DELIVERY: GENDER AND THE LANGUAGE OF BIRTH

Terri A. Winnick

> The man had relations with his wife Eve, and she conceived and bore Cain, saying, "I have produced a man with the help of the Lord."
>
> Genesis 4: 1,2.

> Without assistance from doctors or mid-wives, Rosenberger delivered his son Caleb into the world at 9 pounds, 2 ounces . . . "I like doing it at home," Rosenberger said. "To watch and be the one that does it."
>
> Anderson Independent-Mail: December 31, 1986

Since Eve, language granting women ownership of childbirth has slowly eroded. In our American culture, as in other industrialized societies, words such as "bear" or "give birth to" are falling out of usage, and we now speak of birth as "delivery." In this paper, I argue that this new language accomplishes linguistically the biologically impossible: birth becomes an increasingly *masculinized* activity. It positions the childbearing woman in the passive role and assigns agency to the attendant, who, as often as not in the United States, is likely to be male. In the language used in the second snippet shown above, taken from a newspaper article bearing the title, "Son's Birth Marks Third Time Man Has Delivered His Own Child," the woman is more than passive – she is referentially absent from the entire activity. Her input seems not important enough to even be noted by the journalist. The text of the article in its entirety primarily focuses on John Rosenberger, what he does for a living, his philosophy toward home birth, and his skill in bringing life into the world. Is this way of thinking about John Rosenberger, this captivation with his essentially peripheral participation in his wife's birth experience, an

Gender Perspectives on Reproduction and Sexuality
Advances in Gender Research, Volume 8, 51–85

ISSN: 1529-2126/doi:10.1016/S1529-2126(04)08003-8

anomaly? I think not, for a closer examination shows that even Mrs. Rosenberger, who couches all references to herself in terms of "we," also defers to her husband as the active participant in the undertaking (Giddens, 1986).

In this paper, I develop a theoretical model that argues that the medical model of childbirth now has a masculine orientation which is the logical result of the appropriation and transformation of childbirth by men. Further, as birth became male-dominated and male-controlled, it also became a male-*centered* undertaking. As a result, even now as women increasingly join the ranks of obstetricians, they enter what has been for several generations an essentially male preserve, one in which the attendant to the event, be it doctor, husband, or taxi-driver, whether attending in fact or just happening to be there, is assumed to be the active participant – the "deliverer." The forces which allowed men to claim, through the portal of obstetrics, what is perceived as the important, conspicuous, *necessary* role in birth include hegemonic control of the systems of politics and power in our society, and through that mechanism, control of systems of cultural influence, most specifically, language.

THE NEW LANGUAGE OF BIRTH

Language is a fundamental and yet extraordinarily powerful medium. Language is more than the primary feature distinguishing humans from other species. As our principle means of communication, language links us to culture, and in so doing, shapes our perceptions and determines the way in which we think (Clark, Eschholz & Rosa, 1981; Thorne, Kramarae & Henley, 1983). Language is inseparable from social life. Through language, individuals learn cultural patterns and political and social values (Mueller, 1973). Language also reflects the prejudices of society, with assumptions about relative status, power or appropriate behavior often built into the words we use to talk about different groups of people. As Frank and Anshen (1983) note, ageism, racism, and most importantly for this discussion, sexism, are all perpetuated by our language, even among those who consciously reject those prejudices.

If the "dividedness of our minds is etched into our language" (Griffen, 1989, p. 7), it may be because the language that we use causes us to be divided in our minds. For example, a careful examination of the words used in the two excerpts shown above demonstrates how we have over time increasingly become divided in our minds in the way in which we view woman's participation in the childbearing process. Early writings, such as the passage from *Genesis* in which Eve boasts, "I have produced a man with the help of the Lord," is typical of biblical passages using language that depicts the birthing woman as playing an

autonomous, active role in the process of birth. Eve "bore" Cain; she was not "delivered of" Cain.

Woman's role in maternity as recorded in scripture and other early literature was inherently active. Women are described as *bearing, giving birth*, and *bringing forth children*, ironically despite strongly patriarchal cultures where childbirth was viewed as a service performed for men.[1] In both the Old and New Testaments, other women, called midwives (a word which literally means "with" women), stood by to offer comfort and support to the laboring woman, but their service was not described as "delivering" children, nor was it common for the process of birth to be intruded upon. It is noteworthy that even the dragon in the *Book of Revelation* did not interfere with childbirth, despite its otherwise pernicious intent. With unseemly patience, "the dragon stood before the woman about to give birth, ready to devour her child when it should be born."[2] Words like "deliver," which had no place in scriptural references to reproduction, have only recently developed meanings in regard to childbirth. These new meanings derive from a context of intrusion. Only late in the second millennium, when men became the primary managers of childbirth and technological advances made possible active intervention in the birth process, did new language develop to describe that activity. This new language has become the common language of birth.

"To give birth," to be sure, can still being used interchangeably with the term "to deliver," for subject-active verbs such as "bear" and "give birth" have not fallen completely out of use. However, terms such as "deliver" and "delivery," which position the childbearing woman in the passive or objective role, have become more familiar. Perhaps the new language is replacing the old because the new language more accurately reflects the activity described. As the childbearing role becomes more passive in act or deed, the passive form of the words gain greater currency until *the passive deed now is understood as an active experience*, for passivity has become the way in which, for many subjects, the activity is now enacted. Agency in this convoluted manner then is essentially passive. If, in time, the incongruous subject-object inversion should right itself, the notion of agency may fall out of the understanding of the process altogether.

The word "deliver" likewise is caught up in the process of redefinition vis-à-vis birth. We still say that a woman delivers the child, but it is also acceptable to say that her attendant at the same time and in the same situation *also* delivers the child. The term "deliver" has become so corrupt that it carries little or no reference to the woman's active role in the birth process. In cursory searches of the word "deliver" in a variety of books and articles on childbirth, I was able to locate only one example in which the woman referentially plays an active role – a derogatory reference to the alleged brutishness of a certain ethnic group about whom the "opinion is not uncommon that a mother should be able to practically deliver herself" (quoted in

Shorter, 1982, p. 143). Is it possible that our culture has grown so comfortable with the image of the woman in a passive role that the notion of a woman "performing her own delivery" now seems absurd? Or *unfeminine*? Ann Oakley (1993, p. 24) observes, "Women's imputed need for medical care and control is demanded by the very premise of obstetrical science – women can only be 'delivered of' their babies: childbirth cannot be allowed to be an autonomous act."

Similarly, in the new language of birth, "delivery" has two distinct meanings. The first refers to the attendant's active role. Delivery in this instance is the act on the part of the attendant of relieving the woman of her child. Thus, we say, "The legal requirement that a doctor [be] present to *'do' a delivery* implies that bad and dangerous things can happen without him and with him (emphasis added)" (Shaw, 1974, p. 81). The other use refers to the process of birth in an object sense: "She was nonetheless satisfied with her forceps delivery because she believed that her baby would have died without this intervention" (Klee, 1986, p. 13).

If other language for birth were to fall away and only *deliver* and *delivery* remain – which may be the way our language is evolving – we would have no other way of describing, or even thinking about, the experience of birth other than as something that exists outside of a woman – an act, done not *by* a woman, but *to* her or *for* her instead.

The word "deliver" masculinizes birth in and of itself by definition and through its connotations. "To deliver" is a verb literally meaning "to free," according to the *Oxford English Dictionary*. The image of one who "delivers" or frees, without too much of a stretch of the imagination, is the image of savior, a term that can continue on a steady trajectory of meaning from a messiah to a superhero who flies in just in time to save the day. All are distinctly male representations in our culture, coincidentally quite compatible with the image that has developed around the role of the obstetrician, the "hero who rescued mothers and infants from almost certain death" (Donegan, 1978, p. 166; see also Shorter, 1982). So comfortable is society with this depiction that it is common to routinely ask following a birth occurring outside of a hospital setting (where a physician's attendance is taken for granted), "Who delivered the baby?" overlooking completely what should be fairly obvious, that the woman herself did.

THE LANGUAGE OF MIDWIFERY

Those not part of or else strongly opposed to the medical model of childbirth have developed yet another way of speaking about birth. Notable among them are midwives, especially those who serve home birth enthusiasts. In their practice, they shun "delivery" in favor of expressions such as "be there for her birth," "attend a

birth," or even "catch the baby." In this paper, I will detail how their social history and ongoing constraints have helped shape their philosophy, choice of words, and the way they practice. Since many midwives politically endorse women's right to an active, assertive role in birth (Howell-White, 1999; O'Connor, 1993; Sacks & Donnenfeld, 1984), they intuitively understand that in order for the childbearing woman to be the active participant, the attendant must be yielding. They have a keener awareness of the connotations in the word "deliver," and as a result tend to carefully monitor their language so as to stress the autonomy of the childbearing woman and the merely supportive role of the attendant. The typical midwifery philosophy is deferential: "The midwife is a servant, not a goddess. She's there to serve . . . and to bring her skills and knowledge, but beyond that, it's not her business. The birth belongs to the parents" (Oakley & Houd, 1990, p. 4).

Midwives, whether certified nurse-midwives who tend to practice in hospitals, or direct entry (or "lay" midwives) who often assist women in planned home births, currently serve only a minuscule fraction of the American population (McClain, 1987; Sullivan & Weitz, 1984). Yet prior to the nineteenth century, midwives were the typical birth attendants both in this country and abroad. In other countries as industrialized as the United States, such as Russia and all of Europe, sufficient social, economic and political support for midwives exists, and they continue to manage most routine births, both in and out of hospitals (Rooks, 1997). Only in the U.S. does the hospital-based, physician-controlled medical model prevail, and this has led to a dramatic decline in midwife-managed births in this country. The decline began with the ascendancy of male-dominated obstetrics which began early in the nineteenth century and continued throughout, so that by 1900 midwives were only attending about half the nation's births, and by the early part of the twentieth century, only a small fraction (Dye, 1980; Litoff, 1978). Midwifery's nadir occurred in the 1970s when midwives served fewer than 1% of all childbearing women, and, despite a recent move toward professionalization and increased public exposure, today only assist in fewer than 10% of all births in the U.S. (Rooks, 1997). From a feminist point of view, this is a misfortune since the midwife greatly contributes to woman's autonomy in reproduction. Rothman (1989, p. 70), referring to midwifery as form of feminist "praxis," a Marxist term for activism, asserts:

> Midwifery works with the labor of women to transform, to create, the birth experience to meet the needs of women. It is a social, political activity, dialectically linking biology and society, the physical and social experiences of motherhood . . . it is an ideological and political stance.

