CONTROL OF CHILDBIRTH: A SOCIALIST FEMINIST PERSPECTIVE

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ABSTRACT

"Given support and patience 85% of women can give birth normally and naturally". So states Joan Donley (1986) introducing the first chapter of her book **Save the Midwives.** And yet most New Zealand babies are born in hospitals, many of them with medical intervention in the form of epidural anaesthesia, episiotomies, monitors, caesarean sections and medication. The phenomenal rise in medically-managed childbirth coincides with the rise of Western capitalism, and socialist feminists argue that the relationship is far from coincidental. This paper examines the male domination of childbirth from a socialist feminist perspective with special reference to the New Zealand situation. Strategies for challenging and changing the current situation are proposed.

SOCIALIST FEMINISM AND THE EXPROPRIATION OF BIRTH

Socialist feminists see women's oppression (of which male dominated childbirth is an aspect) as stemming from the class system which is inherent in capitalism (Deckard, 1979). Primitive women were independent within an egalitarian society but the advent of capitalism in the 15th to 18th centuries resulted in a sex ordered division of labour which socialist feminists believe forms the basis of women's inferior status today. The male upper class, linked to capitalism through patriarchy, power and organizational control, thrived. The female lower class was victimised, vilified and ostracized in any area where the system perceived them as a threat. Women became the property of men with little authority, power or individual wealth. Confined to the private domain (as opposed to the prestigious public arena) women became viewed as receptacles for children and as unpaid servants, necessary to maintain the capitalist work force. Midwives and obstetricians can be seen as representative of the polarities in the evolution of class and sex into hierarchical categories.

Maintaining this male advantageous ideology required considerable justification. Ehrenreich and English (1978:28) point out that "the old networks through which women had learned from each other had to be destroyed or discredited . . . and that . . . many women resisted, clinging to old wisdom and customs". One justification was found within medical and technical science, another in the establishment of male ideology which almost automatically excluded woman and her nature. Man is rational and market oriented; his world is 'real' and 'normal'. Women fit neither category and so are regarded as an anachronism.

"The conflict between women's traditional wisdom and male expertise centred on the right to heal" (Ehrenreich and English, 1979:33). Closely associated with this is the right to control birthing. Women's ability to reproduce is an undeniably powerful one, and it is hardly surprising, given their patriarchal history that men should attempt to bring this area within their control. Women are regarded as chattels. They are utilized as clinical material for a prestigious and lucrative occupation as well as training material for medical students. Thus they are economically viable in this role and necessary contributors to capitalism and the status quo.

Birthing, capitalism and feminism then, are closely linked and a description of one invariably involves the others.

TRACING THE COURSE OF MIDWIFERY

Midwifery means 'with women' and dates back to the middle ages when these women shared both information and skills, teaching each other and providing a supportive network (Ehrenreich and English, 1979). Health was not an economic commodity but a combination of wisdom, skill, nurturance and co-operation. Money was seldom exchanged (Chamberlain, 1981). This contrasts sharply with the male system of experts who not only charge large sums for their skill but keep it determinedly exclusive. By this monopoly they maintain an elite group with a competitive, avaricious edge.

The onset of capitalism foreshadowed the demise of women in what was becoming a prestigious field of knowledge and power. Male dominated science and research brought the realisation that by controlling medicine and technology significant economic and political advantages could be gained. Thus began a demarcation process which Witz (cited Knights & Willmott, 1986) describes as having three aspects. First 'pre-emptive deskilling' occurred which restricted midwives to dealing with normal labours while complications were deemed the responsibility of experts. This was enhanced by 'pre-emptive incorporation' through which the male medical profession monopolized birthing instruments such as forceps, and finally 'pre-emptive closure' which effectively prevented midwives organizing themselves independently of doctors.

Myths were presented as scientific truths and women were controlled by this information. For example, it was considered that women were biologically predisposed towards domesticity, passivity and nurturance as well as being socially and intellectually limited (Caplan, Englehardt, and McCartney, 1981). This reflects not fact, but rather the male ideology and norm for women.

In New Zealand state control of midwives was introduced in the 1904 Midwives Act and since then midwives have had to battle to retain any place at all in birthing in New Zealand. Lay midwives were phased out and midwives were trained in hospitals with doctors certifying their registration. Midwives gradually became doctor's assistants rather than practitioners in their own right, losing both their individuality and their independent status. Problems arose. There was a lack of 'clinical material', a male term for the mothers and babies, required to train both midwives and medical students (Donley, 1986). For this reason, and in order for doctors to extend their medical power base, it became necessary to somehow persuade women that it was in their own interest to give birth in hospital. A logical extension of this was to convince them that pregnancy was an illness.

