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**MEDICALIZED CHILDBIRTH IN THE UNITED STATES:
ORIGINS, OUTCOMES, AND OPPOSITION**

by Martelia L. Henson

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ABSTRACT

“MEDICALIZED CHILDBIRTH IN THE UNITED STATES: ORIGINS, OUTCOMES, AND OPPOSITIONS”

Martelia L. Henson

This study focuses on childbirth in the United States as a medical event, specifically concentrating on the historical development of medicalized birth and the cultural and social ramifications of this transformation. The main objective is to apply various aspects of social movement theory and movement dynamics to the rise of obstetric medicine as it is documented in the existing body of childbirth literature, in order to achieve a greater understanding of the appropriation of American childbirth practices by the medical profession. Also included is a discussion of various birth reform movements that have attempted, and are attempting, to challenge the medical monopoly of childbirth in the United States.

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CHAPTER ONE

Introduction

Childbirth is one of the most basic human experiences, and as such is interwoven into the cultural and political structures of society. Within any given society, the event and process of childbirth both create cultural meaning and reflect existing cultural values and ideologies. Throughout most of human history, childbirth was a women-centered event, typically taking place in the home environment. Birth was perceived and treated as a normal, natural part of a woman's life, just one of many important stages in the life course. Women served as the stewards of a society's knowledge of pregnancy, labor, and birth. This knowledge came from a variety of sources, including personal experience, tradition, and religious and cultural beliefs. Birth was often a time of anticipation and celebration. However, it was also acknowledged and accepted that some degree of uncertainty is an inherent part of the birth process, that every birth has the potential to develop complications and even result in death. Women dealt with this reality by using their society's accumulated birth knowledge to prepare for birth during pregnancy and to aid in the management of the birth event itself in terms of objective practices and subjective coping mechanisms.

Over time, as cultural values and goals changed and people began to have greater scientific knowledge and technology at their disposal, childbirth practices in many societies also underwent significant changes in terms of management of the birth process and cultural meanings attached to birth. Nowhere have these changes been more profound than in the United States. American childbirth is medicalized childbirth. Though of course there are exceptions, birth in the United States is an event defined and monopolized by the medical structure. This monopoly is reinforced by the political structure through things such as licensure laws and scope-of-practice regulations; by economic institutions that do not reimburse midwifery services and that increase malpractice rates for physicians

who backup midwifery practices; and by social structures that perpetuate the cultural meaning of birth as a pathological medical event. Obviously, childbirth practices in America have not always been as they are today, nor is American society the only one in which birth has changed throughout history. What is surprising is just how rapidly birth in the United States was transformed into its present state and how completely the medical structure was able to appropriate the process and meaning of childbirth, such that most people are socialized to blindly accept medicalized birth as the only viable practice.

The purpose of this study is to discuss the historical development of medicalized childbirth in the United States and the various birth reform proponents and movements that have challenged the medical model. A considerable body of literature already exists on this topic, with different scholars approaching it from a variety of perspectives. This study seeks to contribute to the current literature by analyzing childbirth practices in the United States from a social movement perspective. Due to its sheer volume, an exhaustive study of existing work on childbirth is beyond the scope of this discussion. However, it seems an accurate assessment that there is a scarcity in the childbirth literature of analyses that explicitly place obstetric medicine and birth reform in a social movement framework. Therefore, this study will focus on both the development of modern obstetrics as well as various movements that have attempted, and are attempting, to challenge medicine's monopoly over childbirth in the United States, and how each of these does or does not fit into a social movement model. Included will be a comparison of what are commonly called the Medical Model of Birth and the Midwifery Model of Care. Each is reflective of the underlying ideologies of its supporters and practitioners. This study will also include a discussion of the specific ways in which medical birth typically differs from non-medical birth, in terms of how birth is managed or controlled, the use of technology, and meanings that are created and conveyed by the two different processes. In order to enhance this discussion, questionnaires were prepared and submitted to a few individual practicing midwives and mothers who have given

birth with the assistance of a midwife. The results of these questionnaires will be presented as a means of supplementing the substantive material.

To present it in a more concise manner, this study is an attempt to answer the following questions:

- How did American childbirth come to be medicalized?
- What effects has this medicalization had on cultural meanings and actual experiences of childbirth?
- What has been the nature of opposition to medicalized birth?
- How successful has the birth reform movement been?

CHAPTER TWO

Background Information

The purpose of this chapter is to provide a basic overview of American childbirth practices in order to establish a backdrop for the main body of this study. The topics discussed in this chapter are: the historical development of medicalized childbirth in the United States; the differences between the Medical Model of Birth and the Midwifery Model of Care, and how these differences affect professional practice; a differentiation between types of midwifery practitioners and the training they receive; and an overview of American childbirth statistics.

Historical Development of Medicalized Childbirth

Due to the abundance of existing childbirth literature, it is not difficult to trace the evolution of childbirth practice in America from the predominance of midwife-assisted homebirth employed by the colonists, to its current state as a highly medicalized event. With few exceptions, most sources present the same basic historical account. Nowhere is it disputed that for most of human history, childbirth has been the domain of women. Women have always assisted each other in labor and delivery and passed on their accumulated collective knowledge of birth through socialization into the female community. At some point in human history, exactly when is uncertain, a small number of women in different societies distinguished themselves in their communities by developing a greater knowledge of birth and a higher level of skill in managing birth than what most women in their communities possessed. These women became the midwives. Their level of expertise in not only childbirth but also in most other health matters earned them a certain measure of respect in society as healers. As birth assistants they fulfilled a predominantly supportive role, many times offering little more

than psychological support and encouragement. This role is reflected in the definition of 'midwife' as 'with woman'.

In colonial America, midwives were present in most communities, where they continued the tradition of providing general health care services in addition to being birth attendants. There were also a few physicians at this time coexisting with the midwives. These physicians were largely uneducated (male) health practitioners who worked without the benefit of scientific medical knowledge of the human body. They were trained through apprenticeship and supplemented this training by studying the few European medical texts they could acquire. Some still adhered to the humoral view of disease, according to which disease was a result of an imbalance in the body's four humours, which corresponded to the natural elements of earth, air, water, and fire. Treatments could include bleeding, leeching, and other such practices.

Childbirth was not even considered to be a subject amenable to the study and practice of medicine. In fact there was somewhat of a stigma attached to men who assisted in births. It was largely viewed as dirty work, belonging to women, and unsuited to the practice of medicine. American physicians in the 17th Century began being called into birthing rooms on occasion, but only when things went fatally wrong and the fetus had to be extracted, usually in pieces. Physicians possessed suitable instruments that were not accessible by midwives. During the first part of the 18th Century forceps became available to most doctors (Edwards, 1984). Through the use of forceps, physicians were now able to assist in complicated births and emergency delivery situations and be fairly confident of a positive outcome. Midwives were prohibited from owning or using forceps, making it necessary to call in a physician in order to take advantage of the new technology in an emergency situation.

Eventually American physicians began to push for the establishment of a more standardized formal system of education, one that utilized the burgeoning field of science to study human anatomy and physiology and incorporate findings into practice. The first American medical school was founded in 1765. As the number of medical schools increased, doctors gained the ability to train much

larger numbers of students than was possible through the old system of apprenticeship. They also became able to develop standards of practice. Subsequently the number of doctors in the country grew significantly and doctors began competing with each other for patients. One possible solution to this was specialization in a certain area of medical study and treatment.

The possession of forceps led to the increased presence of physicians during birth, though they still did not actually participate in the management of birth. With their significant birth knowledge and experience, female birth attendants and midwives were able to maintain their authority in the birth chamber. Gradually, however, male doctors, who originally gained entry to the birth room only as a last resort in tragic circumstances, assumed increasing control in the birth room in terms of guiding the management of labor and delivery. Beginning in the middle part of the 18th Century there was a proliferation of public hospitals. These hospitals served as an ideal environment in which physicians and medical students could gain clinical obstetric experience as well as use birthing women as research tools by which to expand their knowledge of labor and delivery. In the beginning these hospitals served a population of women that was predominantly urban and impoverished. The hospitals offered free physician-assisted labor and delivery services as an incentive to attract large numbers of birthing women for the purpose of using them as teaching resources. The profession was further bolstered when the American College of Obstetricians and Gynecologists was formed in 1888.

Another significant development in the medicalization of birth occurred in the 19th Century. In 1847, Dr. James Simpson, a Scottish obstetrician, administered diethyl ether to a woman who had a deformed pelvis that he anticipated would cause her great pain and difficulty in delivery. This marked the first time that a woman had ever been anesthetized during childbirth. The ether did not render the woman unconscious, rather it served to dull her pain and put her into a relaxed state. Dr. Simpson considered it a great success, as the delivery went smoothly and the mother was grateful to him for relieving her pain and enabling her to have an enjoyable birth experience. Not long after Simpson went public with the

details of the experiment, physicians in America began using anesthesia on their own birthing patients. For their part, many American women started requesting, even demanding to be anesthetized by their doctors during labor and delivery. Despite the fact that the use of ether and other possible anesthetics in childbirth had never been adequately tested to determine the effects upon the mother and the baby, the majority of American obstetricians incorporated anesthesia as a routine part of their birth management practices.

