The politics of the new obstetrics: towards a socialist feminist theory of the new obstetrics

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THE POLITICS OF THE NEW OBSTETRICS:
TOWARDS A SOCIALIST FEMINIST THEORY OF THE NEW OBSTETRICS

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Department of History and Philosophy of Science

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If being pregnant did not involve a woman in patriarchal medical care, if it did not mean having to deal with the relations defining private health care, if it did not mean the loss of pay and the incurrence of financial obligations, and if it meant bringing life into a socialist feminist society, the act of childbirth would take on a wholly different meaning.

Zillah Eisenstein
This thesis is the result of an original investigation conducted by the author and includes no materials accepted by any other academic award in any university. To the best of my knowledge it does not contain any material authored by another person, except when duly referenced.

Helen Scott
ACKNOWLEDGEMENTS

I wish to thank the late Ian Langham for his unique method of inspiring interest in the study of HPS, Evelleen Richards and my supervisor Richard Badham for their academic support.

Without the support of Iain and the women of Berry this thesis would never have been written.
ABSTRACT

The first part of this thesis describes the historical evolution of the new obstetrics concentrating on the major changes that occurred in birth practice over the last two centuries. The recent debate concerning the new obstetrics centres on these major historical changes in birthing practices and is the subject of Parts II and III of this thesis.

Part II provides a critical assessment of the debate, which is polarised around the issue of low/high technology, or the hospital/homebirth setting. The main protagonists of this debate are the medical establishment and the traditional back-to-nature homebirth movement; traditional feminist theories, while not directly addressing the new obstetrics in a high/low technology framework, can be positioned within the range of the debate. More recently the Women's Health Movement and traditional feminist theories have introduced the issue of male dominance into the debate and it is this contribution to the controversy which is evaluated in Part III.

None of the participants in the debate are able to provide an adequate understanding of the nature of technology and the social forces responsible for the institutional setting of birth practices. In conclusion this thesis details the nature of a modified socialist feminist theory capable of revealing the social, economic and political forces responsible for shaping the new obstetrics.
# THE POLITICS OF THE NEW OBSTETRICS:
## TOWARDS A SOCIALIST FEMINIST THEORY OF THE NEW OBSTETRICS

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INTRODUCTION

In the early 1980s as a committed feminist I encouraged a local midwife in her endeavour to offer her services to local women who desired homebirths. As a result I attended the homebirth of two women who were basically anti-medical establishment and wanted more control over the birthing process. These births led me to study the obstetric debate for answers to the question this experience engendered.

I discovered that studies of changes in medical techniques involved in childbirth mostly follow the technological feminist view that technological developments are responsible for changes in society and that these changes represent progress. However, within the last two decades, this attitude to technology has been questioned. One school of thought maintains the determinist view, but argues that technology is the cause of society's problems. The obstetric debate of the 1970s concentrated on these opposing positions.

Another school of thought goes further and questions the technological determinist viewpoint arguing that the technology is the product of the society in which it develops. According to this analysis childbirth and its associated technology is the product of the changing social, economic and cultural patterns of its social milieu. The participation of feminists in the
obstetric debate went some way towards injecting this definition of childbirth into the agenda but maintains a technological determinist attitude to the associated technology.

The debate left many important questions unanswered: Why is homebirth a mostly middle-class phenomenon? Why is the midwife attendant at a homebirth so vulnerable? What are the important factors affecting the perinatal mortality rate? Why are they not addressed?

This study begins by looking at the changing patterns of childbirth over the last few centuries and then examines the more recent debate, concentrating on the limitations of the different participants' perspectives. The final chapter attempts to provide a framework within which questions can be answered and others raised.
PART I

BIRTH OF THE NEW OBSTETRICS:

CHANGING PATTERNS OF TECHNOLOGY AND CONTROL
INTRODUCTION

The history of obstetrics in Britain, Australia and America has a common background in Europe, predominantly Britain, as the customs and practices traditional to these cultures were taken to the colonies. Over the past two centuries there have been three major changes in the customs and practices involved in childbirth in Britain and what were her colonies. The first is the changing position of the midwives in relation to the medical practitioners. Until the eighteenth century, midwives attended all births and were autonomous. The second is the change in the place of birth. Before the eighteenth century all births occurred at home but the last two centuries have seen the move of childbirth into hospitals. This move occurred more rapidly in America and Australia than in Britain. The third change is the introduction of sophisticated technologies to intervene in the childbirth process. These changes have resulted in the medicalisation of childbirth.

1 Midwives Control to Medical Practitioners Control

Britain

Until the seventeenth century, midwifery was an exclusively female occupation. The midwife's function was to help the labouring woman "through her ordeal, to understand, to sympathise". The term male-midwife entered the English language in the 1600s. These male attendants evolved from the barber
surgeons who had used instruments to remove a dead baby piecemeal from the uterus or a live baby from a dead mother. By the seventeenth century, with the development of forceps, they became involved in live but abnormal births. Most of these male-midwives belonged to the Barber-surgeons company, the forerunner of the modern Royal College of Surgeons. However, during the eighteenth and nineteenth centuries, the female midwife covered the area of normal childbirth and the male-midwife abnormal or interventionist childbirth. This position was officially recognised in the Midwifery diploma, granted by the Obstetrical Society in 1872. In 1902, in Britain, the Midwives Act led to the formation of a Central Midwives Board to regulate the training and practice of midwives. This board ruled that a midwife must take general nursing training, which placed her in the position of nurse with all the concomittant inferior status of that position in relation to the medical practitioner. The composition of the board required no mandatory midwifery representation and, until very recently, the majority of the members of the Central Midwives Board were medical practitioners. As a result, midwives were subordinanted to a higher status, rival occupation.

Oakley maintains that physicians in Britain saw the business of childbirth as "foreign to the habits of a gentleman of enlarged academic education". She seeks the answer to this professional lack of interest in childbirth in the cultural perception of
childbirth as polluting (a belief common in many traditional small-scale societies and other religions and cultures).

Neither the College of Physicians nor the College of Surgeons admitted midwives into their membership and the 1958 Medical Act was silent on the subject of midwifery. However, in that same year, obstetrics was recognised as a medical speciality but kept apart from mainstream medical practice. As we have seen, male-midwifery was allied to the surgeons, yet female midwifery was excluded from formal medical or surgical training, with the result that female midwifery became a secondary status health profession.

**Australia**

In Australia, when colonised, the positions of male midwives and female midwives had the same areas of concern as they had in Britain. The Medical Registration Act of 1862, which was the first attempt at state regulation of medical practitioners in Australia, allowed male-midwives into the profession but denied access to female midwives. In 1862 in Victoria and 1889 in Sydney, midwifery training was part of the training of a medical practitioner, and by the 1880s male medical staff also provided formal instruction to midwives. In 1888 the first course specifically for midwives was established in Australia. However, due to the professional medical opposition to
independent midwifery, by 1893 the Diploma of Midwifery required a prerequisite of general nurse training. It was not until 1928 that midwifery was formally incorporated into nursing. Until 1915, the midwives were free of regulation but many of the medical profession were clamouring for the regulation of midwives by an Act similar to that in Britain, and the Midwives Registration Bill was passed in that year in Victoria. The Act placed considerable restrictions on the practice of midwifery and brought midwives under medical control. The Act carefully defined the occupational boundaries of midwifery, including not writing a medical or death certificate and excluding her from cases of abnormality or disease in childbirth. Willis indicates many requirements of midwives, laid down in the Act, that are not demanded of doctors.

The midwife was expected to bathe regularly in disinfectant, including washing her hair with disinfectant. No such procedures were required of doctors in order to attend childbirth.

The Midwives Registration Act of 1915 maintained midwifery as an independent occupation although indirectly controlled by medicine. Furthermore it admitted empirical midwives with no formal training to be registered. The independence of midwifery was shortlived. In 1928 an Act was passed that incorporated midwifery into nursing, controlled by the Nurses Registration Board. From this time on, in Australia, a midwife was first and foremost a nurse.
In the 1920s in poorer areas, a large percentage of births were attended by midwives only, whereas in the upper class suburbs the percentage was less. However, by the 1930s midwifery in Australia had been taken over by medical practitioners, and according to Willis, 1930 marks the end of intense competition between doctors and midwives. It is important to note that maternal and infant mortality rate, the measure often used to argue for particular childbirth practices, did not decline with increased medical attendance at births.

**America**

In America the position of midwifery altered from state to state. As early as 1716, New York City required licensing for midwives. Historian, Francis Kobrin, divides the debate on the position of midwives in 1900 into four groups: one, advocates for the abolition of midwives; two, eventual abolition when enough doctors are trained; three, training the midwife to reach the status of English and European midwives; four, mostly southerners who believed if midwives washed their hands and used silver nitrate, no more could be expected. Accordingly, the Southern states enforced simple training of the rural black midwife, whereas the Northern industrial states tried different social experiments in training and regulating midwives mainly from immigrant backgrounds. By the 1930s the Northern urban midwife was disappearing as a result of several factors. By 1973 only
4,000 of the 3,136,965 births that year were attended by midwives.

There are many and varied reasons for the different status of midwives in America than in Britain. One reason that has been suggested is the more effective male takeover in health, generally, which occurred in America. Rothman sees the elimination of midwives in America as due to competition for both fees and patients. Oakley supports the former when she quotes one American doctor in 1913 who protested that five million dollars was collected in 1913 by midwives, whereas "it should be paid to physicians and nurses for doing the work properly". Patients were required as teaching material for medical training, particularly the poor immigrant women who were more easily controlled. According to Rothman, physicians achieved their aims through their professional associations' access to state power, whereas the often uneducated, unorganised midwives, had no such access. Through a series of state legislations, eventually midwifery was banned in fifty states of America. The same year, 1949, that midwifery was banned in California, obstetrics/gynaecology became a speciality. Efforts to legalise the practice of nurse/midwifery have met with continual resistance from the California Medical Association and the State Board of Medical Examiners.

Common to midwives in Britain, America and Australia is their
loss of autonomy, as control of their profession is transferred to the medical profession, resulting in midwives' inferior status in health care. Secondly, in all three countries, control of childbirth has passed from women's control to predominantly male control over the last one hundred years. In 1970 in Britain, seventeen per cent of medical practitioners were women and in America only eight per cent.\textsuperscript{33} In Britain, until the 1973 antidiscrimination legislation, males were not permitted to practice as midwives.\textsuperscript{34} The transfer of control from midwives to medical practitioners in the period from 1850 to 1930 can be understood as the transfer from female to predominantly male control. This transfer of control was accompanied by a move to hospitalisation of childbirth and the medicalisation of childbirth.\textsuperscript{35}

2 HOME TO HOSPITAL

Maternity hospitals or Lying-in Hospitals were established in Britain in the eighteenth century, and in America in the nineteenth century. These hospitals were established ostensibly for the care and safety of poor, working women and charity patients.\textsuperscript{36} Although this was the explicit reason for establishing the hospitals, other reasons have been identified. Versluyesen\textsuperscript{37} claims that the reason for the establishment of lying-in hospitals was to gain access to previously inaccessible
female patients. Due to the moral codes of the day, doctors were restricted in their access to female clients, whereas for midwives, being women, access to the client's body during childbirth was acceptable. This situation resulted in continued ignorance of childbirth by the medical profession. In contrast, lying-in hospitals, with their charity patients of low status allowed the doctors to gain the access they were heretofore denied for training purposes and as a result the medical profession openly supported the move from home to hospital births.

Spokespeople like Fourness Barrington, lecturer in Obstetrics at the University of Sydney Medical School from 1913, openly supported hospital births. In 1944 in Britain, the Royal College of Obstetrics and Gynaecology advocated that seventy per cent of all births should occur in hospitals and by 1970 this policy culminated in the Peel Report which recommended 100 per cent hospitalisation. For the medical profession the initial benefit of such a move was the availability of training material which would enhance the upgrading of the profession. The other benefit to the doctors was the increased control afforded by the hospital which enabled them to experiment with and develop new techniques.

The lack of availability of pregnant women (in the nineteenth century) was a constant problem for the medical profession. Many
doctors would graduate without attending a single birth and then be called on to oversee a birth attended by a midwife, in the role of expert, whereas the midwife had all the knowledge and experience the doctor lacked. This was an untenable position, and the lying-in hospitals were a possible solution. However, because of the background of the clients admitted to the early lying-in hospitals, that is, patients suffering from malnutrition and disease caused by poverty, doctors still graduated without attending one physiological birth (that is a birth that progresses without requiring any intervention). These circumstances led to childbirth being perceived by the medical profession as a pathological procedure and its subsequent medicalisation.43

The move from home to hospital births increased the control of childbirth by doctors in two ways. The first is related to the social position of the clients and the second to the structure of the hospital.44 The lying-in hospitals were established initially for the underprivileged. In a recent study of case reports in a Boston Maternity hospital in the 1890s, the doctors exhibited their power over patients and how they used this power to enforce their own morality:

(I)nstrument interventions were often justified with moral judgements about patients as too lazy or stupid to deliver by themselves.45
The stringent rules pertaining to personal conduct, religious observance, and the injunction to appear properly grateful for services rendered, together with the possibility of being discharged for what was termed 'any irregularity' and never admitted again, acted as a powerful reinforcement of client compliance to medical demands.46

Wertz and Wertz47 see the ramifications of this as:

1 Charity patients were undernourished and possibly diseased, allowing doctors to treat childbirth as an emergency, a medical rather than a physiological process.

2 As charity patients and unmarried mothers, the women had less social claim on doctors, who proceeded to adopt a mechanistic approach to their clients, whereas the middle-class would have demanded more generally supportive care.

3 These factors allowed the doctor to exercise complete control over the patient.48

It is in the light of this background that the position of patients in the present hospital system can be understood.

The pregnant woman is a 'patient', a sick person; pregnancy is a pathological process, delivery a clinical procedure complicated by all sorts of difficulties and dangers. To say that someone is ill is one of the most effective ways of robbing them of autonomy and authority.49
The structure of the hospital also had a profound effect on the degree of control the doctors could exert. In the home the doctor became involved with the family and as a guest in unknown territory, his authority was compromised. Although he could carry his technology with him, whether he used it or not would depend on the family's wishes. This contrasted with the hospital environment. Here the doctor's authority was supreme. On his own territory, with his technologies all around him, he could decide what technologies were appropriate. Wertz and Wertz refer to some commentators who see the process of hospitalisation as analogous to the industrialisation process. As in the factory, the doctors became the captains of industry and controlled the hospital workplace in the name of efficiency.

Not only doctors advocated hospital births. Different groups of women also supported this move. One important group was the middle-class and professional women involved in the eugenics movement following the work of Gates and Darwin. Another group was the feminists who supported the possibility of painless labour that hospitalisation could provide. One feminist and suffragette, Dr Eliza Ransom, founded her own hospital to provide women with fashionable painless birth known as Twilight Sleep, popular in the 1930s. Defaris noted in 1929 that there was a great demand for painless labour. Reiger claims that this attitude is not surprising. Not only had women's magazines popularized the use of anaesthetics in the 1920s, but doctors warned women about the dangers of labour and of not availing themselves of medical help. De Lee represented a large proportion of doctors when he said that
for the baby labour was a dangerous, crushing threat, responsible for epilepsy, idiocy, imbecility, and cerebral palsy, as well as being a direct cause of death. For the mother, birth was compared to falling on a pitchfork, driving the handle through the perineurium. Using these analogies, De Lee was able to conclude that labour itself was abnormal.55

Arguments such as these, presented by medical authorities, convinced women of the necessity of the technological intervention in birthing available in hospital births.