Donley (1986) outlines the seemingly compelling arguments that were put forward. It was claimed that the ready availability of instruments could save lives, even though it quickly became apparent that such deliveries had complications of their own, such as iatrogenic infection. Cleanliness was claimed as a hospital priority despite the fact that puerperal fever deaths in hospitals were alarmingly high. A final argument was proferred by Dr Doris Gordon, whose attitudes seem representative of doctors rather than of women. She proposed 'twilight sleep' deliveries during which the mother was semi-conscious and oblivious to pain. The risks to mother and baby in terms of their drowsy post-delivery condition and inhibited bonding were apparently acceptable if the overall aim of hospitalized childbirth could be achieved.

One of the insidious effects of these newly promoted methods was that they caused women to lose confidence, not just in their ability to give birth naturally, but in themselves as women with knowledge, capable of withstanding medical personnel. One of the few people prepared to assist the woman in this is the midwife, which explains to some extent her perceived threat to the medical profession. By supporting women and treating them as healthy, intelligent individuals capable of delivering their babies spontaneously at home,

women can come to believe in themselves and are empowered. This directly contravenes what doctors require — a submissive, obedient 'case' happy to place herself in hospital at the disposal of the medical profession.

Childbirth services in New Zealand come almost entirely within medical influence and control. Given that the values therein are those of the men who hold power this bodes ill for women. The woman is seen as passive within medical territory (the hospital) and therefore subject to its rules. Even when the medical team is supportive she is expected to conform to their decree rather than have her own ability acknowledged, utilized and supported.

Obstetrics and gynaecology reflect, and are part of the biomedical model which forms their philosophical orientation. Within this model the body is seen as machine-like and the social, psychological and behavioural dimensions of health are ignored. It is this perspective that led Odent to state "Obstetricians tend to see their role as being solely to ensure that the baby passes from the intra-amniotic to the aerial environment in the best possible thermodynamic conditions with the least possible damage to the vital organs" (Odent, 1984:24). These factors perhaps illustrate the most notable distinction between obstetric and gynaecological specialists and midwives. The former are primarily delivering babies for themselves — for the money, power, prestige and status that go with their occupation. The latter, women, are there for the women and their babies. This is beautifully illustrated at a home-birth. The midwife receives minimal payment for her services and yet gives freely of herself and her time. She stays as long as is necessary, is readily available by telephone and visits regularly. She becomes a friend and adviser, seeing her role as secondary, assisting the woman to give birth as she wishes and requires according to her needs. Her skills are not just those associated with the physical aspects of delivery, but her calm and supportive approach and her belief in women's ability to give birth as they are designed to do.

The midwife empowers the woman, the obstetric specialist attempts to master her.

CHALLENGING AND CHANGING THE DOMINANT IDEOLOGY

Attempting change in midwifery, as in any area of women's oppression, is no simple matter. It involves not only challenging the dominant ideology in its various guises, but also reeducation and the provision of alternatives. Ruzek (1978:143) sums up the complexity of the situation when she states "any encounter with the health care system is the consequence of how a complex array of interlocking values, beliefs, practices and institutional arrangements mesh with her (the woman's) identity and personal position in the social situation".

The fundamental issue in midwifery seems to be women gaining control of their bodies, and recognizing as well as utilizing their choices. Socialist feminists, as already discussed, see capitalism at the root of female subordination. Their approach to change involves a 'sharp and conscious struggle led by women' (Deckard, 1979). The dilemma which emerges then, is, should women attempt to work within the patriarchal structures and try and change them or should they build alternative women's organisations. Given the goal of equity and democracy this latter course would seem counter-productive, although contemplation of its use, particularly in midwifery, is understandable. Seamen (1975, cited Ruzek, 1978) argues strongly for phasing men out of this area, reasoning that men are socialized to regard women's bodies with contempt and their presence in midwifery violates women's right to privacy. Strategies for managing within capitalism, rather than changing it — that may come later — is the other alternative. Overall the aim is the reestablishment of female authority within obstetrics and gynaecology.