Midwives "respect the natural birth-giving abilities of women's bodies" (Rooks, 1997, p. 128), and in so doing, empower women. But more than that, they keep in circulation a unique language used to describe birth, a language which I will

argue shapes both practice *and* praxis and reinforces the feminist ideological and political stance.

By deliberately choosing terms that self-consciously position childbearing women in the subject-active role, the midwife may inadvertently be the last protector of the concept that birth is a feminine activity *accomplished* by women. By her deferential use of the term "assists," or "helps," or the more colloquial "catches the baby" in reference to her own role, the midwife using this language grants to the laboring woman *active* participation in the birth process (Oakley & Houd, 1990; Peterson, 1983; Rooks, 1997). An apt illustration is provided by Beth Rushing (1993, p. 58) who interviewed a lay midwife who claimed she tells her clients: "I'm not going to deliver your baby, *you're* the one who delivers. I'll be there to help you, but you are going to do the work."

This deliberate avoidance of the word "deliver" in reference to their own actions reflects the midwives' philosophy which combines the feminist principles of shared empowerment and solidarity with other women (Rooks, 1997; Rothman, 1989). Often an aspiring midwives' interest in and pursuit of this occupation begins with their own feeling of enlightenment after experiencing a midwife-assisted home birth (Rooks, 1997; Rushing, 1993). They grow conscious of the need to deprogram other pregnant women away from passive acquiescence in matters surrounding maternity that have been built up in the last century or so by generations of women who have followed daughter after mother in the male-dominated, medicalized model of childbirth that is so typical of American style birth (Davis-Floyd, 1992; Mitford, 1992). As one of the midwives interviewed remarked: "With home birth, it's not 'Here's my body, take care of it for me.' They have to do it" (Peterson, 1983, p. 275).

The legal system which grants hegemony in matters of maternity to obstetricians, general practitioners, and other licensed members of the medical profession may also play a role in the development of the midwives' more deferential language. Legal injunctions have restricted the practices of licensed midwives solely to non-interventionist techniques, and have caused lay midwives, because they are at risk for being charged with practicing medicine without a license, to work underground in most states (Kitzinger, 2000; Mitford, 1992; Weitz & Sullivan, 1984). While midwives often ask parents to share the risks (Peterson, 1983), emergencies can expose them to public scrutiny and sanctions. For example, stillbirth and neonatal deaths in a hospital setting are often dismissed with the assumption that everything that can be done had been done. Civil malpractice cases may be filed, but rarely are criminal charges brought in these cases (Corea, 1985; Oakley, 1993). But woe to the non-licensed midwife who assists a woman who loses a child. In 1988, Bloomington, Indiana lay midwife Vickie Smith was charged with manslaughter following her involvement in a home birth that resulted in a neonatal death (Whyde,

1988). Even taking emergency life saving measures may be criminal. Millersburg, Ohio midwife Frieda Miller who gave a drug to stop hemorrhaging was charged with practicing medicine without a license, an offense punishable by imprisonment (AP, 2002). Thus, deliberate avoidance of the active term "deliver," in favor of more non-commital expressions such as "be there for" or "help" may be a self-protective device on the part of these women. Indeed, fear of legal culpability may pose a powerful constraint on speech.

The contrast in language reference and use is striking between those who practice autonomously and those who do not. As the previous discussion has pointed out, a midwife's tone is generally deferential, but in the following sections I will outline how the language of obstetrics has become strikingly operative (i.e. "I'll deliver her now" (in Shaw, 1974, p. 136)) as it became dominated and controlled by male attendants. Indeed, in her intensive investigation of a maternity center in the late 1960s, Shaw describes the customary demeanor of the obstetrician, a role then almost exclusively occupied by males. Empowered by legitimacy, social status and privilege, the attitude of the obstetrician toward the birth process during that period of medical hegemony appears just short of pomposity. From her field notes she writes: "The doctor is the star delivering a baby from a woman. Instead of the doctor assisting the woman with the birth, she *may*, if he allows, assist him" (p. 82).

Arrogance can easily arise in an arena in which power is reinforced by structural arrangements which give physicians not only a legal monopoly on all medical care (Friedson, 1970, 1994), but that also allow them to work in an hierarchical institution where they make all decisions because "the doctor *does the delivery* (emphasis added) and therefore has the right to decide *how* it will be done" (Shaw, 1974, p. 85). Indeed, some scholars (Dye, 1980; Leavitt, 1986) point out that whatever measure of autonomy women managed to retain in childbearing before hospitalization became the preferred birthplace was sacrificed with the wholesale transfer of parturition to the hospital. This loss of autonomy is expressed in the language of birth:

> The active role taken by the doctor and the passive role imposed on the woman made it appear that it was men, not women, who delivered babies; that women could not deliver babies without men; that it was terribly irresponsible, even a form of child abuse, to attempt to do so. The propaganda on these points has been so thorough in recent decades that most people believe it and would be afraid to have a baby outside the male-controlled hospital" (Corea, 1985, p. 306).

In short, structural arrangements and language mutually reinforce the acceptance of the attendant as the active and *necessary* participant in the undertaking.

In the historical analysis which follows, I will show how language, ironically, played as much a part in the early rejection of the male in the role of childbirth

attendant as it does today in his acceptance. "Man-midwife," the first term to describe males in the occupation, displays the dissonance with the gendered connotations that surround the word midwife which, in reference to a female, still requires no modifier. As the new term "obstetrician" replaced the term "man-midwife" in industrialized societies, it too has, for the most part, picked up gendered connotations, and often carries a modifier (i.e. female or woman obstetrician) to differentiate a woman in the role (Donegan, 1978).

Gender role reversals have occurred in a number of occupational roles. Secretaries, school teachers, bank tellers and tailors were once male-dominated occupations, and as women appropriated them, there was a corresponding decrease in status. Conversely, when males enter a female-dominated field, such as nursing, they usually enhance the status of the occupation. The rise of man-midwifery, and its transformation into the science of modern obstetrics, represents what may be arguably the most important, socially defined gender role reversal ever to occur. The appropriation of midwifery by men reversed more than the gender of the occupation and its status – *it also inverted the balance of power between service providers and clients*. What is especially intriguing is that it occurred in the context of the sole biological difference that exists between males and females – a once inviolate, sacred realm, worshiped as a source of women's strength and power.

How did it come to happen that this unique sphere of femininity was usurped, and whom did this usurpation benefit most? Before answering these questions, we must first digress and examine the social contexts, both historical and contemporary, surrounding childbirth. In the sections that follow, I will show how this extreme role reversal developed and offer two explanations for why it occurred. First, the political and structural circumstances were favorable to, and supportive of, the appropriation of midwifery by men. Of no small import was the identification of medicine with science and rationality, nor could the control of institutions of power and influence be ignored. Second, the appropriation was successful because the activity, when performed by males, incorporated a *method* of action and a context of *meaning* that completely identified and defined the activity in male terms. By this I mean, in general, that male participation in *any* otherwise feminine activity not only changes the way the activity is performed, it also changes cultural views of how that activity *should* be performed. As Key (1975, p. 15) succinctly points out, the idea that "man does, woman is" is built into our language through our cultural beliefs regarding gender role expectations which "correlate with language structures and control the syntax of language as they control the behavior of a people" (Key, 1975, p. 19). Language "aids construction of the male supremacist society," including male dominion in birth, because it shapes our perceptions and behaviors in subtle but extremely pervasive ways

(Thorne, Kramarae & Henley, 1983, p. 8). Thus, shifting structural arrangements surrounding birth led to changes in language describing birth. Structure and language mutually reinforced orientation toward the medical model and acceptance of that orientation in culture.

FROM MIDWIFERY TO OBSTETRICS

The marked differences in orientation between obstetricians and midwives, the philosophies that "midwives care for women, and obstetricians control and master childbirth" (Oakley, 1993, p. 72) developed as a result of how each group came to view and practice their roles. Midwifery, now somewhat of a quaint term to the American ear, is perhaps one of the world's oldest occupations, whereas obstetrics as a profession developed only within the last two centuries. Obstetricians developed a view of birth as a medical *problem*, a potentially high risk event, while midwives clung to the belief that birth was a natural phenomenon best managed through "watchful waiting" (Rooks, 1997). It is difficult to sufficiently grasp the marked discrepancies in orientation, ideology and language use typical of each group and its relation to the gender of the participants without first examining at some length the historical circumstances and opportunity structures in which these similar, yet discrepant, roles developed.

As the biblical references to birth attest, from earliest known history, childbirth once was woman's exclusive sphere. Especially in the period before the male contribution to reproduction was completely understood, males, as outsiders, for the most part were barred from participation in this activity (Arms, 1975; Donegan, 1978; Dye, 1980; Leavitt, 1986; Wertz & Wertz, 1989). Midwives, but also female family members and friends, assisted other women in childbirth (Arms, 1975; Kitzinger, 2000; Wertz & Wertz, 1989). Goddesses representing female fertility were the first known deities, and a certain sacredness and mystery surrounded birth (Kitzinger, 2000). Not surprisingly, womb envy and male concern over paternity emerged during this ancient period, sometimes becoming a major obsession, spawning at different periods of history curious practices, phallocentric theories, and repressive laws designed to control women's sexual behavior.

In some less technologically advanced cultures, anthropologists have identified a widespread male-simulated labor and delivery charade known as *couvade*. Kitzinger (2000, p. 44) reports that typically the expectant father enacts the birth himself, dramatizing the sufferings "with a great deal of noise and fuss." It is he who receives the special attention and consideration, while the mother of his child gives birth alone and unattended. Kitzinger points out some functional aspects of the practice, such as acknowledgment of paternity and the diversion of evil

spirits from the mother and child. However, a form of couvade persists even in more technologically advanced societies. Wilson (1977), a Seattle psychiatrist writing in the *American Family Physician*, describes a "couvade syndrome" in which modern expectant fathers undergo sympathetic morning sickness and labor pains. He attributes these symptoms to deep empathy, envy and/or resentment of their partner. Regardless of its source or function, couvade's untoward effect, nonetheless, is to diminish the importance of the woman's role in birth (Corea, 1985).

