Paradigmatic Resonance and Dysjunction in the Development of the Human Sciences: Accountability and Expertism in the History of Parturial Practices.

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Synopsis

This thesis examines the function of discursive paradigms in the process of subjectivisation and the formulation of objects in the development of the human sciences. The history of childbirth practices exemplifies the operations of paradox and paradigm, and of epistemic changes and continuities, in relation to medical, ethical, and pedagogic discourses. The recent past has brought rapid change in the practices and outcomes of parturition with regard to technologisation, and the improvement in mortality rates.

The achievement of technological childbirth has a complex and paradoxical history, and should be understood other than as an inevitable and progressive phenomenon of scientific endeavour, or as a conspiracy of patriarchy which victimises and subjugates women as a matter of intentionality. The histories of the parturient and of the midwife are only partially linked. An examination of childbirth history reveals some of the implications of phallogocentricity for the history of women and for the constitution of gender and gender relations. Midwifery has its own unique but unmistakeable place in the historical discourse of pathologisation and professionalisation - and cannot be regarded simply as an arena of masculine appropriation.

The mechanisms for change in parturial practices have been developing to facilitate the modifications of recent history since around 1800, but there are discursive resonances which are linked also to changes in pedagogic organisation which began in the Middle Ages. Further, in order to analyse and evaluate the history of parturition over the past two hundred years, it is necessary to examine the paradigmatic structures based upon dialectical reasoning which have dominated the development of the human sciences since antiquity. Childbirth provides examples of many historical exigencies which informed a panoply of disparate effects, but it is also in many respects unique and anomalous. An exploration of the operations of power, knowledge and influence in this sphere, reveals as much in terms of its resistances as its susceptibilities, to medical appropriation. The history of childbirth is unusual insofar as the technologies and innovations that developed in relation to it, were in fact, slow to be implemented. Evidence of such paradigmatic dysjunction is provided by the examples of the use of forceps, asepsis and anaesthesia in the nineteenth century. This thesis addresses aspects and effects of professionalisation, and the increasingly disciplinary implications of expert discourses for the pregnant and parturient woman in the twentieth century.

To my daughters ~
Sarah, Catherine and Anna, whose time it took

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TABLE OF CONTENTS

1. Introduction: An Ethical Approach to Childbirth Practices:

1.1. The genesis of the parturient woman and the childbirth practitioner

"...the species of human beings has something in its nature that is bound together with all of time, which it accompanies and will always accompany to the end. In this way the species is immortal, by leaving behind the children of children and remaining one and the same for always, it partakes of immortality by means of coming-into-being." (Plato, *Laws*)

"...a profession which has the confidence of women holds in its hands the fate of society...(it has the) power, not only for the curing of disease, and the maintenance of individual health, but also for imparting a healthy tone to society, and for the healing of its wounds." (E.J Tilt, 1851, *On the Preservation of the Health of Women at the Critical Periods of Life*, p.41).

In the range of human experience, childbirth can be characterised as sharing common requirements and susceptibilities, but distinguished as unique not only in its nature and as an experience among individuals; but also, given the biological phenomena that surround it, in its gender specificity. It has remained the inescapable end process of procreation. In the history of procreative practices; rich in cult and often cruelty, women's sexuality is blatantly and unavoidably expressed. This is apparent also in relation to the constitution of women's experience of menstruation, lactation and menopause. However, for women, the ultimate and unhiding exposure is the experience of childbirth. Steeped in ontological grandeur and mystery, perhaps the most robust expression of humanity, its historical images are those of confinement and enslavement; often also of subjugation and despair.

Parturient women are at one of the most prominent, problematic and vulnerable stages of their existence. How they are treated and regarded has implications for all. As a facet of human

existence, childbirth, while often the site of anomaly and dysjunction, is a field of practices which can demonstrate and reflect the consequences of many other types of cultural and discursive change and transition; educational, religious, scientific, medical or organisational. It has been variously denigrated and aggrandised. It is generally invested with the most profound emotional and ethical ramifications. Childbirth is, perhaps, the object of such attentions partly because it appears to be an arena of practices in which rules are broken. The examples are many. In antiquity, childbirth could not fit into ideals of self-control and self-determination. Historically, it has been the province of the irrational, the uncontrollable, the non-systematic. It has contravened notions of desire, and of virtue - it has created confusion as to what it is possible and acceptable to valourise in women. It encounters problems of sin in the Christian Ethic.

The history of professionalisation and masculinisation in the management of childbirth practices has not been an easy or eventless appropriation; in fact childbirth can appear astonishing in its resistance to a diversity of professionalising interests. However, the exigencies of phallocentrism have had various consequences for birth and the birthing woman. In the late twentieth century as new expert and policing groups have formed around her and the benefits of birth technology have become more generally available, the woman who gives birth is ostensibly faced with a range of possible choices and perspectives, all of which have inspired controversy. These choices range from complete relinquishment of responsibility for the nature of the birth experience to an active rejection of technological birth in favour of what have come to be regarded, by a restructured birth police, as more 'natural' alternatives.

Although both the history of the parturient and the history of the midwife occupy parallel discourses, subject to the same paradigmatic conditions - the subjectivisations of the childbearer and the childbirth practitioner are differently constituted and should be regarded as

distinct. Midwifery was, and remains predominantly the domain of women despite their much-vaunted 'loss' of control. Perhaps the historical questions have been too negatively and exclusively postulated in terms of the loss of a woman's domain to men, rather than asking the perhaps more apposite question as to why, given the generality of the masculinisation of the medical discourse, and every other discourse permeated by phallogocentric strategies, women have persisted and predominated at the point of contact in childbirth, whatever the gender of authority. It could be argued that the unorganised and informal authority of the past which governed the practices of childbirth and were predicated on use and experience (mainly women's), was never exclusively in the control of women, and was fundamentally and necessarily an expression of the prevailing religious and medical paradigms which were steeped in the self-creating and self-denying exigencies that characterised combinations of possibilities at different times. Hence, for a simple example, baptism became a priority of the midwife at the exhortation of the priest during the Christian era. In other words, women could not really lose that which had never been or could be, in their 'possession'.

It is misleading to single out the practices of parturitition in the twentieth century as if they were somehow designed to humiliate and subjugate women. It is however important to point out that the history of women emerges as a theme throughout the history of obstetric practice. The spectacular nature of the changes in childbirth conditions and practice, both in terms of the reduction of mortality, and the increase in technologisation during the latter portion of the twentieth century can appear superficially as a clear and simple example of the linear triumph of science over nature. Certainly, there seems to be a logic to the sequence of events that stretched from the late eighteenth century. The increase in intervention and use of instrumentation was linked to the spread of the puerperal fever epidemics, and in turn to the debates of the nineteenth century concerning asepsis and anaesthesia. This facilitated the technologisation of childbirth which gathered pace in the post-war years of this century.

The development of the practices of childbirth reflects and is to an extent encompassed by that of medical science but it has also a unique separate history which is fraught with paradox and anomaly, not least of which is the problem for medicine of how to categorise and make pathological a process which involves pain without sickness. This is a history which also cannot be explained by any single theory. It does not seem possible, for instance, to make a clear political and economic assessment of the different treatment parturient women could expect historically, according to their wealth and influence. In the nineteenth century, for example, women who were of families who could afford to pay for the more prestigious if sometimes controversial medical expertise and attentions of men were not necessarily in the receipt of the best help available. Certainly women who gave birth in hospitals and institutions were not in the safest possible place.[1] Nineteenth century maternal and infant mortality did not respond to hospitalisation and parturient women were not universally regarded as the obvious and natural beneficiaries of advances in either medical hygiene or pain relief. Childbirth did not become a primary object of analgesic technology until the twentieth century. The modern phenomenon of technological childbirth cannot be simply regarded as exemplary scientific and humanitarian progress. Neither can it be explained as the victimisation of women as a feature of patriarchy. It may be seen as having a complexity of elements in which aspects of patriarchy, and of the interlinked development of science are clearly represented, but it is better and more comprehensively understood as part of the process of professionalisation which has implications for women, both as parturients and as midwives.

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1 See Donnison, 1977, p.53.

The history of childbirth practices and their professionalisation is not simply the story of the need, altruistic or opportunistic, to preserve the life and health of the population, nor to improve the lot of the least wealthy parturient woman and her child.[2] Neither were the improvements in standards of safety and care entirely to do with the maintenance of pure and philanthropic ideals of societal conduct. From the beginning of the nineteenth century, the interest in dystocic childbirth, and the increasing pathologisation of its every aspect, had its disciplinary component (Merriman, 1816). The evidence suggests that even allowing for a history of fear and misogyny, practices were clearly derived from the paradigms of a professionalising discourse, aided by the powerful and developing organising principles and logocentric ordering of an increasingly information and accountability orientated society. The paradigmatic compulsion to examine and record the minutiae of the lives of individuals, far outweighs any notion of intentionality or conspiracy, and places foremost the interests of organising, homogenising, differentiating, categorising and hierarchising exigencies. The objects and subjects of the cultural and scientific discourses are, accordingly, derived in a far from formulaic or deterministic way.[3]

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[2] The comfort of the poor, sick, and distressed, the relief of the parturient's pain, or the reduction of maternal mortality, were not in themselves primary concerns: "What passed for science then did as little to cure patients as Victorian prisons did to rehabilitate convicts. In fact, at that time the treatment by purging and purgatives offered by male doctors was probably worse than the less drastic ministrations of the female folk healers." (Sachs, 1978, p.30).

[3] It is a frequent criticism of discourse analysis, that it stultifies the possibilities for dissent, insisting as it does upon the hegemony of discursive paradigms and the questioning of the role of intentionality. For an analysis of Foucault's approach to discourse and the historical constitution of the subject; see W. E. Connolly (1984, pp. 139-67); and on power, see G. Wright and P. Rabinow (1982).

The internalisation of these goals was paramount, as was the pursuit of self-policing entities of organisation. The concern of medical science was not then primarily the effectiveness of cures, but the formalisation and standardisation of healing and care into recognisable and teachable/learnable categories and the pursuit of legitimating strategies that would filter through every aspect of existence. It is not surprising in this context that women, traditionally excluded from the venues of professionalism, combined around the childbirth scene and held on to their exclusivity for so long compared with other areas of masculine appropriation. Neither is it unusual that a prescriptive repertoire of practices would be developed and refined around the parturient woman; creating needs and an interrelatedness of responses to those needs, containing them within a unified and interrogatory ethos. Within this framework, judgements about events and their significance have appeared difficult to formulate without adopting the axioms of progressivist or antagonist histories. Conventional progressivist medical histories, and the more radical and ideological approaches represented by marxists and feminists, tend to privilege the subject without proper reference to the impact of the development of the subject as an historical and cultural phenomenon. Such approaches tend to concentrate instead upon the exigencies of statecraft, progress, materialism and ideology, the dialectic of oppositionism, and the dualism of cause and effect, none of which can entirely satisfy, except in the compulsion to find a truthful and totalising mode of interpretation.

Evidence of prejudices against women enshrined in the political, legal and religious ideals of Greece, Rome and Israel, and displayed openly or covertly in domestic and institutionalised settings, can be discovered from the outset of Western culture. Some themes are persistent and recurrent, while some aspects have changed and changed again, yet women are created (differently) as objects of axiomatic knowledge wherever they are in time and space. The history of childbirth is especially open to progressivist linear interpretation; a triumph of science and morality; as a natural and hierarchical process or a redemption from the practices

of old. Alternatively, a nostalgic view can be adopted of the supposed primitive harmonies of rationality and spirituality; of reality and myth.

The impact of such notions on interpretations of childbirth history have elements based on realities that can be fairly convincingly extrapolated and substantiated, and partly perhaps, because this is so, it is important to consider the seemingly paradoxical existence of elements of all these effects. Such a view would regard these facets of the event, both actual and symbolic, as functioning in a complex non-hierarchical, non-linear and discontinuous network of effects. The history of childbirth cannot be based simply on the cast-iron certainties of cause and effect, on notions of scientific and social advance, or on theories that seek exclusively to demonstrate sexual aggression/subordination, for these types of explanation can be seen to rely on notions of intentionality which privilege the (unaccounted for) subject *per se* as social actor *par excellence*. It is this domination of the knowing and active subject which has been shaped by the changing exigencies of educational organisation, and the generation and dissemination of knowledge which has determined certain formulations of power practices, including the techniques of childbirth as a facet of an increasingly problematised sexuality. The history of childbirth is neither a continuous one nor one punctuated clearly and inexorably by the progressive transitions dictated by scientific discoveries and technological change. It appears that the health and well-being of the mother continued rarely to be first priority as the a related panoply of event, exigency and organisational practice that informed the profession which grew around childbirth took shape.

The modern system of institutionalised childbirth however, relies for its credibility on the paramount aim of optimum health of the mother. Paradoxically, now that the death of the parturient is a rare occurrence, the history of male-dominated medical practices have led us to believe in and require that ever more spectacular feats of medical trickery must take place.

Perhaps an optimum has been attained regarding infant and maternal mortality, and it is unlikely that the conscious mother can be further reprieved from pain and discomfort, or that delivery can be legitimately speeded up to any appreciable degree. The response from the parturient and her 'representatives' is to move away both literally and metaphorically from the institution; its technology and authority. And the response from the experts is to shift attention to where the spectacle of achievement can be further advanced - for example: in conception technology, in genetic engineering, and *in utero* interventions for foetal disorders.

Although it may therefore be inaccurate to describe the medical history of childbirth in progressivist terms; it is a temptation to view childbirth itself as an unchanging physiological entity which is largely impervious to change, as if technology wrought its alterations on passive material. It can appear that any intervention is of benefit to the natural process, providing it with the failsafe of a guaranteed outcome, which is arguably the greatest innovation in the historical calendar of human parturition. However, in an attempt to provide a broad historical structure in which childbirth is defined and re-defined, it is necessary to examine where and to what extent shifts of discursive emphasis and paradigmatic change have occurred, and which aspects have defined the experience of childbirth, not least for the parturient. It is also important to ask with what broader cultural and historical discontinuities these shifts are aligned, and which ones they reinforce.

While childbirth is far from being an historically static event, it would be inaccurate to stress the emergence of childbirth from a primitive, unscientific and brutal condition to become a civilised, sympathetically technologised, pain-free event. It would be equally simplistic to insist upon the view that in its virtual wholesale remove to the clinic and male appropriation, it has become divorced from some fictional, idealised, goddess-presiding origins. Myths of matriarchy appear to be glamourisations. Amazonian mythology has lent credence to

essentialist and nostalgic idealism regarding the existence of matriarchal societies.[4] This may be a response in part to the fact that crucial aspects of womens' lives have appeared to have limited importance for a history which in general has been created and interpreted by men. The phallocentric emphases upon truth and reason have permeated medical, material and radical histories of childbirth, as all insist on the overwhelming instrumentality of an axiomatic human subject. However, if a flexible and value-aware perspective is adopted and the evidences that exist are not tortured into a particular shape to become supportive of specific and/or dogmatic postures, it becomes evident that some particularities of time stand as testament to unique discourses and others to persistent themes which survive and proliferate, sometimes providing both inexplicable description-defying effects and almost always a less than predictable legacy to the future.

The persistence of unquestioning woman-and-nature versus man-and-science mythology is evident. As Nietzsche has described, the sentimentalisation of women's history can be misleading.[5]

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[4] See Diner, 1973; Rich, 1984; Lefkowitz, 1986; and de Lauretis, 1987.

[5] It is Nietzsche's design to come closer to the creation of the sexes, rather than some transcendental belief in a 'wild woman' as a figure of 'truth' and paradigm. When Nietzsche identifies feminism with the writings of Rousseau, romanticism and mendacity, and disparages the "rule of feeling, testimony of the sovereignty of the senses" (1968, (1901-11) p.58), it is the prevalence, dominance and axiomatic nature of the subject which he brings into question. Whether the subject is male-identified in terms of tyranny, stoicism, and appropriation, or whether it is associated with the female who is "enthusiastic, sentimental, full of secrets" (1968 (1901-11), p.153); both are models of the same axiomatic and dualistic subjectivisation.

In the history of childbirth practices, it is the record of the past two centuries that appears to be the most cataclysmic in terms of cultural and technological change. During this period the event has witnessed the coming to dominance of a masculine medicalised ethic, and the normalisation of the subordination of women in obstetrics. There have been technological changes from the invention of the forceps through to the high technology of the modern maternity ward. This period has seen the massive reduction of pain and mortality following the innovations in asepsis, analgesia and anaesthesia. Most recently there has been a rethinking of the nature of childbirth practices which has spawned a new panoply of experts, including psychologists and natural childbirth exponents.

However, it is important in the review of these developments. and in seeking to explain the dazzling achievements of childbirth science, to emphasise that the past two hundred years of obstetric practice cannot be properly understood without reference to the historical groundworks of antiquity with its concern for regimen, and the educational and pedagogic revolution of the Middle Ages. It is only in the light of these early developments that a breadth of overall vision is allowed that will enable the most comprehensive study. While childbirth practices are themselves part of the broader histories of women, sexuality, reproduction, and of medicine, education and professionalisation; they are also a rewarding area of study because they are often anomalous in terms of these wider discourses, and cast illumination upon them from other perspectives, drawing out unexpected paradoxes.

Until the twentieth century; haemorrhage, puerperal sepsis and dystocia would have accounted for many maternal deaths; hazards against which, from the earliest times, there

were often only religious charms and amulets.[6] Childbirth itself came variously and symbolically to reflect historical preoccupations with confinement and restraint. In symbolic terms; conception, gestation, confinement and renewal characterised aspects of both ancient aestheticism and Christian asceticism. However, the involuntary nature of these processes for women led to a confused presumption that they were incapable of self-examinatory procedures. It could be said that such questions of choice and imposition remain at the heart of human endeavour and ideology.

An examination of the Classical period is essential to discover the genesis of modern childbirth practices; even though the discursive, social, technological and medical shifts that have most affected the course of childbirth would appear to have taken place within the last two hundred years. There seems to be no direct evidence of womens' experience of childbirth and childbirth practices in classical times. The documentation of women's lives that exists cannot be interpreted in a unitary manner.[7] Women themselves are all but silent.

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6 In one example, Galen (*De Uteri Dissectione*, IX 280K) describes an amulet which depicts the womb and what appear to be the fallopian tubes (Jackson, 1988, p.106). The depiction also shows a key which symbolises the locking and unlocking of the womb in pregnancy and delivery. This appears to form a link with other symbols of restraint and release associated with childbirth.

7 While it is certain that the subjective experience of the parturient woman in ancient times will have been determined by prevailing paradigms of discourse and practice, there is a lack of evidence concerning her actual experience of childbirth and labour. However, images of childbirth, compounds of religious and cultural symbolism are more readily available. Also amongst these evidences are the testimonies from various sources of the acknowledged dangers and difficulties (Lefkowitz and Fant, 1982). Young women of childbearing age encountered a territory fraught with risks, with little on offer in the way of medical competence, and without the benefits of any coherent anatomic or scientific theory, or efficient surgical aid or method beyond a knife for cutting the umbilical cord (Pringle, 1983, p.133).

There are, however, in the male voice, various indications of how a definition of the parturient woman came to be constituted, and how a problematic of childbirth practices came to evolve. Also, there are encapsulated in these practices as elsewhere, evidences of tensions in gender relations that would historically persist and develop. In our early history it begins to become apparent that how both women and childbirth come to be regarded, are indivisible. The experience (while exclusively and directly female), is at the centre of a crucial aspect of human existence, an existence dominated by men and male perspectives. It therefore creates and demonstrates important aspects of the changing tensions between men and women, and within their relationships.

Biological imperatives have largely determined womens' role in human existence but have also shaped attitudes and practices for all. Thus, the developing problematic of the experience; its practices and cultural importance reflects, affects, and in some respects encapsulates the entire experience of women. It relates also, in both its conformities and contrasts, to the significant moments in the evolution of the human sciences as a whole, which are historically constituted as a male defined and directed domain. The attitudes of men towards women in general are in certain details indicated by perceptions of female sexuality and about childbirth, but equally striking are the evident paradoxes and contradictions. The examination of the available glimpses of womens' lives and condition is certain partly to reveal repression and marginalisation, but it may also illuminate the operation of historical paradigms and the determination of the parameters of what might be thought or said.

The history of childbirth reveals a concentration upon possible negative or detrimental outcomes and this in turn has fostered certain attitudes about women and their sexuality. Unlike later Christian traditions, sexual activity was not proscribed or pathologised by the

Greeks, but it was similarly watched over, made subject to regimen and incorporated into the management of health and the conduct of living, as an active rather than submissive principle. Nonetheless, female participation in sexual activity was considered a shadowy counterpart to that of the male.[8] Women were at best recipients and at worst, thieves of life, robbing men of their vitality. They behaved, according to what were accepted as the principles of feminine nature: as receptors, receptacles, translators and transmitters. Women's moral fibre was regarded as reflexive with her generational capacities, which must, according to Aristotle, be biologically activated while "...the male is that which has the power to generate in another"; thus giving shape, principal, form, logos (Lefkowitz and Fant, 1982, p.82). While women were acted upon - in terms of men generating life in them, they in turn performed upon these vital gifts - though little of activity is ever ascribed to women where an explanation involving paternal or foetal activity can, with even the slightest coherence and credibility, be propounded.[9]

Physiology, anatomy, and all forms of medical specialisation infantilised and had a generally incapacitating effect upon women. A whole pathology had developed around the womb as part of the Hippocratic tradition. In the humoral strand of medical discourse, men provided primal heat, women were cold and inchoate; their nature and sensibilities closest to that of

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8 See Lefkowitz and Fant, 1982, p.82-5. In Plato's *Timaeus* (91, trans.1959) the procreative faculties of both men and women are described as animated and itinerant, imbued with a love of procreation and unsubdued by reason.

9 Aristotelian notions also informed Christian attitudes by giving relative and hierarchical values to the procreative substances - in the work *On the generation of animals* (716-784), semen is described as being of primary generative significance. In *On the generating seed* and *On the nature of the child* the relative potency and superiority of masculine generative faculties were confirmed (Lefkowitz and Fant, 1982, pp.86-7).

children. Like children, women were considered secretive, conspiratorial and untrustworthy. Such notions shaped attitudes towards the gathering of women, which happened virtually exclusively to mark the rituals of death and birth, and most potently around the parturient woman, making her; her domain and condition, the objects of concern and interference. Women participated in and advised upon the normal functions of women: menstruation, childbirth, nursing, menopause. Women were attended by midwives, wet-nurses, mothers, grandmothers; by a variety of relatives, neighbours and female friends. Predominantly, almost exclusively, male doctors dealt with disease and sickness. The pathologising of normal childbirth facilitated its incorporation into the male experience, and ultimately moulded the experience of women themselves. Normal deliveries were the 'lowly art' relegated to midwives who 'assisted', armed mainly with birthing stools and gravity. Expertise devolved upon complications, and although at first, normal childbirth remained separate from pathology; with male intervention comes the urge to orchestrate and alter. The effects upon childbirth of this intervention are revealed: via drugs, technology and instrumentation; in terms of timing, quality, pain, onset, positionality, and outcomes.

The masculine privileging of the notion of penetration had complex connotations. It was thought to promote well-being in women, but it was also regarded in some respects, as violation, particularly, when it did not take a directly sexual form; that is when it culminated in contagion or corruption via talk, particularly among women.[10] In terms of childbirth, this symbolic aural penetration was feared to take place, and to be most effective, at the gathering of women or wherever women were segregated. In obstetrical terms, infection via penetration came to have sinister material connotations with the spread of puerperal fever as a direct result of manual penetration, premature intervention and mechanical foetal extraction, all of

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[10] mpregnation by ear is also a factor in Christian symbolism (Warner 1978, p.37).

which increased with the coming of the clinic, and overt male management of childbirth practices.

Birth practices and beliefs have, according to the evidence produced by various anthropological studies been conservative and resistant to change historically, wherever in the broad spectrum of human society the examination takes place - from primitive through semi-literate to technically advanced societies.[11] Certainly, there appear to be resonances of the past in more recent history and in current practices, that is, in terms of the exercise of control, the dissipation of functions, and in prescriptive rituals of purification and atonement. Not the gathering offensive of repression and suppression it would be convenient to depict, but everywhere the same uneasy mix of apprehension, containment and celebration. The agents of control and guidance are seen to change, in terms of personnel, intention, and perception of self. Conflicts and alliances are entered into and broken, but everywhere a source of power is recognised, made mystical, or scientised and constrained accordingly - but the discourse surrounding birth is never and nowhere the mandatory province of the mother. In fact, in the checks and admonitions and in the securing of control, she is barely acknowledged, at least with regard to what may be termed personal or human rights, whatever the paradigms of such constructs are at any given time. Indeed, the notion of 'human rights' has changed according to the prevalent cognition of what constitutes the human self. Something more than reproduction is at stake; other kinds of knowledge are stimulated, achieved, consolidated and transferred. The power effects of these knowledges can permeate and be reflective of the needs and norms of subjects in their prevailing historical conditions. It is this inter-related

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[11] See Briffault, 1927; Mead, 1946; Eliade, 1965; Bachofen, 1968.

network of effects that characterise the subjects and practices of the childbirth phenomenon, and which creates ramifications far beyond the event itself.

Self-examination was an essential if unco-ordinated practice of antiquity, but it was not until Christianity that the prime object was the search for bad intentions, for guilt and sin, and the foremost intention to urge confession and submission to judgement. Purification, rather than self-mastery, becomes the goal of training, abstinence, privation and mortification. The Christian code demands adherence to stricter obligations of truth, dogma and canon, and greater acceptance of permanent truths and institutional authority. While Catholic and Reform traditions develop differently, they are similar with respect to attitudes towards women and childbirth. The Christian notion of parturition as the suffering required as reparation for original sin persists as an ideal of punishment of divine devising, linking clearly with a growing requirement to submit to male medical authority.

Disclosure is the overriding paradigm; the bearing of witness against oneself both privately and publicly, to God, and to the community. Faith is impossible without self-knowledge, without the recognition of oneself as sinner and penitent. The acts of revelation and punishment were indivisible, hence childbirth is exposure and punishment; an exhibition of shame and modesty. The opening out of the secretive rituals and practices of childbirth, and the exposure of the practices of midwifery were a necessary part of the revelatory discourse, which also required and created the clandestine. It relied on symbolism, ritual, and theatre, and the emphasis on the rupture and dissociation of self and truth.

In the redemptive tenets of Christianity; marriage, however chaste, was a second-class alternative to chastity; and therefore could not compensate for the travails of childbirth, as ancient injunctions had seemed to promise. The only recourse for Christian women was to

reproduce as closely as possible in their own existences, a demanding and improbable mimicry of the ideals represented by the Virgin, the model of twin redemption via chastity and parturition. The former endorsed and encoded in monasterial practices and available to women of means and vocation, the latter both problematised and ratified by the curse of Genesis.[12]

A major feature of the Christian discourse of parturition, however, was the recognition, according to prevailing paradigms, of the incompatibility of childbirth among the biological

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[12] See Warner, 1978, pp.25-8, 50-78, 134-59. The multiplication of sorrow and conception was central to the Christian redemptive itinerary. The sins of the world are inherited via intercourse; it was impossible to enter the world without sin. The baptism of children, and the euphemistically designated 'churching' of women, were simply the first acts of purification and atonement; an absolution for childbirth. Through Mary, childbirth itself becomes a measure of atonement. The notion of virgin birth as fulfilment of old testament prophecy (*Isaiah* 7:14) occurs in *Matthew* (1:18-25) and *Luke* (1:26-38). The virgin birth was a precondition, not only of Christ's divinity, but evidence also, simultaneously and paradoxically of his humanity. In the *Apochrypha*, in a 'refinement' not widely endorsed, but reiterated, for example, in the fourth century by Ambrose, who claimed that the Virgin remained intact after giving birth. Symbolically, when the midwife proclaims this to Herod's daughter, the doubting Salome, her hand is consumed by fire when she examines Mary, and she is forced to acknowledge the power of God (*James* 19.3, 20:1-3). Fourth century writers who were concerned with virginity, such as John Chrysostom, and Ambrose, had followed Gregory in regarding marriage and childbirth as a necessary evil, attendant upon the Fall. They had reconfirmed the asexual nature of Christ's conception and birth; untainted by stain and contagion. The transmission, rather than the expiation, of original sin via human sexual intercourse was a potent toxic theme. Hence, the dynamic usually associated with fecundity becomes linked instead with a sacred and inviolate womb. The positive effect of these notions upon women was that their bodies, in principle if not widely in practice, appeared to come briefly into their 'possession'; differently constituted as both object and subjective experience, and paradigmatically circumscribed. In another of the paradoxes of iconography, Mary's freedom from pain in childbirth makes her, like the mythological and childless Artemis, the natural recipient of invocations for deliverance from the pains of labour. Symbol both of asceticism and fertility, not only her virginity, but her maternal and 'midwife/deliverer' aspects are also emphasised.

imperatives of women's lives with active principles of self-control and perfectibility. The response to this was to acknowledge and displace the non-perfectibility of the doctrinally necessary, imperfect pain of childbirth by the pedestalisation of the love object, and fantasy images of maternity.[13] Also, in these early responses, there was not as there was to be in the later Christian period, the questioning of the subjective, observing self or the examination of rational processes as anything other than God-given; questions taken up with particular intensity from the end of the eighteenth century. Paradigms of intervention and interpretation have particular relevance to the later history of childbirth. However, the concerns themselves had been developing since the eleventh century, when the privileging of dialectical reason, and the axioms of rationality as applied to knowledge and learning, had brought about a focussing of theological and philosophical attention upon the nature of revelation and God's authority (Maclean, 1980).

Aspects of self-discovery do not properly develop until Puritanical paradigms invest self-examining principles from the middle of the sixteenth century into the eighteenth, with the exposure of the failure of the self and its spiritual performance, which will entail increasingly the need for witness. It will require the surrender of, and search for, oneself, in the expert interpretation of the priest and the doctor. All this has obvious relevance, not only for modern psychoanalytic practices, but also for the present discourse of childbirth.

With the coming of the universities, thought and practice became more explicit, closer, more accurate and organised. Orality and writing continue to overlap, oral testimony and oral examination persisted. Gradually, as the alphabetic shift takes place, first in educational

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[13] See Warner, 1978, 177ff.; Newlyn, 1989, pp.122ff.

practice, and thereafter as alphabetic learning techniques filter through, the particular organisation of time and space introduced by writing begin to dominate in other practices, indeed anywhere that learning took place. Alphabetic cultures encouraged and privileged linearity, progressivism, hierarchisation, and compartmentalisation. The authenticating power of writing only gradually takes hold, though its potential had been realised by Plato. The authority of writing was further enhanced by the advent of print, and ramified by the normative use of calendars, charts, clocks, lists, and records (Culler, 1981).

It is possible that the powers of witness dwindle with the demise of oral cultures and become dissipated and incorporated within the examination which develops increasing currency in writing cultures. In the Medieval period the written testimony becomes markedly more powerful (Ong, 1982). There seems to be a link between witnessing and examination. There is, for example, the question of submission to both as mediating entities. They are also complicitly endorsed and self-perpetuating. Witnessing involves visibility yet exclusivity, it has oral and rhetorical aspects, and involves the notion of presence. Examination also has its oral dimension, which involved, for example, use of inquisitorial techniques. The medical examination equally, required confession and observation. These elements combined in the written record and the written exam. The difference lies in the encompassing of the idea of accountability without presence, as concomitant changes in communication, discourse and discursive structures occur. Writing develops as an imposition on speech; it is an active and penetrative principle, which is therefore culturally understood as male. This leads to both a rigidification and genderisation of category and truth. Its sense of permanency and authority promote therefore a masculine stronghold on knowledge and power.

From the twelfth to the sixteenth century, the printed word encouraged a sense of closure and definitive forms.[14] Disciplinary shifts in organisation and practice, and in ways of compiling knowledge, affected the teaching and learning of medicine as a separate discipline, itself organised into distinct and hierarchical sectors. Gynaecology begins to establish as an area distinguished by its own ethics, practices and prejudices. In England, the tenth century compilations of folk remedies and Greek teachings known as the Leech Books give an indication of what was fairly widely available in the West (Talbot, 1967). These already contained an extensive section devoted to gynaecology, obstetrics, and women's diseases. Influential medical texts of antiquity also had distinct sections dealing with such matters.[15] It seems that the effect on the organisation of information inspired by gender division prefigured, endorsed, and was informed by the burgeoning of the dialectical processes already in place. This was exacerbated by the adoption of new educational practices based on the alphabet, and

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[14] The paradigmatic textbooks of Peter Ramus (1515-1572), for example, promoted notions of self-containment and self-evidence, defining and dividing curriculum subjects (Ong, 1982, pp.96-100, 132-134).

[15] Hippocratic fragments available included *De Mulierum affectibus*, Avicenna's influential Galenic and compilationist *Canon*, which embraced and codified Graeco-Arabic medicine, and was contemporaneously regarded as a medical oracle. Similarly influential was the work of Averroes, again compilatory rather than innovative. Women were unlikely to have been attended or examined by men, although, like Albucasis, some wrote extensively on gynaecological matters, and midwives may have worked directly under male instruction. These works were available to the West in Latin during the Medieval period. The more stringent theoretical structure for practical medical skills began to emerge by the end of the tenth century, and through the eleventh, as Salerno became established as a teaching centre, and a broader range of translated works on surgery, anatomy, therapy, diet, and disease became available. Medical training was based on the Salernitan texts, which amongst others comprised the great monastic collections, though monks themselves were largely prohibited from practice by the religious Councils of the twelfth century. From around the end of the century, change began to accelerate as practical manuals and theoretical treatises were produced in Latin for teaching purposes with the growth of the universities (Talbot, 1967).

examinatorial techniques refined in the universities, which encouraged the rigidification of existing categories, and the proliferation of new ones on the same lines. Medically, areas such as surgery and obstetrics tended to be marginalised, and for the latter, apart from minor debates centring on propriety, it was not until the major discoveries concerning asepsis and anaesthesia which took place in the nineteenth century, that the real debates in this area opened up, dragging with them unresolved historical baggage, ready to be unpacked and reloaded in accordance with the new exigencies, regulations and requirements. Little was added in the Middle Ages to existing clinical knowledge or to the prevailing Aristotelian rationalist doctrines.

The description of childbirth history is only partially sketched with details of the representation, subordination and subjectification of women, and of the relative position of obstetrics according with its cultural ramifications in the developing fields of medical objectification. A more complete portrait is drawn in the attempt to discover the historical process whereby even within the female bastion of childbirth, the parturient woman lost or perhaps never found her voice except in the marginalia of modern discourses or to comply in the standardisation of her experience, annotated by form-filling and chart-plotting. The non-pregnant and pre-parturient woman do not escape implication. Teresa de Lauretis (1987, p.12) writes: "since the very first time we put a check mark on the little square next to the F on the form, we have officially entered the sex-gender system, the social relations of gender, and have become en-gendered as women;...not only do other people consider us females, but from that moment on we have been representing ourselves as women...the F next to the little box, which we marked in filling out the form, has stuck to us like a wet silk dress...while we thought that we were making the F on the form, in fact the F was marking itself on us."

A major effect of measures which generate statistical data and other recorded information (particularly that pertaining to improving mortality rates), is that they can be seen to 'prove' the efficacy of hospital treatment (Donnithorne, 1990, p.15). Throughout birth practices, much of the experience of the parturient is in some way encapsulated, measured, compared, graded, and recorded, often in a shorthand which has no meaning for the subject, and which ignores whole areas of experience, delineating the parameters of those it purports to measure. Some of these recordings are already outlined in brief, and include the life style and history questionnaires at the onset of the clinical experience which forms the preamble to life style advice, and the encoding of the progress of pregnancy in its many aspects, much of this reduced to acronyms.[16]

Sheila Kitzinger (1992, p.64) suggests that when women have attempted to account for their experience in their own terms, their versions have been trivialised or pathologised where they did not concur with the 'scientific' view. Women's testimony has been the object of historical mistrust unless it has passed through the interpretative filter of the priestly, medical or psychiatric orthodoxy presenting itself in the guise of reason and objectivity.[17] This is

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[16] See Comaroff, 1977; Hall et. al., 1980, Graham and Oakley, 1981.

[17] Two specific and related aspects of the discourse of parturition were linked to Christian revelation, in its turn informed by the Classical search for self. The discourse of behaviour modification identified with the latter, intertwines with that of pain and pain relief, which is inescapably permeated by Christian tenets predicated on the teachings of Genesis. The interweaving operations of these historically and paradigmatically distinct discourses bear a continuing influence upon the practices of parturition. Further, while the development of the power of the Logos equated with the Word of God remains instrumental to Christian discourse, it is the increasing grammatocentricity of pedagogic practices and their interaction with the discourse of power and knowledge, that bring the parturient and parturition into sharper focus, especially from the end of the eighteenth century.

particularly evident as science comes to define its objects according to the new principles and technologies of pedagogic practice, and notions of subjectivity achieve a status hitherto unthinkable.

Logocentrism, and the supremacy of the Word of God, share and generate conditions of possibility; the latter a compelling authorial expression of truth and power. Enshrined in the revelatory principles and practices of Christianity, is the increasing historical need to explain oneself; to God and others (representatives of God: priests and confessors; whose purpose is intercession on the behalf of reflective self), then to oneself and others (representatives of oneself: doctors and psychiatrists; whose purpose is interpretation when the notion of the impartiality of the observing self has entirely failed).[18] These exploratory and self-conscious

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[18] The verbalised disclosure of self is a feature of renunciation. Foucault (1988b, pp.16-17, 48-49) points out that the same techniques of exposure have served the human sciences from the eighteenth century with the purpose of reconstructing the self rather than renouncing it. While the Christian inquisition refined the strategies, recording and utility of questioning and confession that were to dominate Western disciplinary discourses, the deployment of interrogatory techniques was also a part of classical medicine. In his treatise *On The Interrogation of the Patient*, basing his appeal on Hippocratic prognostic teachings, Rufus of Ephesus appeals for greater diagnostic breadth in dealing with disease and illness, and the consideration of such factors as time and process. The questioning of patients and of those surrounding them, was also an interrogation of the past that was formulated especially to ascertain origins, causes, and the predictability of future effects. Also considered to be of significance, not only to diagnosis, but to the value of the testimony, is inherited disposition, environment, regimen and habits. Therefore, all internal and external causes; even dreams, should be subject to questioning. The manner, tone and progress of the interrogation would also give clues as to the patient's mental and physical condition. The level of pain, the possibility of malingering, and the propensity for honesty and self-control could also be ascertained. Others should be implicated via consultation, particularly where age or debilitation make patients unfit to describe their symptoms. Doctors must then make judgements on the basis of these interrogations. The value of the reciprocity of feedback is also acknowledged insofar as it is thought that the various effects and inconsistencies of treatment can be also be usefully relayed by the subject (Brock, 1929, 112-19). Hence, the professional ethic of Greek physicians required them then to take account of the patients' own assessment of their symptoms. Their potential

paradigms infuse the examinatory tendencies of techniques associated with the written.[19] Techniques which are both forged and fulfilled by the dual, and perhaps, related, processes of writing and reproduction. Writing, as a method or 'instrument' (a term which as we shall see must be approached warily) of 'reconstituting' the sound of the supposedly more ontologically privileged speech, has parallels with childbirth as the 'technique' or mechanistic expression of the overwhelming necessity of reproduction. The analogy is powerfully metaphorical; it is after all, the writing of childbirth that authorises, organises, and propagates, its medical and ethical objectivisation; appropriating, pathologising, and assimilating its practices and protagonists.

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unreliability is already 'programmed' into this schema. This was especially important for women for whom free examination was fraught with problems. Also, women were not considered capable of the rationality required to give proper account of themselves (Humphreys, 1983, p.49). It is impossible to conceive of this particular development of the doctor/patient relationship taking place without a mutually productive interchange of information and expectation. In this way, a particular form of hierarchical and tutelary relations became normalised between women and the forces of expertism. The intimacy of tutelage begins to extend beyond the accepted relations between women and their husbands and close kin. Women cannot have been entirely passive interlocutors, and would have been complicit in the elucidation of a certain rendering of themselves in medical interpretation. The correct and distinct formulation of the interaction between the male doctor and the female patient was essential: "...at the outset one must ask accurate questions about the cause. For the healing of the diseases of women differs greatly from the healing of man's diseases" (Hippocrates, Diseases of Women, I, in Lefkowitz and Fant, 1982, p.93). There is nothing here necessarily to suggest that women's experience of sickness and disease was considered inferior or less deserving of serious attention. In fact, because of the indications that women were reluctant to divulge their symptoms to men, and the fact that men anyway assumed this to be the case, the pleas for better interrogative methods had more credence and urgency, especially for women, for whom the eliciting and encoding of information required a particular delicacy of approach.

[19] Early evidences suggest that writing, as the encoding of communicable sound must have been preceded by a supplementary reading of signs associated with accountability (Hoskin and Macve, 1986).

Childbirth itself has functioned emblematically throughout history. Anxieties concerning the notion of presence are common to the discourses of parturition and parenthood. They are allied to the concerns of authorship, authority and subjectivity (Gallop, 1982, pp.92-112). Fear of the erasure of self implicit in writing is bound up with its connection with the irremediable disappearance of presence. Writing equates with other forms of reproduction and continuity which also represent the fear of death. For Derrida the historical definition of writing has been its various and simultaneous equation with nourishment and detritus, with vital germination and mortal infection. Weapon and instrument, it is both phallic trace and agent of reproduction.[20]

Writing, undertaken in the absence of the addressee, may be linked to the ambivalence felt towards women and childbirth, and the 'supplementary' role of women in the absence of paternal certainty. Men lack the immediacy of contact with human continuity, and so writing, while inevitably a phallogocentric form, is the object of historical mistrust. In this regard it is useful to bear in mind a minimal and classical concept of writing, which can be identified as

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[20] In *The Post Card*, Derrida (1978a) warns of the power and danger of phallogocentricity. Masculine writing is "marked writing", confounded and constituted with the history of reason (Cixous, 1981, p.249). Derrida (impossibly) enjoins the female reader: "do not read me; my language inseminates; I have no choice." (Boyne, 1990, p.142). The metaphorical link between educational practices and insemination has clear derivation. Etymologically, the link is available in the terms: seminary, seminal, seminar; the latter was not used until the nineteenth century, but it comes from seminary, which itself from the Latin seminarium, meant 'seed-bed', originating from semen, semin, seed, and came to mean place of production, cultivation, or education, by the sixteenth century. Interestingly, while the derivation, transmission and inculcation of knowledge, is etymologically associated with 'seeding', the place of insemination, the 'seed-bed' is metaphorically associated with the womb, and sheds light upon the image of the church as the repository of spiritual gestation and enlightenment.

the written sign as the mark beyond presence which is capable of future iteration, and of breaking free of context. The mark emerges as a rupture, introducing the possibility of extraction and grafting, resonant of apprehensions relating to childbirth subterfuge and substitution. Of representation without presence.[21]

Christian doctrine regards writing as a mortal trace which, like woman, is simply instrumental. This powerful and still active mystique attached to writing has resonance for the manner in which women have been regarded historically.[22] Despite or perhaps because of, the simplistic definition of writing as the tool of phallogocentricity, another link between women and writing is provided. Both are regarded as the arbiters, mediators and disrupters of presence. Necessity and threat. There has been a tradition from Plato which "has maintained the sovereignty of logocentric reason precisely by insisting on the derivative, supplementary character of the written." (Norris, 1987, pp.207).