The move from home to hospital births, purportedly on the grounds of safety, was instrumental in increasing the medical practitioners' control over childbirth and women's decrease in control.56 This change in the birthing process occurred with very little published comment and resulted in the perception of childbirth as a medical event requiring the expert management of a medical practitioner.

Childbirth ... changed ... from a personal, all woman, shared event to being a pathological state from which women will recover, under correct supervision and care.57

This perception, and the reality upon which it is based, is the core feature of the 'medicalisation of childbirth'.58
Once the medicalisation of childbirth became accepted, then the necessity of technological interference became an imperative. The history of childbirth provides three major reasons why this view gained precedence.

Firstly, during the eighteenth and nineteenth centuries female midwifery became the area of non-surgical obstetrics dealing with normal labour, while male midwifery became the area of intervention in labour. Subsequently, the male midwives became incorporated into medicine via the College of Surgeons and became specialised medical practitioners. Eventually medical practitioners gained authority over midwives, and the conception of interventionist childbirth held by medical practitioners came to dominate.

Secondly, the background of the clients used by doctors in their training was a significant factor. The women attending lying-in hospitals were often diseased and malnourished (an important cause of childbirth difficulties - discussed later) and therefore had difficult births. This encouraged the doctors to define childbirth as pathological requiring intervention with technology.

Thirdly, the increased use of interventionist techniques was further reinforced by the financial rewards that could be
Historically the doctor was paid more for an instrument delivery than a normal one thus encouraging the use of forceps materially and ideologically, upholding the view that intervention was an improvement on non-interference in birth. A study in 1902 supports this.

The percentage of instrumental deliveries was low in areas where doctors received an all inclusive salary for his midwifery work and high where he was paid for instrumental deliveries.

This situation continues to the present day. Taylor cites a study by Cartwright who found a higher rate of induction in private hospital patients in the United Kingdom compared with those delivered under N.H.S.

As more women now give birth in hospital and the use of interventionist technologies increases, the dominant conceptualisation of childbirth as a pathological phenomenon requiring intervention has become the culturally accepted one. The result is that in hospitals, where doctors claim ultimate authority over midwives, the pathological interventionist definition of childbirth has become the 'norm' and the routine use of forceps and episiotomy to prevent damage to the mother and baby is the accepted policy.

The historical transformation of childbirth practices did not occur without some criticism. A White House report in 1933 entitled "Fetal, Newborn and Mortality and Morbidity between 1915 and 1930" showed that despite "increase in hospital delivery, the introduction of prenatal care, and more use of aseptic
The number of "infant deaths from birth injuries" had actually increased by forty to fifty per cent and maternal mortality had not declined. Another study from the New York Academy of Medicine on Maternal Mortality in New York City in 1933 investigated 2041 maternal deaths between 1930 and 1932. It concluded with "favourable comments on the work of midwives and on the advisability of homebirths". Both reports gave two main reasons for mortality: one was inadequate or absent antenatal care, the other was excessive use of technology. Similarly in Britain, the British Ministry of Health reviewed 5,805 cases of maternal death in 1932. Among the reasons for death the report considered "by far the most important was the management on the part of doctors". Listed as the most common errors were premature use of forceps, failure to give proper care in cases of toxaemia, and inadequate precautions against sepsis.

However these criticisms were limited and had no effect on the management of childbirth. The usual reaction was that more training and research was required to overcome these difficulties rather than reversing the trend of the medicalisation of childbirth.

The occupational boundaries of medicine were being deferred by a process of professionalisation and an internal hierarchy established within the newly developed medical institutions.

The history of obstetrics closely parallels other changes in the structure of both medicine and society over the same time period. In the broader context production was removed from the
home into factories where capital had more control. Similarly, childbirth was moved into the factory or hospital and out of the home. In both cases a middle class male became the controlling agent for capital, the manager in the factory and the doctor in the hospital. The result was that a new definition of childbirth emerged: it was no longer defined as a physiological process but became a pathology requiring technical intervention. This method of birthing has been criticised since its early development and this criticism continues to the present day.

CONCLUSION

From the beginning of the twentieth century to the present, the techniques involved in childbirth have become increasingly invasive and the medical discipline specialising in childbirth, Obstetrics, has become an important speciality of high technology. By the 1950s, the majority of births took place in hospital, attended by a medical practitioner and a high percentage of births involved some form of sophisticated technology. In the past birth had been controlled by women. The midwife and birthing woman in a partnership of mutual trust controlled the area of childbirth. The medicalisation of childbirth has altered this relationship and the control of childbirth passed into the hands of predominantly male medical practitioners.
In the 1970s a debate concerning the safety and efficacy of the interventionist approach to childbirth which occurs in the present day hospital birth became public. The majority of the medical profession argued that the medicalisation of childbirth was of public benefit although further research was needed to perfect the method. A minority of the medical establishment criticised some aspects of the overuse of the technology and also called for further, more rigorous, testing and research. The strongest criticism of the interventionist approach came from the Homebirth protagonists.

The dominant element of the homebirth protagonists was the traditionalist back-to-nature homebirth movement. This movement has developed from followers of alternative lifestyle philosophies when they recognised that the only way to avoid a technological birth was to birth at home. Both trained and untrained midwives attended these home births and it was an attack on these working women that brought childbirth to the attention of the women's movement.

Part II and Part III of this thesis examine the nature of the resulting debates. Part II provides a critical assessment of the tendency for the debate to polarise around the issue of high/low technology or hospital/homebirth. In Part III, the issue of the control and direction of technology is introduced by an
examination of male dominance through the challenge provided by the activities of the Women's Health Movement and the writings of feminist authors.
NOTES


9 Ibid., p.38.


13 Ibid., p.105.


16 Loc.cit.


19 Loc.cit.
20 Ibid., p.115.
21 Ibid., p.117.
22 Ibid., p.121.
24 Ibid., p.213.
26 Ibid., p.216-7.
28 Ibid., p.52.
32 loc.cit.
37 Ibid., pp.31-2.
38 Ibid.,


48 *loc.cit.*


51 Ibid., pp.143-4.


60 *loc.cit.*


62 Oakley, A., *loc.cit.*, (note 29), p.48. By 1946 in Britain, 54 per cent of all live births occurred in hospital and in America, 76 per cent of all births occurred in hospital by 1944.

63 Purdy, J.S., *op.cit.*, (note 17), p.44. In Australia, of 18,685 registered births in 1919, 8,658 were confined in their own home, that is, fifty per cent of registered births occurred in hospital.


65 *loc.cit.*

66 *loc.cit.*


70 Willis, E., *op.cit.* (note 12); Wertz, R. and Wertz, D., *op.cit.* (note 1).


72 Oakley, A., *op.cit.*, (note 4), p.44.
PART II

INSTITUTIONAL DOMINANCE: THE HIGH TECHNOLOGY/LOW TECHNOLOGY DEBATE
By the 1950s in Australia and America most births occurred in hospitals\(^1\) and in Britain the policy was to move birth into hospitals and deliberately dismantle the domiciliary midwife service.\(^2\) By the 1970s this trend was beginning to reverse as more women (albeit a small percentage of the number of birthing women) chose to birth at home. There are several reasons why increasing numbers of women were choosing to return to the home for birthing.\(^3\) One of these reasons was the inhumanity of the high technology hospital birth which engendered fear and alienation in the woman when she felt most vulnerable. Also many women felt that their power was wrested from them, as decisions pertinent to the birth experience became the prerogative of the experts and the knowledge gained through personal experience was dismissed as irrational.

In response to this trend a public debate began on this issue and was formally recognised by an article in the Sunday Times in October, 1974 and the B.B.C. programme 'A Time to be Born', early 1975. The media coverage concentrated on the tangible criticisms of a hospital birth, the technology, specifically, induction. The debate has continued to centre around the hazards of the technological birth, that is the New Obstetrics, versus the hazards associated with homebirth.

The advocates of hospital births contend that the hazards

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See Tain Chalmers for a comprehensive account of the media coverage, note 136.
incurred by homebirths stem from the hazards of 'nature', and that these hazards are extensive and potentially life-threatening. If 'nature' errs then homebirth presents an extremely high risk situation. Further, they would argue that in the hospital 'nature' is under the control of the experts with the sophisticated technologies available if, or even before, problems of a high risk eventuate. This is the position taken by the medical establishment although some members admit the technologies are not perfect and that further research is a necessity or that the technologies are over-used or abused.

The opposition, supporting homebirth, argue that the technologies are a greater risk than trusting 'nature'. A healthy well-prepared mother does not require technological interference in her birthing process, but in the majority of hospitals interference has become routine, to the detriment of both mother and baby. This position is best represented by the traditionalist back-to-nature homebirth movement.

Feminists have participated in the debate as childbirth is an obvious area of concern for women. The majority of feminists support the view of the medical establishment. This group ranges from the Liberal feminists and the Classical Marxist feminists, both of whom accept the necessity of high technology births while acknowledging imperfections in this approach, to the position held by the Firestone strand of Radical feminism, advocating
total technological births. In contrast, another strand of Radical feminism opposes the above view supporting the homebirth viewpoint and insists that 'natural' births play an important role in women's liberation.

1 HOSPITAL BIRTH / HIGH TECHNOLOGY

Four perspectives fit into the category of supporting the high technology birth. The major voice advocating this position is the medical establishment. Their definition of childbirth as a pathology requiring intervention for a successful outcome (Part I) indicates their position. Also in support for this position are the three feminist theories: Liberal feminism, Classical Marxist feminism and the type of Radical feminist theory developed by Shulamith Firestone (see pp.101-2).

(a) Medical Establishment

The medical establishment increasingly employ a number of complex technological birthing practices in hospital births. Table 1 indicates the growth in use of technological interference in maternity hospitals.
Table 1  Queen Charlotte's Maternity Hospital Statistics

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<td>Induction (per cent)</td>
<td>17.0</td>
<td>15.1</td>
<td>31.4</td>
<td>27.0</td>
<td>26.0</td>
</tr>
<tr>
<td>Caesarian Sections (%)</td>
<td>5.5</td>
<td>5.8</td>
<td>6.3</td>
<td>7.2</td>
<td>9.2</td>
</tr>
<tr>
<td>Forceps (per cent)</td>
<td>13.7</td>
<td>13.7</td>
<td>14.8</td>
<td>25.5</td>
<td>29.1</td>
</tr>
<tr>
<td>Epidurals (per cent)</td>
<td>not recorded</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal Mortality Rate (per 1,000)</td>
<td>24.2</td>
<td>23.2</td>
<td>18.1</td>
<td>15.4</td>
<td>15.5</td>
</tr>
<tr>
<td>Deliveries</td>
<td>3,430</td>
<td>3,341</td>
<td>3,201</td>
<td>3,209</td>
<td>3,049</td>
</tr>
</tbody>
</table>

Source: Craft (1976)

By 1976 about one third of labours in England were induced, which makes induction an obvious starting point in any discussion of technological interference in birth and because of its many and varied effects on the birthing process and outcome. Some of these are listed below. Induction:

1. limits women's movement during the birthing process
2. allows the doctor to obtain control of the onset and rate of labour
3. increases the likelihood of further technological interference
4. causes prematurity in the infant and the necessity of neonatal units utilization.

The medical establishment publicly entered the debate shortly before the B.B.C. program, with an editorial article in Lancet.
titled "A Time to be Born" published in the November 16 issue of 1974. The article concentrated on the 'use' of induction for convenience rather than for postmaturity, the problem induction was developed to address. Induction was developed to help those women whose pregnancy went beyond term, that is prolonged beyond the accepted forty two weeks, causing serious problems for the baby of postmaturity. Oxytocin is the hormone responsible for the onset and maintenance of labour and induction is the introduction of this hormone into a woman's bloodstream to artificially start and maintain labour when this does not occur spontaneously. However Lancet argued whereas the use of this technology was unquestionable in cases of postmaturity, it was not justified if used so that births occurred at convenient times to suit the doctors and staff in the hospitals.

This was not the first time that the medical establishment had discussed this issue in the medical literature.

In 1960 an article appeared in Obstetrics and Gynaecology on the "Complications of Elective Induction: Prevention and Management" by Harry Fields. In a study of 3,324 inductions, he noted many complications and hazards associated with induction. The most significant complications were:

1. spasm of the uterus
2. fetal distress
3. postpartum hemorrhage
Subsequent work has concentrated on fetal distress. In 1972 Ghosh and Hudson suggested that in some cases induction may cause reduced placental blood circulation which leads to fetal hypoxia, which, although not sufficient to cause fetal distress, may result in neonatal hyperbilirubinaemia. Liston and Cambell found in their study that "nursery admission is common in cases where oxytocin is used".

The precaution recommended by Feilds to reduce the incidence of complications can all be seen as a "technical fix". They included:

1 "proper selection of the candidates for induction". As women in this study were all "normal healthy gravid women with no obvious obstetric problems", it is obvious that what Feilds actually recommended was an increase in antenatal interference. For example, the use of ultrasound or amniocentesis would reduce the complications of underweight fetuses. The leading article in Lancet referred to above, admits this problem of prematurity

* "Technical fix" - the idea that problems associated with one technology can be solved or alleviated by still further technology (see David Dickson for further details, note 32).
caused by errors in dating gestation and suggests the use of the above procedures to overcome the problem, while admitting the imperfection of these same techniques.

"Continuous observation during labour". This precaution foreshadows the development of the fetal heart monitoring device which replaces human skills with a machine. Again Feild is supported in this contention by later studies. Liston and Cambell in *Lancet* assert that fetal monitoring is an essential adjunct to the induction of labour. "With high doses of oxytocin we suggest that the fetus should be monitored with 'modern equipment' allowing continual observation of the fetal heart rate".

"Care in the technic of amniotomy", that is, breaking the membranes to induce the onset of labour. This technique in present day practice is often used in conjunction with the administration of the drug oxytocin and it is in the use of this drug that the medical establishment now advises caution. *Lancet* states that "Reports linking fetal problems with excessively frequent uterine contractions usually reflect misuse of the drug" (my emphasis). Similarly, Liston and Cambell caution: "Oxytocin ... must be used carefully". The medical establishment argues that the technology is of "enormous benefit", the problem lies simply in its use or abuse. The implication is that the technology is neutral, and the people who use it need more training and the technology needs further research. The technology itself is never questioned.
"Continuation of oxytocin throughout delivery and the fourth stage". Once a technology is introduced, it is usual to find more technology is required. This has been shown to occur throughout modern obstetric practice. Induction usually causes increased strength of contractions which in turn requires the administration of anaesthesia. This technique reduces the mother's ability to control her body and results in a forceps delivery which requires an episiotomy. "Technology introduced at one stage of the birth process has been shown to engender its necessity in subsequent stages of that process".