The earliest quasi-scientific thinking (Aristotle's humunculus theories, for instance, in which it was thought that the child was deposited, in miniature, into the womb where it grew as if a seed in fertile soil) at first dismissed women's part in reproduction outright and later admitted it only grudgingly. Similarly, the Judeo-Christian culture viewed women's bodies as mere vessels for the male's child. Laws enforcing paternity rights are still common across the globe, and even today in U.S. culture, children more often than not carry their father's last name (Frank & Anshen, 1983). Access to birth control and abortion, a recent achievement in the U.S., is still unavailable in some other countries, and everywhere reproductive rights remain challenged by fundamentalist factions. Less striking but nonetheless suggestive is the observation by Rothman (1989) that some infertile couples will forego potentially successful artificial insemination and opt instead for a surrogate mother to propagate the male partner's seed. But to some observers, the *coup de grace* in the battle to control women by controlling their reproduction at its most basic level, was the appropriation of midwifery and its transformation into obstetrics and gynecology by men. Corea (1985, p. 303) suggests, "In the obstetrician, this male desire to take control of childbearing is expressed."

The emergence of scientific thought provided the catalyst for the positioning and acceptance of males in this role. Science was an overarching endeavor dominated and controlled by men. At first, women were excluded from scientific study and other intellectual pursuits because it was assumed that only males had the capability to engage in rational thought (Todd, 1989). As early as the twelfth century, European universities began offering courses in the science of medicine for aspiring physicians, training primarily upper class male students in philosophy, theology and Latin, the language of medicine. Acquiring a medical education at that time was a far more cerebral than empirical achievement, the experience being devoid of patients, experiments, and dissection. Nor was common healing, including midwifery, part of the curriculum (Ehrenreich & English, 1979; Rooks, 1997). Common healing and midwifery, then as in the past, were usually left to women who employed folk remedies such as herbal and other household concoctions, hence the term "old wives' tales." Following these diverse streams, by the thirteenth century, European medicine consisted of university-educated

physicians in the early stages of professional organization whose purpose was to serve the upper class, and uneducated, unorganized peasant women serving the health needs of the lower classes (Ehrenreich & English, 1973b).

During the fifteenth and sixteenth centuries, the Catholic church took on the supervision of midwives. Their interest in spiritual health at that time was far greater than their interest in physical health. Emphasis was placed on ensuring that midwives knew how to baptize frail infants and to hear the final confession of women dying in childbirth. Midwives were also expected to report to the authorities contraceptive use, abortion and any illegitimate births (Rooks, 1997; Shorter, 1982). Midwives failing to comply with these codes were often suspected of engaging in witchcraft. Between the fifteenth and seventeenth centuries, witch-hunting took on a feverish pace. Associated with the social upheaval accompanying the break-up of feudal society during that period, persons accused of being witches were executed by the thousands. The majority of those executed were women, and at least half of them were thought to be healers and midwives. Their crimes included offering herbs and potions to relieve pain in labor as well as helping women gain some control of their reproductive processes through mysterious, if primitive, methods of birth control and abortion (Ehrenreich & English, 1973a, 1979; Rooks, 1997). In a social world which judged male virility by means of their partner's fecundity, these acts were viewed as demeaning, even castrating, to men (Todd, 1989).

Fear of being accused of witchcraft drove many women healers and midwives underground. Combined with reduced educational opportunities and lack of organization, professional development among women healers and midwives was severely curtailed (Oakley & Houd, 1990; Rooks, 1997). As the early modern period drew to a close, it was clear that no longer would birth and healing be confined to woman's sphere. By the late eighteenth century, the practice of medicine had become a thriving male specialty closely linked with the pursuit of scientific progress. Physicians were especially eager to manage lying-in cases, primarily because they viewed this service as a springboard to family practice. Having gained control of science, men could now become "saviors of women and their health" (Donegan, 1978, p. 39).

THE LANGUAGE OF INTERVENTION

The *Oxford English Dictionary* marks the year 1325 as the first recorded usage of the term "deliver" in reference to childbearing with the words, "be delvuer of hir chylde." This date is somewhat contiguous with the nascent development of the guild of "barber-surgeons." Barber-surgeons, while possessing only rudimentary

anatomical training and tools, were usually called as the last resort in emergency lying-in cases, "where [it was understood] . . . one or both must necessarily die" (Donegan, 1978, p. 42). These practitioners used grim tools such as hooks and desperate measures such as embryotomies (or infant dismemberment) to extract an impacted child in order to save the mother's life. The term "deliver" offers an apt, if crude, description in these cases. If the woman survived, she would indeed be "delivered," or freed, of her child. In an age where aseptic techniques and anesthetic were unheard of, Caesarian sections were usually only performed in cases in which the mother was already dead in order to try and save the child. More often, the child was sacrificed to save the mother, but the methods used were unsanitary, if not barbaric, and often both were lost (Shorter, 1982). The barber-surgeon, who, with later specialization in maternity cases came to be called the "man-midwife," "acquired and continued to carry with him the aura of death," a decided impediment to the growth of the profession (Donegan, 1978, p. 49). Not surprisingly, several hundred more years were to pass before the man-midwife was to able to gain much acceptance at all.[3]

Unlike the barber-surgeons' grisly tools of annihilation, the forceps, invented in the late sixteenth century by Peter Chamberlin the Elder, and kept as a "family secret" for another one-hundred years, was the earliest successful interventionist device, the "gentler method of bringing along the head" (Donnison, 1977, p. 21). It is noteworthy that during this period normal births remained the sole concern of the childbearing woman and the midwife; only when extraordinary measures of intervention were needed were males summoned (Ehrenreich & English, 1979; Leavitt, 1986; Wertz & Wertz, 1989). The man-midwives of the Chamberlin family were highly skilled attendants who during this time acquired a reputation for whom the image of savior, or "deliverer," would not be hyperbole. For the select group of women served by these individuals, the arrival of the man-midwife did not necessarily mean certain death, and "delivery" could be associated with a live birth. Once their secret became known, the forceps was eagerly adopted as a routine obstetrical tool by the Chamberlins' male contemporaries and successors, many of whom, unfortunately, exhibited far less sophistication in their application, as we will discuss later. The use of technology, notably operative interventions, the first of which was the forceps, became the first of two features that sharply divided physicians and midwives in terms of philosophy, practice orientation and language used to describe their work. Forceps' use was characteristically absent among midwives for a number of reasons: they could not afford them, they lacked the strength to use them, and/or they disapproved of their use (Donnison, 1977; Litoff, 1978; Shorter, 1982). Hence while physicians employed active measures to "deliver" children, midwives merely "caught" them as they entered the world. The other chasm between the two groups was that midwives faced the typical

constraints that women have traditionally faced throughout history in terms of freedom and opportunities for advancement. Male physicians did not and hence encountered few impediments to their professionalization (Donegan, 1978; Leavitt, 1986; Rooks, 1997; Wertz & Wertz, 1989), which aligned them squarely with the emergent structural supports and cultural acceptance that the medical profession would soon come to enjoy.

PROFESSIONALIZATION

Prior to the early part of the twentieth century, medicine was an entrepreneurial field. Anyone who wanted to practice medicine could take up the healing craft. In addition to allopathic (or "regular") medicine, a variety of treatment approaches which today we recognize as "alternative medicine" (e.g. homeopathy, hydrotherapy, herbal therapies) were commonly practiced. Patient preference tended to be largely based upon the class of the practitioner. Upper class patients preferred university-trained regular physicians, mostly because of a desire to be treated by a practitioner of the same social standing as themselves, while lower-class patients sought whatever type of treatment they could afford (Rooks, 1997; Shorter, 1982). Regular medicine, which until the middle of the nineteenth century employed leaches, bleeding and purgatives as standard remedies (even for obstetrical cases), was no more efficacious than any other approach (Caton, 1999; Rooks, 1997).

While universities in the U.S. and abroad provided state-of-the-art medical training, certification, and the title of "physician" following the instruction, the acquisition of a formal university education by healers was the exception rather than the rule (Litoff, 1978). Prior to the early twentieth century, most doctors received either no education at all, or attended proprietary (or profit-making) schools. Between the middle of the eighteenth century and the beginning of the twentieth, more than 800 medical schools were founded, most of them little more than short-lived diploma mills (Rothstein, 1972; Wertz & Wertz, 1989).

Not all medical schools required training in obstetrics, and those that did were diminished considerably in practical value by the prudery of the Victorian era. Concessions to standards of modesty and propriety included the use of leather mannequins and artistic renderings of anatomical parts to teach obstetrical techniques (Donegan, 1978). Even prestigious Harvard Medical School in 1815 taught its first course on obstetrics using dolls as instructional aids! Most physicians, certified and otherwise, began their practice without ever observing a live birth. Often the first maternity case new physicians would see is the first maternity case to which they were called (Caton, 1999; Leavitt, 1986).

By the early part of the twentieth century, however, medicine had become streamlined, and allopathic or regular physicians dominated medical practice, aided by structural arrangements that favored and supported their method of healing over other approaches. Structural factors contributing to the demise of most competing sects were educational reform, licensing, and control of the medical marketplace. The 1911 Flexnor report, which exposed the grave deficiencies of medical education, led to the closing of all but a few (mostly allopathic) medical schools (Larson, 1977). Medical regulation, in terms of licensing and laws governing medical practice, was enacted following educational reform (Friedson, 1970). With allopathy legally established as the standard medical profession and granted a monopoly on practice, control of the medical marketplace was assured (Rothstein, 1977; Starr, 1982).

The "professionalization project" of the nineteenth and early twentieth centuries thinned the ranks and radically altered the status and prestige of men calling themselves physicians (Larson, 1977). Women, as midwives or aspiring physicians, were not part of this project, but continued to face the same obstacles women have always faced based on gender expectations. Women were frequently denied admittance to certified medical training programs,[4] and early efforts to train midwives consisted only of short courses in which they were taught only to recognize what they could not do as attendants and under what circumstances physicians should be summoned (Donegan, 1978). Only a very small number of women took part in these programs for a number of reasons. Few were literate, even fewer could afford the tuition, and most felt it ludicrous to be trained for this work by men (Rooks, 1997). Most midwives received no formal training but merely learned and sharpened their skills through empirical practice. As a result, midwives' skills ranged from abysmal to "highly proficient" (Shorter, 1982, p. 47), which was also the case for physicians of the period, as I will show directly. However, it was clear that a hierarchical order was beginning to emerge (Donegan, 1978).