While all creatures instinctively reproduce their kind, and have their 'signs', the sophistication of the human sign system of writing not only makes sense of the world, but comes to organise thought itself. A powerful tool, permitting a diversity of new practices of recording, storage and retrieval of information, which could also be regarded as the ultimate weapon of disempowerment that one, willingly, but without option, loads against oneself. It isolates the

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[21] The Christian tendency to unitary dogma and metaphysical approach to the notion of presence (Ong, 1967), is reflected in the cultural preoccupation with origins, and the logocentric concern, reflected for example in Rousseau, to counter writing's disruptive effect which creates rupture and difference (Norris, 1987, p.126; Gutman, 1988, pp.99-120).

[22] For Nietzsche, for example, woman is emblematic of figurative writing which opposes itself to reason and 'truth' (Derrida, 1979).

thinker and determines the parameters of thought in the very process of transcription. It externalises and erases memory more effectively than any other organisational mnemonic, though these too are permeated by the exigencies of the written. Under a variety of historic circumstances and conditions, writing and its effects succeed increasingly in making a fetish of reproduction. Historically, we inscribe reproduction and sexuality as both integrated and separate discourses into the organisation of our lives, and our ethical priorities. Reproduction is peculiarly regarded as a matter of both danger and necessity; we are constantly involved in regulating its practices, policing its domains, managing the dissemination of its discourses, and encoding its every nuance, as we, in effect, persuade ourselves to it.[23]

The impact of the written was to have its effect upon all aspects of human life and endeavour. If writing is the imperfect reproduction/trace of speech and presence (ruptured and without resonance); human reproduction could be regarded as the imperfect expression/trace of the continuity of human existence (marked by discontinuity and death). The written maintains the impression of the spoken, and after the speaker is gone; it is the permanent trace. Human procreation performs a similar encoding of human life itself. It signifies the acknowledgement and erasure of death, and as writing inscribes and determines that which is to be preserved, it erases the need for memory; the link with 'passed' time: the past. Writing is the dangerous cipher of the word. As the tool of power and knowledge, it is associated with the masculinisation of discourses. However, women too, have been regarded as the unreliable

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[23] In Galenic philosophy, people must be persuaded by the force of desire, even when against the interests of their own safety and well-being, to participate in their salvation, their bodies behaving "in chorus", (Foucault, 1988a, pp.110ff.) - serving a rationale of survival which those who engage in the reproductive act need not acknowledge or understand. A stylisation of consumption, conduct, and relationships was requisite; reflectiveness, prudence in distribution, and timing all become significant factors in sexual activity. Pleasure constituted a necessary inducement to a vital but potentially dangerous act.

ciphers of succession, and both writing and women share a history of fear and ambivalence exacerbated by dependency upon the continuing instrumentality of the object of observation and mistrust.

The historical comprehension of human reproduction, must, like any other act of reading, be a process, like reproduction itself, of looking both forward and back to elucidate meaning. A process requiring scrutiny, synthesis and care. In both writing and reproduction there is a parallel problematic: the recognition of difference and division, and of the necessary ambiguities of the empathy and antagonism of signs; the essential dichotomy of that which is integrated and yet separate. It might be said that a feature of logocentricity is that men speak the Word, but women 'write' the world.[24]

The development of the disciplinary discourse entailed an epistemic change in the late medieval period with the framing of pedagogic discourse in the examinatorial practices of the universities, then again as above, with the puritanical inquisition of the observing and enquiring self. Again, a major shift can be discerned from the latter third of the eighteenth century, as hierarchical grading and accountability become an increasingly normalised part of teaching and learning processes. This has obvious historical implications for women and also for the parturient. In the late twentieth century for example, examination and policing of the pregnant woman has reached new heights with improved techniques for monitoring the effects of alcohol, nicotine, and drug use; of sexual activity, and dietary habits; even and more particularly before conception, then post-conception: on the developing foetus.[25] The

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[24] For an interesting exposition on this theme, see Derrida, 1978, pp.49-57, 89, 93-97, 105.

[25] See *Observer*, May 24, 1992; Thorogood and Coulter, 1992, pp.47-62

'quality' of the newborn is also numerically and hierarchically described and charted. In effect, the new techniques reinstate historically dominant paradigms with ancient resonance, as the quality of offspring testify yet again to the health and purity of the mother. Here, however, she herself is enjoined to offer herself up; to reveal the extent to which her sexual behaviour and her consumption or addiction might prejudice the growth of her child, both within the womb and in the future.

In the twentieth century, even that portion of their lives which prefigures their own existence, that is, the condition of the womb which harboured them, and so on *ad infinitum*, comes to be identified, at least, tacitly, as pre-pregnancy, whatever the intentions of the woman might come to be. This was also evident in the endorsement of (supervised) exercise for young middle-class girls of the nineteenth-century as a prelude for fitness for motherhood.[26] However, such clumsy and authoritarian attempts to regulate young women represent only a minimal and unsubtle invasion of the single woman's life by the exigencies of maternity, when compared to the detailed requirements for directed self-questioning and scope for purposive self-governance explicit in contemporary medical advice to the pre-pregnant woman.

What has occurred in effect in the late twentieth century, is a lifetime monitoring of the female which encompasses even her own social and genetic background and possible propensities, her condition prior to conception (though this has growing significance for males also), her behaviour and lifestyle during pregnancy, and her responsibility; genetically, socially, and in terms of her own predisposition and predilection. Monitoring on this comprehensive scale,

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[26] See Dyhouse, 1977; Atkinson, 1978; Delamont, 1978. The intense physical activity of working women came later to present a different practical and ethical problem. This group were more likely to be subject to hospitalisation for childbearing.

has, in the discourse of medicine arisen around the procreative woman, much as the pedagogic discourse has the learner at its centre, which in turn reinforces the notion of *tutelage* in the parturial relation. Similar policing and investment also determine a woman's eligibility or otherwise, for fertility or other gynaecological treatment; for abortion, for adoption, for benefits and counselling. The medical monitoring of women's lives and the extent to which they are required to reveal themselves; on forms and charts, in clinics, surgeries, and in psychiatrists' rooms, is all linked irrevocably to the matrix of maternity.

One clear result of shifting emphases, and of a refocussed technology, is this renewed emphasis upon the foetus vis-a-vis the health of parents, but more especially, the mother. The earlier viability of premature infants, and the success of premature baby units, intensive care and foetal monitoring have lent credence to these imperatives. Hence, institutional authority, relayed and reinforced in journals, magazines, and in the media generally, while appearing to disinvest the parturient, is reinstated in her life and governs her behaviour and expectations by other means. In the unlikelihood of maternal mortality, upon which policies and practices continued to be predicated long after the threat had been overcome for the majority, the foetus provides a new focus of concern. Again, decreased infant mortality would seem to belie the need for a constant monitoring on the basis of possible infant death, but the accountability of the mother comes to be based upon more realistic exigencies, such as the impact of her behaviour upon the future expectations of the foetus.

The medical emphasis on childhood nurture is supplemented by an extensive reaffirmation of nature affecting the health of individuals prior to conception and decisive regarding their longevity. While the immediate physical entity of childbirth may have shifted to the periphery of medical concern, the emphasis on the well-being and intentions of the potential mother has actually extended the medical sphere of interest and influence with regard to women's health

while reducing the control (always limited) of the mother in relation to the foetus, where medical and technological imperatives prevail. This is most particularly relevant where the decreasing acceptability of abortion parallels the increasing viability of the foetus at an earlier stage of development, irrespective of the needs and requirements of the mother (Donnithorne, 1990, p.16).

A persistent inter-related problematic of death and birth which had resonance in antiquity, reflects also and more particularly, the development of Christian concerns linking birth to mortality and decay. These concerns perpetuated ancient fears of fleshly and spiritual pollution via intimacy with women, but were intensified by the ultimate denial of conception and death embodied by Mary, who, untainted by intercourse yet redeemed by childbirth, assumes Heaven without physical pain or death. In this way, the ultimate female icon is stripped of responsibility for her pregnancy, and absolved from death. The contemporary parturient is freed from the fear of mortality in childbirth, and her fertility is capable of artificial advancement, even to the until recently neglected possibility of 'virgin conception', following from the 'success' of *in vitro* fertilisation (Corea, 1985). Despite the increasing responsibility upon the would-be mother to prepare for pregnancy by the moderation of her own lifestyle, the necessity for nurture in the womb is curtailed by extra-uterine fertilisation, and reduced by the technological advances in the care of the premature. Also at stake is the liberty of the parturient to make decisions as to whether to continue with a pregnancy which is now constricted in parallel with scientific advance in relation to foetal viability.

The responsibility of today's women to ensure that their bodies are fit for pregnancy before conception, by moderation and abstention, has its roots in ancient notions of self-creation through the pursuit of moderate living. Exigencies which were further refined in the Christian era, through the practices of monasticism, as the technologies of dialogic self-disclosure, and

of contemplative self-examination developed into norms of behaviour which came to be adapted to different cultural requirements. One of the more interesting contemporary developments, is the range of possibilities opened up by the increase in available genetic information relevant to the life and potential of the foetus (Corea, 1985). This has particular significance for potential sex selection and the future of the female foetus. Firstly, because a re-focussing enables the potential, if morally questionable, rejection of females at the earliest stage, which has resonances of classical practices when infant females were more likely to be exposed.

Secondly, with the present situation concerning genetic information, we are on the cusp of a developing discourse, which involves the exploration of the potential for future prognostication and the inference of the possibility of inter-generational activity to perform upon the 'perfectible' status of the condition of the womb and foetus. While such specialised knowledge-dependent forecasting remains exclusive, and has only a tenuous hold upon the imagination of its objects, it is of course the long-term inculcation of norms of behaviour and consumption which will ensure the co-operative induction of what will become axiomatic restraints generating their own discourse of permissibility and penalty. Hence the infinite stretching of possibilities for behavioural modification has the effect of maintaining an active conformity over time, with the objects of scrutiny and reform in constant expectation of the next medical bulletin, or perfecting their performance to the next habit-forming/busting edict of the latest health or birth guru.

There are similarities here with later Christian tenets of a more Puritanical nature with their suspicion of the interpretative faculties of the individual - holding out the necessity of reformative behaviour without the prospect of self-generated redemption. The prospects for salvation must be filtered through other less imperfectible and appropriate agencies before

submission to God. This translates in a secular context into a pattern of life consistent with consultancy within the modern panoply of expertise, featuring the inbuilt realisation of failure and the generation of further nuances of benign and complicity-seeking discourses surrounding the desirability and impossibility of human perfectibility.

This has far-reaching implications for the parturient or prospective parturient, who is at present, enjoined to preserve and improve herself for the sake of her potential offspring. Genetic information detailing the possible ravages of past behaviours (of self and others), paradoxically confirms it is impossible in retrospect to effect change or have influence. It is also unlikely, given the long-term nature of genetic developments, to be able to do anything in the future, other than keep good faith by monitoring one's own behaviour, and trusting in the equal good sense and conformity of ones forebears and offspring. This encouragement to have faith (however futile), in a continuity of projected behaviour is appropriate to a society without the certainties of Divine salvation yet perpetually seeking to adapt Christian notions of perfection, judgement and immortality, and Christian technologies of examination, confession, and watchfulness.

For the 'pre-pregnant' woman, there is the prospect, by the moderation of ones own acts, only of a limited countering of possible negative effects, which themselves become exaggerated in order to enhance a new pathology of childbirth, as such issues as the control of pain, process, and mortality recede. The goal is the achievement of stoical self-denial while admitting a Puritanical helplessness and a continuing dependence on the judgement and expertise of others. There are aspects of these objectives in the clearly related rejection of institutional paradigms and of conventional drug therapy by the proponents of 'natural' childbirth. There are also hints of secular continuities with non-conformist traditions which prefer co-operative to authoritarian mediation. The persistence of demands of self-denial and expectation in

modern life has been achieved by the secularisation of religious ideals which has been part of a process of cross-fertilisation which could only occur in the divergence between secular and religious history.[27]

The implications here are two-fold; the first being the impact of intentionality on the interpretation of history and on the position of the subject.[28] The privileging of the subject reinforced notions of a hierarchy of expertise embodied by the author, and normalised obedience to the notion of authority and the necessity for the modification of behaviour. Women, clearly, as the historical recipients of advice and tutelage, and largely disbarred as a sex from the hierarchy of authority, are officially relegated to the realms of those upon whom effects are wrought, with obvious implications for their experience of the medical establishment, now firmly the milieu of masculine paradigms.

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[27] Walter Ong (1967, p.177) identifies this as occurring throughout the Christian period from antiquity through to the eighteenth century, expressed in the separation of external events and interior life, in, for example, Augustine's *City of God*, with the Cartesian interiorising of history established in the Hegelian merger of the history of civilisation and knowledge, when the history of events comes to be regarded as the history of consciousness. The new 'faith' in the instrumentality of the subject is enhanced by the intensification of the notion of intentionality central to phenomenology, and is filtered through Freudianism, which links the exterior and interior worlds.

[28] Following Nietzsche (1968 (1901-11), p.267), whose view that "the 'subject' is not something given, it is something added and invented and projected behind what there is", and Schopenhauer who suggests that "the conception of an ultimate and absolute substantiality of the self falls victim to an illusion that protects the established order even while its essence decays" (Adorno, 1974, pp.152-3), Foucault has challenged the privileging of the subject, and the 'tyranny' of reason in his work, and has himself been variously challenged. See: Sartre, 1966, pp.87ff.; Canguilhem, 1967; Derrida, 1978, pp.31-63; Baudrillard, 1980; Habermas, 1987. For a more favourable Marxist analysis; see B. Smart,.1983, pp.121-41; and M. Poster, 1984.

The second issue is that of the perceived effect of external factors upon consciousness itself, which had an impact upon the development of the technologies of, for example, pain control, which in its earliest manifestations was fraught by an agenda dissociated from relief. Fears concerning the altered consciousness grew with the increased awareness of an active, observing subject, as did the persecution of those thought to be purveyors of magic and hallucinations. These anxieties came to be heightened by the witch-hunts that coincided with the development of Puritanical fatalism, and took their toll of rural healers and midwives, who could be regarded as having a disproportionate, if not heretical influence over procreative processes and therefore over matters of life and death (Hamilton, 1981). Further, they were not only collaborators in illegitimate practices in an age of exposure and revelation, but also were in command of knowledges which empowered them to alleviate the redemptive and ordained sufferings of childbirth, to abrogate the sanctity of human life, and to corrupt vulnerable minds, depriving them of the power of reasoned judgement considered anyway to be under constant and increasing threat.

Historically, midwives were objects of suspicion, ripe for observation, incorporation and control and the later pursuit of the 'ignorant' midwife, echoed that of the earlier hunting of the witch. It is probable that these purges were only about the hatred of women on the most perfunctionary of ideological levels, despite their disastrous impact upon the lives and deaths of numbers of ordinary women. The pursuit of 'errant' women, was partially dependent upon their historical, cultural, logocentric marginalisation in their physicality, spirituality, and intellectuality; in their sicknesses, in their productivities, in their healing. And these elements in turn, were redefined by that continuing pursuit.

The main action is in the setting up of conditions whereby such practices may be regarded as normal, and this is the result of a combination of effects which may only be about

intentionality on the level of operations. That is not to say that human beings are only the 'puppets' of historical coincidences, but that they take their very subjectivity from the paradigms generated by such conditions, and cannot operate 'in truth' outside them. And that is the crux of the historical hiatus which throws up eradicatory, or in the more euphemistic but historically apposite term: 'purificatory' tendencies to purge. We have tended in retrospect to concentrate upon the morality and guiding principles of the often grisly manifestations of these seemingly collective urges. We have called them, (not altogether coincidentally, in a manner also used variously to describe women) evil, hysterical, and irrational. We have attempted either to understand them as the evidence of a circumstantial, temporary and degrading madness, or disowned them entirely as aberrant and monstrous.

However, these moments require more complex analysis. They are more than the result of the conditions which evolve to inspire them, often long before they take place, and more than the instigation of any individual or set of individuals, who can only manipulate circumstances in paradigmatically circumscribed ways, operating within the limits of the prevailing discourse. While the pursuit of the object takes shape and is intensified, a whole series of new practices and exigencies are produced and discovered. For example, the persecution of the witch was motivated largely as a result and development of the prevailing culturally requisite confessorialism, and it is those paradigms and the refinement of techniques and practices associated with them, that leave the most resounding legacy to the future. make appropriate their resurfacing at the level of discourse. It would be simplistic to regard such historical phenomena from the moral high ground of an enlightened present. According to accepted premises of humanist bewilderment and the obligation to explain as aberrant, improper, and even 'unofficial', those political and ideological responses and activities that are depicted as somehow functioning (incorrectly) outside the mainstream of historical discourse. Such analyses often present an impeccable historical catalogue, reinventing the wheel in order to

explicate and demonstrate some particular exegesis, but fail to appreciate or properly reflect upon the irony and arrogance of the self investigating the self. These problems have also beset both materialist and feminist interpretations.[29]

Certainly, the fear and purge of witches in the sixteenth century, was unlikely to be some simple manifestation of collective hysteria. It arose historically at least in part from the association of poisoning, blood, and sorcery, which has its origins in antiquity, and is clearly more fully expounded in the Medieval period. Women in antiquity, though so expedient to the cause of procreation, posed 0such ethical and physical dangers for men. It is women who bear the physical 'mark' of pregnancy, so potent a symbol in Christianity, and as the first nourisher of life, she is everywhere regarded and harried as its possible poisoner. Such fears were predicated on the connectedness of menstruation and lactation, and an ambivalence concerning women's power to nourish their offspring. Such notions also have resonance in the challenges to these taboos that permeate more recent practices. Interestingly, a similar coalition of prejudices appears paradoxically to inform the discourse of childbirth in the late twentieth century. A section of women have not only sought to make and redefine childbirth pain as something of their own, detoxifying it and releasing it from its chemicalised parameters of acceptibility, but have also hastened a concomitant rise in the desirability of breastfeeding,

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[29] Examples of the former include J-P. Sartre, 1966; N. Poulantzas, 1978, pp.146-53; A. Callinicos, 1982, pp.97-111; J Habermas, 1987, who have variously criticised discourse analysis and the Foucauldian 'denial of man'. For a critique of examples of the latter, and also the debate on feminism and post-structuralism, see: Modelski, 1986, pp.121-38; Weedon, 1987; Diamond and Quinby, 1988; Nye, 1988; Scott, 1988, pp.33-48; Bordo, 1990, pp.133-56. For a more general discussion of post-modernism, see: Lyotard, 1984; Arac (ed.), 1989; Harvey, 1989; Morris, 1992, pp.253-79.

largely supported, at least in theory, by the medical establishment.[30] These issues are pursued most aggressively by a more vociferous and politicised middle-class minority. However, that the practical effects are realised only by a minority of women is not entirely relevant, as it has been their concerns; the concerns of a fairly small proportion of predominantly middle class women, that have, in concert with the growing genetic and technological discourse, substantially stimulated the ethical debates of recent times and have to a certain extent both dictated, and colluded with, their direction.

There are ambiguities of origin and reference here. It could be asked whether such movements constitute in essence a removal or renewal of historical exigencies that follow upon the curse of Genesis. The advent of Christianity had promoted certain axioms which ratified notions previously developed in antiquity in relation to women's sexuality. The pains of childbirth were biblically inscribed.[31] They instilled a fear of childbirth, and stimulated the 'nightmares' of men and women alike, beyond the confines of the western world (Mead, 1946). Such anxieties promoted a reliance upon the soothing 'expertise' of whatever *shaman* offered his services. Feminist demands to claw back from medical technology (perceived as male) the pain and energy of childbearing, and the feeding of infants, and the onset of puberty, menstruation and menopause from commercial and pharmaceutical exploitation; tend to conjure the ghosts of an idealised female past.[32] The desire to reclaim biological responsibilities and to eschew the artificial alleviation of their symptoms, appears in some

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30 See Kitzinger, 1990. Also, the Department of Health, 1988; Joint Breastfeeding Survey; 1990, Royal College of Nursing, 1990.

31 Genesis (3:16), Isaiah (21:3-4, 13:8), and Revelation (12:1-2).

32 See Arms, 1975, and Merchant, 1980 for examples.

respects, a justifiable part of a pioneering crusade against what is perceived as women's general marginalisation. However, within the constraints of multi-layered and variously inter-weaving historical paradigms, such activities cannot take place in an ethical vacuum.

It could be argued that at least the initial, perhaps symbolic, rejection of scientific medical technology and relief, appears to incorporate the rigours of early Christian doctrines of penitential self-mortification. However, the drive to do so is derived from the development of certain paradigms of subjectivity and the demands of a particular construction of human rights which are exclusively within the parameters of what can be thought, attempted and achieved, and not the result of the same externally imposed internalised stringencies and ideals. Similarly, when questions of morality permeated the discourse of pain-relief in the nineteenth century, the ethical appropriateness of the alleviation of childbirth pain was tied to all the old Christian taboos, only more directly and unashamedly so, insofar as they provided the authority of historical and theological orthodoxy to support the prevailing disciplinary paradigms. For twentieth century women the questioning of pain relief has different targets and premises. Nonetheless, as attempts to 're-appropriate' childbirth and deliver it from technology, pathology, and commerce, and to liberate child-rearing into the maternal embrace with 'breast is best' propagandising, there is no doubt that here, just as with childbirth practices - the establisment of the new orthodoxy incorporates elements of the old.[33]

In the Christian West, midwives were not simply, it must not be forgotten, the servants and agents of women. They functioned also to maintain the status quo, and to perpetuate existing paradigms. The midwife's role in baptism, in matters of survival and death, made her position

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[33] For an example of relevant propagandising, see Stanway, P. and A., 1978

in the family and community a very influential one. She too could operate the rigours of surveillance in order that families conformed to the needs and norms of the wider community, making sure that men were not fooled concerning the legitimacy of their children, or indeed making certain that they were. For such services, and for the procurement of abortions and contraceptives; secrets, confidences, anxieties, and almost certainly gifts, remuneration and other favours crossed the territory of childbirth. When the intimate links between the parturient and her deliverer are disrupted by the later intervention of the trained midwife, the sphere of childbirth becomes categorised and proscribed. At the same time, aspects of the traditional lines of communication are exploited for the disciplinary purposes of professionalisation. Male influence was a constant. Contraception and abortion, for example, have always been the concern of men, as the phenomenon of exposure in antiquity demonstrated and established.[34] It was in their interests to preserve the mythology that all women have a secret desire for abortion and the prevention of pregnancy, and that men, (represented by priests and doctors) have a vested interest in ensuring conception and birth (though indeed their control over it is problematic). Present-day papal and secular legislation would seem to bear out this stereotype.

The midwife was the key to the growing interest in the family and the individual, and could be a powerful tool. Many of her ministrations had the dignity of secrecy and although by no

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[34] Nietzsche recognised the significance of this phenomenon: "formerly it seemed fair for fathers (among the ancient Germans, for example) to decide on the life or death of the new-born as they saw fit. And like the father, teachers, classes, priests, and princes still see, even today, in every new human being an unproblematic opportunity for another possession." (Nietzsche, 1966 (1886), pp.107-8). Exoneration has been sought via the stereotype of man as the initiator, perpetuator and preserver of life in the absence of women's desire for life and their misplaced responsibility. This has reached radical proportions amongst some of those responsible for modern fertility treatments and the policing of women who are to receive them.

means always under obvious coercion (despite episodic purges such as the witchhunts) she was able to perform the rites demanded by the prevailing discourse. Women of the class who became midwives lacked occupational opportunities and were likely to guard their positions jealously, and would cooperate with authority in order to do so. They might also attempt to preserve their folk integrity by remaining ignorant of advances or impervious to the need for cleanliness. If the community based midwife disappeared, they did so as a result of the interplay of discursive conditions rather than as the outcome of a misogynist conspiracy. However it was a two-way process: unofficial practitioners were invaluable for advice (and for their trustworthy discretion), on sex, abortion, childcare, and herbalism for minor ailments. It was this spread of aid and influence which increased the midwife's need for recognition and prestige, yet testified to the danger she represented to authority and professionalism.

From the nineteenth century, the preoccupations of the medical discourse were with the specificities of the ordering of disease. This ties in with the increasing accountability of the individual, the discourse developing since the onset of Christianity. The diagnostic tradition was the discernment of the balance between health and disease, the rational process of distinguishing one condition from another in a process of emphatic definition. This particularly accelerated the development of medicine on the grounds of Cartesian reductionism which promotes the notion of a certain infallibility attaching to the scientific enterprise, and a concomitant blindness to the fact that both science and medicine are essentially social constructs.[35] Discourse itself cannot behave by design or in a unified

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[35] See Canguilhem, 1981, pp.20ff.; Fox Keller, 1982, pp.113ff. Rabinow (1986, p.372) suggests that while Descartes divorced ethics from scientific rationality, making the institutionalisation of modern science possible, Kant reintroduced ethics in the form of applied procedural rationality. The development of clinical medicine has been imbued with metaphysics since the time of Hippocrates. The epistemological design of modern medicine is positivistic, totalising, and anthropocentrically self-sufficient. However, neither the

manner. It operates *via* the vehicles of power: the priest, judge and doctor, who are the points through which power passes, and where it can be traced.[36]

Often the separation of medicine and ideology is taken as a rationalistic axiomatic, an obvious antinomy, like fact and value, objective and subjective. Yet these are discursive constructs just as rationality itself. Medicine is not outside social experience, it coalesces, and is mutually constitutive with it. The very subjectivity of the patient is a creation of the medical discourse. Particular types of knowledge, relationships, and practices give rise to new social categories. Many of these structures we have come to recognise as commonsense thinking, forgetting to investigate the structures themselves. In certain domains of human existence, such as reproduction, ageing, insanity and death, medicine has exercised a powerful control via its assertion of 'factual' knowledge, and the metaphors supplied by notions of 'natural' truths, which reinforce rather than reconcile paradoxes and prejudices. A concomitant aspect of these principles has been the inherent problematisation of the doctor and patient relationships, and in the eliciting of information from the patient.[37] As the picture of the general health of the individual, from the cradle to the grave, and even from intra-uterine life to the body beyond death, became increasingly detailed and remarkable; rendered calculable against

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human subject, nor the notion of sexuality are anything other than an epistemological construct (Foucault, 1980, pp.183-93; Sheridan, 1980, p.194; Hussain, 1981, pp.169-91).

[36] See Foucault, 1981, p.94. For a general critique of Foucault's approach to discourse analysis, see: Hoy, 1979, pp.85-95; White, 1979, pp.81-115; Dreyfus and Rabinow, 1982; Racevskis, 1983; Cousins and Hussain, 1984; Rabinow, 1986.

[37] For a variety of perspectives on this problematic, see:.Foucault, 1967, pp.159-98; Szasz, 1970; 1979; Lacan, 1979, pp.123-36; Oakley, 1980; 1981, pp.31-61; MacIntyre, 1982, pp.387-394.

shifting ideals of mental and physical health; the condition of pregnancy and labour comes also to be fully pathologised. Professionalisation undergoes stages both of differentiation and incorporation in order to achieve status then preserve the status quo.

The modern technologisation of childbirth processes effectively came to divorce both the midwife and the parturient from their experience of childbirth and its practices. Instinctive behaviours become suspect. The midwife is confirmed as an ally of the doctor rather than of the mother; she conforms to the homogeneity that is being achieved in practice. The parturient herself comes to mistrust and misinterpret the pain and processes of her body, relinquishing herself to the birth experts. Experience is again a question of interpretation, of the instilling of both an inner sense of police and a concomitant mistrust of ones own ability to police oneself. This is the refinement of the questions of intentionality which developed in the late Christian period. Both the midwife and the parturient filter their experiences through the process of expert interpretation.[38]

The examination itself is at the heart of disciplinary procedures that constituted and ordered the individual as the object and effect of power and knowledge. The medical consultation created and problematised the role of both doctor and patient and the relations that were established between them. This is the centre of the medical enterprise. This exemplifies how

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[38] Echoing Nietzsche's tenet (1966 (1886), p.85) that: "There are no moral phenomena at all, but only a moral interpretation of phenomena ", Foucault writes: "If interpretation is a never-ending task, it is simply because there is nothing to interpret. There is nothing absolutely primary to interpret because when all is said and done, underneath it all everything is already interpretation." (Dreyfus and Rabinow, 1982, p.107). Foucault considers that the lessons of Nietzsche, are that the human body in all its aspects is subject to cultural modifications and the minutiae of localised strategies and techniques, making it the site and dispersal point of power and knowledge, facilitating larger scale organisation.

the human subject comes to be invented by the strategies of the developing human sciences, and brings into question the privileging of the human subject with the capacity for moral autonomy, which has been the axiomatic mainstay of Western civilisation, as are the relations of the subject and object, as if they had an *a priori* existence and were not constituted by regimes of truth which are themselves produced by the human sciences.

Under these circumstances it can be seen that the categories of the sick, diseased, disabled and mentally ill, are in fact devised by clinicians and the field of problematic relations in which both they and the patients they categorise are implicated.[39] It is also possible to trace the strategy of categorisation in terms of the parturient woman who is created as a separate entity within her own existence. There is no distinct *a priori* 'natural' setting for the parturient. She is always cast in a field of relations which describe her. However, she is no longer perceived as having a unique and permanently inscribed role in the interplay of such constructions as biological or family events, but that childbirth itself is created as a hiatus in the constitution of familial and societal relations, and the parturient woman is made a distinct object of disruption. This is certainly facilitated by the beliefs and mythologies of the past, and by the early ritualistic 'marking off' of stages in the female maturational cycle, which had in contrast served to entrench family members in the dutiful performance of ritual observance (Lefkowitz, 1983, pp.49ff.). However, the fears associated both with women and with birth, once part of an integrated and organic schema, come to have new and developing modes of representation. Hence the birthing woman has a separate and significant entity which is still implicated in relations which bind the individual deeply into a particularising and polarising of their subjective experience in which they will willingly, almost unconsciously submit to strategies

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[39] For various expositions on the social construction of illness, see.Szasz, 1961; Foucault, 1967; 1970; Sontag, 1978; Scull, 1979; Figlio, 1982; Ingleby, 1982.

that ratify and strengthen their objectification and subjectification. Even in their resistances they are pinned to these categorisations of the self, and of the conduct of the body.

The divorce of subject and experience creates a sense of the condition of pregnancy as something contracted yet somehow superimposed. This both implies and denies the culpability and responsibility of the individual, enjoining their surrender and complicity, implicating them in a growing disciplinary discourse of regimen, and in a life's work of self-policing activity. It has been the view of conventional historiography that these processes are the result of economic, sociological or ideological exigencies. There has been insufficient concern with the strategies and techniques which support and are supported by the prevailing discursive arrangements. Such a shift in perspective provides a challenge to traditionalist, progressivist or 'Great Man' theories. There are within prevailing paradigms a network of conditions and effects which cannot be interpreted as the realm of intentionality, as the activities of a self-interested subject, behaving out of intuition, inspiration or intention. Neither can events be simply a matter of philanthropic concern, or of misanthropy, misogyny or malice. Radical change has been historically identified as being allied to events which entail great social or religious upheaval as first or primary cause, or to the intentions and activities or writings of significant individuals, rather than to the epistemic and paradigmatic shifts that determine them.[40]

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[40] See Foucault, 1989, pp.11-350. Traditional historiography has been challenged by structuralism since the advent of Saussurean linguistics (1959 (1916)). For a general exposition on structuralism, see: Piaget, 1971; Derrida, 1972, pp.247-72; Hawkes, 1977; on post-structuralism: Dews, 1980, p.8ff.; Culler, 1981; Lewis, 1982; on Foucault and post-structuralism: Dews, 1979, pp.127-71; Connolly, 1984, pp.139-67. For a critique of post-structuralism, see: Chiari, 1975; Vigorelli, 1981.

These are located instead in a network of interrelated effects, techniques, technologies and strategies, and are not a matter primarily of subjective action and intention. The shifts of this paradigmatic discursive framework can be located as creating ruptures and discontinuities on a completely different timescale to that determined by the length of battles or the lifespan of kings and philosophers. The role of the active and intending subject is always circumscribed by these paradigms without which there would be not be a framework either for activity or for change. Shifts and breeches can occur within that existing framework, so that the parameters of acceptability are continually stretched and revised by that which is perceived as resistance. Change, however, is rarely as clear-cut as the skirmishes between oppressor and oppressed, or based simply on antagonism and conflict.

In the separation of parturition and of the parturient, it is possible to detect the normalisation and normalising processes of divisory strategies. These are the categorisations that distinguish and internally divide the process of childbirth in the later discourse which are entirely distinct from the delineation of subject and experience which characterised ancient maturational cycles. The latter involved a concentration upon the significance of a hierarchical sequence of biological events predicated on symbolic blood loss. The modern processes build upon such 'staging' techniques, but adulterate them by emphasising discontinuity. The marking off of distinct stages of childbirth process ensures that it is experienced as broken, each stage presupposing a rupture before the next, and each stage occupying a specific ideal temporal duration, which while varied has its own parameters of acceptable and non-intervenable span which themselves become medians of individual experience and create a problematic of ceaseless adjustment, dependent on scientific, technological and psychological paradigms. In this process it was both normal and formative that intrusions and excursions upon the parturient body during pregnancy and childbirth, should have been variously employed and successfully normalised. Many different versions of externally imposed break, have had their

vogue and near-universal application. This schematic ordering of childbirth itself is reinforced and reinforces its division from what can be considered 'normal' life, and the isolation of the parturient as a dysfunctioning entity.[41]

The syntheses of the investment of the body with power and knowledge, and its relation to the constitution of 'truth', and of sexuality, is, however, a process of production rather than repression, constraint or coercion, demanding complicity in modern discourse, rather than submission. Truth and reason are constructs which perform as the liberator and justification of power, and should be approached historically and not metaphysically. Its mechanisms are effective largely because in the modern idiom which became refined from around 1800, they are increasingly concealed (Foucault, 1981). From the nineteenth century, the centring of the coalescence of practices which constitute the modern discourse, was predicated on sexuality and came to be established around both the notion of species and of individuality. The body with its adaptable and reproductive capacities, became the object of science and the focus of manipulating and interdependent disciplinary regimen.

Childbirth practices can be regarded as a combination of effects including ancient anxieties associated with the loss of self-control and with death; the theatricality of divine and sovereign power; the preoccupations with representation and intentionality which developed in the Classical Age; and the refinement of the techniques of surveillance and normalisation. The

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[41] One example is the controversial ultra-sound scan used during pregnancy which has come to supplement abdominal and cervical manipulation (Kitzinger, 1983, pp.26-8). Prospective mothers can mark off their pregnancies as 'between scans'. There are also the effects during labour of the inductive drip, foetal monitoring, artificial rupturing of membranes, and the use of episiotomy and forceps (Kitzinger, 1972; 1983; 1992; Inch, 1982).

minute and detailed techniques of observation, compilation and classification associated with the latter, were the key to the functioning and administration of disciplinary institutions beginning with the educational, and spreading into the prisons, the establishments of the military and into the hospitals (Foucault, 1979, pp.231ff.). They determined the nature of the complicity-seeking, interventionist, regulatory and professionalising discourses of the modern era. Much of the characteristic reliance on the 'expertise' of others stems from the special alliance that women have forged with the doctor since the nineteenth century when their complicity was sought in bringing the family under disciplinary surveillance and control. The medicalisation of society took place via the socially and medically constituted family. The traditional patriarchal structure gave way to new alliances, principally those between the mother and the doctor.[42]

Her responsibilities were centred on the health of her family. Individuals had a new obligation to be well, and women had an obligation to oversee the welfare of others. Enlightenment educational and political aims were fulfilled in the notion of the medical consultation. The complicity with the aims of the experts extends to women in the modern discourses of health and regimen. Diet and exercise continue to be regarded as part of a healthy and 'natural' lifestyle. Despite aspects of economic rationality and consumer conformity that these lifestyle exigencies entail, more importantly they involve certain configurations of power which serve the discourse of expertism. While they are part of a liberationist discourse, the mechanisms of control that surround exhortations to self-control in matters of diet and activity, though advertising themselves, like the childbirth class, as self-help, still rely on a 'club' ethos which

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[42] Donzelot, 1980; pp.82-96. See also Bennet et. al., 1981; Hirst, 1981; Turner, 1984, p162.

guarantees the policing of the individual. The premise is one of voluntariness and choice. One polices others; one is grateful to be policed.

Women have continued to to summon expert aid in all areas of their existence. The boundaries of acceptable patient behaviour in women is not a constant factor. For example, there have been radical changes in the way in which the parturient is expected to behave and in what her behaviour is thought to signify during the process of hospitalisation in the twentieth century. For example, in the more explicitly disciplinarian regimes of the old style maternity hospitals, overt distress at the enforced separation of mother and child was a sign not of 'natural' distress or anxiety at the disruption of the bonding process, but of perversity, insubordination and irrationality (Ingleby, 1982). Of similar disciplinary value, is the current paradigm which entails the observation of the mother for signs that bonding between her and her child is taking place, and it is considered abnormal and aberrant where it does not (Macfarlane, 1977). The level at which bonding takes place is usually recorded both immediately after birth and also in the early post-natal days. It is not just that the criteria for 'abnormal' behaviour have changed, but that mothers have internalised what is expected of them and make efforts not only to conform with what they know tacitly to be the case, but consider their own behaviour to be abnormal where it does not comply. This observation of ones own behaviour engenders a complexity of resolutions. The self-schooled and self-conscious approach is to respond by displaying a mode of conduct which will satisfy the tenets of surveillance (the practical results of failure might after all be unwanted attentions or prolongation of hospital stay). This can interfere with spontaneous attachments, or at best channel them into particular behaviour patterns, but more subtly, the behaviour of the mother whatever its immediate result, conforms to a more general pattern of self-policed behaviour, and a homogenising of response and range of conduct that takes place as standard everywhere.

These disciplinary strategies originating specifically in relations of tutelage determined by the hierarchising and divisory techniques of the *logos*, and confirmed in the encodings of the alphabet and writing, are inscribed in practices which control the individual from birth. They are deeply inscribed upon mothers and deliverers, and all those who inform and observe them in a chain of reciprocal ratification and surveillance. We usually know how we are doing according to those principles of acceptable behaviour, rather than on any immediate interpersonal basis. In fact there is no such division of public and private; the structure of relationships with others is governed by the same examinatory principles as those performed upon the self. It is particular conceptions of the self and what the self constitutes that governs ones approach to other selves who are also in the process of communicating, defining and creating themselves. Nietzsche (1966 (1886) p.209) suggests that "the ordinary man still always waits for an opinion about himself and then instinctively submits to that". All relations can be thus encoded and proceed by and large accordingly. Where relations do not appear to be in accord, they can be incorporated, not subsumed, into the definition of the parameters of the normal and acceptable, and thereby so-called aberrant conduct is necessary both to the constitution of the 'normal' and to what constitutes non-conformity, in a reciprocating cycle of paradigmatic construction.[43]

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[43] Nietzsche (1968 (1901-11), p.425) decries "a deliberate closing of one's eyes to oneself - Wherever dissembling produces a stronger effect when it is unconscious, it becomes unconscious.". That Nietzsche uses woman as a metaphor and representation is to highlight the anomaly that oppositionism has itself produced. He need look no further than the cultural creation of woman for his image. So it appears that the preservation of the creation of 'woman', is dependent upon the rebellion that is stage-managed against this image, a double deception which is recognised by Nietzsche as evidence of the fundamental dualism which is at the heart of the prevailing discourse from which there is no escape (Nietzsche, 1968 (1901-11), p.463).

The constraint this involves comes to us long before we enter a classroom. It is inscribed in our earliest relationships with our mothers, relationships which will help to determine our performance in other prescribed relations of tutelage, whether educational, economic, psychiatric or pathological. Not only will the conduct of those relations be determined, but often their contents also. The neuroses learned as a result of our early relationships and our obsessive and aberrant responses to them go on to supply our need for relations of expertise, interpretation and evaluation throughout our lives. In this schema, deviancy and resistance are inevitably hybrid forms of conformity defined as they are by what constitutes that conformity at any given time.

This can be confirmed by the groups that are created in the margins of heterogeneous and paradoxical alliances, such as that between the mother and doctor in the unfolding of the welfare ethos, or between the various interests associated with professionalisation. The implications for this project are that whatever might appear to be radical change in the paradigmatic and practical functioning of childbirth processes, in fact take place within the sanctions of the existing structures and cannot do otherwise. Therefore, the result for the parturient, while perhaps radical in terms of immediate experience, does not in fact threaten the existing ethos but resides within it; reinforcing disciplinary relations of tutelage and conformity wherever they are manifest - in a conventional maternity hospital setting or in the more soothing environs of the private and sympathetic self-run ante-natal class which abides by the tenets of the usually male gurus of childbirth 'self' help.

Practices are intricate and contingent, permeating, dispersing and organising human existence. This has particular resonance with regard to the female body which becomes a moral matrix for sexual behaviours, and the object of scientific enquiry and concern as the generator of the species. Two major interrelated motivating factors which characterised this era, began to

have a real impact upon childbirth practices. One was the increase in concern with the calculability of the individual and of the population at large. This involved not simply an interest in the generation of individuals and populations, but the rendering of the body calculable by inviegling the individual in the name of his or her best interests to place themselves in the hands of the experts, and by dint of an appeal to that same self-interest, inviting them into the domains of expertise, persuading them to the glamour of calculability, and the appeal of its spotlight.

