives and their supporters resulted in the retention and institutionalization of midwives in Britain. Moreover, obstetrician-gynecologists and midwives began to work in concert, providing all women with a reputable standard of care at birth (Devitt, 1979: 180). The integration of health care services, coupled with improvements in public health measures in general, contributed to reductions in neonatal and maternal deaths in England (Chamberlain, et al., 1980; Devitt, 1979; McKeown, 1965; 1979; McKeown and Lowe, 1974).

ELIMINATION VS. INSTITUTIONALIZATION OF MIDWIVES: A COMPARISON OF THE UNITED STATES AND BRITAIN

There were two major reasons why the midwife was eliminated in the United States, but was retained and eventually institutionalized in Britain. In the first instance, the British midwife received normative reinforcement on a national level. In the United States, support for the midwife was only witnessed at the local level, if at all, and was very fragmented. Whereas British midwives agitated on the political scene for a number of years (gaining momentum with every loss), and gained visibility and supporters through their numerous attempts at professionalization and standardization (eg., creation of midwives' societies and periodicals, etc.), the American midwife operated only on an informal, invisible, and often concealed level (Oakley, 1976: 19). It is quite conceivable that a collective mobility project (Larson, 1977) on the part of American midwives might have averted their elimination.

Secondly, the difference in the definition of childbirth was an important factor in terms of the elimination or institutionalization of midwives. It is realistic to contend that where childbirth has been medicalized (as in Canada and the United States, and only recently in Britain), physician control is more likely. Conversely, a normalized perspective is conducive to the institutionalization of midwives. Anisef and Basson state this notion as follows:

> At least one norm apparently facilitated or impeded the success of midwifery. It rests on the assumption of birth as a natural, normal physiological process or conversely of birth as a potentially abnormal event or even a disease. The former view survived the requirements set by professionalism and medical practice in England but not in the United States (1979: 355).

In Britain, there was a basic acceptance of the difference in types of care offered by obstetricians and midwives (obstetricians being better suited to handle difficult births, while midwives specialized in personalized, family-oriented care of uncomplicated births). In America, the coupling of medical ideology and technology led to the male takeover of women's reproductive health -- what was and is "women's business". Clearly, in Britain, "the definition of childbirth as 'normal' served the same status function as the definition of childbirth as 'disease' served physicians in the United States" (Anisef and Basson, 1979: 359).

On the basis of this analysis of interprofessional relationships in the United States and Britain, it is apparent that medical social control is, to a large extent, contingent on cultural perceptions regarding the nature of "good" obstetrical care, the definition of childbirth as normal versus pathological, and other political factors outside of medicine (though not totally independent of medical influence). Through both the medicalization of childbirth and the technical exclusion of the lay midwife, physicians achieved dominance in reproductive health care in America. In Britain, although midwives were institutionalized, they still remain subordinate to physicians. What was once "women's business" was (and is) controlled by primarily male physicians.

Having outlined the three dimensions of medical social control, the following chapter presents statistical evidence of the extent to which medical social control is exercised in the case of childbirth.

Chapter Five
Exploring the Nature of Medical Social Control: The Case of Childbirth

The purpose of this thesis, as previously stated, is to examine the appropriateness of considering medicine as an institution of social control. A number of researchers have demonstrated the social control functions of medicine in the past, specifically in terms of the control of deviance. For example, Conrad has documented the control of hyperkinesis (1978a; 1978b), political dissidence (1977), and most recently, along with Schneider, child abuse, alcoholism, drug abuse, homosexuality, and various forms of criminality (1980a). In essence, the argument posited by Conrad and Schneider is that as a result of the dominance of medical authority in contemporary society, what was once viewed as "badness" is now typically considered "sickness" by both medical practitioners and the laity (1980a). Similar conclusions have been drawn by Melick, et al. (1979) and Szasz (1970; 1977) regarding mental illness.

Investigations of the medicalization of deviance have led some researchers to consider the possibility that the profession of medicine was and is exercising social control in matters that are non-deviant. This suspicion has been confirmed in the past by several researchers, such as Charmaz (1980), Illich (1973; 1977), Oakley (1975; 1980), and Zola (1977; 1978). Not only has the medical profession medicalized deviance, but additionally it has more or less medicalized social life. "Medicine and the labels 'healthy' and 'ill' (have been made) relevant to an ever increasing part of human existence" (Zola, 1977: 47/ emphasis in original).

The pervasiveness of medical definitions of reality has, in this thesis, been considered problematical. More specifically, the medicalization of birth has been considered in depth in order to uncover the multidimensional character of medical social control. In the preceding chapters, the focus of the discussion has centered on a socio-historical analysis of documents illustrating that as a result of the profession of medicine's successful ascent to the apex of the health care hierarchy, this organized body has become an effective institution of social control. In particular, through the creation and dissemination of medical ideology, and subsequently, the control of technology (i.e., technical autonomy) and control of other health care practitioners, the medical profession has transformed birth from an inherently normal, natural and fundamentally uncomplicated event into a disease-like medical condition.

In the following discussion, statistical evidence will be presented to illustrate medical social control as it pertains to childbirth. Using official statistics from Canada and the United States, as well as selected statistics from other countries throughout the world, the nature of medical social control will be explored. In addition, recent developments such as certified nurse-midwifery and the home birth movement will be discussed, as potential countervailing forces with respect to the medicalization of childbirth. Finally, the implications of the findings presented will be discussed, as a way of highlighting the future of reproductive health care. In particular, the latter will focus on the question of medicalization versus normalization in the future, and the possibility that women may regain

control over their bodies and the birth process.

As a guide for the presentation of findings which follows, the propositions posited earlier for a theory of medical social control will be utilized.

PRESENTATION OF FINDINGS

MEDICAL IDEOLOGY

PROPOSITION 3: In recent years, more and more forms of life have been subsumed under the heading of "illness". This process is referred to as medicalization, and represents the most effective strategy used by the medical profession to ensure its dominance in health care, as well as the maintenance of the status quo.

3.1 A number of behaviors and conditions having non-biophysical origins have been medicalized recently and increasingly normal and natural conditions such as pregnancy and childbirth have been medicalized as well. As such, all stages of the childbearing process are considered, if not pathological, potentially disease-like medical problems.

Historically and presently, ideology is utilized by various groups to present certain definitions and images of society favourable to the maintenance of a particular status quo. Using rhetoric which is publicly persuasive, ideologues foster the internalization of their particularistic ideas among subordinates. In this way, the masses, typically submit to hierarchies of domination.

> Given the ability to influence general information-processing rules, and specific definitions of reality, the dominant group can now get others to do as it wishes without being compelled either to resort to force or to issue direct orders. Once someone complies with the rules of behavior and accepts the conception of reality favoured by others, then he will willingly and "spontaneously" behave in ways that the latter wishes, without having to be forced or ordered to do so (Gouldner, 1976: 206/ emphasis in original).

Although Gouldner is primarily interested in the ramifications of bourgeois ideology in contemporary society, his findings are insightful in the present discussion. Specifically, the medical profession (as a branch of the bourgeoisie) presents considerable evidence of the desirability of utilizing medical definitions of reality rather than other (eg., legal, moral, or social) definitions of reality for the management of human problems. Once a condition is defined as an illness, the profession is given a mandate to exercise social control. In other words, the profession of medicine reserves the right to determine the "best" means for achieving "health" in society.

As noted previously, the first and most significant dimension of medical social control is the redefinition of conditions in illness terms, or what Conrad has called "medicalization" (1979: 6). Since medical practitioners are considered to be the authorities in matters of health and illness, it is this group which determines what is to count as illness.

> In developing its own "professional" approach, the profession changes the definition and shape of problems experienced and interpreted by the layman. The layman's problem is recreated as it is managed -- a new social reality is created. It is the autonomous position of the profession in society which permits it to re-create the layman's world (Freidson, 1970a: xvii).

With the emergence and institutionalization of obstetrical medicine, as well as the solidification of Victorian images of women and their ailments as pathological, it became apparent that childbearing was at the very least a disease-like medical condition necessitating medical management (Ehrenreich and English, 1973a; 1978; Kobrin, 1966).

More recently, the medical profession has propagated the notion that pregnancy and childbirth are not normal physiologic conditions, and thus require medical diagnosis and "treatment". The importance of medical management of human parturition is evident in the preface to Williams Obstetrics:

> . . . the health team providing care for the mother, fetus, and newborn infant currently must deal with an appreciably higher percentage of pregnancies in which the fetus is at increased risk of unfavorable outcome unless an appropriate program for surveillance and at times active intervention is mounted* (Pritchard and MacDonald, 1976: vii).

Implicitly or explicitly, the suggestion is that "normal" childbirth is increasingly becoming the exception to the rule.

In order to maintain the medicalized definition of pregnancy and childbirth, and furthermore, to exercise medical social control, the medical profession has utilized three mechanisms to ensure physician management of these "pathological" conditions. These include the diagnosis of pregnancy as an illness, the designation of the hospital as the appropriate place for birth, and relatedly, the suggestion of the affinity between the sick role and the pregnant role. Each of these aspects of medical ideology has been discussed previously (see chapter 2). In the present discussion, it is only possible to present empirical evidence indicating the relocation of birth in the hospital from the home environment.

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* It should be noted that advances in obstetrical medicine have made it possible for more women to conceive and carry infants, who previously, for health reasons such as diabetes and Rh incompatibility, would have been unable to see a pregnancy through to full term. As a result, there may be proportionally more women who are "at risk", and thus do require active medical surveillance and intervention. Yet, the majority of childbearing women still experience uneventful (i.e., normal) pregnancies, in which active management and the medicalized orientation which accompanies such a program are unnecessary.

Tables 1, 2, and 3 contain the available statistics for Canada, the United States and England and Wales on the percentage of births occurring in hospitals. As is clear from these statistics, the transition from home to hospital for birth has been typical in all four countries. In Canada, in the forty-eight year period between 1926-1974, there has been an 82% increase in institutional deliveries. In the United States, between 1935-1961, there was a 60% increase in births occurring in hospitals. In England and Wales, between 1927-1977, the proportion of institutional deliveries has risen by 83%. It is important to note that although fewer than 2%* of all births in each of these countries occur at home, it was only since the 1950's in England and Wales that more women delivered in hospitals, while the transition to hospitals for delivery in both Canada and the United States has risen gradually and persistently over time.

Looking at selected years in each of these countries, one may note the difference in the timing of the transition to institutions for delivery. For example, in 1938 the proportion of hospital deliveries in Canada, the United States, and England and Wales was 36.4%, 48%, and 35%, respectively. By 1961, the proportion of hospital deliveries was 96.9% in both Canada and the United States, while only 65.5% of all births in England and Wales occurred in hospitals. It was not until 1975 in England and Wales that the proportion of hospital deliveries equalled the Canadian and American rates of 1961 (Chamberlain, et al., 1980: 6).

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* It is extrapolated that less than 2% of American women currently deliver outside of hospitals, based on similarities in obstetric practice in Canada and the United States.

TABLE 1

PERCENTAGE OF BIRTHS OCCURRING IN HOSPITALS, CANADA*, 1926-1974

YEAR	% HOSPITAL BIRTHS	YEAR	% HOSPITAL BIRTHS
1926	17.8	1951	79.1
1927	19.3	1952	81.4
1928	21.5	1953	83.4
1929	24.5	1954	84.6
1930	26.6	1955	86.5
1931	26.8	1956	88.4
1932	27.5	1957	90.2
1933	28.5	1958	91.7
1934	30.0	1959	93.1
1935	32.3	1960	94.6
1936	34.5	1961	96.9
1937	36.4	1962	97.8
1938	39.4	1963	98.3
1939	41.7	1964	98.7
1940	45.3	1965	99.0
1941	48.9	1966	99.2
1942	53.7	1967	99.4
1943	54.7	1968	99.5
1944	61.0	1969	99.5
1945	63.2	1970	99.6
1946	67.6	1971	99.6
1947	71.0	1972	99.6
1948	72.3	1973	99.6
1949	74.3	1974	99.7
1950	76.0		

* Data not available for Newfoundland for 1926-1949.

SOURCE: Vital Statistics - Births. Ottawa: Statistics Canada, 1977.

TABLE 2

PERCENTAGE OF BIRTHS OCCURRING IN HOSPITALS, UNITED STATES, 1935-1961

YEAR	% HOSPITAL BIRTHS	YEAR	% HOSPITAL BIRTHS
1935	36.9	1949	86.7
1936	40.9	1950	88.0
1937	44.8	1951	90.0
1938	48.0	1952	91.7
1939	51.1	1953	92.8
1940	55.8	1954	93.6
1941	61.2	1955	94.4
1942	67.9	1956	95.1
1943	72.1	1957	95.7
1944	75.6	1958	96.0
1945	78.8	1959	96.4
1946	82.4	1960	96.6
1947	84.8	1961	96.9
1948	85.6		

SOURCE: Trends in Infant and Childhood Mortality, 1961. Children's Bureau Statistical Series #76. Washington, D.C.: Government Printing Office, 1964.

TABLE 3

PERCENTAGE OF BIRTHS OCCURRING IN HOSPITALS, ENGLAND AND WALES, 1927-1977

YEAR	% HOSPITAL BIRTHS
1927	15
1938	35
1952	64
1955	64.3
1961	65.6
1964	70.0
1966	74.8
1968	80.6
1970	86.4
1971	89.0
1972	91.4
1973	93.9
1974	95.9
1975	96.8
1976	97.5
1977	98.1

SOURCE: Geoffrey Chamberlain, et al., Childbirth Today: Policy Making in the National Health Service: A Case Study. (Report of a Working Party). Exeter, England: The Council for Science and Society, 1980, p. 6.

What accounted for the transition to hospitals for delivery? First, the campaign by Canadian and American obstetricians (as well as public health officials, insurance companies and upper class women) to medicalize, and therefore hospitalize, birth apparently was successful in those countries (Devitt, 1977: 47). In Great Britain, the medical profession had, until only recently, favoured a normalized perspective on birth, and thus encouraged women to choose between institutional and domiciliary confinements in accordance with their needs and health status during pregnancy. By 1952, fewer women were delivering at home, and the trend has been increasing toward institutional confinements since that time. It is also noteworthy that the publication of the Peel Report in Britain (Department of Health and Social Security, 1970) appears to have had a profound influence on official policy in that country. The Standing Maternity and Midwifery Advisory (Peel) Committee unequivocally stated that British medicine ought to aim for 100% hospital delivery, based on the "greater safety of hospital confinement" (cited in Tew, 1978:56). At present, it is apparent that institutional confinements are as close to 100% as is practicable in Great Britain (Chamberlain, et al., 1980: 6; Lead Article, British Medical Journal, January 10, 1976: 55-56).

Two other considerations, as well, should be noted regarding the transition to hospital for delivery. During the 1930's, 1940's and 1950's, most developed nations such as Canada, the United States and Great Britain experienced rapid industrialization and urbanization. As a result, more women had at their disposal modern and advanced medical facilities in large metropolitan centers. Finally, following

the "baby boom", there was a substantial decline in the birth rate. As such, birth was considered a special time, and women were more inclined to prefer hospital confinements, which doctors claimed provided the greatest opportunity for a successful outcome at birth.

One of the most frequent justifications for the hospitalization of birth is that this transition has resulted in a reduction in obstetric mortality (see tables 4-7). In Canada, for example,in 1921, the maternal mortality rate was 47.5 per 10,000 live births. In 1974, when more than 99% of all births occurred in hospitals, only one out of every 10,000 live births resulted in the death of a mother, and there has been a consistent decline in maternal mortality since 1974. Maternal mortality rates are considered to be at an "irreducible minimum" at present according to some(eg., Marmol, et al., 1969: 135). However, others contend that so long as there are preventable maternal deaths, it is ludicrous to speak of an "irreducible minimum" (Longyear, et al., 1954: 1288).

Statistics for the United States demonstrate comparable trends. In 1935, when 36.9% of all births occurred in hospitals, the maternal mortality rate was 58.2 per 10,000 live births. In 1961, when 96.9% of all births took place in hospitals, the maternal mortality rate was 3.7 per 10,000 live births, and since that time, maternal mortality has been reduced to 1.1 per 10,000 live births (in 1977).

Regarding neonatal mortality rates (i.e., deaths to infants under 28 days old, exclusive), the reductions have been similar, although not as dramatic. In 1921, in Canada, the neonatal mortality rate was 43.4 per 1,000 live births. By 1977, this rate had decreased to 8.3

TABLE 4

MATERNAL MORTALITY RATES, CANADA, 1921-1977
(PER 10,000 LIVE BIRTHS)

YEAR	MATERNAL MORTALITY	YEAR	MATERNAL MORTALITY
1921	47.5	1950	11.4
1922	50.7	1951	10.7
1923	50.0	1952	9.3
1924	53.3	1953	7.8
1925	49.4	1954	7.2
1926	56.3	1955	7.6
1927	55.4	1956	6.2
1928	55.7	1957	5.4
1929	57.0	1958	5.6
1930	57.6	1959	5.5
1931	50.8	1960	4.5
1932	50.2	1961	4.6
1933	49.7	1962	4.1
1934	53.0	1963	3.5
1935	48.8	1964	3.0
1936	56.2	1965	3.2
1937	48.6	1966	3.5
1938	42.9	1967	2.4
1939	42.6	1968	2.7
1940	40.1	1969	2.1
1941	36.4	1970	2.0
1942	30.5	1971	1.8
1943	28.5	1972	1.6
1944	27.8	1973	1.1
1945	23.0	1974	1.0
1946	18.1	1975	0.7
1947	15.8	1976	0.7
1948	15.0	1977	0.5
1949	14.7		

SOURCE: Vital Statistics -Deaths. Ottawa: Statistics Canada, 1977.

TABLE 5

MATERNAL MORTALITY RATES,* UNITED STATES, 1935-1977
(PER 10,000 LIVE BIRTHS)

YEAR	MATERNAL MORTALITY	YEAR	MATERNAL MORTALITY
1935	58.2	1953	6.1
1936	56.8	1954	5.2
1937	48.9	1955	4.7
1938	43.5	1956	4.1
1939	40.4	1957	4.1
1940	37.6	1958	3.8
1941	31.7	1959	3.7
1942	25.9	1960	3.7
1943	24.5	1961	3.7
1944	22.8	1965	3.2
1945	20.7	1970	2.2
1946	15.7	1971[1]	1.9
1947	13.5	1972	1.9
1948	11.7	1973	1.5
1949	9.0	1974	1.5
1950	8.3	1975	1.3
1951	7.5	1976	1.2
1952	6.8	1977	1.1

*Deaths prior to 1960 exclude Alaska and Hawaii. Beginning 1970, excludes deaths to nonresidents of U.S. Mortality rates represent deaths from deliveries and complications of pregnancy, childbirth, and the puerperium.

[1]Based on a 50% sample of deaths.

SOURCES: Historical Statistics of the United States: Colonial Times to 1957. Washington, D.C.: Government Printing Office, 1960.
Statistical Abstract of the U.S., 100th Edition. Washington, D.C.: Dept. of Commerce, Bureau of the Census, 1979.

TABLE 6

NEONATAL MORTALITY RATES, CANADA, 1921-1977
(PER 1,000 LIVE BIRTHS)

YEAR	NEONATAL MORTALITY	YEAR	NEONATAL MORTALITY
1921	43.4	1950	24.4
1922	43.9	1951	22.6
1923	44.5	1952	22.7
1924	41.6	1953	21.4
1925	40.5	1954	19.3
1926	47.7	1955	19.3
1927	45.0	1956	20.1
1928	43.7	1957	20.2
1929	44.3	1958	19.3
1930	42.6	1959	18.4
1931	41.5	1960	17.6
1932	38.0	1961	18.0
1933	37.5	1962	18.7
1934	35.5	1963	18.1
1935	35.4	1964	17.3
1936	34.0	1965	16.3
1937	34.4	1966	16.1
1938	31.8	1967	15.2
1939	30.9	1968	14.8
1940	30.0	1969	13.9
1941	30.7	1970	13.5
1942	28.2	1971	12.4
1943	29.9	1972	11.9
1944	29.6	1973	10.8
1945	28.9	1974	10.1
1946	27.4	1975	9.7
1947	26.5	1976	9.1
1948	25.7	1977	8.3
1949	24.1		

SOURCE: Vital Statistics -Deaths. Ottawa: Statistics Canada, 1977.

TABLE 7

NEONATAL MORTALITY RATES,* UNITED STATES, 1935-1977
(PER 1,000 LIVE BIRTHS)

YEAR	NEONATAL MORTALITY	YEAR	NEONATAL MORTALITY
1935	32.4	1953	19.6
1936	32.6	1954	19.1
1937	31.3	1955	19.1
1938	29.6	1956	18.9
1939	29.3	1957	19.0
1940	28.8	1958	19.5
1941	27.7	1959	19.0
1942	25.7	1960	18.7
1943	24.7	1961	18.4
1944	24.7	1965	17.7
1945	24.3	1970	15.1
1946	24.0	1971	14.2
1947	22.8	1972	13.6
1948	22.2	1973	13.0
1949	21.4	1974	12.3
1950	20.5	1975	11.6
1951	20.0	1976	10.9
1952	19.8	1977	9.9

*Deaths prior to 1960 exclude Alaska and Hawaii. Beginning 1970, excludes deaths to nonresidents of U.S. Mortality rates represent deaths to infants under 28 days old, excludive.