The increased use of induction occurred when Baird in the 1950s recommended its use in the interests of the Foetus. His early work indicated a small but increasing risk to the fetus after the 41st week of gestation. Both the Lancet and the British Medical Journal recognise that induction for social or medical convenience not only occurs but that the argument for its use or not becomes the province of all parties involved. Lancet dismisses social convenience as "pernicious" and medical convenience as arguable:

\[\text{Until unequivocal evidence is available, the public is right in continuing to question medical practices of doubtful validity that are based on convenience.}\]

The Lancet defines medical convenience in terms of the presence of expert staff during daylight hours in case of
complications. Donald expands it to include "the desire to be clear of booked cases before setting off on a pre-arranged holiday", or income tax matters, or, if the doctor has a very busy practice, his wish to catch up by delivering the "backlog" over the weekend. The British Medical Journal sees as logical that induction be used for women with "risk factors" during weekday hours when the obstetric services are more readily available. That obstetric services are not available at night is not perceived as an economic problem by the B.M.J., but is presented as "statutory regulations ensure that midwives, laboratory technicians, and junior hospital doctors have adequate off duty".

According to established medical practice, statistics provide the most conclusive argument with which to judge and evaluate the efficacy of a technique, and by the 1950s, the period when induction was first assessed, the crucial statistic was the perinatal mortality rate (as discussed above). Baird claims that induction was responsible for the dramatic decrease in the perinatal mortality rate in Aberdeen in comparison to the rest of Scotland. A conference was held in response to the controversy this claim engendered. By 1976, the medical establishment was publishing evidence contradicting Baird's claim. Following the leading article on induction in labour in the British Medical Journal, Iain Chalmers et al. published the results of a study of obstetrics practice and outcome of pregnancy in Cardiff
residents, 1965-1973. The changes in childbirth practices during this period included the lowering of the mean age and parity of parturients and "hospital delivery became almost universal, monitoring the fetus during labour was introduced, and induction and acceleration became commonplace". These procedures were all in order to reduce the perinatal mortality rate but despite the introduction and availability of these technologies the perinatal mortality rate failed to show any significant downward trend. Turnbull also contradicted Baird's results, finding that in Cardiff, when the induction rate fell, there was no change in the perinatal mortality rate. However Baird's claim was supported by another study carried out about this time; during 1966-1970 the induction rate at Glasgow Royal Maternity Hospital was 12 and 24 per cent, and it reached 30 and 40 per cent between 1971 and 1975. A study comparing the two five year periods revealed that during this time the perinatal mortality rate fell.

When the medical establishment recognise problems in high technology birth, however, their response usually falls into one of two categories: recommendation of

(i) a technical fix
(ii) technical assessment

- neither response challenging the final authority of the medical profession.
(i) **Technical Fix**

A technical fix solution to a problem created by technology suggests that the problem can be solved by the application of more technology, rather than looking for the possible social, economic or political reasons. This is the proposed solution to the many problems created by induction.

Paediatricians entered the debate in 1976. Henderson-Smart and Shorey in the *Medical Journal of Australia* indicated that 25 per cent of babies with respiratory distress syndrome were delivered by elective induction. They suggested that the reason for the drop in perinatal mortality rate since 1970 is not a result of a decrease in the incidence of respiratory distress syndrome (RDS) but due to advances in the treatment of RDS. In this case the authors recommend a 'technical fix' solution to the problem of RDS caused by induction: that "modern tools are available for accurate assessment of gestation period and lung development". This is one example of the general phenomenon, that induction leads to more intervention. In support of this argument, Paediatrician Peter Dunn cites Kitzinger's report where she states that

when labour was induced women were nearly twice as likely to receive analgesic drugs and be delivered by forceps, while the infant was four times as likely to be transferred to a special care unit, and, when not so transferred, was two or three times as likely to have sucking or breathing problems.
Taylor calls this sequence the "multiplier" effect of the introduction of new medical technology.36

Each stage of the "multiplier" effect initiated by induction causes fetal distress. This iatrogenic* problem has ostensibly been solved by introducing other technologies: the fetal heart monitor and the neonatal special care units. Both the technological solutions to the problem of induction and fetal distress have their own problems and all have met with criticism from the medical establishment: Chalmers and Richards on Instrumental delivery,37 O'Driscoll38 and Brackbill et al.39 on anaesthetics, Richards40 and Bourne et al. on Neonatal and Special Care units, Atlas and Serr41 on fetal heart monitoring devices, to name but a few.

The medical establishment constantly refers to a better evaluation of at risk mothers, so that the iatrogenic effects will be limited to those women at risk. That means that only women assessed during their pregnancy as fitting into the category of women who have difficulties in childbirth should be subject to birth technology. But this assessment is only achieved by further technological interference earlier in the pregnancy. This procedure is called antenatal care. The call for increased antenatal care occurs throughout the medical literature. It is only recently that the iatrogenic risks of

* Iatrogenic disease results from the application of conventional diagnostic and therapeutic procedures. (See Taylor, R., note 36, p.42).
antenatal technology have emerged. Ultrasound is one technology which is significant for evaluating the age of the fetus in utero and important in the present day antenatal care techniques. Papers published in established medical journals demonstrating the possible ill effects of ultrasound on the fetus did not prevent the medical establishment from recommending the use of this technique in 1976. By 1979, in response to these studies, the Federal Drug Administration (FDA) in the United States published a report intended to propose rules and recommendations to manufacturers of ultrasound equipment. Although these studies involved animals, the FDA believed they could not be dismissed, particularly as the studies involved clinical devices in widespread use during pregnancy. In all, the FDA expressed concern about the use of ultrasound, when its biological effects were so little known.

Evidence is accumulating that the same problems of obstetric technology are occurring in antenatal technology. As Shelley Day argues,

having discovered that obstetric interventions make little or no impact on perinatal statistics efforts are now being made by medicine to intervene at an even earlier stage in the antenatal period.

Although research suggests that economic conditions which cause pregnant women to suffer from malnutrition, stress and the diseases of overcrowding, have a greater impact on perinatal mortality rates than antenatal care, the emphasis of the medical establishment continues to be on devising more sophisticated technological solutions for earlier intervention.
In response to the information presented by Moore\textsuperscript{49} that social class has a great effect on perinatal mortality rate (see Table 2 below), Chard and Richards in the concluding chapter of their book\textsuperscript{50} advocate greater use of technology and more research in the antenatal area. When evaluating the effectiveness of antenatal tests to determine congenital malformation, they indicate that at least 70 per cent of mentally handicapped children are not recognised by the antenatal screening procedures. This does not deter them from recommending that all pregnant women be subjected to antenatal screening and the attendant iatrogenic risks. Although they realise that many "congenital malformations stem from adverse environmental factors" they put these in the "too hard basket".\textsuperscript{51}

Table 2 Social Class Distribution According to Outcome - All Singleton\textsuperscript{52} in Birmingham.

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Total</th>
<th>Perinatal Mortality Rates$^+$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>800</td>
<td>7.5</td>
</tr>
<tr>
<td>2</td>
<td>1837</td>
<td>15.8</td>
</tr>
<tr>
<td>3</td>
<td>9027</td>
<td>19.6</td>
</tr>
<tr>
<td>4</td>
<td>2338</td>
<td>26.5</td>
</tr>
<tr>
<td>5</td>
<td>1014</td>
<td>27.6</td>
</tr>
<tr>
<td>Armed Forces</td>
<td>380</td>
<td>26.4</td>
</tr>
<tr>
<td>Students</td>
<td>83</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Unsupported Mothers*</td>
<td>1235</td>
<td>37.4</td>
</tr>
<tr>
<td>Ill-defined and not known</td>
<td>94</td>
<td>21.4</td>
</tr>
</tbody>
</table>

* Includes single, widowed, divorced, and separated mothers

$^+$ Perinatal Mortality is the rate per 1000 births of still births of more than 28 weeks of gestation, together with liveborn infants that die within the first week of life.
Dickson asserts that, by ignoring the roots of the problem, this sort of criticism pretends that a solution can be achieved by technological means. Dunn partially addresses the roots of the problem when he suggests that the new obstetrics technology does not account for the drop in perinatal mortality rates, arguing that this decrease has been occurring for decades. He suggests that both rising socio-economic standards and improved neonatal care contribute to the decrease.

However the debate concerning the hazards of the new obstetrics has largely been carried out within the medical sphere, and offers "a narrow reified view of iatrogenis". That is, viewing the problems arising from the technology as matters for further refinement of medical technique and research, or as a simple matter of "use" and "abuse", and sometimes as a social or psychological drawback; the nature of the technology is never addressed.

(ii) **Technological Assessment**

Another method of evaluation of birth technology is technological assessment, a method of evaluating the impact of a technology and recommending that the undesirable elements can be minimised using the same methodological categories (such as objectivity and political neutrality) as those by which the technology itself is claimed to have been developed.

This method accepts the technology as given without ever looking
at its possible origins. This method of evaluation is used throughout the obstetric debate, in many forms.

(a) One form of assessment is limited to the study of the "psychological drawback of an otherwise neutral process". For example, special neonatal units are assessed with respect to the problems of maternal bonding rather than studying the iatrogenic effects of intensive neonatal care or the possible reasons for the necessity of this technology, for example, malnutrition or induction for convenience.

(b) In response to the increasing amount of literature on the ill-effects of technical interference in the birth process, some Australian doctors conducted a controlled follow-up study entitled "Method of Delivery and Developmental Outcome at Five Years of Age". The aim of the study was to show that, although there may be initial iatrogenic effects associated with birth technology, this did not effect the child's long term development. This study accepts the technology as given and examines the risk associated with the technology at a later stage of development, in order to assess the relative cost of the iatrogenesis that occurred earlier in the child's life. It does not "assess" the need for the technology in the first place or the social factors shaping the development and use of the technology.
The medical establishment assess high and low risk pregnancies according to both clinical and social background. Patients assessed as high risk pregnancies include single mothers, women who have had previous abortions and those who have had previous underweight babies.

Table 3 Documented Problems in Maternal Obstetrical History

<table>
<thead>
<tr>
<th>Score</th>
<th>Problem Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Rhesus isoimmunisation</td>
</tr>
<tr>
<td>2</td>
<td>Parity of four or more</td>
</tr>
<tr>
<td>2</td>
<td>Infertility problems</td>
</tr>
<tr>
<td>2</td>
<td>a Pregnancy followed surgical treatment of infertility</td>
</tr>
<tr>
<td></td>
<td>b Use of fertility drugs to achieve pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Three or more consecutive first trimester spontaneous abortions</td>
</tr>
<tr>
<td>2</td>
<td>One mid trimester spontaneous abortion</td>
</tr>
<tr>
<td>2</td>
<td>One septic abortion</td>
</tr>
<tr>
<td>1</td>
<td>Previous first trimester pregnancy termination</td>
</tr>
<tr>
<td>2</td>
<td>Two or more previous pregnancy terminations</td>
</tr>
<tr>
<td>2</td>
<td>Previous uterine surgery including caesarean section, cone biopsy, or myometromy</td>
</tr>
<tr>
<td>1</td>
<td>Previous ectopic pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Previous accidental haemorrhage</td>
</tr>
<tr>
<td>1</td>
<td>Previous placenta praevia and/or significant third trimester bleeding</td>
</tr>
<tr>
<td>2</td>
<td>Severe hypertensive disorder during previous pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Postpartum haemorrhage apparently unrelated to management</td>
</tr>
<tr>
<td>1</td>
<td>Previous difficult forceps delivery</td>
</tr>
</tbody>
</table>

* A cumulative score of two points on the score sheet at any time indicates a pregnancy risk.
Despite the social component in assessing a pregnancy as high risk, the medical establishment views high risk as a crisis pathology of the reproductive system and sees the solution in a technical way with the emphasis on medical efficiency. That is, the high risk pregnancy should be induced so that any complications can arise when the specialist staff are available and on duty. An alternative approach might address the contributing factors in assessing the high risk pregnancy. For example, why individuals within these categories are, or continue to be "high risk" would be an area of concern. Factors needing attention would include: malnourishment, causes of previous underweight babies (e.g., previous induction), and changing the economic, social and environmental situation that force women into the high risk category.

The limitations of the medical "technology assessment" approach have not been transcended by moves for reform within the medical establishment. For example, the support for "natural childbirth", prevalent in the 1950s, presented the problem of overcoming the dangers of birth technology solely in terms of the mother's individual attempt to make herself physically capable of a natural childbirth. The solutions to problems in childbirth are not, therefore, seen in terms of developing and effectively using the most appropriate form of technology, rather it is interpreted as a case of leaving the mother to rely on her own resources or if she fails in the task (with the inevitable stigma
attached to this failure) the use of technically unquestioned high technology solutions which are accepted as having inevitable dangers.

One final point is that all these various solutions to the problem of childbirth continue to accept the control of the birth process by the medical establishment. The decision of whether a mother can achieve a "natural" childbirth or not is in the doctor's control and if he considers that the mother has failed then he takes over the management of the birth. For example, Odent in France has advocated "natural" childbirth which allows women to move around during labour and as a result has successfully reduced the episiotomy and caesarian rate to six per cent. In answer to the traditional medical "high tech" birth, he claims "that many common problems of childbirth are caused by the very techniques intended to alleviate them". For example, an anaesthetic is intended to alleviate pain but because it usually requires a forceps delivery and therefore more stitching, it actually causes more pain in the long term. Yet, as journalist Rachael Cullen recognises, this tradition of "natural" childbirth in the hospital does not "threaten the status of hospital doctors". (However after years of working according to this formula, Odent writes in his book that he believes that women should be left to control their own births and all obstetricians should resign.)
Another example of reform which does not alter the final structure of control is the call for the greater use of midwives to rectify the problem of lack of continuity of staff during a woman's labour. Richards found that one low risk mother was attended by sixteen different people during a six hour labour. To obviate this problem the medical establishment suggests continuous care by the midwife, whose time is presumably not as precious as the doctor's, and without doubt, a lot cheaper. However the overall control of the birth and the management of technological intervention remained firmly in the hands of the doctors and the structure remains unchanged.

The position of the medical establishment extends from an unqualified optimism to advocacy of various forms of "technology assessment" and "technical fix". Birth technology or New obstetrics are considered a good example of practical preventative medicine by the majority of the medical profession and any problems associated with the technology are seen as a technical matter of fine tuning the technology itself, assessing the problems caused by the technology and developing a "technical fix" or supplementing the technology with "natural" solutions which are ultimately under the unquestioned control of the medical establishment.
(b) Feminist Approaches in Support of Hospital Based Birth

The three feminist approaches in support of the hospital based births are Liberal feminism, the classical Marxist feminism and Radical feminism as described by Shulamith Firestone. What they have in common is the desire to improve the position of women in society and accept the control of high technology in this process. The three approaches, like the medical establishment, recognise the problems associated with the new obstetric technologies but their solutions to these problems differ both from each other and from the medical establishment.

The general position of feminism is unclear, as different feminist theories view home based and hospital based childbirth and its relationship to women's position in society from very different perspectives. Part III of this thesis is devoted to the debate of male dominance in childbirth. This involves a detailed discussion of the different feminist theories including the analysis of childbirth each theory contributes to the debate. Therefore in this section only a minimum account of each theory will be provided. (Liberal feminism is based on the theory of liberalism; that is that every individual's position in society should be according to their own efforts not their origins or biology. Classical Marxist feminism is based on the position adopted by Engels in "Origin of the family", that is, the sexual division of labor in the family is a response to both
property and biology. Radical feminism has two strands, both strands argue that women's position in society is the result of her biology however the solutions differ. The Firestone strand argues for a technological solution to the biological difference whereas the cultural strand sees the solution arising from a celebration by women of their biological difference.)