The second factor was the implementation of the new techniques of extraction, followed by the concomitant technologies of hygiene, and anaesthesia, which created their own objects of medical attention, renewing the focus upon the parturient as the man-made creation of science and technology, rather than an area of natural disaster. One concomitant effect of this was the gradual normalisation of interventionary extraction, now a frequent concomitant of anaesthesia, also normalised as pain relief. Also, in a reciprocal development, better hygiene followed increased interventionism, because it also entailed a greater probability of infection. The crises of the parturient were then a near-perfect hermeneutic effect of the developing obstetric science which was increasingly adept at creating its own objects in an ongoing and reciprocal pathologisation and manageable fragmentation of childbirth, though their efforts may have appeared the result of a sudden upsurge in humanitarian concern for the life and death of the parturient woman. The result of this for the parturient of the late twentieth century is that the treatment of all women is predicated on the abnormal labour created by medical expediencies and contingencies. Each labour is regarded as potentially abnormal, although only a small percentage of parturient women actually experience the problems that the birth scenario is set up to accommodate. Where abnormalities have not been screened previously, they are presumed to be potential hazards after certain, sometimes arbitrary periods of time. Arbitrary because the determining of the delivery date is an inexact science,

even though the period that is allowed to elapse before induction is regarded virtually as mandatory, and is predicated on such calculations.

The history of obstetrics has been presented with an almost relentless optimism even by the sceptics. This is partially due to the virtual elimination of puerperal fever by anti-biotics since the 1930's which cut the maternal death rate to a fraction of the pre-war figure. Today the psychological preparation of the parturient is considered to be of importance - such factors as childbirth classes, counselling and coaching are essential to the encouragement of co-operation and collusion. However, again a balance has been hard to engineer. The appropriation of certain aspects of ante-natal preparation by independent groups, has had what appears to be the opposite effect upon the consciousness of the middle-class parturient. However, there is no particular paradox here. The 'new' principles have established new orthodoxies within prevailing paradigms of self-help, management and responsibility. This aligns with the new framework of expertise in a self-analysing and self-ministering culture.

Since antiquity, childbirth and the parturient woman have come to be defined within changing paradigms of self-awareness, which have accentuated control, moderation, proper process, timing and use, and a problematic has evolved around childbirth practices which paradoxically both ensured and yet appeared to threaten the prevailing order. The related constitution of parturition as an object of medical and scientific knowledge has had reciprocal implications for relations between men and women, and amongst women themselves. This offers partial explanations as to how midwifery developed within a growing male medical establishment and how childbirth space came to be the object of invasion, examination and control.

The little that is known of women's childbirth experiences in antiquity reveals that the paradigms that informed them appear to bear no comparison to those which underly

contemporary childbirth practices. However, such historical resonances were deeply influential in the formulation of definitions which mark out at once and forever childbirth and the parturient woman as legitimate objects of knowledge. It must then be asked how they came to be regarded as rewarding both the investment and the inquisition of power. The discourse of childbirth in the twentieth century, has in discernible ways incorporated some of the legacies of the distant and medieval past, retaining the ineradicable traces of male dominated and phallocentric cultures, together with the age-old compulsion to both constitute and reveal truth and subject. However, in its current objects, practices and technologies, it is largely the product of changing epistemological and pedagogic paradigms created by, and manifested in, practices historically neglected since as axiomatic, but which began from the late eighteenth century to determine and revolutionise the nature of medical and related discourses.

2. The Disciplinary Implications of Modern Childbirth Techniques

2.1. Strategies for intervention

The specificities of the modern technologies of childbirth have a variety of power-knowledge or disciplinary implications. Recent studies of childbirth technology have rigorously questioned the routinization of hospital procedures in maternity cases, suggesting which forms of intervention should be abandoned or further researched in the light of the available evidence (Enkin et. al., 1989, pp.363-5). However, the disciplinary implications of the continuance of obsolete, otiose or under-researched practices has remained largely unexplored.

Childbirth practices generate their own problematic. Additionally, while the purpose of a particular technique can move into obsolescence, it may yet persist as a residue in practice That this is part of the interactive process of discursive activity, shows that not only is it futile to regard any disruption of the status quo as transcending the operative discourse as a revolutionary element, but it also brings into question the notion that discourse analysis as a method of describing and evaluating history cannot take account of change and resistance. In the network of effects that constitute the discourse, and which in turn generate effects; the elements of resistance and disruption are crucial as germinal and cohesive phenomena.

The trend of central importance in modern childbirth technology, is that for most European women, birth practices are institutionalised and hospital birth has become increasingly the norm.[1] The figures available are most significant because they indicate that while most

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1 For example, figures for Britain indicate that hospital births increased from around 15% of births in 1927, to over 60% in 1958, to more than 96% in 1988 (Oakley, 1980, p. 121; Donnithorne, 1990, p.15).

women still give birth 'spontaneously' (and this does not take into account the large majority of women who are in receipt of some form of analgesia), most women do so in an environment which is geared to the needs of the minority, and this, not the level of actual intervention, is what determines the nature of the birth experience for the vast majority of parturient women.[2]

The location of the parturient in the environment of the hospital is a powerful historical and medical reterritorialisation of childbirth entailing the separation of parturient and parturition from all that was previously familiar.[3] Childbirth is recreated as a parenthetical condition within the life of the parturient, though it simultaneously ensures her lifetime involvement in a panoply of disciplinary and management strategies. Prior to the onset of the inquisitorial discourse that developed with Christianity, an encoding of the ancient preoccupation with witnessing began to dovetail with increasingly interrogative

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2 Of integral significance are the figures for childbirth interventions. For example, of all estimated deliveries in England and Scotland, approximately three-quarters are described as 'spontaneous' (a more or less stable figure over this period), with 20.7% of all births in Scotland being induced in 1988, and inductions falling by almost 3% in England over the same time (though accelerations increased almost proportionately). Instrumental interventions and caesarean sections accounted again for around 10% each on average for all births during these years (Donnithorne, 1990, p.15). For an appraisal of the predominance of the hospital delivery as a result of the axiomatic pathologisation of childbirth physiology, and the routinization of specific technologies and procedures therein; see, S. Inch, 1982, ch.2.

3 In ancient Hittite ritual, for example, a requirement of the predominant home birth, was that the home space had to be ritually cleansed. Purification of this space, was the task of both the expectant mother and her husband as preparation for birth (Pringle, 1983, p.132). This suggests the extension of ancient battle imagery where childbearing and soldiering are metaphorically linked, to the home 'territory' - marking its boundaries, stripping the notion 'confines' of its negative, punitive associations. However, the ritually cleansed domestic area still constituted a type of confinement for women in real terms. The home became a cage without bars. Here we do not find coercion but an accepted ritualisation and normalisation of behaviour. Throughout history both men and women have, in certain circumstances, and particularly such as these, been willing, or paradoxically, at least openly complicit, prisoners. .

imperatives, which have later come to inform modern cultures, in which the need for surveillance, superintendency, and mediation has become a distinguishing feature. While different epistemological and paradigmatic exigencies permeate the cultural discourses of these disparate historical conditions, it is not impossible to discern the threads of continuity which are interwoven into current and historical practices.

A developing science of governance over childbirth procedures prevailed. The old forms of 'witness' by the friends, family, neighbours and attendants of the parturient were replaced by the impersonal disciplinary hospital examination. The examination fulfils the function of ratifying the deployment of a hierarchy of observers, and it normalises whatever comes to be regarded as appropriate judgement (Patton, 1979, p.119). It axiomatises the notion of standardisation as an element of truth, it legitimises the very notion of the truth, or at least in Nietzschean terms, constitutes the failure "to recognise untruth as a condition of life" (1966 (1883), no.4). The examination was an integral part of the disciplinary network. While inscribing certain modes of learning, and giving credence to established 'masterworks' as the repositories of the truth, and the privileging of the subject, it also permitted the dynamic exchange of knowledge and information.

It is therefore useful to look at the history of the parturient and childbirth practices in the context of the hospital and the disciplinary placing of individuals into an ordered and confined space, structuring the functions and operations of the objects of professionalising discourses; both the expert and the object of expertise, whoever may people those categories, not only as knowing subjects but as objects of their own knowledge. It is as elsewhere in the operation of strategies perfected over the period of the last two centuries, that subjects and objects are produced by modern techniques which ensure complicity and docility. Subjects are enjoined to behave as if conditions exist that do not, or continue with practices despite the fact that conditions no longer obtain. The possibility of surveillance determines the behaviour of the watched at all times. Just as the rhetoric of a

glorified and obsolete past has underpinned the justification for many aspects of modern interventionism when it has been convenient to conjure it. Not as a matter of conspiracy, but as a matter of automatic consent, whether that consensus is tested or not. It is necessary to behave as if it exists, and as if it either represents our best interests, or conversely functions as the benchmark for dissent and resistance. If tested it is likely that the majority will be in accordance with what they believe to be their own views fairly and axiomatically represented. The constant reinforcement of current axioms, and the behaviours and techniques they inspire, in turn produce the very paradigms that underpin them in an unravellable reciprocity of effects which retain the tinge and patina of the past, while creating wholly new patterns and conditions of possibility.

Where this fits with the patterns produced by the discourse of childbirth is clear. It is not simply that the uncomplicated labour has been overlooked as the potential horrors of childbirth have been dissipated in technological advance, despite the obvious truth of this in practice. As the history of obstetrics is geared to the abnormal, and to the ensuring of a safe delivery for all. The possibility of 'natural' safe delivery, whatever that might now be thought to constitute, is thought to be best accommodated by the hospital. The horrors of the past are still tacitly invoked rather than placed aside as a condition of the acceptance of technologised birth, even overtly invoked by the generation and promulgation of stable or slowly improving mortality statistics which support the innovations wrought by technologisation. Since the earliest advocacy of parturial hospitalisation, which could not be assuaged by the worst epidemics of puerperal fever, there will be the vociferous candidacy of technology parading a disinterested altruism and what genuinely appears to be the salvation of the modern parturient.

The great fears and uncertainties of the past, which were predicated on the unpredictability of the process of childbearing, are now in the modern discourse translated into strengths. The very unpredictability of the process has enabled the obstetric advance to attempt to

control that particular problem. It has been the crux of parturial problematisation. The purposes of the current discourse are served if, within certain limitations, that quality of uncertainty is permitted to show itself once more; not by the admittance of real risk, but by simply allowing the process to find its own edges. Adhering where possible to the demands of the natural childbirth programme individualised to suit each patient, a range of new practices, principles and permissibilities can be generated, and differently encoded. A whole new dialogue between the parturient and the professional is opened up.

Gradually, in modern confessorial discourses, the individual patient is called to account for his or her underlying symptoms and intentions. A phenomenon which has served a medical prioritising of economic efficiency and management, as health services have come to pride themselves on the use of the techniques of psychiatry rather than unnecessary and expensive over-prescribing. This has been what 'alternative' advocates of holistic approaches have argued for in the past, and these measures have reinstated a somewhat discredited psychiatry into the mainstream of medical practice. A transitional, ongoing and parallel account of the patient is filtered through interpretation.

The role of the priest and the doctor, underwritten by ancient complicities with the family, have come to be overtaken by what Donzelot describes as: "the recent appearance of the constellation of counsellors and technicians of human relations." The growing panoply of expertise bring together educative and medical functions, definitions of sexuality and the couple, and the processes of social integration: "The mechanism of confession furnished the family with the means to deal with the inevitable variance between the strategic nature of alliances and sexual attractions. In return, it obtained for the Church a direct hold on individuals, the possibility of a direction of consciences." (1980, p.171).

These phenomena are in part the result of the historical and paradigmatical process whereby: "sex became a matter that required the social body as a whole, and virtually all

of its individuals, to place themselves under surveillance." (Foucault, 1981, p.16). Psychoanalysis reinforced the status quo of sexual differentiation, delineating and encoding sexual dysfunction. The characterisation of gender and the parturial experience is socially ascribed on the basis of the biological given, and obscured by essentialist descriptions.[4] The theme which is common to hysteria, nervous disease, and pregnancy is that of corporeal continuity, of a body that is too close to itself (Doane, 1986, p.170). Women's bodies; regarded as epitomising penetrability and expulsion: sites of menstruation, conception, birth and nurture, had been the objects of a growing medicalisation, from Hippocrates to the present. Their inferiority, their lack of cleanliness and purity, were axiomatically emphasised throughout. The womb was always regarded as a guide to women's mental and physical health.

Although the majority of women were likely to have been treated largely by other women; male concern with the parturient existed in varying forms from Classical times, but their contact was limited until the sixteenth century, and even then was limited in terms of most parturial experience.[5] The earliest records of gynaecological interventionism reveal preoccupations with notions of hysteria. Suffocation by the womb was thought to be responsible for respiratory, digestive and mental illness. The entire organism was thought to be affected by the organs of generation. Cures were thought to be effected by the sexual act or simulations, such as insertion of pessaries or digital examination, or

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[4] Biological exigencies have come without question (in recent history via psychoanalysis) to define social constructs (Freud, 1975 (1901)). Inherent and unchanging truths are regarded as the basis of what constitutes the 'normal' and the 'natural', and the relative roles of men and women (Weeks, 1977).

[5] Savonarola's fifteenth century treatise in the vernacular on gynaecology and obstetrics reveals that male physicians did treat women, and there was evidence of co-operation with midwives, though the latter were regarded, for various reasons, as perpetrators of obstetric malpractice (Lemay, 1985, p.319).

pregnancy and birth.[6] Such ideas seem to have arisen from a genuine belief in the notion of female health being promoted and restored by penetration, fostered by age-old correlative cosmic imagery of generative penetration in nature, rather than necessarily a will to dominate and exploit.[7]

This helps to explain why, within the rigidities of such a system in which the last drop of possibility is drained, that some obsolescent procedures, often acknowledged as such, continue to persist and have their effect upon the paradigmatic ethos long after their day has come and gone, and it also demonstrates why these institutions appear, while so productive, to be ponderous in response to change, seemingly impervious to the ethical transition necessarily imposed by the technological and social revolution, it might be said they have themselves engendered. The processes of shift, incorporation, integration and dissemination are discreet, often slow to penetrate, and are reliant upon the spread and universalisation of localised activities usually predicated on a more generalised discursive

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6 Hippocrates *Diseases of Women*, II, 123, 126, in Lefkowitz and Fant, 1982, pp.93-6.

7 The womb was regarded as having a will and constitution of its own: "the womb is like an animal within an animal" (Areteaus of Cappadocia *On the Causes and Symptoms of Acute Diseases*, II in Lefkowitz and Fant, 1982, p.225). The treatment for a wandering womb would usually involve the use of aromatics, but there is evidence that a man might aid in the restraint of this 'animal'. Either a member of the family or an 'expert' man might lend aid to a sufferer by intimate rubbing or douching just as a woman would - these are perceived as necessary and non-stigmatic duties (Lefkowitz and Fant, 1982, p.227). To assess the extent of dislocation, manual examination was considered necessary. There is evidence to suggest that penetrative intervention may have been carried out by physicians, but more probably it would have been carried out by females under male guidance (Hippocrates *Nature of Women*, VIII, 3 in Lefkowitz and Fant, 1982, p.94). Despite the influence cast by the 'wandering womb' theory, Soranus (*Gynaecology* I) was primarily concerned to emphasise and explore the 'static' physiological nature of the womb, and Galen (*On Prognosis*) had begun to cast doubt upon the validity of correlative uterine conditions by claiming that hysteria was "primarily psychological" (Lefkowitz and Fant, 1982, pp.232-4) - an idea not properly re-discovered or exploited until our own era.

design, which have a ripple effect throughout the system, changing and legitimised along the way.

This is where resistances and 'subversions' have their effect, and why the notions of great men and grand impositions which have had some historical and analytical credence are both overly ambitious and simplistic, and produce only oppressors and victims, and the reification of the rogue and the revolutionary, which are both fictional historical and hierarchically divisional characterisations that inhibit rather than promote the chances of equitable change. This is partly because they do not question the fundamental construction of the notions of equity and equality, and take their humanitarian concerns as axiomatic and God-given. The same imperviousness originating in the same delusions, delayed for example, the effective prevention of the epidemics of puerperal fever about which social and feminist historians become so outraged.[8]

The occupation of specific spaces has in itself come to organise, shape and objectivise activity, whether educational, economic, administrative, therapeutic or retributive. The dual process of homogenisation and individuation also produced the sub-category of the professional body and the self-identifying group, achieved by isolation and specialised attentions and the prevention of dangerous combinations of bodies and categories. The metaphor provided by disease and contagion is pertinent here, particularly in relation to the historical position and treatment of women and of childbirth practices.

Decisions about interventions are based on the gravida's conformity to precise measurements of development cross-referenced with often imprecise generalisations of time which have become enshrined as axiomatically infallible. She must not be late

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[8] See Arms, 1975; Daly, 1979; Griffin, 1984.

according to these criteria. She must concentrate on her commitment to her pregnancy and its outcome. She must adapt her dietary and social patterns to fit this ideal. This is reinforced by all the explicit exhortations that decorate the walls of the clinic, and implicitly by the type of questions that are asked in the preliminary interview, the answers to which will determine the tenor of any ensuing interview, in order to check 'progress', in specific terms (giving up smoking), and in more general terms of attitude improvement.

An analysis of the techniques of self is difficult because unlike the material apparatuses that produce objects, these techniques are often invisible. They are linked to strategies for the direction of others, which take place as an integral part of the educational process, as part of the management of others, teaching them to manage themselves. Thus individuals are created, and society operates via a panoply of power/knowledge strategies which are controlled by everyone, yet no-one. Complicity acquires a kind of dynamism. In such a schema, obedience too becomes a manifestation of the will to power, the will to substantiate the illusion of self.[9]

An optics of power develops with the increasing secretiveness of power practices, another paradox of the modern condition. A controlled and controlling visibility developed during the nineteenth century.[10] The refinement of this panoptics and the development of a system of penalisation on a minute score deeply embroiled individuals in the subjectivisation, objectification and examination of themselves. The regimentalisation of

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[9] See Adorno, 1974, pp.152-3; Deleuze, 1983, pp.63-4;

[10] Foucault, 1979, 195-228; 1980, pp.146-165. In relation to the routines of prisons, factories, schools and other institutions Foucault (1979, p.178) has pointed out that there was: "a whole micro-penalty of time (lateness, absences, interruptions of tasks), of activity (inattention, negligence, lack of zeal), of behaviour (impoliteness, disobedience), of speech (idle chatter, insolence), of the body (incorrect attitudes, irregular gestures, lack of cleanliness), of sexuality (impurity, indecency)."

routine provided the justification for its continuance, the routine itself demanding certain structure and signification. These elements of modern technological institutions are particularly pertinent to an appraisal of the condition of the labouring woman. Her failure, for example to attend the appropriate preparatory clinics, with their inquisitorial requirements; their panoply of checks and examinations of inherited medical history, of weight and bodily fluids, of cervical condition and foetal development, make the gravida feel she has contracted herself into an inescapable system. The discourse of nutrition has always had a different disciplinary agenda for women, and has been a minefield of identificatory obstacles and strategies for the modern woman particularly. The medical strictures concerning weight gain in pregnancy, while efficacious where, for example, other contraindications regarding toxaemia are present, tend, like other blanket strategies to implicate those for whom the benefits are unproven. This is also the case as far as the automatic withholding of food from the parturient during labour is concerned, as this measure always presupposes trauma; a rationale which again is not in all cases proven, and can in some cases create other adverse effects (Thorogood and Coulter, 1992, pp.52-4). Perhaps such measures constitute part of a disciplinary ritual which produces effects beyond the physiological and which conform more closely to the broader discourse of women's relationship to food.

The paradigmatic significance of the hospital can be regarded as its function as a disciplinary space of examination; and its strategic importance: in its arrangement and management of objects. The most minute observation has its place here as part of an enormous and fastidious documentation to which the hospital apparatus becomes geared. The social and medical sciences in their combinations grew in such institutions, and the power and knowledge technologies share a common historical matrix, while developing their own disciplinary compartmentalisations and exclusivities; the hospital environment being condusive to both. The architecture of the hospital and other institutions, has not simply been a matter of changing aesthetics or developing techniques of construction, but

of the professional exigencies of the architect and of the professions that were being housed (Dreyfus and Rabinow, 1982, p.158).

In this way individuals and their sexuality become constituted and defined as historical and cultural constructs, and discourses surrounding them burgeon and multiply. By the eighteenth century, sexuality comes to be monitored, managed and analysed, particularly in terms of population. By the nineteenth century, the discourse of individual sexuality has become entirely medicalised. Women in particular, are in Foucault's terminology, 'hystericized' and saturated with sexual identities (1981, pp.36-49). Women are identified both personally and more generally in terms of the birth, growth and health of the population. The woman's body is the focus of the new sexual sciences, of their regulatory and surveillance strategies, the functions and dysfunctions of their sexuality variously defined, serviced and deconstructed. The correlative and complex effects of confining and confessorial techniques become part of the expectation of women, increasingly defined as pre-parturient, parturient, or "dyspareunist" (Foucault, 1981, p.43).

2.2. A job for life: pre-natal responsibility

The privileging of the foetus evident in modern discourses has various historical precedents. In antiquity, the preservation of maternal life was paramount. This was obviously for pragmatic reasons - a healthy young woman might go on to successful childbirth. An aspect and further example of these priorities is provided by the contemporaneous practice of exposure, societally sanctioned, though to become increasingly unacceptable. The fates of both the unborn and the newborn were the objects of expediency. While the exposure of the newborn had always had a certain societal tolerance under the right conditions (when sanctioned or performed by men, which has

echoes in current thinking on abortion), there is evidence of historical confusion in relation to attitudes towards the unborn child from the earliest times to the present day.[11]

A complexity of expectation and taboo surround the child. This delicacy does not appear to accord with the disregard for children apparently reflected in widespread exposure practices. The availability of new techniques and paradigmatic possibilitiesare responsible for attitude change. In Roman times, the unborn child will be removed piecemeal to preserve the mother, but some distaste for exposure is already manifest. That distaste becomes taboo in the Christian ethic, while the unborn child often suffers a similar fate in order that sacred observances centred upon the child, might take place; reflecting the desire to implicate the child, dead or alive, in religious observance from the outset.

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[11] An early historical example is provided by one of the laws attributed to Numa Pompilius, 716-673 BC, which forbids the burial of a pregnant woman before the extraction of the child whose expectancy of life must be respected (Lefkowitz and Fant, 1982, p.174). Present day examples also exist. A child can claim medical negligence if disabled by pre-natal injury, according to the Congenital Disabilities Act 1976. Mothers can also breach this act, as a duty of care is imposed upon them. They can find themselves liable if, for example they have an accident while pregnant which then has an adverse effect upon the child. Conversely, in a recent case, a woman in Berlin was controversially kept artificially alive after a traffic accident in order that her child (had it lived) could be delivered nearer its full term (Guardian, December 6, 1992). An illustration of the historical significance of the concern with the foetus from conception, are the assertions of the physician and philosopher, Sir Thomas Browne, who not only privileges the foetus in relation to the mother, but also reinforces the woman/nature analogy, and the woman as contaminator theme. He wrote in 1642:

"Every man is some months older than he bethinks him, for we live, move, have being, and are subject to the actions of the elements and the malice of diseases, in that other world, the truest Microcosm, the womb of our mother." (Macfarlane, 1977, p.11). William Shippen Jr (1736-1808), an American anatomist, demonstrated in 1761, the independence of foetal circulation from that of the mother (Cutter and Viets, 1964, pp.208-9). This was at a time when males began to dominate the obstetric scene, even while women predominated in deliveries.

The idea of a powerful and independent foetus pervades the earliest manifestations of what was to become the science of reproduction technology and artificial insemination. The notion of 'immaculate conception', and of the possibility of the growth of the human embryo outside the womb were especially popular fields for speculation among both charlatans and trained doctors (Rousseau and Porter, 1987, pp.60, 86-100). It is also likely that the long history of mythologies surrounding monstrous births which were often regarded as the material manifestation of women's imagination, that persisted into the nineteenth century, fuelled speculation about non-uterine reproduction.

The attitudes that have developed towards prenatal life, are, like those which have evolved towards women, partially dependent upon particular historical images. The foetus, for example, was regarded as a miniature man until the development of a more ontogenetic view in the eighteenth century when the influential notion took hold, that humanity was achieved incrementally by progressive development.[12] This 'version' aligns with other forms of organisation by staged progressivism, giving rise to the reification of cumulative and divided forms in terms of learning and knowledge, and their organisation. In a reciprocal shift, these notions have also come to dominate modern thnking about the foetus, enabling the movement of parameters guiding prenatal care and the acceptability of abortion around the concepts of time and stage with regard to foetal growth, rather than in the more metaphysical terms of its potentialities. For example, the technological ability to ensure the survival of a viable foetus at an increasingly early stage is the paramount factor in determining when termination is morally acceptable. In this way, moral and clinical judgements are relegated to the realm of the potentialities of obstetric technology. Therefore, although technological imperatives have dominated womens' access to abortion, they have paradoxically restricted choice.

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[12] Rich (1984, p.120) observes: "...the medieval church held that a miniscule, fully formed homunculus, complete with soul, was deposited by the male in the female body, which simply acted as an incubator."

The *post-partum* womb, is envisioned as mere space - empty hulk, husk, shell - encapsulating an image of the mother who is an environ which symbolises beginning, returning and death. Ironically, displaying the confidence of modern expertise, it is the same dark, quiet, tomb-like qualities that natural childbirth exponents have encouraged mothers to reproduce for the first environment of the newborn. The nineteenth century promoted the image of the uterus as a sort of fortress-tomb, which imprisoned the foetus, depriving it of light and stimulation, until its release into normal existence (Macfarlane, 1977, p.12). The sexual definition of women has been a matter both of praxis and metaphysics. Mythological resonances of the ancient interpretation of dreams found in the writings of Artemidorus permeates modern psychoanalytical discourse and its uterine images of anxiety (Foucault, 1986).[13]

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[13] Artemidorus' *The Interpretation of Dreams*, discusses dreams in terms of their didactic and predictive value with regard to both the individual (male) and his life practices, and to his position in relation to world events. Here, while dreams depicting women are generally considered to portend change for the dreamer, the legitimacy or 'naturalness' of the relationship involved is of paramount importance and this dictates whether the omens are seen to be favourable or otherwise. As a complementary and parallel symbol serving notions of independent foetal strength and survival, it is inferred that while mother-son incest is associated with ethical breakdown and taboo, it is paradoxically to be considered as auguring well for the dreamer when it occurs in dreams. Fertility and ownership are the key to success and prosperity. The dream penetration of the mother can also represent death for a sick man - but the omens and connotations are usually laden with positive values. The incest dream has an isomorphic quality. Foucault writes: "the subject is seen in a position of activity with respect to a mother who gave birth to and nurtured him and whom he ought to cultivate, honour, serve, maintain, and enrich in return like a piece of land, a native country, a city." (1988a, p.32) The focus here is masculine and phallocentric; penetration is the activity *par excellence*. The important implications are those for the male dreamer who is enriched while the female is always the object, the venue, or means. While indicative of the phallocentrism of ancient discourses, the associations of childbirth for men are portrayed symbolically as largely positive. These evidences of paradigmatic influence should be compared to the discourse of twentieth century psychoanalysis which negatively casts the event of birth as a prime site for the origin of neuroses.

There is a strong indication in the implications of ancient dream interpretation of the need for activity in relation to the mother. Being born is essentially perceived as an involuntary if not passive state from which men must redeem themselves; being mothered seems to be regarded as an ignominious circumstance from which one must set oneself apart. The symbolic implications of mother-son incest are a deposing 'mastery' and a kind of retrospective forging of oneself with regard to even the most female of activities; the act of birth and the process of mothering. In our own culture, ancient myths have been selectively internalised via Freud and psychology and have their place in governing behaviour and in forming the discourse which focusses upon the mother as an object of knowledge. The myths depict marriage and motherhood as the most desirable condition for young women although sympathy is also portrayed for their fears and expectations. The physical and medical vulnerability of women can make the measures taken ostensibly to protect and cocoon them appear superficially as to do entirely with repression. In the masculine imagination of antiquity, the anxieties and apprehensions which devolved upon women and childbirth generated images of hags and monsters which both allayed the fears, yet further compounded, the prejudices that nurtured them.

Of the modern exponents of childbirth techniques, Leboyer expounds an ethos of childbirth which is focussed upon the foetus, and parental, particularly maternal, responsibility towards the birth experience of the foetus. He takes a spiritual metaphysical approach to childbirth, privileging the infant. Such an approach is redolent of historical attitudes concerning the mother's responsibility for controlling her thoughts and imagination which were felt to influence the health and disposition of the child she conceived and carried. This would prefigure the later development of the science of pre-pregnancy which would implicate women in the medical discourse even prior to her own conception; from her grandmother's womb and before. Leboyer (1975) ascribes superhuman qualities to the foetus; it "sees right into our hearts", and knows "the colour of your thoughts" (Kitzinger, 1983, p.126). The privileging of the foetus and its powers of police over the parent have a

long historical tradition. Not only clearly reflecting a belief in the mother's psychological influence upon her unborn and birthing child, Leboyer also, by emphasising the primacy of the foetus, could be seen to be subscribing to Freudian 'birth trauma' theories.[14]

In the image of the cellular, cell-like, and atrophying womb, it is not only the mother who is identified. The foetus too has been historically championed as an incarcerated innocent, active in his efforts to escape. The desire to detach the child from the taint of the mother is fraught with both hostility and sentimentality. One method which has been adopted by some cultures, is to simulate a second birth as part of the pubertal rites of passage for the adolescent male and female, in order that the child becomes individuated and free of the mother. The notion of the passive mother, and heroic infant is present in late twentieth century texts. An example is provided by this cosy image from Frank Hytten, in his work on the influence of ante-natal care and the prevention of handicap, where the dismissive infantilisation of the mother and the full (masculine, phallic) metamorphising of the struggling unborn foetus, is an accepted scientific and cultural metaphor: "The foetus is an egoist, and by no means an endearing and helpless little dependent as his mother may fondly think. As soon as he has plugged himself into the uterine wall he sets out to make certain that his needs are served, regardless of any inconvenience he may cause. He does this by almost completely altering the mother's physiology, usually by fiddling with her control mechanisms." (Macfarlane, 1977, p.13).

The recent reappraisal of lifestyles that has taken place, suggests that the health of the adult is determined to a significant extent by the health of the mother pre-pregnancy and during her pregnancy. The British Medical Journal (June 1992) published the findings of a group of scientists researching this area. They consider that heart conditions, diabetes and

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[14] Freud, 1973 (1915-7), pp.444-5, 455-6.

reproductive problems can all be triggered as a result of the health of the mother. Interestingly, the response of Professor David Barker (head of the Medical Research Council environmental epidemiology unit at Southampton University) is that while the adoption of a lifestyle which includes care with diet and avoidance of nicotine is a factor, the events pre-conception, and those that took place in the womb, determine the individual's susceptibility to certain diseases. His suggestion to health service officials is to completely rethink their advice to adolescent girls who are preparing to become mothers (Observer, May 24, 1992). The policing of pregnancy is particularly aimed at teenagers and the poor, while new realms for the health expert are opened up. Interestingly, following a recent joint initiative of the Health Education Authority and the British Medical Association to campaign targetting under-privileged pregnant smokers, it has been suggested that doctors, health visitors and community midwives are lacking in appropriate expertise to promote the campaign, and must therefore receive training packages in order to do so (Guardian, February 3, 1993).

Fear of excess, whether of appetite or pain, its basis actual or fallacious, permeated ancient consciousness, therefore giving rise to the depictions of intoxication by drink or drugs that pervade mythology[15]. Moderate consumption and activity was regarded as necessary to the regimen of pregnancy in antiquity, as it is in the twentieth century, though the aim formerly was moderation, and latterly with the predictability of outcomes, though strictures in both instances are paeans to the regulated life (Aristotle, *Politics*, (trans.1959, p.217)). As with ancient prescriptions regarding the personality and behaviour of the

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[15] In Euripides *The Bacchai*, the symbolic extremes of bacchic contamination are depicted. Dionysian revels are regarded as corrupting women, and the blurring of sexual distinctions is here also considered a similar threat to stability (Dover, 1972, pp.162ff.). Whatever might be considered as particular, mysterious or spiritual in women is illustrated by such exaggerations and debased into fictions of adultery, irrationality and excess; an excuse for the policing of women at home and beyond.

midwife and the wetnurse, notions of female 'perfectibility' based on immobility and obedience, are plain here in relation to the gravida, and would later develop within the paradigms of technological childbirth. When Aristotle (*Politics*, VII, in Pomeroy, 1975, p.85) suggests that pregnant women should be forced to exercise by the institution of a law declaring that they must take a daily walk to worship, he conveniently and expediently ensures attention both to regimen and religious duty; incurring an axiomatic reciprocity of effects: the spiritual elevation of moderation as goal, and the curbing of female excess associated with sacred ritual. This would seem to involve an unquestioning conjunction of physical and moral health, and of medicine and religion that was to prevail both harmoniously and in conflict in subsequent eras.

Pre-natal care of the foetus has resulted in a modern regimen of pregnancy in which the pregnant woman is exhorted not to take alcohol or tobacco; and labelling further reflects these warnings. The drinking of alcohol was associated both in antiquity and in the Victorian era with a class of women who invited moral approbation. Ancient concerns for healthful conception, and the increasing focus of the developing regimen of pregnancy required that alcohol and drugs were to be avoided because it was believed that mental and physiological debilitation could render the gravida physically and morally unfit. However, some modern research suggests that while there is strong emphasis on the few who are known to be harmed by immoderate drinking by the 'better safe than sorry lobby', there is not enough stress on the fact it is unlikely that light intake of alcohol is necessarily damaging (Rosetta and Weiner, 1984) There is evidence here of the same type of overkill that has been evident in the technologising of childbirth. The same just-in-case ethos of the worst case scenario which has been a feature of expert discourse that has provided endless failsafe mechanisms. The individual, particularly the pregnant woman, is not trusted with sufficient reliable information upon which to make appropriate judgements. The better-not mentality tends to infantilise women at their most vulnerable.

As foetal medicine becomes a growth area, recommendations for the monitoring and policing of the pregnant woman are intensified. In scientific terms, the pregnant woman is "maladapted"; not only if she drinks, smokes, and has an unhealthy diet, but also if she has high blood pressure, toxaemia, or an infection (Observer, Feb. 7, 1993). In the popular imagination, the creation of the maladapted gravida permits a reinvention of the malevolent mother who poisons or "starves" the foetus in the womb.

2.3. Fertility rights: the discourse of 'reprotech'

It has been suggested (Julia Kristeva, 1980) that some feminists comply in undermining women by mythicizing femininity and trivialising the maternal function, dismissing it as inconsistent with cultural activity, and imbuing it with guilt. Simone de Beauvoir (1949) and Shulamith Firestone (1971), have suggested that the liberation of women depends upon the evasion of their biological function, and have welcomed the future possibilities that might become available via the advances of reproductive technologies which may make human reproduction largely independent of the female body, and hence, so the thinking goes, freeing the female from reproduction.[16] This seems an unlikely prospect

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[16] As might be anticipated, feminist appraisals of the 1970's and 80's which have examined modern obstetricy,are almost entirely negative about the effectiveness of the advocacy of natural childbirth Similarly, despite the self-advertisement of the progressivist lobby, this also has attracted little support from feminism. For example, Rich (1984, p.170) argues that "liberation from pain", like "sexual liberation", puts women at the disposal of men and has alienated them from themselves and each other. Mary Daly (1979, p.285) writes: "not only regular hospitalised childbirth but also 'natural childbirth', as we know it now, is nothing more than a romanticized means of helping women to better adjust to the abnormal and intensely painful delivery process mandated by men." Another side of the feminist critique of the seventies, regards the childbirth experience as a barbaric and debilitating experience and therefore welcomes its technological alleviation. Feminist ambivalence towards childbirth has been influenced by analyses which are dependent upon phallogocentric evaluations and modern psychiatric discourse. The work of Simone de Beauvoir (1974 (1949), pp.502, 510-11) provides examples of this approach. Here the fertile woman "dreads the germs of life" and experiences pregnancy predominantly as a state of anxiety

when it is considered that the advance of reproduction technology has greatly increased the pressure on infertile women to go to any lengths, scientifically aided, to fulfil the reproductive function. In fact, as the grip of the hospital upon the life of the parturient appears, at least in terms of the overt exercise of power practices, to have relaxed, the infertile woman becomes entrenched in new expert relations of reproduction.

A new realm of discursive possibilities opens up in relation to the fertility treatment of post-menopausal women. Not only does the extension of fertility involve the valourisation of fertility in itelf, but it also disrupts the categorisation of women according to their reproductive status. The older non-fertile woman has historically been a figure of co-mingled fear and regard. Non-reproductive women throughout history are regarded as occupying a temporary stage of life. There are elements of continuity in the twentieth century discourses of the pre-pregnant woman and the infertile woman which continue to identify women according to their childbearing status at every stage of life. The mature childbearing woman could be seen as less of a threat to the social order than the immature *parthenos* or virgin, or indeed than women, who were sexually active, but without status (King, 1983, p.124). In antiquity, childbirth is both an elevation and a discipline. It is the concern of philosophy and medicine, but not their responsibility; it is not yet in itself morally or scientifically problematised problem. The virgin and the mother would

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transcendance and contradiction, and childbirth as primarily a liberation from her own mother. These antagonisms are reflected not only in the welcoming of technological childbirth, but in antipathy for its detractors. Shulamith Firestone (1979 (1971), pp.198-9) argues that the exponents of 'natural' childbirth should be approached with scepticism, regarding it "as part of a reactionary counterculture having little to do with the liberation of women as a whole." This is to ignore the positive and productive effects the dialogue between the orthodox and radical obstetric movements has entailed, and the benefits a combined approach has had upon the experience of women, who have had little notion of the 'golden age' of childbirth which has been variously summoned to haunt them, with its concomitant image of pain and death which have served both extremes of the alternative lobbies.

undergo something of a reversal in status and significance in the Mariology of the Middle Ages. While the question of procreation would generate a burgeoning ethical discourse in Christian doctrine, motherhood itself would lose status and become linked to a scale of improbable chastities at the apex of which was virginity, its symbolic figurehead; the Virgin Mother. The re-entry of the mature woman into the sphere of parturition and maternity other than as worldly advisor and doting *grande mere*, has begun to excite medical and moral controversy (Guardian, Feb. 5, 1993) as the tip of an iceberg of contention emerges from the murky waters of ancient anxieties. In some respects, the birth myths of Athena and of Jesus, are part of a tradition of the recounting of miraculous, magical or monstrous births, which persisted into the nineteenth century and beyond.[17]

The twentieth century has its own version of this tradition in the media glorification of multiple births, that are in reality the freak result of a modern masculinised science of

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[17] There is also a certain masculinisation of the Demetrian fertility myth in the Christian ethic. The ancient notion of regeneration via the fertile woman, and continuity expressed via the well-being of the community of women within the family, is largely replaced by the notion of an asexual figure whose experience of normal female life on earth is either transmuted or transient, and of a resurrection of the Son, a man born of a virgin. She is miraculously impregnated by the Spirit; he inhabits the earth in order to save it. The earth is now identified as surface and symbol of an 'under-world', to be inhabited and endured by the living. The fertile woman, identified with the most base aspects of nature, personifies on earth the 'pit' of hell where in both ancient and Christian mythology the masculine personification of evil has residence. The man is reborn in the Father, as Athena is born of Zeus. Nonetheless, Christ's birth has none of the clumsiness of the image conveyed by Zeus' forceful and cannabalistic appropriation of the role of mother, the latter discarded and lost to iconography. For the Christian version has the sophistication of conferring a state of grace upon a mortal woman who then becomes a symbol of great disciplinary value in her own right (this is no mere cautionary tale), and also manages to include the presence of the divine on earth. Most significantly, without the crudity of the Athena myth, the notion of regeneration is supplanted by that of resurrection, a notion which despite the earthly incarnation of Jesus, displaces in the final analysis the need for human generation, for immortality is assured without the need for reproduction, the latter has become a pallid shadow of the ideal of resurrection.

fertility. This, while hailed as a wonder for the victims of the success of its inexactitudes, fails to fulfil the excited expectations of many more. The impact upon the discourse of fertility is profound, reinforcing a medical ideal of the human being as the perfectible perpetrator of the species, which in its turn provides justification for the developing science and philosophy of eugenics. It also places the female body under the controlling scrutiny of the doctrines of healthful fecundity for which she is prepared in the womb, and from which she must medically and artificially be aided to recover; the repercussions of which will stretch for a lifetime's length, penetrating the barriers of birth and death, merging the presence of the individual with the silence of generations, interrogating each for retrospective and predictive truths about the other.

The fulfilment of the fertile existence has become a kind of expiation in itself, a modern rendering of the curse of Eve in which any aberration must be tolerated, even extolled. Perhaps this is the twentieth century translation of the fear, delight, desire and fervour which inform Medieval depictions of exorcisms performed by Bishops bringing forth demons from female genitals (Nicholls, 1989, p.174). Apart from these depictions being obvious evidence of persistent male fears about the 'hidden' nature of female genitalia and the womb, and about the associations of midwifery and witchcraft, they were also about acted-out fantasies of masculine power. The appropriation of the symbol world was a parallel and interdependent discourse with that which informed and recorded male attempts to 'colonise' generation, and make it their own. The Medieval delivery of demons is reminiscent of a conjuring trick, an image fostered by the depictions of women being delivered by men from under sheets that covered them from throat to foot, preserving modesty but reinforcing passivity. Such scenes are still common in large Western hospitals where hi-tech births take place (Kitzinger, 1992). Here though the woman is usually supine so that any covering shields her from the sight of herself, while permitting optimum visibility for the obstetrician and attendants without the distraction of the woman's obvious presence. She is as little 'there' as is possible in such a situation. It is a strange but

effective 'disembodiment' permitting the illusion that the modern obstetrician produces babies miraculously 'out of a hat'. The parallels do not end there; by exorcising the modern evils of pain and dystocia, the obstetrician also eliminates as a by-product of this exorcism, the need for the parturient's involvement beyond the slight inconvenience of her presence, which can anyway be physically discreetly covered, and her consciousness diminished by drugs.