SOURCES: Historical Statistics of the United States: Colonial Times to 1957. Washington, D.C.: Government Printing Office, 1960.
Statistical Abstract of the U.S., 100th Edition. Washington, D.C.: Dept. of Commerce, Bureau of the Census, 1979.

per 1,000 live births. In the United States, in 1935 the neonatal mortality rate was 32.4 per 1,000 live births. By 1977, deaths to infants under 28 days was 9.9 per 1,000 live births.

These reductions, most medical practitioners would contend, are not coincidental (Pearce cited in Devitt, 1977: 47). Rather, the advances in medical care in hospitals are believed to account for the improvements in outcomes in birth (Devitt, 1977: 47). Repeatedly, physicians in Canada, the United States, and more recently Britain, claimed that births in hospitals were safer than domiciliary confinements and resulted in fewer deaths. As late as 1975, the American College of Obstetricians and Gynecologists continued to maintain that the place of safety was the hospital because of the pathological character of pregnancy and childbirth, and the necessity, therefore, of hospital technology and personnel:

> Labor and delivery, while a physiologic process, clearly presents potential hazards to both mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation (cited in Annas, 1976: 161).

However, the contentions of physicians that there is a causal relationship between increased hospitalization of birth and reductions in obstetric mortality is not self-evident. Indeed, it seems likely that the relationship between hospitalization and reduced obstetric mortality is a spurious one (Tew, 1978: 56).

There is reason to believe that improvements in nutrition, housing and living standards in general may have played an extremely important function in reducing obstetric mortality (Chamberlain, et al., 1980; McKeown, 1965; 1979; McKeown and Lowe, 1974). As well, from the time following World War I through until the 1950's, medical researchers

and public health specialists made several advances which reduced obstetric (and general) mortality, but were quite independent of the location of birth. For example, following World War I, it was recognized that safety and successful outcomes at birth were directly related to the quality of a mother's general health during pregnancy (including her health, nutrition, and the hygiene of her living conditions), and so pre-natal care was instituted on a large-scale (Chamberlain, et al., 1980: 15).

Chamberlain and his associates have noted as well that several causes of maternal mortality were effectively controlled between 1930-1950 (1980: 15). Most notably, puerperal infection was eliminated through the development of antibiotics. As well, new techniques of blood transfusion resulted in reductions in maternal mortality beginning in the 1940's. In the 1950's, physicians were able to control hemorrhage through the use of such drugs as ergometrine (Chamberlain, et al., 1980). Finally, measures could be taken to control toxemia during pregnancy through attention to nutrition and correction of anemia.

Neonatal mortality declined as well during this period (1930-1950) and since, because of the control of infection. Improvements in environmental conditions (in particular, the control of air-borne and water-borne infections) and the pasteurization of milk were critical in reducing deaths to newborns. Prematurity, a leading cause of neonatal mortality until this time, was also reduced as a result of rising living standards and improvements in maternal health and nutrition (McKeown, 1979). At present, the two major causes of

neonatal mortality are congenital abnormalities and hypoxia (lack of oxygen) during birth.

One final consideration in the reduction of obstetric mortality is that, with the declining birth rate has come proportionally fewer "high risk" mothers. In particular, there are fewer elderly primigravidae (those first-time mothers who are 35 years of age or older), fewer mothers who have three or more children, and fewer births to women from low socio-economic classes. Chamberlain and his associates have noted that these trends have resulted in fewer high-risk childbirths, which account, in part, for reductions in obstetric mortality in recent years * (1980: 9).

In sum, it remains a matter of contention whether hospitalization, per se, solely was responsible for reduced obstetric mortality. On the contrary, the main influences in reducing obstetric mortality since the beginning of the twentieth century are -- in order of importance: (1) rising living standards, (2) improved hygiene (including housing, diet, and other social measures), and only lastly (3) specific preventive and therapeutic measures (McKeown, 1976; McKeown and Lowe, 1974). McKeown has suggested, moreover, that social measures, in fact, "have done as much to reduce morbidity and mortality as has any advance in medical policy" (1976, cited in Chamberlain, et al., 1980: 41).

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* It should be noted that significant improvements have been made in the care of high-risk infants and mothers (i.e., through rigorous pre-natal surveillance and the development of neonatal intensive care units). Surely these advances have resulted in reductions in maternal, neonatal, and postneonatal mortality and morbidity (Chamberlain, et al., 1980: 17).

Indeed, owing to the complexity of the factors involved in the relationship between obstetric mortality and the hospitalization of birth, one would need to compare hospitalized and non-hospitalized women who had both been exposed to the same environmental changes in order to determine whether mortality was greater in non-institutional deliveries. Unfortunately, such controlled research designs and statistical analyses have not been undertaken. As such, the debate concerning the contribution of hospitals to reduced mortality (maternal and neonatal) remains unresolved and polemical.

Some critics of hospital births have claimed that higher obstetric mortality has resulted from the transition to hospitals for delivery (eg., Tew, 1978: 57). In part, they suggest that in hospital deliveries, there is a greater likelihood of intervention -- which is often unnecessary, and at times, lethal -- by overzealous physicians (Devitt, 1977: 47). Although such indictments may bear out in individual cases, official statistics do not lend any validity to such claims. On the contrary, there have been dramatic improvements in obstetric mortality, as indicated in tables 4-7.

Despite the fact that critics of hospital births have been unable to demonstrate a strong positive correlation between hospital delivery and obstetric mortality, many have forcefully argued against institutional confinements on the basis of the social, psychological and economic disadvantages of hospital delivery (eg., Arms, 1977; Devitt, 1977; Mehl, 1976b; Montagu, 1978; Richards, 1978; Stewart, 1976). Such critics contend that home births escape the tainting of medicalization and technologization. Although there is insufficient evidence

to demonstrate conclusively that hospital births are safer than home births, or vice versa (and indeed there is a great deal of controversy concerning the safety of home vs. hospital deliveries -- see pages 216-224 of this chapter), only a minority of the childbearing population is intent on challenging the current status quo in obstetrics. While the majority of childbearing women presumably prefer hospital deliveries, and therefore dismiss the possibility of an other-than-hospital-delivery, advocates of home birth see the introduction of such an alternative as a means of exerting a measure of self-control over the processes affecting their lives. To be sure, it would seem that the current debate should be directed toward reducing the extent to which medical social control pervades the childbearing process, rather than limiting the debate to a question of either hospital or home for delivery.

In 1921, Dr. Rudolf Holmes concluded that

> the basic error has crept into the obstetric field that pregnancy and labor are pathologic entities, that childbearing is a disease, a surgical malady which must be terminated by some spectacular procedure. There is too insistent preachment by those who are defending a reign of terror, of promiscuous operative furor, on the argument that women have so degenerated that childbearing is a phase of pathologic anatomy (cited in Devitt, 1977: 48).

This basic error persists to this day. It has been argued that home births can be safe for some women (but not necessarily all women) and that it is desirable to include home births among the safe alternatives in maternity care programs (Arms, 1977; Haire, 1978a; Mehl, et al., 1975; Stewart, 1976).

Finally, on the subject of the place of birth, it is important to

comment on birthing practices in cross-cultural perspective. In several European nations (eg., Holland and Denmark), the normal environment for birth is considered to be the home, although the "hospitalization" movement in Canada, the United States and Great Britain has led to a decline in home births in these countries (cf. Kloosterman, 1978: 88). In the Netherlands, it is generally thought that home births can yield successful outcomes, in terms of morbidity and mortality statistics, as well as the important social-psychological dimensions of the childbearing process. The critical factor in the success of the Dutch system of home births is that a thoughtful, comprehensive and integrated system of maternity services has been established, including frequent and extensive antepartum examinations, as well as "well-woman" intrapartum and postpartum care (Kloosterman, 1978). In the Netherlands, the availability of this option in childbirth has not compromised safety. Rather, the Netherlands boasts of one of the lowest mortality (both maternal and neonatal) rates in the world. In 1975, the neonatal mortality rate was 7.1 per 1,000 confinements, and the maternal mortality rate was 0.8 per 10,000 confinements.* In other words, home births can be safe, providing that adequate maternity services are available to childbearing women.

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* The reader will recall similarly laudable mortality statistics in Canada and the United States (see tables 4-7). However, in both Canada and the United States, fewer than 1% of all births occur at home, while approximately 47% of all births in the Netherlands in 1975 occurred at home.

Returning to the subject of the relocation of birth, as an indicator of medical ideology, it would seem that if the increased rate of hospitalization reveals anything,it is that the medical ideology has been propagated successfully. "The belief in a pathologic nature of pregnancy (has) spread from the medical to the popular consciousness . . 'human reproduction has become the same as a dangerous sickness'" (Devitt, 1977: 49).

The reader will recall that two other indicators of medical ideology have been noted in addition to the transfer of the location of births, namely, the diagnosis of pregnancy and childbirth as illnesses, and the affinity between the pregnant role and the sick role (Parsons, 1951). Unfortunately, little documentary evidence exists for the latter indicators, and what little that does exist has already been noted in chapter 2. Indeed the lack of research regarding these important questions points to the need for more attention to fundamental aspects of reproductive health care. (In the concluding chapter of this thesis, relevant research questions such as these will be considered.)

MEDICAL TECHNOLOGY

PROPOSITION 4: Once a behavior or condition is situated within the medical framework, it is removed from the realm of public discussion. Moreover, the designation of a condition or behavior as a technical (i.e., medical) problem in turn mandates the utilization of technical solutions to effect resolution of the condition. Through the monopolization of technique, the profession of medicine exercises social control.

4.1 Pregnancy and childbirth, having been medicalized, also have been technologized to a greater or lesser extent by the medical profession. As such, these conditions tend to be "diagnosed" and "treated" by the medical profession and are managed in the hospital, where technicians and technical solutions are easily accessible.

As noted previously, technology has increasingly become a key problem-defining and solving mechanism in modern society. Despite the fact that technology has aided mankind in managing numerous human problems, a number of analysts have noted that technology has become a major form of domination (Ellul, 1964; Marcuse, 1964; Marx, 1978; Novek, n.d.; Weber, 1949). In this way, technology serves to maintain and perpetuate existing social relations. In addition, technology develops an entire system of values and rationalizations which further facilitate sustained growth and domination of the social order in which it emerges.

An important feature of technology is its inevitable monopolization by certain groups. In the present context, technical autonomy, a key characteristic of professions (Freidson, 1970a; 1970b; Larson, 1977), has been utilized by the medical profession as a means of social control. As a result of the profession's monopolization of technical solutions, individuals are obliged to seek the aid of those considered technically competent in operating and/or managing the various technologies, and in turn, managing medically-defined illnesses. Because technique "poses primarily technical problems which consequently can be resolved only by technique" (Ellul, 1964: 92), individuals have become dependent on technicians.

Presumably, the rationality inherent in technique should have resulted in improvements in the way birth is handled. From a technical (i.e., medical) standpoint, this has, in fact, occurred. Critics, however, dispute medical claims that technology has improved outcomes at birth. Suzanne Arms, for example, has described the impact of

technology on birth as follows:

> . . . obstetricians . . . have . . . turned the normal into the abnormal for the sake of preventive procedures, which in turn have caused greater (but more predictable) risk, and this in turn has required even more preventive technology to interfere further with what was once a natural and uncomplicated process requiring no interference at all (1977: 65-66).

Rich has similarly noted that "medical technology creates its own artificial problem for which an artificial remedy must be found" (1976: 187). Ettner has concluded that hospital technology simply breeds pathology and has little rational basis (1977: 17-22).

On a human level, numerous researchers and a number of women have expressed concern that the technologization of birth gives rise to the dehumanization of birth (cf. Anderson, 1979; Arms, 1977; Corea, 1977; Haire, 1978a; 1978b; Oakley, 1975; Ratner, 1978; Rich, 1977). Although it is beyond the scope of the present discussion to examine women's attitudes toward reproductive health care, it is possible to provide documentary evidence of the extent to which birth has been technologized in Canada and in Manitoba. Using available statistics based on annual hospital separations (Surgical Procedures and Treatments, an annual publication of Statistics Canada), it will be possible to demonstrate that childbirth has been transformed from a natural and normal physiologic process into a socially constructed medical, and often surgical, event.

Of the many obstetrical procedures currently used in the medical management of labour and delivery, five are included in the following analysis. These are: Caesarean section, episiotomy, forceps delivery, vacuum extraction, and artificial rupture of membranes (i.e.,

surgical induction of labour).* These forms of intervention have, according to Haire, become "normal accompaniments of birth" as a result of socio-cultural patterning in North American society (1978a). The selection of these procedures is based on the fact that although there are, at times, medical indications for each, many of these procedures are used on a routine basis by practicing physicians (i.e., in medically complicated and uncomplicated deliveries). The routine, and often unnecessary, employment of these technological interventions has facilitated medical social control, by transforming birth into a physician-centered medical event. It is suggested that by documenting the pervasiveness (i.e., frequency) of each of these interventions in the medical management of labour and delivery, it will be possible to illustrate that the profession of medicine exercises social control through technology.

(1) Caesarean Section (see tables 8-10)

Caesarean section delivery, although a relatively infrequent and dangerous operation only thirty years ago, has become a common procedure in modern obstetrical practice. In Canada, for example, during the period of 1969-1976, the proportion of births by Caesarean section has increased by approximately 100%. In Manitoba, for the same period, the number of Caesarean section deliveries has increased by more than 150% (see table 8). Rising Caesarean rates have been noted internationally as well. In the United States, the Caesarean section rate has almost tripled between 1970-1978 (see table 9). Although the

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* These procedures are categorized in accordance with the Eighth Revision of the International Classification of Diseases (1967).

TABLE 8

CAESAREAN SECTION, CANADA AND MANITOBA, 1969-1976

YEAR	CANADA TOTAL	PROPORTION OF ALL LIVE BIRTHS	YEAR	MANITOBA TOTAL	PROPORTION OF ALL LIVE BIRTHS
1969	19,139	5.2	1969	704	3.9
1970	21,521	5.7	1970	808	4.4
1971[1]	23,342[2]	6.4	1971	913	5.1
1972[3]	25,089[2]	7.2	1972	1149	6.6
1973	27,685[2]	8.1	1973	1174	6.9
1974[4]	31,381[2]	9.0	1974	1407	8.1
1975[5]	34,361[2]	9.6	1975	1433	8.4
1976[6]	38,287[2]	10.6	1976	1684	10.1

[1]New Brunswick 1970 Data.

[2]Total excludes Yukon and Northwest Territories.

[3]New Brunswick 1973 Data.

[4]Prince Edward Island 1973 Data.

[5]Newfoundland 1974 Data.

[6]Prince Edward Island 1977 Data; New Brunswick 1975 Data.

SOURCE: Surgical Procedures and Treatments. Ottawa: Statistics Canada, Annual.

TABLE 9

CAESAREAN SECTION, UNITED STATES, 1970-1978

YEAR	NUMBER IN 1000s*	RATE PER 100 DELIVERIES
1970	195	5.5
1971	194	5.8
1972	227	7.0
1973	246	8.0
1974	286	9.2
1975	323	10.4
1976	378	12.1
1977	455	13.7
1978	510	15.2

* Totals represent rounded figures, as opposed to precise totals. Based on National Hospital Discharge Survey Information (collected annually).

SOURCE: Paul J. Placek and Selma M. Taffel, "Trends in Cesarean Section Rates for the United States, 1970-1978". Public Health Reports 95 (1980): 540-548.

frequency of Caesarean section is lower in western European nations, such as England and Wales, Norway and the Netherlands, in each of these countries as well, there has been an increased usage of Caesarean section in the management of birth (see table 10).

There are a number of factors which account for the rise in Caesarean section deliveries. First, Caesarean sections have been used to improve fetal outcomes. Since the 1960's, when there was a decline in the birth rate in Canada and the United States, women and their physicians placed increasing emphasis on the health of the fetus and favourable pregnancy outcomes. As advances were made in obstetrical medicine (eg., improvements in the use of anesthetics, blood transfusions, and antibiotics, as well as extensive prenatal care services), and as the technique of Caesarean section became more advanced, physicians were more inclined to perform a Caesarean section as a means for improving fetal outcomes.

Second, Caesarean section was and is used in the active management of complications of pregnancy, such as difficult fetal presentations, fetal distress*, dystocia (abnormal labour), and maternal disease (eg., diabetes). As physicians resorted to surgical intervention via Caesarean section for complications such as these, the repeat Caesarean section rate rose as well for women delivering subsequent pregnancies

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* Some have suggested that the rise in births by Caesarean section stems from the widespread use of electronic fetal monitoring (EFM), the technology currently used to detect "fetal distress". Although there is competing evidence regarding the relationship between the use of EFM and the rate of Caesarean sections, it should be noted that the EFM was in fairly widespread use by the mid- to late 1970's (Placek and Taffel, 1980). This was the period which had witnessed a larger proportion of Caesarean sections in Manitoba, Canada, and the United States (see tables 8 and 9).

TABLE 10

CAESAREAN SECTIONS AS A PROPORTION (%) OF ALL DELIVERIES IN VARIOUS COUNTRIES 1968-1975

YEAR	CANADA	USA	ENGLAND & WALES	NORWAY	NETHERLANDS
1968	4.8	4.8	4.0	2.0	1.8
1969	5.2	5.3	4.4	2.0	2.0
1970	5.7	5.0	4.3	2.2	2.0
1971	6.4	5.6	4.6	2.5	2.1
1972	7.2	6.4	4.9	2.6	2.3
1973	8.0	7.4	5.0	3.0	2.5
1974	9.0	8.8	N/A	3.7	2.6
1975	9.6	10.2	N/A	4.1	3.0

SOURCES: Iain Chalmers and Martin Richards, "Intervention and Causal Inference in Obstetric Practice". Benefits and Hazards of the New Obstetrics. Edited by Tim Chard Martin Richards. London: William Heinemann Medical Books, 1977, pp. 34-61.
Surgical Procedures and Treatments. Ottawa: Statistics Canada, Annual.
Vital Statistics--Births. Ottawa: Statistics Canada, Annual.

(NIH Consensus Development Statement on Cesarean Childbirth, 1980: 3; The College of Physicians and Surgeons of Manitoba, 1979: 24).

Third, there is some suspicion that Caesarean sections may be performed in the United States (and likely in Canada as well) for the doctor's convenience, to bolster physicians' incomes, and as a form of defensive medicine (in the face of malpractice suits), rather than as a life-saving technique (Larned, 1978; Marieskind, 1979; NIH Consensus Development Statement on Cesarean Childbirth, 1980). A final reason for the increase in the rate of Caesarean section deliveries is attributed to the trend toward specialization within obstetric practice. In several countries, fewer and fewer general practitioners and midwives are managing birth, as they are displaced by medical specialists -- in this case, obstetricians (NIH Consensus Development Statement on Cesarean Childbirth, 1980).

In terms of the Canadian data presented in table 8, as the official statistics fail to categorize Caesarean deliveries according to the medical explanation for performing this technique, one can only speculate that any of the factors previously noted may have contributed to the dramatic rise in the Caesarean delivery rate. According to the National Institute of Health, the major contributor to the rise in Caesarean section delivery rates was for the diagnosis of dystocia, followed by repeat Caesarean sections, breech presentations and fetal distress (1980).

A cross-cultural comparison of Caesarean section rates reveals, as expected that both in Canada and the United States, Caesareans are performed more frequently than in England, Wales, Norway, and the Netherlands (see table 10). The emphasis on the normalcy of

pregnancy and childbirth in Norway and the Netherlands, no doubt accounts for proportionately fewer Caesarean sections in these countries. In addition, the emphasis on home births in the Scandinavian countries may also explain lower rates of Caesarean section (Arms, 1977).

Regarding England and Wales, the intermediate position held by these two countries was also expected in part because of the definition of childbirth as normal (or at least moreso than in Canada and the United States). Relatedly, certified midwives play a more predominant role in the health care systems in England and Wales, Norway and the Netherlands, and typically are less interventionist than physicians, which may explain, as well, their lower rates of Caesarean section (Arms, 1977). However, without empirical evidence documenting that British (or Scandinavian) midwives are less inclined to perform a section than physicians, the explanation for varying international rates for Caesarean section remains conjecture at this time.

By way of conclusion, the rise of Caesarean deliveries may be considered as evidence that the medical profession believes less and less in the normalcy of birth and in nonintervention. In point of fact, the authors of Williams Obstetrics openly admit that "in modern obstetric practice, there are virtually no contraindications to Cesarean section, provided the proper operation is selected" (Pritchard and MacDonald, 1976: 905/ emphasis mine). At this point in time, there is little to suggest a turning point in this trend of rising Caesarean deliveries, although efforts are being made to stop and perhaps reverse this trend through alterations in the clinical practice of obstetrics (NIH Consensus Development Statement on Cesarean

Childbirth, 1980: 6-13).

