

# Biological Body, Social Body, Political Body?: Issues of Medicalization in North American Midwifery

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# Biological Body, Social Body, Political Body?

## Issues of Medicalization in North American Midwifery

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This paper covers various aspects of the contemporary issues faced by the midwifery profession in America with a focus on gendered issues of midwives and their clients. My analysis begins by considering the historically embedded practice of North American midwifery. The shift from birthing and maternity as a women's domain to the territory of the newly trained male medical practitioner is outlined. I then undertake an examination of how midwifery is perceived today, including what footing it has gained and lost since the nineteenth century, and how the proliferation of consumerism has impacted midwifery practice. The overarching theme of the piece is to demonstrate how midwifery has functioned historically and in the present as a means of empowering women and allowing them to retain control over their bodies through pregnancy and the birthing process. This approach is in competition with the dominant biomedical model, which portrays the (male) medical practitioner as an all-knowing presence and the woman as a machine to be handled. The core question considered is how North American midwifery has changed over time and how issues of gendered work and patriarchal domination in medicine have influenced these changes. Methodologically, this paper considers how various scholars conceptualized midwifery and the issue of the medicalization of women's bodies present within the dominant biomedical model. The desire for control, which is experienced by many women, is conceptualized as partially stemming from the negative experiences some women have encountered within obstetrics, and with male medical professionals specifically. I conclude with a discussion of how due to various factors, such as consumerism and neoliberal ideologies, midwifery is located within discourses regarding choice and women's reclamation of control over their bodies.

**KEY WORDS** American, birth, gender, midwifery

**M**idwifery was historically a traditional practice that took place in informal settings such as the home (Fraser 1995). Prior to the medicalization of birth in twentieth-century America, birth, as well as prepartum and postpartum care, were exclusively female domains watched over and executed by the mother along with female family members and a midwife who had often completed some form of apprenticeship (Fraser 1995). As MacDonald (2006) documents “[midwifery achieved] full legal and professional recognition in the 1990s” (237). Midwives acquired lay knowledge through observation,

and less frequently, through formal schooling (Wertz and Wertz 2001). This essay will primarily serve as a review of anthropological literature focused on gendered praxis as it relates to birthing and related activities. It will examine how the gendered sphere of birthing and related practices has changed over time with the move towards medical doctors dominating birthing practice as a medical procedure. These considerations will be centered around North American research, with this essay documenting the eventual take over by medical doctors and the shift towards birth as a medicalized process needing treatment by a physician. These changes will reflect the nuances of medical anthropological studies on the history of midwifery in North America. While reflecting a broad range of influences, most of the sources are situated within a critical approach to anthropology, which reflects power imbalances, and are primarily derived from feminist scholars within medical anthropology. This review will also consider how gender dynamics are present within these power shifts.

Birth has become a problem to be solved (O'Neil and Leyland-Kaufert 1995). During the process of birth women are frequently seen as objects to be manipulated to produce the desired result: a healthy baby, which, in turn, is viewed as the product of a medical process (O'Neil and Leyland-Kaufert 1995). The thorough medicalization of birth has led to an approach to pregnancy and childbirth that diminishes women's roles both as healers and as participants in their own labour (Wertz and Wertz 2001). Midwifery practice focuses on the authority and knowledge of the labouring woman and her ability to remain connected with her body's needs (Davis-Floyd and Davis 1996). Davis-Floyd and Davis (1996) posit "Western society gives authoritative status only to the highly linear modes of inductive and deductive reasoning...mechanistic metaphors for the earth, the universe, and the body have been gaining increasing cultural prominence since the time of Descartes" (240).

Descartes was a proponent of the dualistic separation of body and mind, which eventually became accepted throughout Western medicine. The woman's body was constructed as a machine performing a function, rather than viewing childbirth as a process being performed by a person deeply intertwined with their own experiences and expectations of giving birth (O'Neil and Leyland-Kaufert 1995). Midwives were most frequently family or community members and the space in which a woman gave birth was tight-knit and maintained by women (MacDonald 2006). In fact, prior to the nineteenth century, men were actively discouraged from attending births across North America (Fraser 1995). This meant that women had support networks associated with pregnancy and childbirth and that birth was an event that fostered respect in women's knowledge of their bodies. While some have argued that the actual takeover of birthing by male physicians was more nuanced than some histories suggest, a fundamental shift occurred from midwifery and home-based care, to care provided by the doctor (with more interventions as a result) beginning in more urban areas in the United States (Wertz and Wertz 2001). Gender has always played an important role in midwifery (MacDonald 2006). When midwifery was a traditional practice, women without official credentials cared for each other during labour (Fraser 1995). As doctors became more interested in the business of birth, key differences between men and women were a large part of how (male) doctors rationalized midwives' inability to effectively provide care (Wertz and Wertz 2001). These differences included the fact that a woman was presumed to provide worse care while menstruating, and that it

was surely beyond women to learn the complicated biological facts behind birth and still retain a lady-like status (Wertz and Wertz 2001).