(i) Liberal Feminism

The liberal feminist approach accepts the necessity of high technology childbirth in the case of a high risk pregnancy or if chosen by the birthing woman. However, they maintain that people should not be confined to this type of birth, many choices should be available. This view is aptly described by Professor Peter Huntingford

the right of well-informed people to take full responsibility for themselves in having their children in safety, comfort and with satisfaction.69

The book Birth Primer70 is a consumers' guide to the available types of birth. Liberal feminists contend that the resulting consumer pressure on the existing services will alter the services to suit the demand. Ruzek maintains that consumer choice has already altered existing services

The eagerness of professionals to endorse new procedures and practices is a good indicator of consumers' real power in determining how, if not what, services should be available. To a great extent, obstetricians-gynaecologists are economically motivated to provide what consumers demand.71
Liberal feminists also work towards expanding consumer choice in the area of childbirth as well as protecting consumers against exploitation. An example of the former is the efforts of congresswoman Marthe Griffiths, to introduce a bill which would enable women to make the choice of having the father of the child attend the birth.\textsuperscript{72} The work towards the banning of Pitocin, a drug used in induction, is an example of the policy to protect consumers from dangerous techniques. One of the limitations of this type of consumerist response is that their assessment of the technologies relies heavily upon the information provided by the medical establishment and the drug companies supplying the technology. Yet if, as Jill Rakusen states, "the information we receive is structured and produced by professionals"\textsuperscript{73} and selectively released by self interested corporations, this state of affairs severely restricts the critical ability of a consumer movement.

We thought information would give us power. What we perhaps overlooked is that it is power which gives one control over both information and choice.\textsuperscript{74}

(ii) Classical Marxist feminism

Classical Marxist feminists' general attitude to health care incorporates their approach to the new obstetrics. They demand public financing of care, governmental planning and control of resources, and socially national distribution of services similar
to the system operating in the USSR and the European communist
countries. The specific policy on childbirth is that

Public health institutions shall provide every woman with qualified medical
observation during pregnancy and hospital aid during confinement, and medical and
prophylactic aid to the mother and newborn child.

Accordingly, classical Marxist feminists fight for increased access for all women to high technology obstetric units by campaigning for increased funding for already existing public services and for the establishment of such services in areas where they do not exist. Problems associated with the technology are attributed to the profit motive in the capitalist system causing the inappropriate use of the available technology not the nature of the technology itself.

(iii) Radical Feminism

Shulamith Firestone sees childbirth as a barbaric and painful experience and discards motherhood in favour of technology. Further she maintains that a woman's role in reproduction is the cause of their dependence and exploitation by men. The only way for a woman to achieve parity with men is when children are produced by extrauterine methods. Extrauterine methods or the creation of test-tube babies involves the use of high technology and is the direction obstetric technology is heading today as more sophisticated in vitro fertilisation techniques and
neo-natal units are developed and further researched. This work is dependent on the hospital based medical establishment and accepts the structure of technology as neutral and perceives its consequences as benign.

All three feminist theories accept the dominance of a medical elite within the high technology hospital structure. The liberal feminists do not recognise the restrictions on freedom of choice resulting from: firstly, the dominance of the obstetrician, secondly, the effect of class inequality in restricting the choice of birth open to the poorest sectors of society, and, thirdly, the cultural effect of extreme reliance on technology in creating an uncritical culture of dependence. Similarly, neither Classical Marxist nor Radical feminism questions the benefits of reliance upon the authority of the hospital based medical establishment or the benefits of the technologies developed within that context.

2 HOME BASED / LOW TECHNOLOGY BIRTH

Where the hospital based birth advocates accept high technology solutions to the birthing process and the role of professional medical expertise as essential for successful birth outcome, the home based birth protagonists only accept this solution for the minority of women. They argue that the majority of birthing
women are capable of birthing 'naturally' at home with the support of an attendant who has some childbirth experience and the aid of relatively simple technologies.

This position is supported by two groups. The largest and most vocal group is the traditionalist back-to-nature homebirth movement (TBHM). This movement is composed of a wide range of diverse organisations ranging from the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPPSAC) to the Farm Midwives on the Tennessee Commune. The basic contention they hold in common is that childbirth is a 'natural' and important family event, often more a religious or spiritual event than a medical event. The other group in support of a home based birth is the cultural radical feminists. In their view the most important aspect of childbirth is that it is a woman centred experience rather than a family event. However they share the view of the TBHM that childbirth is a 'natural', domestic and often spiritual experience.

(a) The Traditionalist Back-to-Nature Homebirth Movement

For all their differences of opinion, the homebirth movement and the medical establishment have the same methods of evaluating birth technology. They constantly refer to each other's work. Familiar establishment medical names like Richards, Chalmers, and
Brackbill appear in the homebirth literature which often resorts to medical establishment journals for supportive evidence. This is hardly surprising, as the medical establishment is more likely to receive funding for research. A more unexpected situation is to find the homebirth movement's work referred to in the medical journals. The adherence by both parties in the homebirth/hospital birth debate to the concept of 'impartial scientific fact' underlies this cross legitimation of apparently opposing viewpoints. David Stewart, the most prolific writer and champion of the homebirth movement, states that "ninety per cent of the obstetric practice ... is without a valid basis in science". Marjory Tew examines the Registrar General's statistics on perinatal mortality to find the basis for the Peel Report, and concludes by calling for a "critical and impartial investigation". Doris Haire constantly refers to the lack of scientific evidence and the need for scientific research.

As indicated above, the medical establishment, since the 1930s, base their arguments in support of different techniques on the perinatal mortality rate. An examination of the literature of the homebirth movement reveals that it also relies heavily on an analysis of these statistics. A common theme is the call for more research. Iain Chalmers and Martin Richards, authors who appear in the literature on both sides of the debate, argue for more randomised controlled trials and experimental research before the introduction of medical innovations into clinical
practice. They believe that the failure to employ this technique (randomised controlled trials) seems to have arisen from a basically unscientific approach to research. This call for "scientific" research to evaluate technology is based on the belief that scientific investigation as well as technological development, is carried out in an objective manner.

Unlike the TBHM, Ivan Illich argues that the scientific method is an inappropriate method for the "art" of medicine. However, in general the philosophical position the movement adopts is that of Illich. He evaluates the effectiveness of medical care within the same framework as the medical establishment, that is, he analyses the degree to which medical intervention has reduced mortality and morbidity, as does the TBHM. Secondly, Illich sees clinical, structural and social iatrogenesis as derived from both the process of industrialisation creating a medical bureaucracy and the dependence of consumers on this bureaucracy. Similarly the TBHM assumes that the medical bureaucracy is independent of the economic and political structures of the rest of society and by removing birth from this bureaucracy, birth will be demedicalised. The view that

the hospital staff is working on its own system of reason and is isolated from everyday events of the community outside allows the TBHM to relate the problems specifically to the place of birth. Suzanne Arms, champion of the TBHM claims that the aim of the medical bureaucracy (and Industrialisation), efficiency,
is a significant factor in the dangerous overuse of sophisticated technology in hospital births.\textsuperscript{90}

Illich recommends debureaucratisation, so health care would become an individual responsibility and the "concerns of where, when, how and from whom to receive care should be left to the individual".\textsuperscript{91}

Illich idealises the world of optimal widespread health as

\begin{quote}
A world of minimal and only occasional medical intervention. Healthy people are those who live in healthy homes on a healthy diet in an environment equally fit for birth, growth, work, healing and dying.\textsuperscript{92}
\end{quote}

His romantic rejection of technology and the individualistic solutions he poses to the problems of health care are congenial concepts to the TBHM.\textsuperscript{93} Like Illich, the TBHM assumes that the industrialisation and technological knowledge determine the social formation of the institution of medicine rather than the technology reflecting the social organisation. Their solutions of avoiding the medical bureaucracy, rejecting the technology and concentrating on self-reliance assumes that the medical bureaucracy is independent of the economic and political structures of the society. It can be argued that this "life-style" solution of self-care and self-reliance strengthens the basic tenet of bourgeois individualism, "the ethical construct of capitalism".\textsuperscript{94}
Far from being a threat to the power structure, the "life-style politics complements and is easily co-optable by the controllers of the system, and it leaves the economic and political structures of our society unchanged".95

The TBHM neglects the wider socio-sexual and economic relationships affecting childbirth. This is clearly seen in the basic tenet of the movement, that problems of birth can be solved by simply moving birth from one autonomous institution, the hospital, to another, the family.

This movement seems to reject or be unaware of the view that the structure of the health care sector mirrors the structure of the family96 as they reject the medical institution yet fight to strengthen the family and improve domestic life. David Stewart, champion of the TBHM, identifies the results of a home maternity service as reduced social problems, which he construes as the consequences of weakening family bonds. The social problems which will be solved are "juvenile delinquency, teenage pregnancy, failure to finish high school, drug abuse" and more.97 The importance of the role of each member of the family in childbirth is emphasised by the TBHM.

Maternal bonding is a concept of great concern.

The first twenty-four hours following birth appear to be a critical period for the establishment of the normal mother-infant bonds.98
This concept is taken further through the movement's critique of maternal deprivation of "displaced siblings" when mother births in hospital. Yet Clarke and Clarke\textsuperscript{99} conclude that short-term maternal separation is of little importance for long-term disorders.\textsuperscript{100} The movement also addresses the position of the father in the process of childbirth. Kitzinger and Davies\textsuperscript{101} devote an entire paper by Richman and Goldthorpe to fatherhood. They suggest that problems arise when a husband has to abrogate his "traditional responsibility" as "protector and provider".\textsuperscript{102} In a later book, Kitzinger elaborates this argument labelling male depression caused by the birth experience "father's postnatal depression".\textsuperscript{103} This occurs when a man experiences the contrast between the mother's dependence on him during labour and his isolation when she remains in hospital.

The TBHM tends to adhere to the traditional stereotypical roles in the family with the male as the provider and protector and the mother as the nurturer of the children. Furthermore they see this as "natural" or biologically determined in the same way as they see childbirth as "natural".\textsuperscript{104} The logical extension of this argument is that the father is dominant within the family due to his biologically given sex difference in aggression\textsuperscript{105} and therefore has ultimate authority in the family. Accordingly, whether a woman births in the hospital or in the home, her experience will be dominated by a male, whether husband or doctor. This view of the contemporary family is being
increasingly criticised. Many feminists argue that the structure of the contemporary family is not a "natural" phenomenon but is rather a consequence of established social and political structures. In the societies discussed in this thesis, the structure of the contemporary family is maintained and reinforced by existing social and political frameworks.

The TBHM does not recognise the wider social and economic influences upon the family. For example, the maternal and paternal separation emphasised by Richman and Goldthorpe is irrelevant to many working class members of society. Paternity leave is by no means universal, and consequently the vast majority of the male working class would be separated from the child and mother during and after birthing, whether at home or hospital. In 1971, during the period when homebirths were regaining popularity, forty three per cent of the labour force in the United States were women. An over concern with "displaced siblings" and maternal bonding may become an unnecessary extra psychological burden for the mother who is forced by economic pressures and lack of maternity leave to return to the workplace soon after the birth of her child. These factors explain why the majority of the voluntary homebirth participants and supporters come from the upper and middle educated classes.

While the proponents of the TBHM recognise the importance of nutrition for the pregnant woman, they see this "fixed" by
personal choice, not in terms of the socio-economic circumstances of the woman. When the TBHM calls for maternal avoidance of drug exposure, rest and exercise, it does not acknowledge those women who work both inside the home and in the workplace, and therefore do not have the opportunity to rest or exercise. Equally significant is the fact that many of those factors which could endanger health are beyond individual control: that is, work hazards and pollution. The answer to the problems in childbirth and pregnancy that result from malnutrition, drug exposure, exhaustion, work hazards and pollution are considered by the TBHM to require a high technology solution or "technical fix" rather than looking at the wider social, economic or political context.

In some areas the TBHM's approach to birth technology does not go beyond the perspective of the medical establishment. For example, the attitude to antenatal tests to detect the possibility of defective foetuses or high risk pregnancies imitates that of the medical establishment rather than examining the possible problems associated with this technology and looking for alternative causes which might be found to have environmental and social solutions. Their approach, like that of the hospital based adherent, suffers from the limitations of the "technical fix" and "technological assessment" perspective.
(i) Technical Fix

The TBHM solution to high risk pregnancies is to rely upon complex technologies rather than addressing the possible causes. Repeatedly, the TBHM advises women of the importance of the antenatal clinic and tests. This early technical interference allows the TBHM to screen out those pregnancies considered high risk and relegate the births to the medical establishment where the solution is a "technical fix".

Yet tests such as screening for spina bifida and other genetic defects usually result in increased stress for the mother; produce results which can easily be confounded by miscalculation of dates, etc; and often results in the need for further medical intervention.112

(ii) Risk Assessment

The TBHM accepts the technology as given without ever questioning its origins, the problem is its overuse or abuse. When assessing the efficacy of homebirth outcome in comparison to hospital birth outcome113 the TBHM uses the same statistical categories as the medical establishment (to assess a low technology birth as opposed to the hospital based high technology birth). The pain and fear surrounding the traumatic experience of childbirth makes
this a crucial time in the life of every woman yet the limitation of assessment of birth "successes" to statistical categories of survival rates neglects to examine the impact on mothers' consciousness (and hence upon the child) of different practices.

Finally, although the TBHM has contributed important information to the debate in the form of the statistics listed below in Tables 4, 5 and 6, it does not recognise their full implications.
Table 4  Foetal, neonatal and post-natal mortality per 1000 live births in selected countries, 1955 and 1973

<table>
<thead>
<tr>
<th>Country</th>
<th>Late Foetal Mortality (28 weeks +)</th>
<th>1955</th>
<th>1973</th>
<th>% Fall</th>
<th>Neonatal Mortality (0-27 days)</th>
<th>1955</th>
<th>1973</th>
<th>% Fall</th>
<th>Post Neonatal Mortality (28-364 days)</th>
<th>1955</th>
<th>1973</th>
<th>% Fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>17.0</td>
<td>12.9</td>
<td>7.8</td>
<td>39.5</td>
<td>4.5</td>
<td>2.0</td>
<td>55.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>30.8</td>
<td>22.3</td>
<td>7.4</td>
<td>66.8</td>
<td>17.4</td>
<td>3.9</td>
<td>77.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>18.2</td>
<td>18.6</td>
<td>8.5</td>
<td>54.3</td>
<td>11.1</td>
<td>2.1</td>
<td>81.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>France</td>
<td>17.5</td>
<td>20.8</td>
<td>8.5</td>
<td>59.1</td>
<td>17.8</td>
<td>4.8</td>
<td>73.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>17.3</td>
<td>14.0</td>
<td>8.5</td>
<td>39.3</td>
<td>6.1</td>
<td>3.0</td>
<td>50.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England and Wales</td>
<td>23.7</td>
<td>17.0</td>
<td>11.1</td>
<td>34.7</td>
<td>7.6</td>
<td>5.7</td>
<td>25.0</td>
<td></td>
<td></td>
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</tbody>
</table>

Table 5  Gross National Product per Capita

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>5910</td>
<td>3.0</td>
<td>2.4</td>
</tr>
<tr>
<td>France</td>
<td>4540</td>
<td>4.7</td>
<td>5.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>4330</td>
<td>4.1</td>
<td>4.3</td>
</tr>
<tr>
<td>Japan</td>
<td>3630</td>
<td>9.4</td>
<td>9.6</td>
</tr>
<tr>
<td>Finland</td>
<td>3600</td>
<td>4.5</td>
<td>5.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>3060</td>
<td>2.4</td>
<td>2.3</td>
</tr>
</tbody>
</table>
From the above statistics we can deduce that Japan showed a great improvement in neonatal mortality rate from 1955-1975 (Table 4), an improvement which coincided with a great improvement in socio-economic conditions (Table 5). Sweden has had consistently good socio-economic conditions and a low perinatal mortality rate, whereas Britain, with a less "healthy" economy had the highest perinatal mortality rate in 1973, of the countries listed. The implication is that there is a relationship between socio-economic conditions and perinatal mortality rate. All these countries have access to the new obstetric technology which

*Perinatal mortality rates of different countries must be treated with caution as different countries access stillbirths from as early as 20 weeks, overestimating that other countries treat as abortion.*
would imply that socio-economic conditions have a greater impact on the perinatal mortality rate than new obstetric techniques. Furthermore, the improvement in perinatal mortality rate is not related to the number of doctors per 10,000 population (Table 6).

