

# From **The Captured Womb**

*A history of the medical care of pregnant women (1984)*

## Chapter 11. *Women, the state and the medical profession*

...Antenatal care has involved some kind of relationship between three elements in society: women, the state and the medical profession. Antenatal care is something that is done to women. It represents an attempt to control the behaviour of women's bodies. Of course this is obvious. Pregnancy is a condition only experienced by women. But the obviousness of this point does not make it uninteresting, indeed, on the contrary, it raises the essential and provocative question of how far it is possible to separate the ideology and practice of antenatal care from the ideology and practice of womanhood.

Since antenatal care is an exercise done to women, it must involve some element of controlling women. The term for antenatal care in some languages is, even, as noted earlier, antenatal 'control'. In a sense, any activity targeted at a particular social group has these overtones of social control, less well-developed when participation is voluntary (e.g. anti-smoking campaigns), more so when it is not (e.g. imprisonment). As Michel Foucault has observed of systems of social control in general, no history of the body can be written without considering the body's location in a political field. Given the intimate relation between the economic and political structure, and the way in which 'knowledge' about the body is constituted, we need to abandon the tradition 'that allows us to imagine that knowledge can exist only where the power relations are suspended and that knowledge can develop only outside its injunctions, its demands and its interests' (Foucault, 1977, p. 27). Because of the covert social control function of antenatal care, there is a dialectical relationship within the philosophy and practice of antenatal care over the years between what is happening to antenatal care and what is happening to women. It is not simply that, as antenatal care acquires the status of a commandment, the power of women declines: indeed, if anything, the reverse is the case, and the greater enfranchisement of women has been accompanied by a vigorous renewal of the commandment of antenatal care. Some aspects of the relationship between women's situation and the practice of antenatal care have already been discussed; for example the continuing high rate of maternal mortality in the 1920s and early 1930s focused the attention of antenatalists - of both the state and the medical profession - more and more sharply on the mother's condition. Conversely, as the risks encountered by women in childbearing became less in the 1950s, mothers gradually began to acquire within the medical perspective a new guise as containers of fetuses. The economic poverty of women's lives in the family before and after the First World War nurtured a holistic approach to pregnancy care, and urged a medico-political awareness of the need for a national health service. Since the promotion of childbearing cannot be separated from its prevention, the inability of women over most of the period covered by this book to obtain free and safe abortion and contraception has hedged the health-promoting

potential of antenatal care with limits not of its own making (and represents the investment of not only the state but the Church in women's reproductive role).

There are many other examples of links between the domain of antenatal care and the position of women, and among these the relationship between feminism and antenatal care is probably the most complex. Antenatal care was born almost at the moment the woman's movement died, and it has lived through the birth, youth and middle-age of another woman's movement. As antenatal care's mentor, J. W. Ballantyne, once said (1914, p. 104), 'the vote can't compensate women for loss of motherhood, but nor, on the other hand, was it ever intended to.' Political investment in women's health care between the wars was an obvious and much-needed direction for ex-suffragettes to take, and as Jane Lewis shows in her historical analysis of *The Politics of Motherhood* (1980), they were joined by many women activists who would not have allied themselves with feminism at all. It was possible in those days to defend the interests of women and not be called (or call oneself) a feminist, just as it has always been possible to defend the interests of men without being known as a masculinist.

In the twentieth century's second wave of feminism, the promotion of motherhood did not at first loom large. Feminist ideology in the early 1970s was an ideology of women's liberation from the burden of reproduction: the ideological platform included free abortion on demand, free and easily available contraception and sterilization, and twenty-four-hour-a-day childcare. The feminists were not demanding natural childbirth, or the rights of women as patients, or the need for self-determination in the achievement of motherhood; motherhood itself was viewed as an obstacle to the goal of sex equality. The battles of women in antenatal clinics to have their voices heard and their interests as individuals considered were strictly off-limits to feminism. There were good reasons for this initial location of feminist health care interests outside the sphere of maternity; the long evolution of an equal rights (women-must-become-equal-to-men) philosophy, the childless background of the first women's liberationists in the late 1960s and early 1970s. Indeed, it could be said with some justification that it was as these early liberationists themselves embarked on motherhood that motherhood became of interest to the women's movement as a whole.

Yet almost in order to make up for this feminist lack of interest in maternity care, obstetricians have tended to equate the protesting consumer with the ardent feminist. A wealth of epithets and caricatures of 'women's liberationists', the 'vocal minority', etc, abounds in debates about the consumer point of view, and there is supporting evidence to suggest that obstetrics and gynaecology may be a particularly misogynist medical specialty (see, for example, Scully, 1980). Its misogyny springs, in part, from its masculinity: in 1982 four out of five NHS doctors working in obstetrics and gynaecology in Britain were men. Men have figured prominently, too, in the technical and institutional history of obstetrics, as we have seen countless times in the pages of this book. Divisions within medicine - obstetrics, gynaecology, paediatrics, neonatal paediatrics, fetal medicine, reproductive medicine - have

segmented women's bodies into competing professional charters and domains of medical work; womanhood and motherhood have become a battlefield for not only patriarchal but professional supremacy; the medical profession has been able to harness paternal/patriarchal assumptions about women's personality and role to the service of its own ascent to professionalization.

The motive of professionalization and professional dominance as an explanation of changes in medical care should never be underrated (Freidson, 1972). New antenatal technologies, for example, are scarcely welcome merely in themselves, but rather as items in the medical armamentarium - witness the placing of lay female self-help groups under police surveillance in the United States in the early 1970s (Ruzek, 1979). The anthropologist Margaret Mead, a long-time commentator on the habits of the so-called civilized world, made the acute observation that 'men began taking over obstetrics and they invented a tool [the vaginal speculum] that allowed them to look inside women. You could call this progress, except that when women tried to look inside themselves, this was called practising medicine without a license' (Mead, 1974, p.6).