Gratitude for the virtual eradication of mortality in childbirth, for the guarantees of hope in infertility, and for the likelihood of healthy offspring; renders the modern parturient understandably willing to collude in this assumption of expertise 'for her own good'. The representatives of Medicine and the Church have participated in a historical struggle for ultimate influence over minds and souls. In the twentieth century, the figure of the priest and the promise of a spiritual life ever-lasting appear to succumb smoothly to the more secular ideals represented by the doctor, the modern incarnation of an earthly redeemer. The notion of the man 'bringing forth' from a woman has deeply rooted religious and secular motivations which are both historically and subconsciously misogynistic, but are not only, merely, or simply misogynistic. When the Medieval woman was delivered by a man, or a priest was close at hand, it was likely to mean that both she and her child were in danger of their lives and souls. Baptism was the ultimate 'delivery' of the innocent child; metaphorically, from the maw of eternal oblivion, and physically, from the 'pit' of sin and allurement. This delivering from evil was an imperative which often involved the piecemeal removal of the child. Such scenarios may in themselves have fuelled the gruesome fantasies of monstrous and demonic deliveries. Of women's direct experience of these tribulations there is virtually no trace. The curse of Genesis was, after all, upon them.

These stories were clearly also about the appropriation of generation. At the most mundane level they represented an exaggeration of fears about illegitimacy, adultery, and

women's deceptiveness. Anxieties about masculine loss of power, control and status were manifest not only in the taboos relating to coitus, which was a predominant fear of antiquity, but also in relation to issues of succession, when the perceived threat of child substitution prevailed. The power of this perception derived not from those actualities for which there is scattered evidence (Lefkowitz and Fant, 1982), but in the existence of the fear itself, persistent if redundant. Indeed, its redundancy as a substantial threat is underlined by the ancient willingness to 'adopt' in order to ensure legitimate if not natural lineage. Similarly, the persistence of the belief in the likelihood of debilitation following upon the sexual act, and of indignities compounded by women's corruption, fostered belief in the Christian notion of resurrection, which, given the credence given to popular mythologies, seemed less far-fetched and uncertain than faith in the female as the 'instrument' of reproduction and perpetuity. Reliance upon the perceived unreliability and irrationality of women required a literal loss of self to self, or self to God. The fear of the 'pit', its mystery and its temptations, was profoundly endorsed by analogy and symbolic resonance.

An exclusively masculine regeneration and the promise of the Kingdom of Heaven, held great appeal, offering as it did a salve to pride, and the security of a life everlasting without reference to the veracity of progeny, or the survival of either 'species' or of state. There is a modern parallel in the current debate revolving around ageing research and regeneration technology. Stereotypically associated with women's fears about loss of youth and allure, these fears have in reality been broadly exploited by the male owned cosmetic and pharmaceutical companies, and by the predominantly male cosmetic surgeons. It is wealthy male establishment figures who are the main sponsors of ageing research in the U.S.A. (Corea, 1985, p.318), and the wealthy are also the main beneficiaries of the expensive and dubious science of cryonics (the storage of the dead). It appears to open up the possibility of freeing mankind from the exigencies of Eden, and from the necessities of normal human reproduction. The freezing and storage of embryos is a ghostly echo of

cryonics, a practice concerned with the other end of the life-extending spectrum. These are the manifestations of a discourse which has at the heart of its techniques an obsession with recording and storing information for possible retrieval. It was almost an inevitability that these techniques should overlap with the medical need to perfect and preserve. Today in the U.S., it is a commercial prospect which reflects a slavish belief in scientific progress. The results are the storage of those who have not begun life, and those for whom it is over, in order that both (one in actuality, one as a matter of faith) may be brought to health and life in the future.

However far-fetched, that such possibilities are on the scientific agenda, says much of a persistent and seemingly time-impervious paradigm since the onset of Christianity, that is; the ideal of freedom from death and birth, and the search for the certainties of Resurrection and eternal life, now endowed with the new sinister metaphor and materiality of human cryonics. It may also herald an entirely new phase of dependency and interaction with the figures and repositories of expertise, and a new reliance upon technicians and superintendents which might last for generations. The fascination of the affluent West with such putative 'life-after-death' phenomena as cryonics and the reservation of sperm samples, demonstrates also an aspect of first world arrogance which takes as implicit a certain historical stagnation and an inability to make imaginative leaps beyond the demands of the present generation, despite the illusion of 'Space Age' credibility which remains a delusion.

There are implications also for the issue of the new reproductive technologies. For example, apart from the metaphysical and aesthetic arguments that surround the moral questions which centre on the development of body banks and sperm banks, there is the perceived threat of paternal anonimity and the individual loss of history, which may be at the root of Christian, moral, and therefore phallogocentric objections. The indefinite nature of paternity (which features somewhat covertly on the discursive agenda,

particularly as male rituals of childbirth cheerleading have become established at the bedside of the parturient) appears to be again at issue here. However, in the exigencies of the modern idiom, this would appear to push the documentary society a stage further. The creation of beings of uncertain history, creates also a new object for scientific and ethical scrutiny. The experiments of the new reproductive technologies render the histories of individuals open to new types of genealogical examination. The new sciences of uncertainty, make the documentary histories of individuals, their recordable minutiae, a part of the history of documentation, which with artificial insemination, surrogacy, and donor ova, has entered a new phase. A division of individuals on the basis of their susceptibility to conventional genealogical documentation might feasibly occur.

The proliferation of textual matter regarding gynaecology and obstetrics, with the stream of medical tomes and literature aimed at lay and professional readers alike has to be understood in the context of questions of origin and authorship which mystify and elevate authentication.[18] It has been suggested that parenting provides authorship with its most apposite symbol (Gallop, 1982, pp.106, 109-112). Certainly, that would reflect anxieties about presence which are common to both discourses.[19] The paradigms that may emerge attendant upon the new technologies could involve a new and ultimate privileging of presence; a presence without origins. A power that creates individuals with the possibility

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[18] See Barthes, 1972, pp.143-50; Foucault, 1977, pp.113-38; Shevelow, 1989; Morgan, 1988, p.354.

[19] Some feminist writers have tried to make a case for a differentiated subjectivity of women authors (Miller, 1986, pp.102-20; Modelski, 1986, pp.121-38). However, such a notion assumes a transcendence of the existing discursive structure and ignores the idea that the nature of the text is to promote reader identification. Equally, identity of the writing subject, whether man or woman is societally constructed (Bordo, 1990, pp.133ff.). Axiomatic gender divisions have been reinforced also by the orthodoxies of Marxism, feminism and psychoanalysis, which have made the institutionalisation of heterosexuality and motherhood acceptable and normalised categories.

of rendering the definite identification of paternity an impossibility. This does not imply a new privileging of the mother in this context. Rather, the very secrecy that surrounds male donors privileges an omnipotent 'pretend-paternity' and creationist fantasies. It is the modern rendering of the myths of monstrous or divine births, with hints both of Frankenstein and the Holy Spirit.

It may be that from the technological advances in the creation and dissemination of information, a complexity of exchanges will evolve, and modern individuals whose own histories bear the traces of new technologies, will no longer, can no longer, tolerate the simplified and progressive account of history, or totalising theories (Lyotard, 1984, p.64). Perhaps they will testify to the concept that there is no natural, non-assigned authorship. However, as the indefinite nature of paternity (always historically problematised) is legitimised and normalised in modern reproductive technologies, and as old anxieties are freshly problematised, medicalised individuals may come to inhabit what Norris (1987, p.154) describes as: "a dream-machine of surveillance, with everyone plugged into the system and unable to perceive or resist its effects."

As with most scientific innovation, it has become the standard response to believe (particularly by those who perpetrate them) that the new technologies are benevolently servicing a growing humanitarian need. However, the modern subjective experience of infertility is as much a creation of the new techniques of reproduction, as the dysfunctional parturient was constituted via the technologies of childbirth. The fragmentation created by binary structuring; the eternal 'couple' of discursive technique, the multiplication of oppositionisms, takes its effect at the level of discourse. The proliferation of discourses takes place under a paradigmatic 'umbrella' of the thinkable and sayable, but can operate both in conflict and collusion; and in arrangements of contiguity and continuity. Hence, the practices and principles of the 'past' do not inhabit the past exclusively, in a linear causal chain, but remain active, fluid; with the potential to become what is sayable and

thinkable again. The past is not the inert base material of the present; it does not anticipate the present; it is not its pallid understudy. Such notions are an arrogance of the present, which is the result of a historical discourse which privileges both presence and progressive linearity. They are to be found in historiographies which privilege traditionalist truth, origin and foundation-seeking narratives, or progressivism and ideologism. A less value-laden, but nonetheless productive and dynamic model might be one which devolved upon a 'process', rather than progress orientated approach. This would also displace the insistence upon linear or hierarchical development.

An analysis of discourses reveals historical interchange, interaction, drift, cross-fertilisation and proliferation. Discursive elements can become relevant or successful in later, more appropriate historical circumstances having been marooned or abandoned in their own period of origin; 'orphan' discourses 'coming good', as in, for example, alphabetic writing practices. Alternatively, seemingly suited practices-to-match-paradigms, such as Benthamite panopticism in the nineteenth century, which has been represented as a philanthropic gesture to posterity, did not require universal operation or concrete expression to have paradigmatic influence. They may, with insufficient explanation, wither in their own ground, re-root and come to fruition in the unforeseen future; producing effects (combination, assimilation, mutation, hiatus, extinction) that ripple and shudder in a network of other unrelated activities, spaces, ideas and events.[20] Similarly, it is the pervasiveness of the principles which attend the new technologies, and the conditions they engender which have the most significant cultural impact.

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[20] The subtle and forceless technologies of the 'gaze' (Foucault 1979, pp.195-228) permeate twentieth century institutions and on a practical level have manifested themselves in recent prison-building projects, as for example, the recent rebuilding of Strangeways, although 'panopticism' had limited substantive architectural impact in its own time.

Discourses, though disparate, can also operate in parallel, but not necessarily sequentially, nor in strict temporal or spatial alignments. No discourse or practice is cast in stone; once the conditions of possibility for their existence have transpired, they may after a period of invisibility, come to necessarily hitherto unthinkable endorsements when the cluster of paradigms and effects produce the appropriate climate and environment. The modern episteme is shaped by the processes of bureaucratic organisation and technological advance which characterise all aspects of Western culture including and epitomised by the medical discourse. Such processes have become values in themselves. The greater specificity in clinical medicine from the middle of the nineteenth century occurs when observation relies on perpetual visibility, and the gaze becomes the mainstay of rational discourse and clinical experience, determining the structure of relations between and concerning individuals (Foucault, 1973).

A new 'invisibility' of techniques developed in post-Revolutionary cultures. They were to discipline the body and render it docile in ways that were facilitated by the medical discourse such exigencies created. The body became invested with new techniques of examination and inspection which had been prepared for in the more highly visible cultures which exhibited regal power. The disciplinary gaze of the clinical examination subjected the body to a minutiae of intimate judgements and classifications in a field of surveillance in which the individual was enjoined to complicity, and where even resistance was predicated on the same principles of acceptance of the body's objectification and subjectification. The individual now attains a recordability and significance that are quite new, and which implicate the individual in other fields of relations, and determine the subjective experience of those relations.

Increasingly, as conception technology becomes the focus of concern in the discourse of reproduction; there is a concomitant interest in the determination and prediction of life chances based upon an examination of the life of the foetus in the womb. This includes a

minute inspection of the mother's life, including her life respectively in the womb of her mother (Corea, 1985). In the service of these exigencies, the involvement of the mother and the mother-to-be (the right of the woman to bear children is paramount), is an enhancement rather than a hindrance to the process of implication and conformity.[21] The renewed interest in lifestyle, values and behaviour is central to the natural childbirth ethos, and can only extend the possibilities in relation to the disciplinary integration of all aspects of female existence as they obtain with reference to the possibilities and exigencies of reproduction and childbirth. There is therefore a natural 'letting in' of those areas of seeming radicalism, inasmuch as they concur with existing and developing paradigms, and insofar as the conflicts they entail are productive of dialogue and conditions of change and ferment.

Gena Corea (1985, pp.318ff.), questions the distribution of control and responsibility in the operation of the sophisticated technologies of what she describes as the biological and pharmacratic revolution of the late twentieth century. These include *in vitro* fertilisation clinics, artificial insemination, embryonic transfer, sex predetermination, surrogacy and surrogacy agencies, which despite, or possibly because of the moral debate that surrounds it, reinforces the notion of woman as incubators and donors, described by Lea Melandri as "an equivalent more universal than money" (de Lauretis, 1977, p.27). The fear of infertility has a long pedigree, and was a feature, for example, of the ancient preoccupation with suppositious children.[22] While it is true that the modern discourse of fertility has, as other aspects of the medical discourse, the notion of inbuilt failure, this is a productive

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[21] It has been suggested that terms like 'barren' and 'childless', have been used in relation to women to nullify the need for their further identification (Rich, 1984, p.11). This could be regarded as too simplistic as it implies a dismissal of the non-fertile woman which is belied by the wealth of research and documentation that subjectivises her.

[22] See Lacey, 1968, p.170; Herrin, 1983, p.172; Humphreys, 1983, pp.44-5; King, 1983, p.112

rather than repressive strategy, generating today the massive professional industry around the infertile woman. It is too simplistic to regard women as the victims of reproductive technologies, or as the objects of a conspiracy to use them as "living laboratories" (Rowland, 1992). Far from repressed, she is the centre of expert attentions in her every aspect. The infertile woman has come also to regard herself as the rightful object of expert attentions.

The developing modern discourses of conception technology and of foetal preservation however rooted in historical exigencies and cultural distortions, are rendered discursively as normative, 'civilised', and legitimate life-enhancing pursuits, the desired outcome of a progressive and beneficient science. Irrespective of the undoubted benefits to the individuals that are produced by, imbued with, and who evangelise the current tenets of the medicalised discourses of fertility and perfectibility, it is certain that the procedures that characterise them, from the vulgar promises of cosmetic and restorative surgery to the moral certainties of corrective and preservative operations performed *in utero*, serve in some measure to reinforce the glamour and 'tricksterism' of modern obstetric medicine and gynaecology. Illusion has had a part to play in obstetrics from its earliest history - ironically, as the mystificatory armarium of the male obstetrician developed, a parallel discourse began to seek out and interrogate unorthodox practices and 'quackery'.

2.4. New axioms of childbirth

The gradual normalisation of hospital birth also meant a higher incidence of forceps use, episiotomy and artificial induction. These are part of the limited 'magic' of the obstetrician and long remain in his repertoire. The parturient, once committed to the masculinised environment of the hospital, was more likely to be exposed to time-saving and interventionist procedures. Certainly a combination of changes including better ante-natal care and monitoring, and the increased facilitation of standards of domestic hygiene

created conditions under which the mother-to-be need not go in fear of her life or that of her infant. These practices and their elaboration were facilitated by the move to hospitalisation, but once the basic tenets of hygiene and care are normalised, the improvements in mortality are not exclusively a feature of the hospital.[23]

In the majority of cases it is unlikely that the facilities available to the hospital, (and the vogue for certain electronic aids varies as the hospitals attempt to affirm their technological grip on the parturient) are actually necessary to the safety of the birthing process (Richards and Chalmers, 1987). The disadvantages of episiotomy and induction when used on a large scale and as an automatic process; can include increased probability of pain, the use of anaesthesia and analgesics, and infant intensive care. These possibilities might be seen to outweigh the fractional increase in maternal and child safety they might ensure. In the latter part of the twentieth century some of these practices, particularly their axiomatic use, has come into serious question (Haire, 1972; Chalmers, 1978).[24]

The logic of hospital procedures becomes the essence of the birthing process, accepted and respected by all parties. Entering the hospital catches the parturient in a web of tacit complicities in unquestioned subsidiary procedures.[25] For example, until the mid-seventies when the practices began to be abandoned, entrance into the hospital was often

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[23] In the Netherlands, for example, where home births are popular, there is a low rate of maternal and perinatal mortality (Donnison, 1977, p.196; Kloosterman, 1978).

[24] It has recently been implied that the extent of such incursions may, for the parturient, incur psychological effects similar to that of physical or sexual violation (Kitzinger, 1992, pp.62-80).

[25] See Rosengren and De Vault, 1963. A comprehensive survey of the technological strategies available to modern obstetrics in the active management of labour is contained in S.Inch, 1982, ch.4; Sheila Kitzinger, 1983, pp.45-83.

marked for parturients by initial 'hygiene' procedures which involved the shaving of the perineum, and the administering of emetics (Kantor et. al. 1965, pp.509ff.). These humiliating and mystificatory practices continued for the majority of women long beyond the stage where it could be considered necessary for purposes of hygiene, and began to appear routinely disciplinarian (Romney, 1980, pp.33-5). Although they served to reinforce the hallmark of sterility, new paradigms of self-determination have forced such practices into obsolescence. The unnecessarily prolonged continuation of such procedures can only be interpreted as having functioned as a disciplinary measure; a step in the process of making childbirth manageable and homogeneous while simultaneously operating upon the individual's sense of themselves. Just as the removal of excess hair had signalled the entrance into prison or into the military.[26]

The release or removal of hair has provided a religious metaphor for liberation and capitulation since antiquity. The parturial practice of shaving the perineum began as a practice which was designed to rid the parturient poor of pubic lice (Kitzinger, 1983, p.31). The procedure becomes routinised in the disciplinary discourse of hygiene/retribution, and has only of recent years died out as an unquestioned practice. Like the routine use of lithotomy stirrups, so redolent of the straps and chains of the old-style penitentiary, and echoing the practices of self-renunciation peculiar to Christian martyrology, the shaving of body hair for the parturient is not intended as ritual humiliation, but as a marking off of the period from which the parturial body becomes the province of the hospital. It signifies a secular surrender to the doctor. In the overlapping and multi-purpose mechanisms of organisational power that were common to the prison, the hospital, and the school; rules of hygiene warded off outbreaks of infection, but they also implemented the principles of examination and inspection and further normalised the

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[26] There was for example, a latent dual hygenist and disciplinary purpose in the practice of shaving convict's heads (Ignatieff, 1978, pp.100-1).

regimentation and regulation of individuals. The processes most designed to bring about a certain dehumanisation, also marked the exclusivity of the group, and the significance of undergoing personal transformation in order to qualify for a specific, 'expertly' delineated experience, which particularised the individual, while standardising their treatment.[27] This is both more and less complicated than theories which emphasise the reflexiveness of different institutions such as the prison, factory, barracks, school and hospital, or the efficiency of state apparatuses. For this is insufficient explanation in itself for how such operations dictate human experience at every level, relying as they do, so deeply upon intentionality, and attempts to do so are necessarily over-stretched and convoluted.[28]

In the case of the experience of parturition, it is the question of predictability which is at stake. The refinement of the ancient and later Christian experiences of self-scrutiny into questions of intentionality came to predominate after the late Middle Ages. From 1800, the growing discourse of expertise privileges notions of perfectibility which are based on the ability to predict outcomes; increasingly a matter for science rather than of magic or charlatanism, though this persists in popular amateur expert discourses. The concomitant

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[27] Following an outbreak of 'jail fever' at Gloucester Castle in 1784, the medical discourse of hygiene had begun to pervade the prison, bringing in train a range of disciplinary procedures. Reformers such as G.O.Paul, had to convince fellow magistrates that a more humane and regulated regime concerning health and diet would not compromise the retributory aspect of confinement. In fact it was recognised that hygenic procedures could fulfil punitive functions. A clear parallel between the exigencies of the prison cell and the labour ward can be discerned in this reassurance concerning Prison Discipline Society rules (1820, p.iii): "It is true that they (the society) consider it desirable that prisons should be clean, and the food given to the prisoners plain, wholesome and sufficient; but they are equally anxious that everything which borders on sensual gratification or unnecessary comfort should be entirely prohibited." (Ignatieff, 1978, pp.167-8).

[28] See Althusser, 1971. The elements of interest and veracity to be found in such partial explanations, which rely on the acceptance of the 'Grand Theory' structure, also imply the notion of conspiracy, too simplistically and unquestioningly (Foucault, 1972, pp.3-20; Smart, 1982).

result of the privileging of prediction, is the development of procedures whereby certain outcomes were not only accounted for; but were, if possible, guaranteed.

In childbirth labour, this has, for example, justified the administration of hormones before the completion of the expulsive stages to prevent haemorrhaging, and the performance of episiotomy to paradoxically lessen the haphazard effects of perineal tearing (Kitzinger, 1984). The 'predictability' factor, as important to how the parturient sees herself and her experience, as it is to the professional reputation of the obstetrician, and those he 'oversees', also leads to the giving of sedatives for presupposed exhaustion, the requiring of abstention from eating and drinking in case of possible surgery, and the administration of pain relief presupposing a breakdown of personal endurance. What is at stake here is the delineation of parameters which can accommodate a preordained loss of control; of the 'just-in-case' strategy, itself often creating the very condition the measure sets out to make manageable in an inter-justificatory web of procedures which persist because of their guaranteed self-perpetuating nature.

Some of the more consequential practices such as induction and episiotomy (one often leading to the other in a chain of 'produced' biological effects) have also been reviewed in terms of the necessity of their routine perpetration (Francome, 1989). It is not that these procedures are the result of a lack of research or experience, or of faulty and neglectful observation; or that they would never be justified under any circumstance. Quite the reverse. Obstetrics is saturated with certain types of knowledge. It is the fact that such procedures are precisely the result of a particular all-encompassing formulation and technique of enhancing the knowledges and status of a specific field of practices, which underwrites the acceptance of the axioms of such practices. Whatever measures the outcome of scientific researches might seem to indicate are thereby sanctioned, which makes them permissible, even essential for everyone, for the sake of good measure. Hence the host of natural unpredictabilities which characterise childbirth, are replaced artificially

by a perhaps greater number of unpredictabilities predicated on the generalised use of certain techniques and technologies, but which have the implicit sanction of all involved. As these strategies produce new and imposed variables; they extend the parameters of unpredictability. They produce what passes for a technical homogenisation of effects which can be in fact better accommodated for within the paradigms of accepted modes of knowledge acquisition and practice, and this continues to reassure those who are 'trained' to accept and react to these particular modes; these include both the birthing woman and the managers of birth.

In this schema, it is somehow regarded as safer to be afflicted by the results of an 'interference', than by a more random physiological hazard, because the establishment is better equipped to cope with the conditions it has itself engendered in a reciprocity of fulfilled needs. The physical and emotional language of childbirth is transformed by this project. It becomes the event which is most feared, and that which is most swiftly and efficiently dealt with. The parturient complies because she has a genuine desire for her experience to come within the realms of predictability and treatability, whatever cost that might incur. She is willing not only to undergo that transformation of herself and her experience, but to do so with the minimum of resistance, until it is difficult to be certain where the 'real' and 'natural' experience begins and ends, so closely does it coalesce and merge with the technologised experience that has come to be regarded as 'normal'.

The elements of prison-house deprivation which characterised the maternity ward until the latter half of this century, where new parturients were constrained to undergo impersonalising and defamiliarising procedures, have largely fallen into disuetude; their anachronistic aspects becoming increasingly unsustainable. Disciplinary techniques would come to require more subtlety, and a greater measure of self-direction would be necessary to reimplicate the parturient in the birthing process after a period of antagonism during which some emphases would come to be shifted in line with emerging principles of self-

directedness. These elements characterise developing discourses - the fracturing of care and principles a precursor of seemingly new principles of 'enlightened' practice penetrating and being absorbed by the mainstream. Routine procedures which were more thoroughly adopted in America, are gradually being rejected by clients and deliverers alike (Wertz and Wertz, 1977). Routine analgesia, the episiotomy, the use of forceps and lithotomy stirrups, and the insistence upon the use of beds for birth, came into increasing question from the seventies.[29] The parturient has begun to appear as the effectual party in the birth process.

2.5. Negotiating labour: the birth plan

The likely behaviour of the parturient in the delivery room is discreetly monitored and encoded according to the extent to which she has involved herself in an understanding of her condition, and the alliances she has formed in order to enlighten herself.[30] The elective birth plan she is encouraged to devise, if it exists, will by its very existence, rather than its content, signify much about the her background and lifestyle, and her probable level of cooperation with the regulations of the institution.[31] Assertiveness and the possibility of disruptive behaviour will be indirectly perceived, manipulated and ameliorated at this stage, probably by establishing a process of negotiation whereby some of the demands made by the gravida might be non-commitally met. This is the great attraction of childbirth as an object of science and morality. Its inherent unpredictability provides the object of interventionary challenges, and also permits a level of impersonality

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[29] See Chalmers, 1978; Huntingford, 1978; Inch, 1989.

[30] For a feminist interpretation of the relative frame of reference of obstetricians and parturients, see: Graham and Oakley, 1981. pp.50-74.

[31] For the history of the birth plan, see Kitzinger, 1983, pp.162-171.

and non-commital medical response that reinforces the image of objectivity and caring spontaneity. The knowledgeable and sceptical parturient is susceptible to the subtle deflections of the ideology of 'for-your-own-good', and 'in-your-best-interests' purveyed by benevolent authority.

In reality, the alliance of the parturient with the independent childbirth teachers, while in itself a sub-relation of tutelage, is regarded much as her clandestine (but nonetheless tutelary) alliance with the childbirth advisors and attendants of former times - potentially dangerous, but also a matter of production and necessity. The general irregularities of form and process inherent to childbirth, have inspired a hoard of techniques and strategies for its physical organisation, both in terms of the spaces where it is permissible for it to take place, and in terms of the location and disposition of the parturient body itself. Various techniques and appliances have at different times been employed to keep the irregularity of gesture and posture under control, and in more recent times there has been a standing-off by the professionals which has enabled some women to determine their own positionality, and to experiment with vertical positions such as squatting and kneeling (Schwarcz et. al., 1979). This appears to be part of the negotiated 'settlement' between orthodox and unorthodox practices, the latter trading their notoriety for celebrity, and the former incorporating some of the more popular measures into the obstetric curriculum while maintaining and enhancing its authority.

In this rapprochement which neither stems the productivity of the debates or the antagonisms, and which does not and cannot work at the level of conscious conspiracy, the parturient is the object, site and means. She is caught in the fluctuating fortunes of the hostage and the beneficiary, implicated in the process of medicalised reciprocity. In the dialogism of these processes there is both domestication and preservation of difference. A manageable homogeneity and docility will always be ensured, as the interdependent web of technological events becomes broken by the negotiated disuetude of some of its

interconnecting strands, thus permitting new patterns of disconnection and partial arrangements to emerge. The physical restraint of the parturient is non-productive, and new power-knowledge permutations involving observation, measurement and expertise are predicated on the active participation and decision-making of the parturient. This appears to be 'progressive' because it appears to be self-generated. It is a matter, not of conspiracy or coercion; but of concert and co-efficiency.

The hospital cannot lose. If the parturient and her child fare worse under the newly ratified regime, then all credit to the hospital who were prepared to be open-minded and fashionably experimental, in their accommodation of the demands of the recently created parturient-expert. She must bear the consequences of the responsibilities she has been encouraged to arrogate to herself. The hospital authorities told them so, and of course, the benefits of technologised childbirth is still an option. Of course, if all goes well, and in the catalogue of checks and the scrutiny of possible advantage, the balance sheet shows in favour of the sharing of childbirth know-how and decision-making with the mother, then the laurels must go to the hospital, and its enlightened policy-making, operations, organisation and professional staff. It cannot be said to cling to obsolete orthodoxies, nor to stifle experiment and change. It is the sort of place to where not only those wanting to relinquish control, but also those wishing to assume control; may do so with impunity. Respectively, either within the sharp and expert operations of high-tech, or under benevolent and reluctantly interventionist supervision.

2.6. The predictive trace: foetal monitoring

Since the late 1960's, as the possibilities for the induction and augmentation of labour have increased, the elaboration of childbirth technology and practice has included the extension of foetal testing for possible neural and chromosomal abnormalities. The charting and graphing of the potentialities of both parturient and foetus have become routine

procedures (Chalmers, 1978, p.44). Scanning and monitoring equipment are not only the elaborated tools of prediction, they are also disciplinary apparatuses. Since the nineteenth century, when carceral discipline pervaded most institutions, the admittance of the parturial woman into the maternity ward imposed the rigours of disciplinary procedures, which if conformed to might impose some sort of regularity and order upon an event whose process was often unpredictable and haphazard. Childbirth was regarded as an arbitrary process which had to be made manageable and recordable. The nineteenth century Benthamite panopticon, for example, was designed as a careful deployment and distribution of surveillance which implicated individuals into constraints they might not otherwise have willingly countenanced.[32] Such structures, even if not architecturally realised, entail a normalisation of such hierarchical observation and normalising judgement as to render individuals under a type of compulsion which is to do with the voluntary disposition of bodies rather than physical coercion. However, the self-imposed constraints generated have palpable effects in terms of tying the individual into the networks of discipline and holding them there via guilt, fear, appeals to safety and self-interest, and self-generated attentiveness to a duty to the self and others, which is sometimes tacit and sometimes explicit. This enables regulation and management of individuals as populations, while relying on the dual techniques of homogenisation and differentiation, both of which have goals and strategies linked to accountability. This has particular and obvious relevance for childbirth practices.

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32 The ideals of the Benthamite penitentiary devised in the late eighteenth century, with its surveillance panoptics based innovatively and to a surprising extent, (even to Bentham himself), upon exposure to the light, never really came to the sort of architectural fruition that Bentham had envisioned (Bentham, 1962 (1843); Foucault, 1977, p202; Hale, 1982). However, its essential disciplinary potential; the notion of open, democratic, omnipresent inspection determining the behaviour of individuals became inscribed in every area of institutional life and had disciplinary repercussions everywhere (Pasquino, 1980; Melossi and Pavarini, 1981).

Many women are routinely given ultrasound checks which give a 'window' upon life inside the womb. Perhaps the ultimate subtle and forceless revelation; though of proven efficacy in specific cases; its use as a routine procedure is not so far sufficiently tested (Enkin et. al., 1989, p.56). Often, it offers little in the way of information to the pregnant woman, except a confirmation of her pregnancy. In fact, it is most likely, that any information rendered by the ultrasound scan, remains the privileged secret of the hospital. Although the gravida cannot understand the significance of much of the blurry image she sees, and is reliant upon an expert interpretation of the data of her own body, data her body has created; it is hospital policy in most areas to keep this information from the parturient. This is usually the case with the sex of the foetus - information which is routinely withheld even when it can be ascertained with some accuracy (Enkin et. al., 1989, p.55).

Now a fixture of ante-natal procedure, the ultra-sound scan, has, like other forms of foetal monitoring, supplanted while appearing to supplement, older forms of monitoring. Reinforcing the sense that the pregnant body becomes the property of the hospital when the parturient becomes implicated in antenatal procedures. Beyond a perfunctionary description of the blurred images on the screen, the findings of the early ultrasound scan are not disclosed to the mother, but are recorded for further analysis and logging elsewhere. Further consultation with the mother will only take place if an intervention is indicated by what is revealed.

What the scanner ostensibly provides, is a more accurate predictive facility. The ascription of an expected date of delivery is essential as interventions often rely upon failure to reach deliver-by dates, or where they are pre-empted by early onset of labour. According to the scan a foetus may be small or large for the dates given by the mother, who, although she may know for certain the actual date of conception, will not be believed against the findings of the ultrasound equipment. This echoes the ancient mistrust of the testimony of the woman, which is associated with mystical and pagan predictive abilities and has

therefore in some permutation of these associations, an aura of anti-science, and her judgement cannot therefore be trusted above that of the precision equipment she has herself come to trust above her own knowledge and intuitions.[33]

During labour itself, the monitoring of contractions and foetus as routine also produces copious information, and afterwards, there is the Apgar test for the new-born, which takes its place among other 'tests' for perfection, and the minute examination of such factors as 'bonding' (a criterion of only fairly recent paradigmatic interest) which are then reduced to a damning or confirming mark, against which all other 'progress' is measured. Something quite separate from the developing relationship of child and mother is being generated here, as with the various forms of childbirth recording; new principles, paradigms and subjectivities are being created, and parameters and axioms encoded.[34] Belonging,

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33 Consultation is historically both a medical and a devotional ritual. In antiquity, the gods at shrines of healing were regularly worshipped and consulted. The most famous of these was the temple of Asclepius at Epidaurus where devotees would remain all night and receive in their dreams instructions as to their future treatment. Consultation was also clearly derived from early oracular devotions. From the eighth to the fifth centuries the Delphic oracles were regularly consulted about everyday occurrences and the achievement of moderate and regulated behaviour . Interestingly, the oracles were delivered by an entranced woman, the Pythia, though "...the formal response was handed over to the enquirer in writing, by the male priests, who may be supposed to have reduced a relatively incoherent answer to intelligible forms - in major cases, to hexameter verse" (Andrewes, 1971, p. 267). Not only were male interpreters considered necessary, but here is also a privileging of writing and writing structures, and an encoding of interpretation and prediction (Sourvinou-Inwood. 1987, pp.215ff.). In an interestingly typical strategy in view of historical perspectives regarding women and intoxication, and their repercussions for the chidbirth anaesthesia debates, later allegations of fraud included accusations that the female oracle was intoxicated by vapours (Andrewes, 1971, pp.267-8, 270).

34 It is interesting that all parties to information gleaning and gathering are complicit in this process while only superficially being aware of its import and origin. For example, in the United States, where such information is also generated in copious quantities, there is in fact no law requiring accurate medical records to be made, and almost everywhere there is no compulsion to keep records that are made for more than a brief period of time (Arms, 1975, p.88).

identity, presence - all are factors in the conduct of ante-natal, parturial, and post-natal monitoring and recording. The records go on being generated for some time after the birth, to ascertain the post-natal condition of the mother and the rate at which she regains strength and health physically and mentally. Such checks gradually shift entirely to the health and development of the infant, and periodically continue into the first years of the child's life, therefore, ensuring the implication of the family in continuing medicalised relations of revelation and confiding.

One of the more recent measures to have a successful disciplinary implementation is the continually recorded foetal heart monitoring, which has largely replaced the more intimate and intermittent use of the auroscope or 'ear trumpet'. The latter had a detective function, while the monitoring machine is, like other measures, ostensibly preventative in intent. External monitoring involves the use of abdominal straps which house the gauge and ultrasound to ascertain both uterine contractions and foetal heart rate so that their trace can be checked periodically for signs of stress. Less frequently employed internal monitoring involves the attaching of electrodes to the foetal scalp.[35] The consequences of foetal monitoring have an impact beyond the switch from detection to prevention.[36] Firstly, the attendant does not necessarily check the readings of the monitor any more regularly than the conventional method of monitoring by 'trumpet'. The difference in the nature of this contact is however quite different. Personal contact is minimalised, the intrusion upon the parturient reduced to the interpretation of an electronic trace. Again, the attendant mediates between the machine and the mother, and an 'expert', if inaccurate, interpretation is the result.

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35 See Caldeyro-Barcia et.al., 1973; Gabat et.al., 1973; Beard, 1977, pp.14-21.

36 See Quilligan and Paul, 1975; Gassner and Ledger, 1978, pp. 193-7; Kelso, I.M., 1978.

Secondly, there are physiological and emotional disadvantages of the practice of foetal monitoring, which include the need for the immobility of the parturient with its attendant physiological complications, the distancing effect emotionally of the use of monitoring equipment, and the possible consequent stress effects upon the foetus (Kitzinger, 1983, pp.36-45). The periodic or prolonged immobility of the mother is requisite also for the intravenous administration of inductive oxytocics. In both cases, supine hypertension can register accurately as distress upon foetal heart monitors, as the flow of blood to the foetus is restricted. This not only leads directly to a manufactured need for intervention, but serves to justify the implementation of the techniques and equipment that create the circumstances of their own use. The supplementation of processes taking place in 'real' biological time, to synchronise them with medical or hospital time, may be intended to enhance an uncertain natural process, but the effect is, at least in part, to further complicate those processes, sometimes slowing down, rather than speeding up the progress of events.

When these chains of medical events take place, it is not a clear case of cause and effect, and they cannot be regarded either strictly in terms of intention, ignorance or wilful neglect. Neither can it be the case that the arrangement of the modern childbirth scenario happens somehow by accident, for it is clear that a subtle and complex web of operations and principles are at work. Women are not as has been suggested, the victims of these interventions (Kickbusch, 1981, pp.151-68). They have a momentum which is quite distinct from any political or ideological agenda. Both parturient and obstetric staff are caught in these exigencies of routine and interdependent effects, which generate a perpetual reciprocity of needs and solutions.

Machines can also dominate the labour scene, displacing the body of the parturient enabling the transfer of responsibility for the birth from the mother to the hospital. The

internal structures of the birthing areas are almost universally an architectural echo of the isolation unit, giving a heightened sense of confinement and concentrated depersonalisation. The manufactured sense of danger, and the need for containment has connotations of the isolatory practices of the past.[37] The residue of separatory tactics still

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37 The need for isolatory practices, and the demand for segregation in clinics, became increasingly apparent during the Middle Ages, when leprosy and epidemics were rife. However, such practices would have hardly been thinkable without the discourse of differentiation, which had permeated every aspect of education and knowledge. Epidemics produced social and moral disorder, and instigated isolatory practices. The categorising, oppositional and encyclopaedising discourses of the Enlightenment period epitomised by the work of Bacon, Descartes, Newton and Locke, were reflected, for example, in the separation of the mad to a separate and distinct category by 1800 (Foucault, 1967). The influence of the same factors which create and uphold such divisions, also affect and are affected by the changing notions of reason and unreason, which were prevalent at the time. The female hysteric, came also to be medically categorised. Practices of exile and isolation had existed from the earliest times but ritual exclusion became refined upon those who persisted at the margins of society, and who had often defied categorisation and classification beyond their institutional confinement (which comes to identify them). Foucault (1967) uses the example of the 'ship of fools', which was used in Europe to house and extradite those regarded as deviant or insane. These were not unlike the later prison hulks. The iconography of failed and fruitless journeying, and of storm and quest, known to antiquity, coincides here with other prevalent notions of transmutation and metamorphosis which had always been linked to water, and to madness, obsession, or social disquiet. Some of these factors are also prominent in the nineteenth century. Freudian dream interpretation links such dreams to childbirth trauma. The powerful evocation of the movement from water to light associated with birth imagery, also has resonances in later evolutionary theory. Interestingly, the mad were also traditionally treated by bathing - a purificatory, ritualistic, baptismal process, or "a second birth". (Darnton, 1984, p.172). Hysteria was linked metonymically with the womb, and its treatment in the nineteenth century involved ritual stripping of individuality by the use of head shaving and immersion in water (Ehrenreich and English, 1979, pp.124-5). These treatments, typical of imprisonment, also became part of the ritual entry of the parturient into the hospital. Gradually the independent activity of women came to be classified as hysterical. It was only with Freud that hysteria was eventually 'divorced' from gynaecology, and categorised as mental disorder (Freud, 1973 (1915-7), pp.349-52, 422-3, 433-5; 1973a (1932-3), p.176; 1977; Wollheim, 1971, pp.138-50). This network of complementary images which link parturition and 'irrationality' has its repercussions in later definitions of childbirth psychosis. The paradigmatic effect was to link female biology to mental illness, and place women under the expert jurisdiction of the discourse of psychiatry.

persist. Confinement is an effective and tested strategy of a two-fold and paradoxical operation of individualisation and homogenisation. Isolation has been historically regarded as a strategy to make safe and manageable, and such paradigms with their long histories die hard. Isolatory and obsolete practices have their resonances in the notions of contaminatory contact with the newly delivered woman that has pervaded the Christian codification of ancient prejudices.

Although interventions can be predicated on their use, the machines that monitor birth have had a mixed reputation for reliability.[38] Despite doubts about the precision of their functioning, the restriction of their actual use has not been the object of serious question. It is likely that the shift of emphasis to the safety of the foetus implicates the mother in an unquestioning complicity. Studies in America and Britain, which have assessed the effects of foetal monitoring continue to question the value of universal and routine monitoring.[39] It is certain that the machinery of childbirth creates an environment of surveillance, monitoring and accountability, and increases the possibilities of interpretation and analysis, further problematising and increasing the complexities of modern childbirth. What purports to make of childbirth an uncomplicated, sterile, painless and effortless experience, has actually extended its discourse and broadened the range of skills and expertise required of the birth attendant, while there has been a concomitant decrease in the participation and involvement of the parturient.

In the 1970's, larger and better-equipped American hospitals began to employ a panoptic technique whereby several mothers could be simultaneously monitored by oscilloscopes which were placed in a central room. (Arms, 1975, p.61) This would not surprisingly fulfil

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38 For example, up to 66% of readings were inaccurate in some studies (Arms, 1975, p.61).

39 See Gassner and Ledger, 1978, pp.193-7; Kelso, 1978; Enkin, et.al. 1989, pp.189-98.

a dual function of the sort that typifies the creation of subjects and objects in Western technologies and ideologies. Not only does the rendering of childbirth labour into a manageable electronic trace depersonalise the labour experience, this is further compounded and sanitised by channelling this information into a central location where the individual being monitored is not party to the reactions of the person interpreting the information being generated. The birth experience is thereby reduced to a sort of statistical survey - even the analyst does not need to know anything about the person they are monitoring other than their trace. This phenomenon could be regarded as a sophisticated realisation of nineteenth century ideals of rationalisation and depersonalisation as institutional paradigm and technique.

One of the consequences of the monitoring of childbirth labour is that despite the more apparent effect of depersonalisation which is a feature of sophisticated surveillance techniques in whichever institutions they occur, a concomitant effect is to make the individual the object of accountability. In the case of the banking of the oscilloscope trace, the parturient becomes comparable, and measurable against, if not other 'individuals' in the strict sense, then at least against other discernible traces. The parturient is transformed as electronic writing, but she has an altogether new visibility, a new form of representation, a self-portrait. And to that extent, she is a significant, calculable individual, not only productive in the material sense of childbirth (this may here be the least of her functions that she will anyway perform artificially or otherwise), but as a result of childbirth, as a medically 'perfected' state, the means of an extended discursive interest, a catalyst for an almost independent set of interpretable information. Something that warrants its own room. It could be said that in the production of this short-lived but potentially infinite 'shadow-self' (an epithet which in no way reflects its relative importance), the parturient not only renders herself calculable and creates a version of modified subjectivity, but she also renders other parturients calculable and subject to cross-referencing.

Thus the parturient generates in one activity two interdependent but distinct products: the infant she will eventually leave hospital with, and as certainly and unconsciously as a mollusc's silver mark; the calculable, referential, and distinctive signature of the electronic trace. A residue entirely personal yet unspecified, a detail that speaks more immediately of species than of individuality, yet opens the individual to a hunt for numberless specificities. A detached, dependent winding trail, only visible in a certain light, subject to a particular predisposition to see, a grasp of *a priori* knowledge and the will to interpret. A question of the positioning of self in relation to the possibilities of a given time, at a particular angle or perspective, in order to catch the significance of a manufactured, spectacular if barely representative mark. It is located temporarily in the order of things, where there is the possibility of implicating it in an unknowable future of expert interpretation by recording for posterity its permanent trace. These are acts which rely on the possibility of future meanings, born of commission rather than intention, reliant not on cause but on contingencies.