Anesthetized childbirth was taken further with the introduction of ‘twilight sleep’ at the beginning of the 20th Century. This method combined the drugs morphine and scopolamine to render the birthing woman essentially unconscious throughout the entire birth process (Banks, 1999). This prospect appealed to women of the upper classes, who desired the easiest birth possible. With twilight sleep, women avoided the experience of birth altogether. Essentially, birth using twilight sleep consisted of physicians and medical staff using instruments to remove the baby from the body of the unconscious woman, and she awoke a mother with no memory of giving birth at all. Soon the popularity of twilight sleep caused most upper class women to begin birthing in the hospital. For the majority of women in the United States, however, birth still occurred at home, though by this point many homebirths were assisted by physicians. The push for hospital birth continued and by the middle part of the century, around 88% of all births took place in the hospital. This move from home to hospital was the final step in the complete transformation of American childbirth into a medical event requiring significant intervention by highly trained physicians using technological instruments and drugs (Banks, 1999).

Divergent Models of Birth

Discourses on childbirth, particularly those based on feminist and midwifery perspectives, often include references to the Medical Model of Birth and the Midwifery Model of Care and how they differ. Each model reflects the ideologies

of its practitioners and supporters and serves as a guide for the type of birth care they provide.

Most midwife organizations, such as the Midwives Alliance of North America (MANA), include an outline of the Midwifery Model of Care in their mission statement. This model adheres to a definition of birth as a natural, normal event that does not necessitate medical treatment. Emphasis is placed upon the autonomy and control of the mother over her own labor and delivery. The mother is acknowledged to be the expert in terms of her own body and as inherently capable of managing her own pregnancy, labor, and delivery successfully. The role of the midwife or other birth assistant is to provide the mother with reliable and adequate information concerning pregnancy and birth, psychological support and encouragement, and comprehensive pre-natal care. The midwife's role is one of non-intervention into the natural birth process. However, the Midwifery Model does acknowledge the basic level of risk intrinsic to the birth event. Thus practicing midwives serve mothers who are at low-risk for complications. High-risk pregnancies are posited as best handled by medical practitioners equipped to deal with serious complications. Cooperation between midwives and physicians is viewed as ideal in birth, such that physicians provide backup support for midwife-assisted births.

Adherence to the Midwifery Model of Care is evident in the actual practice of midwife-assisted birth. Pre-natal care is comprehensive in that it includes: the monitoring of the physical health of the mother and fetus; education in terms of available options, nutrition, and the mechanics of labor and delivery; and emotional and psychological preparation for birth. Some women also supplement the midwifery care they receive with visits to family physicians. No matter the place of birth, laboring women retain control of the event. The place of birth itself is chosen by the mother, except in those rare cases which require relocation to a hospital due to complications. The mother is free to move around as she wishes, to birth in any position that is comfortable, to drink and eat during labor and delivery, and to have anyone in attendance that she chooses. The midwife is present for the entire labor and delivery and she provides emotional support and

encouragement to the mother throughout the process, as well as physical support which can include things such as massage of the mother's back or abdomen. Intervention is either minimal or absent, birth is permitted to follow its own natural course. Following the birth, the mother and baby are not separated but given the opportunity to bond. Most women who birth with a midwife breast feed immediately. Midwife care also usually extends for a certain period of time following birth so that the midwife can monitor the baby's progress and assist the mother in childcare activities.

The Medical Model of Birth stands in striking contrast to the Midwifery Model. The Medical Model is essentially a composite of views and guidelines articulated by the obstetric profession and those which can be observed but are not usually discussed. The basic tenet of this model is that childbirth is a medical event that is inherently pathological, and thus requires intervention by a highly trained physician and his or her medical staff through the use of various instruments. This medical intervention reduces the risk of complication and negative outcomes and can even eliminate these altogether if all possible means of intervention are employed. The physician is the expert in matters concerning pregnancy, labor, and delivery and therefore should be in control of the whole process. The mother is not viewed as autonomous, as sufficiently knowledgeable about her own body, or as capable of successfully managing the birth event. Further, the Medical Model places no importance upon the mother's psychological or emotional experience of birth, as it is deemed largely irrelevant to the physician's job, which is to successfully deliver the baby. This is reflected in the designation of the Medical Model as a model of birth as opposed to the Midwifery Model of Care.

The Medical Model of Birth is borne out in the management of physician-assisted birth. The place of birth is the hospital. A number of hospital staff members, generally nurses, are involved in the labor and delivery and are often strangers to the birthing woman. The nurses have designated procedures to follow, including the administration of interventive measures. They administer drugs for pain control, as well as drugs to either slow down or hasten the

progression of labor. The primary purpose of slowing down labor is to delay delivery until the doctor arrives. Labor is hastened primarily so that delivery will fit into the doctor's schedule. Increasingly common is the use of an electric fetal monitor, which allows the nurses to observe the baby's progress and watch for signs of fetal distress. The use of fetal monitors enables nurses to monitor labor without actually having to interact with the mother or even be in the room with her. The mother is required to labor and birth in a prone position. Her clothes are taken from her and exchanged for a hospital gown and she is prohibited from eating or drinking anything throughout the entire event. Instead she is given an I.V. to prevent dehydration, a measure which essentially ensures her confinement to the hospital bed. The doctor is absent during labor, he or she is only present for the delivery. The doctor routinely performs an episiotomy to prevent tearing of the perineum during delivery. This will require stitching following birth and involves a certain amount of pain and recovery time. During delivery the mother is often given additional pain medication. In cases where a complication arises, the doctor may dismiss other alternatives and decide a cesarean section is the best course to take. This also has lasting consequences for the mother. Following birth, the baby is taken from the mother so that it can be weighed, measured, bathed, and submitted to the Apgar test. The mother and baby sleep in separate rooms. The mother is not encouraged to breast feed immediately and typically does not do so. While the preceding description does not purport to apply to all physician-assisted hospital births in the United States, it is certainly representative of the typical management of birth in hospitals in which physicians are the primary attendants.

Types of Midwifery Practice

Lay or direct-entry midwifery is the type of midwifery that has been practiced for most of human history. Lay or direct-entry midwives primarily assist at homebirths. They can have their own practices or work in cooperation with other midwives. They often employ birthing assistants and serve a relatively small

number of women. They usually have no formal midwifery or nursing education, but receive their training through first-hand experience and apprenticeships to other lay midwives. Ideally, lay midwives operate with physician backup, but many times have difficulty finding physicians willing to provide this support. They are generally unable to obtain malpractice insurance, though coverage for their services is being offered by increasing numbers of private insurance companies and by Medicaid. The legal status of lay or direct-entry midwifery varies from state to state. In states where lay midwifery is illegal or where its status is undefined, lay midwives can be, and are, prosecuted for practicing medicine without a license. Lay midwives can become accredited through the Midwifery Education and Accreditation Council (MEAC). Those practicing in states where lay midwifery is legal can be licensed by that state. Lay midwives can also become nationally certified and earn the title of Certified Professional Midwife by passing a written examination and skills assessment administered by the North American Registry of Midwives (NARM). In states where lay midwifery is not legal, certification can still be beneficial as testimony of a midwife's birth knowledge and skill to her clients.

Another form of midwifery practice is nurse-midwifery. Nurse-midwives typically practice in freestanding birth centers and in hospitals. Nurse midwives are licensed nurses who have also been educated in a midwifery program that has been accredited by the American College of Nurse-Midwives Certification Council. They must pass a nationally administered written examination and can be licensed in individual states. Nurse-midwives can also earn the title Certified Professional Midwife by passing the NARM written examination and skills assessment.

American Childbirth Statistics

It is useful at this point to briefly present some statistics related to American childbirth practices. One of the main justifications offered for the medicalization of birth is and has always been its safety. Available data, however, indicate the

assertion that medicalized birth is safer than alternative methods is inaccurate at best.

At the beginning of the 20th Century, less than 10% of all births in the United States took place in the hospital. By 1936, around 40% of all births took place in the hospital and by 1970 hospital births accounted for 99.4% of all births (Banks, 1999). Though the number of out of hospital births began an increase during the 1970s that is continuing today, around 96% of all births still take place in the hospital, with most of these being physician-assisted (Blevins, 1995). When birth began to move to the hospital on a large scale in the beginning of the 1900s, the maternal mortality rate actually increased for a period of time, due to the rise in puerperal fever caused by unsanitary physician practices and hospital conditions. After practices and conditions were improved and remedied the epidemic occurrences of puerperal fever in the 1930s, maternal mortality rates did improve dramatically. These rates, however, have not changed significantly since that time, despite the routine use of more and increasingly ‘high-tech’ methods and tools of intervention.