The appropriation of midwifery and its transformation into obstetrics, a speciality of allopathic medicine, was pivotal to the emergence of the medical profession as a high status, male-dominated occupation (Donegan, 1978). Moving beyond emergency high risk cases to a more routine attendance at uneventful births, where successful outcomes are commonplace and competent performance is likely, became a particularly attractive proposition to the swelling ranks of physicians (Wertz & Wertz, 1989). While midwives seem to be drawn to the profession for numerous reasons, among them a sense of inherent empathy with childbearing women (Peterson, 1983; Rooks, 1997), fledgling male physicians were often attracted to obstetrics because it had the potential to develop into a lucrative family practice. Therefore, physicians took up the profession despite what was

viewed as its most formidable obstacle, the cultural prohibitions against male interest in these intimate matters, a trend that was particularly pronounced during the Victorian era (Litoff, 1978; Wertz & Wertz, 1989). As male encroachment in this sphere became more widespread, a veritable social reform movement arose during the middle of the 19th century, fueled by Victorian prudishness and anxiety that men involved with these intimate matters may be tempted to take sexual advantage of the women that he served. The reform movement, intent on driving men out of the midwifery, claimed that man-midwives were amoral, indecent and depraved, licentious practitioners of an altogether "bawdy profession" (Donegan, 1978, p. 167).

SAFETY

In response to charges of impropriety, physicians employed language that lingers today as the most powerful counter-argument to their cause, language that easily overcome the defenses of the most strident objectors, words made more authoritative by the makers' association with science (Todd, 1989). "Deliver" and "delivery," the language of intervention, speaks directly to issues of safety. Using these words, physicians were able to convince the women and their families that childbirth was *dangerous*, that it would be in their best interests to employ a skilled attendant whose ministrations were inherently safer than the uneducated midwives, and, who could, at the same time, offer a less painful birth (Dye, 1980). Certainly, spokespersons for the profession argued, the woman's "well being and safety were more important than preserving decency in the lying-in chamber" (Litoff, 1978, p. 135). Wertz and Wertz (1989, p. 93) assert:

> The doctor's strategy . . . was to tell women that safe delivery was such a deeply imperiled event that they needed doctors constant advice in order to make it a planned and conscious success. At the same time, the doctors endlessly reiterated that each woman's individual and social fulfillment turned basically on being a mother. By calling women to a necessary but threatened destiny, which doctors were best able to aid, doctors make themselves indispensable comforters of women.

These claims of course were somewhat grandiose considering that early obstetrical treatment was typically only one pair of forceps removed from ordinary midwifery. Yet by shrewdly couching childbirth in terms of risk, over which science will eventually prevail, and placing themselves in the role of expert, or "deliverer," male physicians were finally able to take control of obstetrics, and in short order, the medical profession. The first to support the obstetrical specialist, or *accoucheur* (as he was called by the elite), "who campaigned against the profession of midwifery on the grounds that pregnancy was a disease and demanded the care of a doctor,"

were upper class women, regarded during the Victorian age as "weak invalids" by nature, who found this argument especially convincing (Ehrenreich & English, 1973b, p. 15; Oakley, 1984; Rooks, 1997). Thus, it became fashionable among the elite to have a physician, as a man of science, present and taking control of birth.

Women to be sure were complicit participants in male empowerment in this sphere. The primary reason was self-interest. Recall that childbirth was women's domain throughout most of history – women in consort with other women had the power to control the location and circumstances of the event and all but exclude men from the experience. Seen in this light, women seeking relief of pain in childbirth (indeed, they clamored for this relief!) exhibited how far reaching was the scope of their autonomy (Leavitt, 1986). The rationality of science with its technological advances promised, and eventually delivered, pain-free childbirth (Caton, 1999) and women were not about to be denied this comfort. Moreover, women realistically feared death in childbirth, for it would have been exceedingly uncommon for a woman at that time to not have at least one person in their social network who had not succumbed, so it was only natural for them to seek ways to reduce that risk (Dye, 1980; Leavitt, 1986).

Thus, even the celebrated "social childbirth" in which the support and assistance of other women in labor was part of a shared cultural experience was happily exchanged for less prolonged and painful labors (Wertz & Wertz, 1989). "Women ceded control over physiological processes of birth to the medical profession in order to gain control over their birth experience" asserts Howell-White (1999, p. 9). Of course this desire would undergo revision yet again as later generations began to seek a "peak experience" in birth, one that is enhanced by being awake and aware (Dick Read, 1954). But for childbearing women prior to the twentieth century, "controlling their birth experience" meant demanding an entirely *different*, less painful experience than the one to which they were accustomed. This demand for change, ironically, attests to the autonomy in decisions surrounding childbirth that women previously enjoyed. The ceding of power was essentially an autonomous act – power was theirs to give.

In a patriarchal world, however, childbirth was the only arena in which women had power to spare. In all other spheres, women have far less power than men. The words we use with their connotations and shades of meaning reflect the social organization that exists: *Man does, woman is* (Key, 1975). Men control the language, the culture, the prevailing point of view. Women respond to, but do not always create, the social contexts in which their lives are played out (Davis-Floyd, 1992). Control of a woman in childbirth, once a means of control has been established, becomes yet another appendage of male dominance in other spheres, a reinforcement of her helplessness (Rothman, 1989; Todd, 1989). Once power is relinquished, it is exceedingly difficult to restore.

THE EMERGENCE OF THE MEDICAL MODEL

To say that childbearing women were better off in the care of a physician during the period of obstetrical professionalization, however, would be grossly inaccurate. Ehrenreich and English (1979, p. 97) argue that physicians of that era were less competent, less patient, and far more likely to interfere with birth in order to save themselves time. Indeed, the male entry into the profession coincided with sharp increases in maternal and infant mortality, and rates continued to climb even in the early decades of the twentieth century as physicians managed an ever increasing proportion of the births. Maternal mortality rates rose more than 14% between 1915 and 1929, and neonatal deaths by an astonishing 41% during the same period. The U.S. rates were higher in the 1920s than in all other industrialized countries (Louden, 1992). An escalation in the number of obstetrical operations (including needless use of forceps), the lack of understanding or failure to practice antiseptic techniques, and hospitalization account for many of these deaths (Dye, 1980; Tew, 1990).

Leavitt (1986, p. 51) reminds us, "Forceps could be an instrument of salvation for birthing women; it could also be the means by which women were reduced to post-partum invalidism," if used too soon so the tissues tear, providing a site for which bacteria can grow and lead to septicemia. Yet obstetrical textbooks at the turn of the century promoted aggressive intervention, instructing physicians to manage every stage of labor and birth with anesthetic and instruments.[5] By 1920, a reasonably well-informed doctor

> believed that "normal" deliveries, those without convulsions, deformed pelves, protracted and difficult labor, and threat of sepsis or tears in the woman's perineum, were so rare as to be virtually non-existent . . .. They concluded, therefore, that routine intervention should be made in every labor and delivery in order to prevent trouble" (Wertz & Wertz, 1989, p. 141).

The ironic outcome, sadly, was the increased morbidity and mortality associated with "the carelessness, the impatience, the scorn of proper antisepsis, and the numerous instances of clumsy, dangerous and unnecessary interference" by attendants at that time (Louden, 1992, p. 295).

Unfortunately, obstetrical intervention had taken hold before aseptic techniques were fully understood and accepted. DeLee (1916) in his textbook for nurses stressed the importance of cleanliness by recounting the story of the famous mid-nineteenth century Hungarian physician Ignatz Simmelweiss, who is considered the father of aseptic technique. Simmelweiss noticed that the clinic operated by midwives next to the hospital at which he practiced lost fewer than two of 1000 maternity patients while the hospital lost almost ten times that many. Upon investigation, Simmelweiss discovered that physicians

in the hospital were likely to move from examining cadavers to maternity patients without washing their hands, or to examine one patient after another without washing their hands between exams. Midwives may not have been any cleaner, but they were less likely to carry contagious disease (Shorter, 1982), and more likely to encounter soap and water, at least in carrying on their routine household tasks.

The highest maternal mortality rates were found in maternity hospitals. Originally established in the late eighteenth century primarily to provide charity to poor, often unwed expectant women, they attest to the desperate circumstances of those women, for outbreaks of puerperal, or childbed, fever were known to regularly close the wards (Oakley, 1984). Maternal mortality rates recorded in 1867 indicated that 28 of each 1000 women succumbed to puerperal fever.[6] With so many poor and usually unhealthy women delivering together under one roof, disease and infection spread rampantly. Popular wisdom dictated that it would be far safer to return to the former practice of giving birth at home. Charity outpatient centers subsequently established for poor women to deliver in their own homes with the aid of midwives, in contrast, lost only 5 of 1000 women (Donnison, 1977).

That issues of safety were a topic circulating in scientific discourse is not surprising at a time when puerperal fever was a major cause of maternal death (Brown, 1923; Nicoli, 1929). The literature of the early twentieth century reveals that even though U.S. public health officials tended to support the training of midwives and improvement of midwifery services, finding it sufficient to reduce any problems (Holmes, 1908; Levy, 1923, 1929), American physicians endorsed the medical model and sought to upgrade medical education instead (Brown, 1923; Lobestine, 1922). European countries favored the former approach and have enjoyed marked improvement in both maternal and infant mortality using the midwifery model for most cases (Litoff, 1978). Indeed, following legislation mandating training and supervision of midwifery, midwives have become professionalized in European countries, where they routinely assist in the majority of births (Oakley & Houd, 1990; Shorter, 1982; Willett, 1981).

Yet the alarming mortality rates did not undermine the reputation of nineteenth and early twentieth century obstetricians, largely because of a successful public health campaign aimed at convincing the American public that these new methods and techniques were a *normal* and *necessary* part of childbirth care. Intervention was not framed as part of the problem, but rather as part of the solution (Shaw, 1974). In a deft political move, the larger scientific community, instead of condemning its own role in perpetuating unsanitary and alarmingly dangerous practices, found a scapegoat on which to blame the appalling mortality statistics – the unlicensed, uneducated, unsophisticated, and most of all, powerless

midwife (Ehrenreich & English, 1979). Spicing the stew was "prejudice against the intelligence and capability of women, immigrants, black people, and poor people," groups most likely to be overrepresented within the ranks of midwives (Rooks, 1997, p. 24). Mortality will improve, they claimed, as soon as something is done about "the midwife problem" (Rucker, 1923), namely regulating them out of existence.