The notion of trace, and of the successful entrance into discourse of certain elements of the past which seemed immediately inoperative despite the discursive conditions which produced them, is again revived in the refinements of parturial monitoring. Infant measurement in the hospital persists into the first moments of life. The quality of the newborn is assessed according to graded measurements of condition and health, such as the Apgar ratings developed in the 1950's. The use of such systems is almost universally accepted. An ascending numerical score for a variety of assessments of infant health, such as heart rate, respiration, reflexes and muscle tone is used, almost immediately after birth, and then again (with ten as the perfect score) a few minutes later. Such techniques are a useful short-hand for deciding the necessity or otherwise of intervention, but as with the use of such modes of measurement elsewhere, for example, for educational purposes, there is almost wholesale reliance upon what these measurements indicate. Better ante-natal monitoring and scrutiny might be thought to increase predictability factors, therefore

ostensibly reducing interventions. However, it is likely that the pattern and focus of interventions will shift, bringing the expertise of the childbirth psychologist into the arena of childbirth professionals, providing a more tangible link with the religious and confessorial practices of the past with which there has been a medical overlap, deepening rather than lifting the mystification of the obstetric process.

2.7. Birth punctual: induction

The twentieth century breakdown of childbirth operations into manageable compartments, segments, and hierarchical and progressive stages has been a feature of the development of the modern human sciences, and could be said to mirror reciprocally human reproduction and maturation. It occurs primarily in education, in psychology, and in historiography itself. The identifiable developmental stages of pregnancy and birth and of early child development are presented as hurdles, precursors of examinations; exercises, in fact, in accountability; one stage preceding another, one following on from the other in normative order. The mother is unused to experiencing these processes as anything other than a linear progression, fractured by interventions.

From antiquity, the paradigm of opportune and appropriate timing has persisted as an ideal or goal, insofar as much historical process is perceived as linear, temporal progress, particularly with regard to scientific and technological change. The ancient regard for proper timing and process, and the ritualisation of maturation have their resonances in later eras - when these notions are better facilitated by the adoption of sophisticated techniques of measurement and categorisation. This relates clearly to the recognition and valourisation of the specificity of maturational stages which create power-knowledge structures around, for example: youth, old age; parturition, motherhood; often creating a rigid compartmentalisation, and an incapacitating sentimentalisation of unavoidable aspects of human existence. Such preoccupations regarding timeliness have necessarily had

repercussions upon childbirth practices. While forms of intervention have been part of medical practice from the earliest times, this has particular relevance for the present century where the history of the control, both technological and moral, exerted over childbirth is permeated by a near obsessive desire to serve the ideal and interests of correct timing.

The punctual birth has its place among the variety of exigencies and ideals that centre upon timeliness and the idea of progression stage-by-stage. They have persisted throughout the historical elaborations of phallogocentricity, culminating in the rigours of nineteenth century Benthamism, and later in the educational and psychological structures imposed upon human development such as that proposed by Piaget (1971). Sex divisions and age divisions, later utilised extensively in the highly categorising discourses of education and the organisation of knowledge, begun around the twelfth century and refined in our own, were also considered to be very significant in antiquity. From the earliest times, the exigencies attached to the biological and maturational stages of a woman's life justified their exclusion from social, cultural and political life.[40] Such antecedents have also

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40 The all pervasive association of women and nature appears to have been culturally and historically multi-purpose; used variously to justify the exclusion of women as earthbound, animalistic or unscientific, or to promote their reification as mystical, life-giving and nurturant (Cantarella, 1986). The ancients held failure to fulfil biological destiny to be a fatal and tragic flaw. Such beliefs promoted the more practical idea that it was better to be tested in childbirth than fail to qualify for fulfilment of ones lifes purpose. Moreover, the fertile woman must not die in childbirth. The achievement of the status of a *gyne*, that is, the achievement of full womanhood, requires that a series of bleedings should take place in order and at a 'proper' time; at menstruation, at the loss of virginity and finally in the post-partum period. The observance of appropriate rituals was thought to ease the transition from innocence to experience and to mollify the deities who held sway in matters of fertility and sexuality. Not only in myth, but in the writings of Aristotle, *Historia Animalia* and *Peri Gynaikon*, the *gyne* is explicitly compared to a sacrificial beast (King, 1983, p.120). Lochial loss was the prefigurement of real physical maturity; a purificatory evacuation which obviously required birth as a pre-condition. Hence, childbearing itself was considered to be near the pinnacle of what women could achieve, but not entirely an end in itself - more a prelude to another "loss" which represented purging and thanksgiving.

existed since classical times, in notions concerning the onset of female maturity and the constitution of full, womanly status. The rites of passage and initiation between different life-stages: that is, the death of the child and the birth of the woman had a high mythic profile.[41]

In the initiatory rites of passage to maturity, the rituals and taboos surrounding bloodshed and childbirth were a complex mixture of prescription, purificatory practices and 'correct' timing. In Xenophon, Plutarch and Socrates, it is clear that timeliness was problematic; it was both a strategy and an art. Prudence and restraint were required to eliminate need precisely and satisfactorily. Diet, activity, season, age, attainment of status; all were considerations which contributed to the delicate balance of appropriate timing (Foucault, 1988a). The resonances of these concerns can be identified in modern technological childbirth practice where, however, they are symptomatic of entirely distinct paradigmatic

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41 Among the major childbirth deities, Artemis the huntress requires sacrifice before birth. A childless virgin, she is emblematic, in so far as she does not, like her devotees, shed blood. Among the non-deities is Iphigenia, the human heroine in Aeschylus' *Agamemnon*, who is also unlike the mature woman or *gyne* insofar as she was to be a human sacrifice, she was also to be denied the maturational norms of marriage and children. The majority of these victims are women. However, this is not necessarily a feature of ancient misogyny; Lefkowitz (1986, p.95) argues that womens' lives are not considered less valuable otherwise they would not be thought suitable gifts for the gods. Also, figures such as Iphigenia, in this regard prefiguring the later Catholic saints, are regarded as not only virtuous, but courageous. There the analogy ends, because while she provides a counterpoint to her father's unnatural violation of family life, her Christianised counterpart is more likely to confirm her martyrdom by rising above such earthly concerns and willingly depriving herself of them; an anathema in the ancient ethic. It is the quality of the thwarted life, cut off at the height of its earthly potentialities that idealises Iphigenia as a figurehead for the cult at her 'tomb' at Brauron, which was not strictly a place for worship but rather for ritual display.(Dowden, 1989, p.44). Childbirth goddesses and cult figures were not heroines of childbirth - they were those who did not achieve 'passage' and who unlike ordinary mortals did not rely on passage for their life's achievement.

exigencies created by the development of modern scientific discourses. Discourses that are steeped, however, in centuries of logocentricity and the precedence of male-defined concerns. Mythic images would later come to have a high scientific profile in the discourse of psychiatry that has borrowed so profusely from the ancient mythological lexicon. They are a more appropriate borrowing than those of Christian martyrology because of their more secular concerns, and their application as a foil to an aesthetics of earthly existence rather than an illustration of the appeal of the afterlife.

Childbirth was the embodiment of memory and a flawed and fractured continuum. It underlined and compartmentalised the passage of time, yet provided the ancient and pre-Christian world with a notion of eternity which became central to human existence and imagination. These ancient catalysts informed, and were appropriated and codified by later Christian paradigms reflected in Marianism, and in notions of a life subordinate to spiritual immortality. Death and childbirth and fertility are everywhere linked in ancient mythology, and are reflected, for example, in the Eleusinian myth of Demeter and Persephone which explores the mysteries of burial and renewal.[42] Abstinence and withdrawal is regarded as part of a necessary sacrifice; the only means to reinforce the goal of the resumption of normal familial relations, the joyful restoration of good health, plentiful harvest, sexual relations, and the cycle of reproduction. Such myths delineate the ancient understanding of natural processes, and reinforce the requirements of appeasement and thanksgiving. They do not approach the sophisticated codifying power of Christianity and its inquisition of behaviour and belief, as spiritual eternity surpasses earthly regeneration as the focus of human toil and aspiration in the Christian West.

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[42] See Cantarella, 1983; Humphreys, 1983, pp.157-60.

In Christian thought, redemption by fasting, and the renunciation of sexuality were ideal goals in themselves. For Christians, marriage and childbirth were an expedient but futile exorcism of the passing of time; their attendant rituals temporarily obscured the view of the grave. It could be said that procreative marriage was both a reminder of, and challenge to, the fear of death. This paradox was reflected in the sanctioning of marital intercourse and the concomitant interrogation and codification of its every aspect (Foucault, 1988a). Marriage, childbirth and bereavement were human markers, the doomed and pathetic constructions of faithlessness and fear. The body, like the soul, is thus predisposed to virginity. The life of a woman was a series of transitory and episodic disruptions, emphasising loss, bondage, and discontinuity. Paradoxically, the stability of societal structures appears to have depended upon this fragmentation of women's lives by marriage and childbirth. There are parallels with increasing refinements of measurement; a splintering of knowledge, the worrying at the minutiae of detail that attended an increasingly inquisitorial discourse, and characterised an intensifyingly logocentric ordering and organisation of existence, that in the late Christian period, was sufficiently troubled to tease out the permutations of intention as well as of activity. Certainly, in the development of the West, women were regarded as the embodiment of fractured time, as the slaves of nature, and of their own bodies. A source of corruption during menstruation, unapproachable during pregnancy and the period of lactation: fertile women were steeped in cautions on significant dates in the religious calendar. But amid these fears of derangement, enslavement, and rupture, there was also a seemingly paradoxical sense of biological and cyclical ordering; of inevitability, continuity, anchorage and exemplary passive acceptance and humility. Even in their circumscribed existences, women had what were regarded as natural opportunies to express fortitude, perserverance and faith.

Timeliness has quite different implications for the modern parturient. Labour-hastening induction is an extensively employed childbirth intervention which addresses, with mixed results, the physiological needs of childbirth, but pays little attention to psychological

ones.[43] When the modern parturient is perceived to have passed the sometimes arbitrary point in time when her birthing might optimally take place, (though certainties about conception are rare), she is frequently subject to interventions to hasten the onset of labour. Questions have been repeatedly raised during the last two decades regarding the effectiveness of obstetric induction in relation to the reduction of perinatal mortality and also with regard to the consequent failure of attention to value and quality of experience.

The simplest inductive measure is amniotomy or the artificial rupturing of membranes to stimulate labour, but its drawback is to create the conditions for the onset of infections which can lead to further remedial treatment. The second method is the introduction of artificial hormones or oxytocics which simulate and supplement those produced naturally by the pituitary gland. The disadvantage here is that the second stage of labour can become protracted because the womb loses some of its expulsive power, and the solution can be to supply more of the drug that created the problem. If the rhythm of childbirth is altered by these measures, the result is often panic and loss of control, signalling the appropriateness of further interventions.[44]

It is not simply that every procedure has its risks. This is true of most surgery where judgements both clinical and ethical have to be made as to the relative dangers of performing particular operations in certain circumstances, and administering anaesthetic in

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43 It has been used as routine in America (See Arms,1975, p.55ff.), and although frequently employed in Britain, this is usually after a certain specified period or if there is obvious danger to the foetus. See also Kitzinger, 1975; Macfarlane, 1977; Cartwright, 1979, pp.155-164; and Yudkin et. al., 1979. Induction has inherent dangers, such as the possible decrease in the amount of oxygen available to the foetus, and the increased level of cranial pressure.

44 See Kitzinger, 1983, pp.45-58; Enkin et. al., 1989, pp.153-6, 264-282; Newburn and Borton, 1989, pp.9-10.

order to do so (Richards, 1977). The situation in childbirth is somewhat distinct from these exigencies. Measures used as routine are ostensibly to preserve or save life as in any other area of medicine and surgery. However, it is relatively rare that life-threatening situations actually arise in normal childbirth to justify the levels of intervention that have been regarded as standard practice. Most interventions throughout medicine have their in-built risk factors and that is accepted. Many such measures cause other complications. In childbirth technology this is pronounced and exceptional.

An entire realm of clinical procedures has evolved which depends entirely on the perpetuation of these standard interventions and whole technologies have been devised around them. This would seem to have very little to do with the actual experience of giving birth, if birth as an entity independent of technology or at least of its effects can be defined. The notion of 'natural childbirth' is adhered to as an axiom for which there is little evidence. However, it is still possible to refer to a less managed experience for which there are many permutations given the range of technological options available.

The experience for most women will usually fall into this category of the partially managed. Nonetheless, it is the experience that is automatically conjured by the term 'natural childbirth', not the technologised realm of machines and instrumentation, that instils the most fear in the parturient. She often willingly eschews the type of birth for which she is 'naturally' equipped, regarding the non-technological birth as by definition non-assisted, because she has no other model. The barrier between what can be considered assistance or interference; what constitutes natural and normal, and what is to be thought of as managed and produced has become impossibly broken as new norms and paradigms of behaviour, pain, and the desirability of relief and intervention pervade the discourse of childbirth.

2.8. Unphysiologic postures: episiotomy and lithotomy

The Victorian response to the pathologisation of female sexual responsiveness was to hystericize all aspects of women's existence, and to insist upon the passivity of the mother in childbirth, enabling the obstetrician actively to 'perform'.[45] There are similarities with the measures employed to ensure complicity in twentieth century counterparts. As with other interventionist measures, drugs can necessitate the use of oxytocics to speed up a sluggish labour, and in the expulsive stage, episiotomy and forceps are more likely to be used.[46]

The use of perineal incision or episiotomy is often performed in the interests of the foetus if labour has been prolonged. It is often performed if complications have set in as a result of other interventions.[47] Many childbirth techniques have entailed the parturient being supine or lithotomised.[48] This procedure can lead to an adverse effect upon blood pressure, heart and respiration, and the inhibition of contractions and spontaneous delivery, all of which can result in an increased use of episiotomy and forceps (Schwarcz

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45 From the late eighteenth century, the female body has been regarded as saturated with sexuality and the pathologisation of the maternal is an obvious result of this process, as it is in this guise that women are most clearly linked to the social body, and are most fully and easily integrated into medical practices via the regulation of childbirth and child rearing practices (Sheridan, 1980, p.187).

46 The adoption of these measures occurred in about a third of all births in America in the early seventies (Arms, 1975, p.78). See also Mehl et. al., 1979, ch.15; Kitzinger, 1983, pp.66-75; 1984.

47 There is a high prevalence of this technique is in the U.S., where it was performed upon 70% of women during the seventies, compared with only 15% of births in Britain (Arms, 1975, p.82).

48 The preference for the more passive supine position was advocated over the birthing stool or chair hitherto favoured by midwives, by the English physician, John Leake, and in France by Julien Clement (Naroll et. al., 1961, p.953).

et. al., 1979). The use of lithotomy stirrups, more prevalent in larger hospitals, can result in an increased need for episiotomy due to unnatural tension upon the pelvic floor. The final stages of delivery can also be inhibited: "Use of the lithotomy (supine) position has two purposes: it makes maintenance of asepsis easier and it contributes greatly to the convenience of the obstetrician. These advantages more than compensate for the somewhat unphysiologic posture and the discomfort of the position itself." (Bryand, et. al., 1966, pp.532-3).

In Britain, the use of lithotomy is mainly restricted to the provision of restraint for the repair of perineal trauma. This may be as the result of expeditious measures leading to episiotomy or tearing. Although midwives are permitted to perform episiotomies, they do not suture wounds (Inch, 1982, p.138). This leads to a further fragmentation of experience and care for both attendants and parturients, refining the disciplinary potential for all involved.[49]

There are imagistic resonances of the past in aspects of modern hi-tech birthing which have, where employed, served to normalise the technological staging of the final phase of the labour scenario. The uniform 'no-frills' approach of covering the parturient body except for the relevant area, creates a visual and psychological fragmentation of the parturient body by exposing the vagina while physically placing the rest of the supine body

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49 Symbolic binding and freeing were often employed in ancient rituals of passage. Part of this disciplinary matrix involved complex symbols of restraint and release (King, 1983, pp.120-1; Pringle, 1983, p.139) which were not necessarily restrictive or negative. The loosening of hair or garments or the slackening of a girdle donned at puberty, ritually un-knotted for marriage and birth, were positive indications of passage. The girdle, dedicated to Artemis, is negatively associated with strangulation; but its release, with bloodshed and catharsis. Similarly, evidence that a woman's hands might be bound with wool during childbirth is likely to have signified impending release rather than incipient punishment. These are the early indications of a complex intertwining of the images and practices of the 'twin' confinements: childbirth and penal incarceration.

under a clinical sheet, and metaphorically beneath a cloak of sedation. The all-covering sheet of the past was intended to preserve modesty and reputation on both sides, but permitted the outbursts and expressions of labour to be manifest in an interaction between the parturient and her attendants.[50]

In this modern shrouding of the parturient, the minimalisation afforded by the exposure of the most intimate parts of the body, guarantees the concentration of the attendants upon that which ratifies and enhances their status, that is the palpably successful delivery. Ideally, this should take place with maximum cooperation and complicity and yet with the minimum of parturient consultation and interference guaranteed by the previous management of labour, which while ensuring that intervention will be high on the possible agenda, providing a role for expertise, also ensures a certain docility and dependence which sanctions the interventionist response. Here there is a similarity of technique serving a disparity of interests, and producing a similarity of effect insofar as the obstetrician is seen to magically produce issue from a disembodied source reinforcing his professional and celebrity status with peers, associates, tutees and parturients and their families alike.

Although modern hospital midwifery is dominated by women, very few midwives have status as independent practitioners.[51] The process of separation begun with the

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50 In Riolan's *De la Grossesse et accouchement des Femmes* (Paris, 1620), positions for prompt confinement and speedy delivery are discussed. Also, it is urged that the patient's view of the proceedings should be obscured. It is clear that this is a departure from the classical texts such as that of Soranus, that while emphasising the importance of preserving the modesty of the parturient, are in favour of the mutually informative dialogue.

51 Since the Sex Discrimination Act of the mid-seventies in Britain, men have qualified as midwives though this has not gone unopposed. As recently as 1975, it was suggested by the Royal College of Midwives that both husbands and wives might oppose such moves. (Donnison, 1977, p.199) This sounds

prohibition of non-certificated practice is achieved as the contact with the parturient for the vast majority of births takes place only episodically within the hospital, with the separation of ante-, and post-natal care from the birth experience itself, regarded as normal and axiomatic practice (Kitzinger, 1972; Robinson et.al., 1983). Even delivery and aftercare are separated. In some institutions the stages of labour, which cannot always be accurately identified even by the parturient herself, are handled in different venues by different staff - the delineating process of differentiation and categorisation having been taken here also to its conclusion.

The modern genderisation of science would explain the impact of birth technology on childbirth practices. Deriving from the notion of the mythic hero overcoming obstacles and storming strongholds, the growing association of discovery and active research with men, and the passive scientific domain with women. This is typified by the manner in which one scientist describes his pursuit: 'I liked to follow the workings of another mind through these minute teasing investigations to see a relentless observer get hold of Nature and squeeze her until the sweat broke out all over her and her sphincter loosened.' (Fox Keller, 1983, p.20).

This type of violent metaphor is pervasive in the modern discourse of science, just as the association of childbirth with masculinised battle metaphors has been a commonplace since antiquity (Huston, 1986, pp.119ff.). However, while in the past, it was clearly regarded as the site of women's travail; the modern metaphor has come to represent the objects of science as the battlefield of scientific endeavour, and to endow the image with misogynist and triumphalist connotations.

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like a revamping of old ideas - particularly that the sex of the midwife is essential to her function, or the idea that the male midwife might, given the intimacy of his role, take sexual advantage, or be accused of doing so by a jealous husband or that other stereotype; the unbalanced woman.

Masculinised modern science also has a seeming immutability and universality, although methodologies of observation, measurement, prediction and explanation do not hold good for ever. It is necessary, as the Foucauldian project has revealed: "to defamiliarise the phenomena of man, society, and culture, which have been rendered all too transparent by a century of study, interpretation, and conceptual over-determination." (White, 1978, p.256). Modern approaches to history, in privileging the subject and intentionality perpetuate the belief that whatever webs of random interdiscursivity can be traced, above all "there is somewhere a spider which has done the work." (Chiari, 1975, p.185).[52] The development of medicine has been represented as allied to a progressive comprehension of human need, while in reality it has been the point of application for prevailing conceptions as to what 'human' and 'need' constituted.

52 See also Lemaire, 1977, pp.67-75; Henriques et al, 1984.

3. "Withstanding the Cataclysm"[1]: The Organisation of Pain

3.1. The deployment of modern analgesia

The historical interest in the nature of pain, and the development of a problematic concerning its control, have ramifications for women and for childbirth practices, which are not as obvious as might superficially appear. Certainly, the phenomenon of pain in childbirth is characterised by involuntary suffering. However, this is particularly significant in terms of timing rather than inevitability. The privations of childbirth were seen to entail a tacit lack of self control and this fits neatly with preconceptions about what was the proper exercise of self control for men, and the impossibility of womens' attainment of similar goals of restraint.

Childbirth in antiquity was regarded not only a physical danger but potentially a moral one. The paradigmatic milieu is different to that of the Christian Era, and that of the West in the nineteenth century. Just as intimate relations between men are relatively unstigmatised in our early history compared with later eras - childbirth also becomes a problem of morality in a similar manner, and reinforces the subordination of women in novel ways. Pain and suffering are also associated with immaturity and inexperience. A commonplace of the earliest obstetric writings is that women having their first child (and therefore not having yet gained full status as a *gyne*) will suffer most anguish and be least prepared. Those having subsequent children are assured an experience of far less pain and discomfort (Lonie, 1981, 30-11).

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[1] A. Rich, 1984, p.166. Feminist writers have contributed to an apocalyptic vision of childbirth which has created certain parameters for pain, and a language to describe them.

The discourse of pain reflects the negative connotations of lack, imposition, avoidance, futile resistance, malfunction, disease, retribution, humiliation, unintentionality and destruction, and yet it is at the productive heart of the discourse of childbirth interventionism. Pain appears at the crux of notions of cause and effect, and at questions of mind and body disequilibrium. The involuntary pain of labour has been the source of much deliberation and intervention. It is particularly problematised because it does not fit clearly into any of the negative characterisations. The pain of childbirth has had therefore to be rendered in the language of explanation. In Christian terms, as just retribution for the Fall of man from grace, and in terms of medical expediency, it must be pathologised in order to be acknowledged and laid siege.[10]

The relief of pain in childbirth will become a major focus for those involved with its practice. The need for pain relief and the type most effective for the modern childbearing woman has been a cause for debate in the late twentieth century. It has involved the most fundamental issues concerning the rights of women and babies; the nature of childbirth pain itself; and the demands of science and technology. However, the debate has been a long time developing. The search for analgesics in childbirth and the ethical debates which have surrounded pain relief began early in our history with the ointments, unguents and incantations of ritual practice. Later, the childbirth space came to be variously associated with the use and abuse of potions, alcohol and drugs.

The search for relief of pain and suffering in childbirth became a focus of medico-philanthropic concern and police. In ancient times, notions developed which have pervaded the discourse of childbirth pain ever since, and found their most succinct expression in the anaesthesia debates of the nineteenth century. However, the great moments of change in medical practice associated with the nineteenth century discovery of asepsis and anaesthesia had little immediate impact on childbirth practices. This was at least partly because childbirth itself was the focus of attentions other than humanitarian

within which safety, hygiene and pain relief, imperatives elsewhere, were very low priority. The long history of the pharmacological control of childbirth pain began with pre-clinical self-administration. Early Eastern and Oriental sources mention the use of opiates and intoxicants, while from the Middle Ages, alcohol and potions were the usual recourse in Europe (Enkin et. al., 1989, p.219). While pain relief in childbirth from the Christian era came to be associated with the avoidance of a deserved and natural punishment of the female flesh; the alleviation of pain and tedium for the parturient and her attendents came in antiquity to be irrevocably associated with intoxication and the crowd of pleasures to which all mortals were prey, and to which women in their acknowledged trials and weaknesses were particularly prone. Although women of the twentieth century have been the prime recipients of drug therapy[2] - in the history of drug use since antiquity, females have been regarded as the great poisoners.[3]

In relation specifically to childbirth in antiquity, the abuse of alcohol and drugs was linked to prevailing notions about the dangerous and irrational powers of the imagination,

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2 For example, middle-aged women are and have been one of the largest groups taking psychotropic drugs in the latter portion of the twentieth century (Barrett and Roberts, 1978, p.43). The exigencies of biology have also facilitated the creation of the 'inadequate' and infertile middle-aged woman. This may have increased the potential market for these particular drugs.

3 In ancient mythology, dangerous women such as Kalypso and Kirke themselves intoxicate - literally and metaphorically (Dowden, 1989, pp.189-202). The temptress, siren and purveyor of 'malignant' drugs lull men into forgetfulness of themselves and their better judgement. Men were ever aware of their own propensities and of their power to corrupt which could be unleashed by a relaxation of control. The parallels between the lewd drunken half-man, half-beast; the satyr, and the mounted Amazon therefore underline not altogether paradoxically the latter's threat to patriarchy, and the existence of the state and status quo. Women such as Medea, were regarded as sorceresses, and drugs, potions, and poisons were their especial province, with which they threatened and destroyed. Medea's concerns could be regarded as typical regarding family and love; but she strikes monstrously at the very heart of these (Ehrenberg, 1974, p.202; Just, 1989).

precariously balanced with those concerning the efficacy or otherwise of pain relief. Galen acknowledged the usefulness of wine for the relief of pain, however, he also appreciated its mind-altering properties and the need to avoid immoderation (Brock, 1929, pp.233-4).[4] So abstention from alcohol and other substances was not only essential to conception, and pregnancy; these restraints extended also to childbirth practice. Early pharmacology may have used childbirth as a testing ground for relaxants, stimulants, aromatics and painkillers (as the labouring woman might be assumed to be otherwise healthy). Drug use in childbirth, become as the general use of intoxicants by women and reinforced the damaging exaggeration of existing commonplaces, which came to be a central feature of later witch hunts and persecution.

In Platonic thought drinking enhanced emotion, but dissipated memory and rationality; it entailed a reversion to childishness and a loss of self-control; it could reduce a man to his lowest condition. Training via temptation, however, would help men to resist pleasures. The drinking of wine at festivals was for men 'codified' by competitions which measured the maintenance of control (Humphreys, 1983, p.17; Canto, 1986, p.83). Self-mastery is achieved by suppressing extremes of joy and grief. Women are regarded as capable of such extremes, their natural outlet are the practices surrounding birth, death and worship.[5] The containment and curtailment of emotional expression might be considered expedient but

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[4] Such ambiguities are also to be found elsewhere. The worship of Demeter and Dionysus involved ritual respect for what were after all, two dietary staples: grain and the grape. The consumption of wine and food were important aspects of ritual practice in some ecstatic cults. This too fuelled fears about intoxication. For Plato, the 'noblest' victory is the counteraction against self-indulgence and 'the conquest of pleasure'. In this economy it was essential to avoid compulsion and slavery to desire (*Laws*, (trans.1970), book VIII, p.339). The ancient strictures were a test of personal will and strength unlike those of the Christian ethic which tested obedience and subjugated the will.

[5] See Humphreys, 1983; Gardner, 1986; Just, 1989.

eradication would equally jeopardise the status quo - upsetting the delicate balance between the need for objects of censure and for objects of desire.[6]

The ancient preoccupation with dietary regimen and concomitantantly with the consumption of alcohol, was linked to but exceeded that regarding sexual activity. In Galen and elsewhere abstention was fundamental to the pleasure economy and became linked to questions of morality in the Roman Empire.[7] Dietary austerity was also a feature of Christian monasticism and its dictates and paradigms prevailed elsewhere throughout the history of Western Europe. The Aristophanic image of women as potential gluttons and drunkards was a comic exaggeration of real fears concerning both over-indulgence and female excess (Ehrenberg, 1951, p.202). This sort of entertaining calumny had universal cultural resonance, even when the fears and prejudices on which it was predicated had

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[6] When public law however, did come to prevent women participating in dubious rites, worshipful or funerary, it was as an acknowledgement of women's potential power, and of the fear of civil disorder, if they were left freely to express irrational and ecstatic disturbance. The physical trembling associated with emotional or Dionysiac tendencies was also connected to desire and coitus, in turn linked with epilepsy and insanity. The effects of madness and delirium were associated with both orgasm and childbirth (Lefkowitz and Fant, 1982, pp.166, 198).

[7] In Rome, abstemiousness for women was very important and punishment for intemperance was severe (Pomeroy, 1975, p.35). A man could with impunity divorce his wife for such abuses, or for the "...use of drugs or magic on account of children". Husbands also incurred penalties as the safety and purity of reproduction was regarded as paramount. Conception was also thought to be favourably affected by temperate behaviour as it required physical and temporal balance: "In order that the offspring may not be rendered mis-shapen, women must be sober during coitus because in coitus the soul becomes the victim of strange fantasies; this furthermore, because the offspring bears some resemblance to the mother as well not only in body but in soul". Similar post-natal strictures were applied. The wet nurse also must be modest and temperate in demeanour and appetite, for she was to introduce balance into the life of the infant. Virtue was believed to be imbibed at the breast, hence cleanliness, abstemiousness and sobriety were particularly emphasised (Soranus *Gynaecology* I, 19-20, 60-4, in Lefkowitz and Fant, 1982, pp.165-6, 173, 221).

outwardly been by and large rejected. The image of Dionysian enslavement continued to have the effect of all stereotypes. Sexual and social segregation further contributed to these attitudes; the proceedings of the religious festivals predominantly attended by women drew particular interest and derision.[8]

The notion of 'beneficial' pain, in terms of the testing of one's endurance, rather than in terms of aiding labour, may have prefigured Genesis, though both pain and its relief are usually negatively regarded in terms of the loss of control. Intoxicants were considered inappropriate as analgesia in childbirth. The methods of self-prophylaxis advocated by modern childbirth practitioners such as Leboyer and Lamaze, are not entirely without precedent. Soranus believed that the relief of pain could be achieved by relaxation and distraction (*Gynaecology* I, 47-56). Soranus also claimed that there was a practical need for the sobriety of midwives where errors of judgement might prove fatal: "She will be well disciplined and always sober, since it is uncertain when she will be summoned to those in danger" (*Gynaecology* I, in Lefkowitz and Fant, 1982, p.163). There was also the fear that she would administer intoxicants or prohibited abortives and thus abrogate the power conferred gratuitously by segregation. However, midwives were punished primarily for administering drugs rather than for causing abortions (Gardner, 1986, p.159).

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[8] Women are often fictitiously depicted as irrational slaves of their sexual desires and appetites in three Aristophanic comedies: *Lysistrata*, *Thesmophoriazusai*, and the *Ekklesiazusai*. Their major comic vice is Bacchic dipsomania. In *Lysistrata* women's predominant concerns are wine and sex, and the sacred Thesmophoria is portrayed in the eponymous play as an excuse for alcoholic excess. In *Ekklesiazusai* a woman in disguise supposedly reveals herself by drinking too much and by not observing male protocol (Just, 1989, pp.162-7). These images reinforce notions of irrationality, animality, lack of will and self-control, disorderliness and over-emotionality, which confirmed women's 'slave' mentality and their subordinate place within political, social and domestic structures. Above all they testify to her immoderation. While the strictures of Genesis had not yet permeated attitudes towards childbirth pain, doubts about the moral strength of women determined taboos concerning its relief. The very body of the gravida, swollen and overripe, was a potent symbol of involuntary activity, of passive and parasitic excess.

Aristotle praises endurance and continency, deploring all unbridled pursuits. Not only pleasure, but pain also can deflect the individual from good. Pleasure, like health, if pursued properly, is in itself good, and it stands in opposition to pain which incapacitates and is "...an impediment to activity" (*Ethics*, VII, viii, (trans. 1953)). So childbirth pain could be regarded as instrumental to women's believed incapacity and prescribed passivity. This passivity is encouraged in the developing master/doctor and patient relationship if only at first indirectly in childbirth. Some medical reliefs suggest and depict the possibility not only of arrangements of tutelage, but of related medico-erotic themes.[9]

It appears that women may be more likely to be encouraged to accept pain relief during the late twentieth century. a period of ostensible 'moral relaxation', when standards of morality are in fact especially interrogated and problematised. This coincides with , a period of maximum institutionalisation and medical technological control. Contemporary dissent in this area is largely of an ascetic nature, increasingly identified in a pseudo-classical manner as part of a lifestyle. The medical aim appears to be to astigmatise pain relief in childbirth (for it is not an issue elsewhere). Dissenters emphasise individual choice and achievement, aestheticism and moral superiority. However, these notions, both medical and lay, both pro- and anti-technological childbirth, revolve around the strictures of Genesis. The nature and pathology of pain itself has become inextricably linked with the experience of childbirth. Even in antiquity, where, for example, masculine pain suffered from battle-inflicted wounds is compared to that of parturition.[10] Historically,

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[9] One example found on an Etruscan vase at Ostia unusually depicts a gynaecological examination carried out by a male physician (Scarborough, 1969, pl.9).

[10] The battle metaphor, employed since antiquity in relation to childbirth (though in this iconography referring positively to the 'mother/warrior'), has persisted in corrupted form, into our own century when, for example, Frederick.C.Irving (1942) can endorse the modern obstetric forceps thus: "nothing else in the obstetricians armamentarium can compare with it in value." (Cutter and Viets, 1964, p.192).

pain is variously regarded and described as heroic, cathartic, evil, saintly, as evidence of forbearance, of justice or retribution. It is evidence of divine or kingly control over the body, or of individual, state or collective control. As punishment, it is regarded as dark, mystical, purifying. It is to be embraced or avoided, balanced and calculated. Attitudes towards pain, as towards pleasure, have attendant prescriptive ideologies, culturally and discursively determined - their effect on women and childbirth evident and complex.

Whatever the strictures of the prevailing discourse, it is evident that from the earliest times pain relief had been sought in childbirth via the use of herbal potions and alcohol. Opium-soaked sponges were still used in the nineteenth century, and a variety of methods including bleeding, and mesmerism had been largely ineffectually or unsuitably employed. The debate surrounding inhalation analgesia included the expression of uncertainties about the possible physiological efficacy of physical pain (Youngson, 1979, p.27). While these doubts were partly the result of religiously inspired prejudices, they have persisted into the natural childbirth debates of the latter half of the twentieth century where the notion of pain as instrument of power and self-possession has thrived. In this regard it is clear that both pagan and Christian prerequisites for the creation of the healthful self and soul are co-mingled and adapted for modern exigencies.

Marian theology reinforced women's obedience, silence and humility as positive advantages; depicting a perfect, chaste, remote, Christ-like figure promoting an impossible ideal of female perfection. The Virgin held out the prospect of salvation via chastity and childbirth, which satisfied on a spiritual level. She exemplified an ideal of maternal intimacy and nurture; and provided an icon of the possibility of a shared but untainted flesh believed to be envisioned by God. The Virgin birth was miraculous because both contraventions of the human body: intercourse and parturition, necessary to existence, but

representing the disruption of divine intention, are sublimated and redefined. Fantasies of perfectibility include the notion of a masculinised painless generation, an inviolate chastity and unstained motherhood: "A virgin not sterile, but fertile, married to a man, but made fruitful by God; bearing a son, but knowing not a man; forever inviolate, yet not deprived of progeny. A virgin pregnant but incorrupt, and intact even in childbirth. A virgin before marriage and in marriage, a pregnant virgin, a virgin giving suck, a perpetual virgin. A virgin without concupscence concerning the saviour. A virgin bearing a child in the womb without hardship, giving birth to God without pain." (St.Peter *Canisius De Maria Virgine incomparabile* 1577, 11.1, in Maclean, 1980, p.24) This obsessive litany suggests the impact of theological prejudice on the discourse of pain - which fluctuated from the belief that women were destined by divine decree to suffer, to the desire to masculinise and perfect generation by alleviating such pains. The first option denotes a God-fearing society, and the second a scientifically advanced and Godless culture. The roots of both extremes exploit similar paradigms concerning women, and both entail submission to authority and the externalised interpretation of pain. The scientific ethic is interrogated on the basis of its response to childbirth pain. The problematisation of pain is always one of contradiction and paradox: for example, whereas women are normally thought of as longsuffering, and able naturally to endure pain, even this is only relative to the capacity of the male.[11]

There is no traumatic and ultimate transition for Mary - an idea which is also reflected in Eastern religious iconography. She has an abstract and ersatz experience of sexuality, parturition, and bereavement. This, for women in the West, remains an impermeable ideal which all the seemingly neutralising and normalising forces of psychiatry, counselling, and

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[11] For example, it was believed that when both a man and a woman are subjected to judicial torture, it is the woman who must be tortured first and questioned, in the belief that she will confess sooner, "because she has a weak and unstable constitution." (Maclean, 1980, p.78).

natural childbirth classes, can serve only to provoke, promote and perpetuate. Mary's challenge to the earthly certainties of decay brings its ultimate reward, but mute suffering is her abiding image. Her maternal labour is not shameful or agonising, (though her pregnancy and childbirth travails are symbolised by the romanticised image of weary journeying and in the conditions in which she is finally delivered) rather it is a transforming experience outside the agency of the subject, in the manner of the Annunciation and the Assumption. Eve may be the first mother, but she contrasts with Mary, not only because she errs, but because she is linked to God in a relation of subjugation rather than submission.[12] Both are associated with the defiance of time and death; Eve, by the birth

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[12] In her work on Medieval drama, (1989, pp.122ff.) Newlyn points out the tension between the images of Eve and Mary, the first as vocal and active, the second as silent and passive, this stereotypical dichotomy personified in the figures of, for example, the figures of the matchmaker and the maiden. The former, a dangerous but necessary supplement to the functioning of the family, advises on obtaining, then manipulating a husband. This relates to domination and deception themes, but it is also indicative that women are capable of wit, wisdom, and strategies of survival. The Eve/Mary dual image is reconciled/synthesised to a certain extent in the Virgin, in her role as recipient of prayers from women who as virgins beseech her that they be delivered from evil, and as wives, to be delivered safely of their children. The figures of Eve and Mary are also 'twinned' in that despite their seemingly diametrical opposition, they are both depicted biblically and popularly, in their different ways, as at odds with the serpent. The extremes of reified Marianism; venerated virgin and mother, the noble and aristocratic object of courtly desire, and of the Eve of Genesis and Pauline doctrine; the weak tempted temptress and corrupter of men, provide the Christianised version of the Janus-faced image of ancient fable. The ingeniously deceptive and exploitative creatures who peopled the mythologies, alternating between vindictiveness and victim, between sorceress and grandmother, are again developed in the Chaucerian shrew. These images provide the axes upon which paradigms concerning women and their biology were predicated and reflexively expressed, and which fuelled the witch persecution in Europe until the middle of the seventeenth century. These populist images of Mary seem far from the ascetic ideal, but are in combination, close to the ambivalent figure of the wise-woman, the older trusted relative, guardian and advisor, who, prized at community level among those who suffered without aid or redress, was also culturally and officially reviled. In her intercessions to her son on behalf on those in need, she seemed to exemplify the ancient role of mediator and go-between.

of sons, and Mary, through the loss of a son. The Assumption is an immortal 'passing over' which constitutes a denial of both birth and death.

It is in Christian mythology, that the earth becomes associated with a nether region signifying primarily death. It is the underside of a heaven desired as the goal and destination of existence; part of a spiritual ambition not available in Classical iconography.[13] The spiritual journeys and pilgrimages common to both cultures, are extended into death in Christianity. The examination of conscience, very much an earthbound phenomenon in the Classical search for a perfectible selfhood, is extended even into death with the later Medieval notion of purgatory, reflecting the increased examinatorial preoccupations of the period (Hoskin, 1992). It is in Christian imagery that the creatures of the elements become symbols of lechery, and part of an erotic bestiary. As Persephone inhabits the underworld as an integrated and alternating aspect of fertile life in which she may also breathe the air; Mary lives on earth in an ephemeral and unfettered way, in anticipation of the next world in which she will be reunited with her son, while Demeter, earthbound, awaits her daughter.

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[13] The ancient Eleusinian pilgrimage and other essentially female mysteries, come in Christianity to be masculinised and universalised by the journeys and privations of Jesus. The cult of the Virgin also developed in response to the demands of changing paradigms, supplying an essential sympathetic iconography embracing submission, chastity, motherhood, supplication, suffering, and the promise of eternity. There are continuities in the notion of sorrows and deliverance, darkness and rebirth, which permeate both eras. In the Demetrian myth, Persephone, snake-like, becomes a creature of the elements of earth and air, just as Mary, as an expression ultimately of her ethereal spirituality, gives birth on earth as virgin, in lowly conditions which emphasise her humanity and accessibility. Persephone reconciles her lost chastity and freedom (returned to her in the arcadian air where she may be reunited with her mother and her female friends) with her desiring and fecund nature, which must inhabit the world of darkness, but only as a period of yielding and gestation in order that the earth may again erupt into fertility. Such stories expressed the exigencies of pagan life, and to a certain extent, and with a knowing fatality, promoted and celebrated their acceptance.

In Christian iconography, the woman and the serpent are reconciled. Eve and Mary epitomise the two sides of the perceived relationship of women and evil. For Eve, her encounter with the serpent is believed to determine her future role as a sexual being, which will be one of striving, strife, and humiliation. This provides the justification for her subsequent role in marriage and society, for her treatment in medical, ethical and theological debates, and for her sexual and social status. The graphic serpentine replacement of a woman's lower half in the grotesques of Christian iconography suggests the permanent impact of the encounter of Eden upon her sexual being. It also symbolises man's fear of her fabled chameleon-like qualities and her threatened metamorphosis, reinforced by the realities of female desire, (in conflict with ideal images of chastity), pregnancy, and childbirth. The half-woman/half-serpent also incorporates another, seemingly disparate image; that of the Virgin crushing the head of the serpent beneath her heel. Unlike Eve, she has not only overcome the devil by the force of her purity, but also by the superior power of her intellect.[14]

As the discourse of the subject develops into its more recent forms, the idea that pain is cathartic and reformative persists in the notion of birth as transformation as it is refined in Freudian analysis; a scientific example of the legacy of confessorial practices. By positing

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[14] The devil is always described as a clever, even worthy opponent, usually in a masculine incarnation. The defeat of the serpent is a triumph of the Virgin on the behalf of women, and the intermingled image of woman and snake, symbolises more than the conflicts and dangers of heterosexuality, more, paradoxically, than some sort of Pauline hermaphroditic ideal. It is the perfect Marian image also, because it transposes that part of her physical being which has been deconstructed by the simultaneity of virginity and parturition, with the symbol of her triumph over her own body, in birth and in death, and over the sins of the world: which is provided by the effectively decapitated serpent. The image of the snake, in the context of antiquity, has a positivity which typifies sexual symbolism of the time. Sexuality is regarded as something to be engaged with and controlled as evidence of ones self-containment. However, this also heralds the later deployment of the image of woman as that of one who inhabits an underworld.

a sexual instinct, Freud opened up the possibilities for the scientific domination of sexuality, which has gone on to pervade all areas of the medical discourse (Hutton, 1988, 121-144). The psychoanalytical inquisition of intentionality interprets childbirth transformation as a sublimation of penis envy or anal compulsion. Such images and analyses create and dominate both male and female fantasies of childbirth. They are respectively set against conception as the result of desire, and yet reaffirm the primacy of the Father.