As doctors are the only professionals with access to the obstetric technologies, and if technology is a significant factor in improving the perinatal mortality rate, those countries with a high proportion of doctors per population could expect a low perinatal mortality rate. According to Table 6 this is not the case. West Germany has both a high standard of living and a large proportion of doctors in the population and yet has a high perinatal mortality rate. Similarly, Italy has a large proportion of doctors and a high perinatal mortality rate. However, it is West Germany that provides the greatest anomaly.

One suggestion that could be made and this fits the general ideas of THBM is that the anomaly in West Germany be explained by the place of birth as Germany has 100 per cent hospitalisation. However, Sweden with its low perinatal mortality rate also has 100 per cent hospitalisation. A comparison of the Netherlands and Sweden also contradicts the TBHM's argument. The Netherlands has only approximately 50 per cent hospitalisation as over half the births occur at home, yet with good socio-economic conditions, the perinatal mortality rate is higher than in Sweden.
(Tables 5 and 6). Finland provides a similar contradiction. This country has a low perinatal mortality rate yet socio-economic conditions are not significantly good and it has 100 per cent hospitalisation. Kitzinger suggests that what is significantly different about Sweden and Finland is that midwives, with "high status" and "excellent training", attend most births and "most babies are delivered by them" whereas, for example in West Germany, midwives have the status of attendants to the obstetrician.

(b) Cultural Radical Feminism

The common view held by cultural radical feminism and the strand of radical feminism developed by Firestone, is that women's role in reproduction and child rearing is a primary cause for women's subordinate status in society. The two theories differ significantly in their solutions; cultural radical feminism argues that by changing women's experience of childbirth, women's relationship to power and fear will be altered. According to Adrienne Rich, women have become alienated from their bodies, that is from their essential femininity. She maintains that the medical management of childbirth is one of the ways that men have sought to divorce women from their bodies, to deprive them of the powers that would otherwise be theirs as a result of their biological role in motherhood. Modern obstetrics is to be
criticised for standing in the way of women "knowing and coming to terms with their bodies" through childbirth. Similarly Rossi criticises modern obstetric practice for interfering with the "natural process ... of spontaneous birth", the natural relation of women to their own bodies.

For cultural radical feminism the act of childbirth should be a women-centred event, attended by women only and in a women's place. What the cultural radical feminists have in common with the TBHM is the belief that women's role in reproduction and childrearing is a "natural" biologically determined part of women. Women who experience problems in childbirth do so because of their inability to express their power in a male dominated society, is the underlying assumption, and therefore the issue of high risk pregnancies or difficult births is not addressed. This attitude to women who experience difficulty in childbirth, rather than increasing their feeling of power, could cause them to feel both guilty and inadequate. As a commentator remarked,

Some women feel guilty because they do not enjoy the experience.

Common to the TBHM and cultural radical feminism is the definition of childbirth as "natural". Yet "natural" childbirth has always been a socially constructed and "historically contingent" experience. Women have always relied on some form of social support in childbirth to aid them in a birthing process that is given meaning and structure by the social and cultural
context. The assumption of the cultural feminists is that "natural" childbirth will allow women to get in touch with what they see to be a biological essence, defined as their femininity. They thus ignore the important role of culture in determining the nature and meaning of any human practice, especially one of such symbolic significance as the origin of human life. As Germaine Greer states: it is always the case that human beings insofar as they are animals have biological urges, but their status as determinants of behaviour is extremely hard to gauge because the simpler biological programming is overlaid by extraordinary complex cultural patterning.

In an argument based on the same view of a non-social "nature", the TBHM assumes that trusting nature provides a better outcome than trusting technology or "unnatural" birth. Yet, to distinguish between natural and unnatural in this fashion presupposes the existence of a socially unmediated view of nature and the external world. However, in all societies the definition of nature, and its social meaning, is a cultural act, never a purely biological or environmental phenomenon. Ultimately, the creators of this world can be none other than the socio-historical process of human beings.
CONCLUSION

The hospital based birth and home based birth protagonists share certain assumptions that have come under criticism in the last decade.

The hospital based birth supporters admit to some problems associated with the technologies but see the solutions in terms of technical fix and further research or the use or abuse of the technology; the technology itself is accepted as given. The home based birth supporters concentrate on those women assessed as low risk accepting the use of the technology for the high risk pregnancy. The low risk women are assessed as capable of "natural" childbirth, a view that presupposes that childbirth is a purely biological event independent of the society on which the event occurs. Both sides of the debate neglect the extent to which technology is politicised and nature is a social construct. The technology is part of the hospital structure, which is a political structure with a hierarchy each with differing degrees of authority. The family, the site of "natural" childbirth, is itself a structure of authority and control.

Although participants in the debate argue from opposing sides, they both see successful birth outcome as the product of the level of technology. Using a measure of success, the perinatal
mortality rate, both sides present evidence in support of the high technology approach to birth or the low technology approach to birth. Neither side examines the role of who creates and controls the technology, i.e., the role and structure of the institutions themselves. Similarly, neither side discuss the evidence which suggests the importance of socio-economic conditions on birth outcome. Social class is a determinant in assessing a pregnancy as high or low risk and evidence suggests that improvements in socio-economic conditions over the past two centuries have had a significant effect in lowering the perinatal mortality rate in that period.

Moreover, while concentrating on kinds of technology both sides uncritically accept 'scientific' evidence, demanding more controlled tests and scientific research. As well as ignoring effects created by the political and economic control of technology, and neglecting the political dimensions of technology itself, both the hospital based and the home based birth protagonists uncritically accept 'scientific' evidence as an uncontroversial basis for assessing technology.

In the 1970s these views of the neutrality of science and technology came under criticism. Critics of this apolitical view of science and technology include Commoner, Clarke, Dixon, Elliot and Elliot and Bookchin. They see the directions of technology and scientific development as being politically,
economically and/or socially determined. Dickson postulates that technology itself plays a political role

(i)ntimately related to the distribution of power and the exercise of social control.\textsuperscript{13}

Although some would argue that changing the directions of science and technology would alter social practice (eg, Clarke) others (eg, Bookchin) would disagree, maintaining that the whole social system would need changing.

A liberatory technology presupposes liberatory institutions; a liberatory sensibility requires a liberatory society ... To speak of 'appropriate technologies', 'convivial tools' and 'voluntary simplicity' without radically challenging the political 'technologies', the media 'tools' and the bureaucratic 'complexities' ... is to completely betray their revolutionary promise ...\textsuperscript{135}

In accordance with this charge in the social critique of science and technology, the obstetric debate began to shift in the mid 1970s and became politicised as women began to recognise the limitations of a purely technical view of the problem. Furthermore, the attacks on midwives attending homebirths brought the importance of who attends and controls birth to the attention of the women's movement and resulted in their active participation in the debate. Consequently the issue of male dominance arose as a major issue more significant than the high technology/low technology or hospital/homebirth debates. However as we shall see in Part III, the initial attempts to explain and criticise the social relationships surrounding obstetric technology in terms of male dominance were ultimately inadequate.
NOTES


7. Ibid., pp.477-479.


10. loc.cit.


12. Ibid., p.479.

13. Ibid., p.480.


24 loc.cit.


28 loc.cit.


30 Ibid., p.viii.


34 Ibid., p.858.


43 Henderson-Smart and Storey, op.cit., (note 33), p.858.


51 Ibid., p.161.


53 Dickson, David., op.cit., (note 32)


57 Loc.cit.


61 Ibid., p.349.


63 Loc.cit


69 Huntingford, Peter, "Obstetric Practice: past, present and future", in Kitzinger and Davies (Eds.), op.cit., (note 4), p.249.


78 Traditionalist Back-to-Nature Homebirth Movement (TBHM) is not a formal movement but one composed of different organisations all with a common basic belief.


84 Haire, Doris, *op.cit.* (note 1).


90 *loc.cit.*


92 Illich, I., *op.cit.* (note 87), p.274.
93 Stewart, D., *op.cit.* (note 82); Arms, S., *op.cit.* (note 88).
95 *loc.cit.*
98 Haire, D., *op.cit.* (note 1), p.27.
100 *Ibid.,* p.182.
103 Kitzinger, S., *op.cit.* (note 88)
104 Stewart, D., *op.cit.* (note 82).
113 Mehl, L.E., op.cit. (note 3)
114 Kitzinger, S., op.cit. (note 103), pp.49-52.
115 Ibid., p.51.
116 loc.cit.
117 Ibid., p.53, citing Royal Commission on the NHS.
118 Ibid., p.52.
119 loc.cit.
121 Rich, A., Ibid., pp.149-182.
122 Ibid., pp.178-179.
124 Rothman, B.K., op.cit. (note 79).
129 Navarro, V., op.cit. (note 67).
131 Stewart, D., op.cit. (note 82).
133 Bookchin, M., Towards an Ecological Society, Black Rose, Montreal, 1981;


134 Dickson, D., *op.cit.* (note 52), p.10.


PART III

MALE DOMINANCE: APPROACHES TO WOMEN'S CONTROL
INTRODUCTION

In a discussion of women's control in the obstetric debate we must first redefine childbirth. As we have seen the medical definition views childbirth as a pathological disease-like state requiring technological intervention. In contrast the TBHM defines childbirth as a natural physiological event. Within the parameters of these definitions whether women or men control childbirth becomes irrelevant. However, anthropologists including Margaret Mead, have for many years defined childbirth as a cultural event and it is within this definition that the concept of women's control of childbirth becomes relevant.

In 1949, Margaret Mead concluded from her analysis of childbirth in different cultures, that women learn what to expect, how to behave and even what to experience, in childbirth and that men have a strong influence on this learning.¹ In the three societies, Britain, Australia and North America, studied in this thesis, the predominantly male medical profession has dominated the area of childbirth for nearly a century and it is their definition that women in these societies learn.

However women involved in the women's health movement are in practical ways attempting to increase women's control of childbirth which is altering many birth attendant's definition of
Similarly, feminists are trying to develop a theoretical understanding of the importance of women's control in childbirth but, as we have seen in Part II, they have not been able to break out of the medical or TBHM definitions.

(i) Natural Childbirth and Male Control

Mead views the practice of "natural" childbirth as another example of males defining female experience. As Rohrbaugh argues, the trend towards the presence of the father and his involvement in "natural" childbirth has a striking resemblance to the male couvade. Paige and Paige maintain that only in cultures where male ownership of the newborn child is not clear, do men resort to symbolic control through participation in the birth process. It has been further argued that because of the changing role of the female in the last fifty years, men have felt the need to reassert their control over "their women" and "their children" and this has been achieved by participation in natural childbirth. Rothman suggests that the best modern example of the couvade ritual is represented by the Leboyer birth, a method of "natural" childbirth highly acclaimed throughout the three societies discussed.

Frederick Leboyer is a French obstetrician who has defined birth as a trauma for the child. He seems to try to make amends for the supposed nightmare of being born by

*Couvade: exists in cultures where father rather than mother underwent labour pains and a long recovery period. Some anthropologists view the couvade as a symbolic attempt to assert paternal rights over the newborn child.
repeating the birth more "gently". Shortly after birth the baby is placed in body-temperature water and then massaged. The bath and massage are done by Leboyer himself, as he describes it, but in this country (U.S.A.) the Leboyer bath is typically done by the Father. The symbolic reemergence from the amniotic fluid and the rebirthing by the father's hands is the male improvement over the female's birthing. The implicit message is that even "natural" childbirth requires male intervention for successful outcome. Similarly, the TBHM identify the role of the father in the birthing process as one of great importance and for some the neglect of the father's role by the medical profession provided the impetus for their active involvement in the movement.

(ii) The Traditional Back-to-Nature Homebirth Movement (TBHM)

The importance of the role of the father in the birthing process is most obvious in the introduction of the concepts "paternal post-natal depression" and "paternal bonding" by the TBHM. Paternal bonding is presented as an argument against hospital births. The reason given is that the father is separated from the baby when the mother and baby remain in hospital after the birth. Similarly, paternal post-natal depression results from the loss of control of the mother a husband experiences when she remains in hospital. Implicit in this concern is the position of the father in relation to the mother within the family. Whether childbirth occurs in the hospital or in the home, a male,
in the role of husband or doctor, will be in the position of control over the birthing woman.

The TBHM's attitude to feminists is illustrated by the authors of the book "Children at Birth", a book written in support of home birth.

Lately there is an assumption that FEMALE attendants are naturally better than male - that all women are sisters and only a woman can empathise with another woman. Maybe this is right but I doubt it. Cast your mind back over the history of childbirth - Dick-Read, Lamaze, Bradely, Brewer, De Lee, Semmelwiese, Leboyer - all are males. These men have contributed greatly, not only to the feeling, joy, pride of the MOTHER, the FATHER. Today we have many concerned females - and more power to them - but also we have unconcerned, sadistic and political women.\textsuperscript{11}

The TBHM fails to give adequate recognition to the supportive role feminism plays for the women in the TBHM. Yet feminism legitimates a woman's desire to choose both her birth attendants and her place of birth. Feminism also provides social support for women birth attendants in their position as working mothers, whose irregular working hours do not allow them to fulfil the expected wife-mother role.\textsuperscript{12} Despite this support, even when mention is made of feminism, it is more rhetoric than reality, one hears phrases like "taking our bodies back", "consciousness raising" and "patriarchial dominance" from women whose entire lifestyle expresses strongly traditional gender-role values.\textsuperscript{13}

Although the TBHM has gathered evidence in support of female
birth attendants, it does not address its implications. Kitzinger in her study of perinatal mortality rates of different European countries concluded that Sweden and Finland provided the lowest perinatal mortality rate and the significant factor was that births were attended by trained midwives. A survey referred to by David Stewart, the most prolific American writer on the subject of homebirth and the champion of NAPSAC (National Association of Parents and Professionals for Safe Alternatives in Childbirth) indicates that one hundred per cent of mothers when asked "which would you prefer to attend your future births - a doctor or a midwife?" chose a midwife. However, the philosophy of the TBHM shows little concern with the question of who controls childbirth, the emphasis is on the place of birth and the avoidance of technological interference. Adherence to this position causes Stewart to disregard his own evidence in support of female attendants, maintaining that non-interventionist doctor is the same as a midwife.