It should be noted, in closing, that the safety of elective Caesarean section delivery has never been established conclusively. In fact, women who have had a Caesarean do face the possibility of scar rupture and other forms of morbidity, as well as double the risk of maternal mortality when compared with women who have had vaginal deliveries. In addition, infants may be exposed to risks when delivered by Caesarean section (NIH Consensus Development Statement on Cesarean Childbirth, 1980: 9; Placek and Taffel, 1980). In particular, Caesarean section has been associated with low-birth weights and low APGAR scores, when compared with spontaneous and forceps deliveries (Placek and Taffel, 1980: 547). That the widespread use of Caesarean section introduces unnecessary risk to both mother and child is, in and of itself, problematical. When one considers that this procedure is not always essential as a means for arriving at successful outcomes and that physicians rely on this technique to transform reproduction into a medical (i.e., surgical) event, indeed there is cause for concern that medical practitioners are exercising social control through technology.

(2) Episiotomy (see table 11)

According to Pritchard and MacDonald, "except for cutting the umbilical cord, episiotomy is the most common operation in obstetrics" (1976: 346). As indicated in table 11, it is apparent that a large proportion of childbearing women have been assisted at birth with an episiotomy. In Canada, the rate of episiotomy steadily increased

TABLE 11

EPISIOTOMIES,* CANADA AND MANITOBA, 1969-1976

A. CANADA

YEAR	NUMBER OF EPISIOTOMIES	NUMBER OF EPISIOTOMIES WITH FORCEPS	TOTAL	PROPORTION OF ALL LIVE BIRTHS
1969	72,476	31,364	103,840	28.1
1970	74,253	34,590	108,843	29.3
1971[1]	77,458	38,633	116,091[2]	32.1
1972[3]	81,304	37,537	118,841[2]	34.2
1973	85,268	40,076	125,344[2]	36.5
1974[4]	90,453	40,822	131,275[2]	37.4
1975[5]	96,088	42,272	138,360[2]	38.5
1976[6]	95,016	39,048	134,064[2]	37.2

B. MANITOBA

YEAR	NUMBER OF EPISIOTOMIES	NUMBER OF EPISIOTOMIES WITH FORCEPS	TOTAL	PROPORTION OF ALL LIVE BIRTHS
1969	6,786	717	7,503	42.1
1970	6,565	1,093	7,658	42.0
1971	6,372	1,161	7,533	41.8
1972	6,354	1,120	7,474	43.0
1973	5,878	1,191	7,069	41.7
1974	5,702	1,076	6,778	39.2
1975	5,043	1,159	6,202	36.2
1976	4,852	975	5,827	34.8

*Includes deliveries in which forceps are used in concert with episiotomy, as well as deliveries in which episiotomy is performed exclusively.

[1]New Brunswick 1970 Data.

[2]Total excludes Yukon and Northwest Territories.

[3]New Brunswick 1973 Data.

[4]Prince Edward Island 1973 Data.

[5]Newfoundland 1974 Data.

[6]Prince Edward Island 1977 Data; New Brunswick 1975 Data.

SOURCE: Surgical Procedures and Treatments. Ottawa: Statistics Canada. Annual.

between 1969 and 1975 (from 28.1% to 38.5%). It is noteworthy that there was a reduction in the rate of episiotomy in 1976, however without more recent data, it is not possible to suggest that this slight reduction is evidence of a declining trend.

The proportion of episiotomies in Manitoba has steadily decreased between 1969 and 1976, although it should be noted that even as late as 1976, approximately one out of every three women had an episiotomy prior to delivery. While one might be encouraged by the downward trend in episiotomy in Manitoba, it is conceivable that the rising Caesarean section rate may contribute to the falling episiotomy rate (see table 8). It is also possible that physicians may be allowing the perineum to stretch on its own, and in turn are opting to repair lacerations (either major or minor) rather than deciding to perform an episiotomy.

A final consideration in the reduction of episiotomy is that birth order may explain the lower rates of episitomy evident in Canada and Manitoba. As women have succeeding births, the perineal tissues and muscles become more elastic, and in such cases there may be no need for an episiotomy. However, since the official statistics do not differentiate according to birth order (i.e., primiparous versus multiparous), one can only speculate as to the relationship between birth order and reduced episiotomy rates.

As in the case of Caesarean section, there are medical justifications for perfoming an episiotomy. As well, there are potential hazards associated with episiotomy (eg., infection, hemorrhage, and imperfect healing of the scar which may require women to have

gynecological surgery at a later point in time). While physicians herald this technique as "neater" and more efficacious than "sloppy" Nature, it is noted that interference of this kind is often coupled with other technological interventions (eg., anesthesia and forceps extraction), which further transform birth into a physician-centered and controlled experience. Larned's description of the medical profession's overdependence on technology seems exceedingly cogent:

> In an overzealous appreciation of technology, many doctors are transforming a perfectly normal reproductive process into a surgical procedure. Once the merry-go-round of birth machinery and professional intervention is set in motion, it's difficult to slow it down (1978: 30).

(3) Forceps Deliveries (see table 12)

There are a number of types of forceps currently in use in obstetric practice. In normal deliveries where forceps are used to extract the fetus, either "outlet" or "low" forceps are generally applied. In more complicated births, physicians typically use "mid" or "high" forceps.*

The proportion of live births in which forceps have been used in Canada has fluctuated during the eight-year period between 1969-1976.

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* "(Outlet or) low forceps . . . are . . . applied <u>after</u> the fetal head has reached the perineal floor . . . Midforceps . . . are applied <u>before</u> the criteria for low forceps are met but after engagement of fetal head has taken place . . . High forceps operations are those in which forceps are applied before engagement has taken place. <u>No variety of high forceps delivery has any place in modern obstetrics except in the rarest circumstances</u>" (Pritchard and MacDonald, 1976: 867-868/ emphasis mine). It is interesting to note that during the period of 1969-1976, 46,484 mid and high forceps deliveries (10.5% of all forceps deliveries) were performed by Canadian physicians (<u>Surgical Procedures and Treatments</u>, 1969-1976).

Between 1969-1973, the rate of forceps deliveries increased from 12.6% to 14.6%, and remained at that rate until 1975. In 1976, there was a decline in the proportion of forceps deliveries nationwide. In Manitoba, proportionally fewer forceps deliveries were performed than was the case for Canada as a whole, and again, there was a reduction in forceps deliveries in 1976.

As in the case of the reduction in episiotomies, it is possible that rising Caesarean section rates may have contributed to the reduction in forceps deliveries (NIH Consensus Development Statement on Cesarean Childbirth, 1980: 5). As physicians rely more extensively on Caesarean section, it follows that interventions designed for vaginal deliveries will be used more infrequently.

It is noteworthy that similar patterns have been discovered in Britain. Chalmers, et al. have noted that in Cardiff, there was an increase in forceps deliveries between 1968 and 1973 (1976). The explanation advanced to account for the rise in forceps deliveries during that period was that with the introduction of epidural anesthesia in 1973, there was, as well, an increased tendency toward forceps delivery (Chalmers, et al., 1976: 735-738).

It is curious that for both episiotomy and forceps delivery, Manitoba physicians show a tendency to be less interventionist when compared with Canadian physicians as a whole. Such a pattern would seem to be an interesting area to investigate in the future, to determine if there are particular aspects of the training and/or practice of physicians within provinces which lead to different tendencies in the management of birth.

TABLE 12

FORCEPS DELIVERIES,* CANADA AND MANITOBA, 1969-1976

YEAR	CANADA TOTAL	PROPORTION OF ALL LIVE BIRTHS	YEAR	MANITOBA TOTAL	PROPORTION OF ALL LIVE BIRTHS
1969	46,412	12.6	1969	857	4.8
1970	49,148	13.2	1970	1,213	6.7
1971[1]	52,150[2]	14.4	1971	1,263	7.0
1972[3]	48,620[2]	14.0	1972	1,226	7.1
1973	50,185[2]	14.6	1973	1,281	7.6
1974[4]	51,304[2]	14.6	1974	1,193	6.9
1975[5]	52,592[2]	14.6	1975	1,243	7.3
1976[6]	47,263[2]	13.1	1976	1,050	6.3

*Includes outlet forceps deliveries with and without episiotomy; and low forceps deliveries with and without episiotomy.

[1]New Brunswick 1970 Data.

[2]Total excludes Yukon and Northwest Territories.

[3]New Brunswick 1973 Data.

[4]Prince Edward Island 1973 Data.

[5]Newfoundland 1974 Data.

[6]Prince Edward Island 1977 Data; New Brunswick 1975 Data.

SOURCE: Surgical Procedures and Treatments. Ottawa: Statistics Canada, Annual.

(4) Vacuum Extraction (see table 13)

Despite early enthusiasm for vacuum extraction as a means for removing the fetus from the birth canal, this practice is used only minimally in the United States (Pritchard and MacDonald, 1976: 882), Canada and Manitoba (see table 13). The major reason why the vacuum extractor is used so infrequently is that physicians fear damage to the fetal head or loss of infants altogether. In some European countries such as Finland, the vacuum extractor is considered superior to forceps and some researchers dispute American reports of fetal damage as a result of using the vacuum extractor (Sjostedt, 1967 cited in Pritchard and MacDonald, 1976: 882). Given the lack of certainty regarding this technique and its benefits, it appears that Canadian physicians prefer to utilize other means than the vacuum extractor to remove the fetus (as indicated by the small proportions of all live births in which this technique is used).

(5) Artificial Rupture of Membranes (see table 14)

Elective induction of labour has been referred to by Haire as an "American idiosyncracy" (1978a: 189). As the proportion of births in which induction is performed steadily increases in Canada, it is conceivable that induction may become a Canadian idiosyncracy as well. At present there are two forms of induction used in the management of birth. The first involves chemical stimulation (which, in addition, is often used to augment ineffectual labour) and the second is performed by puncturing the membranes of a pregnant woman. It is the latter form of induction to which the present discussion is addressed.

TABLE 13

VACUUM EXTRACTION, CANADA AND MANITOBA, 1969-1976

YEAR	CANADA TOTAL	PROPORTION OF ALL LIVE BIRTHS	YEAR	MANITOBA TOTAL	PROPORTION OF ALL LIVE BIRTHS
1969	198	.05	1969	23	.13
1970	368	.09	1970	59	.32
1971[1]	658[2]	.18	1971	102	.57
1972[3]	615[2]	.18	1972	117	.67
1973	371[2]	.11	1973	82	.48
1974[4]	413[2]	.12	1974	81	.47
1975[5]	456[2]	.13	1975	117	.68
1976[6]	483[2]	.13	1976	116	.69

[1]New Brunswick 1970 Data.

[2]Total excludes Yukon and Northwest Territories.

[3]New Brunswick 1973 Data.

[4]Prince Edward Island 1973 Data.

[5]Newfoundland 1974 Data.

[6]Prince Edward Island 1977 Data; New Brunswick 1975 Data.

SOURCE: Surgical Procedures and Treatments. Ottawa: Statistics Canada, Annual.

The primary impetus behind the increased utilization of induction was that this procedure was considered to be a viable mechanism for reducing perinatal mortality associated with stillbirths and post-maturity of the fetus. Several clinicians have noted that allowing a pregnancy to progress beyond the fortieth week of gestation imposes increasing risks on the fetus, which may be complicated further by toxemia in the mother (Baird, 1976; Lead Article, British Medical Journal, 1976; Howie, 1977; Lynch, 1977; McNay, et al., 1977; Richards, 1975). In order, then, to provide a means for minimizing perinatal mortality and morbidity, several hospitals and physicians have adopted a "progressive" (i.e., liberal) policy with respect to induction. In some hospitals, as many as one-third to one-half of all pregnant women are induced or have their labours augmented by active management on the part of their physicians (cf. Howie, 1977: 88; Lead Article, British Medical Journal, 1976: 729; McNay, et al., 1977: 347).

In Canada, as noted in table 14, although the rate of induction has increased by 50% between 1969 and 1976, the number of women who have been induced remains relatively low overall (in 1976, 22,788 or 6.3% of all Canadian childbearing women were induced). In Manitoba, the rate of induction has increased much more substantially between 1969-1976. The percentage increase in the artificial rupture of membranes was a remarkable 270%(an increase from 4.6% in 1969 to 16.9% in 1976)! Particularly why the more frequent use of induction has occurred in Manitoba is unclear, however in other locales (eg., England and Wales), this procedure has been justified on the grounds

TABLE 14

ARTIFICIAL RUPTURE OF MEMBRANES, CANADA AND MANITOBA, 1969-1976

YEAR	CANADA TOTAL	PROPORTION OF ALL LIVE BIRTHS	YEAR	MANITOBA TOTAL	PROPORTION OF ALL LIVE BIRTHS
1969	15,372	4.2	1969	818	4.6
1970	16,042	4.3	1970	939	5.1
1971[1]	16,065[2]	4.4	1971	707	3.9
1972[3]	15,298[2]	4.4	1972	828	4.8
1973	16,813[2]	4.9	1973	1,103	6.5
1974[4]	16,475[2]	4.7	1974	1,759	10.2
1975[5]	17,704[2]	4.9	1975	2,763	16.1
1976[6]	22,788[2]	6.3	1976	2,830	16.9

[1]New Brunswick 1970 Data.

[2]Total excludes Yukon and Northwest Territories.

[3]New Brunswick 1973 Data.

[4]Prince Edward Island 1973 Data.

[5]Newfoundland 1974 Data.

[6]Prince Edward Island 1977 Data; New Brunswick 1975 Data.

SOURCE: Surgical Procedures and Treatments. Ottawa: Statistics Canada, Annual.

that the risks associated with prolonged pregnancies are presumed to be far greater than any risks of labour and delivery (Baird, 1976; Lead Article, British Medical Journal, 1976; Howie, 1977). Indeed, it is possible that physician preference for induction may have led to the proliferation of this form of active management of birth (Rindfuss, et al., 1979).

There are several medical indications for which induction is recommended and practiced. As previously noted, toxemia and post-maturity have been among the most common justifications for this technique. In addition, induction and/or the augmentation of labour are common in cases of pre-eclampsia, diabetes, and Rh incompatibility (Howie, 1977; Rindfuss, et al., 1979: 439).

As well, several analysts have noted that increaingly induction is performed for the convenience of the physician, mother or both. In a survey conducted by the Department of Health and Social Security in Britain, it was discovered that some women prefer induction as it allows them to make arrangements at home while they are in hospital (cited in Lead Article, British Medical Journal, 1976: 729). For the physician, the ability to plan deliveries offers benefits as well. Rindfuss, et al. have provided indirect evidence of the widespread elective use of induction in Canada and the United States, by analyzing birth registration data. Comparing births in 1951 and 1971, they found that previously the pattern of births by day of the week was almost random. In 1971, there was a definite pattern in the timing of births, with proportionally more births occurring during the week (particularly on Tuesdays and Wednesdays) than on weekends and holidays (Rindfuss, et al., 1979: 441-442).

On the one hand, it is argued that planned induction guarantees that labour and delivery of "at risk" women will take place under optimal conditions (i.e., extensive obstetric and emergency services are more readily available on weekdays during daylight hours). On the other hand, one cannot discount the many iatrogenic risks associated with this technique. Some of the risks of induction include neonatal jaundice, respiratory distress syndrome among pre-term infants, maternal hypotension, and uterine rupture (Howie, 1977: 91-94; Richards, 1975: 596). As well, the increased incidence of induction has been linked with other forms of active intervention in birth. Most notably, analysts have discovered higher rates of Caesarean section, episiotomies, forceps deliveries, and pharmacological intervention (both anesthetics and analgesics) in pregnancies that have been induced and/or augmented (Richards, 1975: 596).

There is no doubt that in certain cases, it is advisable to induce labour. At the same time, the risks of elective induction are substantial enough that this procedure cannot be considered safe or in the best interests of all women for which there are no medical indications for induction. "Nevertheless, the basic assumption underlying the practice of induced labor is that man is merely giving nature a prod, and most doctors see nothing wrong with it" (Arms, 1977: 68).

Clearly, the greater tendency to induce labour via chemical and surgical means represents further evidence of the extent to which birth has been technologized, and thus controlled by the medical profession. Moreover, it is important to note that while many physicians

justify the widespread use of induction on the grounds that it will yield dramatic improvements in perinatal mortality, one must exercise caution in causally linking induction with better outcomes at birth. Again, as in the case of the relocation of birth in hospitals, birth is much more than a physical event. To it are attached important social and psychological dimensions which should not be minimized. When a form of intervention is introduced for convenience, without medical indication, and most importantly without regard for a woman's freedom of informed choice, such procedures seem particularly inhumane (Arms, 1977; Haire, 1978a; 1978b; Richards, 1975; Robson, 1976). Finally, when it is remembered that the efficacy of this and other techniques has <u>not</u> been determined conclusively (cf. Richards, 1975: 599-600) and yet, physicians continue to manage birth actively using these techniques, one is compelled to remain skeptical of the assumptions, intentions and actions of medical practitioners.

(6) Summary: Medical Social Control Through the Dominance of Technique

It was noted previously that in modern obstetrical practice, technologies of various forms have come to play a major part in the management of the birth process. It was further noted that the pervasiveness of many technologies in modern obstetrics may be viewed as a means of ensuring or promoting professional control and disabling dependence among patients (Illich, 1973; 1977). Based on both socio-historical analysis of documents and secondary data analysis of official statistics, one can conlude that not only has birth been technologized, but also that the profession of medicine uses the

various technologies to exercise social control, and thus maintain its dominance (Brack, 1976; Sablosky, 1976).

Numerous critics of the technologization of birth have expressed concern about the prevalence of technical intervention, and the consequences of such procedures. The damage (whether physical, psychological or social) to women and children has been termed iatrogenic by some (Mendelsohn, 1979), and morally, if not legally, cause for malpractice suits (Birnbaum, 1978). Others have commented on the depersonalization, dehumanization, and outright distortion of birth in the hands of medical specialists (Arms, 1977; Caldeyro-Barcia, 1977; Corea, 1977; Ettner, 1977; Haire, 1978a; Ratner, 1978). What tends to be lacking in the polemical debate between physicians and their critics is the recognition of the more subtle consequences of such interference: the fact that the unity of medical technology fortified by medical ideology has fueled professional dominance.

Obstetrical technology and technicians have insidiously transformed what was once normal and natural into something that is abnormal. Moreover, "history teaches us that what is introduced for the unusual, the infrequent, and the abnormal, with time, becomes (or approaches) the usual" (Ratner, 1978: 125). In a discussion of induction of labour, McNay and her associates have acknowledged that "when the induction rate is low only pregnancies at very great risk are included in an induced group, but as the induction rate rises, more and more relatively normal cases are induced" (1977: 350). It is likely that similar statements would be appropriate and legitimate regarding Caesarean section, episiotomy, and forceps deliveries. It appears

as though what were once used in extraordinary cases are now frequently used in both "normal" and "abnormal" cases.

A final point regarding the predominance of technique deserves comment at this time -- a point that has been alluded to previously. That is, in several cases, there is competing or lacking evidence regarding the benefits of various technologies. Indeed, unlike many pharamcological products, changes in technique seldom are subject to experimental investigation, assessment and regulation. In part, this tendency may reflect the fact that the public (and the State) assume that because medicine is a scientific (and also humane and benevolent) enterprise, physicians will refrain from using techniques which threaten the lives of their patients. In the case of the technologies described herein, it is dangerous to assume that such quality controls have been instituted or are effective. In most cases, controlled studies have not been undertaken to provide overall evaluation of techniques, their use and the accompanying practice (Richards, 1975: 600). In other words, technicians have instituted the widespread use of techniques without careful consideration of the benefits and risks. As noted by Richards, "current orthodoxy in obstetrics seems to favour technical innovation without rigorous quality control" (1975: 600).

A reversal of this pattern of the dominance of technique seems possible in view of recent developments such as consumerism, self-help advocacy, certified nurse-midwifery, home births and improved education. However, medical social control pervades the health care system today. It seems likely that a reduction in obstetrical

intervention will be insufficient to restore the "taken-for-granted-ness" of birth so long as medicine remains an unchallenged elite at the apex of the medical division of labour, with the ability to define the nature of birth and other conditions. For it has been (and continues to be) their authority to define the problem which subsequently has provided physicians with a mandate to intervene via technique. So long as birth is defined as pathophysiological, women are likely to be the recipients of "meddlesome midwifery" (Ratner, 1978: 125). Furthermore, so long as physicians define the question, and determine the solutions, alternatives will be minimal. One alternative -- certified nurse-midwifery -- has been the focus of much attention recently, and it is to this subject that the discussion now turns.

INTERPROFESSIONAL RELATIONSHIPS: MIDWIFERY, 1920 TO THE PRESENT

PROPOSITION 5: Through its control over medical language and technology, as well as through its political lobbying and persuasion, the profession of medicine has risen to the apex of the medical division of labour. As such, it has been afforded the authority to determine who will be considered a legitimate practitioner in health care.