It is evident also that despite fundamental disparities, both Classical and Christian doctrine mark out a masculine Godhead as originator; Zeus as 'father' of all men and God the Father. However, what later constitutes the West's near-obsessiveness with origins and creation are not dwelt upon in Christian teachings beyond the details of the Book of Genesis.[15] Philosophy and theology of the Medieval period sought unifying principles:

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[15] It is tempting to identify in the powers of the mythic Zeus, a parallel with Christian theology where God the father is regarded as the originator of all, choosing the Virgin Mary to give humanity to his son, who is later reborn via the Father. There are indeed similarities here, but there is less compulsion in Christian monotheism to account for unorthodox creation which is a matter of dogma within acceptable paradigmatic susceptibilities of the era. Pertinent here, is the detail of the story of the birth of Erichthonius. He was the earthborn result when Athena avoids rape by Hephaestus (Euripides *Medea*, 825, and Aeschylus *Eumenides*, 869), and he exists under her patronage. Therefore Athena is the intended 'parent' though her virginity (and 'masculine' integrity) remains intact. The analogy with the Marian myth of 'desexualised' childbirth is compelling, but the symbolism here is unusually complex. Athena is both disqualified and reified insofar as she is not herself entrusted with the task of birth because she is female (her role is diffused in the generalised and passive metaphor of the earth), yet as a revered goddess she retains her masculine attributes untainted by the physical violation of rape, and remains also untouched by the physical act of childbirth (a claim only rarely and briefly considered in Mariology (Warner, 1978). The image of motherhood does not suffer by this omission however, when it is remembered that Athena assumes motherhood through guardianship. While these considerations are intriguing, it is also perhaps important to bear in mind that almost all goddesses are in fact mothers, and it is the mother who is the crucial mythological figure, reinforcing the ideals of family and continuity.

the single godhead, monoculture, the unity of the perfect asexual being. The distinction of the sexes, as other differentiations, reinforced both dualistic process and synthesising unitary goals. Childbirth symbolically reinforced these seemingly diverse principles, born of each other, paradoxically by providing the challenge of the two in one, the violence of schism, the 'nightmare' from which men retreated, the antagonism of signs employed to ensure and ratify the goal of truth and unity. Anxieties about origins are fully discursified much later in the nineteenth-century polemic surrounding evolutionism, and its effects continue to be evident in present-day ideologies and historiography (Boardman et al, 1986). The Virgin as a symbol of untroubled obedience and harmony stood in opposition to the image presented by the twin poles of death and birth which wrought so profound an effect upon attitudes towards, and upon the practices of childbirth, as Brown (1990, p.416) describes; in a potent if historically questionable image which unmistakeably conjures obstetrical forceps: "...sexuality and the grave stood one at each end of the life of every human being. Like two iron clamps, they delineated inexorably mankind's loss of the primal harmony of body and soul."

Julia Kristeva (1986, pp.99ff.), following the Freudian example, regards childbirth as the freeing of woman from her uniqueness, and as an event which gives her access to the 'other'. Perhaps this is the modern reconstitution of a form of perfect union on the Christian model; it is characteristically predicated on lack, separation and loss. She questions, however, as a fundamental perversity, the historical silence concerning women's mental and physical suffering, self-denial, voluntary anonimity, and obliteration, in childbirth, which (both perversity and parturition) should be regarded as the basis of all social life, of a reproductive society, and of a normative household. Kristeva also stresses the transforming element of childbirth, calling the peculiarities of the maternal body "a catastrophe of being", a heterogeneity which "explodes with pregnancy - the dividing line between nature and culture" (Kristeva, 1986, p.115). This apocalyptic imagery of childbirth, common to feminist analyses, is nonetheless a feature of writing within a

phallocentric discourse. It is arguable that parturial relations with their complex conjunction of subjugation, subjectivism, transformation, inevitability and accountability, is encoded into the interplay of all aspects of society; social, educational, political, legal, economic, and has, in the process, developed as a normative condition the exposure and manipulation of women.

The qualities of submission and passivity, though present in the self-creating philosophies of antiquity, become codified in the self-denying tenets of the Christian era.[16] The deepest refinement is the subtle inculcation of these strategies via learning and the way in which we learn to learn. The importance of an interpretative filter developed out of the preoccupation with intentionality and self-examination which arose in the later stages of medieval Christianity, and which were echoed and embodied in the educational paradigms that were developing in the universities. What did become valourised, and what would eventually become an invading paradigm of practice, was the development of techniques which ascribe particular value to the measuring and tabulation of events and phenomena, whether physical or emotional - to subject all experience to a grid of reference, and later to

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[16] Pedagogy also begins to emphasise the similarly productive opposites of silence, of listening and of exposing oneself to the expertise of others. These aspects were in fact, the natural concomitant of the questioning, rhetorical and confessorial aspects of dialogue. Both served interdependently the interrogatory, disciplinary mode. The ground was prepared during the imperial period, when truth-seeking and endurance was also connected via Stoicism and Pythagoreanism, to the paradigms of silence and listening. Silent reading and reflection also are recommended by Plutarch . Complementary to the Platonic rendering of oneself through contemplation and dialogue, the rigidity of the dialectical structure starts to dissipate in the imperial period (Ong, 1967). Hence, listening and looking for the truth of one's existence from within oneself develops during the early Christian period, and only crystallises into a growing dependency on outside authorities when, paradoxically, the discourse upon the subject and the interior life intensifies into the polemic on intentionality. This debate features later in Christian thought, and is centred on puritanical ethics, which combined with the new and instrumental pedagogic practices emanating from the universities from the twelfth century.

have a suitable acronym for every experience, and an appropriate mnemonic for every problem. Indeed a problematic response to each experience. And this included the experience of pain.

The implications of this for the childbearing woman would continue to have an impact into our own century, reflected in many of the changes in attitudes towards medical and professional authority over more than two hundred years, and with regard to the moral dilemmas surrounding pain relief during this period. Anxieties and imperatives regarding the latter are particularly highlighted in the Victorian period when notions of expertise and authority become increasingingly strictly encoded and when the technologies of asepsis, analgesia, and anaesthesia are rapidly developing. Simultaneously, the demands of morality engender both rigidities of behavioural norms and a concomitant discursive explosion which is predicated on the deviance and irregularity created by normative categorisation itself, rather than simple conformity or non-conformity to its designs.

The experience of certain of these exigencies was obviously common also to men, and yet their subjective and objective position continued to be differently constituted. The historical condition of women, and of their biological life runs an interlinking parallel to ethical and scientific developments, so that their experience vis-a-vis the latter is differently circumscribed. Hence, for example, in the first case, their sexual and social behaviour is considered as a direct counterpoint to mens; casting them in the subordinate roles of wife, mother, patient, invalid, and whore. Varying expectations according to class and status are still within the parameters of prevailing discursive paradigms. In the second related case, one potent example of the relative remoteness of female experience, was the development of gender-specific codes in the nineteenth century, by which their perceived worthiness was adjudged, both medically and morally, for the receipt of pain relief in childbirth. Such judgements had also to be made in relation to surgery, but these questions inhabit an entirely different frame of reference.

The willing submission to authority permeates much of this and related discourses. In the nineteenth century, when obstetric pain relief came to be acceptable and not regarded simply as an abrogation of divine intention, it formed part of a more general trend towards the paradigms of benevolence, and can be seen as part of a 'reward' culture which demanded evidence of need, greater co-operation and obedience. This culture emphasised an ever-narrowing conformity while broadening the parameters of diversity, deviancy, and dissent, and the problematic associated with them. The administration of the new analgesia was the province of the doctor, and brought the parturient (in her need) under the supervision of the doctor in a relationship of tutelage, and within the auspices of the institution.

The developing discourse of professionalisation, expertise and control are of abiding significance for women, for it is this and the refinements of an increasingly logocentric discourse which historically endorses phallocracy, rather than solely the predominance of men as professionals. Though of course this is no mere coincidence. Even so, it is of at least equal importance to consider the matrix upon which, in the discourse of medicine, these developments are predicated, and how they are reflected in the dual operation of the determination of objects, and the constitution of the subject. It is clear that these developments are not inspired by the will to power of any specific group, or conspiracy of different interests and ideologies, or the cultural urge to either repress or improve. The model is rather a productive than a coercive one, arising from, and giving rise to a network of effects, technologies, practices and paradigms.

Before 1800, and until intrusive interventionism in childbirth was normalised, the use of such analgesic alternatives as were available was largely the province of the midwife, and subject to the usual suspicions regarding the lack of scientific sophistication and control. Pain relief in childbirth, based on herbs, balsams, and spirits, had come increasingly to be

regarded as practice arising from illegitimate knowledge and unacceptable power. After 1800, gradual technological and scientific change, and the accent upon medical paradigms which both incorporate and replace theological demands increasingly replicate, and are indeed constituted by, the pedagogic example of hierarchical tutelage, monitoring and accountibility. The body is subservient to ideals of health, endlessly interrogated as to the body's integrity in relation to prevailing tenets. The emphasis remains upon self-questioning and individual responsibility (in order to submit oneself to the appropriate authority).

The history of childbirth reform since the nineteenth century clearly has its roots in the self-creating practices of antiquity with their emphasis upon moderation and self-control, and also in the confessorial and revelatory practices of Christianity. The doctrine of self-denial and abnegation in the Christian ethic, could not have existed without the ancient pursuit of the perfected self. Similarly, the cult of the individual from which arose the theoretical privileging of the subject, came from the paradigmatic conditions of possibility created by the mortificatory discourse of Christianity. The balance between concern for the individual and concern for the species appears also to have been disrupted by the discursive shifts which characterised the era of Benthamism and of Darwinism. Here the preoccupation with species involved the minute regulation of the individual, and the development of complementary subjectivising and homogenising techniques.

Childbirth reformers have variously reverted to these self-creating exigencies, which also relate to the modern paradigm which regards successful parturition as that which conforms to criteria of safety and perfectibility; and to the necessities of the experience of childbirth pain as a 'natural' concomitant of the curse of Genesis. These reforms are also a refinement of educational techniques elaborated since the Middle Ages, which have permeated and directed academic and medical discourse. The routinisation of the body, the inculcation of good habits and the heightening of sensitivities to guilt rather than to

pain were features common to both the institution of the prison and the maternity ward. The advent of Benthamism marked a break with the old regime which had administered punishment arbitrarily because the emotion of the inflicter could not be measured or accounted for properly (O'Brien, 1978; Fraser, 1982). In childbirth, the increased use of asepsis made outcomes less arbitrary, and the acceptance of childbirth anaesthesia made the process more predictable by dulling the responses of the parturient.

Strategies such as these problematised the uncertainties of pain; and normalised the processes that would promote its alleviation and efficacy. In the debate about the psychological and physiological efficacy of childbirth pain, and the acceptability or otherwise of childbirth anaesthesia, the scientific exigencies of experimentation and advance would prevail. However, of paramount importance was the nature of the debate itself. The opposing sides were expressing two perspectives on the same discourse, and the result was the preservation of rhetorical and pedagogic traditions and the deepening establishment of professional paradigms and credentials. While it was evident that pain might serve as a chastening agent which in the case of the parturient fulfilled Christian edict and strengthened moral fibre, the very arbitrariness of pain offended regulatory principles. Further, the alleviation of childbirth pain would place the parturient, an historically powerful figure in the family, in the hands, debt and supervision of the doctor. If properly administered to, she would be restored to the sweetness and passivity which was expected of her. Conversely if the worst fears about her possible dissolution under the influence of anaesthesia were realised, then her latent sexuality was exposed, thus providing a satisfying justification not only of age-old prejudices, but also the future pathologisation of women's sex, making it both problematic and manageable.

The problematisation of childbirth pain emphasised docility and dysfunction. Not only complicated by the historical infiltration of ancient and Christian beliefs and taboos regarding what was considered the essential nature of women, the debates surrounding the

use of forceps, the transmission of puerperal fever, and the use of asepsis and anaesthesia were also deeply infiltrated by the problematisation of pain. The caution displayed everywhere about the anaesthetisation of the parturient in childbirth was one effect. However, this issue was also affected by other areas of contention. For example, the use of anaesthesia for the relief of pain might be thought to work to the advantage of the obstetrician insofar as it rendered the parturient docile, and contributed to the ideal of perfect painfree childbirth and babies produced as if by magic. However, as arguments concerning the evidence that puerperal fever was the result of increased interventionism gained sway, it was a natural concomitant that obstetricians should be wary of a procedure which would facilitate a further increase in the potential for instrumental intervention. So there was some evidence of male resistance to technologisation, as it could be seen to retard the process of professionalisation which required certain outcomes to ensure trust, respect and elite status.

Both the self-styled nineteenth-century saviours of the parturient woman and the latter-day 'alternative' practitioners have devised modes of normalising heroic roles for themselves and in the latter case, for the male partner, enhancing the dependence of the woman on both. In 1815, Walter Channing (1786-1876), professor of midwifery in the medical department of Harvard College, used ether in childbirth, but it was not until 1848 that he published *A Treatise on Etherisation in childbirth: Illustrated by 581 cases.* Whether this was an unusual medical, moral or altruistic matter of caution or simply self-aggrandisement, or a combination of these factors is uncertain, but the multiple reasons for delay in bringing universal relief to the parturient woman were amply provided in the issues surrounding the open introduction of the obstetric forceps.

As part of the armoury of interventionist equipment, the obstetric forceps functioned as a magic wand. The many obfuscations surrounding the introduction of forceps demonstrate the prevailing exigencies of establishing professional reputation. The early obstetric

celebrities appear to have prolonged the birth experience by their pre- and post-natal prescriptions, and hence their own mystificatory role. They spun out the *post-partum* period with exhortations to isolate the mother, to use poultices, and to undertake prophylactic and 'purificatory' rituals. By so doing they enhanced their stature among those who could be impressed by the seeming magic of those who could intervene in childbirth labour, even by painful methods. The same motives permeated later attempts, facilitated by new technologies, to reduce the timespan of potential dangers. Though this was often a false hope, and one which might even be frustrated by such interventions in themselves.

There was certainly evidence of professional and economic chicanery on the part of the three generations of the Chamberlen family who devised the protopype of the later popular version of the instrument.[17] However, the length of time that the implementation of this

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17 The story of the introduction of the obstetrical forceps into childbirth practice, and of the Chamberlen family who were accredited both with their invention and the delay in their general availability demonstrates the earnestness with which professional rivalry and the desire to establish medical legitimacy was pursued. The Chamberlen family, who were implicated in the development of the two-blade forceps, originated in France and became prominent from 1560. They had an important role in seventeenth century midwifery. Like the barber-surgeons they often found themselves at odds with the College of Physicians. Peter Chamberlen the Younger campaigned for the establishment of a corporation of midwives with himself at its head. Chamberlen was, however, opposed by midwives whose work contrasted with his:

"for he deliv's none without the use of instruments by extraordinary violence in desperate occasions, wch women never practised nor designed for they have neither parts nor hands for that art." (J.H.Aveling, *The Chamberlens and the Midwifery Forceps*, London, 1882).

Far from acknowledging a superior skill in their would-be mentor, these women demonstrate pride in their midwifery and their resistance to overt male-initiated change. These were not ignorant rural women come to midwifery by default, but literate and ambitious women, ready to professionalise in parallel with their male counterparts. With the right physician they would be ready to collude. Chamberlen retaliated with the hyperbolic *A Voice in Rhama, or, the Crie of Women and Children* (1647), against the ignorance of midwives, "uncontroled femal-Arbiters of Life and Death", in general, and a war of words most vociferously perpetrated by Chamberlen and his influential contemporary, Percival Willughby, was

technology took, indicates rather more than the intentions of one man or even three. Other versions of this instrument had been used all over Europe, and similar medical tools had been available since ancient times (Lefkovitz and Fant, 1982). It is unlikely that during the long intervening years between invention and implementation that obstetricians were unaware of the potential of these tools. Despite the secrecy surrounding the introduction of the Chamberlens' obstetric forceps, similar inventions, were known and used before the mid-eighteenth century.[18] They were documented as having been used

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initiated. After Peter Chamberlen's death in 1683, his son, Hugh Chamberlen the Elder, b.1630, also clashed with the College of physicians. He also continued to use obstetrical forceps, and to perpetuate the secretive and commercial machinations which surrounding their deployment. In the Netherlands, a version possessed by a Dutchman, von Roonhuyse, an acquaintance of Hugh Chamberlen, was made available to a limited circle of obstetricians. Promising to lead the reader through the labyrinth of procreation and childbirth, and to "unlock the most abstuce Cabinet of nature", Paul Chamberlen (1635-1717) wrote justifying the use of instruments by the male physician who fulfilled his role in "this Mysterious Office" in the interests of dispelling the ignorance, deficiencies and imperfections of female practitioners who were anatomically unskilled. Hugh Chamberlen Senior wrote in the translator's preface to Mauriceau's second edition of *Traite des Maladies des Femmes* (1672), apologising for not having published "the Secret...we have to extract Children without Hooks" but that the use of the instruments were the prerogative of other extant members of his family. Forceps were used however, in their different versions between 1600 and 1725, especially in the Netherlands and France. The Anatomist, Jean Palfyn (1650-1730), had a similar invention which he revealed in 1720, and the forceps of Drinkwater, Giffard, Chapman, Pugh, and Dusee, were all in use before the mid-eighteenth century (Cutter and Viets, 1964, pp.48, 50, 55-9). The dilemmas surrounding the introduction of the obstetric forceps in terms of the lapse between invention and implementation, had historical antecedents and later repercussions, and were significant with regard to the facilitation of other interventionist strategies.

18 Before forceps, many other similar instruments were used. There was, for example, in Jacob Rueff's (1500-1558) midwifery manual, (1554), the depiction of four similar instruments, a vaginal speculum, and dilator, a duckbill pincer (with teeth), and a locked pincer with cupped ends like a forceps, which was probably used for stones. Such instruments were 'weapons' in the male physician's professional armoury. Paradoxically, it was their traditional and often self-imposed exclusion from the vicinity of the childbed, that from the earliest manifestations of axiomatic role division by gender which would inform the later professionalising discourse, that cast them as overseers, tutors, prophets and predictors. These are roles

successfully, particularly in cases of dystocic exhaustion (Johnstone, 1957). The fact that delivery was usually 'concealed' means that it is likely that versions of the obstetric forceps were probably used with more frequency than anyone was prepared to testify to. Particularly as the results of their inclement use may have resulted in more harm than good. Experienced practitioners were well aware of the glamour attached to the 'magic' of instrumentation, and how such inventions could be an effective part of the professional armoury of those aspiring to expert status. Obstetric opinion was not uniform, and ranged from de la Motte, who questioned entirely the use of instrumentation; to Jean Astruc (1684-1766), who, in *The Art of Midwifery Reduced to Principles* (1767), suggests that all obstetricians should avail themselves of the use of forceps, because of the more terrifying instruments they replaced and because he considered them to be "the last step to perfection of the art of midwifery" (Cutter and Viets, 1964, p.87).

The first public demonstration of etherisation in childbirth took place in 1846, and therafter its cautious use was stimulated and advocated elsewhere (Cutter and Viets, 1964, pp.167-70). James Simpson, Professor of midwifery in the medical faculty at Edinburgh from 1846, administered inhalation analgesia frequently in cases of difficult birth. Improvements on the complicated use of ether were sought. Simpson and his colleagues inhaled various substances themselves, including the more manageable chloroform. The arguments devolved upon the moral and religious exigencies perceived to be attendant upon the question of anaesthesia in childbirth, went to and fro, recorded in the pages of the *Lancet* of the middle years of the nineteenth century.[19] At this time, the expression of sexual

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that modern technology (beginning with the development of the obstetric forceps) would eventually be developed to facilitate and ratify.

[19] In 1848, Simpson expressed his views on the religious and ethical debates surrounding anaesthesia in an 1848 pamphlet, *Answer to the Religious Objection Advanced against the employment of Anaesthetic Agents in Midwifery and Surgery*. He felt that the medical objections were based on an obsolete mentality: the religious sensibilities of 'antiquated' and spiteful older women, who regarded as literal the travails

emotion in women was considered close to mania, and was therefore, in the prevailing medical discourse, pathologised as such (Nead, 1988). Simpson observed (1847a, p.12) that the pain and impatience of the parturient manifested itself: "with loud crying and wailing, and frequently expressions which, even with sensible, highly principled women, border close upon insanity." The chloroforming of women could, it was feared, produce such a result. However, it could also have the reverse effect if properly administered. It could quell the inherent emotionality of the childbirth experience; muting it, making of it just another medical and manageable event.

Childbirth pain revealed the parturient as an object of science; its perceived effects came to constitute the essence of her subjectivisation (Barker-Benfield, 1976; Weeks, 1981). It is clear that the pain of childbirth labour entered the realms of expert alleviation via a model of affliction. Though equally the notion of purposive pain had served the argument of experts who opposed its artificial circumvention, and similar arguments which continued in the twentieth century to fuel the natural childbirth debate. Charles Meigs, writing in the 1850's, objected to all interference, including the use of asepsis; and more particularly, anaesthesia, on the grounds that it was unnatural and encouraged inebriation. He believed such moves might also damage the interrogatory relationship between doctor and parturient, which aided diagnosis (Youngson, 1979, pp.106-9). Meigs was an experienced obstetrician whose conservative mistrust of chloroform is not unlike the doubts raised by non-interventionists of the late twentieth century, who also believe that communication is the key to the combat of fear, advocating, in the more modern idiom; care and counselling,

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promised in Genesis. He was himself not beyond a similar rhetoric, avowing that it is the task of the obstetrician to alleviate the effects of the 'curse' of childbirth, and condemning objecting colleagues as 'anti-scientific'. The major objections were lodged by men such as William Protheroe Smith and G.T.Gream. The latter expressed the view that Englishwomen: "would undergo even the most excruciating torture, or...suffer death itself, before they would subject themselves to the shadow of a chance of exhibition such as have been recorded." (1848, p.15).

and a watchful consultation with trusted partners and assistants. Their advocacy depends also on the description of pain in terms of a power or force.[20]

The changes that brought about the acceptance of anaesthesia in childbirth, were the result of an equally loud collective voice being raised in favour of pain relief. However, while it is insufficient to regard the retardation of 'progress' in obstetrics as part of some conspiratorial misogynist plan, it would be equally naive to suppose that the adoption of anaesthesia for pain relief in childbirth was entirely the result of the opinion of enlightened doctors who had somehow seen the light before the rest. The arguments do appear to be fraught with both humanitarian and unenlightened intentionality, but what actually moved practice into new realms of pain relief for the parturient, was the development of a new refinement of disciplinary paradigms, which required the docility of bodies and compliant patients. The relinquishment of consciousness and control in the parturient had positive advantages in this respect. Not only did it produce the requisite docility, but it rendered the supine and unconscious parturient body available to a new realm of pathologisation and made it the focus of new technologies and techniques.

The delay in implementing relief and hygiene strategies can appear at best a colossal and collective oversight, or at worst, a malignant refusal to acknowledge the connectedness of strategem and symptom. However, it is not enough to speak in terms of strict cause and effect, and it is historical and cultural arrogance to be astonished or indignant at the seeming ignorance of unenlightened forebears. The effects of the utilisation of certain obstetric techniques were productive of a whole new range of symptoms, new objects of problematisation, and of moral and clinical judgements. This, in turn generated new and

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[20] This is not new in the Western confrontation with the problem of pain and its effects. The curse of women was described by the Romans as *poena magna*; the word *poena* deriving from the latin for penalty or punishment (Rich, 1984, p.156).

further technologies to cope with the results of existing norms and techniques, and a wealth of literature concerning those techniques, practices and the ethical difficulties they engendered. There was no stagnation here as a result of failure and ignorance. Quite the reverse.

The discursive explosion surrounding all matters social and medical in the nineteenth century, a century erroneously reknowned for its 'silences' and its so-called preservation of traditional and unchanging values, was facilitated by subtle and seemingly well-intentioned disciplinary techniques. Silence and forbearance was the ideal state of womanhood, and childbirth pain came to be regarded as incompatible with that function. The status quo appeared to be better served by the anaesthetising of the parturient, who would be grateful to be removed physically and emotionally from the extremes of childbirth, which had come to be framed as an offence to dignity, vanity, sensibility and propriety. This enabled her to enter a lasting and discursively productive relationship with the doctor and other experts.

Just as deviance, madness and abnormality were the product of rational discourses reliant for their existence upon divisory tactics that aimed to ostracise, classify and rehabilitate, so too were the new problematisations of childbirth and the parturient body. High mortality rates were not the object of these discourses, though they did in time decline. The difficult and dystocic birth leading to death was a 'natural' tragedy that families had come to endure over centuries without respite. It attracted little medical attention beyond helpless observation and philosophical regret in the Classical period. Christianity had required intervention for the sake of baptism, which normalised intervention as a corollary rather than as a matter of intention, but excited little interest in the plight of the stricken mother. In the history of the technologisation of childbirth, women are presented as having reason to be particularly grateful for the attentions of the medical profession and their developing technology, having remained so long on the margins of direct interest.

The use of chloroform as pain relief and anaesthesia in surgical cases promoted an increase in the number, scale, and ambitiousness of operations, and its triumph in this area contrasted with the opposition to its use in childbirth. The complexity of the arguments that raged around childbirth anaesthesia continued to have an impact upon practices. When childbirth labour slowed, the doctors' ministrations remained largely based on purgation. The notion of retention and congestion fostered by the use of analgesics, persisted into the modern discourse, where, like the increasingly obsolete practice of perineal shaving, purgatives have been given as a matter of routine. The administration of enemas became an automatic part of hygenic childbirth though it has served very little purpose beyond the disciplinary. It became part of established practice in the nineteenth century as it was felt that contamination via faecal matter might be a contributory cause of puerperal fever (Kitzinger, 1983, p.30).

The heavy imbibing of alcohol during childbirth remained a cheap and dramatic alternative, often no more or less harmful or inefficient than other remedies in the folk repertoire. There is evidence in the annals of the Obstetrical Society that even respected practitioners resorted to the use of strong drink as a pacifier. (Donnison, 1977, p.94) This is particularly interesting in the context of the temperance movement at the time. Among the most vociferous of the anti-drink campaigners were the eminent medical figures of the day who were aware of the dangers of alcoholism among the poor. Yet some of their number may have countenanced its use in childbirth, while outwardly condemning the iniquities of the childbirth scenario when it had an unqualified and all-female cast. The older midwives were seen as purveyors of drink to cover their own deficiencies in skill, knowledge and appropriate action. There were elements of comprehensible truth in all this. It is likely that legitimate practitioners did use alcohol as pain relief out of genuine compassion, and that the old-style midwives may have promoted addiction, but the ability of both to alleviate suffering was impaired by the lack of effective and acceptable alternatives. Those

doctors who were not convinced that they should perpetrate the scourge of Eden faced using either these methods or the more dangerous and largely untested ones that were becoming available, while midwives were further constrained by the restrictions placed on their sex, and the prohibition against their use of drugs and instruments.

The Victorians interrogated and medicalised sexuality. The great social 'scourges': prostitution and alcoholism, provided a major focus for scientific, philanthropic and religious interest. These discourses permeated the investigation of reproduction. The madonna/whore dichotomy began in antiquity with the association of the mother with the begetting of legitimate progeny; was refined in the Christian schema as Marianism and magdalenism, and persisted into the nineteenth century in the general scientising of sexuality (Trudgill, 1976). The discourses overlap insofar as part of the moral problematic set up by the Victorians centred on the evils of alcohol and intoxicants (Harrison, 1971). This was also associated with the arguments that evolved around childbirth analgesia, traditionally provided by the administration and imbibing of strong drink.

The hysteric and the parturient became classified objects of science, and women were cast as madonna or whore in the ethical consternation of the time. They learned their subjective experiences in this way (Harrison, 1977; Bland, 1982). Foucault (1981, pp. 146-7) writes: "the hystericization of women, which involved a thorough medicalization of their bodies and their sex, was carried out in the name of the responsibility they owed to the health of their children, the solidity of the family institution, and the safeguarding of society."

The same exigencies, variously wrought, inform the current discourse of expertise in which one measures ones performance in a self-referential way, which not only pins the individual to a panoply of expertise but to the idea of expertism as a personal goal.

Several of the figures prominent in the obstetric debates were also temperance campaigners. One example was James Edmonds, who also advocated, as did many of his contemporaries who were concerned with promoting professionalisation, the divorce of midwifery from medical practice as it was time-consuming work which called for regulation, and separation from mainstream practice. Unregulated birth practices were also obviously susceptible to alcohol abuse. Women's involvement with the temperance movement was obviously linked to the need to reform men, and they were complicit in this campaign (Donzelot, 1980). However, alcohol was also associated with women via childbirth, pain relief and poverty. Representative of others who shared the same catalogue of related interests, Edmonds was also interested in the use of asepsis in childbirth. Like his colleagues who entered the childbirth debates, it was the 'ordeal' of 'delicate-minded' women which seems to have figured prominently, whether the argument was for or against the use of anti-septics and analgesics in childbirth.[21]

Interestingly, many physicians professed a knowledge of and wrote about both prostitution and midwifery. One example was that of the work of William Acton (1857), who concerned himself with the question of sexual vice in relation to the reproductive function (Nead, 1988, p.144). Artistic illustration also took its cue from the prevailing medical paradigm. In the engravings of the period, young women are often portrayed as 'lost', and pregnancy or childbirth symbolises the depth of their iniquity. The idea of physical degeneration in relation to prostitution was erroneously taken as a matter of medical fact. Examples of this debate are to be found in the work of William Tait (1840), who promotes the myth of the prostitute's decline, and like Acton, adopts the high moral tone of his contemporaries and contending as others did that prostitution should be scrutinised and regulated. By pointing out that most prostitutes die of the same maladies as 'respectable'

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[21] For details of this debate, see Donnison, 1977, pp.75-90.

women, Acton (1857a) directly links the two strands of sexual objectification by comparing the health of two thirty-five year olds, one a respectable childbearing woman, the other a prostitute (Nead, 1988, pp,147-8). It is possible that Acton perceived the similarities between what had been fashioned as two types of sexual enslavement. The popularity of these works testifies to prurient as well as medical or moral interest.

It might be said that given the state of knowledge at the time, childbirth anaesthesia was introduced too rapidly and enthusiastically by some. Alternatively, it is possible to regard the hindrance that was placed on its adoption as routine practice as part of what was perceived and problematised as a moral dilemma. After the 1936 Act prohibited unqualified practice and the salaried midwife became the norm, the parameters of her expertise once so contracted as professionalising processes took their toll of personnel and practices, began once again to legitimately expand. They encompassed both ante-natal care (thought increasingly to affect outcomes), and the provision, (as the home birth service began to contract) of domiciliary analgesia, previously only administered under medical supervision. The coincidence of the relaxation of surveillance as self-policing was internalised by the trained midwife, and the perfection of techniques such as the safe provision of nitrous oxide, occurred in a network of interrelated effects which facilitated and were facilitated by the exigencies and events themselves. The conflicting interests as to who should oversee examination, training and practice, continued thoughout the period up to the second war (Donnison, 1977).

In the late twentieth century, pain relief in childbirth has again come under a different sort of scrutiny and a new mode of policing, both within and outside mainstream institutional authority but emphasising self-prophylaxis in line with other paradigmatic shifts. Historically, pain itself has been identified negatively with evil, sin, and more ambiguously with involuntary subjugation. It seems appropriate that deliverance should in some way evolve as self-generated and with purity of purpose. Pain relief itself has come to be

regarded as part of submission to authority. To the middle-class sensibilities that have helped shape and inhibit the professions and institutions, a new self-help ethic based on notions of a reconstituted 'primitivism' has emerged; incorporating, paradoxically, the old suspicions about the use of drugs and 'technology' to alleviate pain. This is probably not the challenge to the medical authorities it might at first appear; nor is it the constitution of a particular antagonism towards submissiveness in the face of expertise. 'Working with the experts' has become part of a tame patienthood operating from the nineteenth century. Much of what has developed institutionally via disparate and struggling interests has come about by a process of reconciliation, toleration and incorporation.

It is also unsurprising that certain obstetric practices persist despite their obsolescence. Practices are not necessarily abandoned on the basis that they incur only diminishing returns. Stated intentions are of only limited veracity, even by those who believe in the essential truth of their stated aims. Obsolete practices can have an alienating yet incorporative efficacy all their own. It is unhelpful and inaccurate to regard innovations and 'new' interest groups, as functioning outside existing discursive paradigms. Ante-natal groups operating outside the establishment, owe a great deal to establishment practices. They tend to be exclusive insofar as they are, while ostensibly open to all comers, only really available to the middle classes and the articulate. They have a discreet managerial style and tend towards an apologetic prescriptiveness, the foil of client participation covering the usual for-your-own-good strategies. These are not new paradigms, but extensions of existing ones, and what was perhaps initially conceived as maverick, quickly becomes mainstream. These groups do have influence on existing practice. It is probably accurate to say that they arise out of existing practice; not only as a response to it, but out of the same exigencies, providing a parallel and incorporable set of strategies that operate alongside the changes that are already set in train. They are simply another facet of that which already exists.

The *modus operandi* of these groups borrows much from the discourse of psychology and psychiatric therapy. Mother is a figure whose behaviour must be modified while her collusion is sought continually (Chodorow, 1978). In most middle-class therapies there is this aspect of 'correction' of existing behaviour via detailed explanatory and revelatory critique, which perpetuates the illusion of its newness and uniqueness, while relying on techniques which have a long historical pedigree. Tactically there is nothing new here, just refinements of what was already available with a private self-help label attached.

The 'effectiveness' of labour analgesics has maintained the illusion of obstetric magic. However, maternal drug use is known to increase the risk to the foetus, as most substances taken by the mother cross the placental barrier and alter the uterine environment.[22] The effect of sedation upon the parturient, while it may not altogether counter pain, wrests control from her, and renders her more docile and amenable to intervention. In modern times, Pethidine, a morphine derivative, is frequently used. It produces feelings of drunkenness, drowsiness and general lack of control. Although some studies have indicated that pethidine produces effective pain relief, early studies on the effects of pethidine concluded that there were only minor variations of its affect upon pain thresholds - Macfarlane (1977, pp.42-3) rather simplistically concludes that unless pethidine was effective it would not have been used so extensively and as a matter of routine.[23] If this was sufficient explanation, it would perhaps also give clues as to why other more obsolete practices continue. Clearly, explanations for this must be rooted in something other than practical effectivity. As medicine displaced religion, a new mystification developed based on the doctor rather than the priest. Henceforth, the

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22 See Kron, 1966; Aleksandrowitcz, 1974, pp.121-41; Petrie et al, 1976.

23 Pain relieving drugs were used in more than 80% of cases in mid-seventies Britain, and almost as high a number in the U.S., and though the numbers are smaller in Europe, and drugs are less readily administered in the Netherlands, most women in the West receive some medication (Haire, 1972).

parturient woman becomes an object of rescue; that is, liberated from pain by technology. She is freed by Christianity from superstition and by modern science from the dangerous religious archaism of Genesis.

3.2. Drill: the psychoprophylactic prescription

In the context of modern obstetrics women are no longer enjoined to silence, nor are they the passive objects of science. The complicity of the birthing mother must be sought and readdressed according to discursive conditions, which will have their origin both within and outside the hospital and orthodox interests.[24] The measures employed in the hospital environment are geared to deal with deficiencies in the parturient; with her *inability to* begin labour, conduct, and end it satisfactorily. She is impotent against the pain that is seen to overwhelm her in her battle against the vagaries of an errant and inefficient womb.[25] Perhaps some control can be asserted with the use of TENS machines; the patient manipulated devices which can stimulate certain nerves, enabling the birthing woman to exercise some discretion as to when she uses pain control.[26] Information about, and availability and/or effectivity of, such devices is patchily available, and is more likely to be the resort of the better-informed or more vociferous parturient. The effectiveness of such methods is likely to be at least partially psychological. Many

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[24] For a recent study based on women's experiences of maternity care, see V. Mason, 1989.

25 For an appraisal of the obstetric view of pain, see K. O'Driscoll, 1975, and for the varying perceptions of differing childbirth roles, whether parturial or in the hierarchy of attendance, see J. Walker, 1976 and S. MacIntyre, 1982.

[26] TENS equipment is a portable transcutaneous method of electrically stimulating the nerves with a weak current near the site of pain to block the transmission of messages to the brain which indicate pain.

hospitals encourage such partial control, with the connotations of liberalised self-help it entails. Methods like this are easily incorporated into mainstream practices because they do not have a disruptive effect on other clinical procedures, and are more likely to make the parturient co-operative. The more responsibility the parturient assumes for her own labour within the auspices of the institution, the simpler it becomes to implement interventions should those techniques appear to fail, or the more enlightened the institution appears if the process does not require interventions.

The procedures of alternative birthing groups are often predicated on the same premises, largely because the expectations created by modern technologised childbirth have been that the onset of labour will have to be induced, that the womb will require stimulation, and that the pain associated will be unendurable. The measures taken by natural childbirth classes are geared to countering these negative connotations, and to instil some confidence into the pregnant woman about the inherent abilities of her own body. This will include detailed discussion about the way in which the uterus functions during labour, the way to use relaxation to counter pain, and how to assert oneself in the institution (Kitzinger, 1990). All these measures rely on the same axioms of the childbirth discourse as elsewhere, the terms of reference are dictated by the norms of technologised childbirth. Also, much of what can be gleaned in these classes is provided also by the classes run by the institutions themselves, though their information is more likely to be supplemented by the inculcation of the norms of the hospital, and what the hospital can offer in terms of relief and intervention, and the urging of a level of conformity to produce the best results. In these ways, the parturient places herself in the hands of the expert of whatever school of thought early in her birth career. She is the subject of physical, emotional, and behavioural scrutiny in a multi-variable pattern of surveillance.

The creation of the abnormal birth was not the intentional purpose of men who wished to interpose themselves between the parturient and her experience as the purveyors of a

powerful and disciplinary role, though this indeed has been the effect. The operation of these relations and strategies could not take place without the collusive behaviour of the very class of women who have been regarded as the most articulate advocates of resistance to the more outdated modes of this system. Historically, the situation of women of the poorer classes has swung from one extreme to the other. Having been left by doctors to the ministrations of the midwife wherever possible, they became the obvious target for hospitalisation. In the twentieth century they have been often the unquestioning recipients of all that the technologies of childbirth have had on offer. Unquestioning because the language of dissent is framed on the whole within a privileged lexicon, and it is often only those who have access to knowledge and authority that pass the necessary 'tests' which make their protests legitimate.

While the calculability and control of the poor became a focus of the medicalising discourses during the welfare exigencies of the nineteenth century, women of the wealthier classes always attracted a different type of attention from the professionalising groups, whether as the focus of obstetricians, family doctors or psychiatrists, and for that reason were subject to much unnecessary and more spectacular interventionism. They were more likely to have individual attention from doctors and so escaped the vagaries of a hospital lying-in during the period of the height of the puerperal fever epidemics (Donnison, 1977). However in the post-war era, in Britain for example, they were increasingly likely to be delivered in maternity homes or in hospitals, where they were imbued with the medical certainties of institutionalised birth which they themselves came to promote by their very compliance. It has been this class who have been most vociferous in their condemnation of the extremes of technologised childbirth, and who have attempted to make subsidiary arrangements alongside existing provisions, extolling the virtues of 'natural' childbirth, ostensibly for all women, when in fact, access is largely a matter of privilege.

The history of relations between the middle class family and the professional has been one of achieving fine balances (Donzelot, 1980; Zaretsky, 1982). The doctor sought favour and reputation among families of the middle class, not least for pecuniary advantage, but also because the better-off were more susceptible both to science and fashion. The route to family practice lay in obstetricy, but it was a route fraught with problems. The middle class faith in professionalism, was matched by the fears and lack of trust in the integrity of the male doctor in so intimate and delicate a situation (Porter, 1987). The doctor after all was exerting power over the reputation of his peers, and it was in the interest of both that the element of mutual trust and forbearance was observed.

The modern relation has elements still of this acquiescence, and a kindly paternalism is often regarded as the best of care even when the prevailing ideology appears to foster scepticism. The desire to submit to external authority breeds its own need for, and reciprocal reliance upon, that same authority. Technically this is the case because even the normal birth becomes, in the rarefied atmospere of the technologised scenario, a high-risk activity. Complicity guarantees a perfect and technologically enhanced outcome. Failure to submit to this even in principle, is to implicitly jeopardise the safety of the child that is to be born.

The majority of women who give birth in a modern setting do not disappoint the expectations of those who deliver them, and the processes whereby this complicity occurs cannot be meaningfully frustrated by the 'natural childbirth' lobby. While they advocate that mothers disassociate themselves from automatic procedures, they place themselves beyond criticism by remaining within the auspices of medical expertise. The realms of their own expectation is that of the perfect outcome. The message of the alternative birth groups has had, and will have in time its effect upon obsolete practices; but its role has been reforming rather than transforming. For the parturient-to-be, unlearning and relearning her expectations could be regarded as a two-fold imposition and effort, whereas

accepting the definition of her experience as offered by the hospital with its promise of pain-relief and life monitoring and saving equipment, can appear with non-illusory justification; the obvious, safest and least quixotic option.