The United States has the most expensive health care system in the world, with health care currently accounting for around 14% of the gross domestic product (Weiss and Lonnquist, 2000), and its practitioners have access to the most advanced medical technologies and procedures. Yet the United States continues to have some of the worst infant mortality rates of all industrialized nations, 8.4 infant deaths per 1000 live births. Japan, with the best rates, has about 4.4 infant deaths per 1000 live births, almost half of the American rate (National Center for Health Statistics, 2000). Many birth reform proponents point out that in countries where the infant mortality rates are lower than those in the United States, midwives are employed as the main birth attendants in many or most births. Further, while the World Health Organization recommends a worldwide cesarean section rate of 10-15%, the American cesarean section rate is around 25% (Blevins, 1995). This rate reflects the increasing practice of performing elective and unnecessary cesareans. Basically, the situation is this: despite being part of the world’s most expensive health care system, employing the most

technologically advanced interventive measures, and being administered by highly trained physicians, obstetric medicine has failed to live up to the claim of increased safety that is used to justify its control over American birth practice.

CHAPTER THREE

Literature Review

The voluminous nature of the existing body of childbirth literature renders an exhaustive review beyond the scope of this study. The works reviewed in this chapter and which will be used as the basis for the analysis in subsequent chapters are primarily works that are critical of the medicalization of American childbirth and those that approach it from a non-medical standpoint. It is important to note that most non-medical childbirth literature does tend to be critical of the medical treatment of birth in the United States. The primary focus for this literature review is upon the main explanations that have been offered to account for the development and continued evolution of medicalized childbirth in the United States.

The medical literature on childbirth that is referenced in this study tends to come in the form of either obstetric textbooks or instructional guides for women who are planning for childbirth. Though instructional guides for expectant mothers are certainly not within the realm of scholarly literature, they are nonetheless important as they reflect the nature of contemporary birth practices. Obstetric textbooks are chiefly concerned with the pathologies and complications of birth, as well as with the instruments and techniques used to deal with these. Attention is focused upon female reproductive anatomy and the ways in which obstetric medicine has been able to successfully manipulate it and the birth process to conform to the medical ideal. The fact that there is a spiritual, emotional, physical being, the mother, within which the process of birth occurs, is given little if any consideration.

Though not the dominant form of medical birth literature, there do exist medical histories of childbirth and how it changed with the advent of obstetric medicine. These texts have essentially rewritten the historical record, so that obstetric medicine is presented as having rescued birth from the hands of

incompetent female midwives (Banks, 1999; Edwards, 1984). An especially ludicrous example of this type of work is provided by Elliott McCleary's *New Miracles of Childbirth* (1974), in which he makes numerous such claims, citing the use of obstetric technology as being a particular blessing to birthing women. The most surprising thing about this book is that McCleary did not provide sources for his claims. Despite using various statistical data, the book does not contain a bibliography of any sort. Rather, as a means of corroboration, he provides a list of 'experts' (all medical doctors), who, he says, affirmed his findings.

The 'how-to' guides targeted to expectant mothers enforce the primacy of the physician and the hospital in ensuring a safe birth experience. The progression of pregnancy is marked by the level of interaction between the mother and the medical system, in terms of the frequency of doctor visits, the type of technology used at different stages (such as ultrasound), planning for the hospital stay, etc. These books also typically include a section on possible complications during labor and delivery, reiterating the necessity of medical birth for a positive outcome. Recently, medical literature, especially instructional guides for women, has begun to include discussions of alternative birth options, mainly the use of midwives as primary birth assistants. However, the focus tends to be on nurse-midwives as the only viable physician substitutes, and their care is posited as being optimal in the hospital setting. The common theme running through most medical birth literature is the safety and desirability of physician-assisted birth in the hospital setting. One especially pertinent example of this type of pro-medical 'how to' guide is that written by Kallop (1988). Kallop, a registered nurse, repeatedly directs expectant mothers to rely only on the guidance and instructions given by their doctors. She also presents hospital birth as a given, natural part of the process, with chapters that cover topics such as preparing for the hospital stay and what to expect in the hospital. Further, Kallop explicitly states that hospital birth equals safe birth. However, this claim is very rarely corroborated by valid, reliable empirical evidence. The claim of the increased safety of medical birth is essentially presented as a given

fact, a matter of commonsense. It is important to note that nowhere in the critical literature accessed for this study is it disputed that obstetric medicine has been a godsend for women with high-risk pregnancies and births that encounter serious complications. However, the routine application of obstetric interventions in the majority of all births based on their benefit to high-risk births is superfluous. Generally, the actual justification offered for routine obstetric intervention can be viewed as an example of circular logic. The rationale used is the ideology that the application of science and technology always makes things safer and better. Thus, the argument goes, childbirth has been improved and made safer because of the application of obstetric technology.

Non-medical childbirth literature comes in the form of historical accounts of the practice of midwifery and the medicalization of birth, critical analyses of this development and current obstetric practice, and instructional works for expectant mothers who seek alternative birth experiences. Critical examinations of birth generally include an outline of the historical development of medicalized childbirth as a foundation for analysis and also draw upon available quantitative data, such as that collected by the World Health Organization (WHO) and the Center for Disease Control (CDC), concerning childbirth practices and their outcomes. Beyond critical analyses of medicalized birth, an increasingly important area of childbirth research seeks to examine birth as a subjective experience for women and their families, employing qualitative research methods to investigate topics such as the influence of cultural beliefs and expectations upon how women define their own birthing experiences and how they approach the role of motherhood.

One way researchers have analyzed medicalized childbirth is by examining the role of technology in obstetrics. Often the development of obstetric technology is presented as one of the key tools by which physicians were able to gain (and retain) control of American birth practices. Midwives were generally prohibited from using instruments, such as forceps, which significantly improved birth outcomes in difficult cases. Thus physicians gained entry into

birth rooms because they had access to better technological obstetric tools. Technology in birth literature applies to any type of obstetric intervention into the birth process. As such, anesthesia is included under this topic and its restriction to physician use provides another example of how the employment of technology served to create a place for doctors in American childbirth. While most studies give relatively minor attention to the role of technology, several analyses have it as the primary focus.

For example, Hiddinga and Blume (1992) used the historical development of cephalopelvimetry in obstetrics to show the importance of technology to the evolution of the profession. Cephalopelvimetry involves measuring the pelvis and the head of the fetus in order to identify malproportion and thus distinguish between normal and abnormal births. Physicians began to engage in this practice during the 18th century. It was becoming increasingly common for abnormal births to be attended by physicians, though normal births remained the domain of midwives. According to Hiddinga and Blume, measuring the pelvis and the fetal head initially served the purpose of identifying those births that indicated the assistance of a physician, with his special instruments and methods. Physicians began to do research on the pelvises of skeletons and later on birthing women, seeking a more precise way to measure the pelvis and fetal head and to establish a more objective guideline for identifying abnormality. Gradually, cephalopelvimetry was used to expand the circumstances considered abnormal enough to warrant medical assistance and intervention as well as to identify new abnormalities.

Pelvimetric measurement also worked with other obstetric technologies to expand the scope of obstetric practice. As procedures such as cesarean section and induction of labor became safer, tools such as X-ray equipment were developed to detect abnormalities earlier in pregnancy. This enabled physicians to exert more control throughout pregnancy (instead of just during birth) and to predict the "need" for cesarean section and labor induction. With the introduction of ultrasound technology, the very objective of cephalopelvimetry changed from the measurement of the mother's pelvis and the head of the fetus

to the monitoring of fetal development throughout pregnancy in order to ensure normalcy. Hiddinga and Blume see a reciprocal relationship between the obstetric profession and technological development, such that shifting professional concerns lead to the development of new instruments and techniques, and that technological developments alternately allow for the expansion of physician control over pregnancy and birth.

Another work related to the role of technology in changing birth practices is the study done by Amanda Banks (1999), in which she focuses on the use and construction of birth chairs. She traces the recorded history of birth chairs and shows how their design changed significantly as physicians became increasingly involved in the management of birth. Originally, birth chairs were more like small stools, they were close to ground so the birthing woman could use the floor as a brace, and they featured seats that were open in the middle. This design worked with the force of gravity to aid in delivery, and the midwife (or other birth attendant) would simply kneel and catch the baby. Obviously, women using birth chairs birthed in an upright position. Over time, birth chairs came to be built so that they were extremely high off the ground, preventing the birthing woman from using the floor as a brace during delivery. One of the main reasons for this, according to Banks, was that doctors did not want to kneel down so low on the floor in order to catch the baby. Further, birth chairs came to be equipped with rigid backs and straps for the woman's arms and legs and eventually were transformed so that the woman had to birth in a prone position, such that they ceased to be birth 'chairs' altogether and became tables. Two important conclusions Banks draws from her research are that, first of all, birth technology changed to reflect the interests of physicians, and secondly, that the changes made in birth chairs effectively rendered the birth process more difficult and painful for women, thus supporting the medical view of birth as a pathological process in need of obstetric intervention.

Through the use of ethnographic study of obstetrical ultrasound, Janelle Taylor (2000) expands the role of technology from that of facilitating the medicalization of childbirth, to its role in the cultural experience of birth.

Taylor examines one of the most important themes in critical feminist birth literature, that of childbirth and reproduction as analogous to capitalist production. Basically, this analogy asserts that modern American childbirth practice puts the obstetrician in the role of capitalist manager, who oversees the production of the valued commodity (the baby) by the unskilled and alienated worker (the mother). Taylor makes the assertion that this analogy to production, while insightful and significant, does not provide an adequate representation of modern reproductive and childbearing practices in the United States.