5.1 Because pregnancy and childbirth have been medicalized and technologized, the medical profession has determined that the most competent technicians are obstetricians. As a result, there is no place for midwives, traditional birth attendants.

With the institutionalization of obstetrics and gynecology at the turn of the century, as well as technological diversification within this field, the American midwife all but disappeared from the management of birth. Despite evidence of the midwife's competence as a birth attendant, the medical profession created mechanisms (i.e.,

control of birth through redefinition of birth as pathological, control through takeover of birth technology, and inflammatory defamation of the midwife's character and technical ability) to ensure its jurisdictional management of female reproductive health care. As determined in chapter 4, "there seems to exist (both historically and today) a need among organized medicine to quash other viewpoints and procedures . . . (I)t has been important for the dominant medical philosophy to eliminate its opposition" (Mehl, 1976b: 4).

During the period of 1910-1920 in the United States and Britain, organized medicine was engaged in a vigorous campaign designed to relegate the midwife to obscurity. The American campaign was by and large successful. After 1920, fewer medical practitioners published articles in journals concerning "the midwife problem", primarily because there were fewer practicing midwives and the number of midwife-attended births had also greatly decreased. For example, in New York City in 1909, midwives attended 40.55% of all births. By 1920, fewer than 27% of all births were attended by midwives. In the state of New Jersey, in 1918 there were 399 practicing midwives, compared with over 700 midwives only nine years earlier. In Birmingham, Alabama, the number of midwife-attended births dropped from 968 in 1917 to only ten in 1924 (Litoff, 1978: 82-83).* Apparently, the anti-midwife campaign in America contributed to the demise of the traditional birth attendant.

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* Of course, it is possible that where midwife-attended births decreased that it was a function of under-reporting of such births in the face of intimidation by physicians.

However, the organized campaign by the medical profession was only partially responsible for the disappearance of the American midwife. Equally important was the fact that midwives in the United States (unlike their British counterparts) were an ineffective adversary to organized medicine, having neither the political clout nor popular support necessary to counter successfully medical opposition. There were few midwife associations or publications through which the midwives could defend themselves in the face of public, as well as organized medicine's, attacks. Midwives failed to gain credibility in the legal arena, and thus were unable to take part in the drafting of legislation regarding their practice.

Although many public health officials and some -- albeit a limited number -- of physicians spoke out on her behalf, the midwife's limited training continued to work to her disfavour. With the publication of the Flexner Report in 1910, even supporters of midwifery in the medical community saw it as most important that the wanton state of medical education be rectified prior to any efforts to educate lay midwives.* By 1930, few programs for the training of midwives were institutionalized, and even fewer states actively campaigned to control or license midwives.

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* Sablosky has noted that not only did the Flexner Report chart the future of medical education, but as well, that "the recommendations that came out of this report were responsible for the demise of midwifery and seriously threatened the continued existence of the early black medical schools and the sectarian medical schools" (1976: 11). Barker-Benfield has suggested that the Flexner Report made clear the assumption that "medical progress went hand in hand with the systematic domination of midwives by 'obstetric physicians'" (1976b: 62).

Finally, around the period prior to World War Two, the birth rate fell considerably. As such women no longer viewed reproduction as a routine aspect of adult life. Instead, birth came to be regarded as a significant event. "It was easy to juxtapose this attitude with the view that childbirth was a complex medical disorder requiring the services of the highly trained medical practitioner" (Litoff, 1978: 114).

Hence, a number of factors contributed to the virtual disappearance of the lay midwife. In brief, these factors included claims to expertise by the medical profession backed by universities and the State, a significant monopoly of practical technology, dissemination of the ideology suggesting the pathology of reproduction, industrialization and urbanization which promoted the transition from home to hospital for delivery, and the inability of lay midwives to present themselves as formidible adversaries to organized medicine (Brack, 1976: 18-24). By 1930, the professional control of childbirth was virtually complete (Brack, 1976; Litoff, 1978).

However, during this same time period, many of the proponents of midwifery were resolved <u>not</u> to surrender their struggle against organized medicine. In fact, at the height of the anti-midwife campaign, there was mounting support for the new concept of nurse-midwifery, first introduced by Dr. Fred J. Taussig from St. Louis, Missouri in 1914 (Litoff, 1978: 122). He, along with several others, suggested that the most viable way to resolve the "midwife problem" was to incorporate the practice of midwifery as a branch of nursing.

Subsequently, efforts were undertaken to develop specialized

programs of midwifery to which nursing graduates only would be admitted. Unfortunately, relatively few of these programs survived. Among those which did succeed in remaining in operation were the Maternity Center Association (established in New York City in 1918) and the Frontier Nursing Service (which was initiated by Mary Breckinridge, a graduate nurse, over the period of 1920-1928 in rural Kentucky). It is noteworthy that both of these nurse-midwifery programs continue to offer safe childbirth alternatives to parturient women.

Notwithstanding the progress made by the Maternity Center Association and the Frontier Nursing Service in maternal and child health care (including the provision of prenatal instruction, the supervision of expectant women not under medical care, the selection of women requiring hospitalization for delivery, and assisting those women preparing for home births), acceptance of the concept of nurse-midwifery was not widespread. In point of fact, Litoff has suggested that "many of the forces responsible for the demise of the early twentieth-century lay midwife may have also worked against the growth and development of nurse-midwifery programs" (1978: 127).

Little progress was made in terms of the institutionalization of nurse-midwifery in the United States until the mid-1950's. In 1955, the American College of Nurse Midwifery was established by a group of nurse-midwives. Fourteen years later, the American College of Nurse Midwifery amalgamated with the Kentucky-based American Association of Nurse-Midwives, to form the American College of Nurse-Midwives (ACNM), the current national professional association of nurse-midwives in the

United States.*

This body is responsible for the evaluation of nurse-midwifery programs and monitors the ACNM national examinations for certification. In addition, the ACNM publishes the Journal of Nurse Midwifery in which accredited programs are reported. As well, scholarly articles on the practice of nurse-midwifery and more generally, the subject of maternal and child health care are published in the Journal of Nurse-Midwifery. The ACNM, like other professional organizations, also devotes considerable attention to the question of legal recognition of its membership. (In 1976, an edition of the Journal of Nurse Midwifery was published specifically for the purpose of reviewing the legislation and practice of nurse-midwifery in the United States. Appendix A illustrates where nurse-midwifery has been legalized. As of this writing, there is no national legislation to institutionalize midwifery, as has been done in Great Britain.)

In spite of efforts made by the ACNM, nurse-midwives have yet

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* The development of the American College of Nurse-Midwives is significant in that one of the most critical stages in the professionalization of any occupational group is the creation of a professional organization which functions as the representative and overseer of the work group, and which also specifies the social organization of the work group in relation to other workers and the wider society. It is the professional organization which defines the roles and responsibilities of the individual practitioners, as well as the ideology of the occupational group. Most importantly, the professional organization is charged with initiating political activity designed to obtain state sanction for the occupational group's claims (Bucher and Strauss, 1961; Freidson, 1970a; Goode, 1957; 1960; Hughes, 1960). "It seeks to influence events so as to protect (the occupational group's) vital interests and implement(s) their professional values" (Bucher and Stelling, 1969: 11).

to receive clear support from organized medicine or the public. It appears that the modern-day nurse-midwife is typically confused with the lay midwife of the early twentieth century. The term "midwife" generally has negative connotations, and in fact, Litoff reports that "part of the slow acceptance of the nurse-midwife 'is due to the fact that crusaders who set out to eradicate unskilled midwifery early in the century did their job perhaps too well'" (1978: 129).

Currently, the overwhelming majority of childbearing women are inclined to seek out the services of physicians (whether General Practitioners, or obstetricians) during pregnancy, and as noted previously, less than 1% of all live births occur outside of hospitals (see table 1). As noted in tables 15 and 16, both the proportion of births attended by midwives (certified, lay, and granny midwives) and the number of lay midwives has decreased substantially in only a few decades.

The American College of Nurse Midwives has reported that while 21,336 births were attended by midwives in 1971, this number was sharply reduced to 10,102 live births in 1974. Since birth certificates only state "midwife", it is difficult to ascertain what proportion of all live births are attended by "certified nurse-midwives" as opposed to "lay" or "granny" midwives. As of 1976, approximately 7,500 births were reportedly attended by certified nurse-midwives, according to the ACNM (Health Resources Statistics, 1976-1977 Edition). As indicated in table 15, there has been a gradual increase in the number of births attended by "midwives and others" since 1974, and it will be interesting in the coming years to see if more substantial numbers of births will be attended by midwives (certified and lay).

TABLE 15

LIVE BIRTHS BY ATTENDANT AND PLACE OF DELIVERY, UNITED STATES, 1950-1977*

YEAR	BIRTHS ATTENDED (1000)		
	BY PHYSICIANS		BY MIDWIVES OR OTHERS[2]
	IN HOSPITAL[1]	NOT IN HOSPITAL	
1950	3,126	252	177
1955	3,819	101	128
1960	4,114	49	94
1965	3,661	33	66
1970	3,708	5	18
1972	3,234	7	18
1973	3,115	7	16
1974	3,134	11	16
1975	3,105	11	28
1976	3,124	12	32
1977	3,278	13	36

*Represents registered births. Prior to 1960, excludes Alaska and Hawaii. Beginning 1970, exludes births to nonresidents of the U.S.

[1]Includes all births in hospitals, institutions, and clinics.

[2]Includes births with attendant not specified. This category presumably includes both lay and certified nurse-midwives.

SOURCE: Statistical Abstract of the U.S., 100th Edition. Washington, D.C.: Dept. of Commerce, Bureau of the Census, 1979, p. 63.

TABLE 16

LAY MIDWIVES, UNITED STATES, SELECTED YEARS, 1948-1975

YEAR	NUMBER	NUMBER PER 100,000 POPULATION*
1948	20,700	14.3
1956	11,500	6.9
1964	6,690	3.5
1967	5,201	2.7
1968	4,760	2.4
1969	4,425	2.2
1970	4,089	2.0
1971	3,736	1.8
1972	2,880	1.4
1973	2,503	1.1
1975	2,354	1.1

*NOTE: Between 1948-1975, there has been a 92% reduction in the number of lay midwives in the United States.

SOURCE: Health Resources Statistics, 1976-1977 Edition. (Health Manpower and Health Facilities). Hyattsville, Maryland: U.S. Dept. of Health, Education and Welfare. Public Health Service. Office of Health Research, Statistics, and Technology. National Center for Health Statistics, 1976-1977, p. 162.

Indeed, if the number of midwife-attended births does increase, that may be an indicator of the effectiveness of the ACNM in extending the mandate of its members.

Critics within organized medicine abound today, expressing viewpoints reminiscent of those typical at the height of the anti-midwife campaign. For example, in his presidential address to the Central Association of Obstetricians and Gynecologists, Dr. Russell J. Paalman stated:

> Can a nurse-midwife pick up all the early signs of impending disaster and consult an obstetrician in time? Is not every pregnant woman entitled to a trained obstetrician's care and delivery in a modern obstetric suite? . . . Except in a very few deprived areas, is there a place for nurse-midwives in the United States? I think not! (1975: 140/ emphasis mine)

At the same time, however, there is mounting support for nurse-midwives among feminists and dissatisfied health care consumers (Fidell, 1980; Sablosky, 1976). As noted by Oakley,

> the argument that women should control their own reproductive health care is a new statement of an old view which crops up recurrently in the history of obstetrics and gynecology throughout the centuries -- that female control (of women's medicine generally, and childbirth particularly) is "natural" (or rather that male control is "unnatural") (1976: 56).

According to the American College of Nurse-Midwives, there were an estimated 2,000 certified nurse-midwives in the United States in 1977, with approximately 140 new graduates annually. The ACNM contends that the number of lay midwives has declined as the number of certified nurse-midwives and hospital deliveries have increased (Health Resources Statistics, 1976-1977 Edition).

The modern nurse-midwife is never considered an independent practitioner and functions within the framework of the organized

health care system.* Primarily, the responsibilities of certified nurse-midwives include: the provision of antepartum, intrapartum, and postpartum care directed towards individualized needs of pregnant women; the evaluation of the progress of labour and delivery; the management of labour and delivery; the surveillance of labour and delivery in order to detect untoward signs requiring medical attention; and the provision of care to newborns and mothers following birth. In addition, nurse-midwives serve an important educative function.

There is considerable evidence of the efficacy of nurse-midwifery. For example, from 1960-1963, a pilot program using nurse-midwives was introduced in Madera County, California to relieve a health manpower shortage. During this period, prenatal instruction was increased, there was a reduction in the number of premature births, and most significantly, there was a sharp decrease in neonatal mortality. However, because the local council of the California Medical Association refused to support the program on a long-term basis, or proposals to revise state legislation permitting the practice of nurse-midwifery, the Madera County program was terminated in the summer of 1963. Interestingly, following cancellation of this program, prenatal instruction was severely curtailed, prematurity increased (from 6.6 to 9.8 per 1,000 live births) and neonatal mortality rose as well

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* The certified nurse-midwife's subordinate status reflects the fact that she is first a nurse, and only secondarily a midwife (litoff, 1978: 131). This, moreover, reaffirms the inevitability of physician domination of midwives noted by Barker-Benfield (1976b: 62).

(from 10.3 to 32.1 per 1,000 live births -- an increase of over 200%). After locating "no other reasonable explanations", the researchers concluded that the improvements in maternal and child health prior to the discontinuation of the program, were almost totally attributable to the nurse-midwives' care and concern for their patients (Levy, et al., 1971).*

The apparent success of nurse-midwives in California has prompted some legislators to consider licensing midwives as a means of improving the quality, quantity and kinds of health care services available to pregnant women. According to Roger L. Carrick of the Department of Consumer Affairs in the State of California, legislative action is forthcoming in 1981 (The Professional Midwifery Practice Act of 1980, SB 1829) to license professional midwives to practice in consultation with physicians in "normal" childbirth cases. This bill was introduced in response to "a growing awareness of the maternity care crisis in California" (Personal Communication, May 20, 1980).

In a more recent study of a nurse-midwifery service in New York City, Haire reports similar favourable findings. Briefly, she determined that

> educating mothers for the childbearing experience, permitting one or two of the mother's lovedones to provide her with strong emotional support during labor and delivery, and avoiding unnecessary intervention in the birth processes can significantly improve the outcome of pregnancy, even when two-thirds of the obstetric population would be considered high risk or at risk (Haire, 1980: 2/ emphasis mine).

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* The researchers acknowledged that because their study was retrospective in nature, they were unable to control for all extraneous factors or reporting inadequacies which might have contaminated the results which were reported. As a result, one must interpret their findings with some caution.

After reviewing the records of the North Central Bronx Hospital from January 1 to December 31, 1979, Haire found that there were few transfers to another hospital, that fewer than 30% of all mothers received analgesia or anesthetic drugs, that in over 85% of all cases, mothers delivered spontaneously (i.e., vaginally). She found that only 2.34% of all deliveries were assisted with the use of forceps or vacuum extraction, that no elective inductions were performed, that episiotomies were performed in 26% of all births, and that the overall Caesarean section rate was 9% (7% primary and 2% repeat) (Haire, 1980: 2-3). Although Haire does not provide contrasting statistical evidence for physician-attended births, it is clear from her analysis as well as her previous work (1978a; 1978b) that she favours the institutionalization of nurse-midwifery and a return to non-interventionist maternity care as a way of improving the outcome of pregnancy (Haire, 1980: 3).

In another study conducted by Mehl and his associates between 1970 and 1975 in Santa Cruz, California, further evidence of the efficacy of midwifery is presented. In a two-part study in which the outcomes of deliveries attended by non-nurse midwives (i.e., non-certified nurse and lay midwives, but not foreign-trained midwives) and a matched sample of physicians were compared, the researchers concluded that the non-interventionist patient management philosophy common to midwives produced more favourable outcomes (eg., significantly less fetal distress, meconium staining, postpartum hemorrhage, birth injuries, and infants requiring resuscitation, as well as higher APGAR scores) than was true for doctors at the Santa Cruz

Birth Center (Mehl, et al., 1980). They also note that the less interventionist subsample of physicians studied did compare far more favourably to the midwives (in terms of outcomes) than their interventionist colleagues. Finally, they state that "excessive interference seems to be of little value regardless of who does it" (Mehl, et al., 1980: 28).*

In speculating on the differences between the midwives and physicians, the researchers suggest that "perhaps there is something about formal training programs (for physicians) that lead their graduates to be more interventionist than necessary" (Mehl, et al, 1980: 28). Given the fact that the major function of medical education is the socialization of recruits, and moreover, that this process is largely responsible for fostering the internalization of the professional ideology (Becker, et al., 1961; Mendelsohn, 1979; Merton, et al., 1957; Scully, 1980), such a conclusion seems exceedingly plausible.

Although there continues to be considerable opposition to all types of midwives (but most especially lay midwives) within the ranks of organized medicine, there is recognition among some** that certified nurse-midwives can make a meaningful contribution to reproductive

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* As in the study by Levy, et al., (1971) reported earlier, Mehl, et al. acknowledge several limitations of their study methdology. For example, potential problems in terms of the completeness and accuracy of the records reviewed, inability to examine attitudinal differences in terms of the perception of the normalcy or pathology of birth between midwives and physicians, and the inability to address the issue of midwife screening may have resulted in bias in the matching design (1980: 21).

** It is apparent that American nurse-midwives are gaining some measure of credibility among political leaders, given that the 96th Congress recently authorized Medicaid payments for the services of nurse-midwives. This development has increased the legal possibility for alternative forms of maternity care for those who previously had no access to nurse-midwives (American Journal of Nursing, 1981: 448).

health care. In addition to their skills as childbirth educators, nurse-midwives have been found capable of providing comparable care in "normal" childbirth at a lower cost than physician-attended deliveries. However, health economist Robert G. Evans has warned that "the mere identification of the fact that . . . midwifery . . . offers better care at lower costs is one of the weakest forces for implementation (of legislation). If anything, experience seems to suggest the reverse" (1980: 16).

The recent achievements of American nurse-midwives provide a stark contrast to the Canadian scene. Although midwives have existed throughout much of Canada's history, there remains considerable opposition within organized medicine to the legalization of nurse-midwifery. There is very little historical information on midwives in Canada, although Hurlburt has noted that among the Indian and Inuit populations, traditional birth attendants still function as they did historically, but are now being displaced somewhat by "outpost nurses" (1981: 30). Moreover, she has noted that the demise of lay midwifery in Canada coincided primarily with the increase in hospital births across the country beginning in the 1900's (see table 1).

More recently, nursing schools at three universities in Canada have developed specialized programs to train graduate nurses in the essentials of midwifery. These include the University of Alberta's "Advanced Practical Obstetrics Program" which was initiated in 1943, the "Outpost and Public Health Nursing Program" at Dalhousie University, and Memorial University's "Outpost Nursing and Nurse-Midwifery Program". Each of these programs provide comprehensive training in midwifery

comparable to that available in Britain, although additional training would be necessary for certification.

In 1974, the Canadian Nurses Association (CNA) issued a statement recommending nurse-midwifery. According to the CNA, the nurse-midwife is "the health professional best equipped to meet the growing needs for counselling services and for greater continuity of care within this area of the health system" (cited in Hurlburt, 1981: 31).

Between 1974-1975, three nurse-midwives' associations were formed (in 1974, the Western Nurse-Midwives Association, which has members in British Columbia, Alberta, Saskatchewan, the Yukon and Northwest Territories; and in 1975, both the Ontario Nurse-Midwives Association and the Atlantic Nurse-Midwives Association came into being). Each of these regional associations as well as the Canadian Nurses Association (see Appendix B) and the Registered Nurses Association of British Columbia (see Appendix C) have argued for the recognition and eventual legalization of nurse-midwifery in Canada, because it is contended that midwifery is a part of the "ordinary calling of nursing" (Hurlburt, 1981: 31). However, acceptance by the medical profession and the public is still pending on the legalization question.

In a recent article, the following comments were made by selected Canadian physicians regarding midwives (Schroeder, 1980: 11):

> For years, we were dependent on them. But on the whole, we think the proper method is to develop doctors who are trained in those areas. Most women . . . go to a hospital to have their baby now. (Dr. Garret Brownrigg, Registrar of the Newfoundland Medical Board)
>
> Delivering at home is a retrogressive step. Too many things can go wrong with which a midwife would be unequipped to deal.