After all, the experience of technologised childbirth still takes place in a certain configuration of time and space, it is still to do with women's bodies situated in certain relationships of power, it is still a lived experience: most women's experience, and the gambles are just as real; whether they emanate from some personal quirk of individual biology, or from a machine or tactic which is superimposed. Echoing the question which has been variously posed since the last century, it must be asked: what, after all, is 'natural' childbirth? Is the modern construction of childbirth invalid because it abrogates what is anyway another historical and cultural construct: the notion of the natural?[27] What is 'natural' is also culturally defined and then medically made manageable. The indefinability of 'natural' childbirth, and therefore its potential for scientific exploitation was not missed by the professional bodies of the late nineteenth century.[28] In the twentieth century, the childbirth event becomes increasingly broken and episodic. There will be an expert available for each eventuality, a manager for each potentially unruly piece of business, a

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[27] The broad acceptance of the ideology of 'natural' childbirth by established obstetric forces, is part of the prevailing 'progressive-regression' principle that has invaded the notion of 'politically correct' thinking, and is to be found in green politics, in specifically centred educational, psychological and penal reform programmes, in health, dietary and domestic advice which is usually directed at women, and most explicitly in childbirth practices. Minson (1985, pp.112-3) writes: "Environmentalist groups or adherents of natural childbirth techniques who aim to enhance the quality of life are not to be thought of as unwitting pawns of the state. Nevertheless they are caught up in a liberal space of government, in a liberal police of the social."

[28] Members of the General Practitioners Union argued that civilisation had made 'natural' labour indefinable, and that birth should be properly handled and controlled by medical practitioners who should not remain 'idle spectators' (Donnison, 1977, p.130).

monitor for each uterine physical contraction, a negotiator for every stage of the 'contract' the parturient tacitly signs with the experts. It appears, and probably is, dangerous to wilfully place oneself outside this now almost fully 'staged' event, and to disobey its inexorable regulatory timetable. The vagaries of technologised childbirth run parallel, or have even replaced, what are perceived as 'natural' hazards, and the delicate chain-like balance of technological effects and counter-effects, can be dangerously ruptured by non-complicity.

There is a certain naivety in the supposition that it is possible for the *majority* of women in the West who have on the whole, though not exclusively, come to have certain expectations of the hospitalised experience of childbirth; to be able to function outside existing paradigms by somehow embracing a 'natural' experience which is not in the realms of her expectation. This was never really possible or available except in a certain mythologised version of female historical experience. The clinical version of childbirth can and does tolerate piecemeal rather than pioneering change, thus enhancing its prestige.

The 'best' that could be reasonably expected of the natural childbirth movement is that the parameters of the discourse of childbirth can shift and emphases change, as conditions of possibility extend and new paradigms emerge. The important thing here is to recognise that whatever resistive measures are on hand, they too, are paradigmatic. The myth of the 'natural' has upheld misogynistic and phallocentric practices from ancient times. It should also be remembered that the prime thinkers and movers behind the advocacy of a 'return' to 'natural' practices tend also to be male professionals of established if maverick reputations, and the arguments, as in the nineteenth century, arise in the medical debate between male peers. The ante-natal classes that purvey their philosophies are often run by females who appear to predominate at the level of both theory and practice However, their role as acolytes is often overlooked both by themselves and those adherents and

tutees who believe themselves to have entered a truly feminine ethos, or indeed, that such a thing is possible.

Fathers-to-be have been largely encouraged to be present both at classes and at the birth itself, even though the hospital was initially unwelcoming (Kitzinger, 1983, pp.92-7). The male has been regarded as a potentially disruptive factor; which is a not unusual reaction to masculine activity historically, where men are seen to be the motivators of change, and may therefore pose a greater threat to the ethos of childbirth than the demands of the parturient herself. In fact, the advent of the male partner in the birthing room has coincided with an increased clamour for reform. However, it has not been within the institutions that the amateur male attendant has invited contention. The hospitals have almost universally relaxed over this issue in the last quarter of this century, particularly as the potentially intrusive male is also invited to place himself within relations of tutelage, either as part of an integrated preparatory package offered by the institution itself or as a tutee of the 'independent' ante-natal movement now marshalled unobtrusively in the service of a slightly redefined status quo.

However, as the institutions have relaxed, the desirability of the male presence has also been subject to debate and prescription by the alternative movement as a backlash reaction which reinstates a potent and disruptive phallic power, and again, these arguments are promoted most rigorously and influentially by men themselves. One recent example is Michel Odent (1981) who having initially in his schema, promoted the notion of the male partner as birth attendant, has more recently invented and advocated a mystical all-female scenario, presumably with himself as a kind of presiding high priest. This kind of 'invisible', behind-the-scenes control that has always been at the crux of childbirth practices, as men have come in and out of obvious prominence while always retaining a controlling interest, according to the paradigms that prevailed at any given time. The Victorian era in Britain was, despite its prudish pretensions, a time of high male visibility,

and a time when men were more overt and unquestioned in all their activities, and yet, the debate surrounding male midwifery would seem to indicate that the presence of the male in childbirth abrogates certain notions of masculine control. This was the case with the 'midwife-predator'; the male *accoucheur*, because of the perceived threat to marital harmony (Porter, 1987). This is also the ostensible objection to the participation of the male partner at the birth scenario.

It is interesting, however, that Odent, the 'enfant terrible' of modern technological childbirth, and the scourge of what had become conventional hospital midwifery, having promoted what appeared to be an 'anything goes' birthing ethos, which for instance helped to ease the entrance of the male partner into the *delivery room (Gillet, 1979), now finds* himself at odds with the natural childbirth movement who pride themseves on having overcome that particular reluctance. This is because Odent now appears to be advocating a 'purified' exclusively female support environment for the parturient. In this scenario, the male doctor/teacher mainly observes and conducts, not because as of old he was constrained to do so, but because, within the paradigms of 'natural' childbirth, this is regarded as the optimum position to which the doctor may choose to 'withdraw'. At the scenario of childbirth, the doctor has ever been the watcher - the one who establishes watching at the heart of procedure even in his absence; waiting for the appropriate moments of intervention; reserving specialist attentions for expert hands.

Withdrawal of course is not the intention. The phallus is still at the centre of these exigencies. The male partner should not be welcome in the presence of his birthing wife because, divested of her ancient 'mystery',it is suggested that their sexual life thereafter will inevitably cool. This appears as some modern manifestation of the fears about the man-midwife as predator theme; the subtle but ancient competition between the husband-tutor, and the doctor-tutor for female attention and cooperation. Odent enlists the trust of the parturient woman, and then turns her partner away for the good of the partnership. With

the relatively high living standards in the West, and the support of a vast technology which largely assures infant and maternal survival, the dangers of childbirth must somehow therefore be relocated in other sets of relations.

There is a precedent in the ancient enjoining of the male to a potentially harmful but necessary fulfilment of the procreative experience, which presupposes a reluctance upon the part of the male. In ancient discourse, preservation of the life of the mother was an ideal rather than realistic medical priority, in order that she should again attempt reproduction. In Christianity, a woman's reluctance to fulfil this role was channelled into other phallogocentric forms of devotion. In the development of this particular latent thread of the modern discourse of natural childbirth, the doctor asserts his expertism from a respectful distance. The father of the child is required yet again to protect himself from harmful images associated with the female, and the mother herself must once more choose between the doctors' versions of the event. The main point here however, is that, despite the protestations of the nature/mystical school of childbirth, there is no detectable seam between the parturients experience of childbirth, and the phallogocentric gloss upon it. One cannot begin where the other ends.

The assertion of the dangerous realities of witnessing the experience of childbirth and the possible latent traumatisation of the father (yet another trauma the parturient is responsible for; yet another set of problematisations around which to work an expert discourse), is part of an eroticisation of the childbirth experience. The modern advocates of 'alternative' birth practices have been regarded as revolutionaries with their orgasmic vision of childbirth pleasure. Far from denying the sexuality of the parturient, the 'natural' childbirth lobby, such as Leboyer and Odent, have accentuated the notion of sexual pleasure in childbirth, even seeming to regard themselves responsible for such pleasure.

Questions concerning intention, attentiveness and scrutiny, and about who holds and manifests the gaze has been subject to a myriad of speculations and circumscriptions. Particularly associated with nineteenth-century panopticism, strategies devolved upon illumination and watchfulness were also a feature of ancient childbirth strictures to prevent the deceptive introduction of suppositious children (Gardner, 1986, p.52). In a reversal of similarly prescriptive detail, the mystique orientated philosophers of the 'new' birth styles eschew the bright visibility of the orthodox clinic. Leboyer (1975) emphasises that birth should take place not in total darkness but in a darkened room; Odent (1981) also points out that a lair-like semi-darkness is appropriate to many birthing mammals. The woman and nature theme here is the obverse side of the clinical approach, it does not disrupt the premises of the old discourse but simply extends them in a different direction. The important aspect is that both phallogocentric modes place women in a ritualistic setting, and place her in relations of tutelage that she must decode and comply with before getting on with the business of birth. That is not to suggest that the experience of birth can be anything other than a conglomeration of these conflicting / complementary exigencies anyway. There is no access to a kind of primary experience that existed before paradigmatic influences took shape. They always took shape.

There has often appeared to be a problem with combining the view of the genders. Apart from the ancient strictures regarding witness which later permutated into a more thorough examinatory discourse (and a more masculinised discourse), there have always been ambiguities regarding the gaze in relation to the witnessing of medical encounters; childbirth providing one specific example. The parturient has been at times, particularly in the past two centuries, kept from the vision of herself. There has been not only the historically prevalent and irrational fear of women's gaze as the outlet of sorcery, but also the notion of a certain lascivious promiscuity attaching itself to the act of focussing or

giving detailed attention when the gaze is owned by women. In medicine, it seems that men could hardly bear to witness such attentions.[29]

The power of a Michel Odent and that which recommends him to the modern idiom and marks him as its creature, is a form of the most subtle discretion. Having ensured that the values he represents are so well assimilated and accepted that the overt presence of any male is unnecessary, he himself need not disappear. The integrity of his presence is to be so accepted that he transcends the designation 'male'. So, while the hospitals have gradually made of the attendant father-to-be a sort of celebrity, which offsets his disruptive power, the role of the professional obstetrician is further extended by the not insignificant authority of a movement which places itself ostensibly at odds with the existing system. Its stars create a 'new' refinement: a category so sure of its grip that it establishes itself almost without overt reference to its gender specificity, as the amateur and professional celebrities of childbirth continue as ever in collusion and in combat.

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[29] One example demonstrates that keeping women out of medicine was not simply a matter of concerted misogyny, but a paradigmatic exclusion which permeated institutions and practices. When, in the nineteenth century, Sophia Jex-Blake and her colleagues at the University Medical School in Edinburgh argued that they should be treated on the same basis as men, the judgement of the male establishment was that the concept of womanhood was disturbed by the notion of mixed anatomy classes. There was the fear of a "promiscuous attendance" with men during clinical expositions or the dissection of cadavers: "The judicial suggestion that a partition be erected down the middle of the anatomy room similar to the one which segregated male prisoners from female in the Pentonville prison Chapel, gives a clue to the kind of male-female relationships comprehended in the dominant ideology of the time. What was needed was a screen not between the women's eyes and the nude corpses, but between the women's eyes and the men's eyes. Men might watch women at work on corpses, but these men had to be superiors such as professors supervising students or doctors supervising nurses." (Sachs, 1978, p.30). A similar tutelary and professional protectiveness worked against the partners of parturient women when they were turned away from the delivery room.

The notion of symbolic conquest to overcome unfathomable processes pervades also the emulatory rituals of the *couvade* which are in part a response to the nebulous quality of paternity. The exclusion of men from the childbirth scenario has in some cultures resulted in ritual mirroring of the physical constraints of pregnancy and parturition as practiced in the *couvade.*[30] Ethnologists attest to the powerful images supplied by women in the physiological crisis of childbirth, which can make men visibly afraid. Pregnancy and nursing similarly impress. The appropriation of childbirth in myths and legends is reflected in actual ritual practices which simulate the processes of labour.[31] Parallels can be drawn between shamanism and psychoanalysis. The work of Levi-Strauss (1972) suggests that symbolic incantation gives language and expression to female pain, detaching it and explaining it, integrating it into the whole of experience and making it accessible via masculine interpretation.

Both the shaman and the psychoanalyst manipulate experience into 'primitivist' codes, and both become the active interpretors of 'truth'. Both become the heroes of the experiences they interpret. In the particular case of the shaman, he presents himself as the saviour who wrestles with an evil which is identified as female, on behalf of the parturient with her body serving as the battle-site of this heroic struggle - not her struggle, but that of the shaman. The birthplace is also often regarded as a site of power and danger from which the community must be protected by isolatory rituals. Shamanistic rituals operate like other expert appropriations of the female body, such as those of the Victorian perpetrators of the

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[30] The fictive and abstract character of the *couvade* has, in the view of ethnologists from Briffault (1927), (including Eliade, 1965; Bachofen, 1968; Bettleheim, 1968) led to practices which supposedly symbolise the father asserting possession of his offspring. It is also part of the function of the *couvade*, that the male mirroring of the processes of childbirth, make the latter meaningful and manageable, so that the male can return to (and disseminate in) normal life.

[31] See Huston, 1986, p.122-7. Displays of open hostility towards the labouring woman, involve the symbolic use of arrows and swords, and the simulation of birth pangs (Coward, 1983, p.231).

'rest cure', the modern 'dieticians', and the advocates of the regimen of pregnancy which entails observance of taboos where "women appear as lay figures in the men's drama" (Ardener, 1975, pp.2-3).[32]

Aspects of shamanism are reflected in the perpetration of childbirth technology and anti-technology; it is also apparent in the tutelary relationship explored in the relationship between doctors and their middle class female patients in the Victorian era (Duffin, 1978), which presaged modern psychiatric treatments and childbirth interventions. Victorian women were caught in a discourse of weakness and sickness, which the middle-classes came to see as being inherent to the female. To be female was a pathological affliction, and pregnancy and childbirth were pathological conditions. Ideally, pregnancy rendered women of all classes accountable, and brought them under specific types of scrutiny, both physiological and moral. Although poor women were expected to withstand arduous labour, both parturient and economic; genteel women were enjoined to indolence, inactivity and incapacity (Poirer, 1983).

The nature of 'confinement', a term of only recent usage in relation to childbirth, extended into what Foucault (1979) has described as a 'carceral' discourse, with echoes of ascetic monasterialism. The parturient poor of the city would be likely to find themselves subject to the regulatory confinement of a hospital ward, while women of the wealthier classes would be equally 'confined' within their own domestic milieu. There is a possibility that some women feigned illness to avoid pregnancy, just as their counterparts in the twentieth century have pleaded mental ill-health to secure medical permission for an abortion (Duffin, 1978, pp. 50-2). As with some forms of psychiatric illness associated with childbirth, these illnesses are the creation of the very discourses that require their

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[32] See Turner, 1984; and Thorogood and Coulter, 1992, pp.47-62.

existence, and the claims of expertise to alleviate their symptoms create an ever-increasing spiral of reciprocal relations between the subject/object thus constituted and the medical discourses that engender them.

As mental illness came to be allied to women's reproductive capacities, belief in an inherent inferiority dignified the establishment of a hierarchising, 'civilising' system. Reproduction, nurturing and the rearing of children thus guaranteed the inhibition of social and political power for women. Motherhood was somehow the obverse of the intellectual life which unfitted women for childbirth, while at the same time, eugenicism permeated the tenets of the educative process, which idealised motherhood. As the emphasis upon the social duty of motherhood became clear, women's education centred upon forms of domestic training as a preparatory regime for mothering.[33] This was no longer necessarily regarded as an unchangeable feature of female biology, but positively as a societal function ripe for the investment of expertise, for which women required training and goals, and the guidance and support of professionals.

Gradually, rather than a passive object of docility, the body becomes instead the site of positive interventions by self and others; a trend which has become increasingly heightened towards the end of the twentieth century as every aspect of ones physical behaviour and output can be monitored and recorded, often as a matter only of self censorship against a medically devised norm (Kern, 1975). What occurs is a very effective implication of the self in a complex of relations with oneself and others which necessitates a disciplinary scrutiny of every aspect of behaviour, and throws out failures to be scooped up by the relevant experts at every turn. These forms of medicalised control are something which

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33 See Delamont, 1978, pp.134ff, 164ff; Duffin, 1978, p.87.

are universally accepted and conformed to, confirming positively every form of inspection, intervention and improvement.

For the woman with nervous symptoms, the abdication of responsibility for herself and relinquishment of the self to the doctor was an echo of Christian renunciation. The ordered schedule was to be a feature not only of the institutions where bodies were regulated; the schools, clinics, factories, barracks and hospitals, but also of the home. The expert doctor required that the middle-class woman who was pathologised in this way, must submit like a nun in obedience to a higher moral authority. Their finite energy must be exerted only in the interests of the household and reproduction. A secular version of the conventual life, it must have presented a welcome viable alternative for some middle-class women, but for others, it was disastrous (Lane, 1980; Bassuk, 1986, pp.139ff.). This phenomenon instituted the demand for cooperation and dependency which also characterised the developing technological discourse of childbirth. The same motives informed the confining of the otherwise healthy parturient within the auspices of the clinic. For the respectable woman, and for the parturient, potential complications and dangers were emphasised, in order to justify the ministrations of the experts and the new regimes of control, the reliance on examinatorial practices, on charts, surveys, tables and taxonomies.

Anti-technology should not be regarded simply as productless nostalgia, nor as a fearful backsliding retreat arising from a particularly negative perception of scientific 'progress'. The paradigmatic concern to elaborate the mind-over-matter thesis in relation to childbirth implies a certain freeing of the parturient from her physical experience, when, in fact, she is open to new forms of judgement which privilege the cerebral over the instinctual, and accentuate the incongruity of physical pain, linked inexorably in relation to childbirth with punishment and atonement. Freedom from pain in this context infers a liberation from a type of inherited guilt. Hence, psychoprophylactic teachings have their mutually influential

parallel in other diverse forms of psychotherapy. The discourse of divulgence also inspires a concomitant drive towards containment and control, from which the technological exigencies of childbirth are also derived.

The advent of the childbirth teacher who offers a service outside the hospital though not beyond the prevailing discourse is a 'new' professional who has arrived as a result of what has been described as the 'cultural birth' produced by the alienating procedures and atmosphere of the hospital as a result of the fear-pain-tension syndrome (Dick-Read, 1959). The self-help techniques of psychoprophylaxis taught by the natural childbirth classes are structured breathing and muscle relaxation exercises, and the conscious development of conditioned reflexes against childbirth pain, sometimes based on the use of imagination and mnemonics to ensure maximum distraction rather than participation, usually with the assistance of a partner who is similarly trained to pick up on cues and to give them where appropriate.[34] This makes the notion of 'natural' childbirth somewhat inappropriate, as the training required to produce a child by these methods is in some ways as much a form of control of the processes of birth as the technologies of the hospital, and is a continuation of both the incitement of women's involvement with their own bodies, and the regulation of that relationship.

The leading exponents of 'natural' methods have exerted an influence from the late fifties, but more particularly since 1970 when paradigmatic conditions favoured positive perspectives on the past and valourised a simpler, more natural way of life that was commonly believed to have existed. This is the dangerous and unrealistic myth of a golden age of primitivism. They include at least tacitly, those such as Lamaze (1970 (1951)), Leboyer (1975), and Odent (1981) among others, who have offered their own rather

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[34] For a survey of natural childbirth techniques, see Kitzinger (1983, pp.101-134).

circumscribed definitions of what constitutes the natural. Just as the hospital attempts to ensure the perfect and guaranteed result, the advocates of 'natural' childbirth can only strive towards that most unnatural of births; the painless one, the one which should be ideally "without" fear, violence or intervention. The use of TENS still adheres to this philosophy. It is still a technological response to pain, intended to distance, isolate and eradicate. Women are invited to control pain themselves as part of a discourse which has come to favour the self as expert; a care-of-self paradigm which has ancient connotations which are refined in Christianity's interrogation of intentionality. Similar imperatives permeate the debates of the anti-anaesthesia lobby of the nineteenth century. Like them, Odent (1981) argues indirectly for the physiological efficacy of pain when he declares that the cries of the birthing woman, which he interprets as ecstasy, actively aid the release of the perineal muscles (it was similarly encouraged in antiquity, when other forms of female expression were circumscribed). He advocates the active participation of the mother in the experience of childbirth, while delineating the nature of the experience to which she should actively subscribe. It is another secularised and medicalised ritual of female worship, and the health celebrities are now the household gods.

While Church and orthodox medicine are often in conflict with regard to interventions, the resistance of the alternative practitioners, with their professing of the sanctity of life and nature, and their quasi-religious mystique, to any 'artificial' means of countering pain has rendered them acceptable to those who consider that childbirth analgesia somehow interferes with holy writ.[35] The childbirth tutor, versed in modifications of the techniques preached by the male gurus of childbirth is as in thrall to the authority of the male as the trained hospital nurse and midwife to the male hierarchy. Devotees such as Grantly Dick-Read who began his advocacy of 'natural' techniques in the 1940's, were supportive of

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[35] In 1956, Pope Pius XII endorsed the Lamaze technique as conforming to the will of the 'Creator' (Arms, 1975, p.146).

change but insisted as later experts do, that the relationship between the doctor and the woman is an important and charismatic one. 'Natural' or rather non-technologically assisted childbirth advocates such as Lamaze, were influenced by experiments conducted in the 30's and 40's, by Soviet obstetricians, using techniques such as the utilisation of the power of suggestion, hypnosis, and Pavlovian reflex theory. Forms of conditioning were used in order to teach the parturient to administer their own verbal analgesia during childbirth labour. It is interesting that the ideas prevalent at this time were reflected in titles such as *Childbirth Without Pain* (Pierre Vellay et al., 1974), which are value-laden predications on lack, while preaching in actuality the superimposition of entire systems and strategies overlaid on childbirth, and dominating its practices just as surely as any technological means. Yet this is much more subtle, giving implicit control to the parturient, teaching her how to take a new form of control over that which she has 'lost' a control she probably never truly had.

The same principle might be said to apply to the use of TENS. Interesting also, however, that new techniques, while often linked to old confessorial principles, adopt the ostensibly non-coercive and persuasive techniques of hypnosis and suggestion. The use of TENS does offer a method of pain control which is only indirectly subject to the interpretations of others, and permits the extension of the interpretative range to the parturient herself. This involves the parturient in interdependent permission-requesting strategies, which involves her acceptance of other forms of authority, and perhaps of an institutional environment which has permitted a measure of control. This process has historical and cultural parallels. For example, cooperation brought limited powers to the nineteenth-century matriarch, while requiring her collusion with the health authorities to bring her family within the realms of social acceptability and within the range of medical welfare and concern (Donzelot, 1980).

These techniques are implicit in the regime developed between psychiatry and its clients, where states of relaxed self-hypnosis take place as the patient delivers information of themselves to themselves, through the often unspoken filter of interpretation, so internalised by dint of the strategies in themselves. So it is with childbirth - the 'psychoprophylactic method', (like a rote-learnt alphabetic or tabular chant), introduced by French physician, Fernand Lamaze in 1951, was intended to alleviate childbirth pain by self-induced methods. The ideology of self-control had though to be fully inculcated before the effect of psychoprophylaxis could bear results.[36] Therefore there is a marriage of the modes of psychiatry and childbirth practice, whereby the processes of childbirth are filtered through a new interpretation of pain, a new creation of pain, one that will respond to the self-analgesia of repetition and mnemonics. The classroom idiom comes to the labour ward, at the grassroots level, to train up the mind and responses of the parturient, and to create a 'sub-class' of technological 'refusniks'; all accommodated within the existing discourse, but generating further debates among professionals, who then appear to be in the vanguard of new ideas about childbirth. These exigencies are subject to discursive conditions which require optimum productivity in terms of text, talk, and expertise.

The development of the guiding principles of professionalisation were embodied in the priest, the doctor and the psychiatrist, as the medium of knowledge about the self, which is being perpetually reconstituted by discourse. In the later stages of the twentieth century, these capacities are being extended to all types of 'expert-celebrities' and 'celebrity-experts', extending even to the 'expert-self', supported by the panoply of norms, ideals, averages, charts, measurements and graphs by which we are daily invited to measure ourselves, our lifestyles and partnerships in every regard. These are not the expression of repression

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[36] In England these methods have been broadly adapted and given a more positive profile, by such critics of the orthodox systems as Sheila Kitzinger (1972, pp.17-25) whose 'psychosexual' method also involves physical and psychic education, active co-operation, and self-direction.

although they have been consistently portrayed as such. In the case of childbirth self-prophylaxis, the active participation of the parturient is encouraged. Indeed, without her utmost concentration and effort of will, the methods cannot be effective. What is initially required is a huge commitment in terms of faith and will-power. Once that is made, the parturient 'belongs' to the system, as much as it is her chosen method. Once that conscious decision has been made, the aim is the dulling of consciousness to pain during labour itself, while a refocussing of concentration is achieved by a strict respiratory drill, stimulated by verbal cues, in a parodic dialogue which has created its own meanings and significances. A similar effect can be created by the use of TENS. This serves not only to reinforce the aura of self-generation, but it operates in the dualistic manner that is common to the discursive process.

Firstly, one is implicated in a system which has a certain homogeneity with an ideology that one can recognise and adhere to, made particularly acceptable because of the inbuilt subversion made possible by the personalising of meanings that will have significance only in this specific context. Secondly, the other mode of this enterprise is that of individualising and isolating. Both of these elements are crucial to modern interventionist professionalising discourses, because they entail an initial period of tutelage, and a process of examination which gauges the success or failure to use the method effectively as an individual. Similar to other facets of medical or educational discourses, the method itself is last on the agenda of scrutiny, while the object/subject is always first, a measure of the importance which is historically ascribed to the notion of subjectivity.

In the post-seventies era, women are newly subjectivised in the biological discourses of infertility that includes reproduction technology, and the anti-ageing discourse of mid-life

trauma which centres on the alleviation of menopausal and viripausal symptoms.[37] The female subject/object created and fostered by the raised expectations emanating from new expert ministrations and exhortations, both medical and commercial, is open to new forms of scrutiny as regards lifestyle, emotional and material history and intentionality. This scrutiny will obviously necessitate a new generation of ethical committees, vetting procedures, and expert counsellors, regardless of whether these events and possibilities will only affect very small numbers of people. The psychological effect of having inappropriate parents of any age (whether or not they are 'naturally' fertile) will also attract psychiatric attention and social policing. The accepted experience of the majority is one of uncomplicated fertility, which normalises the new medical interventions. It is only when 'pockets' of deviance (that is; infertility) can be defined that the behaviour of the majority becomes remarkable, and comes tacitly under scrutiny. That is when the training for self-scrutiny and judgement comes into its own and the self-policing instincts of the majority ratify and control the areas of deviancy.[38]

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[37] Appraisals of aspects of the relative experiences of home and hospital births are included in the following: Oakley, 1976: Kitzinger, 1978; Richards, 1978; Tew, 1989. This has recently included post-menopausal women in in vitro fertilisation programmes in Rome, which has, of course, stimulated further medical and ethical debate. The fear of the older non-reproductive woman is reflected historically in the female monsters of Greek mythology some of whom are wild, youthful and uncontained, or old and fearless women beyond the cares of procreation (Bremmer, 1987, pp.41ff.). As non-childbearers these were possible agents of corruption. While risk and danger were represented by the temptations of youth; the older, worldly but infertile woman unoccupied by childbearing, also posed a threat and helped to feed the myths and fears surrounding childbirth. In the Christian ethic, such women had the option of dedicated chastity, but were also prey to condemnation as potential heretics, in a dual codification of ancient fears. It was, after all, females such as these who delivered parturient women, who shared their secrets and conspired to facilitate their deceitful practices.

[38] There is a parallel example in ancient practices, where the precautionary prescriptions of such as Soranus in his *Gynaecology*, create an environment of professional tutelage which permits a tacit endorsement of the intimate female world of parturition. Despite the prescriptions regarding its personnel,

It is an established truism that self-help groups have had a poor reception from the established medical profession. However, this is too simplistic a view. A certain reciprocity of rewards and exclusions exists between adjacent discourses. While popular literature exhorts and encourages self-diagnosis, there is still ambivalence. This is expressed by the frequent caveat of maintaining deference: 'under medical supervision'. This encourages deference and complicity, and yet reinforces a fear of 'bothering' the doctor with 'inconsequentialities'. Self-diagnosis is still portrayed as inferior, while just enough tantalising information is provided to enable the attempt (Faulder, 1985). This elevates not only the process of self-examination, but also ratifies the notion of the doctor giving his precious time, placing an intrinsic value upon medical diagnosis, and upon the medicalisation of everyday life. Authoritarian intervention is normalised even at the level of entertainment.

The late twentieth century has seen female responsibilities towards herself and others increasing, as in the guise of childbearer, potential childbearer or infertile woman, she becomes ever more deeply implicated in the medical paradigms and strategies that both liberate, improve and circumscribe, urging ever more reflection and activity. These developments have to do with an increase rather than a decrease in choice. The whole of modern scientific and medical and pedagogical development has to do with the broadening and reification of free choice rather than restriction. We are spoilt with possible options, and are continually having to steer a path to evade conflicting demands and to reconcile what is often irreconcilable. The pressures of this can serve to bring professionals and experts into the life of the individual in a world where every T.V. pundit, film star,

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this close and closed world of women, not only served to preserve family honour and discretion, but also the publicly endorsed private rituals which surrounded child exposure.

celebrity and women's journalist is a self-ascribed expert, whose panoply of advice adds to the list of irreconcilables to be pondered.

The 'support' network for the modern mother, wife, worker and parturient is inexhaustible, there is always a sincere friend on the T.V. screen, on a video, in an instruction manual, on a surgery poster, in the racks of the psychiatrist's waiting room. The responsibility of the modern woman to maintain this army of expertise is a compelling burden. She becomes an instrument of her own police mechanism, in fact, the instrument, as her contact with her confessors need not be direct, (though indeed there is always a sample of people who are enjoined to reveal themselves on panels, in audiences, by telephone, and survey, and to set the example of honesty and truth telling in public, creating the benchmark for ones relationship with oneself and others.) In this sense the notion of police cannot simply be regarded as a negative expression of a repressive ideal. Regulatory, disciplinary and unrelenting certainly, but not necessarily undermining. We are increasingly enjoined to fulfil whatever potential is under investigation for that day, to have an opinion on this or that issue, or about some or other object of contention, or a topical word or two for that chat show phone-in.

The tutelary complex proliferates around the individual, who is bombarded by the messages it generates. A sort of myriad conformity is enjoined in which although anything goes, it does so because to name it and speak it out is to domesticate, normalise and control. The more diversities and perversities can be discovered, the greater the need to tame and incorporate them and to advise their victims and perpetrators as to their proper course. This is a never-ending round of strategies that generate and assimilate behaviours and create the appropriate channels, skills, locations and personnel - the club, group or helpline to subscribe to. Whatever one's affliction, enlightenment or peccadillo, it can not only be catered for, it should also not be regarded as unique. Indeed, once fully integrated, one can oneself advise and direct others on the basis of personal experience, a self-

proclaimed but legitimated 'expert', a conduit for expertism. Hence the need for new forms of elite training to differentiate yet another legitimate group of 'experts' and professionals is established. This discourse in turn goes on to ratify its own objects, hone in on new sites of influence, and perfect its own invasive techniques. The spread of lay skills is neither an abrogation of categories nor is it a 'liberation' of the individual. Rather, it permits a universalisation of certain requirements of expertise, in the creation of new disciplinary forms of subjectivisation.

4. Childbirth and Psychiatry

4.1. Post-natal bonding: a measure of true belonging

Psychological testing in combination with routine medical tests is a feature of modern childbirth. Macfarlane (1977, p.24) suggests that this will ultimately improve obstetric predictability. Further, he speculates that: "...detail of the interactive behaviour of mother and child can give us clues as to how a foetus actually does develop into a social being. Perhaps psychologists are attempting to be modern-day prophets, taking over from the astrologers of yesterday." (1977, p.112).[1]

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[1] In an illustration in Rueff's midwifery manual, the childbirth scene is depicted as progressing appropriately with female neighbours and attendants, with the parturient woman being delivered on a birth-stool by a midwife who has a bag of obstetrical instruments fastened to her girdle and hanging at her back. Cutter and Viets (1964, p.189) go on to describe the scene: "a tub of water stands on the floor in readiness for the child. Two neighbours support the patient. Scissors for dividing the umbilical cord and string for tying it are on a table nearby. In the background are two men observing through a window a new moon and the stars, ready to cast the horoscope of the new arrival. They would be the only men allowed in the lying-in chamber in Rueff's time and would not be allowed to take part in the delivery." These are interesting details. Apart from the superficial simplicity of the scene there is evidence that the practical skills are those of the midwife while it is men on the periphery casting horoscopes and generally lending the sort of mystique which might later be associated with witchcraft. There is here evidence of a two-fold transition. Women come to take on the peripheral and subordinate role under the supervision of men, and were also regarded at worst as witches rather than healers, and at best, unprofessional peddlers of charms, gossip, magic and narcotics. Men gradually take on a more central and integral role, if always at a certain remove from the event itself. This is not a slick transition but one which depended on the elevation of certain extraneous ritual into healing techniques when perpetrated by men, and the simultaneous denigration of these rituals as unscientific when carried out by women. It may be of significance that horoscope-casting was to do with the prediction of future outcomes rather than healing, and that astrology permeated the medical discourse and lent it its early preoccupation and presumptions concerning the possibility of making predictions about the future course of disease and sickness. This will have particular effect upon childbirth practices in our own century. In this schema, astrology becomes prognosis, alchemy becomes pharmacology. Women are regarded as oracular channels, the unprofessional

While it is certainly possible that modern obstetric practice has created a psychology of childbirth (which must be examined, explained and serviced), it is equally certain that whatever obtained before the parturient psychotic was created was as much a construct of the conditions of childbirth as anything the technology of the delivery room, or the homogeneous and simultaneous tutelary potentialities of the maternity ward could offer.[2] Just as interventions in the birth process often escalate the need for further interventions, it might be said that the psychoses associated with modern childbirth are a product of similar cumulative effects. Having implicated the Western woman of the late twentieth century in the scrutiny of her prehistory and present lifestyle pre-conception, the opportunities for expert appraisal of child-rearing, have been extended by the linking of the progress of the child to the post-natal psychological condition of the mother.[3]

The new deviant, the mother-neurotic, is endlessly interpretable in her anxiety about her relationship with her child, her child's health, the changing relationships with other family members, and perhaps the interruption of her career, and the certain disruption of a childless lifestyle (Cox, 1986). An entire advisory discourse has evolved around the creation of a lifestyle for the family with young children. They have their own places, spaces, experts, gurus, literature and support. They know what they should be achieving. Failure to achieve, while perhaps having catastrophic consequences for the individual, will in the scheme of things, simply involve a change of emphasis, another safety net, where a

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purveyors of poisons, testing grounds for drugs, potions, instrumentation. Female medicine was always more remedial; and male more predictive. This division has permeated modern obstetrics in the regimen of pregnancy, and the timetable of labour.

2 See Day, 1982, pp.17-45; Hamilton, J., 1982; Thune-Larsen, 1988, pp.229-40.

3 See Ballinger, 1979. pp.293-300; Hall *et al.*,1980; Wellburn, 1980.

different set of experts approach the problem created for them by another interrelated professional group. There is always an inbuilt failure feature and a reassuring expert for all seasons on hand.

The discourses of science and of Christian theology create motherhood as their subject and object. It is the condition described by Kristeva (1980, p.238), as 'elsewhere', 'thoroughfare', 'filter', and 'threshold'; the meeting of nature and culture. The self-examinatory practices of Christianity were strategies to interrogate every thought for its potential subversion. This is a more ambitious aim than the control and regulation of the body which was pursued in ancient practice. In the Christian ethic, bodily self-control was implicit but not paramount. This was the beginning of the history of psychological practices that have developed to the present century. More importantly here, it reveals an obsession with the seeking out of intentionality. The war waged with oneself, can be regarded as the root of anxieties about anything hidden or 'other', or concerning that which is subterranean, unknown, unseen. Freudian psychiatry has seized upon the awe and fear associated with childbirth and the cultural ambivalence surrounding the parting of mother and child - the ultimate symbol of revelation in a revelatory culture.

The importance of Freud and Bichat to the modern disciplinary discourse, lies in the fact that the health of the individual has come to be regarded as a more prestigious and rewarding discursive object than his or her salvation (Foucault, 1973, p.198). The use of childbirth anaesthesia and the eventual technologising of birth comes to be legitimated. It removes the debates of hygiene, and of suffering, from the realms of spiritual purity to the pragmatic and disciplinary need for a bodily regimen of cleanliness and well-being. As the mother's behaviour, linked to her childbirth experience becomes increasingly a matter of accountability and comment, she becomes more deeply implicated in a web of relations of

her own devising.[4] She is told at every turn it is her fault, but not her responsibility, in a reworking of the old themes of confession and absolution. However, there is no doubt as to the mother's integral role, and the continuing part played by her childbirth experience, in whatever pattern of relationships and behaviour that establishes itself thereafter: "In some of the studies I do of young infants, I feel I can pretty much tell in advance which babies will stay awake and not cry during the tests - simply by talking to the mothers beforehand. This might be because the mother has in some way, pre- or postnatally, influenced the child's behaviour, and I can recognise it from her anxiety; or it might be that she is making me so anxious that, when I handle the baby, I do it badly and the baby cries." (Macfarlane, 1977, p.26)

The dialectical processes of separation and structured reunification take place in relation to the child and mother.[5] A practice which has of recent years waned in acceptability is the separation of mother and child for post-natal checks and treatments; the latter had ostensibly coincided with maternal recovery time (Enkin et. al., 1989, pp.295-303). These practices, which treated the child as a product of the hospital have diminished as more subtle and scientific methods have ensured the status of the hospital in relation to the child, and a different attitude has come to prevail which, while encouraging the mother to have immediate and prolonged contact with her child, is not necessarily a sign of institutional

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[4] See Bibring, 1961, pp. 9-62; Dunn and Richards, 1977; Klaus and Kennel, 1982.

[5] Sexual differentiation and the ability to experience continuity through time *via* the discontinuity of physical reproduction, operated as a sort of safety mechanism; and for Christianity, was something of a sideshow. The story of the Fall suggests the punitive and salutary effect of childbirth; and the fear of moral and mortal dangers in the recreation of human life. There is rebirth in the Father, and heavenly reunion with the mother, but true joy is in the afterlife, which is not to be found or resolved on earth. The reunion between Mary and her son, must take place beyond death, through suffering and penance. Here there is no harvest, and fleshly pleasure is overcome.

relaxation. Rather, it is that the monitoring of the relationship between the mother and child yields a more productive result by way of the longer-term implication of the family in tutelary relations.[6]

In the benign emphases of modern psychiatry, nourished by the media and by advertising, the stress is upon private fulfilment in the areas of childraising and domesticity, in which the interiorisation of expertise is the goal. The psychiatric discourse has exemplified and heightened the notions of dependency, reinforcing the implicit eroticism of the doctor-patient 'couple' (Doane, 1986, p.169), who were fostered and prefigured in the major debates of the nineteenth century. Lacanian psychology also regards reproduction as the fundamental reality which provides the mainspring of other discourses. Perhaps the ultimate division, which characterises the divisive nature of logocentric practices, is the fragmentation of childbirth: the castratory loss following the phallic fulfilment of pregnancy.[7] This is a facet certainly of the cultural construction of childbirth, and also of

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[6] In ancient tutelary relationships, a delicate balance of strategies had to be devised to make allowances for the freedom, dignity, and power of decision making of the other. Timing and status were important; an age imbalance was usual and in both marriage and in homosexual relationships there was an element of tutelage. A woman's relationship to her male relatives and to a panoply of male experts rely on an acceptance of tutelage in its various forms. This might be in relation to the private and personal concerns of marriage and lineage, or later in confession to her priest, or later still to her psychiatrist. Such acceptance can be found in the practice of the midwife under the actual or written guidance of the male physician or in the compliancy of the parturient woman herself when she is advised upon the latest techniques for the hastening and betterment of her own natural processes in childbirth. It is also to be discovered in the anxiety of the new mother to 'do-things-by-the-book', and the power that this 'voluntary' subjection of ones behaviour to scrutiny confers upon the notion of expertise.

[7] See Lacan, 1977, pp.1-7, 1979, pp.281-91; Gallop, 1982, pp.15-32, 105-12, 113-31. Hegelian philosophy epitomises the axiomatising of the lack of female instrumentality in the organisational strategies of Western phallogocentrism when it insists upon the metaphor of the powerful foetus, thereby ignoring the process of childbirth by speaking in terms of the child "breaking free". In the fragment *On Love*, Hegel states that reproduction has a dialectical logic, it is a process "of unity, separated opposites,

the appropriating phallocentric rendering of reproduction which privileges knowledge over experience (partly because that is the mode of paternity) and forges co-operative alliances between men, and between men and women: "There is evidence that by the unceasing creation of modes, principles, and symbols of continuity men have obscured the fact that the material base of human history is human reproduction." (O'Brien, 1982, p.107).

In antiquity, the hostility and incompatibilities between men and women are acknowledged, but the possibility of reconciliation and compromise is allowed. This is not an option paradigmatically available to Christians, who are permanently implicated in a perpetual relation of sin and anxiety. Sexuality and procreation merely reinforce that the two are not one as God intended.[8] A certain quality of estrangement still pervades the concerted efforts to permit and promote intimate contact and subject to surveillance the development of bonding. Consequently the mother may behave as if she is being

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reunion" (Keohane et al, 1982, p.105). Male/female dualism has pervaded Western consciousness and reinforced the logocentric organisation of the thinkable in terms of opposition, whether in terms of irreconcilable dualisms, or incorporative dialecticisms (Cixous, 1975, p.116; Jardine, 1986, p.85; Suleiman, 1986, p.24). The couple analogy is also available in the mother/doctor configuration, and in the notion of separation inherent to the psychiatric discourse of childbirth. The parent/child hierarchy has tutelary implications. Given the cultural prevalence of evolutionary and linear progressivism punctuated by successive hierarchical stages, as an explanatory and ideal formulation incorporating a model for achievement, the analogy of human reproduction and maturation suggests itself as the representation and ratification of other social arrangements.