Unlike the TBHM, the women's movement views this evidence of the importance of women's control of childbirth as the major significant issue and consequently see the main task as challenging medical hegemony and male dominance of childbirth in several different ways.
The Women's Health Movement (WHM) does not necessarily constitute an organised or integral movement, however, the general aims throughout the movement are the same: to increase women's control over their bodies and childbirth. Although the WHM and the midwives associations adhere to basic common goals, neither group would be considered to have a theoretical base; the aims and objectives of these groups are derived from praxis. The three feminist theories discussed later in Part III do not underpin or provide a full understanding of the overall practice of WHM or midwives associations although ideas from all three theories can often be recognised in their work.

Participants in the WHM are working both within the public medical system for change in birthing practices and outside the public sector in birthing centres and private homes. Whatever sector, public or private, these women are challenging the medical hegemony and male dominance in the area of childbirth. By 1976 in Britain and 1983 in Australia midwives had begun to form associations. These associations brought together midwives from vastly different philosophical and working backgrounds, ranging from lay or empirical midwives working in the TBHM to those trained midwives working in large obstetric units under strict medical supervision and from those who see the issue as one of male dominance to those who view technology as the major
factor. These different ideas maintained by members of these associations result in conflict arising continually within these associations. However the common factor that brought these midwives together, the belief that the role of the midwife should be restored to that of attendant and advocate for the birthing woman, assures their continuing role in the obstetrics debate despite the disparate origins of the members.

In Britain, the British Association of Radical Midwives is dedicated to restoring the role of the midwife for the benefit of the childbearing woman and her baby. It was inspired, according to Rakusen and Davidson, by the loss of skills and autonomy allowed the midwife because of the move from home to hospital birth, a move which, in effect, ultimately reduced midwives to the status of the North American maternity nurse. Its specific objectives include:

1. Midwives should be given TOTAL RESPONSIBILITY FOR ALL NORMAL expectant, labouring and newly delivered mothers up to twenty-eight days after the birth
2. Flexible working arrangements which ensure continuity of care
3. Women having a real, fully informed choice concerning all aspects of their maternity care
4. Ensuring that attention is primarily directed towards universal availability of humane care in all aspects of childbirth, rather than scarce resources being directed
towards funding the increased use of interventions of questionable value

v Improving home help services

vi Improvements in midwives' training to include:

a Seminars with consumers expressing their views; and

b Training in the art of supportive conversation and supportive silence, and better training in natural childbirth methods

vii More opportunities for women to become midwives without first having to train as nurses

viii Decentralisation of ante-natal care into neighbourhood clinics in all areas.19

Unlike the British Radical Midwives Association, the Australian Progressive Midwives Association is composed of homebirth midwives and does not include or exclude midwives working in the hospital system. It developed from the need felt by homebirth midwives to form a structure which would be accepted by the Australian Nurses Association as a branch with delegate rights.20

Its aims and objectives are defined by its origin, Homebirth Australia. Under the umbrella of Homebirth Australia, this association was seen as providing support for isolated midwives attending homebirths and facilitate the passage of information between these midwives. With Homebirth Australia, the Progressive Midwives Association is lobbying for government remuneration of midwives in private practice through the national
health scheme, independent midwifery practice, the introduction of a direct entry midwifery course and general community education about homebirth. With respect to community education, members of the Progressive Midwives Association have given lectures to midwives in training in teaching hospitals.

In the United States there is no clear cut organisation of midwives yet by 1982 there were one thousand five hundred professional nurse-midwives practising in America and an uncounted number of lay midwives. These midwives are supported by many local women's centres and state women's unions. Ruzek maintains that the arrest of three lay midwives in California in March 1974 for practising medicine without a licence mobilised feminist support for midwives and changes in birth practices.

Midwives in groups or associations, attending homebirths or working in birthing centres controlled by midwives, are challenging the medical hegemony of childbirth. However, the vast majority of midwives are trained and working in hospitals where the medical profession dominates and defines childbirth. Although midwives working within the medical system in Britain still have the opportunity of attending homebirths, the current policy in Britain is to bring all births into the hospital. In the United States, the only chance of training and working in a homestyle birthing program is by joining the Frontier Nursing Service and the waiting list extends over several years.
Australia, all midwives who expect public remuneration and training work in public hospitals. Rothman suggests that the only way for them (midwives) to get true professional autonomy is to opt out of the medical system". In fact this is exactly what many midwives are doing in Britain, Australia, and America; they are setting up in private practice, attending homebirths or working in midwife controlled birthing centres. However, private practice has the problem that if abnormalities arise in the birthing process then the midwife is dependent on hospital back-up with all the subsequent ramifications.

Not only women working in the area of childbirth have organised into groups, but women consumers and other interested women have formed loose organisations. Part of the aims of these groups is to lobby governments for change in obstetric policy in the public system. For example, women are the dominant force in Homebirth Australia (HA). Besides forming a network for midwives and interested people, HA are fighting for homebirth midwives to be paid by the national health fund, Medicare. In Britain, examples are the National Childbirth Trust and Association for Improvements in the Maternity Services (AIMS). Similarly, the International Childbirth Education Association (IDEA) in America, composed of feminists, homebirth movement activists and backed by many prominent physicians, lobby for change along the lines suggested by Doris Haire, as do many other health movement activists. These groups activities have had some impact on maternity services inside and outside the public hospital system.
(a) Public Medical System

In Britain, in response to the high perinatal mortality rate in South Yorkshire, the health education section of the NHS has established a network of pregnancy support groups with the aid of community midwives and health visitors. Rather than falling "into the trap of merely exhorting women to be responsible" or increasing the technology of antenatal care and obstetrics in the area, this program used extra resources for health education "to concentrate on helping women to take initiatives". In association with groups such as the Radical Midwives and the Association for Improvements in the Maternity Services, their "eventual aim is that consumers will be recognised as the appropriate people to monitor the maternity services", rather than the high technology orientated medical specialists. Another aspect of the service is the ante-natal classes, which are conducted in community centres away from the alienating high technology setting of the hospital clinics. This approach to childbirth realises many of the aims and objectives of the Radical Midwives Association in Britain. It also indicates that the National Health Service agrees with some of what critics of the present system recommend. For example, it is agreed that the type of antenatal care Dunn recommends would make better use of records and "wider use of ancillary staff".

It has also been argued that this system provides a better form
of diagnosing complications. For example, Rakusen and Davidson cite a study that showed that diagnosis derived from talking to women (medical history) is far more effective than technological tests. It has also been claimed that prematurity declines significantly where nurse/midwives are involved in conducting prenatal care. For example, a project initiated in California between 1957 and 1960, where nurse/midwives conducted prenatal care and 78 per cent of all deliveries, prematurity declined significantly. Wertz and Wertz also indicate the importance and success of employing nurse/midwives for prenatal care, in the case of working class mothers. As they state,

Doctors have considered numerous means to overcome their liabilities, such as employing nurse-midwives who would engage poor women in their homes instead of clinics for prenatal care, and follow them through hospital delivery. Where such plans have been tried experimentally, mortality rates have dropped sharply.

In America, some hospitals have consequently introduced homestyle birth programs which employ nurse midwives in the hospital context. Similarly, in Australia, birthing centres attached to large hospitals have been established where midwives control the birth until 'problems' arise. The criteria for transfer to the labour ward and obstetric intervention in the birthing process include taking more than the allotted time in any of the three stages of labour. However midwives attending homebirths or working in midwife controlled birthing centres would argue for greater flexibility in determining such criteria. This is not possible in the hospital setting where obstetricians control
birth and therefore set the criteria. Despite these problems, the new homestyle birth programs or 'birth rooms' hospitals expose obstetricians to experiences, such as birth over an intact perineum, which are part of a reevaluation of present obstetric practices. Yet critics argue that these homestyle birthing programs established within the public medical system are inadequate as a method of demedicalising childbirth. Medical practitioners still determine the criteria for women entering the program and the criteria for women reverting to the high technology birth. The medical hegemony over childbirth is not challenged. In addition, the midwives working in these programs have been trained to define birth according to medical criteria. They are operating within the medical establishment, paid by the medical establishment and therefore find it difficult to "stand firm" as advocates for the client to birth in her own way; such actions would "jeopardise her relationship with physicians, nurses and hospital administrators". In this way the control of the birth remains firmly in the hands of the medical practitioners. Some midwives have looked to private practice as a way of overcoming this problem of control over the birthing process.

(b) Private Practice

Some nurse-midwives and all lay midwives work as private practitioners, either attending births in the home or working in
birthing centres established and controlled by midwives. These midwives and their clients offer a serious challenge to the medical hegemony over childbirth. Homebirths and birthing centres provide a new set of social relations for both the nurse midwife and the client, the results of which are similar to the self-help programs of the women's health movement (although the similarity is greater in the birthing centres than in the home with its family emphasis). The process of self-help is based upon the movement for increasing women's knowledge about their bodies "thereby ... demystify[ing] medicine". Marieskind and Ehrenreich maintain that this process changes the social relations in health care production, which "necessarily implies a change in the relationship of people to technology". In orthodox medical practice the technology is owned and controlled by the physicians and their ancillary technicians, the patient is the "material to which the technology is applied", and the relationship of the patient to the technology is one of alienation.

In the self-help clinics, however, the patient is encouraged to understand the technology on the principle that only when the technology is no longer controlled by those in authority can the technology be critically judged and used by the recipient. According to Marieskind and Ehrenreich the self-help movement has been the "major focus of the women's movement in the last six years" and it has provoked "wide scale skepticism about the safety and efficacy of the technology applied to women's care".
If the principles of the women's self-help movement are applied to childbirth, their practical application is similar to that of the activities of the Women's Homebirth Movement. Rothman argues that homebirths or birthing centres are the only way for midwives to get "true professional autonomy" and for childbirth to be demedicalised. Nurse/midwives trained in the hospital settings find it a very radicalising experience to attend a homebirth. Here a nurse/midwife comes face to face with alternatives to the medical model and can reject at least part of that model. By sharing her experiences with other midwives, an alternate ideology becomes possible. As Rothman states,

> Without the institutional support that encourages the practitioner to think s(he) is in control, control may come to be seen as an illusion; the soundness of the medical model, so firmly based on the practitioners doing the birth, is shaken for that nurse/midwife. Eventually she may move away from the medical model completely.

The information and confidence gained by women through their participation in self-help groups has increased their ability to challenge medical authority. A number of campaigns have developed from involvement in self-help groups and their very existence has had effects on obstetrics practice. There are, however, a number of drawbacks associated with private practice.

The midwives in private practice ultimately work within the same constraints as those working in the public system, that is, in the end the doctors control their practice in several ways.
Firstly, as medical doctors define childbirth as inherently pathological and therefore requiring medical attention, midwives are either arrested or condemned for practicing medicine without a licence. Secondly, doctors control midwives support services. If complications arise during a birth, midwives are dependent on "backup" services controlled by doctors and when a client enters these services, then the client and the midwife must relinquish all control of the birthing process. Rothman likens the position of midwives today to that of midwives in the 1700s:

The technique that the barber surgeons of earlier times and the obstetricians of today have used to maintain power over midwives is to define the skills that they [the surgeons] monopolise as being essential for abnormal birth. The midwife is therefore dependent on the surgeon for backup services, which he holds the power to provide or deny. In this relationship, the midwife loses all autonomy in her work. The surgeon can define what is normal and abnormal, as well as control the training of midwives and the services they can provide.

Within the hospital setting, nurse/midwives are trained to define birth as pathological according to the obstetricians criteria. As long as this definition is accepted, midwives in America are limited to the status of machine minder and handmaiden to the obstetrician - the only person qualified to carry out medical practice. Midwives hold a similar position in Australia, unless they have opted out to attend homebirths. In Britain, recognition that midwives were heading in the same direction provided the impetus for the formation of the Radical Midwives.
Some protagonists for homebirth go so far as to argue that this training makes nurse/midwives an unsuitable attendant for a homebirth. According to this argument hospital trained nurse/midwives are likely to resort to the use of "medical" drug technology to restart contractions and regard a labour as high risk and transfer the woman concerned to hospital where labour reverts to the obstetrician's control. A lay midwife, in contrast, is argued to have a different approach. For example, if the contractions stop in the middle of labour, a lay midwife might look for reasons for this anomaly. The experience of midwives has shown that worry about an event unrelated to the birth can cause contractions to cease and, once a solution is found to the problem, the contractions will restart. At present, however, Mehl's study of homebirths indicates, contrary to the above argument, that lay midwives had the highest incidence of hospitalisation of clients when compared to other alternative attendants at homebirths, doctors and nurse/midwives. There are two possible factors in the present situation of midwives that explains the phenomena. One is the fear of legal prosecution if things go wrong. The other is the problem of access to simple birth technology, a problem lay midwives share with nurse/midwives.

Linda Bennett, Donna Walker and Kate Rowland, for example, were lay midwives arrested by armed officers in California. The appellate court ruled that because pregnancy was not a disease
but a normal physiological process, they could not be practicing medicine without a license. In August 1976 the State Supreme Court reconsidered the charges and ruled that they could be charged under the Medical Practice Act. However the charges were dropped and the case did not proceed. Ruzek argues that:

A conviction of the midwives would have reinforced health activists' belief that the male-dominated legal and medical professions collude to maintain vested class interests, power, and authority over women. An acquittal would have legitimated feminists' claim that childbirth is the appropriate province of women and would have been a clear victory for women's right to choose who will assist them in crucial life-events, typically presided over by medical men. Either outcome would have serious repercussions for established medicine.

The possibility of a reoccurrence of the above event or even more serious charge if anything happened to the mother or baby encourages the lay midwives to be over-cautious and therefore have a high rate of hospitalisation.

The higher rate of hospitalisation by midwives in comparison to doctors attending homebirths is also due to the difference in access to technology. Midwives are not permitted even the simplest technologies like the plasma drip for the most common risk in childbirth, haemorrhaging, or equipment for suturing a tear or episiotomy. Without these simple technologies, hospitalisation becomes a necessity for some women. To have access to the technology, the women and the midwife must
relinquish all control to medical authority, usually male authority. Only if the labour progresses without any problems can private practice ensure women's control of birth.

There are two additional ways that private practice is presently limited in its ability to change the control of childbirth. Firstly, the midwives have a lack of cohesion. Wertz and Wertz suggested that midwives' allegiance to their clients rather than each other led to their overthrow in the nineteenth century. This lack of solidarity and community was expressed by each homebirth midwife interviewed by Rothman. This situation may be overcome when midwives work in birth centres where there is a sense of integration into a community. Secondly, midwives attending homebirths or working in birthing centres drain away the force for change from the public sphere. The users of these services are often educated, middle-class women, women who might otherwise exert pressure on the medical establishment for change in obstetric practice.