By the beginning of the twentieth century, physicians were serving the vast majority of middle- and upper-class childbearing women, leaving midwives to serve the poor. From the beginning, no strong disapproval existed for women working as midwives among the poor, as physicians were hitherto uninterested in serving indigent patients. Merry Weisner (1986) reports that medieval city councils in Europe regularly provided funds for midwives to serve the destitute. And in this country, Florence Nightingale in 1861 organized a school expressly for training midwives to serve needy women (Donnison, 1977).

Prior to 1900, midwives still attended approximately half of all births, the bulk of which were indigent patients that physicians disdained. Although the idea of using poor women as "teaching material" had been attempted in the past in charity hospitals, it had been abandoned due to high mortality (Oakley, 1984). However, by the beginning of the twentieth century, poor women had been rediscovered as the ideal and necessary resource to upgrade medical education. With general acceptance of aseptic techniques already in place, the profession was certain that other problems could be overcome with better obstetrical training. Once again, medical schools began to staff charity hospitals and "outdoor clinics" in order to teach students and experiment with new obstetrical techniques. Indigent women were assisted at no charge on the condition that students were able to participate or observe (Litoff, 1978).

Nancy Dye (1986, p. 554) provides an extensive historical examination of a turn of the century New York midwifery dispensary providing maternity services in exchange for empirical training. Dye pays particular attention to how the doctor-patient relationship became structured within these contexts. She discovered that the physician, who until then had been largely the obsequious servant of the elite, inverted the relationship when serving poor women. In these relationships, he (as most were male) was able to reserve for himself "unilateral authority." Poor women tended to be agreeable to these arrangements, but only when they perceived medical intervention as desirable. Frequently they hedged their bet by engaging at the same time a local midwife whose ministrations were familiar and preferred to the roomful of medical students who often busied themselves taking turns doing vaginal exams. Patients were often ordered by physicians to dismiss the midwife; those who refused were considered insubordinate and denied care. Dye showed that physicians whose professional identity had been thus offended

would often leave the case, no matter how grave, whenever the woman refused to concede complete control to his authority. Training in charity hospitals and among the indigent continues to this day as an integral part of medical schooling. With the near elimination of the independent profession of midwifery in this country, women, especially poor women, were left few options for autonomy in birth.

THE DEMISE OF MIDWIFERY IN THE U.S. IN THE TWENTIETH CENTURY

While the public acceptance of the science of obstetrics continued on a sharp linear increase, the practice of midwifery descended on somewhat of an extinction curve during the first three decades of the twentieth century. Better general health prevailed throughout most of the population. The prevalence of rickets had diminished, and women were no longer wearing corsets; both of which had been tacit contributors to complications in childbearing (Donegan, 1978; Leavitt, 1986). Increased attention to hygiene and increasing use of drugs such as ether and chloroform provided the safety and pain relief women had so eagerly sought (Caton, 1999).

Eventually, as most women, even indigent women, were becoming swept up and included in the new definition of birth – the male-dominated, medicalized model of control of the childbearing woman – a cultural revolution in birthing was underway (Davis-Floyd, 1992; Howell-White, 1999; Rothman, 1989). When a professional role such as midwifery, imbued with a feminine gender identity, carrying the connotations associated with this identity, begins a gradual shift and then a complete gender reversal, what female association it carries falls away to be replaced by a male mode of operation. Assistance converts to dominance, and science, technology, and most importantly, *action*, are imposed. Or, as Wertz and Wertz (1989, p. 137) assert, "The medical posture became one of manipulation, intervention and active combat."

Though time and science have not yet been able to change the fact that women physically give birth to babies,[7] the masculine orientation in the medical model of birth is striking. Since males first appropriated this role, there has been a reconstruction of the activity such that the birth attendant not only appears to be the primary actor, but indeed *is*. The connotations in the word "delivery" are all innately interventionist. Birth becomes something *done* to women. Too often the modern attendant does not receive the child, but rather *seizes* it. While the dragon in the biblical *Book of Revelations*, bound as he was by his cultural context and ways of knowing, was content to stand before the woman and wait for her child to

be born, the modern obstetrician lacks the dragon's constraints. With the woman in a completely passive position, reduced to "lumps of flesh from whom a baby is pulled," the physician takes the baby from her, literally, with forceps or by performing a caesarian section (Shaw, 1974, p. 74). The biblical notion of women of the active childbearing woman

> is a far cry from prenatal care that focuses primarily on the uterus and fetus, the possibility of pathology, and a sequence of tests and procedures; and on childbirth care that interferes with normal processes to such an extent that 30% of women cannot give birth on their own bur must be assisted by Caesarian section, forceps or vacuum equipment to pull the infant out of its mother (Rooks, 1997, p. 2).

Other gadgets and tools such as ultra-sound scanners, intravenous drips containing drugs which can either speed up and slow down the labor process according to the doctor's convenience, and fetal monitors proliferate, turning the birth into a high-tech medical event (Arms, 1975; Oakley, 1984). This trend toward obstetric intervention continues unabated. A recent report from the Bureau of Vital Statistics notes that while caesarean births have declined slightly (from 22.8 to 20.8% of births) in the last ten years of the twentieth century, the use of fetal monitors and ultrasound have increased, and the rate of labor induction has doubled. Now more than a third of all births are induced or stimulated (Curtin & Park, 1999).

These changes are reflected in the language of birth – granting agency to the doctor as "deliverer" permits and indeed normalizes aggressive intervention. As participants submit to and experience the way birth *is* handled, it becomes firmly entrenched in cultural assumptions about the way birth *should* be handled. The more the new assumptions gain currency, the more they permeate the culture, the more persons begin to lack alternative ways to think about them, the more the legal system begins to support them as necessary and useful, the more resistant they become to change (Todd, 1989). Thus, is the American medicalized model of birth anchored in our culture, our consciousness, and our language (Davis-Floyd, 1992; Mitford, 1992).

TWO DISTINCT IDEOLOGIES

Throughout this paper, I have been tracking the development of two separate ideologies of birth, the medical model and the midwifery model. It is easy to see at this juncture how each went careening off in different directions: The male-dominated medical model gained ascendancy, bolstered as it was by culture and structure and so embedded in our common language that it was difficult to even envision another approach. The midwifery model, its flimsy supports further

undercut by medical regulation, its ideas and language archaic, was fated at best to lie dormant, at worst to be remembered as an historical artifact. With the advent of formal education, certification and a new developing technology, modern maternity, or obstetrics, became redefined by the development of a medicalized model of birth as a *delivery*, a doctor-controlled process to which women would at first eagerly, and eventually mindlessly, submit. Midwifery, in contrast, would become mired in serviceable, if dated, techniques which would for the most part rapidly fall out of fashion as scientific progress and its attendant promise of safe and painless birth became more alluring.

The disparity in the early training and methods between midwives and physicians was as marked as the disparity between the statuses that the two professions would each develop. Midwifery has not been the lucrative practice for women to the degree that obstetrics has been for male physicians, a fact that is still the case today with lay midwives forced to work underground and even licensed or certified nurse-midwives serving as low-paid doctor's assistants (Peterson, 1983; Smith, 1992). Their non-scientific demeanor in a growing scientific age and lack of education led midwives to seemingly pale in comparison to the paragons of knowledge and expertise that physicians came to represent, and for which they were so well rewarded (Howell-White, 1999).

For a span of several generations, long enough to erase any substantial imprint on the culture, midwifery, for both the attendants and the childbearing women, would remain the refuge of the remote, the alienated, the marginal, and the poor. Midwives still served rural women on horseback in Kentucky, for example, where childbirth assistance became more often a charitable than a business transaction, or Iowa where they often assisted women as an act of friendship (Peterson, 1983). Yet during this period of subordination, midwives developed an ideology even more woman-centered and non-interventionist, embracing the feminist precepts of empowerment and solidarity (Rooks, 1997; Rothman, 1989). Whether proactively political or merely self-protective, this ideology paradoxically developed within a tradition of practice rich in empirical wisdom but limited, if not totally blocked, by the derth of educational and employment opportunities for women in this field.

This matrix of differences in the development of the two ideologies of birth have each contributed to two different perceptions of childbirth that are reflected in the language as well as the practices of each group. Most midwives did not, and still do not, *deliver* but merely *catch the child*, reserving autonomy for the woman in a way that male practitioners do not. Donegan (1978) notes that early physicians scoffed at the midwives' use of this homespun expression, a phrase which to them merely displayed the midwives' ignorance, as they appropriated the term "deliver" to describe their involvement. However, this language use reflects the perception of

birth as a natural woman-centered, *woman-powered* phenomenon that is best left undisturbed, a tradition that modern day advocates of midwifery share (Peterson, 1983; Rooks, 1997).

Man-midwives, on the other hand, represented scientific progress. Their profession was built upon interventionist strategies from which women's participation, both as attendants and as active agents in the birth process, was impeded. Their training was in intervention, and their focus was to approach the abnormal or pathological as the rule rather than the exception (Shaw, 1974). John Smith (1992, p. 137), a twentieth century obstetrician who has come to question his own involvement in this role, argues that male "boredom . . . with uncomplicated pregnancies may pose a hazard to those pregnancies" to the degree they are interfered with in order to speed events along and make them more challenging. Thus, particularly active language came into their vocabulary and into their perception of their role. As males also dominate cultural institutions, their language fell into common usage and their perception of birth became the common perception. Males in every capacity, whether as barber-surgeons, man-midwives, physicians or obstetricians, did, deliberately and *manfully*, act upon the bodies of women, to *deliver*, or save, them from their child – even when there was absolutely no need to do so. This image of savior or deliverer is so imprinted upon the sphere of male action that any male who usurps the doctor's role somehow comes to bask in its reflected glory. This is why we are so inordinately impressed with the John Rosenbergers of the world, the taxi-driver, and even the husband in the delivery room who cuts the umbilical cord. Shaw (1974, p. 100) remarks that it is not by accident that husbands were until quite recently barred from the delivery room. The doctor, she asserts, did not want to share the "starring role" with another male.