Drawing from her ethnographic study of an obstetrical ultrasound clinic, as well as from existing literature, Taylor (2000) advances a view of reproduction as consumption. Consumption here includes not only that of objectified commodities but also intangible subjective experiences and social interactions. Taylor identifies four ways in which modern reproductive practices can be viewed in terms of consumption. First, pregnancy is characterized by changes in the actual consumption of food and other substances on the part of the expectant mother. Pregnancy itself may occur because a woman stops taking birth control pills. Pregnancy is also marked by a woman's inability to take most types of medication. Further, pregnant women are expected to change their patterns of food consumption, in terms of both the types and the amount of food they consume, and they are expected to refrain from smoking and drinking alcohol. These changes in food and substance consumption in pregnancy are generally used to judge whether or not a woman is a 'good' mother. Women who violate these expectations may be subject to social sanctions, as consumption patterns are tied to maternal love and responsibility, and women are expected to want to be 'good' mothers. One reason for undergoing ultrasound examination cited by several mothers in Taylor's study was that they wanted observable proof that the fetus really existed, in order to justify their sacrifices in terms of food and substance consumption. Both maternal food consumption expectations and routine use of ultrasound during pregnancy reflect the medical view of birth and how this view characterizes obstetric prenatal care. Basically, since every birth is inherently pathological, every aspect of it needs to be objectified and

monitored to identify complications. This has come to include not only labor and birth, but the entire duration of pregnancy itself, beginning as soon as possible following conception. Women are socialized to view the health and development of their babies as being, to a great extent, dependent upon the choices that they themselves make in terms of exercise and patterns of food and substance consumption. Obtaining ultrasound examinations are accepted as necessary to assure fetal health and development. In a sense, ultrasound is yet another way that women can (and should) take primary responsibility for fetal health, while at the same time ultrasound serves as evidence that a woman has been a 'good' mother by making the right consumption choices.

Another way that Taylor views pregnancy in terms of consumption is that prospective parents engage in consumption of material goods on behalf of the fetus. Pregnancy has come to be characterized by the purchase of a wide array of products for the fetus, including items such as clothing, furniture, and strollers. Many such items have been successfully promoted as necessary items for 'good' parents to have on hand by the time the baby is born. Thus, product consumption has become equated with parental love and child-rearing aptitude. Taylor found that one of the main reasons articulated by mothers for the use of ultrasound technology was the desire to learn the sex of the fetus so they could begin buying it clothes and toys, which continue to be largely sex-typed.

The third way that Taylor identifies pregnancy with consumption is with the assertion that the experience of pregnancy itself is consumed as an intangible commodity. Women in the United States who have access to health care, including prenatal care, essentially contract, according to Taylor, with their health care providers to have a certain kind of pregnancy experience. Also involved in this type of consumption is the use of instructional guides intended for expectant mothers, guides that typically reinforce the medical model of birth, while at the same time offering women a perceived sense of control over their pregnancies. The predominant pregnancy experience promoted in contemporary American society is somewhat of a generic, one-size-fits-all model, characterized by certain experiences. These include things such as regular

appointments with an obstetrician/gynecologist, routine ultrasound examination, and Lamaze or other medically endorsed childbirth classes. Taylor's study places particular emphasis on ultrasound as a defining element of the pregnancy experience, including routine discovery of the sex of the fetus and the procurement of ultrasound pictures which are shared with family, friends, and acquaintances. Also part of the experience is scheduling and planning for birth in the hospital, even the use of pain medication and cesarean section. For many American women today, receiving an ultrasound examination and getting pictures of the fetus have in essence become status symbols, meaning they indicate that a woman is a 'good' mother and that she has the opportunity to do everything possible to ensure the health and safety of her baby and is responsible and informed enough to do so.

The final way that Taylor views pregnancy in terms of consumption is that the mother/parents 'consume' the fetus. By this she means that through the use of ultrasound and by consuming on behalf of the fetus, the fetus is given a specific identity and it becomes a person. In her ethnographic study of ultrasound examinations, Taylor observed that both mothers and those performing the procedure conferred personal traits upon the fetus, particularly related to its position and the nature of its movements, as well as the identification of its sex. By seeing and hearing the fetus through ultrasound, by purchasing products on its behalf, and by showing ultrasound pictures to family, friends, and acquaintances, mothers/parents create personhood for the fetus. Taylor illustrates this very well by recounting her discussion with one expectant mother in particular who had previously experienced a miscarriage. This mother explained that she was delaying as long as possible the purchase of any items for the baby and the discovery of its sex out of fear that she would have another miscarriage. Taylor described this woman's view as akin to a superstition, in that the woman felt creating an identity for the fetus might in some way be increasing the likelihood of a miscarriage. In addition, the mother stated that buying things for the baby before the actual birth and having them in the home made it more difficult if the baby did not survive. Taylor draws the conclusion

that both the production analogy of reproduction and the consumption model are applicable to the study of American childbirth practices. While on one hand medicalized childbirth has reduced the fetus to a commodity and alienated the mother from the birth process, it also offers the mother a sense of control and involvement during pregnancy by transforming the fetus into a person and reconstructing pregnancy into an experience of informed and active consumption.

The analogy to capitalist production is a common theme in critical childbirth literature, particularly that which is considered feminist literature. One of the foremost proponents of this analysis is Barbara Katz Rothman. Rothman (1989) presents reproduction in contemporary society as influenced by the overall commodification of life in general. Babies have become commodities in that they generate substantial income for the medical establishment and because they are in high demand among individuals and for society as a whole. The development of new reproductive technologies, such as in vitro fertilization, has served to bolster the role of babies as commodities. According to Rothman's analysis, as babies have become more valuable to medical practice, doctors have assumed greater, even total, control over the birth process, thus displacing the birthing women themselves and relegating them to the role of alienated and unskilled laborers. She further asserts that various prenatal diagnostic procedures function as 'quality control' measures, such that 'products' determined to be 'defective' can be 'disposed' of. Taylor (2000) provides support for this position by citing medical texts that recommend routine ultrasound examination for the primary purpose of facilitating selective abortion of fetuses who have certain defects or abnormalities. Rothman (1989) emphasizes that birth became analogous to capitalist production within a larger society that was already characterized by the commodification of work and life and the alienation of people from the products of their labor.

Rothman (1989) also presents medicalized childbirth, as do many other feminist writers, as resulting from the increasing rationalization of society. Broad societal acceptance of science and technology as value-free, as superior to

the 'old ways', and as inherently beneficial to humanity paved the way for the acceptance of medical control of and intervention into birth as the safest, easiest, most desirable way to manage birth. Essentially, science and technology had devalued the role of nature and even spirituality in people's lives and were even viewed as the 'triumph' of humanity over the uncertainties of the natural world. Applied to childbirth, advances in science and technology resulted in the triumph of science, in the form of medicine, over nature, in the form of women.

Obviously, one of the most important mechanisms in the facilitation of the medicalization of birth, as discussed by Rothman and other feminist writers, was the patriarchal organization of society. The disparate power relationships between men and women in America has historically been so intertwined with all social structures and institutions that an examination of its impact upon the medicalization of childbirth can be somewhat of a daunting and complex endeavor. As such, it is not surprising that the childbirth literature is saturated with analyses of medical birth in the context of a patriarchal society and a male-dominated sex-gender system. Some specific works that address this topic have been done by Adrienne Rich (1976), Lauri Umansky (1996), Naomi Wolf (2001), Ann Oakley (1986), and John Smith (1992), to name a few. The interesting thing about the work by Smith is that he himself is an experienced obstetrician and gynecologist, having been in the profession for about 20 years. Based upon his own personal experiences as well as upon existing literature, Smith provides a rather scathing account of medicalized reproduction and childbirth. He identifies the patriarchal organization of society, and the creation and perpetuation of gender roles that serve to enforce male dominance, as the source of the negative impacts medicine has had on the event of childbirth. According to Smith,

...it is clear that women suffer most severely because they are at the hands of a specialty that is dominated by males, acting and thinking like males, and an entire system of medical research and treatment that has been shaped by males (p.2).

Of obstetricians and gynecologists (who are predominately male), he goes on to state “They bring their male prejudice against females and their need to be dominating and controlling to the doctor-patient relationship”(p.26). In terms of the initial appropriation of childbirth by medicine, patriarchy and male dominance was influential in bringing doctors into the birth room through the use of technology. Doctors were able to restrict the use of obstetric interventions, such as forceps, to authorized medical practitioners. Midwives, as females, did not have access to the medical education that males did, thus male doctors gained an advantage in the birth room when serious complications arose. This is just one example of the role that patriarchy played in the development of medicalized birth. The power of men to control not only the legal, political, educational, and economic structures of American society, but also cultural institutions and values, and how this power helped legitimate obstetric medicine will be discussed in the next chapter.