Midwives in private practice are quite often catering to a middle-class clientele. For a working class woman the option for a homestyle birth in the private sector is not available financially. Some lay midwives, however, refuse remuneration for their services. They perceive their work as one of dedication, a luxury not available to working class or single mothers. Even if the midwife's services are free, however, other aspects of a
homebirth could remain unattractive to the poorer woman. In an environment of poverty and overcrowding, a hospital birth may supply the poorer woman with space and care. She does not have to cook or take care of the children; she can rest. Her loss of control over the birthing process in the hospital is a small problem compared to her general lack of control over her whole life and the comfort is enough recompense. The relationship between women's control and class differences will be discussed fully later in this thesis.

Any critique of present birthing practices that attempts to reinstate women's control over their own bodies, cannot avoid this wider context. "Homebirth" is not a purely "natural" form of birth. It involves the replacement of one institutional form (the hospital) by another (the home). The issue of women's control inevitably leads to a critique of the family as the site for homebirth!

In discussing the question of women's control and the form that it has taken in the various movements considered above, the issue of male dominance and control continually re-emerged. In the remainder of this chapter we shall review the different feminist approaches to this question as a basis for assessing their usefulness in understanding women's control of childbirth.
2 Feminist Theories

As mentioned briefly, by the 1970s three main theories could be distinguished in contemporary feminism; Liberal feminism, Classical Marxist feminism and Radical feminism. These categories are analytic and not exclusive. They are not designed to typecast authors but to illustrate themes and facilitate a study of the limitations of different approaches.

(a) Liberal Feminism

One of the basic tenets of liberalism is that the economic fate of every individual should be determined through their own efforts rather than by birth and heredity. An associated political program is to remove any social obstacles to selection and reward on the basis of achievement. Mary Wollstonecraft applied liberal philosophy to the woman question when she argued that since women had equal ability with men they should be granted equal rights. The liberal feminist position was recrystallised in the 1960s by writers like Betty Friedan and advanced by such organisations as the Equal Opportunities Commission in England and by the National Organisation of Women (NOW) in America. The movement demanded equal opportunity for women to enter the upper reaches of the job market and equal treatment when they get there. They launched a campaign for equal rights: equal rights in the eyes of the law, equal job
opportunity, equal pay, equal access to education, equal promotion and professional advancement, equal credit. They identified the attitude that women are inferior as ideological, supported and reinforced by a system of socialisation which trained children in sex specific roles. This socialisation would be combatted by pressure on the educational system, on publishers of children's books and on toy manufacturers. However, while they are critical of the education system, liberal feminists have tended to see education programs as their most effective weapon for change. It is argued that, armed with knowledge gained through education programs and published literature, women are able to make informed choices and exert consumer pressure on existing services.

According to Liberal feminist theorists, a most important area for reform and an area where inequality of the sexes is glaringly apparent, is the area of health care. The sex typing in health occupations and the sexist attitudes of obstetricians and gynaecologists indicate the necessity for more women to be admitted to medical schools, particularly in the above specialities. As Fee states,

Women physicians should be more capable of treating the health problems presented by women patients with respect, if only because the female body would be less alien and the female mind less mysterious. The overwhelming male bias of gynecology and psychiatry would be difficult to maintain if even half of their practitioners were female.
The assumption of Liberal feminists is that a campaign for equal "rights", which will give women access to all levels of authority within the existing system, will effectively redress the imbalance between the sexes and allow women equal control over all areas of their lives. In the area of childbirth, Liberal feminism offers women four strategies for changing existing practices. Firstly, in accordance with the free market philosophy, a pregnant woman would choose the male or female obstetrician who could supply the birth she desired. Secondly the woman would be armed with knowledge gained through education programs to make demands should any deviation from the desired birth practice occur. Thirdly, the types of births women choose would exert consumer pressure on existing services to change to meet women's needs. Finally, dangerous techniques or policies restricting a woman's choice, are fought at a government level.

At the level of the hospital, it is argued that reforms will automatically result from the inclusion of equal numbers of women in obstetrics. In addition, Liberal feminists fight for reform on a national level through government intervention. For example, Liberal feminists lobby agencies like the Federal Food and Drug Administration (FDA) for enquiries into birth technologies of dubious safety (Pitocin) and for the introduction of Bills in Congress changing hospital policies.

Yet in a number of ways, the Liberal feminist strategy for reform
can conflict with the interests of women from different race and class backgrounds. The option to choose the obstetrician whose practice most suits a woman's needs is not available to the poorer woman forced by economic circumstances to attend the hospital clinics. Unable to pay for private medicine, and living in areas short of alternatives, the poorer woman is forced to accept without question the high technology and medically controlled childbirth practices of the clinic, in fear of being refused access.

(b) Radical Feminism

According to Radical feminism, in order to change women's position in society, the family, the basis of the hierarchical sexual division of society, must be overthrown. Women, it is argued, constitute a class of their own, as the sexual division of labor and society is the most basic hierarchical division in our society. According to Robin Morgan, "sexism is the root of oppression, the one which, until and unless we uproot it, will continue to put forth the branches of racism, class hatred, ageism, competition, ecological disaster, and economic exploitation". 77

There are two strands to this form of feminism in its approach to childbirth: that expounded by Shulamith Firestone 78 which
identifies women's role in childbearing as the cause of her oppression, and the other strand Cultural feminism, a theory that argues that women's biology is better and different, and that childbirth is a way of getting close to feminine nature. Both strands explain women's position as a result of their biology, their strategies for change are however, significantly different.

Firestone argues that women will only be liberated when technology relieves women of that aspect of their biology that causes their oppression. She treats women's position in society as biologically determined and 'atemporal static condition'. Yet, as Eisenstein has pointed out, inequalities are due to changing social assessments of the biological difference. Sayers supports Eisenstein when she states that "Women's dependence on men changes as a result of changing modes of production and of the way biological sex differences are articulated with these modes of production". Defining patriarchy as a biological system rather than a political system with a specific history limits Firestone's strategy for analysing change particularly in the control of birth practices. Her solution to women's oppression rooted in childbirth lies in the "Technical Fix" of test-tube reproduction, and the avoidance of physiological birth. In this way, her universalistic biological explanation is marred by a crude technical solution to what is defined as biological phenomenon.
Yet, in the context of technological births, Hamner and Allen point out, reproductive engineering is now in the hands of males and male dominated governmental and other agencies which at present fund research in this field. Many feminists argue, as do Hamner and Allen, that "reproduction engineering offers a vehicle for total control of female reproduction" not technical liberation. Consequently, as the successes of the in vitro fertilization program have been publicised feminists are becoming increasingly concerned about this area of research.

Cultural feminism, on the other hand, asserts that women should seek "liberation through gaining a higher evaluation of their essential 'feminine' characteristics", such as the caring and nurturing aspects of motherhood. The goal of cultural feminists is that women will achieve equality through pursuing an essentially different role from men, one that is confined to the home while men's primary role is in the public sector. They maintain that women will develop spiritual power and liberation as a result of "getting in touch with their bodies".

The repossession by women of our bodies will bring far more essential change to human society than seizing the means of production by workers.

Cultural feminists propose that by changing women's experience of childbirth women's relationship to power and fear will be altered.
The concept of understanding our spiritual selves and remedying inequalities of power is represented in the homebirth movement by authors such as Suzanne Arms and Danae Brook. In her book *Naturebirth*, Brook states:

*I think female emancipation has to go further and mean more than political, sexual or financial freedom. It must embrace motherhood ... This new freedom has to come from female understanding of the female psyche and anatomy, because self-awareness does not split the two.*

The idealism of this approach is clearly apparent. The approach is based on the hope that a revaluation of femininity will change the concrete reality of women's lives. Yet, materially, the goal of achieving sexual equality on the basis of celebrating woman's essential difference and assigning men and women to different spheres of activity does not recognise the economic reality of society, particularly the economic inequalities widely prevalent between women and men and the increasingly large number of women in the workforce. Often the wage these women bring into the home is essential for the maintenance of their children. As Sayers argues, because of the way the economy has developed it is unrealistic for women to expect to achieve full equality with men by remaining confined to the home. This goal may have been viable in the past but industrialisation has progressively subordinated domestic labor to social production, such that women can now only hope to achieve full equality with men by participating equally with them in social production.
Ultimately, like the Firestone strand of Radical feminism, Cultural feminism is based on the concept that women's position in society is determined by her biology. Both strands agree that woman's role in reproduction accounts for her inferior status and view men as the main enemy of women's liberation. Radical feminism presents a theory of women's oppression based on biological determinism instead of an historical formulation which connects and interrelates the sexual stratification with the economic class system - an enterprise which is attempted in an inadequate form, by classical Marxist feminism.

(c) Classical Marxist Feminism

Marxist feminism adopts the argument presented by Engels in *The Origin of the Family* when he recognises that the original division of labor is the family. Engels argues that this division was a response to the twin aspects of biology and property. The fact that women bear children and therefore have a greater degree of certainty than men as to who are their biological offspring, directly affects the status of women in society. Marxist feminists argue, however, that this male/female relation alters with changes in the mode of production. Both Marx and Engels claimed that when women and men's physical differences are overcome through technological advance, women will be able to join the class struggle and thus gain equality.
However, the entry of women into the workforce has not created sexual equality. As Braverman's analysis indicates, while the trend is to equalise participation rates of men and women in the workforce, women are employed in the traditional sex-role types of occupations which are the lowest paid. When a woman enters the workforce, the work in the home becomes her second job - she works a double day. Domestic labour within the family so necessary to the reproduction of labor power for capitalism, remains unpaid, yet socially necessary and the arrangement serves the stabilisation of capitalism. Women are recruited into the labor force by capitalism at times of economic necessity (eg, wartime) and then pushed back into the family when economic downturn increases unemployment. As Fee comments

Capitalism, many Marxists argue, cannot free itself from dependence on sexism any more than it can transcend class oppression or the pursuit of private profit ... So a necessary condition of the complete liberation of women, Marxist-feminists would say, is the rejection of capitalism.

Marxist feminists conclude that sexism is nourished by capitalism and once this constant nourishment and support is removed, then women's liberation can be achieved. However, feminist critics of Classical Marxist feminism point out that the traditional unequal division of labor between sexes within the family continues to prevail in socialist countries. The continuation of sexism in socialist countries, feminists argue, is due to "women's specific situation within the family being relatively autonomous from the mode of production".
Classical Marxist feminism's approach to the new obstetrics is based on the concept of equal accessibility for all women to improved hospital-based services which will change to meet the needs of birthing women once the profit motive is overthrown. Further, it is assumed that a change in hospital based services will result from women gaining power in society due to her full participation in the workplace. However, as we have seen, women's position does not necessarily change with entry into the workforce and likewise the medical institution and birthing practices could remain unchanged particularly where there is no rhetorical base for a critical assessment of either the institution or its technology.

In the late 1970s some feminists became aware of the inadequacies of theories which dealt with only the economic class system (Classical Marxist feminism) or the sexual class system (Radical feminism), and attempted to devise a theory of power that integrated both sexual and economic forms of inequality.

In this section of the thesis we have shown the emergence of a critique of male dominance in the shaping and control of birth techniques and the activities of the Women's Health Movement. The traditional theories of Liberal feminism, Radical feminism and Classical Marxist feminism are however, unable to adequately address the issues involved. The next section of this thesis will therefore be concerned with further development of a theory of socialist feminism able to incorporate the activities of WHM and provide an adequate understanding of their role and potential.
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PART IV

TOWARDS A SOCIALIST FEMINIST THEORY

OF THE NEW OBSTETRICS
The debate surrounding the issue of birth technology has been restricted by two main factors. Firstly, the discussion of the technology has been constrained by crude high/low technology distinctions and secondly, the discussion of women's control has been restricted by the limitations of traditional feminist writings and the lack of any clear theoretical understanding of actions carried out by the women's health movement. In this chapter we will be addressing both the areas of technology and women's control from a different perspective. The issue of "appropriate" birth technology is examined in terms of the political shaping of technology and who controls and tests birth technology. The issue of women's control is addressed through the recognition of the importance of both sexual and capitalist power relations in determining the extent of women's control over birth technology. Both the issues of technology and women's control inevitably raise the issues of class and power. In conclusion we shall present an elaborated version of socialist feminism as the only theoretical structure capable of adequately addressing these issues.

1 INSTITUTIONAL DOMINANCE

The debate surrounding the issue of institutional dominance concentrates (as we have seen in Part II of this thesis) on the technology involved in birth practices in two institutions, the
hospital and the home. Historically, the move from home-based birth to hospital-based birth was concommitant with a move from low technology to high technology birth (Part I).

The majority of the protagonists for the hospital based birth are totally committed to the concept that the more technology developed in the area, the greater safety and efficiency of the birth process. They conceptualise technological development as progress. However there is a minority, who, although they support the use of technology, is critical of the overuse of technology and/or lack of adequate testing of the technology. This minority however, still see the solution to problems arising from the technology as having a 'technical fix' solution (Part II). This approach is most apparent in their response to studies which have revealed that socio-economic conditions effect birth outcome, for example, a recent statistical study carried out in Sydney's western suburbs.1 The hospital based birth protagonists universally respond to the evidence of social causes of birth difficulties (whether subscribing to a 'gung ho' approach to technology or technology with reservations) by advocating a technological solution. For example, although there is a direct correlation between a history of malnutrition and inadequate pelvic size, the solution - caesarian - is presented as a technological fix.

The home based birth protagonists respond to the evidence of
socio-economic conditions causing birth difficulties in two ways, both inadequate. Firstly, the home based birth supporters see these problems as arising from or being solved by individual choice or action. For example, a common problem in pregnancy, high blood pressure leading to edema is commonly caused by stress. The solution advised by the home birth protagonists is rest. Yet this solution is not available to pregnant women who are forced to work within the home or in the workforce to support their family. Where a woman cannot choose the social conditions of her pregnancy, resulting in a "high risk" pregnancy, the home based birth protagonists would resort to the hospital based system and a "technical fix" thereby ruling out of court issues of changing the pregnant woman's socio-economic conditions.

In direct contrast, if a healthy pregnancy occurs the home based birth protagonists have a simple technophobic explanation, this is due to "natural" childbirth, rather than "inhuman" high technology.

The resulting debate between high technology or "natural" low technology births inevitably concentrates on the issue of safety and efficiency of the two approaches. However, in one sense there is little difference in the outcome of either approach for neither participants in the debate address birth as a socio-cultural event or the implications of socio-political factors on birth practices. Similarly both participants define
the debate in terms of degrees of technological advance, as if technology is a neutral bystander in society rather than a manifestation of social and political relations.

2 MALE DOMINANCE

A more recent arrival to the debate is the argument for women's control over birth practices. This approach addresses the issues that childbirth is a socio-cultural event but does not expand the concept to include the technological context of birthing practices.

Part I of this thesis indicates that the male medical profession has dominated births for nearly a century. Yet, evidence indicates that the most successful birth outcomes result from two sets of factors: the presence of a midwife attendant and the high socio-economic background of the parents regardless of institutional setting (pp.61-3). The Women's Health Movement attempts to address these issues by increasing the role of midwife within the public and private sphere without adequately addressing the specific problems which arise from working in both these settings.

In the public sphere the effectiveness of midwives is severely limited by the strictures of the institutional setting. It is
only in private practice that midwives can achieve autonomy. However, in present conditions, the private sphere is largely accessible only to women of high socio-economic backgrounds and changes in childbirth practice becomes inaccessible to the lower socio-economic groups.