INSTITUTIONALIZING THE MEDICAL MODEL

Few would dispute that modern women willingly negotiated the deal. They bartered autonomy for comfort and perceived safety. Although fewer than 5% of American women gave birth in hospitals as late as 1900, by the 1920s more than half did, and by 1970, almost all did, and to this day still do (Curtin & Park, 1999). Early in the twentieth century, they were attracted to the hospital for a number of reasons. For one, it was promoted in the popular press as a cleaner, safer, and more comfortable place for a woman to give birth. But probably more importantly, only in hospitals were they able to receive a type of pain relief viewed as too risky and too difficult to administer at home, the anesthetic scopolamine, commonly known as "twilight sleep" (Wertz & Wertz, 1989). As long as home

was the typical birthplace, physicians were loathe to administer this drug, despite shrill accusations that they were "callously indifferent" to their patients' pain (Caton, 1999, p. 141). Indeed, the clamor for this new anesthetic where a woman could "just go to sleep and wake up and find she'd become a mother" turned into a social crusade and became a plank on the platform during the first wave of feminism.

No matter that the "woman was separated from the people she loved; she was in an unfamiliar environment controlled by others; and she was unconscious during part of her labor and delivery. She was also without the fears and anxieties that had haunted generations of her foremothers," Leavitt (1986, p. 181) explains. In the beginning, that was enough. With twilight sleep, the laboring woman entered the hospital and was anaesthetized almost immediately with a combination of drugs which masked, but (and this she did not know) did not remove, her pain. Women under twilight sleep required more supervision as they were likely to scream and thrash about, and they had to be confined in special cribs to keep from hurting themselves. Twilight sleep patients required restraints and obstetrical intervention, establishing a number of management procedures such as delivery tables and stirrups that since have become institutionalized into the hospital routine. These drugs had a powerful amnesiac effect, so that when the women awoke, they remembered not a bit of their suffering (Caton, 1999). This was the "birth experience" women so eagerly sought to attain (Howell-White, 1999, p. 9). In their zeal to obliterate the unpleasant aspects of birth, women paradoxically managed to lose control of their bodies. The twilight sleep movement helped change both the location and the definition of the birthing experience and institutionalized a dominant role for physicians in the process (Leavitt, 1986).

The transfer of birth to the hospital intensified the idea that birth is a perilous event, reinforcing the reliance on highly trained professionals to safeguard one's well-being. The long term battle with germs could be better fought in the hospital, and in that location women could be subjected to a plethora of procedures such as shaving and enemas and sterile drapes intended to make her as sanitized as her environment. Finally, the permanence of the hospital permitted the emergence of technological innovations that could be called into service to supervise and micro-manage the birth process (Martin, 1987; Wertz & Wertz, 1989).

But more than anything else, the hospital undercut birth's social moorings and became a relatively isolated, and ultimately alienating experience. Leavitt (1986, p. 194) reminds us that hospitals could not provide the supportive environment that the community of women did in years past, and in fact "obliterated a millennia of women's own birthing traditions." Even after twilight sleep gave way to the spinal block, or epidural, in the 1940s, it was becoming increasingly clear that there was a profound difference between pain and suffering. Medicine was increasingly able to

control pain, but its inability to control suffering caused faith in science to decrease (Caton, 1999).

One can be free of pain yet still experience psychological suffering from alienation. A woman can feel alienation in childbirth if there is an absence of social support in this time of travail, as was certainly the case in the early years of hospitalization when even expectant fathers were separated from their partners and confined to waiting rooms. The importance of social support during labor has been recognized and incorporated back into the medical model. Yet even with support, a woman can still feel alienated, in the Marxist sense, an alienation from the birth experience itself. This alienation cannot be remedied by the medical model because it is an outcome, or product, of the medical model. Marx viewed alienation in the broadest sense – as the deprivation of human needs, the giving up of one's self, or even as "making [an action] external to one's self" (Zeitlin, 1990, p. 89). In this last sense, the childbearing woman suffers alienation because her actions are perceived, or at least spoken of, as if they are external to herself. She is a passive participant in the experience. Her labor is no longer meaningful to her. She can no longer draw true self-actualization from childbirth, for self-actualization now belongs to someone else.

QUESTIONING THE MEDICAL MODEL

A slight stirring of a movement, but noticeable nonetheless, began in the middle of the twentieth century. Physicians and hospital administrators were suddenly confronted with women for whom mortality was no longer a concern and pain only an option who were now desiring to "experience" childbirth. These women were questioning the cold impersonality of the medical model of birth. Wertz and Wertz (1989, p. 173) assert that "hospital birth became a regime against which many women began a critical struggle, questioning the need for such extensive manipulation, questioning the safety of the procedures, and demanding that birth be an experience that permitted them a sense of self-fulfillment."

The first adjustment was "natural childbirth," a movement that arose in the 1950s, with the Lamaze movement following rapidly upon its heels. Ironically conceived by male obstetricians who had no lived understanding of birthing pain, each began with the premise that pain is merely psychological, indeed only the expression of fear, a fear that women are capable of controlling through conditioning. Proponents of natural childbirth claimed that as a woman learns to relax and overcome her fear, she will overcome her pain and a joyous birth experience will result (Dick Read, 1954). With Lamaz (1970), the conditioning is psychoprophylactic; Lamaze advocates contend that through breathing and

other exercises, the laboring woman can block pain signals with powerful counter-signals.

Similar in concept, yet different in technique, the Dick Read method of natural childbirth and Lamaze recognized and attempted to jolt women from their growing passivity in the birthing role. And, while each method challenged the woman to educate herself and to control her own labor (Wertz & Wertz, 1986), they also imposed upon the woman a set of standards, arguably masculinized in their regimentation, by which to judge her progress. These methods also ushered in the practice of holding childbirth classes for both expectant parents, a custom which elevated the father's role from interested outsider to that of an integral member of the birthing team (Mitford, 1992). Since both methods require expectant mothers to have a labor coach (usually the father or, more recently, a professional coach called a "doula"), the natural childbirth movement has incorporated a source of social support for the childbearing woman. Empirical studies have shown that support has positive psychological and medical benefits (Caton, 1999). Though they did not wrest control of birth from doctors, and may have even ultimately decreased the woman's confidence in her own ability and increased her dependency on the staff (as the discussion below will show) these movements were a first step in rehumanizing birth (Wertz & Wertz, 1989).

Labor nurse Susan Diamond (1996) adds that the childbirth classes designed to prepare couples for natural childbirth may also introduce a source of conflict for the parents and the medical staff when the couple enters the hospital. While the purpose of the classes is to teach the couple what to expect so that they will be better prepared to deal with and control the experience, it is not in the interest of the staff or the institution "to encourage patients to be actively involved in their own treatment decisions . . . to explain each procedure, to ask her opinion, to keep her informed" (p. 66). Prepared parents, she insists, make the staff's job more difficult, and some are punished for this infraction. For example:

> When a [prepared patient] 'succumbs' to her pain and fear and begs for relief, the staff, quite often, relishes her 'failure' . . .. The antagonistic glee some doctors exhibit is appalling. *I knew she would be hollering for an epidural. These people think they know everything from their classes and then the real world hits them!* (emphasis in the original) Perfectly reasonable human beings . . . become almost sadistic in their vindictiveness. They want to see the patient's plans fail so they can say "I told you so." They want to swoop into the room with an epidural cart and *play the savior* (emphasis added), self-righteous about their years of experience with laboring mothers (p. 67).

Diamond further argues that no matter how well informed the patients may be, they are still at the mercy of the staff, who may resort to scare tactics about her or the baby's safety to get the mother to acquiesce to the procedures the expectant parents had preferred to avoid.

The difficulty lies in the rigidness of the medical model and its inability to absorb contradictory definitions of birth. "Concerns about the mothers' emotional needs, about a warm, loving, positive birth," she notes, "are always secondary to concerns about the pathological characteristics of the birth process" (Diamond, 1996, p. 67). Yet childbirth classes are not without benefit to the medical personnel, she reports, for they teach the parents what routines to expect, "which saves the staff some explaining" when they begin to use them (p. 68). Indeed, Davis-Floyd (1992, p. 184) suggests that prepared childbirth, rather than posing a threat to the medical model of birth, actually helps sustain it. Rather than "retain[ing] control over *birth*, . . . the method they are taught generally promises only that the laboring woman can retain control over her *behavior* (emphasis in original)." It provides anticipatory socialization, keeps the childbearing woman occupied in labor, and coopts the husband. "Mother, coached by father, behaves herself, while Doctor delivers the baby" quips Rothman (In: Davis-Floyd, 1992, p. 165).

CHALLENGING THE MEDICAL MODEL

While the natural or prepared childbirth movement altered neither the location of birth, the physician as attendant, nor the power differential of the participants, the home birth movement, which arose in the decade of the 1970s, presented a clear challenge to the developments in childbearing that had become normative by the second half of the twentieth century. Home birth proponents not only eschew the hospital as a location for birth, they also replace the physician with the midwife as attendant and "emphasize a redefinition of the client-patient relationship . . . retaining [for the childbearing woman] personal authority in decision making" (O'Connor, 1993, p. 149). In short, home birth enthusiasts completely reject the medical model. They view birth as natural and normal, not potentially pathological. Even in terms of risks, proponents of home birth tend to view the *hospital* as the most dangerous environment in which to give birth.

Though interest in home birth rose concomitant with the second women's movement, some, but not all, proponents of home birth are feminist. Bonnie O'Connor (1993) interviewed twelve couples who had babies at home and found that none considered themselves feminist. More frequently they were members of staunchly conservative religious groups, such as the Amish (also Williams, 1999). They had in common dissatisfaction with modern maternity and the way it is practiced, faulting in particular the invasive procedures and the physician's lack of empathy or even interest. Most intriguingly, O'Connor found that the illegal status of the midwives *enhanced* the perception of the quality of care. She notes:

> Several women reasoned that the midwives' legal status contributed positively to the safety of employing them as birth attendants. Awareness of their own liability, they felt, prompted the midwives to be very conservative in taking risks with a client's health or well being... In the same vein, privileged legal status was cited as a factor in making physicians cavalier toward their patients and in shielding their errors from scrutiny (p. 163).