CHAPTER FOUR

Application of Social Movement Theory to the Medicalization of American Childbirth

Obstetric Medicine as Social Movement

To some, perhaps many, social movement scholars, the application of social movement theory and movement dynamics to the rise of American obstetric medicine might appear unproductive. However, childbirth literature shows that the campaign to medicalize childbirth practices in the United States was characterized by many aspects that are amenable to the various social movement attributes identified in movement literature. The following discussion will attempt to examine the rise of American obstetric medicine in terms of its coherence with various social movement properties and the extent to which it can be analyzed using specific social movement theory.

First, however, it seems imperative to address an obvious criticism of this particular examination of medicalized childbirth. Obstetric physicians belong to one of the most ubiquitous and influential institutionalized social structures in the United States, the American Medical Association (AMA). As such, obstetricians enjoy far greater amounts of wealth, status, and power than most American citizens, not exactly a reason to ‘take to the streets’ in protest or to challenge the existing societal organization. However, the obstetric profession, even the AMA, has occupied its privileged place in society for a relatively short period of time. This being the case, one might assume that the ascension of obstetric medicine to its current position was inevitable, that it was a natural and logical development initiated by various scientific and technological breakthroughs that began in the late 1800s. On the contrary, as the following discussion intends to show, obstetric

physicians in the late 19th and early 20th centuries embarked upon a deliberate campaign to appropriate the event of childbirth into the medical domain, to turn it into a source of financial gain by eliminating all non-physician competitors and create a monopoly. The realization of this objective would fundamentally alter not only existing American birth practices, but also the very meaning of childbirth itself. Garner (1996) defines a movement as being:

constituted by human beings engaged in discourses and practices designed to challenge and change society as they define it. It is formed by people who, over the course of time, are involved in non-institutionalized discourses and practices of change (12).

Thus, as I hope to demonstrate, the rise of American obstetric medicine definitely qualifies as a social movement. Not only did members of the profession engage in discourses that were in opposition to established childbirth meanings and practices, they engaged in various other social movement activities, including the employment of all available resources to collectively challenge and disrupt the existing social reality.

Ideology

A shared ideology is one of the most fundamental components of a social movement. A movement's ideology is the coherent set of beliefs shared by movement participants, concerning the condition of some existing social reality and how it falls short of a movement-specific notion of the ideal and 'right' nature of societal organization. Ideology can also be conceptualized as a view of the essential nature of humanity and of human life. An ideology provides the foundation for collective activity. It serves to unite a group of like-minded individuals, for the purpose of challenging a social arrangement that violates their conception of how human society should function.

The ideology of a social movement organization (SMO) shapes the kinds of discourses it engages in, as well as actual movement goals and tactics. Further, in some social movements, the particular ideology shared by participants may even determine the actual structure of the SMO. Thus, in a movement whose ideology is based upon the inherent equality of all people and the necessity of an egalitarian society, members may strive to institute a decentralized, informal organizational structure in which each person is a vital participant.

The ideology that guided the movement to medicalize American childbirth held the burgeoning field of science to be humanity's greatest achievement, in terms of discovering truth, solving society's problems, and opening up a future of endless possibilities. Inherent in this view, of course, is the notion that science is value-free and further that it is superior to all other paths to knowledge due to its reliance upon unbiased empirical investigation. One of the main products of science is technology, and as such technology became ascribed with the same positive attributes accorded to science. An important aspect of the ideology of science held by the medical profession at large was the perception that through science, 'man' now had the ability to conquer nature and manipulate nature toward 'his' own purposes. It should be noted that the diffusion of this idea can be traced, to a large extent, to Renee Descartes' mechanistic conception of society and the human race. Descartes asserted the existence of what is termed 'mind-body dualism'. Essentially, he believed that the human mind and the human body were separate entities, not literally of course, but in the sense that they functioned independently of each other. The discovery, in the latter part of the 19th century, that bacteria was a cause of disease helped to refute the popular assumption that disease resulted from an imbalance between body and soul (or psyche). This discovery was also used to promote the idea that a person's mental, emotional, or spiritual state was not an influential factor in the health and wellbeing of her or his physical body. For the purposes of this discussion, the main importance of Descartes' predication is that it encouraged physicians to approach the human body as if it were a machine, a machine whose maintenance and repair were their responsibility. The physician was thus the highly skilled and knowledgeable

caretaker (mechanic) of the body. His job was to evaluate the nature and cause of any malfunction, and, with the aid of the technological instruments at his disposal, to repair it in the manner that he deemed appropriate. The subjective mental or emotional state of the person being treated was irrelevant to the body's physical condition, the rightful domain of the medical profession. {Note: Since the majority of physicians were (and are) male, they will be referred to here as 'he'.}

As medicine became increasingly informed by science and assisted by technology, the medical profession itself came to be included in the ideology that privileged science and technology as the beacons of society. Taken together, medicine, science, and technology were equated with progress and modernity, ideals that were becoming increasingly valued within the larger society and incorporated into the structure and function of existing social institutions. It is not surprising that physicians (for the most part) began to develop an exaggerated sense of self-worth and to perceive themselves as being exceptional human beings, possessing a body of knowledge and skill not only superior to that of any other profession, but one that was also of more significance to the advancement of humankind.

Discourses and Framing Activities

Social movement organizations constantly engage in discourses, through which they communicate the goals and ideology of the movement to both existing members and to persons or groups outside of the movement. This practice gives SMOs the opportunity to strengthen the commitment of existing members, as well as to reach out to potential movement constituents and mobilize them, or to at least foster acceptance of the movement within the larger society.

The use of movement discourses requires that SMOs engage in frame construction and frame alignment. Framing involves the use of language and symbols to present an issue in a manner that promotes the ideology and goals of the movement. It is also a conscious effort to influence public opinion. Kebede and Knottnerus (1998) assert that 'collective action frames' have two functions

relative to this discussion: punctuation and attribution. Punctuation involves focusing on a particular social issue or situation, defining it as a social problem that needs to be changed. With attribution, SMOs assign blame for the problem to a specific source and outline the solution.

McCaffrey and Keys (2000) examine framing activities by SMOs involved in movement-counter movement (M-CM) struggles. They distinguish three main framing strategies SMOs use in the face of counter movement attacks, but these can also be applied to framing activities in general, that are not directly related to M-CM interaction. Through the practice of polarization-vilification, according to McCaffrey and Keys, SMOs first identify a “definitional dichotomy” between their movement and opposing movements, so that there is a clear distinction between ‘us’ and ‘them’. SMOs then attempt to discredit adversarial groups by attributing to those groups and their members various negative characteristics, promoting a view of opposition movements as constituting a malevolent threat to the goals and ideals of the SMO. Another framing strategy is ‘frame debunking’, through which SMOs endeavor to promote their ideology by discrediting the ideology of an opposition movement via “scrutiny and deconstruction” of counter movement frames.

Until childbirth in the United States became medicalized, birth was not a medical event. In fact, before the introduction of forceps brought doctors into the birthing room, doctors themselves did not perceive medicine as having anything to do with childbirth. It was considered appropriate that birth was a women-centered event, something that men largely had no knowledge of or experience with. Women came together in their shared roles as mothers to attend one another in labor and delivery, provide each other with emotional and psychological support, even to assist with household chores during recovery from birth.

In order to achieve their goal of appropriating childbirth, one of the main tasks for obstetric physicians was to change the existing cultural view of birth as a normal, natural process. To this end, medical discourses began to define, or frame, birth as inherently pathological, with every birth likely to encounter complications or end in death. Discussion and debate in the medical community

focused on specific pathologies of birth and how they could be dealt with. Despite the fact that doctors were basically inexperienced and had little knowledge of the event of childbirth, they did not focus on aspects of the natural progression of labor and delivery before moving on to the consideration of abnormal situations. This would be akin to a student entering a discipline and immediately studying a specialty in the field, without learning the basics. But by ignoring normal birth, doctors effectively focused public attention on the dangers of childbirth. This practice can be considered as an example of ‘punctuation’ (Kebede and Knottnerus, 1998), in that birth was presented as a problematic social reality that needed to be improved. The basic solution to the ‘problem’ of childbirth was for doctors to intervene using scientific research and technology.

In addition to the existing view of birth as natural and normal, another obstacle to the growth of obstetric medicine was the profession of midwifery. The employment of midwives was firmly entrenched in both the experience and perception of birth, and midwives possessed a far superior knowledge of the birth process. Medical discourse thus used the strategy of ‘attribution’ (Kebede and Knottnerus, 1998) to identify midwives as a main source of the pathologies of birth, and of the high rates of mortality and morbidity in the United States. Midwives contributed to the birth ‘problem’ and should therefore be replaced by doctors. Medical discourse and framing of female midwives is also an example of ‘vilification’ (McCaffrey and Keys, 2000), or what is commonly considered to be ‘scapegoating’. Midwives were depicted in extremely negative ways, characterized as being dirty, incompetent, and ignorant, among other things. The campaign against midwives greatly benefited from patriarchy and the ideology of science. As an association of men targeting a group of women, obstetric medicine was able to take advantage of male dominance and societal gender role expectations. Due to the fact that they were indeed male, the discourses of obstetric physicians were imbued with a great deal of credibility and authority, certainly more than midwives could compete with. Further, it was largely accepted that women were not as intelligent as men, that they could not be educated beyond a certain academic level, and that their most suitable occupation

was as homemakers and nurturers of their families. Thus, women were deemed incapable of effectively managing childbirth, whether it be in the capacity of midwife, birthing woman, or supportive friend or relative and they were denied access to the education that obstetricians received.