Perhaps the most important and basic need has already been met to some extent — that is an awareness of the problem of sexist, profit-oriented health care and the patriarchal, biomedical system that delivers it. Donley (1986)

points out that maternity services today owe more to political and patriarchal ideologies than the actual needs of mothers and babies. Women, however, are learning about the system, the means by which it degrades and disadvantages them, and that they are not powerless against it. As the male advantageous structure of capitalism is exposed there is awareness, then anger, and finally action. The publicity surrounding the treatment of women at National Women's Hospital led to a new level of public awareness, resulting in outrage at the arrogance and misuse of power by some members of the medical profession. The delays in implementing the recommendations of the Cartwright Report (1988), however, point to the difficulties in challenging established power bases even with this new level of understanding.

Other reports have confirmed that women do want change. For example, the New Zealand Nurses Association Consumer Survey 1987-8 committee on midwifery policy found a number of pressing concerns regarding maternity care in New Zealand. These included a lack of continuity of care by midwives resulting in conflicting advice, lack of choice and lack of domicillary services.

An area of particular significance in discussing change in New Zealand is the needs and perspectives of Maori women. Their socioeconomic situation, which often includes unemployment, poverty and stress has, according to Donley, "firmly integrated them into the health system of Western medicine" (1986:121). Given their inability to pay private obstetricians they make up a large proportion of the women attending free clinics and being practised upon by house surgeons and registrars. As with other areas of health the most effective change for Maori women will be self-responsibility. As a result of the Maori cultural mobilization a number of changes are already occurring. Maori health centres are being established, for example Waahi Pa in Huntly. These reflect Maori traditions and values which are holistic. The Maori input into birthing and midwifery issues is negligible, however. In order for effective change to occur it must be sought and acknowledged, so empowering Maori women to address their needs in a culturally appropriate manner. Ideally Maori midwives will train to give Maori women what they require in childbirth.

Ruzek's (1978) extensive article on strategies for change offers a framework for the ways in which the dominant ideology may be challenged and change introduced. In the main they are strategies designed to empower women and reduce professional control, not just of women and services, but related resources as well.

EDUCATION

Education is seen as essential for both women as users of care and men as the prevailing providers. Not only must women be encouraged to know and understand their bodies, but also to question traditional medicine and their acceptance of it. Women need to be educated to request midwifery services and promote the midwife as an expert in pre- and postnatal care. Self help groups are an important aspect of providing both information and support. The Women's Resource Centre in Dunedin is an example of one such group.

Medical personnel are another important target for education. In 1985 I was invited with another breast-feeding mother to speak to a class of medical students at Otago University. By talking about our experiences, values and preferences we were able to present a women's perspective, something that had been previously lacking. Ripper and Wiles (1984) detail a teaching programme for medical students which encompasses a similar ideology. Students conducted pelvic examinations on each other in a "thoughtful, respectful and mutually beneficial way" (p2) and learned how a woman feels, as well as how best to meet her needs during the procedure. While the response from students to such innovations tends to be overwhelmingly positive and the benefits for women obvious, there is also considerable resistance. Traditional methods are being challenged and women are being placed in the posi-

tion of experts, threatening the specialist position.

One of the major effects of education is that it reduces the knowledge differential between doctor and patient, therefore reducing the power of one over the other.

SELECTIVE UTILIZATION

Selective utilization is a strategy which involves women sharing information and utilizing only those doctors found to be sympathetic, understanding and skilled. While some American feminists groups have developed standard evaluation criteria, a less formal system already operates in most New Zealand hospitals. Nurses know which doctors they consider competent enough to entrust with their care and the care of those close to them. Most lay women, however, are not privy to this information and are vulnerable when they make their selection or accept allocation as is the case in Professorial Units. More extensive availability of this information would be a simple and effective way of empowering women, but has its problems. Women (especially nurses) risk breaking confidentiality by sharing their experiences and may be victimized by their more powerful colleagues. At community level, however, there is much potential for this strategy.

COLLECTIVE CLIENTELES

Ruzek (1978) suggests three other strategies aimed at returning control of childbirth to women. The first is 'collective clienteles'. These are organized groups with collective awareness which gives the political power of a large group with shared values. A collective opposition to technological, illness-orientated childbirth is likely to have greater impact than individual efforts. Parents' Centre is an example of such a group in New Zealand. Since its inception in 1957 Parents' Centre has played a major role in supporting and educating women in taking control of their birthing. This has included fund raising for alternative birthing units in some areas, where mothers can deliver in a homelike atmosphere close to medical services. It has become an effective pressure group in maternal issues and is representative of a number of groups where women can share ideas, support each other and have an impact on hegemonic structures.