> This business of home birthing has got carried away to the cult level. (Dr. Robert F. Robertson, President, College of Family Physicians of Canada/ emphasis mine)
>
> A large part of modern obstetrics involves the sort of prenatal care that only doctors can give. Besides, why develop another breed of practitioners when there's a falling birthrate? No, no, hospitalized obstetrics is definitely the answer. (Dr. Michael E. Dixon, Registrar of the Ontario College of Physicians and Surgeons/ emphasis mine)

A Quebec physician, responding to a proposed midwife plan in that province, has suggested that the return of midwifery would be "an unacceptable regression and would threaten dramatic improvements achieved in hospitalized childbirth over the past 20 years" (The Winnipeg Sun, November 7, 1980: 17). As indicated in the preceding statements by members of the Canadian medical community, the institutionalization of nurse-midwifery is not likely in the foreseeable future in this country despite the merits attributed to this group of health care practitioners here (Powis, 1979; 1981) and elsewhere (Donnison, 1977; Haire, 1980; Levy, et al., 1971; Litoff, 1978; Mehl, et al., 1980).

As evidenced in the foregoing discussion on medical ideology, medical technology and interprofessional relationships, there is reason to conclude that nurse-midwifery presents a realistic alternative to interventionist obstetrics. In addition, there has been an implicit assumption throughout this thesis that women should be in control of their own reproduction. To the extent, however, that nurse-midwives might simply replace obstetricians as "controllers" or "managers" of pregnancy and childbirth, such a move will not offer a significant change in the health care system. Given the opportunity to gain a "license and mandate" (Hughes, 1958) to practice,

and technical autonomy comparable to that of physicians, it seems conceivable that problems in the organization and delivery of maternity care will be perpetuated by nurse-midwives, rather than arrested and rectified.

Just as Marx believed that it was not enough to transfer the control over the economic mode of production from the bourgeoisie to the proletariat (1978), so too, it is not enough to transfer the management of childbirth from one group of technically autonomous practitioners to another. "Passing the control of childbirth and feminine health services from the hands of men to women would just mean a new face to replace the old, with dependency on an authority figure still the rule" (Arms, 1978: 75).

The central question being addressed seems not one of women versus men or midwives versus physicians. There are some men and some physicians who can offer as good (or better) care as females and/or midwives (i.e., in terms of compassion and humanism, etc.). What is more critical is to locate and institutionalize as uncontrolling, undominating, and natural as humanly possible a system of care for parturient women: a system which offers quality care and safety, without sacrificing or compromising human freedom, choice and dignity.

RECENT DEVELOPMENTS: THE HOME BIRTH MOVEMENT

Time refuses to stand still. In virtually every sphere of human endeavor, change has become an inevitable fact of life. In the field of health care, there have been considerable changes made within the last few decades (cf. Haug, 1976; 1977; Haug and Sussman, 1969; Jager,

1980; Malone, 1980; Ruzek, 1977; 1978; Stewart, 1976; Woods, 1979), the impact of which is likely to be greater in the coming years. As feminists and self-help advocacy groups are making their voices heard (Fidell, 1980), it is likely that more (and perhaps, radical) changes will be instituted in the delivery of health care, and in women's health care in particular.

Ruzek (1978) has noted some of the recent developments in women's reproductive health care (eg., elective procedures in childbirth are now performed with less frequency; a woman's spouse or loved ones may attend delivery of the child in some cases; mandatory feeding schedules have all but disappeared; there are provisions for sibling visitation; in an effort to foster the maternal-infant bond within the first few hours of life, segregation or separation of the mother and child is no longer routine hospital policy; and so on). However, the overwhelming majority of changes which have taken place are within the framework of "physician-attended-hospitalized-births". Few alternatives to this type of birth currently exist. One development geared towards making available an important alternative in this area, and which is gaining momentum and support among select segments of the population, is the home birth movement.

Historically, children were born at home because hospital confinements were too costly or because hospital facilities were not available. As well, many couples believed that the home was the proper place for birth (Devitt, 1977). However, with the near complete elimination of the American midwife, and concurrently, the emphasis by physicians on the need to hospitalize birth, obstetrics shifted its focus from

domiciliary care to institutional care.

Inspired by Ashley Montagu's publication "Babies Should Be Born at Home" in 1955 in The Ladies' Home Journal (cited in Devitt, 1977: 47), as well as a recognition of a general disinterest and inability of hospitals to provide gratifying socio-emotional care during and following birth (Ashford, et al, 1976), several individuals decided to opt for home birth. Since that time, increasing numbers of women (primarily white, middle class, healthy, college-educated women) have revitalized domiciliary deliveries in the United States (Devitt, 1977: 51). Working together with lay interest groups such as the International Childbirth Education Association (ICEA) and the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), these individuals have banded together in a social movement directed towards changing the status quo in maternity care.

The basic assumption of the home birth movement is that pregnancy, labour and delivery are normal, physiological processes rather than pathological events. Furthermore, advocates of home birth acknowledge that while some women do require the technologies and personnel available in hospitals, these women represent a minority of all cases. Just as hospital birth is not for everyone, soo too, home birth is not for everyone. Therefore, it is contended that "blanket rules" should not be applied, and that the best care is individualized care. While it is recognized that complications can occur during the maternity cycle which may require expert attention, advocates of home birth believe that only those not at risk should opt for home delivery.

At the same time, however, they favour a home-oriented or "family-centered" birth experience for those women unable to deliver at home. Where possible, intervention should be reserved for only those women and infants who might otherwise experience life-threatening circumstances (American College of Home Obstetrics, 1976; Campbell, 1976: 279).

Because of widespread opposition to home birth among many physicians and the public, home birth advocates and sympathetic physicians have instituted fairly rigid screening mechanisms (primarily during prenatal care) "to ensure that only healthy women who are not likely to develop complications are followed during home birth" (Devitt, 1977: 51; Hudson, 1976). In addition, hospital back-up is pre-arranged in the event of untoward complications which might require the facilities of a hospital. Ideally, the establishment of "flying squads" (i.e., paramedical teams which can carry out surgical procedures if needed, or can transfer the woman to a hospital in relatively short time) modeled after the British and Scandinavian systems would allow for more organized emergency back-up (Arms, 1977; Kloosterman, 1978; Oakley, 1980).

In accordance with the belief in the normalcy of pregnancy and childbirth, attendants at home births refrain from interfering in the birth process unless necessary. No surgery is typically performed, and there is minimal use of pharmacological medications. Presumably those in need of surgery or medication will have been diverted to a hospital for delivery. Some indications for hospital birth include diabetes, hypertension, toxemia, multiple births and maternal illness

during pregnancy.

As the medical ideology strongly opposes domiciliary confinements (Lead Article, British Medical Journal, 1976; Matthews and Fox, 1976; Slatterly, 1976; Reid, 1976; Zinkin and Cox, 1976), several investigators have undertaken research to determine the relative safety of home births. For example, in a study conducted by Mehl and his associates in Santa Cruz, California (1975), the researchers determined that women did not experience greater complications at home than those in the general population. While the investigators refrained from concluding that home birth was safer than hospital birth, they reported lower neonatal morbidity and mortality in the home birth group when compared with the general population.

Based on their findings, they concluded that "selected women with benign prenatal courses can labor and deliver at home without a significant increase in neonatal and maternal risks" (Mehl, et al., 1975: 130). Furthermore, they found that the home environment of those studied (primarily white, middle class families) were not necessarily "breeding grounds" for infection, an accusation commonly employed by physicians who oppose home delivery. In fact, Mehl, et al. found comparable rates of post-partum infection among those at home and those in hospitals, which led them to conclude that "in the less pathogenic environment of the home, hospital asepsis was not necessary to prevent infection" (1975: 131).

In a case study of his own clinical home obstetric service, Ettner has also reported favourable results. Between January 1 and June 1, 1975, Ettner observed 56 homebirths in Chicago. Of these, 92.8% of the mothers were in a semi-sitting position for delivery, as opposed

to the customary supine position. In 82.1% of all cases, the amniotic membranes ruptured spontaneously, and the remainder were artificially ruptured late in the second stage of labour. No episiotomies were performed. No procedures for stimulating or inducing labour were performed. Neither forceps nor vacuum extraction was used to extract any fetus. No medications (either pre-delivery or during delivery) were administered to any of the women. No women or infants required post-delivery hospitalization. Most importantly, no women or infants died as a result of a home birth monitored by Dr. Ettner. Although no attempt was made at comparing this sample with a comparable group of women delivering in hospitals, and although this sample size was small, there is every indication that healthy women can deliver naturally and safely at home, with the proper supervision and assistance (Ettner, 1976: 57-59).

In a study conducted by Cox and his associates of a British domiciliary obstetric and neonatal practice (1976), although favourable outcomes were realized in virtually all of the home deliveries (n=155), the authors make considerable efforts to denigrate this childbirth option. Fearful that no home birth can ever offer complete safety, the authors recommend efforts to increase hospital deliveries in that country to 100%. (It will be recalled that as late as 1977, only 2% of all British births occurred outside of hospitals. See table 3.) Despite a strong medical bias, the authors acknowledged the need for hospital policies (with regard to maternity care) which reflect and incorporate a less rigid and more personal framework (Cox, et al., 1976: 85).

In a review article of research on home births, Mehl has discerned that even in the face of compelling evidence as to the safety of and personal preference for home births, the medical establishment refuses to endorse the viability of home birth as a safe option (1976a). The medical ideology which has pre-empted alternative viewpoints and practitioners historically resists out-of-hospital births today as well. In a caustic, although legitimate, critique of medical ideological thought (derived from a statement by the New York State Branch of the American College of Obstetricians and Gynecologists), Mehl points to the tautological reasoning which inheres in medical opinions:

> . . . the position paper states that out-of-hospital delivery is not a valid subject for research and, therefore, by definition, any research findings on out-of-hospital delivery are invalid and not worthy of consideration. . . pilot projects testing the safety of out-of-hospital deliveries are also, by definition, not valid activities. The other consideration the position paper raises is that the fetus cannot give informed consent for delivery outside of a hospital. This is an interesting position since the fetus cannot give informed consent for delivering in the hospital (hospital delivery has never been proven to be the safest place to deliver), for fetal monitoring, Cesarean sections, or for any other obstetrical procedure. . . Clearly, it is convenient to require the consent of the fetus for activities which one does not want to occur and to accept the consent of the mother for what one does want to do. This kind of decision-making process is underscored by the concept of the physician as the decision-maker as opposed to the mother. It would seem that the philosophy from which the District II ACOG has responded is one in which the physician decides what is right for a mother and infant within the framework of his/her value system without regard to the mother's or couple's values (1976a: 8).

As in so many other areas, it appears that when the results of empirically valid research contradict one's personal opinions, then it is convenient and justifiable to dismiss the findings as invalid.

The old adage prophesied by William I. Thomas nearly a century ago remains true and unchallenged today: "if men define situations as real, they are real in their consequences" (1928: 573). Physicians have defined home birth as invalid, and thus it is invalid, as are the research findings on the subject, and home birth advocates themselves. Conversely, only "physician-attended-hospitalized-birth" is valid.

The medical profession not only relies on its ideology to invalidate home birth. In addition, Mehl notes that the medical profession utilizes intimidation as a form of resistance to change. Historically, and recently (for example, in Santa Cruz, California), midwives who attend home births have been arrested and charged with "practicing medicine without a license" (Christeve, 1974). Physicians, as well, who attend home deliveries have been ostracized and intimidated by their peers (Mehl, 1976a). Finally, physicians utilize intimidation in their relationships with clients, to convince them that only hospital delivery offers safety and the best chances for successful outcomes at birth.

There is some evidence that home birth can be a viable, safe alternative for some -- but not all -- parturient women (Hudson, 1976). Ultimately, the choice of how birth is to be managed (whether at home or in a hospital, with the assistance of a midwife or a physician, whether naturally or technologically) must be decided by patients <u>along with</u> professionals -- not by professionals exclusively. As Freidson has noted,

> it is a question of public, not only professional, policy to determine how people said to be ill shall be managed in the course of treatment. It is a moral rather than technical question whether or not civic identity and rights should be sacrificed to the putative demands of a treatment technology. And it is a social rather than medical question to ask what degree of the convenience of the treated should be subordinated to the convenience of the treater, whether or not the treated should be provided with full information about alternative modes of management of treatment and the freedom to choose his mode, whether or not institutionalization should take place, and what the routines of management in institutions should be. For such issues, the profession is a rather special source of advice in that it is expert in what treatment is necessary and therefore what technical limits are imposed on the alternatives for management. But with those limits given, the alternatives remain a matter in which lay choice is quite legitimate and professional autonomy illegitimate (1970a: 345).

CONCLUDING REMARKS: ON THE NORMALIZATION OF PREGNANCY AND CHILDBIRTH

As a result of the foregoing analysis, one can, with some measure of certainty, conclude that medicine operates as an institution of social control. Furthermore, it is clear that today, just as years ago, this small group of experts has come to influence what society understands as illness, who shall treat the presumed illness, and with what means.

One would have to be grossly naive to fail to recognize the valuable contributions that medical practitioners (and researchers) have made to society over the course of human history. However, as a segment of the elite in society, the profession plays a critical role in maintaining (and in fact, defining) the status quo.

As noted in the previous discussion, the profession of medicine utilizes primarily three mechanisms in the exercise of its control. The first of these, medical ideology, is the most salient mechanism

of social control. The redefinition of behaviors and conditions within the framework of medical language or imagery, in turn, determines both how the "medical problem" will be resolved (i.e., what technical solutions will be employed) and which experts will be dominant in the management process.

Over time, the medical profession has utilized its autonomous position to transform social understanding and perception of the reproductive process. Whereas only a century ago most births took place in the home, today virtually all births take place in hospitals. Whereas previously most births were perceived as non-problematical (that is, Nature was self-sufficient), increasingly birth has become a problem in need of technical management. Several obstetrical procedures, originally designed to deal with the extraordinary case, have become routine forms of intervention in a great many pregnancies and deliveries. Finally, whereas previously individuals considered birth to be "women's business" (i.e., within the purview of empirically experienced, rather than professionally trained, midwives), there has been a shift in focus away from traditional birth attendants to "men of science". It seems possible that the mandate of certified nurse-midwives may be extended with time. However, so long as the profession of medicine maintains its dominant position in the health care system, it is doubtful that any substantial changes will be made in terms of the organization and delivery of health care.

The essence of this thesis is that "control" tends to give rise to several consequences, few of which can be considered desirable (eg., manipulation by experts, individualization and depoliticization

of medically defined problems, circumscription of human freedoms and choices, and disabling dependence on technology and technicians). In light of the consequences of control, the only reasonable avenue to follow in the future seems to be one in which there is an emphasis on de-control and de-medicalization (that is, normalization). By altering conceptions or definitions of the birth process (i.e., the language regarding birth), it is likely that birth may once again become a normal aspect of daily life.

It would seem that the only way to alter the present arrangements in the organization and delivery of health care is to revolutionize it in practice (Marx, 1978). Interpretation and criticism of this system are not enough -- "the point is to change it" (Marx, 1978: 145/ emphasis in original). Among the changes which would radically reform the current health care system are the following:

(1) Medical education programs must be humanized. Since it is over the course of medical education that the roles, values, and relationships typical to professional practice are learned, efforts must be made to instruct prospective physicians in not only the core curricula (as already established), but as well in interpersonal dynamics which will perhaps humanize the doctor-patient relationship. Physicians must learn that disease is much more than a physiological state -- it is also a social state (Freidson, 1970a). Moreover, physicians must come to the realization -- painful as it may be for some -- that they are not "made in the image of the Almighty" (Scully and Bart, 1978: 215). Their expertise and significant contributions to society are acknowledged, but physicians are only human.

They would be well-advised to cease making more of their "powers", and instead re-direct their energies toward providing quality care in a dignified and equitable manner.

(2) The doctor-patient relationship must be reformed such that it is based on mutual respect and participation, rather than a relative power imbalance (cf. Szasz and Hollender, 1978).

(3) Patients must actively participate in the health care system, inasmuch as they are affected by it. That is, patients must learn to take responsibility for their lives. With ever-widening opportunities for education and self-help in many industrialized nations, patient participation in their own health care seems more likely in the not-too-distant future. Until patients take this step, it is doubtful that the doctor-patient relationship will be altered significantly (Arms, 1977; Illich, 1977).

(4) Tools (i.e., technologies) must become convivial (Illich, 1973), so that one need not have an advanced education to perform routine and simple tasks. Individuals must regain control over their tools, rather than allowing technology to control them, and the direction of civilization (Ellul, 1964; Gendron, 1977; Illich, 1973; 1977; Marx, 1978).

(5) Medicalization must become a thing of the past, because it is this phenomenon which is fundamental to the exercise of social control in health care. At present, the only one to benefit from medicalization is the profession of medicine (Conrad, 1979) -- patients, as a result, face manipulation, humiliation, and dehumanization at best, and debilitation and death at worst. Efforts must be made to

normalize most especially those conditions or behaviors which have been medicalized unnecessarily (eg., birth).

(6) Finally, the autonomy of all professionals must be challenged, if not eliminated entirely, and those "professionalizing" occupations must refrain from attempting to obtain autonomy such as that experienced by the medical profession. As has been discovered in the preceding analysis, autonomy has frequently been used as "a mask and a weapon . . . (in) a . . . struggle for advantage" (Geertz, 1964: 52). Therefore, a crisis in health care and in society in general will be sustained so long as health care professionals are able to act with impunity (i.e., when they are autonomous). An emancipated society will bring about the demise of autonomy for a minority, and instead will be based on the principles of interdependence and mutual accountability.

Before such alterations can be instituted, several unanswered questions will have to be addressed. It is to this subject that the discussion now turns.

Chapter Six
The Medicalization of Pregnancy and Childbirth: Implications for Future Research

It is said that there are three components of a good problem: an articulation of what is known, an articulation of what is not known, and finally, a statement of what is sought. In the preceding chapters, an attempt has been made to present "what is known" about social control, the institutionalization of medicine, and its subsequent ability to exercise social control through the creation and dissemination of its ideology, the control of medical technology, and the control of the medical division of labour. In addition, corroborative evidence has been brought forward to illustrate how medicine's ability to exercise social control has transformed the way in which reproduction is perceived, and thus managed.

Concurrently, a number of unanswered questions have been raised pointing to the serious gaps which exist in this field of inquiry. For example, what predisposing factors can help to explain why the exception became the rule? Why did procedures once reserved exclusively for the upper class Victorian woman become assimilated throughout the class structure? Why is Nature considered no longer adequate to handle itself, with reference to birth? Why have members of society willingly, eagerly and unquestioningly allowed technicians to run their lives? To any of these and numerous other questions one can speculate as to possible explanations. However, speculation is only a beginning. The task is to resolve to replace speculation with substantiated evidence, plausible explanations, and directions for the future. In other words, the third component of a good problem: "what is

sought". In the ensuing discussion, attention will center on proposing relevant research questions in this field of inquiry.

Although one could conceivably devote an entire thesis to outlining directions for future research, this discussion will focus on five critical issues. These are: (1) the effect of competing ideologies with respect to the definition and subsequent management of childbirth; (2) the reasons for and apparent widespread acceptance of medicalization; (3) the reasons why what was the exception becomes the norm (eg., why treatment modalities reserved for the upper classes become assimilated throughout society); (4) the heuristic value of considering pregnancy as sick role; and (5) the examination of medical philosophies with respect to illness management, specificially regarding "prevention" and "intervention" orientations held by members of the medical profession.

THE EFFECT OF COMPETING IDEOLOGIES

As noted in chapter 2, the dominant ideology influencing the definition of childbirth is that of the medical profession. According to the ideology of medical care, pregnancy and childbirth are considered to be illnesses or illness-like conditions, and thus require professional management and control. One challenge to this ideology is derived from the popular health movement (including feminists, natural childbirth advocates, and the self-help movement).

According to the popular health movement, and growing numbers of women, pregnancy and childbirth are considered as natural processes which women should control. While the former paradigm views it as

appropriate for women to forfeit control and decision-making power to physicians who actively intervene in the childbearing process, the advocates of popular ideology express the belief that medical assistance is largely unnecessary and should be reserved for those individual cases in which indications for the use of technology present themselves (Comaroff, 1977: 115-134).

In order to determine how competing ideologies influence women's perceptions of the childbearing experience, it would be useful to examine this relationship in a rigorous fashion. In addition to examining the relationship between ideologies and perceptions, one could, as well, broaden the scope of analysis to include intercultural and intracultural variations on the key variables (i.e., ideologies and perceptions of the childbearing experience). In such a study, it would be fruitful to examine the perceptions of the childbearing experience among laity. As well, it might be interesting to investigate physicians' perceptions regarding the childbearing process, as a way of understanding how the underlying assumptions of the professional ideology influence the management of birth. As of this writing, no such investigation has been attempted.

THE GENESIS AND DIFFUSION OF THE MEDICALIZATION PROCESS

Conrad and Schneider have noted that in contemporary society,

> ...when medical designations of . . . reality are in competition with other designations, we may well witness a hegemony of medical definitions; that is, a preponderant influence or acceptance of medical authority as the "final" reality and a diminishing of other potential realities (1980a: 28/ emphasis in original).

Similarly, McKinlay has referred to the tendency by which society's members accord medical practitioners with the extraordinary characteristics of "generalized wise men" (1973).