Growing public acceptance of the ideology of science and the adoption of ‘progress’ as a social value was also an asset to medical discourse aimed at eliminating midwifery. Obstetric medicine was becoming increasingly informed by scientific research, while midwifery continued to be based on traditional, ‘unscientific’ practices, without the benefit of new developments in the treatment of birth pathologies. There was thus an ‘us’ versus ‘them’ conceptualization established, in which doctors, armed with science and technology, embodied the ideal of progress in the effort to make the ‘problem’ of childbirth safer and better. Alternatively, midwives, as practitioners of ‘primitive’ and dangerous methods, perpetuated birth pathologies and impeded progress toward safer birth management.

The relationship of obstetric discourse to the patriarchal organization of society and the ideology of science shows that physicians involved in the movement for medicalized childbirth utilized the strategy of frame alignment. Frame alignment is the process by which SMOs construct movement frames that are consistent with existing dominant frames of the broader society. Collective action frames will only be successful if they are compatible with the identities and ideologies held by potential movement constituents and supporters. Obstetric discourse that characterized women in negative ways that implied inferiority corresponded to widely held sexist views and male-dominated social organization, while the promotion of obstetric medicine as scientific appealed to the growing value of progress through science and technology.

Movement Resources

The accessibility and employment of resources is a fundamental necessity for the development and success of a social movement. The concept of resources as

applied to collective action is typically used in an all-inclusive manner. It can apply to material objects, such as money and various communications technologies, as well as to more subjective things, such as existing movement or social networks and media coverage. The obstetric movement of the late 19th and early 20th centuries to medicalize childbirth is presented here as having access to two main types of movement resources: social capital and technology.

It is somewhat problematic to employ a precise definition of the concept social capital, as different social movement scholars have provided varying interpretations of what social capital actually entails and includes. Here I will attempt to simplify this by drawing mostly upon the conceptualization of social capital outlined by Edwards and Foley (1997). Social capital must foremost be understood as being ‘nested’ within and among different social structures. Social capital is thus shaped and given meaning by the organization and social dynamics of the structures within which it is located. It is perhaps most easily understood as a product of relationships between individuals and larger groups, one that is accessed by individuals and by other affiliated groups as a means of engaging in some type of collective action. Individuals and groups have access to social capital as a result of their association with certain larger groups or collectivities. Social capital is shaped by its particular social location, including the relation between its social location and the dynamics of the overall organization of society. Therefore, though many different individuals or groups may have access to social capital based on membership in a certain group, not all social capital is equally valuable, as it reflects a multitude of inequalities that are embedded in all social structures and institutions. This aside, all social capital by definition has some value. The primary function of social capital is to facilitate collective action.

Social capital was an important resource in the facilitation of obstetric movement activities, indeed it contributed significantly to the group’s success. Physicians had access to a certain level of social capital as men (of course, they were also white). By virtue of their sex, doctors belonged to a collectivity that held all of the real power in society. Men had political, economic, and social

power that women were denied. Thus, obstetricians already possessed an advantage over midwives. Obviously, a tremendous amount of social capital was available to obstetricians through their membership in the medical profession. Doctors had long been involved in various types of professional associations, though these tended to be somewhat fragmented and did not carry a great deal of influence within society as a whole. This situation was changed drastically in the middle of the 19th century. The beginning of that century had been characterized by a large scale nationwide alternative health movement. It developed mostly as a backlash to the barbaric practices of the medical profession, and called for a return to natural treatments involving things such as plants and herbs, massage, etc., things offered by non-physician practitioners. At this time, though they did possess obstetric forceps for the ‘treatment’ of birth, doctors were still practicing without the aid of scientific knowledge, and they continued to use methods such as bloodletting and leeching. The alternative movement was successful in getting states to repeal existing medical licensure laws. This enabled alternative caregivers to expand their practices, and gave people the health care choices they wanted.

In the face of strong competition from alternative practitioners, physicians took action and in 1848 they formed the American Medical Association (AMA). The AMA was established for the express purpose of protecting the livelihood of physicians by eliminating competition from non-physician practitioners, as well as by limiting access to medical education. The AMA had some measure of access to national and state political institutions and began to work for the reinstatement of licensure laws. Members were also encouraged to run for public office, in order to facilitate medical manipulation of public policy. Though the popularity and influence of the alternative health movement had already begun to wane, physicians realized the need to prevent the ability of similar shifts in public opinion from jeopardizing their profession in the future. The AMA was overwhelmingly successful in their push for licensure laws, with virtually every state establishing some provision for the licensure of physicians by the late 1800s.

Perhaps the most important action taken by the AMA to establish a medical monopoly occurred in the first decade of the 20th century. The organization had previously conducted its own investigation of the current state of medical education in the United States, and the results had shown almost half of the country's medical schools to be far below desired standards. Organizational policy, however, prohibited physicians from publicly criticizing one another. As a way of circumventing this tenet, the AMA commissioned an investigation into the matter by an external researcher, which was named the Flexner Report. The results were published and corroborated the AMA's findings concerning the quality of the country's medical schools. The Flexner Report was used by the AMA as the basis for a nationwide effort to eradicate the medical institutions it considered undesirable. This action was accomplished primarily due to the existence of state licensure boards that were controlled by the AMA. Basically, half of the nation's medical schools closed because their graduates were legally barred from medical practice by the AMA through state sanctioned organizations (Blevins, 1995).

The other main resource available to the obstetric movement that allowed members to realize their goal was obstetric technology. Physicians became involved in childbirth due to their possession of forceps. Although the use of forceps was by no means an assurance of a positive outcome, forceps enabled doctors to deal with certain complications in labor and delivery for which midwives had no effective treatment. For reasons Edwards (1984) describes as largely unknown, the possession and use of obstetric forceps remained restricted to physicians, giving them another advantage over midwives. The real catalyst for the transformation of American birth practice into a medical event would appear to be the introduction of anesthesia for the treatment of pain and discomfort during labor and delivery. The use of obstetric anesthesia was also confined to the medical profession. The introduction of anesthesia into the birth process was significant because it quickly came to be demanded by women themselves, particularly women of the middle and upper classes. The role of the physician in birth greatly expanded with his access to technological interventions,

successfully displacing midwives, though their services continued to be used by poor and working class women. Technology has also been a movement resource for obstetric medicine in the general sense that it advanced the perception of medical birth as safer and more enjoyable.

Social Movement Theory

Since the 1970s, social movement research has been dominated by resource mobilization (RM) theory. This approach focuses on organizational dynamics and the accessibility and employment of resources as explanatory factors for a group's ability to mobilize movement participants and engage in political struggle. RM theory downplays the importance of ideology and grievances. The rationale is that these elements are consistently present within any given society, yet they usually fail to result in mobilization for collective action. Consequently, there must be another source (or sources) of movement formation and success. These sources, according to resource mobilization theory, can be found at the meso-level of analysis, that is, at the level of the social movement organization itself. SMOs are able to mobilize supporters and participants, and to routinely be involved in political conflict, as a result of the availability of various movement resources, as well as the organizational structure of the SMO itself. RM theory considers it a given that SMOs are characterized by formal and centralized structures (Buechler, 1993).

One of the most valuable contributions of RM theory to the study of social movements is that it discredited previous conceptualizations of collective behavior as being crazed, irrational, and spontaneous. As explained by Buechler (1993), RM theory describes social movements as “normal, rational, institutionally rooted, political challenges by aggrieved groups” (p.2). Further, under RM theory, individuals are rational social actors who decide to become involved in social movements based upon a cost-benefit analysis, through which they identify the expected benefits of participation as exceeding the costs involved.

In recent years, resource mobilization theory has received a great deal of criticism from movement scholars. Much of the movement literature now presents a view of RM theory as an inadequate analytical tool, because it largely ignores important cultural dynamics as well as the influence of macro level structures and institutions. Further, more and more studies are producing results that directly contradict certain tenets of RM theory, particularly the assumption that SMOs must be highly centralized and formal structures in order to survive and be successful. Interest in the cultural aspects of social movement activity and organization has increased significantly. These developments have led to the growing popularity of what are commonly referred to as new social movement (NSM) theories. NSM theories have many different characteristics, but a brief overview of the main elements will suffice at this point in the discussion. These theories tend to view movement activity within both the cultural and political arenas as equally important to movement success. NSM theories present contemporary movements as pursuing subjective, identity-related goals rather than access to material resources. Particular emphasis is placed on cultural processes related to grievances, ideology, and identity. Finally, these theories acknowledge the importance of informal, decentralized, diffuse groups of movement participants, which Buechler (1995) refers to as ‘movement networks’.