This extreme philosophical inversion is espoused by the most minuscule proportion of the childbearing population. As O'Connor (1993) points out, estimates of completed home births were remarkably stable at around one percent of all births throughout the period between 1970 and 1990, a percentage that remains unchanged today (Curtin & Park, 1999). This small proportion could have been easily dismissed by the medical establishment, yet curiously was not. The home birth movement caused hospitals to begin wallpapering their delivery rooms and calling them alternative birth centers (Klee, 1986; Nelson, 1983). Home birth also brewed a storm of controversy in medical journals (see Acheson, Harris & Zyzanski, 1990; Pearse, 1979), possibly because this small, but vocal minority with its sharp critique of the medical model had something to say which *resonated* at some deep level with women. It made women cognizant that alternatives to the medical model exist, and it made at least some of them start questioning, at least in a small way, their assumptions.

Davis-Floyd (1992) studied 100 childbearing women, most of whom desired an ordinary hospital birth. Interestingly, Davis-Floyd noticed a pattern that developed among her subjects, a shift in thinking that occurred between their first and subsequent births. Around a third of the women reported being dissatisfied with their birthing experience. They resented the medical intervention, harbored feelings of anger surrounding the birth, and some developed severe post-partum depression. She noticed a strong shift in their values and beliefs that spilled over into other areas of their lives as they prepared for subsequent births. While most planned to use the hospital again, but next time as more assertive consumers, 8% planned to have their next child at home. She reports:

> I noticed that as they switched from hospital to home birth, they not only fired their obstetricians and searched for midwives, but also developed decided affinities for naturopaths, massage therapists, recycling, herbs and whole-wheat bread. It seemed that something farther-reaching than a simple change in birthplace was going on with these women. It seemed as if they were actually using their births as a means to change their personal belief systems (p. 293).

Similarly, Howell-White (1999) studied 200 childbearing women who were self-selected into one of three different medical treatment conditions: the standard hospital birth with an obstetrician, a certified nurse midwife (CNM) working in a hospital, or a CNM working in a out-of-hospital birthing center. All three treatment conditions were covered by a managed care plan, thus cost was no incentive in any choice. She found that when given a choice, almost half of the women chose

CNM's for their care. Those choosing obstetricians scored highest on concern about risk and potential complications, and those choosing CNM's scored highest on measures of egalitarian ideals. Intriguingly, Howell-White identified the same shift in belief systems following the birth as among Davis-Floyd's (1992) subjects. When reinterviewed following the birth, she found the proportion of patients willing to select a CNM for subsequent births greater than the proportion willing to select an obstetrician again (86 vs. 65%). She too reports that her subjects began to redefine their belief systems once having experienced the event. They found their births to be less dangerous than expected, and emotionally less gratifying than desired.

TAKING BACK MATERNITY

Within the last century of so, there has been a radical changing of the guard in terms who attends to the needs of childbearing women. For millennia, birth, as woman's exclusive domain, was woman-centered. But males came to appropriate it because management of birth provided a portal to professional practice in other areas of medicine, and they dominated and controlled it as they dominated and controlled all social institutions. Under male tutelage, midwifery became obstetrics, and its orientation became masculine. In the beginning, males were called upon to act aggressively in the most desperate of circumstances, and action became the predominant mode of operation regardless of circumstances. In time, maternity became male-centered, as males claimed for themselves the conspicuous and necessary role in the activity. This inversion of roles, with males as the active participants and women as the passive recipient of services, became normative and was reflected in the language used to describe birth, as women no longer "gave birth" to children, but were, somewhat gratefully, "delivered" of them instead.

As physical suffering was conquered, however, in its place rose a vague, almost ephemeral spiritual suffering. Missing from the masculinized medical model was emotional support, gratification, and a sense of accomplishment. Women began a quest for a meaningful birth experience and stumbled upon midwifery with its laissez-faire approach, sensitivity and constraint. In it they found the more natural, woman-centered model of childbearing. Fueled partly by the feminist movement with its insistence on women regaining control of their own bodies (Boston Women's Health Collective, 1979), but also in reaction to widespread dissatisfaction with the doctor's brusque and chauvinistic attitude (Smith, 1992; Zadoroznyj, 2001), childbearing women in increasing numbers were beginning to appreciate once again the midwife, whose forte is emotional support (Rushing,

1993), who *listens*, for whom "there is 'all the time in the world' " (Shaw, 1974, p. 136).

Howell-White (1999) suggests that we may be yet again in the process of cultural redefinition – shifting away from total reliance on the medical model for maternity. She predicts that we are moving closer to the European model of birth which combines elements of both the midwifery and medical models of birth. In most European countries, most maternity cases are attended by midwives working in hospitals, where women enjoy the unique social support typical of midwifery, and yet have access to emergency intervention if needed. Midwifery has become a dynamic profession in Europe because concern about infant and maternal mortality early in the twentieth century prompted decisions to provide governmental support to train and supervise midwives (Oakley & Houd, 1990). In this country, in contrast, the same impetus resulted in a sustained campaign to quash the practice. Thus, while midwifery in the U.S. is not as vibrant or broadly accepted as it is in Europe, its professionalization project is certainly underway and the profession is growing rapidly.

With professionalization, midwifery has become more mainstream. While some traditional midwives still practice in remote areas or among immigrant populations today, it is a mischaracterization of the profession as a whole to view modern day midwives as uneducated or merely empirically trained. There are now approximately 50 schools of midwifery, and these educational programs graduate around 400 new midwives each year. Most midwives are college educated, either before entry to midwifery training or while in the process of acquiring midwifery training, and many programs are now requiring master's degrees. Nor do many midwives attend births at home these days. In fact, the percentage of home births attended by midwives has dropped to less than 5% (Rooks, 1997). Instead, midwives routinely train and practice under the supervision of physicians in hospitals (Benoit et al., 2001).

The European model is already being realized in the U.S. by the growth of CNM practice in hospitals settings. While the number of births occurring in hospitals remains unchanged at 99% of all births, the proportion attended by physicians has dropped to 92%. Midwives accounted for 7% of all births in 1997, with almost all of the growth in CNM's (Curtin & Park, 1999). Since the midwifery model dovetails nicely with the tenets of low-cost, low-intervention health care provision favored by managed care providers, third party support, particularly managed care, may have had a role in shaping these trends (Rooks, 1997).

In the late 1990s, there were around 10,000 CNM's practicing within the United States. Although there were three times that number of obstetricians, midwives entered the twenty-first century comprising a full quarter of the practitioners dedicated to serving childbearing women (National Center for Health Statistics,

2001). If one considers the increasing numbers of women physicians who are choosing obstetrics as their specialty, childbirth assistance is rapidly losing its status as a male-dominated field, and may even become a female-dominated field in the future.

These very recent and exciting developments beg numerous questions for social scientists to explore. If women, as practitioners, regain control of obstetrics, what will happen to childbirth? Will it become re-femininized under female control just as it became masculined under male control? Or has its masculine orientation become indelibly imprinted with the medical model institutionalized in our structural arrangements, culture and language? Very likely maternity patients themselves will determine the answer to that question. Recent research conducted by Zadoroznyj (2001) identifies growing reflexive consumerism among maternity patients. She found among her subjects increasing involvement in managing many aspects of the birthing experience, but more than that, they were demanding "full recognition of the birthing woman's social personhood . . . [where] provider and patient are equals" (p. 137). Where early twentieth century women clamored for the medical model and an obliteration of the birthing experience, this research suggests that today's women are calling for an enhanced birthing experience and "open discussion and communication which takes into account women's feelings and wishes, and of course takes time" (Zadoroznyj, 2001, p. 137). Can the medical model "deliver" this? Perhaps, but to do so, its orientation must radically shift. To do so, it must become more like the midwifery model.

The midwifery model of birth is not about whether childbirth occurs in a hospital or in the home. It is not about whether males manage childbearing women or women do. The midwifery model is a philosophy, one with a unique language which describes a shared understanding about the primacy of the birth experience over the technological aspects of birth (O'Connor, 1993). Also understood is that the childbearing woman herself owns and accomplishes the birth. Both of these tenets are radical departures from the medical model, for neither emotionality nor deference are typical masculine approaches to any activity.

In this paper I have suggested that the masculinized language of birth has pushed women farther and farther away from the center of natal activity. As a consequence, too many women have come to view birth as an activity in which they merely participate, instead of an action that they *accomplish*. The solution may be to restore women's primacy in management of the activity, which is suddenly happening as more women begin reclaiming their roles as healers, either as midwives, physicians or obstetricians, and more patients seek their care. But one must be on guard lest the old routines get not replaced but reinforced, which is likely to happen if women healers think, speak and act like men. As George Bernard Shaw once sagely remarked, "It was clear to me that what women had to do was not repudiate their

femininity, but to assert its social value; not to ape masculinity, but to demonstrate its insufficiency (cited in Key, 1975, p. 147)."

Hoffert (1995, p. 4), in her analysis of the speech of women activists in the earliest days of the women's rights movement, found that speech was "the single most important weapon" in that movement. More importantly, "the transformation of society that women's rights activists envisioned was expressed in words long before it began to take place in fact." Consider language reforms already in place, such as the use of "Ms," the elimination of the generic "he" in reference to all human beings, the suffix "-person" instead of "-man," the coinage of new expressions such as "server" or "attendant." When first proposed, many of these language changes were met with ridicule, but all were gradually adopted, and each has certainly raised the consciousness of speakers and listeners and may even have helped lessen the degree of sexism in society (Frank & Anshton, 1983).

Taking back maternity entails more than accepting concessions such as wall-papered delivery rooms (DeVries, 1980) and husbands as co-participants. These modifications merely mask the continued control over reproductive processes imposed by the male-dominated culture (Rothman, 1989). Reclaiming birth requires far more than a changing of the guard in terms of attendant, but rather a changing of a culture, including thought and the language used to express it. Twenty-first century women have rediscovered the ages-old wisdom of the humble midwife, and are appreciating her deference to, and respectfulness of, things female. But in order to truly reclaim ownership of birth, women must go one step further. They must self-consciously listen to their own speech and question the assumptions built into the words and expressions that all in this culture so carelessly use. If they do not restore female ownership of birth in language, regardless of the sex of the attendant, they will not be able to restore female ownership of birth in act, leaving the idea of childbearing women as active participants in birth to erode away completely.

NOTES

1. See, for example: "To Enoch was born Irad . . ." *Genesis* 4:18.
2. *Revelation* 12:4.
3. Shorter (1982) claims that some traditional midwives adopted from barber-surgeons hooks and crochets and performed embryotomies when faced with the same desperate circumstances, illustrating how "interventionist lore had filtered ineradicably into village culture" (p. 63). Interestingly, midwives were averse to the use of forceps.
4. Not until 1847 was the first woman, Elizabeth Blackwell, admitted to medical school.
5. Textbook author Joseph DeLee (1916, 1934), who aggressively promoted these policies, would later retract from this position, alarmed by the needless injury of mothers and their infants that resulted (Leavitt, 1988).