For some phenomena (eg., physiological problems such as diabetes, cancer, etc.), it is clear that medicine has the requisite competence for managing these human ills (which, of course, is not to suggest that these maladies have etiologies that are entirely physiological). However, increasingly, the boundaries of medical expertise are widening to enfold matters external to the profession's legitimate sphere of competence. The primary explanation of this trend is traced to the "monopoly of credibility" which medicine has achieved over time (Larson, 1977). Furthermore, the layman's fetish for science (Charmaz, 1980; Hayek, 1952) -- the new repository of truth (Szasz, 1977) -- helps to explain why medicine has been able to extend its mandate (Conrad and Schneider, 1980a; Hughes, 1958; McKinlay, 1973).

Earlier in this thesis, mention has been made of the numerous studies that have been conducted which were aimed at exploring the genesis of medical autonomy, and subsequently, medicine's dominance in health care (eg., Freidson, 1970a; 1970b). What is now needed is to determine exactly what historical, social, cultural, political, philosophical and medical events have led to the diffusion of medical definitions of reality (i.e., medicalization) in society. Another important question is why there is so much variation inter-culturally in terms of medical designations. For example, why was birth considered essentially normal in Britain, yet pathological in North America?

In order to ascertain what factors have resulted in the

proliferation of medicalization in society, it would be useful to conduct retrospective and longitudinal studies on the management of illnesses, especially those which have only recently come under medicine's control. By exploring the genesis of specific sub-disciplines within medicine (eg., obstetrics and gynecology, psychiatry), mindful of the situational contexts within which these fields arise, it may be possible to detect the critical stages involved in the medicalization process. Also important in such analyses is an examination of socio-cultural (i.e., popular) perceptions of the role and efficacy of medicine in expanding the boundaries of its jurisdiction.

THE TRANSFORMATION OF THE "EXCEPTION TO THE RULE" TO "THE RULE"

The history of childbirth may be seen as a series of transformations of the "exception to the rule" into "the rule". Examples of this tendency abound. For example, male accoucheurs were at one time only called in to handle complicated deliveries. Now the descendents of man-midwifery (obstetricians) manage virtually all deliveries in North America. Surgical and medical procedures once reserved solely for wealthy patrons are now performed universally, independent of socio-economic considerations (Ehrenreich and English, 1978). The most recent example -- the movement to return birth to the home -- will, in all likelihood, experience a similar sequence (provided, of course, that confinements at home are recognized as a safe alternative to hospital confinements). At present, the preference for home birth is most common among the educated, middle and upper class, white populations. It is conceivable that this practice, as well, will experience

proletarianization (i.e., dissemination throughout the class structure).

The reasons for these democratizing tendencies will likely emerge as a fruitful subject of inquiry. Beginning with a socio-historical analysis of reformism (around the middle of the nineteenth century), and then the subsequent emphasis in the political spheres on the need for governments and service-sectors to intervene in the "private" matters of individuals may yield plausible explanations for the assimilation of medical practices, independent of one's ability to pay. It is likely that just as the moral reformers lobbied to alter people's conceptions of morality (Gusfield, 1963), so too, medical reformers sought to alter the status quo in therapeutic relationships. In spite of the apparent benevolence inherent in many medical reforms, the dominance of the medical profession has inhibited efforts on the part of individuals to exert self-control in the therapeutic setting. In fact, many reforms provided the medical profession with a prime opportunity to exercise and/or expand its social control.

PREGNANCY AS SICK ROLE

To date, the application of the Parsonian sick role to pregnancy has prompted both harsh criticism (McKinlay, 1972) and inconclusive findings (Rosengren, 1961; 1962-3; 1966). Primarily because of the theoretical and methodological problems inherent in the Parsonian model (see, for example, Segall, 1976), many questions regarding the sick role, in general, and its applicability to pregnancy, remain unanswered.

If, indeed, one can demonstrate the appropriateness of the sick role during pregnancy, then it is essential that researchers develop behavioural indicators of each of the defined rights and duties of the sick role. Although one can theoretically argue (as McKinlay has done, 1972) that pregnancy is a normal state rather than an illness, since the prevailing ideology of medical care posits that pregnancy is to be treated like an illness (in terms of diagnosis, treatment, and hospitalization), then research must examine the empirical questions which have yet to be clarified.

"PREVENTION" VS. "INTERVENTION"

Throughout the foregoing chapters, efforts have been made to emphasize the fact that an interventionist philosophy among medical practitioners has led to patients' loss of autonomy and the profession's dominance. Moreover, it has been noted that what is needed in the current system of health care is an emphasis on prevention rather than crisis intervention or curative medicine.

Although intuitively a prevention orientation would seem to offer a more comprehensive system of care in that it would promote health, the preceding analysis of the management of pregnancy and childbirth illustrates the enigma of modern scientific-technical medicine. "Preventive medicine . . . is as oppressive and dangerous as 'curative' medicine -- maybe more so, since doctors use the shield of preventive medicine to hide any number of truly aggressive procedures" (Mendelsohn, 1979: 147/ emphasis in original). In light of this revelation , it seems important that future research focus on the

providers of health care, in order to understand more fully the ways in which perceptions are created and then translated into actions.

In this chapter, five research issues have been presented for future consideration. In fact, these represent merely the tip of an enormous iceberg, which must be investigated and scrutinized in the future. It will be the task of this and other sociologists to tackle these questions in the hope that serious scientific research can yield the answers which may result in social change in health care.

APPENDICES

APPENDIX A

PATTERNS OF LEGISLATION AND ACTUAL PRACTICE OF NURSE-MIDWIFERY IN THE UNITED STATES AND JURISDICTIONS, 1980

I. STATES AND JURISDICTIONS WITH SPECIFIC RECOGNITION OF NURSE-MIDWIFERY IN LEGISLATIVE STATUTES OR OFFICIAL REGULATIONS:

A. Certified Nurse-Midwives Practice Fully:

Alabama	Hawaii	New Mexico	South Carolina
Alaska	Indiana	New York	Utah
Arizona	Kentucky	North Carolina	Virgin Islands
California	Maryland	Ohio	Virginia
Colorado	Massachusetts	Oregon	Washington
Connecticut	Mississippi	Pennsylvania	West Virginia
Florida	New Hampshire	Puerto Rico	Wisconsin
Guam	New Jersey	Rhode Island	

B. Certified Nurse-Midwives Do Not Practice Fully:

Delaware	Michigan	South Dakota*
Idaho	Montana*	

II. STATES WITH PERMISSIVE LAWS, BUT NO SPECIFIC RECOGNITION OF NURSE-MIDWIFERY:

A. Certified Nurse-Midwives Practice Fully:

Arkansas	Louisiana	Tennessee
District of Columbia	Maine	Texas
Georgia	Minnesota	Vermont
Illinois	Missouri	Wyoming

B. Certified Nurse-Midwives Do Not Practice Fully:

Iowa	North Dakota	Oklahoma
Nebraska	Nevada	

III. STATES WITH RESTRICTIVE INTERPRETATION OF LAWS AND CERTIFIED NURSE-MIDWIVES DO NOT PRACTICE FULLY:

Kansas

* Exception: Nurse-Midwives practice in Federal Government Hospitals.

SOURCE: American College of Nurse-Midwives (Report of the the Legislation Committee). Washington, D.C.: ACNM, July, 1980.

APPENDIX B

CANADIAN NURSES ASSOCIATION STATEMENT ON THE NURSE-MIDWIFE

POSITION: At present, the provision of health services to Canadian women during the span of their reproductive life is fragmented, uncoordinated, and sometimes inadequate. In addition, there exists a growing demand for more extensive counseling and educational programs in this area.

FUNCTION: The nurse-midwife provides a family-oriented service that offers comprehensive care to the mother and child during the entire maternity cycle. The nurse-midwife is prepared, through her education and experience, to give the supervision, care, and advice that women require during pregnancy, labor, delivery, and following birth. This care includes: supervision of uncomplicated pregnancies, conduct of normal deliveries, institution of preventive measures, detection of abnormal conditions in mother and child, procurement of medical assistance when necessary, execution of emergency measures in the absence of medical help, and care of the healthy newborn. The nurse-midwife provides counseling, not only for the individual woman, but also for the family and members of the community. This assistance includes advice on common gynecological problems, family planning, and child care, as well as prenatal education and preparation for parenthood.

PREPARATION: National standards regulating educational programs and practice should be developed jointly by nurses, physicians, and nurse-midwives, and implemented by nursing regulatory bodies. Nurse-midwifery programs should be provided in institutions of nursing education. These programs should be offered at two levels: postbasic (diploma or baccalaureate) and master's degree.

QUALIFICATION: A Nurse-Midwife is a person who is eligible for registration as a nurse in a province of Canada, has successfully completed a prescribed course of study in nurse-midwifery in a recognized educational program, and has acquired the requisite qualification to be certified to practice nurse-midwifery.

PRACTICE AND REMUNERATION: The nurse-midwife functions as a member of the health care team. The amount of physician participation and supervision depends on the degree of deviation of the maternity cycle from the normal. The scope of activities and responsibilities varies according to the setting. Remuneration should be on the basis of a salary that is adequate, competitive, and reflects responsibility, experience, educational qualifications, and seniority.

CNA supports the establishment of a national organization of nurse-midwives and agrees with the principle of formal liaison between this organization and CNA.

ACCEPTED BY THE CNA BOARD OF DIRECTORS, FEBRUARY 6-8, 1974.

SOURCE: Report of the Task Committee on the Future of Nurse-Midwifery in British Columbia. Vancouver: RNABC, June, 1979, pp. 13-14.

APPENDIX C

REGISTERED NURSES ASSOCIATION OF BRITISH COLUMBIA POSITION STATEMENT ON MIDWIFERY

The Registered Nurses Association of British Columbia supports recognition of the nurse midwife as a health professional authorized to provide comprehensive care to mother and newborn infant during the maternity cycle. This role is consistent with other extensions of nursing practice which have already led to qualified registered nurses exercising high levels of assessment and management skills.

The qualified nurse midwife should have expertise in general nursing, as well as advanced education and training in maternal and newborn care. With this preparation, the nurse midwife will be able to:

1. Provide supervision, care, support and advice during pregnancy and the puerperium, including management of labor and delivery, to the low-risk mother and baby in consultation with the family's physician and other health care workers.

2. Provide expert nursing care to high-risk patients, under the direction of the physician.

3. Provide counselling and teaching related to preparation for parenthood, family planning, infant care and common gynecological problems.

SOURCE: Report of the Task Committee on the Future of Nurse-Midwifery in British Columbia. Vancouver: RNABC, June, 1979, p. 12.

APPENDIX D

GLOSSARY OF MEDICAL TERMS

ANALGESIC: an agent that relieves pain without causing loss of consciousness.

ANESTHETIC: a drug or agent used to abolish the sensation of pain.

ANOXIA: absence or deficiency of oxygen (reduction of oxygen in body tissues below physiologic levels).

APGAR METHOD OF GRADING INFANTS: grading system to assess infants one minute after birth and five minutes after birth; points are awarded for five signs -- heart rate, respiratory effort, muscle tone, reflex irritability and color; the point range is 0 - 10, with 10 indicating that the infant is in the best condition, scores of 5 - 9 indicating the need for varying amounts of supportive treatment, and scores of 4 or below indicating the need for prompt and active therapy.

ASEPSIS: freedom from infection.

BREECH DELIVERY: delivery in which the fetal buttocks present first.

CAESAREAN SECTION: delivery of a fetus by incision through the abdominal wall and uterus.

CLITORIDECTOMY: excision of the clitoris.

ECLAMPSIA: convulsions and coma occurring in a pregnant woman.

ECTOPIC PREGNANCY: displacement or malposition of the fetus (as in the fallopian tube).

EPISIOTOMY: incision of the vulva for obstetric purposes (i.e., to prevent laceration at the time of delivery or to facilitate vaginal surgery).

FORCEPS DELIVERY: extraction of the fetus from the maternal passages by application of forceps to the fetal head; designated LOW or MIDFORCEPS delivery according to the degree of engagement of the fetal head and HIGH when engagement has not occurred.

GRAVIDITY: the condition of being pregnant, without regard to the outcome (expressed as primigravida, secundigravida, etc.).

HYPERTENSION: persistently high blood pressure.

HYPOTENSION: abnormally low blood pressure.

LABOUR: the function of the female organism by which the product of conception is expelled to the outside world. The FIRST STAGE begins with the onset of uterine contractions and ends with complete dilation of the cervix. The SECOND STAGE extends from the end of the first stage until the infant is expelled. The THIRD STAGE is completed with the expulsion of the placenta and contraction of the uterus. INDUCED LABOUR refers to that which is brought on by extraneous means (eg., via chemical stimulation or artificial rupture of the amniotic membranes). SPONTANEOUS LABOUR occurs without artificial aid.

MATERNAL MORTALITY RATE: the number of deaths among parturient women occurring during a specified period, expressed per 10,000 deaths to childbearing women.

NEONATAL MORTALITY RATE: death rate of infants within 28 days of birth, expressed in terms of 1,000 neonatal deaths.

OVARIECTOMY (also OOPHORECTOMY): excision of one or both ovaries; NORMAL OVARIECTOMY is the removal of an apparently healthy ovary.

OXYTOCIN: a hormone which stimulates uterine contractions and milk ejection (this hormone is naturally stored in the posterior pituitary gland, but also can be produced synthetically).

PARITY: the condition of women with respect to having borne viable offspring (expressed as para 0, para 1, para 2, etc.).

PARTUM (also NATAL): referring to labour or childbirth; ANTEPARTUM (or PRENATAL) pertains to the period before birth; INTRAPARTUM (or INTRANATAL) pertains to the period of delivery; and POST-PARTUM (or POSTNATAL) refers to the period following delivery.

PARTURITION: the act or process of giving birth to a child.

PERINATAL MORTALITY RATE: death rate of infants about the time of birth (from the 28th week of gestation to the first week of life and includes stillbirths), expressed in terms of 1,000 perinatal deaths.

PERINEUM: the pelvic floor and associated structures occupying the pelvic outlet (located between the vagina and anus).

PLACENTA: the organ joining fetal and maternal tissues during pregnancy, which is the major agent of nutrition and homeostasis, and which is vital to the survival of the fetus.

PREECLAMPSIA: a toxemia of late pregnancy, characterized by, for example, hypertension.

PREMATURITY: underdevelopment of a fetus, typically measured in terms of gestational age and/or birth weight.

PUERPERIUM: the period or state of confinement after childbirth.

RH ISOIMMUNIZATION (or INCOMPATIBILITY): when a fetus is threatened or damaged by the antibodies of a sensitized Rh-negative mother.

SEPSIS: the presence in the blood or other tissues of pathogens or toxins; PUERPERAL SEPSIS is that occurring after childbirth, due to matter absorbed from the birth canal (also referred to as PUERPERAL or CHILDBED FEVER).

STILLBIRTH: delivery of a dead child.

SUPINE POSITION (or LITHOTOMY): lying on the back (face upward).

TOXEMIA OF PREGNANCY: a group of pathologic conditions, essentially metabolic disturbances, occurring in pregnant women, manifested by preeclampsia and fully developed eclampsia.

UTERUS: the organ in which the fertilized ovum becomes embedded and in which the developing embryo and fetus is nourished.

VACUUM EXTRACTION: delivery of a fetus by application of a vacuum.

VAGINA: the canal of the female, extending from the vulva to the cervix uteri.

VULVA: the external genital organs of the female.

*Definitions derived from the following sources:

Dorland's Pocket Medical Dictionary (22nd Edition). Philadelphia: W.B. Saunders Company, 1977.

Dorland's Illustrated Medical Dictionary (25th Edition). Philadelphia: W.B. Saunders Company, 1974.

Oxorn, Harry and William R. Foote, Human Labor and Birth (2nd Edition). New York: Appleton-Century-Crofts, 1968.

BIBLIOGRAPHY

Alford, Robert R., "Paradigms of Relations Between State and Society". Stress and Contradiction in Modern Capitalism. Edited by Leon Lindberg, et al. Lexington, Mass.: D.C. Heath, 1975, pp. 145-160.

American College of Home Obstetrics, "Statement of Purpose". Safe Alternatives in Childbirth. Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1976, p. 183.

American College of Nurse-Midwives, Report of the Legislative Committee: Patterns of Legislation and Actual Practice of Nurse-Midwifery in The United States and Jurisdictions, 1980. Washington, D.C.: ACNM, July, 1980.

"News: Nurse-Midwife Payments OKed with Medicare-Medicaid Bill". American Journal of Nursing 81 (1981); 448, 466.

Anderson, Sandra F., "Childbirth as a Pathological Process: An American Perspective". Nursing Dimensions - Women's Health Care 7 (1979): 22-25.

Anisef, Paul and Priscilla Basson, "The Institutionalization of a Profession -- A Comparison of British and American Midwifery". Sociology of Work and Occupations 6 (1979): 353-372.

Annas, George J., "Legal Aspects of Homebirths and Other Childbirth Alternatives". Safe Alternatives in Childbirth. Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1976, pp. 161-180.

Arms, Suzanne, Immaculate Deception. New York: Bantam Books, 1977.

_____, "Why Women Must Be In Control of Childbirth and Feminine Health Services". 21st Century Obstetrics NOW! (Second Edition). Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1978, pp. 73-88.

Ashford, J.R., S. Clayton, J. Richmond, J.A. Davis, J.D. Baum, Christine Cooper, D.H. Garrow, J.A. MacFarlane, D. MacCarthy, Chloe Fisher, W.O. Goldthorp, P.J. Huntingford, Biana Gordon, Sheila Kitzinger, M. Lee-Jones, L.I. Zander, Diana Smith, M. Richards, and P.S.B. Russel, "Letter: A Place to be Born". British Medical Journal 1 (January 31, 1976): 279.

Babbie, Earl R., The Practice of Social Research. Belmont, Calif.: Wadsworth Publishing Company, 1975.

Baird, Dugald, "Letter: Induction of Labour". British Medical Journal 1 (April 10, 1976): 896.

Baker, S. Josephine, "Schools for Midwives". American Journal of Obstetrics 65 (1912): 256-270.

Barker-Benfield, G.J., "A Historical Perspective on Women's Health Care -- Female Circumcision", Women and Health 1 (1976a): 13-19.

_____, The Horrors of the Half-Known Life. New York: Harper and Row, 1976b.

Becker, Howard, Through Values to Social Interpretation. Durham, N.C.: Duke University Press, 1950.

Becker, Howard S., Outsiders. New York: Free Press, 1963. (Revised Edition, 1973).

_____, Blanche Geer, Everett C. Hughes and Anselm Strauss, Boys in White: Student Culture in Medical School. Chicago: University of Chicago Press, 1961.

Bell, Susan, "Political Gynecology: Gynecological Imperialism and the Politics of Self-Help". Science for the People, September/October, 1979, pp. 8-14.

Berger, Peter L., Invitation to Sociology. New York: Anchor Books, 1963.

_____ and Thomas Luckmann, The Social Construction of Reality: A Treatise in the Sociology of Knowledge. New York: Anchor Books/ Doubleday, 1966.

_____ and Stanley Pullberg, "Reification and the Sociological Critique of Consciousness". History and Theory 4 (1965): 196-211.

Berkanovic, Emil and Leo G. Reeder, "Can Money Buy the Appropriate Use of Services? Some Notes on the Meaning of Utilization Data". Journal of Health and Social Behavior 15 (1974): 93-98.

Bird, Caroline and The Members and Staff of the National Commission on the Observance of International Women's Year, What Women Want. New York: Simon and Schuster, 1979.

Birnbaum, David, "The Iatrogenesis of Damaged Mothers and Babies at Birth". 21st Century Obstetrics NOW! (Second Edition). Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1978, pp. 105-113.

Blackwell, Elizabeth, Opening the Medical Profession to Women. New York: Schocken Books, 1977.

Blishen, Bernard, Doctors and Doctrines: The Ideology of Medical Care in Canada. Toronto: University of Toronto Press, 1969.

Bloom, Samuel W., The Doctor and His Patient. New York: Russell Sage Foundation, 1963.

Boston Women's Health Book Collective, Our Bodies, Ourselves. New York: Simon and Schuster, 1979.

Bottomore, T.B., Elites and Society. New York: Penguin Books, 1966.

Brack, Datha Clapper, "Displaced -- The Midwife by the Male Physician". Women and Health 1 (1976): 18-24.

Britt, David W., "Social Class and the Sick Role: Examining the Issue of Mutual Influence". Journal of Health and Social Behavior 16 (1975): 178-182.

Bucher, Rue and Joan Stelling, "Characteristics of Professional Organizations". Journal of Health and Social Behavior 10 (1969): 3-15.

_____ and Anselm Strauss, "Professions In Process". American Journal of Sociology 66 (1961): 325-334.

Bullough, Bonnie and Vern L. Bullough, "A Brief History of Medical Practice". Medical Men and their Work. Edited by Eliot Freidson and Judith Lorber. Chicago: Aldine, 1972, pp. 86-102.

Bullough, Vern L., The Development of Medicine as a Profession. New York: Hafner Publishing Company, 1966.