The social position of the medical profession is such as to ward off all lay attacks on its ideology and practice. For, as Brian Harrison observes in his commentary on 'Women's Health and the Women's Movement in Britain 1840-1940': 'A profession of any kind is in some respects antithetical to the popular pressure group, for it is by definition concerned with exclusion, whereas the popular agitator seeks comprehensiveness. The profession fears the layman [sic] who is the agitator's main asset; the profession fraternizes with those in authority, whose unpopularity fuels the reformer's fire; the profession defends an interest, whereas altruism is the popular agitator's proudest boast' (Harrison, 1981, p. 34)...

### Medicine and the agency of the state

The state too has its misogynist policies. For example, the economic dependency of wives and mothers has been an assumption behind state welfare schemes ever since the state first began to take some responsibility for the wellbeing of its members; this assumption has always been profoundly contradicted by the realities of family life and the sexual division of labour under capitalism (Lewis, 1983). Yet the misogynies of the state and the medical profession do not merely parallel or mutually reinforce one another. The medical sociologist Eliot Freidson has described the alliance between the state and the medical profession in the following terms: 'The foundation of medicine's control over its work is thus clearly political in character, involving the aid of the state in establishing and maintaining the profession's pre-eminence. The occupation itself has formal representatives, organizational or individual, which attempt to direct the efforts of the state toward policies desired by the occupational group ... it is by the interaction between formal agents or agencies of the occupation and officials of the state that the occupation's control over its work is established and shaped. The most strategic and treasured characteristic of the profession - its

autonomy - is therefore owed to its relationship to the sovereign state' (Freidson, 1972, pp. 23-4).

Ultimately, therefore, the medical profession is not autonomous and the state is. Indeed, the extent to which the health sector, together with its relevant professions, is embedded in the state's corporate power has grown in recent years. The allocation of health care resources has increasingly been perceived in Western capitalist societies as a public responsibility, and increasingly funded out of the public purse (though the state also has an interest in fostering private sector care). The organization of medicine builds upon the class relations of capitalist state social organization, both practically and ideologically.' Social policy and health policy are, from this point of view, indistinguishable (McKinlay, 1979). Though the state's intervention in political, social, economic and medical life has multiplied, in practice, so far as medicine is concerned, the state exercises control over the social and economic organization of medical work, but leaves the profession control over the technological side. Significantly, the state does not supervise or intervene in the process of medical-technological development or evaluation. Since medicine has technical autonomy, and since medical work has become increasingly technological, medical hegemony over the lives of patients is substantial. We have seen how this is manifested in antenatal care in the period since the Second World War. And more generally, of course, charting the history of antenatal care since its beginnings has provided an exercise in the exact articulation between the process of medical professionalization on the one hand, and the infiltration of state power into citizens' lives, on the other.

#### Antenatal care and the control of women

Ballantyne's edict, 'A new discovery calls for a new commandment' (1914, p. 1) likened the birth of antenatal care to the invention of motor cars. Just as the latter had produced new laws and regulations governing safety on the road, so the former necessitated the obedience of women to new sets of laws regarding pregnancy hygiene. Although Ballantyne admitted the then imperfect state of medical knowledge concerning life before birth, he insisted that mothers' obedience to the laws of 'gestational therapeutics' should possess all the urgency of a biological imperative. Doctors might not know very much, but women must consult them. Always fond of metaphors, Ballantyne compared doctors to potters and fetuses to the vessels on the potter's wheel: 'When the potter ... fashions a vessel upon the wheel he may find his work marred not only by reason of some inherent defect in the clay from which he makes it, but also on account of faults of handling, of turning, of drying, of firing, of glazing, and of decorating; the expert workman may do much even with an inferior material, whilst in the hands of the bungler the finest substance may be fatally spoiled' (Ballantyne, 1914, p. 810).

Ballantyne's enthusiasm for the laws of antenatal hygiene was, of course, in part a protest against the eugenicists' argument that unhealthy parents bred unhealthy babies and both were best eliminated by natural selection. His view was that, on the

contrary, both parents and doctors might have to contend with inferior biological material, yet a proper alliance between them would be able to save many infants 'from many evils which are in no sense hereditary'.

In this purported alliance between mothers and doctors, the main imperative for mothers was to solicit, and pay attention to, medical advice. It was recognized in the 1920s and 1930s, and even later, that uneven enthusiasm among doctors for antenatal care meant that on occasions mothers would have to demand it - but the major problem was nevertheless perceived as an educational one. Women had to be educated in two ways. First they had to see the need for medical antenatal care. Second, this aspect of anticipated motherhood had to be set in the broader context of 'mothercraft', a necessary skill in women that could only be produced by education...

Wherever the idea of ignorance among mothers had come from, it was not based on evidence. In the 1920s and 1930s the attitudes and practices of women concerning motherhood were not actually surveyed. This absence of data made no difference to three developments. Firstly, the education of mothers did not mean education by other mothers within the community; it meant education by voluntary workers of superordinate social status, or by health-care professionals. Secondly, the educational side of antenatal work evolved integrally with medical antenatal care, and has only since the 1960s split off from this as a recognizably different exercise. Thirdly, as antenatal care has developed, the vocabulary of mothers' assumed ignorance has increasingly been translated into the more exact invective of 'why don't women attend for antenatal care?' It is within this invective, some of which was traced earlier in this book, that the motive of controlling women is most nakedly revealed.

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