Resource mobilization theory appears more amenable to the examination of obstetric medicine as a social movement. For one thing, the primary goal of the campaign to medicalize childbirth was to bolster physician income by creating a new medical specialty that would help offset an increase in the number of practicing physicians. Thus, obstetric medicine can be conceived of as engaged in collective action in order to gain access to material resources, in addition to social status and occupational power. The movement was also characterized by a relatively formal, hierarchical organizational structure, dominated by the AMA. Collective goals, tactics, and policy were articulated by the leaders of the AMA, and power filtered down through various state groups representing the AMA and its affiliated groups, including the American College of Obstetrics and Gynecology (ACOG). Nationwide movement activities of individual groups were

guided by corresponding goals and patterns of discourse, increasing the potential for the institutionalization of medical practices that reflected the interests of the AMA and its members. Also integral to the success of the movement for medicalized childbirth was the availability of various resources that facilitated collective action by the obstetric profession. The social capital accessed by obstetricians through their collective male identity as well as their membership in the growing medical institution, combined with exclusive possession of new obstetric technologies, were requisite elements for the medicalization of childbirth. However, the cultural arena cannot be ignored in the application of social movement theory and dynamics to the rise of obstetric medicine. Despite having an advantageous organizational structure and the accessibility of significant resources, it would have been exceedingly more difficult, and would have taken much longer, to completely alter birth practices without also redefining the cultural meaning of birth and doing so in a way that reflected existing cultural discourses. The contest over the management of American childbirth practices is ultimately a struggle for power, the power to define the fundamental meaning of the birth process itself. Obstetric medicine has been the indisputable winner in this struggle. In winning, it ceased to be a social movement and became an immutable part of institutionalized medicine in the United States.

Birth Reform Movements

Within the body of childbirth literature there is often discussion of the birth reform movement, implying the existence of a single unified movement. While this practice enables easier analysis, it conceals the reality of birth reform. The birth reform movement in the United States actually encompasses a multitude of SMOs, networks, and movement communities. All of these groups share the same fundamental ideology regarding childbirth, and typically have some level of interaction with each other. The basic ideology shared by birth reform proponents is one that conceptualizes childbirth as a natural, normal process, one that does

not require medical control or intervention. Each movement, however, expands this ideology to place the natural birth event into a specific context. Participants and organizations within the birth reform movement also differ in terms of goals, discourses, and strategies, as well as in how successful they have been in achieving their goals. In this discussion, different branches of the movement will be referred to as movements themselves. Though it is virtually impossible to identify every group or organization involved in birth reform, there are several main discernable movement categories.

Movement Categories

The first type of birth reform movement to develop was the natural childbirth movement, which began in the 1950s. Medicalized childbirth reached its peak during the 1950s, as the majority of births involved the mother being essentially unconscious, the exclusion of all relatives and friends from the event, including the father, and the routine use of all possible interventions. The natural childbirth movement was initiated by a few physicians who objected to current obstetric practices, as well as several individuals, generally female, who had had negative hospital birth experiences. Most of the movement activity, however, was carried out by parents. Natural childbirth advocates sought to change medical birth by limiting the use of anesthesia, involving fathers in the event, and curtailing forceps delivery. Birth reformers became childbirth educators, providing parents with prenatal education and promoting various breathing and relaxation techniques to facilitate conscious labor and delivery. To this day the natural birth reform movement emphasizes parental agency in the birth process without challenging existing medical control of birth. It has been the most successful of the birth reform movements, leading to the incorporation of natural childbirth techniques such as Lamaze into hospital birth and the increased occurrence of unmedicated births employing minimal intervention.

Another type of movement involved in birth reform is the midwife movement. This movement became active in the 1960s. The original goal was to reduce

medical intervention into childbirth by bringing the practice of midwifery into hospital birth. Proponents emphasized the normal process of birth as being optimal when the birthing woman was prepared, conscious, and in control. This was espoused as being best facilitated by midwives, who had a more natural and nurturing birth philosophy than physicians. It called for the widespread institution of midwife training programs and certification that would enable midwives to be primary birth attendants, though still under physician control. The midwife movement at this time thus promoted the interests of nurse-midwives. It was not until the 1970s that the midwife movement included lay, or direct entry, midwives. Initially, however, nurse-midwives and lay midwives tended to view each other as antagonists and the movement was sharply divided. They formed a cooperative relationship in 1981 by creating the Midwives Association of North America (MANA), which has become one of the largest and most inclusive birth reform SMOs in the United States.

The third main division in the birth reform movement is the homebirth movement. This movement was undertaken in the 1970s, largely as a result of the Women's Movement and the influence of the leftist counterculture. The support base for the homebirth movement is comprised mostly of lay midwives and parents. The effort to reform birth within the medical system is viewed as a futile attempt to realize the full potential of the birth experience, as it is impossible for birth to be truly 'natural' under the administration of the medical system. The primary claim is the fundamental right and inherent ability of women to birth where, how, and with whom they choose and to exercise autonomy throughout labor and delivery. The only place for medicine in childbirth is as a last recourse in the event of complications.

Within the homebirth movement, there are further distinctions between movement groups based upon differing justifications for homebirth. For some, especially feminist organizations, the struggle against medicalized birth is a means of female empowerment, of reclaiming power and body 'ownership' that had been lost to the male-dominated profession of obstetric medicine, and also as a significant component of women's subjective identity development. For other

groups, however, including those associated with various religious beliefs, homebirth is framed as a form of resistance to government intrusion into their lives, it is a practice sanctioned by God, and a source of familial bonding. Groups within the homebirth movement generally downplay their differences and interact through movement networks to promote acceptance of homebirth.

It should be understood that these movement divisions are not dichotomous realities. The American childbirth reform movement, similar to the Women's Movement and the Gay Rights Movement, is extremely diffuse, involving a complex system of interaction between the goals, discourses, and movement activities of SMOs, networks, and movement communities. This being the case, it is acceptable to discuss a few movement characteristics of the birth reform movement in a more generalized fashion.

Discourses and Framing Activities

As previously discussed, movements engage in discourses and framing in order to promote their ideology and goals to movement participants and potential movement constituents in a way that is congruent with existing cultural discourses. These activities have been especially important to birth reform organizations, as the perpetuation of specific birth practices has been so dependent upon cultural meaning. Obstetric medicine had been successful in appropriating the management of childbirth, to a significant extent, because of the ability of physicians to redefine birth as a pathological, medical event, and also the widespread acceptance of their view that women were incapable of managing birth as well as doctors. Birth reformers had to first provide an alternative definition of childbirth, one that emphasized the normalcy of birth and that repudiated the classification of birth as a medical event. Emphasis was placed upon birth as a natural physiological process of the healthy female body, as opposed to an actual pathological condition that was foreign to, and disruptive of, the healthy human body. Pregnant women were not sick and therefore did not need to receive medical treatment. It was acknowledged, however, that

complications did sometimes arise in labor and delivery that necessitated medical assistance, but this occurrence was rare for the vast majority of birthing women.

There also developed a distinctive body of feminist childbirth discourse, especially during the 1970s, which was pointedly critical of medicalized birth, depicting it as a tool of female oppression and exploitation in the hands of the male-dominated medical system and supported by a patriarchal social structure. Medical control of birth practices and cultural meanings of birth was framed as an especially powerful means of subjugating women, one that allowed the medical profession and other participating institutions to profit from the female reproductive role, one of the most important roles of women's lives. Feminist birth discourse established a dichotomous relationship between women as mothers and obstetric medicine. It was significantly influenced by countercultural ideology that rejected the intrusion of (and control exercised by) macro-level capitalist institutions and the state in general into people's everyday lives and experiences. Participants in what is referred to as the counterculture sought a return to nature, to traditional ways of living, and to cooperative and egalitarian social interaction, as a way of achieving 'authentic' human experience. Drawing upon this idea and approaching it from a Marxist perspective, feminist writers and activists posited a production analogy of medicalized birth, in which medical birth was depicted as a process of industrial capitalist production. As the physician had assumed the role of 'manager', the mother, as the unskilled laborer, had been alienated from the whole process of labor and delivery. Consequently, women needed to revolt against medical control of birth, to reclaim their rightful autonomy as birthing mothers. Childbirth in feminist discourse was imbued with meaning both as an event in and of itself and in relation to the totality of a woman's identity and life experience. As expressed by Umansky (1996), "Important for its own sake, a positive birthing experience could also raise a woman's consciousness about power and control" (p.68).

Another identifiable strain of birth reform discourse relates birth practices to consumerism. Espoused by various types of birth reform movement groups, this view draws upon discourses of a growing consumer movement to frame medicine

as a business, and to identify mothers and their birth partners as consumers who have the right to make informed choices from among a variety of care options. Mothers should educate themselves about the realities of medical birth versus alternative birth options in terms of safety, cost, and subjective benefits, and then have the ability to employ whichever method they prefer.

Theoretical Perspectives

The birth reform movement in the United States is best understood from the approach of new social movement (NSM) theories, also referred to in movement literature as identity-based theories. The primary location in which birth reformers have challenged the existing system is in the cultural arena of meaning and identity. As a NSM, birth reform does not seek access to material resources, but agency and autonomy, through the ability of women to have birth experiences of their own design, experiences that are subjectively meaningful to them and are integrated with individual identities. Thus, alternatives to medical birth are sources of enhanced quality of life. Further, the birth reform movement is not characterized by a formal, centralized organizational structure, but is carried out by a diffuse and complex arrangement of movement groups and communities.