Burns, Janice, "The Medical System as aSource of Sexist Ideology". Paper presented to Women's Studies Seminar on Women and Health, University of Wellington, Victoria, New Zealand, 1978.

Bush, Malcolm, TomDewar, Kathy Fagan, Linda Gelberd, Andrew Gordon, Alicia McCareins, and John McKnight, "Beyond Need: Toward a Serviced Society". New Ecologist 5 (1978).

Caldeyro-Barcia, Roberto, "Some Consequences of Obstetrical Interference". Birth and Family Journal 2 (1977): 34-38.

Campbell, A.G.M., "Letter: A Place to be Born". British Medical Journal 1 (January 31, 1976): 279.

Campbell, Margaret, "Why Would a Girl Go Into Medicine?" Medical Education in the United States. Old Westbury, N.Y.: The Feminist Press, 1973.

Carrick, Roger Lane, Personal Communication, May 20, 1980.

Carr-Saunders, A.M. and P.A. Wilson, "The Emergence of Professions". Men, Work and Society: A Reader in the Sociology of Occupations. Edited by Sigmund Nosow and William H. Form. New York: Basic Books, 1962, pp. 199-206.

Cartwright, Ann, The Dignity of Labour? A Study of Childbearing and Induction. London: Tavistock, 1979.

Cartwright, Frederick F., A Social History of Medicine. London: Longman Group Limited, 1977.

Chalmers, Iain and Martin Richards, "Intervention and Causal Inference in Obstetric Practice". Benefits and Hazards of the New Obstetrics. Edited by Tim Chard and Martin Richards. London: William Heinemann Medical Books, 1977, pp. 34-61.

_____, J.E. Zlosnik, K.A. Johns and H. Campbell, "Obstetric Practice and Outcome of Pregnancy in Cardiff Residents, 1965-1973". British Medical Journal 1 (1976): 735-738.

Chamberlain, Geoffrey, Derek Russell Davis, Katherine Elliott, Christine Fells, and Sheila Hillier, Childbirth Today -- Policy Making in the National Health Service -- A Case Study (Report of a Working Party). Exeter, England: The Council for Science and Society, 1980.

Chambliss, William J., "The Saints and the Roughnecks". Society 11 (1973): 24-31.

_____ and Robert B. Seidman, Law, Order and Power. Reading, Mass.: Addison-Wesley, 1971.

Chard, Tim and Martin Richards (eds.), Benefits and Hazards of the New Obstetrics. London: William Heinemann Medical Books, 1977.

Charmaz, Kathy, The Social Reality of Death. Reading, Mass.: Addison-Wesley, 1980.

Christeve, Jackie, "Midwives Busted in Santa Cruz". The Second Wave: A Magazine of the New Feminism 3 (1974): 5-10.

Cody, Edmond F., "The Registered Midwife: A Necessity". Boston Medical and Surgical Journal 168 (1913): 416-418.

Coe, Rodney M., Sociology of Medicine. New York: McGraw-Hill Book Company, 1970.

Cohen, Leah and Constance Backhouse, "Women and Health: The Growing Controversy". Canadian Women's Studies 1 (1979): 4-10.

Cole, Stephen and Robert LeJeune, "Illness and the Legitimation of Failure". American Sociological Review 37 (1972): 347-356.

College of Physicians and Surgeons of Manitoba, The, Perinatal and Maternal Welfare Committee for 1979. Winnipeg: The College of Physicians and Surgeons of Manitoba, 1979.

Comaroff, Jean, "Conflicting Paradigms of Pregnancy: Managing Ambiguity in Ante-Natal Encounters". Medical Encounters: The Experience of Illness and Treatment. Edited by Alan Davis and Gordon Horobin. London: Croom Helm, 1977, pp. 115-134.

Conrad, Peter, "Soviet Dissidents, Ideological Deviance, and Mental Hospitalization". Paper presented at the Midwest Sociological Society Meetings, Minneapolis, Minn., 1977.

_____, "The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior". Dominant Issues in Medical Sociology. Edited by Howard D. Schwartz and Cary S. Kart. Reading, Mass.: Addison-Wesley, 1978a, pp. 72-79.

_____, "The Medicalization of Deviance in American Culture". Deviance -- The Interactionist Perspective (Third Edition). Edited by Earl Rubington and Martin S. Weinberg. New York: Macmillan, 1978b, pp. 81-89.

_____, "Types of Medical Social Control". Sociology of Health and Illness 1 (1979): 1-11.

_____ and Joseph W. Schneider, Deviance and Medicalization -- From Badness to Sickness. St. Louis: C.V. Mosby Company, 1980a.

_____, "Looking at Levels of Medicalization: A Comment on Strong's Critique of the Thesis of Medical Imperialism". Social Science and Medicine 14A (1980b): 75-79.

Cooley, Charles H., Social Organization. New York: Charles Scribner's Sons, 1909.

Corea, Gena, The Hidden Malpractice. New York: Jove/HBJ Books, 1977.

Coser, Lewis A., Masters of Sociological Thought: Ideas in Historical and Social Context. New York: Harcourt Brace Jovanovich, Inc., 1971.

Cox, C.A., J.S. Fox, P.M. Zinkin, and A.E.B. Matthews, "Critical Appraisal of Domiciliary Obstetric and Neonatal Practice". British Medical Journal 1 (1976): 84-86.

Denzin, Norman K., The Research Act. Chicago: Aldine, 1970.

Devitt, Neal, "The Transition from Home to Hospital Birth in the United States, 1930-1960". Birth and Family Journal 4 (1977): 47-58.

_____, "The Statistical Case for the Elimination of the Midwife: Fact vs. Prejudice, 1890-1935". Women and Health 4 (1979): 81-96 and 169-186.

Dewar, Thomas R., "Rethinking the Professional's Legitimate Role". Paper presented to the Annual Conference of the Minnesota Association of Voluntary Social Services Agencies, October 13, 1976.

Dibble, Vernon K., "Occupations and Ideologies". American Journal of Sociology 68 (1962): 229-241.

Domhoff, G. William, The Powers That Be -- The Processes of Ruling Class Domination in America. New York: Vintage Books, 1978.

Donegan, Jane B., Women and Men Midwives -- Medicine, Morality and Misogyny in Early America. Westport, Ct.: Greenwood Press, 1978.

Donnison, Jean, Midwives and Medical Men -- A History of Inter-Professional Rivalries and Women's Rights. New York: Schocken Books, 1977.

Dorland's Illustrated Medical Dictionary (25th Edition). Philadelphia: W.B. Saunders Company, 1974.

Dorland's Pocket Medical Dictionary (22nd Edition). Philadelphia: W.B. Saunders Company, 1977.

Dreifus, Claudia (ed.), Seizing Our Bodies: The Politics of Women's Health. New York: Vintage Books, 1977.

Dreitzel, Hans P. (ed.), Recent Sociology Number Two. New York: Macmillan, 1970.

Dubos, Rene, Mirage of Health. New York: Harper Colophon Books, 1979.

Duff, Raymond S. and August B. Hollingshead, Sickness and Society. New York: Harper and Row, 1968.

Dunkerley, David, Occupations and Society. London: Routledge and Kegan Paul, 1975.

Durkheim, Emile, The Division of Labor in Society. Glencoe, Ill.: Free Press, 1933.

_____, Suicide. New York: Free Press, 1951.

Dye, Nancy Schrom, "History of Childbirth in America". Signs 6 (1980): 97-108.

Eastman, N.J. and L.M. Hellman, Williams Obstetrics (12th Edition). New York: Appleton-Century-Crofts, 1961.

Edgar, James Clifton, "Remedy for the Abuses of Midwife Practice". American Journal of Obstetrics 63 (1911): 901-904.

Ehrenreich, Barbara and John Ehrenreich, "Medicine and Social Control". The Cultural Crisis of Modern Medicine. Edited by John Ehrenreich. New York: Monthly Review Press, 1978, pp. 39-79.

_____ and Deidre English, Complaints and Disorders. Old Westbury, N.Y.: The Feminist Press, 1973a.

_____, Witches, Midwives and Nurses. Old Westbury,N.Y.: The Feminist Press, 1973b.

_____, For Her Own Good. New York: Anchor Books, 1978.

Ehrenreich, John (ed.), The Cultural Crisis of Modern Medicine. New York: Monthly Review Press, 1978.

Ellul, Jacques, The Technological Society. New York: Vintage Books, 1964.

Emmons, Arthur Brewster and James Lincoln Huntington, "A Review of the Midwife Situation". Boston Medical and Surgical Journal 164 (1911): 251-262.

_____, "The Midwife: Her Future in the United States". American Journal of Obstetrics and Diseases of Women and Children 65 (1912): 393-404.

Ettner, Frederick M., "Comparative Study of Obstetrics -- With Data and Details of a Working Physician's Home OB Service". Safe Alternatives in Childbirth. Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1976, pp. 37-66.

_____, "Hospital Technology Breeds Pathology". Women and Health 2 (1977): 17-23.

Evans, Robert G., "Money, Midwives and Medical Men". Paper presented at Midwifery . . . is a Labour of Love, Vancouver, B.C., February 29 - March 1, 1980.

Fidell, Linda, "Sex Role Stereotypes and the American Physician". Psychology of Women Quarterly 4 (1980): 313-330.

Foote, John A., "Legislative Measures Against Maternal and Infant Mortality: The Midwife Practice Laws of the States and Territories of the United States". American Journal of Obstetrics and Diseases of Women and Children 80 (1919): 534-551.

Forcese, Dennis, The Canadian Class Structure. Toronto: McGraw-Hill Ryerson Limited, 1975.

Forman, Alice M. and Elizabeth M. Cooper, "Legislation and Nurse-Midwifery Practice in the United States of America, Report on a Survey Conducted by the Legislation Committee of the American College of Nurse-Midwives". Journal of Nurse-Midwifery 21 (1980): iii-57.

Fox, Renee C., "Training for Uncertainty". The Student-Physician. Edited by Robert K. Merton, George G. Reader, and Patricia Kendall. Cambridge, Mass.: Harvard University Press, 1957, pp. 207-241.

Freidson, Eliot, "The Impurity of Professional Authority". Institutions and the Person. Edited by Howard S. Becker, Blanche Geer, David Reisman, and Robert S. Weiss. Chicago: Aldine, 1968, pp. 25-34.

_____, Profession of Medicine: A Study of the Sociology of Applied Knowledge. New York: Dodd, Mead and Company, 1970a.

_____, Professional Dominance: The Social Structure of Medical Care. Chicago: Aldine, 1970b.

Geertz, Clifford, "Ideology as a Cultural System". Ideology and Discontent. Edited by D.E. Apter. New York: Free Press, 1964, pp. 47-76.

Gendron, Bernard, Technology and the Human Condition. New York: St. Martin's Press, 1977.

Gerson, Elihu, "The Social Character of Illness: Deviance or Politics?" Social Science and Medicine 10 (1976): 219-224.

Goode, William J., "Community within a Community: The Professions". American Sociological Review 22 (1957): 194-200.

_____, "Encroachment, Charlatanism and the Emerging Profession: Psychology, Sociology and Medicine". American Sociological Review 25 (1960): 902-914.

Gordon, Linda, "The Politics of Birth Control, 1920-1940: The Impact of Professionals". The Cultural Crisis of Modern Medicine. Edited by John Ehrenreich. New York: Monthly Review Press, 1978, pp. 144-184.

Gouldner, Alvin W., The Dialectic of Ideology and Technology: The Origins, Grammar and Future of Ideology. New York: The Seabury Press, 1976.

Government of Canada, Surgical Procedures and Treatments. Ottawa: Statistics Canada, 1969 through 1976.

_____, Vital Statistics - Births. Ottawa: Statistics Canada, 1969 through 1977.

Government of Canada, Vital Statistics - Deaths. Ottawa: Statistics Canada, 1977.

Government of Great Britain, Department of Health and Social Security, Domiciliary Midwifery and Maternity Bed Needs. Report of the Sub-Committee (Chairman: Sir John Peel). The Standing Maternity and Midwifery Advisory Committee. London: HMSO, 1970.

Government of the United States of America, Eighth Revision of the International Classification of Diseases Adapted for Use in the United States, Volume 1. Washington, D.C.: U.S. Department of Health, Education and Welfare. Public Health Service. National Center for Health Statistics, 1967, pp. 624-627.

_____, Health Resources Statistics, 1976-1977 Edition (Health Manpower and Health Facilities). Hyattsville, Md.: U.S. Department of Health, Education and Welfare. Public Health Service. Office of Health Research, Statistics and Technology. National Center for Health Statistics, 1976-1977, pp. 161-164.

_____, Historical Statistics of the United States: Colonial Times to 1957. Washington, D.C.: Government Printing Office, 1960.

_____, NIH Consensus Development Statement on Cesarean Childbirth. Presentation at a Public Session on September 24, 1980 at a Consensus Development Conference sponsored by the National Institute of Child Health and Human Development and the National Center for Health Care Technology. Washington, D.C.: Department of Health, Education and Welfare. National Institutes of Health, 1980.

_____, Statistical Abstract of the U.S., 100th Edition. Washington, D.C.: Department of Commerce, Bureau of the Census, 1979.

_____, Trends in Infant and Childhood Mortality, 1961. Children's Bureau Statistical Series #76. Washington, D.C.: Government Printing Office, 1964.

Graham, Harvey, Eternal Eve: The Mysteries of Birth and the Customs That Surround It. New York: Doubleday, 1951.

Graham, Hilary, "The Social Image of Pregnancy: Pregnancy as Spirit Possession". Sociological Review 24 (1976): 291-308.

Graham, James M., "Amphetamine Politics on Capitol Hill". Whose Law? What Order? A Conflict Approach to Criminology. Edited by William J. Chambliss and Milton Mankoff. New York: John Wiley and Sons, Inc., 1976, pp. 107-122.

Greenaway, W.K. and S.L. Brickey (eds.), Law and Social Control in Canada. Scarborough, Ont.: Prentice-Hall of Canada, Ltd., 1978.

Greenfield, Natalee S.,'First Do No Harm...'. New York: Two Continents Publishing Group, Ltd., 1976.

Greenwood, Ernest, "Attributes of a Profession". Men, Work, and Society: A Reader in the Sociology of Occupations. Edited by Sigmund Nosow and William H. Form. New York: Basic Books, 1962, pp. 206-218.

Griffin, Susan, "Rape: The All-American Crime". Ramparts 10 (1971): 26-35.

Gusfield, Joseph, Symbolic Crusade. Urbana: University of Illinois Press, 1963.

Haire, Doris, "The Cultural Warping of Childbirth". The Cultural Crisis of Modern Medicine. Edited by John Ehrenreich. New York: Monthly Review Press, 1978a, pp. 185-200.

_____, "The Cultural Unwarping of Childbirth: How?" 21st Century Obstetrics NOW! (Second Edition). Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1978b, pp. 567-584.

_____, "Improving the Outcome of Pregnancy Through Increased Utilization of Midwives". Unpublished article adapted from a Testimony presented at a Public Hearing Sponsored by the Mayor's Blue Ribbon Commission on Infant Mortality, Washington, D.C., February 14, 1980.

Haug, Marie R., "The Deprofessionalization of Everyone?" Sociological Focus 8 (1975): 197-213.

_____, "The Erosion of Professional Authority: A Cross-Cultural Inquiry in the Case of the Physician". Milbank Memorial Fund Quarterly - Health and Society 54 (1976): 83-106.

_____, "Computer Technology and the Obsolescence of the Concept of Profession". Work and Technology. Edited by Marie R. Haug and Jacques Dofny. Beverly Hills, Calif.: Sage Publications, Inc., 1977, pp. 215-228.

_____ and Marvin Sussman, "Professional Autonomy and the Revolt of the Client". Social Problems 17 (1969): 153-161.

Hawkins, Richard and Gary Tiedeman, The Creation of Deviance. Columbus, Ohio: Charles E. Merrill Publishing Company, 1975.

Hayek, F.A., The Counter-Revolution of Science: Studies on the Abuse of Reason. Glencoe, Ill.: Free Press, 1952.

Hepburn, John, "Social Control and the Legal Order: Legitimated Repression in a Capitalist State". Law and Social Control in Canada. Edited by W.K. Greenaway and S.L. Brickey. Scarborough, Ont.: Prentice-Hall of Canada, Ltd., 1978, pp. 70-84.

Hobbes, Thomas, Leviathan, Part I. New York: Gateway Editions, 1969.

Hobel, C.J., "Recognition of the High-Risk Pregnant Woman". Management of the High-Risk Pregnancy. Edited by W.N. Spellacy. Baltimore: University Park Press, 1976, pp. 1-28.

Hollingshead, August B. and Frederick C. Redlich, Social Class and Mental Illness: A Community Study. New York: John Wiley and Sons, Inc., 1958.

Howell, Mary C., "Pediatricians and Mothers". The Cultural Crisis of Modern Medicine. Edited by John Ehrenreich. New York: Monthly Review Press, 1978, pp. 201-211.

Howie, Peter W., "Induction of Labour". Benefits and Hazards of the New Obstetrics. Edited by Tim Chard and Martin Richards. London: William Heinemann Medical Books, 1977, pp. 83-99.

Hudson, C.K., "Letter: A Place to be Born". British Medical Journal 1 (January 24, 1976): 216-217.

Hughes, Everett C., Men and Their Work. New York: Free Press, 1958.

_____, "The Professions in Society". Canadian Journal of Economics and Political Science 26 (1960): 54-61.

_____, The Sociological Eye: Selected Papers on Work, Self and the Study of Society. Chicago: Aldine-Atherton, Inc., 1971.

Huntington, James Lincoln, "The Midwife in Massachusetts: Her Anomalous Position". Boston Medical and Surgical Journal 168 (1913): 418-421.

_____, "The Pregnancy Clinic and the Midwife: A Comparison". Boston Medical and Surgical Journal 173 (1915): 764-766.

Hurlburt, Jane, "Midwifery in Canada: A Capsule History". The Canadian Nurse 77 (1981): 30-31.

Illich, Ivan, Tools for Conviviality. New York: Harper and Row, 1973.

_____, Medical Nemesis. New York: Bantam Books, 1977.

Jager, Manfred, "24-Hour Release Possible for New Mothers, Babies". Winnipeg Free Press, September 26, 1980.

Jordan, Brigitte, Birth in Four Cultures. Montreal: Eden Press Women's Publications, 1980.

Kempe, C.H., F.N. Silverman, B.F. Steele, W. Droegemueller and H.K. Silver, "The Battered-Child Syndrome". Journal of the American Medical Association 181 (1962): 17-24.

Kleiber, Nancy and Linda Light, Caring for Ourselves: An Alternative Structure for Health Care. Vancouver: Vancouver Women's Health Collective, 1978.

Kloosterman, G.J., "The Dutch System of Home Births". The Place of Birth. Edited by Sheila Kitzinger and John A. Davis. Oxford: Oxford University Press, 1978, pp. 87-92.

Kobrin, Frances E., "The American Midwife Controversy: A Crisis of Professionalization". Bulletin of the History of Medicine 40 (1966): 350-363.

Kolker, Aliza, "The Social Construction of Pregnancy". Paper presented at the 30th Meeting of the Society for the Study of Social Problems, New York, August 24-27, 1980.

Kotelchuck, David (ed.), Prognosis Negative: Crisis in the Health Care System. New York: Health Policy Advisory Center, 1976.

Kronus, Carol L., "The Evolution of Occupational Power: An Historical Study of Task Boundaries Between Physicians and Pharmacists". Sociology of Work and Occupations 3 (1976): 3-37.

Larned, Deborah, "The Epidemic of Unnecessary Hysterectomy". Seizing Our Bodies. Edited by Claudia Dreifus. New York: Vintage Books, 1977, pp. 195-208.

_____, "Cesarean Births: Why They Are Up 100 Percent". MS. Magazine, October, 1978, pp. 24-30.

Larson, Magali Sarfatti, The Rise of Professionalism: A Sociological Analysis. Berkeley, Calif.: University of California Press, 1977.

_____, "Professionalism: Rise and Fall". International Journal of Health Services 9 (1979): 607-627.

"Lead Article: A Place to be Born". British Medical Journal 1 (January 10, 1976): 55-56.

"Lead Article: Induction of Labour". British Medical Journal 1 (March 27, 1976): 729-730.

Lear, Julia Graham, "Women's Health: The Side Effects of Sex Bias". The Victimization of Women. Edited by Jane Roberts Chapman and Margaret Gates. Beverly Hills, Calif.: Sage Publications, 1978, pp. 225-250.

Leavitt, Judith Walzer, "Birthing and Anesthesia: The Debate Over Twilight Sleep". Signs 6 (1980): 147-164.

Lemert, Edwin M., Human Deviance, Social Problems, and Social Control. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1967.

Levin, Tom, American Health: Professional Privilege vs. Public Need. New York: Praeger Publishers, 1974.

Levy, Barry S., Frederick Wilkinson and William M. Marine, "Reducing Neonatal Mortality Rate with Nurse-Midwives". American Journal of Obstetrics and Gynecology 109 (1971): 50-58.