6. In contrast, maternal mortality rates were 8.3 per 100,000 in the U.S. in 1999 (National Center for Health Statistics, 2000).
7. Corea (1985) predicts that the goal of science is to eventually remove women from the process completely.

REFERENCES

Acheson, L., Harris, S., & Zyzanski, S. J. (1990). Patient selection and out-of-hospital births in one family practice. *Journal of Family Practice*, *31*(2), 125–136.

Arms, S. (1975). *Immaculate deception: A new look at childbirth in America*. Boston: Houghton-Mifflin.

Associate Press (2002). Community rallies around Millerburg midwife on trial. *News Journal*, March 13, 8A.

Benoit, C., Davis-Floyd, R., Teijlingen, E. R., Sandall, J., & Miller, J. F. (2001). Designing midwives: A comparison of educational models. In: R. G. DeVries, C. Benoit & E. R. Tiejlingen (Eds), *Birth by Design: Pregnancy, Maternity Care and Midwifery in North America and Europe*. New York: Routledge.

Brown, W. H. (1923). The trend in maternal and child hygiene. *American Journal of Public Health and the Nation's Health*, *13*, 636–638.

Caton, D. (1999). *What a blessing she had chloroform*. New Haven: Yale University Press.

Clark, V., Eschholz, P. A., & Rosa, A. (Eds) (1981). *Language* (3rd ed.). New York: St. Martin's Press.

Corea, G. (1985). *The mother machine: Reproductive technologies from artificial insemination to artificial wombs*. NY: Harper and Row.

Curtin, S. C., & Park, M. M. (1999). Trends in the attendant, place, and timing of births, and in the use of obstetric interventions: U.S., 1989–1997. *National Vital Statistics Reports*, *47*(27), http://www.cdc.gov/necdphp/drh/pdf/nvs47_27.pdf.

Davis-Floyd, R. E. (1992). *Birth as an American rite of passage*. Berkeley: University of California Press.

DeLee, J. B. (1916). *Obstetrics for nurses*. Philadelphia: Saunders.

DeLee, J. B. (1934). Obstetrics vs. Midwifery. *The Journal of the American Medical Association*, *103*(5), 307–311.

DeVries, R. G. (1980). The alternative birth center: Option or cooptation? *Women and Health*, *5*(3), 47–60.

Diamond, S. L. (1996). *Hard labor*. NY: Tom Doherty Association.

Dick Read, G. (1954). *Childbirth without fear*. London: Heinemann Publishing.

Donegan, J. B. (1978). *Women and men midwives: Medicine, morality and misogyny in early America*. Westport, CT: Greenwood Press.

Donnison, J. (1977). *Midwives and medical men: A history of interpersonal rivalries and women's rights*. NY: Schocken Books.

Dye, N. S. (1980). History of childbirth in America. *Signs*, *6*, 97–108.

Dye, N. S. (1986). Modern obstetrics and working-class women: The New York midwifery dispensary. *Journal of Social History*, *20*, 549–564.

Ehrenreich, B., & English, D. (1973a). *Witches, midwives, and nurses: A history of women healers*. Old Westbury, NY: Feminist Press.

Ehrenreich, B., & English, D. (1973b). *Complaints and disorders: The sexual politics of sickness*. Old Westbury, NY: Feminist Press.

Ehrenreich, B., & English, D. (1979). *For her own good: 150 years of expert's advice to women.* Garden City, NY: Doubleday Anchor Books.
Frank, F., & Anshen, F. (1983). *Language and the sexes.* Albany, NY: State University of New York Press.
Friedson, E. (1970). *Professional dominance: The social structure of medical care.* New York: Atherton Press.
Friedson, E. (1994). *Professionalism reborn: Theory, prophecy and policy.* Chicago: University of Chicago Press.
Giddens, T. (1986). Home delivery. *Anderson Independent Mail,* December 31.
Griffen, S. (1989). Split culture. In: J. Plant (Ed.), *Healing the Wounds.* Santa Cruz, CA: New Society Publishers.
Hoffert, S. D. (1995). *When hens crow.* Bloomington, IN: Indiana University Press.
Holmes, R. W. (1908). The midwives of Chicago. *Journal of the American Medical Association, 17,* 1346–1350.
Howell-White, S. (1999). *Birth alternatives: How women select childbirth care.* Westport, CT: Greenwood Press.
Key, M. R. (1975). *Male/female language.* Metucken, NJ: Scarecrow Press.
Klee, L. (1986). Home away from home: The alternative birth center. *Social Science and Medicine, 23,* 9–16.
Kitzinger, S. (2000). *Rediscovering birth.* New York: Pocket Books.
Lamaz, F. (1970). *Painless childbirth: The psychoprophylactic method.* New York: Henry Regnecy Company.
Larson, M. (1977). *The rise of professionalism.* Berkeley. University of California Press.
Leavitt, J. W. (1986). *Brought to bed: Childbearing in America, 1750–1950.* New York: Oxford University Press.
Leavitt, J. W. (1988). Joseph B. DeLee and the practice of preventative obstretrics. *American Journal of Public Health, 78*(10), 1353–1361.
Levy, J. (1923). Maternal mortality and mortality in the first month of life in relation to attendant at birth. *American Journal of Public Health and the Nation's Health, 13,* 88–95.
Levy, J. (1929). Maternal and infant mortality. *American Journal of Public Health and the Nation's Health, 19,* 225–228.
Litoff, J. (1978). *American midwives: 1860 to the present.* Westport, CT: Greenwood Press.
Lobestine, R. W. (1922). Practical means of reducing maternal mortality. *American Journal of Public Health and the Nation's Health, 12,* 39–44.
Louden, I. (1992). *Death in childbirth: An international study of maternal care and maternal mortality, 1800–1950.* Oxford: Clarendon Press.
Martin, E. (1987). *The woman in the body: A cultural analysis of reproduction.* Boston: Beacon Press.
McClain, C. S. (1987). Some social network differences between women choosing home and hospital birth. *Human Organization, 46*(2), 146–152.
Mitford, J. (1992). *The American way of birth.* New York: Dutton.
Mueller, C. (1973). *The politics of communication.* New York: Oxford University Press.
National Center for Health Statistics (2001). *Health, U.S.: 2000.* Hyattsville, MD: Public Health Service.
Nelson, M. K. (1983). Working-class women, middle-class women, and models of childbirth. *Social Problems, 30,* 284–297.
Nicoli, M. (1929). Maternity as a public health problem. *American Journal of Public Health and the Nation's Health, 19,* 961–968.

Oakley, A. (1984). *The captured womb: A history of the care of pregnant women.* Oxford: Blackwell.
Oakley, A. (1993). *Essays on women, medicine, and health.* Edinburgh: Edinburgh University Press.
Oakley, A., & Houd, S. (1990). *Helpers in childbirth: Midwifery today.* New York: Hemisphere Publishing Corporation.
O'Connor, B. (1993). The home birth movement in the U.S. *Journal of Medicine and Philosophy, 18,* 147–174.
Pearse, W. H. (1979). Home birth. *JAMA, 241*(10), 1039–1040.
Peterson, K. J. (1983). Technology as a last resort in home birth: The work of lay midwives. *Social Problems, 30,* 272–283.
Rooks, J. P. (1997). *Midwifery and childbirth in America.* Philadelphia: Temple University Press.
Rothman, B. K. (1989). *Recreating motherhood.* NY: Norton.
Rothstein, W. G. (1972). *American physicians in the nineteenth century: From sects to science.* Baltimore: Johns Hopkins University.
Rucker, M. P. (1923). The relation of the midwife to obstetric mortality, with especial reference to New Jersey. *American Journal of Public Health and the Nation's Health, 13,* 816–822.
Rushing, B. (1993). Ideology and the reemergence of North American midwifery. *Work and Occupations, 20,* 272–283.
Sacks, S. R., & Donnenfeld, P. B. (1984). Parental choice of alternative birth environments and attitude toward childrearing philosophy. *Journal of Marriage and Family* (May), 469–475.
Shaw, N. S. (1974). *Forced labor: Maternity care in the U.S.* New York: Pergamon Press.
Shorter, E. (1982). *A history of women's bodies.* New York: Basic Books.
Smith, J. M. (1992). *Women and doctors.* New York: Atlantic Monthly.
Starr, P. (1982). *The social transformation of American medicine.* New York: Basic Books.
Sullivan, D. A., & Weitz, R. (1984). Obstacles to a practice of licensed lay midwifery. *Social Science and Medicine, 19*(1), 1189–1196.
Tew, M. (1990). *Safer childbirth? A critical history of maternity care.* London: Chapman and Hall.
Thorne, B., Kramarae, C., & Henley, N. (1983). *Language, gender and society.* Rowley, MA: Newbury House Publishers.
Todd, A. D. (1989). *Intimate adversaries: Cultural conflict between doctors and women patients.* Philadelphia: University of Pennsylvania Press.
Weisner, M. E. (1986). Early modern midwifery: A case study. In: B. Hanavalt (Ed.), *Women and Work in Preindustrial Europe.* Bloomington, IN: Indiana University Press.
Weitz, R., & Sullivan, D. A. (1984). Obstacles to the practice of licensed lay midwifery. *Social Science and Medicine, 19,* 1189–1196.
Wertz, R. W., & Wertz, D. C. (1989). *Lying-in: A history of childbirth in America* (expanded edition). New Haven: Yale University Press.
Whyde, K. (1988). Midwifery: Defendant and law both going on trial. *Indianapolis Star,* April 24, F1.
Willett, M. K. (1981). Midwifery in seven European countries. *Journal of Nurse-Midwifery, 26*(4), 28–33.
Williams, C. (1999). Personal communication.
Wilson, L. G. (1977). The couvade syndrome. *American Family Physician, 15*(5), 157–160.
Zadoroznyj, M. (2001). Birth and the 'reflexive consumer': Trust, risk and medical dominance in obstetric encounters. *Journal of Sociology, 37*(2), 117–139.
Zeitlin, I. (1990). *Ideology and the development of social theory* (4th ed.). Englewood Cliffs, NJ: Prentice-Hall.