Because it is in opposition to a powerful social institution, the medical system, and because its participants (mostly women) tend to occupy devalued social roles, the birth reform movement has had to contend with having relatively little access to social capital in relation to the obstetric profession. The natural childbirth movement gradually increased its store of social capital as parents organized themselves to address shared grievances concerning hospital birth. As a collectivity, disgruntled parents were able to influence hospital procedure so that natural childbirth principles and techniques became more widely accepted. Nurse-midwives had access to a small amount of social capital due to their existing affiliation with the medical profession through training and employment as nurses. In the 1970s social capital became more available to birth reform organizations through their alignment with the Women's Movement. The

Women's Movement provided birth reformers greater access to political structures, as well as to a multitude of existing movement networks that were allies and branches of the Women's Movement, including those of the women's health movement and the alternative health movement. Involvement with the Women's Movement also increased visibility for birth reform discourses.

Although they do interact with political institutions through such activities as lobbying efforts and litigation, birth reform organizations have mainly operated within the cultural arena in terms of employing movement tactics. One of the main tactics has simply been to engage in public education campaigns, typically through the publication of books that are targeted to a mainstream audience of mothers or potential mothers, and that contrast medical and alternative birth practices, predominantly through personal narratives of birth and comparative ethnographic studies of birth practices in different cultures.

In recent years, midwives have increasingly engaged in empirical and scholarly research that contradicts medical claims of safety and efficacy. Further, they have publicly criticized medical research for not being methodologically sound and have provided evidence of this. A related criticism articulated is that members of the obstetric profession do not keep abreast of new developments and that they outright disregard credible research that contradicts medical claims, a criticism that is reasonably well documented in both childbirth and medical literature. These activities are components of an overall movement tactic aimed at 'frame debunking', used by birth reform proponents to discredit the claim of safety that serves as the foundation for medicalized birth.

In a climate of growing consumer dissatisfaction with institutionalized medicine, birth reform discourse has effectively co-opted the scientific ideology of the medical system in its pursuit of legitimacy. The scientific rhetoric that has been used as the basis for medical supremacy has been employed by birth reformers to first discredit medical safety claims, and then to dispute opposition claims of the dangers of out-of-hospital birth. This is especially important to the homebirth movement, which has had to contend with the deeply embedded

cultural idea that equates hospital birth with safe birth and largely impedes any rational consideration of homebirth as a preferable birth practice.

The consideration of birth reform within the framework of identity-based social movement theories is aided considerably by Yang's (2000) conceptualization of emotion as an important component of movement activity. He defines emotion as fundamentally linked to self-identity. Emotional 'achievement' involves the "attainment of self-validating emotional experiences and expressions through active and creative pursuits" (p.3). From this perspective, emotional achievement typically involves participation in activities that are in opposition to institutionalized practices or violate cultural norms. As such, according to Yang, "Thus the experience of the self in edgework becomes the direct antithesis of that under conditions of alienation and reification" (p.7) and facilitates 'authentic' experience. Social movements are a source of identity development and emotional achievement. Emotion plays a significant role in the mobilization of birth reform movement participants as well as in discourse formation and movement activities in general. The primary factor that causes people to become involved in birth reform efforts is a firsthand negative encounter with medicalized birth, both in terms of subjective experience and objective outcomes. Specifically, birth reformers typically identify anger as a main motivating factor for participation in movement activities. The concept of emotional achievement articulated by Yang corresponds with the framing of alternative birth practices as the remedy for the alienation caused by medical management of birth. Birth under the control of mothers themselves involves personal agency and creativity and thus fosters the enhancement of self-identity.

It is somewhat difficult to approach the birth reform movement in terms of its engagement in political struggle, that is, with various institutions of the state. The difficulty lies in the close relationship between these institutions and the medical structure that impedes policy changes related to birth practices, even now that birth reform organizations have increased access to, and support of, political actors. Pellow (2001) provides a valuable tool for resolving this predicament, a theoretical model he calls the 'political economic process' perspective. This

perspective is a revision of the political process model of social movements, which focuses on the state as the primary site of movement activity because of its monopoly over public policy. Pellow states that, while this may have once been the case, changes in economic policy over the last three decades have rendered the political process model inadequate. The contemporary political process in the United States, he contends, is better understood as a political economic process, as it no longer takes place solely within political institutions. In fact, Pellow asserts that the state has essentially lost its monopoly over the making of policy to corporations, who have ceased to represent merely one of many interest groups competing for state support. Because economic institutions regularly shape policy, social movement tactics aimed at political reform must now be directed at these institutions as well as the state. The state is being increasingly relegated to the role of mediator in relations between corporations and social movements.

Pellow's (2001) political economic process perspective seems to offer a useful framework for the study of the American birth reform movement. The medical system is one of the most economically and politically powerful institutions in the United States. It has the power to shape all laws governing the practice of medicine, including what conditions fall under the jurisdiction of medicine and the requirements for medical practitioners. This medical monopoly of health care allows physicians to set their own prices, and facilitates the cooperation between medicine and economic institutions such as the pharmaceutical industry, the producers of medical technology, and insurance providers, to maximize profit. Further, the medical system is subsidized by the state, in the form of state-funded medical schools and teaching hospitals, as well as government funding of medical research. For all of these reasons, it has been extremely difficult for the birth reform movement to make any significant progress in challenging medicalized childbirth in the political arena. Reform groups routinely succeed in getting legislation introduced, typically related to midwifery practice, but such legislation is rarely enacted, at least in the original form. Further, the medical profession continues to initiate the prosecution of midwives by the state under 'scope of practice' regulations, and for the use of obstetric instruments and prescription

drugs that are legally restricted to physician use. In a number of states, the practice of lay midwifery is illegal. Lay midwives continue to operate in these states but must do so in secret, depending upon word-of-mouth to obtain clients, and living in constant fear of exposure. It also limits the ability of women to choose their birth methods.

One way that movements seek to effect political change is through cooperation with economic institutions. An example of this is the establishment of 'good neighbor agreements' between environmental organizations and corporations who violate environmental policy, in which the corporations agree to improve their business practices to a certain extent. This tactic requires widespread movement mobilization and participation in order to be effective with national and multinational corporations. Mass mobilization is the only viable way to achieve this because it can affect profit through public influence of consumer activity. The birth reform movement has sought to establish a more cooperative relationship with the obstetric profession, but this effort has been only marginally successful. The biggest achievements of the birth reform movement, in terms of its interaction with the medical community, have been the acceptance of natural childbirth principles and techniques by doctors, and the incorporation of these into the medical management of birth, as well as the growing willingness of hospitals to employ nurse-midwives as primary birth attendants. However, these developments are viewed by some birth reform advocates as the co-optation of some ideals of the birth reform movement by obstetric medicine, in reaction to growing public dissatisfaction with medicalized birth. By espousing their alleged commitment to natural childbirth and by creating 'homey' hospital birth centers that employ nurse-midwives, physicians have been able to curtail the cultural rejection of the medical model of birth that had begun in the 1970s, and to therefore keep birth in the hospital under their control.

The successes achieved by the natural childbirth movement of the 1950s and 1960s inspired great hope among birth reform organizations, hope that through continued effort they would see even more substantial changes in American birth practices at some point in the near future, changes that would serve to dismantle

both the cultural meaning and actual experience of birth as a medical event. This optimism deteriorated in the next two decades, as birth reformers were thwarted in the political and cultural arenas through the medical profession's exercise of an increasing amount of power in the political and economic structures, as well as through the development of new technologies that promised an unprecedented guarantee of safety in childbirth. The prevailing sentiment among most birth reformers now seems to be that real, lasting, large-scale change in American childbirth practice is unlikely, that most of the changes that do occur will consist of minor modifications of the medical model, with the overall system remaining intact. Birth reform ideology is most alive at the micro level of individual social interaction and in the construction of meaning and identity by individual social actors. In this sense, birth reform can be viewed as a 'lived' movement, one that is grounded in participants' everyday lives and that is sustained through involvement in diffuse movement communities and networks.

Conclusion

The original inspiration for this thesis was my own personal interest in learning more about midwives. I was intrigued because I had previously been largely unaware of the very existence of alternatives to the medical model of birth that I, like the majority of American women, have been socialized to accept as normal, natural, and desirable. As I began my preliminary research, however, I discovered that the topic of American childbirth is quite a bit more complex than an exclusive focus on midwifery would convey. The existing body of childbirth literature is so extensive that a thorough consideration of all the dynamics addressed by various scholars would warrant a book at the very least. However, my growing interest in childbirth practices necessitated that I move my focus beyond midwifery to consider exactly how birth in the United States developed into a medical event in the first place.

This study is by no means a complete representation of the historical development of medicalized childbirth in the United States and the subsequent challenge posed by birth reform movements. It is my hope, however, that I have provided a coherent and insightful discussion of the rise of obstetric medicine and birth reform, and shown that each fits into a social movement model and lends itself to analysis in terms of particular theoretical models within the social movement literature.

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