The transition from woman-focused midwifery to highly regimented medical practice meant that labour and delivery moved out of the home where it had traditionally taken place and into the sterile and more easily controlled setting of the hospital. Hospitals were slowly becoming recognized as a place where doctors — and only doctors — could impose control over women, especially those who were categorized as deviant such as the poor (Wertz and Wertz 2001). The rationale for this is based on safety concerns, which are ostensibly mitigated if birth takes place in a hospital setting (Wertz and Wertz 2001). This view was taken despite the fact that obstetricians and hospital births were performed with little understanding of when interventions were necessary and were often made more dangerous by the doctor's overuse of basic tools such as forceps as well as overconfidence more generally (Wertz and Wertz 2001). Doctors often found themselves in situations where they were expected to do something to expedite birth, even if letting the birth progress without intervention would have resulted in a normal birth. The sentiment that doctors "should" be doing something led to increased use of forceps and various other procedures (Wertz and Wertz 2001). However, this shift in care stems from what Cheyney (2011) refers to as "a reflection of a larger patriarchal and technocratic society that constructs women's reproductive bodies as inherently faulty and in need of medical management..." (520). These practices and perspectives became dominant as midwifery was pushed into the margins of society and was gradually illegalized in the United States in the nineteenth century, and as childbirth became every bit as much the domain of medical practice as any illness or trauma (Wertz and Wertz 2001).

Despite the shift away from midwifery in the nineteenth century, by the 1990s public opinion began to shift somewhat towards increasing acceptance of midwifery in North American contexts (Davis-Floyd and Davis 1996). Midwives provide pregnant and labouring women control and power in the birthing process by presenting options that are not generally available within the highly regimented medical establishment (MacDonald 2006). With a midwife, women have the option to deliver their children at home with very little medical intervention in cases where this is deemed medically appropriate and desirable. This allows for control over details such as clothing, atmosphere, and personnel, which may seem ineffectual, but when all these decisions are made without the woman's input (as in the hospital setting), it is often experienced as disempowering (Cheyney 2011). These options also include having the mother be a part of the decision-making process and having one's voice and concerns heard and responded to consistently throughout the birthing process with the midwife (MacDonald 2006).

The birth process is otherwise under the control of the medical gaze, and predominantly male decision-making and ideas about what acceptable birth conditions should be (O'Neil and Leyland-Kaufert 1995). Foucault (2003) posits that "the gaze has produced a more scientific objectivity for us than instrumental arbitrations of quantity" (XIV). Foucault suggests here that that which can be observed by the trained gaze of the doctor has come to, in many respects, replace those other processes that were once given precedence. This also means that the authority of "the gaze" is attributed to those professionals trained within institutions. In the case of midwifery this implicitly discredits the knowledge and training of midwives (Wertz and Wertz 2001). This point is emphasized

by Cheyney and Everson (2009) who found that doctors tended to identify midwifery as an inferior profession and a risk filled choice for pregnant and labouring mothers. One doctor stated “when (doctors) hear that homebirth is relatively safe, they just don’t believe it because they all know of cases where a mother or baby has [been] transported [sic] and they were in danger” (Cheyney and Everson 2009, 7). This culture of distrust among doctors towards midwives relates to the efforts of midwifery to assist women to have labours and deliveries that involve as little technology and unnecessary intervention as possible. As labour and delivery have been redefined as medical issues, the idea of letting birth proceed without immediate technological intervention has, for many medical professionals, begun to seem negligent (Cheyney 2011). For those working within the medical institution, constant monitoring and control are safeguards, which in the context of the medicalization of birth, should be used in all cases regardless of the likelihood of complications (Cheyney 2011).

Eventually medical professionals came to view attending labours as another possible way of making money and therefore asserted their professional dominance over midwives and made a pronounced effort to vilify them in the United States and across North America (Wertz and Wertz 2001). MacDonald (2006) emphasises that

[gender was] (i)ntegral to the displacement of midwives [as] was the redefinition of childbirth as a medical event, fraught with danger and in need of intervention by obstetricians. Gender ideals of women as frail and dependent — and thus incapable of either giving or attending birth unaided by male experts — flourished during this time... (237).