LEGISLATION AND PUBLIC POLICY

Secondly, Ruzek (1978) targets legislation and public policy. As a result of changes within the Health Care System and pressure from various groups, including midwives, changes to the Nurses Act are underway and are likely to enable midwives to practice independently from doctors. This is only the first step but an important one. These proposed legislative changes will only benefit New Zealand families if midwives take up the challenge to work with women and empower them to reclaim the childbirth experience.

POWER DIFFUSION

Thirdly, Ruzek (1978) proposes the diffusion of power from a select medical elite to nursing practitioners and midwives. In support of this stance the Chairperson of the Otago Midwives Section of NZNA authored a comprehensive report for submission to the Regional Planning Unit of the Otago Area health Board (Pairman, 1989). The thrust of this report was the need for, and desirability of a 'Continuity of Care' scheme for low risk mothers provided by midwives. It was proposed that they could offer preconceptual, antenatal, labour and postnatal care, advice and education for low risk women in the Otago area. Working in liason with the Professorial Unit they could increase women's options for place and nature of delivery as well as being a resource centre based within the community. By providing the kinds of services women have indicated they want, Pairman proposes change in an informed and constructive way. Such changes are likely to be perceived as threatening the status quo, however, and it remains to be seen which values emerge in the priorities — women's interests or medical ideology. Proposed changes to the Nurse's Act will help facilitate the development of these much needed alternatives.

Self help and alternative practices are a direct challenge to those health professionals who hold traditional values. Not only do they threaten the power differential, they also have the potential to expose the monopoly system that has been used to control birthing, both directly and indirectly. Obstetricians and gynaecologists in particular face capitalism's ultimate losses — power, prestige and money.

CONCLUSION

Change may emerge in a number of ways, from the recognition of dysfunction to the desire to expand capabilities or the recognition of a missing function (Olsen, 1979). Whatever precipitates it, change first requires that a situation be recognized and acknowledged. To some extent this has already been accomplished. Change also represents threat, however, and this can lead to resistance. Within the patriarchal system resistance occurs because there is a desire to maintain the social ideology, including its inherent power and economic structures. In demedicalizing childbirth it may reasonably be expected that resistance will be fierce and uncompromising. There is a great deal at stake for all involved parties.

Women, it seems, have two options. Either they can convince the medical hierarchy that what women desire is to their advantage or as Ruzek (1978) puts it, 'good business'; or they can go it alone providing their own alternative structures. Some see the task as "breaking down the barriers between the world of the consumer and the world of the medical professions" (Odent, 1984:24). While not as radical as many feminists desire this quiet reasoned approach is also powerful and compelling. Women have illustrated that knowledge sharing and collectivity are powerful weapons. Whether they are sufficient to challenge the prevailing social ideology, only time will tell.

REFERENCES

Caplan, A., Englehardt, H. and McCartney, J. (Eds)., (1981) *Concepts of Health and Disease : Interdisciplinary Perspectives*, Addison Wesley, Massachusetts.

Cartwright, S. (1988) *The Report of the Cervical Cancer Inquiry*, Government Printing Office, Auckland, New Zealand.

Chamberlain, M. (1981) *Old Wives Tales*, Virago Press, London.

Deckard, B. (1979) *The Women's Movement*, Harper and Row, New York.

Donley, J. (1986) *Save the Midwives*, Women's Press Ltd, Auckland.

Ehrenreich, B. and English, D. (1979), *For Her Own Good*, Anchor Books, USA.

Knights, D. and Willmott, H. (Eds) (1986) *Gender and the Labour Process* Gower, Aldershott.

Odent, M. (1984) *Entering the World*, Penguin Books, England.

Olsen, E.M. (1979) Strategies and techniques for the nurse change agent, *Nursing Clinics of North America*, 14(2):323-336.

Pairman, S. (1989) *A Continuity of Care Scheme for Low Risk Women*, Submission to the Regional Planning Unit of the Otago Area Health Board.

Ripper, M. and Wiles, C. (1984) *Teaching Medical Students How To Do Vaginal Examinations*, Paper presented at the Women and Labour Conference, Queensland, May 1984.

Ruzek, S.B. (1978) Strategies for change, in Ruzek, S.B. *The Women's Health Movement*, Prager Publishers, USA, pp143-180.