Lichtheim, George, "The Concept of Ideology". The Concept of Ideology and Other Essays. New York: Vintage Books, 1967, pp. 3-46.

Light, Donald, "Uncertainty and Control in Professional Training". Journal of Health and Social Behavior 20 (1979): 310-322.

Litoff, Judy Barrett, American Midwives, 1860 to the Present. Westport, Ct.: Greenwood Press, 1978.

Longyear, Harold W., Harold A. Ott and Palmer Sutton, "Maternal Death Studies -- Do They Have Practical Value?". American Journal of Obstetrics and Gynecology 67 (1954): 1288-1294.

Lorber, Judith, "Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients". Another Voice: Feminist Perspectives on Social Life and Social Science. Edited by Marcia Millman and Rosabeth Moss Kanter. Garden City, N.Y.: Anchor Books, 1975, pp. 75-105.

Lynch, Anthony, "Letter: Induction of Labour and Perinatal Mortality". British Medical Journal 1 (March 12, 1977): 708.

Mabbott, J. Milton, "The Regulation of Midwives in New York". American Journal of Obstetrics 55 (1907): 516-527.

Macintyre, Sally, "The Management of Childbirth: A Review of Sociological Research Issues". Social Science and Medicine 11 (1977): 477-484.

Malone, Patrick, "Technology vs. Human Contact". The Miami Herald, September 14, 1980, pp. 1E, 6E.

Mannheim, Karl, "Ideology and Utopia". Ideology and Utopia: An Introduction to the Sociology of Knowledge. New York: Harcourt, Brace and World, Inc., 1936, pp. 55-108.

Marcuse, Herbert, One Dimensional Man. Boston: Beacon Press, 1964.

Marieskind, Helen I., An Evaluation of Caesarean Section in the United States. Washington, D.C.: Department of Health, Education and Welfare, 1979.

Marmol, Jose G., Alan L. Scriggins, and Rudolf F. Vollman, "History of the Maternal Mortality Study Committees in the United States". Obstetrics and Gynecology 34 (1969): 123-138.

Marshall, T.H., "The Recent History of Professionalism in Relation to Social Structure and Social Policy". Canadian Journal of Economics and Political Science 5 (1939): 325-340.

Martin, Franklin H., "Gynecology as a Specialty". American Journal of Obstetrics and Diseases of Women and Children 80 (1919): 249-255.

Martin, Leonide L., Health Care of Women. Philadelphia: J.B. Lippincott Company, 1978.

Martindale, Lois J., The Pregnant Role: An Examination of the Parsonian Model of the Patient-Physician Role as it Applies to Pregnancy. Ph.D. Dissertation, Wayne State University, 1977. Ann Arbor, Michigan: University Microfilms International, 1977.

Marx, Karl, The Economic and Philosophical Manuscripts of 1844. Edited by Dirk J. Struik. New York: International Publishers, 1964.

_____, Grundrisse. Translated by Martin Nicolaus. New York: Vintage Books, 1973.

_____, The Marx-Engels Reader (Second Edition). Edited by Robert C. Tucker. New York: Norton and Company, Inc., 1978.

_____ and Frederick Engels, Pre-Capitalist Economic Formations: A Collection. Moscow: Progress Publishers, 1979.

Matthews, A.E.B. and J.S. Fox, "Letter: A Place to be Born". British Medical Journal 1 (February 14, 1976): 395.

McKeown, Thomas, Medicine in Modern Society. London: George Allen and Unwin, Ltd., 1965.

_____, The Role of Medicine. London: Nuffield Provincial Hospital Trust, 1976.

_____, The Role of Medicine: Dream, Mirage or Nemesis? Oxford: Basil Blackwell Publishers Ltd., 1979.

McKeown, Thomas and C.R. Lowe, An Introduction to Social Medicine (Second Edition). Oxford: Blackwell Scientific Publications, 1974.

McKinlay, John B., "The Sick Role -- Illness and Pregnancy". Social Science and Medicine 6 (1972): 561-572.

_____, "On the Professional Regulation of Change". Professionalization and Social Change. The Sociological Review Monograph No. 20. Edited by Paul Halmos. Keele: University of Keele, 1973, pp. 61-84.

_____, "Who is Really Ignorant -- Physician or Patient?" Journal of Health and Social Behavior 16 (1975): 3-11.

_____, "The Business of Good Doctoring or Doctoring as Good Business: Reflections on Freidson's View of the Medical Game". International Journal of Health Services 7 (1977): 459-483.

McKnight, John, "Professionalized Service and Disabling Help". Disabling Professions. Edited by Ivan Illich, Irving K. Zola, John McKnight, Jonathan Caplan and Harley Shaiken. London: Marion Boyars Publishers, Ltd., 1977, pp. 69-91.

McNay, Margaret B., Gillian M. McIlwaine, P.W. Howie, and M.C. Macnaughton, "Perinatal Deaths: Analysis by Clincial Cause to Assess Value of Induction of Labour". British Medical Journal 1 (February 5, 1977): 347-350.

Mead, Margaret and Niles Newton, "Cultural Patterning of Perinatal Behavior". Childbearing: Its Social and Psychological Aspects. Edited by S.A. Richardson and A.F. Guttmacher. Baltimore: Williams and Wilkins Co., 1967, pp. 142-244.

Mehl, Lewis E., "Home Delivery Research Today: A Review". Women and Health 1 (1976a): 3-11.

_____, "Statistical Outcomes of Homebirths in the United States". Safe Alternatives in Childbirth. Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1976b, pp. 73-100.

_____, "Options in Maternity Care". Nursing Dimensions - Women's Health Care 7 (1979): 26-38.

_____, Gail H. Peterson, Nancy S. Shaw and Don C. Creevy, "Complications of Home Births". Birth and Family Journal 2 (1975): 123-131.

_____, Jean-Richard Ramiel, Brenda Leininger, Barbara Hoff, Kathy Kronenthal and Gail Peterson, "Evaluation of Outcomes of Non-Nurse-Midwives: Matched Comparisons with Physicians". Women and Health 5 (1980): 17-29.

Melick, Mary Evans, Henry J. Steadman and Joseph J. Cocozza, "The Medicalization of Criminal Behavior Among Mental Patients". Journal of Health and Social Behavior 20 (1979): 228-237.

Mendelsohn, Robert S., Confessions of a Medical Heretic. Chicago: Contemporary Books, Inc., 1979.

Merton, Robert K., George Reader and Patricia L. Kendall (eds.), The Student-Physician. Cambridge, Mass.: Harvard University Press, 1957.

"Midwife Plan is Rejected". The Winnipeg Sun, November 7, 1980, p. 17.

Mills, C. Wright, The Power Elite. New York: Oxford University Press, 1956.

Montagu, Ashley, "Social Impacts of Unnecessary Intervention and Unnatural Surroundings in Childbirth". 21st Century Obstetrics NOW! (Second Edition). Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1978, pp. 589-610.

Moore, Wilber E., The Professions: Roles and Rules. New York: Russell Sage Foundation, 1970.

Moran, John F., "The Endowment of Motherhood". Journal of the American Medical Association 64 (1915): 125-126.

Muecke, Marjorie, "Health Care Systems as Socializing Agents: Childbearing the North Thai and Western Ways". Social Science and Medicine 10 (1976): 377-383.

National Women's Health Network, Menopause (Resource Guide 1). New York: NWHN, 1980a.

_____, Hysterectomy (Resource Guide 2). New York: NWHN, 1980b.

_____, Breast Cancer (Resource Guide 3). New York: NWHN, 1980c.

_____, Maternal and Child Health (Resource Guide 4). New York: NWHN, 1980d.

_____, DES (Resource Guide 5). New York: NWHN, 1980e.

_____, Self-Help (Resource Guide 6). New York: NWHN, 1980f.

_____, Birth Control (Resource Guide 7). New York: NWHN, 1980g.

National Women's Health Network, Abortion (Resource Guide 8). New York: NHWN, 1980h.

_____, Sterilization (Resource Guide 9). New York: NWHN, 1980i.

Navarro, Vicente, Medicine Under Capitalism. New York: Prodist, 1976.

Novek, Joel, "A Critique of Technological Pessimism". Unpublished manuscript. University of Winnipeg, no date.

Noyes, Clara D., "Training of Midwives in Relation to the Prevention of Infant Mortality". American Journal of Obstetrics 66 (1912): 1051-1059.

Oakley, Ann, "The Trap of Medicalised Motherhood". New Society 34 (1975): 639-641.

_____, "Wisewoman and Medicine Man: Changes in the Management of Childbirth". The Rights and Wrongs of Women. Edited by Juliet Mitchell and Ann Oakley. Middlesex, England: Penguin Books, 1976, pp. 17-58.

_____, "Cross-Cultural Practices". Benefits and Hazards of the New Obstetrics. Edited by Tim Chard and Martin Richards. London: William Heinemann Medical Books, 1977, pp. 18-33.

_____, Women Confined: Towards a Sociology of Childbirth. New York: Schocken Books, 1980.

Oxorn, Harry and William R. Foote, Human Labor and Birth (Second Edition). New York: Appleton-Century-Crofts, 1968.

Paalman, Russell J., "The Abundant Life: Presidential Address". American Journal of Obstetrics and Gynecology 122 (1975): 139-143.

Paine, A.K., "The Midwife Problem". Boston Medical and Surgical Journal 173 (1915): 759-764.

Park, Robert E. and Ernest W. Burgess, Introduction to the Science of Sociology. Chicago: University of Chicago Press, 1921.

Parsons, Talcott, The Social System. New York: Free Press, 1951.

_____, "The Professions in Society". Essays in Sociological Theory (Revised Edition). Glencoe, Ill.: Free Press, 1954, pp. 34-49.

_____, "Equality and Inequality in Modern Society, or Stratification Revisited". Sociological Inquiry 40 (1970): 13-72.

Pavalko, Ronald A., Sociology of Occupations and Professions. Itasca, Ill.: F.E. Peacock Publishers, Inc., 1971.

Pfohl, S., "The 'Discovery' of Child Abuse". Social Problems 24 (1977): 310-323.

Pilivian, Irving and Scott Briar, "Police Encounters with Juveniles". American Journal of Sociology 69 (1964): 204-214.

Pitts, Jesse, "Social Control: The Concept". International Encyclopedia of Social Sciences. Volume 14. Edited by David Sills. New York: Macmillan, 1968, pp. 381-396.

Placek, Paul J. and Selma M. Taffel, "Trends in Cesarean Section Rates for the United States, 1970-1978". Public Health Reports 95 (1980): 540-548.

Powis, Julianne, "Nurse-Midwifery: Are We Missing the Boat?" The Canadian Nurse 75 (1979): 21-23.

_____, "The Quiet Revolution: Establishing a Nurse-Midwifery Practice". The Canadian Nurse 77 (1981): 26-29.

Pratt, L., A. Seligman, and G. Reader, "Physicians' Views on the Level of Medical Information among Patients". American Journal of Public Health 47 (1957): 1277-1283.

Pritchard, Jack A. and Paul C. MacDonald, Williams Obstetrics (15th Edition). New York: Appleton-Century-Crofts, 1976.

Ratner, Herbert, "History of the Dehumanization of American Obstetrical Practice". 21st Century Obstetrics NOW! (Second Edition). Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1978, pp. 115-146.

Redfield, Robert, "The Folk Society". American Journal of Sociology 52 (1947): 293-308.

Registered Nurses Association of British Columbia, Report of the Task Committee on the Future of Nurse Midwifery in British Columbia. Vancouver, RNABC, June, 1979.

Reid, Mark, "Letter: A Place to be Born". British Medical Journal 1 (February 14, 1976): 395-396.

Rich, Adrienne, Of Woman Born. New York: W.W. Norton, 1976.

_____, "The Theft of Childbirth". Seizing Our Bodies. Edited by Claudia Dreifus. New York: Vintage Books, 1977, pp. 146-163.

Richards, M.P.M., "Innovation in Medical Practice: Obstetricians and the Induction of Labour in Britain". Social Science and Medicine 9 (1975): 595-602.

_____, "A Place of Safety? An Examination of the Risks of Hospital Delivery". The Place of Birth. Edited by Sheila Kitzinger and John A. Davis. Oxford: Oxford University Press, 1978, pp. 66-84.

Rindfuss, Ronald R., Judith L. Ladinsky, Elizabeth Coppock, Victor W. Marshall, and A.S. Macpherson, "Convenience and the Occurrence of Births - Induction of Labor in the United States and Canada". International Journal of Health Services 9 (1979): 439-460.

Robson, David, "Letter: Induction of Labour". British Medical Journal 1 (April 10, 1976): 897.

Rodriguez-Trias, Helen, "Sterilization Abuse". Women and Health 3 (1978): 10-15.

Rosengren, William R., "Social Sources of Pregnancy as Illness or Normality". Social Forces 39 (1961): 260-267.

_____, "The Sick Role During Pregnancy: A Note on Research in Progress". Journal of Health and Human Behavior 3 (1962-3): 213-218.

_____, "Social Instability and Attitudes Towards Pregnancy as a Social Role". Social Problems 9 (1966): 371-378.

_____, Sociology of Medicine: Diversity, Conflict, and Change. New York: Harper and Row, 1980.

Ross, Edward Alsworth, Social Control. New York: Macmillan, 1901.

Roth, Julius, "Professionalism: The Sociologist's Decoy". Sociology of Work and Occupations 1 (1974): 6-23.

Rowden, David W., Jerry B. Michel, Ronald C. Dillehay, and Harry W. Martin, "Judgements about Candidates for Psychotherapy: The Influence of Social Class and Insight-Verbal Ability". Journal of Health and Social Behavior 11 (1970): 51-58.

Rueschemeyer, Dietrich, "Doctors and Lawyers: A Comment on the Theory of the Professions". Canadian Review of Sociology and Anthropology 1 (1964): 17-30.

Ruzek, Sheryl Burt, "Emergent Modes of Utilization: Gynecological Self-Help". Women and Their Health: Research Implications for a New Era. Departmetn of Health, Education and Welfare Publication No. (HRA) 77-3138. Edited by Virginia Olesen. Washington, D.C.: National Center for Health Services Research, 1977.

Ruzek, Sheryl Burt, The Women's Health Movement: Feminist Alternatives to Medical Control. New York: Praeger Publishers, 1978.

Ryan, William, Blaming the Victim (Revised, Updated Edition). New York: Vintage Books, 1976.

Sablosky, Ann H., "The Power of the Forceps: A Comparative Analysis of the Midwife -- Historically and Today". Women and Health 1 (1976): 10-13.

Sallach, David L., "Class Domination and Ideological Hegemony". The TV Establishment: Programming for Profit and Power. Edited by Gaye Tuchman. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1974, pp. 161-173.

Schroeder, Andreas, "Birthright". Today Magazine, Winnipeg Free Press, October 4, 1980, pp. 10-13.

Schwendinger, Herman and Julia R. Schwendinger, The Sociologists of the Chair: A Radical Analysis of the Formative Years of North American Sociology, 1883-1922. New York: Basic Books, 1974.

Scully, Diana, Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists. Boston: Houghton Mifflin Company, 1980.

_____ and Pauline Bart, "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks". The Cultural Crisis of Modern Medicine. Edited by John Ehrenreich. New York: Monthly Review Press, 1978, pp. 212-226.

Segall, Alexander, "The Sick Role Concept: Understanding Illness Behavior". Journal of Health and Social Behavior 17 (1976): 163-170.

_____ and Lance W. Roberts, "A Comparative Analysis of Physician Estimates and Levels of Medical Knowledge among Patients". Sociology of Health and Illness 2 (1980): 317-334.

Sigerist, Henry E., On the History of Medicine. New York: MD Publications, 1960.

Slaughter, Frank G., Semmelweis, The Conqueror of Childbed Fever. New York: Collier Books, 1950.

Smith, Harvey L., "Contingencies of Professional Differentiation". Men, Work and Society: A Reader in the Sociology of Occupations. Edited by Sigmund Nosow and William H. Form. New York: Basic Books, 1962, pp. 219-225.

Sorokin, Pitirim A., Society, Culture and Personality. New York: Harper and Row, 1947.

Stewart, David, "Homebirths -- A Modern Trend -- Is It Progress?" Safe Alternatives in Childbirth. Edited by David Stewart and Lee Stewart. Chapel Hill, N.C.: NAPSAC, Inc., 1976, pp. 1-3.

Strong, P.M., "Sociological Imperialism and the Profession of Medicine: A Critical Examination of the Thesis of Medical Imperialism". Social Science and Medicine 13A (1979): 199-215.

Sudnow, David, "Dead on Arrival". Where Medicine Fails. Edited by Anselm L. Strauss. Chicago: Transaction Books, 1970, pp. 111-129.

Szasz, Thomas S., The Second Sin. New York: Anchor Books, 1964.

_____, The Manufacture of Madness. New York: Harper and Row, 1970.

_____, The Theology of Medicine. New York: Harper Colophon Books, 1977.

_____ and Marc H. Hollender, "The Basic Models of the Doctor-Patient Relationship". Dominant Issues in Medical Sociology. Edited by Howard D. Schwartz and Cary S. Kart. Reading, Mass.: Addison-Wesley, 1978, pp. 100-107.

Tew, Marjorie, "The Case Against Hospital Deliveries: The Statistical Evidence". The Place of Birth. Edited by Sheila Kitzinger and John A. Davis. Oxford: Oxford University Press, 1978, pp. 55-65.

Thomas, William I., The Child in America. New York: Alfred A. Knopf, Inc., 1928.

Tonnies, Frederick M., Community and Society. New York: Harper and Row, 1963.

Tsalikis, George, The Patient's Freedom of Choice and the Community Health Centers. Winnipeg: Canadian Public Health Association, 1972.

Vollmer, Howard M. and Donald L. Mills (eds.), Professionalization. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1966.

Waitzkin, Howard B. and Barbara Waterman, The Exploitation of Illness in Capitalist Society. Indianapolis: The Bobbs-Merrill Company, Inc., 1974.

Walsh, Mary Roth, Doctors Wanted: No Women Need Apply -- Sexual Barriers in the Medical Profession, 1835-1975. New Haven, Ct.: Yale University Press, 1977.

Wardwell, Walter I., "Limited, Marginal and Quasi-Practitioners". Handbook of Medical Sociology (Second Edition). Edited by Howard E. Freeman, Sol Levine, and Leo G. Reeder. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1972, pp. 250-273.

Watkins, C. Ken, Social Control. London: Longman, 1975.

Watson, James D., The Double Helix. New York: Atheneum Publishers, 1968.

Webb, Eugene J., Donald T. Campbell, Richard Schwartz and Lee Sechrest, Unobtrusive Measures. Chicago: Rand McNally College Publishing Company, 1966.

Weber, Max, The Methodology of the Social Sciences. Edited by Edward Shils and Henry Finch. Glencoe, Ill.: Free Press, 1949.

_____, The Protestant Ethic and the Spirit of Capitalism. New York: Charles Scribner's Sons, 1958.

_____, Economy and Society, Volumes 1 and 3. New York: Bedminster Press, 1968.

Weiss, Kay, "Vaginal Cancer: An Iatrogenic Disease?" International Journal of Health Services 5 (1975): 235-251.

Wertz, Dorothy, "What Birth Has Done for Doctors: A Historical View". Paper presented at the Annual Meetings of the American Sociological Association, New York City, 1980.

Wertz, Richard W. and Dorothy C. Wertz, Lying-In: A History of Childbirth in America. New York: Schocken Books, 1979.

Wilensky, Harold L., "The Professionalization of Everyone?" American Journal of Sociology 70 (1964): 137-158.

Wilkinson, Gregg S., "Patient-Audience Social Status and the Social Construction of Psychiatric Disorders: Toward a Differential Frame of Reference Hypothesis". Journal of Health and Social Behavior 16 (1975): 27-38.

Williams, J.W., "Medical Education and the Midwife Problem in the United States". American Journal of Obstetrics 65 (1912): 500-502.

Wilson, Thomas P., "Conceptions of Interaction and Forms of Sociological Explanation". American Sociological Review 35 (1970): 697-710.

Wiseman, Jacqueline P., Stations of the Lost. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1970.

Woods, David, "Hospital Obstetric Units See Need to Provide the Comforts of Home". Canadian Medical Association Journal 120 (1979): 1442-1444.

Ziegler, Charles Edward, "How Can We Best Solve the Midwifery Problem". American Journal of Public Health 12 (1922): 405-413.

Zinkin, P. and C.A. Cox, "Letter: A Place to be Born". British Medical Journal 1 (February 14, 1976): 395.

Zola, Irving Kenneth, "Healthism and Disabling Medicalization". Disabling Professions. Edited by Ivan Illich, Irving K. Zola, John McKnight, Jonathan Caplan, and Harley Shaiken. London: Marion Boyars Publishers, Ltd., 1977, pp. 41-67.

_____, "Medicine as an Institution of Social Control". The Cultural Crisis of Modern Medicine. Edited by John Ehrenreich. New York: Monthly Review Press, 1978, pp. 80-100.