Women were deemed unfit to give birth without medical intervention, due in part to ideas about their incompetence. This understanding could then be imposed upon midwives whose practices were understood more and more to be inadequate based on their gender and their lack of formal medical training. Due to the proliferation of these ideas, midwives were pushed underground and only remained common in isolated communities (MacDonald 2006). The narrative of women as fragile, dependent, and in need of male protection was used to push the expertise of traditional midwives out of focus and present them as antiquated when compared to doctors who had the newest forms of technology at their disposal (such as forceps and pain medications). Doctors not only portray the midwife as an inadequate birth attendant, but also render the birthing woman’s body as incapable of delivering a baby without medical intervention. Through this process women’s bodies are deemed inadequate and needing predominantly masculine oversight and intervention (Wertz and Wertz 2001). The issues of control relating to gender and birth are still present in how midwives are treated as professionals and how their expertise is valued or devalued. In North American birthing culture, midwifery is still seen as a less respected choice for a pregnant woman and as a less prestigious career path than medicine (Fraser 1995).

The ways that women and others advocate for midwifery has changed significantly and this is reflected in how scholars have begun to shift their discussion of issues surrounding midwifery and midwifery activism. As the neoliberal focus on consumerism has intensified, so too has the discourse surrounding the advocacy for midwifery access

(Craven 2007). Among upper class individuals in the North American context choice is a deciding factor in opting for midwifery care. This lines up with the neoliberal discourse around choice, which is prominent in Western society more generally (Craven 2007). A woman's right to choose her care provider, and therefore retain control, are central parts of midwifery activism (Craven 2007). As Craven (2007) states "midwifery advocates frequently drew attention to their legitimacy as consumers to make claims to the right to have a homebirth with the practitioner of one's choice" (705). This further connects with the ethos of women having options as a key tenant of midwifery, namely that midwifery provides women more control and choice, both of which are central aspects of neoliberalism (Craven 2007).

Even as the forms of advocacy have changed, gender remains a central issue within midwifery care. Indeed, midwifery is a profession dominated by women and this tends to follow the philosophy of women taking care of women without unnecessary medical intervention, which in a technocratic setting is frequently coded as male (MacDonald 2006). Since midwifery has become a licenced profession with varying degrees of acceptance throughout North America, it may seem that advocacy and activism related to midwifery are no longer relevant (Davis-Floyd and Davis 1996). However, this is not the case. Despite the ongoing devaluation of midwifery there is a growing interest in the patient focused approach that midwives take, which allows women to advocate for themselves and their babies without feeling pressure from a doctor (Cheyney 2011). Midwifery is generally seen as advocating for women to be their own decision makers, and recognizes and values the intuitive nature of their bodies (Davis-Floyd and Davis 1996). Midwifery is also frequently understood to champion women's health and comfort more generally, while mainstream medical institutions tend to consider a person as a collection of parts to be narrowly examined and repaired in isolation from the person that those body parts make up (Cheyney 2011). Often advocacy is recognized as going beyond having midwives be seen as valued professionals, it also includes having the values of midwifery more widely understood and disseminated throughout the medical community.

The literature presents midwifery as a profession that historically has had its validity as a career choice highly contested due to gendered praxis. The literature explores midwifery as it was first practiced among women, and also considers modern practices of midwifery as a licenced profession that has gained wider acceptance. Of particular interest are issues of gender inequality, which contributed to the illegality of midwives, and the mainstream acceptance of medical obstetrics care. This literature review focuses on North American perspectives and experiences and demonstrates how gender has been intertwined with midwives and their practice since day one. The literature demonstrates that midwives were an integral part of healthcare for many women historically, and that the resurgence of midwifery allowed it to regain some of its status as a respected profession. What remains at issue is the legitimacy given to midwives and their clients as midwifery challenges the over-medicalization found in some mainstream obstetrical practice. In this article, I discuss scholarship from the 1990s and early 2000s. As we move beyond the 2010s, scholarly engagement with midwives' roles should ideally seek to explore midwifery care as it relates to historically marginalized groups such as LGBTQ+ and Disabled populations, as well as how power dynamics continue to shift in our increasingly commodified society. The relationship of midwifery to technology, both as practice and discourse, also

merits further inquiry as midwifery reacts or tries to avoid becoming implicated in the increasingly technological medical environment.

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