The Women's Health Movement has challenged the medical model, as a result of the experience of midwives in private practice, and provided a critique of birth technology itself. However, midwives have little power to control or change the technology in the public sphere where male dominance is institutionalised. The position of midwives at present remains the same as in the previous century when male control and high technology emerged to dominate the area of childbirth.

Without an adequate understanding of the socio-economic limitations on the effectiveness of "private" midwives and the institutional constraints on "public" midwives, the Women's Health Movement ultimately fails to address the issues of socio-economic change and is unable to advance much beyond the limited high/low technology interpretation of birth practices.

Similarly, traditional feminist theories have so far failed to provide an adequate theory capable of addressing these issues. Liberal feminism concentrates on women's control in isolation from an examination of the effect of different socio-economic
conditions on women. Classical Marxist Feminist theory ignores the problem of women's control altogether, concentrating on providing equal services to all socio-economic groups, without recognising the structural difference in power and conditions between the sexes within these groups. Radical feminists adopt a technocratic or technophobic position ignoring the role of male dominance in shaping the nature and use of birth technology. In contrast to these theories a Socialist feminist theory is required to provide an interpretation of birth practices capable of incorporating both an understanding of the shaping and control of technology and the structural source of male dominance.

3 SOCIALIST FEMINIST THEORY

(a) Patriarchial Control / Class Antagonism

As we have seen traditional critiques of high/low technology and male dominance in birthing practice are inadequate; a new theory is required that incorporates our understanding of both a social shaping of technology and the complex structures of male control. In the remainder of this thesis, this will be addressed by outlining the character of a modified socialist feminist theory capable of addressing these issues.

Socialist feminism is a synthesis of theories of class and gender
and could provide a framework for analysing both the socio-economic and the male dominance factors in the obstetric debate.

Socialist feminist theory grew out of the recognition that class as well as sex was responsible for women's position in society. It led to a synthesis of radical feminism and classical Marxism, interrelated through the sexual division of labour. According to Eisenstein

For socialist feminists, historical materialism is not defined in terms of the relations of production without its connection to the relations that arise from women's sexuality - relations of reproduction.²

This involves the recognition that capitalist patriarchy is the source of women's oppression which in turn suggests that socialist feminism is the answer to women's oppression. So socialist feminism analyses power both in terms of its class origins and its patriarchal roots.

According to Socialist Feminist theory, Classical Marxists erroneously define exploitation and oppression as equivalent concepts whereas they assert that exploitation is what happens to men and women workers in the labour force whereas women's oppression occurs from her exploitation as a wage labourer but also occurs from the relations that define her existence in the patriarchal sexual hierarchy - as mother, domestic labourer, and consumer.³

Patriarchy was present before capitalism but in the mid-eighteenth century in Britain and the mid-nineteenth century in
America, the relationship between patriarchy and the new industrial capitalism developed. This mutual dependence of capitalism and patriarchy is called capitalist patriarchy, which by definition breaks through the dichotomies of class and sex, private and public spheres, domestic and wage labor, family and economy, personal and political, and ideology and material conditions.

Socialist feminist theory maintains that women's oppression is not defined by her biology but by the way men, within a capitalist context, have chosen to interpret and politically use the fact that women are the reproducers of humanity.

Capitalism and patriarchy are integral processes as

patriarchy provides the sexual hierarchial ordering of society for political control and as a political system cannot be reduced to its economic structure; while capitalism as an economic class system, driven by the pursuit of profit, feeds off the patriarchal ordering.

Patriarchy and capitalism are not always in perfect harmony and tensions and contradictions exist in society. For example, as increasing numbers of women enter the workforce, the control of patriarchal familial relations are undermined but the ghettoization of women in the workforce maintains the sexual hierarchy in society. It could be argued that this loss of control in patriarchal familial relations is redressed by the increased patriarchal control in the area of reproduction.
Rosalind Petchesky maintains that the dynamic interrelationships "between public and private, and production and reproduction, are surfacing in a concrete and historically precise way". She identifies the relationship between control over the institutional and technological means of reproduction (specifically childbirth and sexuality) and male power as a critical relationship. By this she refers to socialist feminist's growing understanding of the fact that control over the material conditions and techniques of childbirth is an important instrument of patriarchal and capitalist domination and therefore an important part of the socialist feminist struggle.

(i) Class Antagonism

Only a theory which incorporates an analysis of capitalism and its relation to birth practices, particularly medical dominance and its technological orientation, can address the social issues which are essential feature of birthing practices and technologies.

For example, as we have seen, socio-economic conditions have a significant effect on perinatal mortality rates. Kitzinger suggests that "the challenge to prevent preterm births and underweight babies is a matter for wider social changes". Severe malnutrition in pregnant women in the 1930s was responsible for the universally high death rate in the offspring
of their daughters. At present in Britain areas of high unemployment have high perinatal mortality rates.

Another social factor is the reproductive hazards of the workplace. This is an area of investigation that has only recently emerged as groups like "Women and Work Hazards Group" have become established.

Finally, the wider phenomenon of medical dominance and the dominance of capital accumulation direct "medical" attention towards "a technological drug and profit orientated solution" to birthing problems.

(ii) Patriarchial Capitalism

The development of birthing practices is an indispensable feature of the political economy of the welfare state within patriarchial capitalism.

In the latter part of the nineteenth century the area of childbirth ceased to be controlled by women and became controlled by predominantly middle-class male doctors. The changing pattern of control over childbirth (Part I) occurred at the same time as the interrelationship between capitalism and patriarchy was developing. This involved links between (1) the position of doctor in the sexual division of labour within the hospital and
the manager in the division of labour within the factory and (2) the patriarchal control of childbirth and capitalist interest in the reproduction of labour power.

Willis maintains that doctors' control of health care and obstetrics as part of health care, occurred in part because of their suitable class links, and places the subordination of midwifery in the context of historical "struggle between male and female workers in which the better organised male craft unions succeeded in overriding the interests of women workers".15

During the nineteenth and twentieth centuries in most capitalist countries, the state has taken over responsibility for the collective reproduction of labour power by providing education, social security and medical care. Gough maintains that there are two important factors in explaining the growth of the welfare state, firstly the degree of class conflict and especially, the strength and form of the working class struggle, and secondly, the ability of the capitalist state to formulate and implement policies to secure the long term reproduction of capitalist social relations.16

As he argues, for capitalist societies to continue there must be a mechanism for not only the renewal of the means of production but the renewal of the general conditions of a capitalist society. The forces of production are not only the material
conditions of raw materials, machines, etc., but the labour power of workers which must not only be physically regenerated but must continue to work within a "certain set of economic and social relationships". The reproduction of labour power involves three factors; firstly the fitness of workers, secondly, the reproduction of the next generation of workers and thirdly, the reproduction at an ideological level which involves the legitimisation or justification of the existing mode of social and economic organisation. The increasing role of the state in this area is a crucial part in the rise of the capitalist "Welfare State".

(b) **THE SOCIALIST FEMINIST ALTERNATIVE**

The Socialist Feminist alternative extends socialist feminist critiques of patriarchy and class antagonism into the area of technology by drawing upon contemporary theories of technological change and control to explain the role of birth technology.

(a) **Technology**

The Women's Health Movement is recognised by Socialist Feminists as the first step of political action\textsuperscript{18} \textsuperscript{19} as "women try to take control over their lives"\textsuperscript{20} and it was the first step towards
recognising the role of technology as an important area of discussion. Marieskind and Ehrenreich see the Women's Health Movement as part of a larger struggle towards a socialist medicine.\textsuperscript{21} The movement began with consciousness raising and self-help groups when feminists realised that so many aspects of their lives had been medicalised.

(t)he feminist interest in health and body issues represents a strategy to subvert the ideology of sexism at its base: in the social interpretation of biological sex differences.\textsuperscript{21}

This led to the establishment of self-help clinics with non-hierarchial structures, staffed by women who encourage women attending clinics to know and control their own bodies. The resultant change in social relations has led to a critical look at the technology involved in women's health. Marieskind and Ehrenreich turn to Braverman for direction in understanding the technology:

The technology, the 'science' of management was determined by the imperatives of class domination.\textsuperscript{23}

Yet, a socialist feminist analysis needs to go further than class domination and include an analysis of power relations of both sex and class. Game and Pringle when discussion the sexual division of labour in the workplace, link "machines and computers to masculine power and sexuality" and furthermore they argue that this link will uncover the "social processes which create the new technology and give it its particular social meaning".\textsuperscript{24}
Socialist feminist theorist Zillah Eisenstein, in rejecting Firestone's theory of reproduction technology as women's liberator, describes technology as an "intrinsic dimension of society's power structure" and maintains that "male ruling class needs define technological development".25

Shelley Day provides the most comprehensive analysis of birth technology from a socialist feminist perspective in her paper "Is Obstetric Technology Depressing?".26 She bases her analysis on Marx's essential insights into the constitution of technology.

In the Marxist View, technology is intrinsically contradictory, since it embodies at many levels the fundamental class antagonisms of capitalist society, and obstetric technology in particular further embodies the antagonisms in the relations between the sexes.27

However, Day makes the mistake of making obstetric technology a special case where the relations between the sexes are involved rather than understanding that relations between the sexes are an intrinsic part of all technology as are class antagonisms.

Socialist Feminist theory has been developed over the last ten years yet has not developed a sophisticated analysis of technology. The theories that have emerged in the last twenty years refuting the myth of the neutrality of technology28 provide a basis for working towards a socialist feminist theory of technology. As mentioned above, one of the earlier theorists of the politics of technology is David Dickson.29 He studies the
power relations in a capitalist society and the role of technology in this society. He proposes two factors which are central to the role of technology and play a part in determining the nature of technology itself.

The first is the material factor which Dickson describes as sustaining and promoting "the interests of the dominant social group of the society within which it is developed". The other is the ideological factor which acts in a more symbolic way in supporting and propagating the legitimating ideology of the society within which the technology is placed. However this is not a one-way system, as Dickson points out:

\[\text{technology and social patterns reinforce each other in both a material and ideological fashion.}\]

Like the Socialist Feminist theory, Dickson sees the importance of both material conditions and ideology in power relations in a capitalist society.

Dickson's thesis is that

\[\text{One can only understand the nature of technology developed in any society by relating it to patterns of production, consumption and general social activity that maintains the interests of the politically dominant section of that society.}\]

Within capitalism Dickson contends that the interests of the dominant section of society are maintained by hierarchial patterns of social organisation, accompanying authoritarian forms of social control and a predominantly functional attitude to nature.
Dickson's theory has two serious limitations. The first is that his theory is limited to examining power relations in a capitalist society and does not discuss the "mutually reinforcing dialectical relationship between capitalist class structure and hierarchical sexual structure". Dickson's critique is rooted in the bourgeoisie/proletarian distinction ignoring the critique of power rooted in the male/female distinction, which focusses on patriarchy. The second limitation of Dickson's theory is his failure to detail the structural origins of the elite dominant class he describes and in determining the direction of technological development. Furthermore, according to Dickson, the solution to problems of technology requires a change in the political and social structure, however, without locating the power of the dominant class within an adequate framework, how this change will occur is unclear.

Both these limitations can be addressed. The first by extending Dickson's theory to include an analysis of power integrating the capitalist class structure with the sexual hierarchical structure and the resulting patriarchial system of social control. The second by modifying Dickson's theory from a politically determinist approach to a theory that views the technology as incorporating the tensions and contradictions of the power relations in patriarchal capitalist society. According to Socialist economists changing social relations in the workplace cannot be simply accounted for by the technological innovation
demanded by the capitalist profit motive but these changes must be seen as the outcome of the continuous tensions between workers and capitalists. However Phillips and Taylor extend this argument to include "tensions between the workers themselves, particularly between men and women workers". This approach is consistent with a socialist feminist view of technology as the embodiment of the conflicting forces that have led to the growth of the welfare state in patriarchal capitalist societies. Technology as social relations must be located in the structure of both capital and patriarchy in the problematic task of production and reproduction.

As illustrated in the following areas, it is only this socialist feminist perspective that can fully explain the historical and contemporary evolution of birth practices.

(b) Birth Technology

Both the social relations of production and reproduction are embodied in birth technology. The erosion of power of midwives vis a vis the predominantly male medical profession result from the social relations of production at work and the technology developed in the downgrading of the profession is a reification of these relations. It is not only in obstetric practice that technology is defined as requiring male "skills". Cynthia Cockburn in her case study of the printing industry argues that
The appropriation of muscle, capability, tools and machinery by men is an important source of women's subordination, indeed it is a part of the process by which females are constituted as women.36

In the sphere of reproduction, the power of the medical practitioner is hidden in the resultant technology yet continually increases the doctor's power with respect to the patients and the other medical personnel. For example, many obstetric technologies like the oxytocin drips and fetal heart monitors require the mother to remain still in a supine position allowing doctors complete control over the birthing process although evidence shows that birthing women are assisted when able to move around and assume different positions. Moreover, even if midwives wished to use these technologies, they are prevented from using them. If it is felt that they are required then, the doctor must be allowed to take over the birthing process. Similarly, technological devices introduced to address the problem of perinatal mortality rate although not effective in their stated aim, increase control over reproducing mothers. The continued development of this technology encourages a form of reproductive engineering by which capitalist patriarchy gains ever-increasing control over social relations of reproduction.

In the case of high perinatal mortality rates, the real causes, social class and economic conditions, are often ignored and the rates defined as technical problems; and the resulting
technological solution only furthers the control by patriarchal capitalism over reproduction. For example, if ante-natal technology indicates problems for the fetus or mother then the pregnancy is terminated or further technological interferences introduced rather than addressing the social causes. Thus the woman's control over her pregnancy is transferred to the technology and the doctor controlling the technology.

In this way, under the banner of technological progress, present obstetric technology incorporates the social relations of patriarchal capitalism, in the interests of sex and class domination.

CONCLUSION

In conclusion, we have described the historical evolution of birthing practices and the various interpretations of this process by contemporary proponents and opponents of high technology birth. As we have shown, the traditional terms in which this debate has been carried out provide an inadequate understanding of both the nature of technology and its institutional context. Moreover the interpretations of male dominance provided by traditional feminist theories have not been able to resolve these theoretical weaknesses. In this context, all we have been able to do in this thesis is to reveal some of
the social, economic and political forces responsible for shaping and controlling birth technology and detail the nature of a modified socialist feminist theory capable of understanding and explaining these forces. A full interpretation of the nature and role of birth technology from a socialist feminist perspective remains to be written. If this thesis has succeeded in showing the need for such treatment of this topic, it will have succeeded in its task.
NOTES


3 Ibid., p.22.

4 Ibid., p.23.

5 loc. cit.

6 loc. cit.


9 Ibid, p.52.


11 Ibid., p.22.

12 Ibid., pp.22-23.

13 Ibid., p.154.


17 loc. cit.

20 Loc.cit
21 Marieskind, H. and Ehrenreich, B., op.cit. (note 17).
22 Ibid., p.38.
23 Ibid., p.41.
27 Ibid., p.25.
29 Dickson, David, Alternative Technology, Fontana/Collins, Great Britain, 1974, p.11.
30 Ibid., p.10.
31 Loc.cit
32 Ibid., p.10-11.


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