[8] It was a commonplace of Christian commentary that imperfections in those supposedly created in God's image could be regarded as inevitable rather than anomolous. The theme propounded that God foresaw the Fall and therefore, rather than creating a perfect sexless being, man was made a divided entity capable of reproduction. At the Resurrection, nature would be reunited with herself as God had intended and therefore sexual difference was, like life on earth, temporary, and to disappear. However, complex doctrines exemplified by the writings of Gregory of Nyssa, (*De hominis opificio*, 12.9), propounded that God had not intended the division of the sexes but undivided perfection (Veyne, 1987, p.294). Division made sexuality possible and the resultant coupling and childbirth amplified divisiveness. In fact, viewed in this way, procreation appeared to be against God's will.

monitored, thus the surveillance in itself will inhibit 'natural' responses, and promote institutionally acceptable ones. Gradually a mutually generated 'scientific' encoding occurs whereby that which is objectively unmeasurable, can be devolved upon criteria that can be evaluated. The careful tagging of mother and child testifies not only to the need to ensure that mismatchings do not occur, but also that the mother may not recognise a child as her own, particularly as the practice of tagging subliminally reinforces that the hospital possesses the child produced within its confines. The confirmation of true belonging is reliant upon identification bands and labels.

While the post-natal procedures that entail the immediate removal of the child from maternal contact have been largely abandoned, the benefits of exploiting the symbiotic and physiological bond between the mother and child have been realised by the obstetric institutions. One example is the natural post-natal maintenance of infant body heat (Philips, 1974); another is infant suckling which promotes *post-partum* uterine contraction thus helping to avoid haemmorhage (Kitzinger, 1983, p.76). However, the latter can be more readily assured by the use of drugs such as syntometrine to expedite *post-partum* expulsion, which may require that further interventions such as manual cord traction to remove the placenta have to be adopted (Kitzinger, 1983, pp.76-7). It is also unlikely that breastfeeding is promoted solely on the basis of its natural efficacy. What has occurred is a re-examination of the newborn and a focussing upon their interests, making them the object of comparison and scrutiny.[9]

The mother has generated a wealth of contentious information about her abilities to nurture a child (Martin and White, 1988). The arguments have a historicity based not simply in what constitutes fashionable childrearing, but in the deepest of anxieties about

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[9] See Kron et al, 1966; Aleksandrowich, 1974, pp.121-41.

the sustaining of life, and the nurturant role of women.[10] As the object of enquiry, the parturient and the mother have generated a wealth of material and information, they have provided endless scope for scientific and expert attention. A panoply of experts attend her needs, and exist only in relation to her as an object of knowledge, that which she herself constitutes as her subjective understanding of self-hood is a negotiated portrait; defined and redefined in her relations with the professionals she 'employs'. There are birth control and fertility advisors, health experts, visitors and aides, the host of obstetric specialists, those who prepare, scan, evaluate, oversee, anaesthetise, intervene and deliver. Then there are the paediatricians, the child psychologists, the psychiatrists who specialise in what has been labelled as post-natal depression, itself graded in a hierarchy of seriousness and severity, which ranges from the euphemistic 'baby blues' to the longer term and dangerous puerperal psychosis.

There is something for everyone. Far from decrying the reduction of childbirth to a relatively simple technological event, which is likely to be further minimalised in the interests of childbirth safety and the ensuring of the status of the institutions where it takes

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[10] There are ancient resonances concerning anxieties and strictures about breastfeeding. In the work of Soranus, there are prescriptive passages which refer to both midwives and wetnurses. Both must be of good character, health and habits; for the nurse, sex and drink is disallowed and self-control essential (Lefkowitz and Fant, 1982, pp.110-11; Gardner, 1986, pp.241-3). As for the ideal midwife, who should perfectly combine masculine strength and deft but child-like hands, there is also an ideal physical description for the nurse. She is required, for example, to have a suitable frame and breasts (*Gynaecology*, II.19). Wealthy mothers rarely fed their children themselves, and as the character of the nurse was thought to be imparted to the child (I, 19-21), her behaviour was accordingly scrutinised. Sobriety and good character had to be (with difficulty) assessed and guaranteed (Lefkowitz and Fant, 1982, pp.164-8). Certainly, under these circumstances there was some pressure upon women of status to feed their own babies. Nursing mothers themselves were subject to similar strictures as those placed upon employed wet nurses. The latter were to lead as blameless an existence as that ideally mapped out for wives, while for the former an ideal of 'complete' motherhood, involved continuity of nurture by the 'natural' mother (Lefkowitz and Fant. 1982, p.132, Lefkowitz, 1986, p.50).

place, it is rather that there has been a vast extension of the powers of expertise, and a veritable discursive explosion around the pregnant, parturient and parent woman, where the creation and examination of objects seems limitless and up for appropriation. It should not be forgotten, that in generating the subject; there will be a reciprocity of effects

Of recent years, there has been an ostensible encouragement of breastfeeding by both the institutions and the alternative movements, although it has moved in and out of general acceptability. The choice of artificial feeding available has been improved by the promotion of commercial preparations which have been a *'natural' concomitant of rigid* hospital routines, and isolatory practices. The 'breast-is best' lobby have made objects of both the breast-feeding, and non-breastfeeding mother, and the champions of one or the other have come to examine themselves as subjects of that discourse.[11] Often the rhetoric

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[11] For statistical information, see Department of Health, 1988; Joint Breastfeeding Survey, 1990, Royal College of Midwives, 1990. For details about the pressure upon the modern parturient to breastfeed, see Stanway, P. and A., 1978, Kitzinger, 1979; Renfrew and McCandlish, 1992, pp.81-98). For expositions on aspects of the modern medicalised phenomenon of breastfeeding, refer to Stein et al, 1987; Palmer, 1988. Historically, ancient concerns became refined in the Christian ethic. All physical secretion was subject to pious scrutiny, and the nature of lactic fluid had been a source of moral and medical confusion since ancient times. Darnton (1984, p.187) suggests that the "ambiguous border areas of the body, where the organism spills over into the surrounding material world" must be policed because they are chaotic and mystical, and challenge the existing categories. Childbirth and child nurture both enter this realm of ambivalence and attract policing because of their aspects of extension and separation, of their two-in-one symbolism, of the disruption of the parameters of what is distinct and independent life; a vexed question throughout the Middle Ages to the Enlightenment, and a matter of increasing medical and ethical concern in the present day. Also of historical interest, Rousseau, "the prophet of breast-feeding and maternal love", who was responsible for elaborating a paeon to 'complete' motherhood by emphasising the desirability of maternal nurture also reflected the preoccupations of the time (Darnton, 1984, pp.230, 239). Additionally, the expression of the Enlightenment need to classify and order phenomena was epitomised by Rousseau's *Confessions* (1777-8). This was the ultimate expression of the impulse to 'truth-telling' and admittance of moral failure. The reader is inveigled by 'honesty' and the power of self-exposing rhetoric

of the hospital is undermined by the practical exigencies of rotas, rosters and routines, and early attempts to accommodate the newly realised paradigms of maternal feeding were clumsily adapted to the clock, and often unsuccessful as a result. Demand feeding does not lend itself to the precise fracturing and compartmentalisation of time implicit in the organisation of a large-scale institution. Conflicting advice may have to be sifted according to the immediate needs of changing shifts and the avoidance of disruption to schedules. Recent evidence suggests that infant feeding is slightly declining despite recent joint medical and lay initiatives (Donnithorne, 1990, p.14)

Modern ambivalence regarding breastfeeding has historical antecedents. The juxtaposition of conception/pregnancy and consumption/digestion, is a feature encapsulating the fears of both antiquity and Christianity concerning charm and endangerment, immoderation, greed, power, and decay. Freudian psychology makes the negative equation 'faeces - penis - baby'. For Freud, the ultimate signifier for childbirth and for standards of normality, is the phallus: "...an entirely unfeminine wish to possess a penis is normally transformed into a wish for a baby, and then for a man as the bearer of the penis and giver of the baby..." (1973a (1932-3), p.134). All of women's desire is interpreted as being predicated on this lack; the desire for a baby replacing desire for a penis (Gallop, 1982, p.99; Nye, 1988, pp.148-50). Childbirth, in this schema, is diminuitively portrayed as penis envy. The desire for the penis translates in the adult woman into the desire for a child. As Cixous (1981, p.262) has postulated: "What's a desire originating from a lack? A pretty meagre desire." In the configuration with childbirth, the equation is made either with waste, or with castration and loss. Juliet Mitchell (1975, p.102) points out that: "Children believe that babies are born anally, like faeces: the straining, the release, the production of something new out of oneself is a prototype of birth." The equation of childbirth with

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(Gutman, 1988, pp.99-120). This 'baring of the soul' became a literary convention, and later, a paradigm of psychiatric discourses.

waste is inherent in the Freudian notion of 'gift', which comprises faeces in the case of the child, and the child itself as a gift to the mother in the first instance, who then gives the child to her husband.[12]

The association of childbirth and evacuation has ancient connotations; labyrinthine legend in Freud's analysis is a representation of anal birth: the bowels become twisted paths and the umbilical cord, Ariadne's thread. (Freud, 1973a, (1932-3), p.54). The psychoanalytic appropriation of myth legitimises interpretation (Cassirer, 1955, Deleuze and Guattari, 1977). Oedipus, with its powerful inversion of the exigencies of birth enhances the mystification of the mother/child relation and can be regarded in the modern discourse as an assertion of maternal passivity. Its original import was yet another representation of the feared abrogation of familial relations, and an illustration of activity in relation to the mother, which, for men, had positive symbolic connotations. The theme of contamination is also implied. Birth anxiety in Freud and elsewhere, is the model for all subsequent situations of danger, and the originator of all later neurotic disturbance (Rank, 1924). The proximity of the vagina/uterus to the anus/bowel fostered such analogies, as did the ambiguity towards the internal workings of the stomach, where it appeared the largely mysterious processes took place whereby both the individual and the foetus were nourished. From antiquity, the imagery of sexual desire also often centred on the stomach

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[12] "If one is not aware of these profound connections, it is impossible to find one's way about in the phantasies of human beings, in their associations, influenced as they are by the unconscious, and in their symptomatic language. Faeces - money - gift - baby - penis are treated there as though they meant the same thing, and they are represented too by the same symbols." (Freud, Lecture XXXII, *Anxiety and Instinctual Life, "New Introductory Lectures on Psychoanalysis*, p.101, in Mitchell, 1974, p.103). The act of being born is linked, as in Hegelian philosophy, to foetal activity, and is diagnosed as the root of anxieties, particularly those related negatively to excretion, isolation and darkness:"We believe that it is in the act of birth that there comes about the combination of unpleasurable feelings, impulses of discharge and bodily sensations which has become the prototype of the effects of a mortal danger and has ever since been repeated by us as the state of anxiety." (Freud, 1973 (1915-7), p.444).

and umbilicus; and sex and eating were often similarly problematised.[13] Both were historically fraught with prescription, prohibition, and exhortations to abstain.

The negative association of childbirth and waste is accentuated by the theological appropriation of images provided by the humoral theory of ancient medicine. Chrysostom (*To the Fallen Monk Theodore*) describes the seething and corruptible elements of the body: 'phlegm, blood, bile, rheum, and the fluid of digested food' in women as 'most persuasively camouflaged'; by the superficiality or 'whitened sepulchre' of her outward appearance. (Musurillo, 1962, pp.65-66) Women's active potential for adulteration and poisoning was a persistent theme; Chrysostom calls especially to account "those who prepare the draught and concoct the envenomed potions." (Warner, 1978, p.59). It was against this background, that the fear and persecution of women as witches later developed. At the end of the thirteenth century, the *De Secretis Mulierum* of Albertus Magnus reinforced such beliefs. Here again, the sexual act was associated with consumption (Jacquart and Thomasset, 1988, pp.74-75, 80). In antiquity, there were the questions of desire and self-mastery, but in Christianity there was a deep encoding of greed and concupiscence, that found its material symbol in the swollen stomach of the female. That the body of whatever gender, engulfed and corrupted food and drink, and then emitted it as waste was a potent image which had obvious parallels with the procreative acts of conception, gestation and childbirth; and with the compelling and evocative addenda of lust and enfeeblement; secrecy and corruption; effluence and pain. It is hardly surprising that fasting, like chastity, featured high on the agenda of Christianity.[14] This is

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[13] See Lefkowitz and Fant, 1982, pp.92-94, 165-6, 220-1; Just, 1989, pp.163-6, 186-7.

[14] There was a more subtle connection between female sexuality and the consumption of food. Fasting caused amenorrhea; so that young girls, also encouraged to physical discipline, silence, and self-mortification, might avoid the scourges: menstruation and childbirth, that marked a polluted womanhood. As other aspects of women's biology and of childbirth, were subject to prohibition and indignity, so too was lactation and breastfeeding. Suckling was an indirect result of the Fall, and depictions of it,

a central correlative image, which has complex connotations affecting the status of women. For example, they had an interrelated responsibility for both biological and domestic nourishment, and in that position of trust they were most suspected; the possible abuse of power located where power was believed to reside.

The myths associated with menstruation included beliefs in the power of menstrual blood to produce crop failure, disease and other supernaturally induced terrors. A woman's physiology was regarded as possibly venomous - even her gaze while menstruating could prove deadly. It is understandable that, ratified by 'scientific' and religious authority, the popular superstitious beliefs in women as poisoners, abortionists, and sorceresses, identified women negatively with the associations of their normal biological functioning in a misogynistic and hostile discourse.[15] However, from the twelfth century, but more

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particularly those of Eve in fourteenth and fifteenth century illuminations, represented the natural and necessary humiliation of women. (Warner 1978) Lactation, as in antiquity, was associated with menstruation and they shared similar taboos. Menstruation was of course linked etymologically via its cyclical analogy, to the lunar cycle, and with literary sentimentality, it was linked also to blossom before fruit, as in the texts attributed to the Salernitan midwife, Trotula: "just as trees do not bear fruit without flowers, likewise women without flowers are unable to fulfil their function of conception." (Jacquart and Thomasset, 1988, p.71). The historical prevalence of the 'nature metaphors' which include earth and field, to describe the fertility of women, has in itself emphasised a vegetating passivity, as well as obvious romanticisation.

[15] In the *Summa Theologicae*, Aquinas insists that only 'purified' menstrual blood can be part of embryology; stripped of any of the more positive ancient connotations of healthful purging, normal menstrual blood had only the remaining evil and unclean associations of decay and waste, as did the fluids expelled in childbirth. The purified blood imagined by Aquinas, was a non-active but facilitating female 'semen', a mediated blood (Jacquart and Thomasset, 1988, p.77). It is clear that theological imperatives motivate and assimilate scientific enquiries in a reciprocal arrangement. Although in the Medieval era, the taboos of menstruation also affected lactation, the developing disciplinary programme could accommodate suckling, because it required abstinence to ensure that concupiscent thoughts did not transmit to the nursing child, a notion which was of ancient origins. Representations of the act of suckling

particularly in the fourteenth, European depictions of the lactating Mary are softened and domesticated; made intimate and intense. The visual image of the bare-breasted Virgin had ambiguous iconoclastic significance; it was an acknowledgement of women's power over life and death, and represented also an exertion of power over women which was displayed in the figure of the Virgin who epitomised an unattainable perfection. There was also the ambivalent mixture of threat and promise in the depiction of the power of conception, nourishment, shelter, and sustenance of life, which may have had an especial significance for the fourteenth century observer who endured times of hunger, plague and social upheaval. This banal image of comfort may well have been 'the body's best show of power' (Miles, 1986, p.205).[16]

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usually emphasise women's subjection and provide reinforcement for the acceptance of the trials that accompany the taint of Eden.

[16] A mother and child iconography appears to be developing, until indications in the fifteenth century that the pedestalisation of women will not permit of images that are immodest and lowly. This is especially so, as the desirability of an activity which retained the stain of Genesis was obviously questionable, and which had for the wealthier classes been regarded as the province of servants (Warner, 1978, pp.203-205). The strain of Puritanism which, for the first time, asks profound questions regarding intentionality, also makes enquiry of such images, testing them for their purity of design and purpose. More particularly, in the general attribution of the necessity and certainty of human failure, the arrogance of maternal nurture must also be scrutinised, and the failure to nourish adequately and without sin, made a prerequisite of penitence and absolution. The blood-taint of maternal milk has a comfortable and comforting place in such mythologies.

5. Professionalising Childbirth

5.1. The emergence of expert discourses

Midwifery was, from earliest times, the cornerstone of family medicine; consequently, the latter was relatively open to women of the lower classes. Regarded as distinct from the parturient woman since ancient history, *intellectually able* and *intelligent* women were themselves, likely to be of or constitute a sub-class *who* did attract some regard *despite* their lack of status. The ambiguity, anxieties and double standards regarding unregulated and potentially dangerous women was paradoxically related to their exposure to men, and their probable 'contamination', both sexually and intellectually. Women were not only divided from men, but in subtle ways, increasingly from each other. Yet they mingled in their households, and created a potentially explosive cultural overlap. Childbirth attendants affected nearly every aspect of female life and procreative activity; love, birth, death, contraception and abortion.[1] They were also (because they could not openly manifest their power) involved in the management and manipulation of others, and in the tutelage of deception, delight, and concealment. They were 'tarnished' simultaneously with the fears associated with the symbolic connection between birth and death; the dread of old women, of tears, of gossip and familiarity. They represented infringements of the normalised and divisive regulation of space and time between the sexes. In a world of

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[1] There is some evidence of continuity in modern practices where the polymorphous aspects of women's sexuality are given attention in centres that deal with contraception, abortion, pregnancy counselling, care and testing, examinations and therapies, and childbirth classes and clinics. This echoes the old practices of the community midwife who counselled on all aspects of sexual and family life, though the modern equivalent is a discursive apparatus which emphases confidentiality, and is detached from the community on other levels. Usually childbirth attendance itself is a fractured form of care which may involve more than one stranger.

potential political intrigue, a mirror was to be found in domestic arrangements which were the possible breeding-ground for illicit gathering, and complicity, for spying, disloyalty, conspiracy and dissension. These fears in turn permeated a variety of other contexts, which could operate to the disadvantage of women, determining the nature and nuance of prejudice and belief. Understandably, these anxieties fuelled the rather strident prescriptiveness regarding the suitablity of midwives and wet nurses who unavoidably over-stepped the barriers of status. This was the problematic concomitant and function of isolation, categorisation and policing.

From its earliest history, childbirth came to be constituted as a specialist field, and was regarded as one in which women had natural abilities rather than expertise. One of the most important and influential guides was Soranus's *Gynaecology*.[2] Therein the cautiousness of the provisos and concern with the avoidance generally of unnecessary physical stress, capitalised on the natural resources of the parturient and her attendants. There is patient regard for time and an informal sensitivity to the forces of gravity. The general recognition of the need for kindliness, reassurance and the preservation of dignity

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[2] Soranus's *Gynaecology*consisted of a sophisticated range of obstetrical and gynaecological topics which were discussed in four books addressed to midwives. Two of these books were concerned with 'normal' deliveries and concentrated on descriptions of female genitalia, on hygiene, on aspects of normal pregnancy, labour and birth, and on infancy. The other two were concerned primarily with the abnormal; describing gynaecological disease and its treatment by dietetics, surgery and drugs. Here also, dystocia or difficult labour is treated at some length, and is attributed not only to foetal malpresentation, or problems with the birth canal, but also to psychological causes. Impending danger was to be ascertained by careful attention to respiration and pulse. It is evident that in such cases, physicians consulted with midwives as to the proper course of action. Lubrication of the uterus was thought to be most efficacious; while forced dilatation or surgery was a last resort. Soranus entirely rejected more brutal methods such as violent shaking or the sudden dropping of the childbed. Although he was conscious that methods to accelerate delivery increased the danger of prolapse or dislocation, it is suggested that the amniotic sac should be ruptured manually if it remained too long unbroken. He was also clear that surgery was the likely recourse after dilatation if birth still did not progress properly (*Gynaecology*, IV.7 in Jackson, 1988, pp.88-92).

within an all-female support system, are all salient features of this guide. The reduction of fear and suffering appears to be at least as important as the need for balance, control and symmetry. What is remarkable and seemingly precursive of later attempts to organise and pathologise childbirth, is the detailed ordering of the experience. The 'players' are positioned as if on a stage. Soranus advises: "...three women should be ready who are able gently to calm the fears of the woman who is giving birth, even if they do not happen to have experience in childbirth. Two should stand on the sides, and one behind her so that the mother does not lean sideways because of the pain. If no birthing stool is available the same arrangement can be made if she sits on a woman's lap...Finally, the midwife, with her dress belted up high in an orderly way should sit down below, beneath and opposite the mother."[3]

Calm, reassurance, fearlessness and sympathy must be imparted to the gravida - who must be kept frankly informed. Certainly it was felt that trust could only be established through reassuring eye contact, and that a balance should be sought to preserve the gravida's modesty where breaches might lead to tension.[4] It is clear that the gravida should be helped with prophylactic breathing, restraint and other appropriately timed aid to avoid strain or prolapse and to deliver the infant safely (Lefkowitz and Fant, 1982, p.225). The practicing midwife must have more than mere manual dexterity. Even under the guidance of a physician she must exercise her judgement regarding delivery according to

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[3] Soranus, *Gynaecology*, I, 67-9 in Lefkowitz and Fant, 1982, p.224

[4] This frank exchange of gazes will diminish over time. When the male midwife stands before, then above the parturient in the centuries to come, they will avoid each others eyes and the woman's genitals will be completely covered from view (Donnison, 1977). Disclosure will feature again in the twentieth century as the now fully demystified site becomes the open theatre of a technologised event during which intellectual and emotional contact between gravida and deliverer comes to be regarded at worst, as redundant, or at best, to be partially, though not disinterestedly, reinstated.

presentation, to know when and how to effect placental expulsion and when to cut and tie the umbilicus. She must know how to check pulse and respiration for signs of impending danger, how to use lubricants effectively and to manipulate without violence (Jackson, 1988, p.104). It appears that midwives were also consulted about issues related to care after childbirth and this indicates that there must have been some continuity and further involvement by these women in family life. It is not perhaps impossible to see in the opportunities for intervention occasioned by childbirth the early signs of a collaboration between the family and the agents of expertism.

It is not clear what women's experience of these arrangements might have been. Unacclaimed or clandestine groupings were multi-functional, though they clearly did not always operate in the service of women. In a paradoxical prefiguring of the later normalised relations between the family and external expert agencies, there was a collusiveness between the family and the outside world via midwives, nurses, educators, matrons, servants, match-makers and confidantes. These mediatory figures tended in antiquity to be organically bound to the family by kinship, friendship or subordination, and unlike their modern 'counterparts', they were not bound by a collective professional ethic which refined the regulatory relationships already established, and which created a discursively productive distance between the family and the panoply of expertise it would employ.

It is interesting also that it is the female midwives of antiquity who are the figures best placed for this type of incursion into private life. It is this position of relative privilege that is a site upon which the disparate roles of servant, confidante, mediator, advisor and supervisor are interwoven and reconciled. A model perhaps for the later invasion of medical expertise, from the doctor, the consultant, the counsellor and the psychiatrist. In the prescriptiveness of Soranus, the prevalence of masculinised ideals are indeed articulated, but the evidence of this lies not so much in the advice itself, but in the

regulatory strictures regarding personnel. It is evident that the age and status of a woman did not ostensibly disbar her from midwifery so long as she was strong and able. Also, childlessness was not a bar; after all, many of the goddesses who were associated with childbirth were themselves childless, and were considered consequently the more capable of unemotional 'masculine' single-mindedness.

It is of significance that childlessness was no bar to midwifery; and that in the ancient myths childlessness was regarded as the prerogative of the gods. Its acceptability is a reminder that in the pre-Christian era a certain value was placed upon virginity, and that childlessness and virginity provided welcome evidence of certain ascetic (therefore scientific, authoritative and 'manly') qualities. In this way gynaecology could also become an appropriate field of study for men. There is a sexual dimension to the interchangeability of masculinity and science. For while parturition itself remains an impervious female event, it was widely held that conception relied entirely on men which gave scope for other areas of control over childbirth.[5]

More specific demands made of the midwife involved the need for literacy, articulacy, diligence, discretion and respectability, and modesty of habit and desire (*Gynaecology*, I, 3-4). These requirements reflected a general preoccupation with the perfecting of individual existence, and not simply a vision of passivity and restraint reserved for the behaviour of women. The need for a range of diagnostic skills and the acquirement of knowledge to act upon initiative is certainly not regarded as the prerogative of men. Midwives were expected to be multi-skilled and to prepare themselves by seeking

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[5] For example, one view was that: "...men are necessary not only for conception...but also to bring on labour by having intercourse with their wives". For male doctors, penetrative interventions became legitimised by such attitudes, which could also be translated into exhortations to attempt "...to speed up labour with appropriate drugs." (Aristotle *Historia Animalium*, 584a 30-1 in King, 1983, p.111).

appropriate advice where difficulties arose. Also, while adhering fairly rigidly to certain strictures, they should be able to exercise judgement regarding individual cases: "We call a person the best midwife if she is trained in all branches of therapy (for some cases must be treated by diet, others by surgery, while still others must be cured by drugs); if she is moreover able to prescribe hygenic regulations for her patient, to observe the general and individual features of the case, and from this to find out what is expedient, not from the causes or the repeated observations of what usually occurs or something of the kind" (*Gynaecology*, I. in Lefkowitz and Fant, 1982, p.163). Pathologisation was clearly beginning to encroach on a natural process, and followed the patterns of the understanding of disease. Despite the emphasis on observation, questioning and examination - a certain rigidity and universality of approach and regulation is already to be discerned.

Soranus writes of the 'suitable' midwife that she must be literate in order to comprehend the art through theory (*Gynaecology*, I.37 in Scarborough, 1969, p.47). The notion that women must become versed in theory as well as having practical and remedial skills also suggests an early shift towards professionalisation. Accent on the exercise of judgement and for a level of literacy which induced a power of thought capable of theorising, disguises the fact that the insistence on theory already presupposed a fixed, legitimate and male inspired body of knowledge. The fortitude and patience required to gain such knowledge must be 'manly'. 'Manliness' was not entirely an epithet for intellectual muscle, it also denoted the extreme physical fitness that was considered essential to endure the long hours of labour. However, manly qualities are already intellectually differentiated and thought to be necessary even or especially within a predominantly female arena.

The private world of women might appear to threaten the establishment of the political realm envisioned in Platonic dialogue (*Symposium*, *Republic*, in Lefkowitz and Fant, 1982, pp.66ff.). This emblematic space of women, redolent of secret and taboo is problematic

because it appears (while a symptom only of existing paradigms) separate and other.[6] At a more profound level - the utter separation of male and female activity and the enclosed nature of the latter, heightened, particularly for the men who insisted upon and perpetrated such social and societal parameters, the sense of a secret and mysterious world of women from which they absented themselves and felt themselves to be excluded. These parallel lives had serious implications for gender relations in so far as the social arrangements that accommodated them, created, reinforced and ensured both the fears and the containment of such fears.

The guidance and guardianship of women reinforced their supportive and subordinate role; their dependence emerged as normal against this background. Restraint and submission to authority must have been considered virtuous among women themselves, whose gatherings for social and religious purposes, were depicted in the undercurrents of popular literature and myth as either menacing or ridiculous.[7] In reality, the practices of female assemblies

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[6] The fear of the gathering and collusion of women pervaded the ancient unconscious. In Artimedorus' *Interpretation of Dreams*, for example, while the act of penetration between men had varied but rarely negative connotations, similar acts between women were regarded as unnatural, transgressive subterfuge (Foucault, 1988a, pp.3-25). Relations between women in dreams signified futility and widowhood; an act of mourning for the absent male - but most importantly, and most damaging to the male psyche is the significance of the communication of a secret knowledge between women.

[7] Fears surrounding possible female subterfuge, although often popularly satirised, obviously attach themselves at the heart of the family to the issue of paternity. Where children were considered a part of a man's wealth and estate, female infidelity, or even the possibility of adultery, could not be permitted for either men or women when it cast doubt upon the integrity of the family. These concerns were reflected across the spectrum, not only in the dramas of Aristophanes, but also in Euripides, where substitutions at birth and exchanges of children passed off as legitimate, take place. They were also reflected in actuality, in the numerous law suits brought over inheritance (Ehrenberg, 1951, p.199). Euripides records instances of inter-female corruption and Aristophanes satirises the fears of Athenian society with his jokes about women and deception at the Thesmophoria (*Thesmophoriazusai*, 502-17) (Pomeroy, 1975). Aristophanes underlines his satirical theme regarding the exclusive organisation of women in his *Women in Assembly*

were sanctioned as a necessary concomitant of family worship, circumscribed because of their sacred nature. Acceptable modes of conduct, regulation and police must have been transmitted amongst women themselves. Also, the status and known conduct of the wife and mother was paramount in the law courts as elsewhere.[8] It had from early antiquity been an important issue. The members of the influential fratries and their wives played a significant policing role in this regard.[9] The regulatory role of women upon their peers and among their relatives; and for the serving classes upon their mistresses and owners was a major element of domestic and familial policing.[10]

(Dover, 1972, 190ff.). The importance of an indoor life for women is a commonplace of both comedy and tragedy, as is the notion of female gossip as a potential means of corruption. In reality, the mode of the disciplinary agenda was to board up the exits and entrances , and write into law in the second century of our era, even the specific details of illuminating the scene of parturition (Gardner, 1986, p.52).

[8] In court, mothers were often exonerated by the direct testimony of their sons, but it is also clear that a woman's offspring tacitly 'police' the mother in a more oblique way, by bearing witness to her chastity. Infidelity was not simply the wronging of a husband but of the family, the family gods and the fatherland. A second century document suggests that: "The greatest glory a free-born woman can have - her foremost honour - is the witness her own children will give to her chastity towards her husband, the stamp of likeness they bear to the father whose seed produced them" (Lefkowitz and Fant, 1982, p.104).

[9] By the fourth century, fratries were removed from their political role, but membership was still necessary for Athenian citizens and they still had an important legitimating role. The suitability of wives-to-be, the legitimacy of children introduced to the fratry, particularly adoptees, could be determined by their powerful witness in the law courts. Adoption was common and subject to even more formalised procedures and better documentation (Andrewes, 1971, pp.92-4, 123). Adoption was a popular option which ensured continuity, and attracted perhaps even more complicated procedures than childbirth, but devolved responsibilities much more clearly upon the male, for whom new opportunities for social engineering and for a certain detachment from the feared intimacies of childbirth, presented themselves.

[10] The spying of one woman upon another was, according to Aristotle (*Politics*, VI, 5,13 (1322b - 1323a) in Lacey, 1968, pp.227-9) formalised by the institution in some places of a superintendency of women. It appears that these were not common but where they existed they were to ensure conformity and propriety (Lefkowitz and Fant, 1982, pp.242-3; Humphreys, 1983, p.86; Lefkowitz, 1986, p.92). Certainly, an

Under these circumstances it was of the utmost importance that the midwife, in her position of power within the family, "...must be respectable since people will have to trust their household and the secrets of their lives to her and because to women of bad character the semblance of medical instruction is a cover for evil scheming" (*Gynaecology*, I, in Lefkowitz and Fant, 1982, p.163). The superstitious midwife was perhaps the most feared - the links between women healers, midwives, witchcraft, and the powers of deception are clear. Their knowledge and practice of medical folklore was easily associated with witchcraft, or denigrated as anti-science. As midwives were usually non-citizen, and therefore perhaps unusually had opportunities for learning and the exercise of skills not available to women of a higher class - their very learning made them a dangerous group. Their accomplishments made them opportunistic, they had access to men's world and men's talk (Just, 1989). Not only this but they had access to the family, arguably in its variety of historical forms, one of the most important societal structures. They presided over questions of fertility and conception and other personal aspects of women's existence. The quasi-religious nature of popular medicine and the remedial self-help aspect of family medicine in particular, nurtured the growth and function of 'clandestine' activities and alliances which formed around the parturient woman, and the practices of child substitution and exposure. The latter should not perhaps be described as clandestine as much as secretive but societally sanctioned and encouraged.

When their sphere of influence extended even into the realm of exposure, they permeated what was perhaps the most intimate aspect of family life. They were called upon to recognise and make judgements about which children were worthy of rearing (Pomeroy, 1975, pp.165, 169). Late abortion and exposure were blurred moral areas, complicated by

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unofficial superintendency operated more generally among women. Ostentation, adultery and immoral behaviour, were as feared by women and would have attracted disapprobation and ridicule.

high infant mortality. There is no direct evidence of the impact of exposure practices upon mothers. However, from the standpoint of the health of the mother alone, it was preferable to late abortion in circumstances where parents were forced to limit their families. Social distress and acceptance of this form of family limitation was finely balanced and honed by certain ritualistic public practices which provided a framework for its continuance, control and ultimately for its ostensible disappearance. Girl children were regarded as an expendable luxury - perhaps maintained by the wealthy, but considered an expense elsewhere.[11] Second born boys may also have been exposed in order to protect an inheritance intact, a situation satirised in Euripides and Aristophanes.[12]

Exposure was a practice permeated by tacit paternal control.[13] Abortion, although forbidden in the Hippocratic tradition, was certainly practiced, probably mainly among

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[11] While Pomeroy (1983, pp.211-8) suggests that the lack of statistical evidence about girls, who are either uncounted or undercounted, is possibly due to fathers not wishing to own to girls, it may also be a cover for their tacit unease about discarding them.

[12] It is possible to speculate as Lacey (1968, p.165) does, that in such instances: "The mother's feelings might also have been a little relieved by the fact that an exposed boy might have more chance of being acquired as a suppositious child, since a father who longed for a son would have been more willingly hoodwinked than others". For those infertile wives who dared not disappoint, it was: "No wonder that we hear of suppositious children being smuggled in by wives who were either barren or miscarried, or whose children were stillborn, or whose children died soon after birth" (Lacey, 1968, p.170). Even if such practices took place on a small scale - the fact of their existence or the belief in their possibility permeated social consciousness and gender relationships and reinforced fears about clandestinity among women, and the notions that permeated childbirth practices.

[13] It was a symbolic paradox revealing the dispersal of family power, that a man could order the exposure of his own child yet a woman had to prove herself usefully fertile in order to be accepted as a complete and trusted member of her family. However, despite the seeming absolute power of the father with regard to exposure there were notable exceptions. For example, where a divorced husband refused to acknowledge responsibility for a child, his ex-wife could opt for exposure. Also, the father's decisions were regulated. The symbolic sanction of witness remained integral to both law and practice. Parents who decided to opt

women in private collusion.[14] Wealthier families enlisted physicians, but the rest relied on midwives and trusted female relatives (Scarborough, 1969, pp.94-5). Physicians were selective as they did not wish to alienate rich clients (Jackson, 1988, p.108). Abortion was only regarded as a capital offence late in classical law. Despite its earlier ostensible prohibition, both Soranus and the Elder Pliny had given advice on abortion according to circumstance and discretion (Gardner, 1986).[15] The need for population control at family

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for exposure for their children would not be legally penalised "...provided that they had displayed them first to their five nearest neighbours and had secured their approval" (Lefkowitz and Fant, 1982, p.173, Jackson, 1988, p.107). A more marked shift in emphasis occurred with the effective ending of the male prerogative when exposure was prohibited in AD 374 (Gardner, 1986, p.6). Previously, mothers who discarded infants without the consent of the father would be transgressing against his property; now they would be seen to be more comprehensively in moral error. There was in antiquity, a possible link between the symbolic sacrificial aspects of childbirth and also the theme of child sacrifice in terms of the expedient surrender of the child to the father. As the child was the property of the father he was entitled to expose it. Resonances of these fears and practices are apparent later, modified in stories of the forced abandonment of children on behalf of the parent. Significantly, as a reflection of the anxieties relating to paternal possession, the transgressor was often the substitute or step-parent and usually a woman. These were recurring cultural and literary themes. Rich (1984, p.259) points out that maternal infanticide was a common crime in Western Europe in the Middle Ages to the end of the nineteenth century. It was a crude option practiced when women could not socially, emotionally or economically raise children they had conceived. However, it was also a desperate response, not only to poverty, but to the Christian denunciation of illegitimacy, contraception and abortion. It must be inferred that among the changes in family limitation practices which developed from antiquity, is that males begin to adopt a more remote position as regards responsibility for their perpetration, and as societal sanction and legitimising ritual thus diminish, the 'eradication' of exposure ensues from the period when the practice proves generally unacceptable, and it comes simultaneously (as cause and consequence) to be regarded as a clandestine aspect of maternal behaviour, sometimes aligned with witchcraft, and punishable by death.

[14] Slaves and prostitutes, for example, were not considered appropriate bearers of legitimate children. Abortion for this group increased their worth, and was sanctioned by men (Lefkowitz and Fant, 1982, pp.87-8).

[15] However, from the early years of the Christian era the focus of responsibility is upon the mother. The present day dilemma of family limitation is also considered to be primarily hers. Even so, she is

level often required the sexual abstinence of wives, while husbands turned to prostitutes and homosexuality again reinforcing polarities of sexual behaviour and forcing women into their own company.[16]

It is likely that in clandestine ways, women have always been able to make abstract use of isolation and exclusion. However, the subterranean marginality that seems to pervade the fringe arrangements surrounding childbirth and therefore family health, emphasised by childbirth historians and commentators, either as evidence of *ignorant malpractice* or of a halcyon era of woman-dominated health care, can obscure both the function and operation of these gatherings. The notion of womanly identification fulfilling the needs of women against the odds can also provide a distraction from perhaps more significant historical processes that were in the making. Disparate personal, familial, public and private needs create and are created by 'cabalistic' groupings -and evidence of strong all-female support groups notwithstanding these function actually wholly within, and ostensibly largely in relation to, or against a masculine ethic and milieu. These networks of women which appear to have gathered on the sidelines of history have in fact been deeply influential - particularly in relation to the censure and concern they have attracted from those considered to be representatives of the mainstream. The early 'magical' practices which surrounded childbirth, yet were incompatible with official religion, continued to be usefully deployed on the margins. These marginal groups seem not only either directly or obliquely to have arisen out of specific needs surrounding the female and her biology, but they arose

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constrained to make her decisions within male derived legal, moral and medical paradigms. The notion of censuring abortion according to the viability of the foetus is a modern one which is temporarily adjusted according to the foetal life-saving achievements of medical science and when an appropriate technologically-correlative moral adjustment takes place.

[16] Notions of waste and debilitation may have prevented widespread use of *coitus interruptus*. There are oblique references to this in the Augustinian *Confessions* (Scarborough, 1988, p.101).

also from familial and social concerns of men. This inextricable mix of biological and societal imperatives surround maternity and childbirth and all the related issues of contraception, abortion, the handling of labour and of infants and so on.

Not only were midwives likely to be slaves, the latter were also the most likely household figures to have been entrusted with the intimate role of attending at births, and their attendance provided both material and symbol resonance to the ancient fear of unfreedom already associated with childbirth. The possibilities of inter-cultural cross-transmission were fostered by such domestic arrangements, which were often the result of exigencies created by childbirth, and remained active and fertile throughout the Middle Ages and Renaissance, and into the nineteenth century. Other birth assistants may have included elderly female relatives who resided in the family home, their role underlining the integral and organic nature of childbirth as a feature of domestic life. Freedwomen would also have been familiar to households as nurses, wet nurses and housekeepers. This coterie of childbirth were cast in an interdependency which appeared to abrogate social taboos of association, and yet the resources of the household were galvanised around parturition; roles were ascribed, tasks were dispersed and dispensed, and apprenticeships were undertaken. What emerged were forms of cooperation and management which provided a model of hierarchical tutelary relations, which could be as much emulated as usurped. Gradually, co-operative female groupings became increasingly implicated in more official forms of policing activity. It is not impossible to detect in these processes a continuity of purpose which will come, via a diversity of routes and a panoply of roles to enlist the midwife in the cohorts of the doctor; not always as a matter of obvious and sudden coercion, or as an example of cataclysmic change or reversal, but ultimately in the professionalising interests of both.

Midwifery continued throughout the medieval era to be among womens' few 'permitted' public roles; due in part to the continuing and increasing public perception of the

impropriety of men attending women in childbirth. In midwifery, the traditions of women healers persisted throughout early Medieval Europe and England. For a few, midwifery would be part of religious or charitable duty; but for others it was a paid 'profession'. The eleventh century Salernitan midwife, Trotula, was among those attributed with influential medical writings, which complemented Classical learning with practical observation. However, given the difficulties for women of the period, her work is difficult to authenticate.[17]

Medicine remained relatively open in these spheres until the thirteenth century. However, the midwife was also regarded with suspicion; her position, for a woman, was one of power despite her degraded profession. Her power had overtones of the old world. It may be that women's fear of failure as wives and mothers led, in part to the association of midwives with magical and mystical practices in the struggle to ensure fertility. Fear of the random and unscientific mysticism of womanly collusion surrounding childbirth, came eventually to bring it clearly and unavoidably under male jurisdiction. They performed purificatory and dedicatory duties, but their contradictory and quasi-legitimate function was also to accommodate shameful necessities. The midwife was repository of a feared and fearful secrecy, and the perpetrator of possible abuses of power. She operated dangerously on the brink of both religious sanctification and diabolic supernaturalism. Perhaps close as they were to everyday witnessing of physical distress, and committed to seeking its alleviation, they appeared to lack Christian regard for the mortification of the flesh. The spiritual guidance they relied upon, was less than scientific, and tended towards

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[17] A physician, Rodulfus Mala Corona, who visited Salerno in 1059, says that only one very wise woman equalled him in medical knowledge (Bullough, 1966, pp.44-45). This observation might indicate a number of options: either it is noteworthy that a woman should be so knowledgeable, or it is disparaging because she is merely a woman, though that would by implication undermine his own knowledge. It could also indicate that women had some acceptance as practitioners; after all, they had dominated the medicine of the ordinary family, of rural dwellers, and of the poor.

paganism and astrology rather than Christian orthodoxy. The aggressive and vengeful childbirth goddesses of antiquity contrast with the serene Mary and the long-suffering Christian mothers and martyrs.[18] The religious Councils of the early Middle Ages, attempted to prohibit superstitious practice, and the impact of this attempted eradication upon childbirth, is likely to have thrust parturient and midwife deeper into clandestinity and covert practices, giving credence to the detractors and witch-finders who were to follow.[19] The midwife's collusion, however, was not to be relied upon as exclusive to her patients. As of old, and for her own survival, both wittingly and otherwise, she perpetuated the rigours of surveillance, even in her secret ministry.

Outside prostitution, only the midwife was party to the sexual activity of the Middle Ages. She was important as a witness for the proceedings to annul marriage.[20] The midwife had far more gynaecological knowledge than the physician, who would have rarely performed internal examinations. Most intimate investigations were carried out by women. Midwives were regarded then as one of two kinds of women with sexual expertise. Both

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[18] Early Christian martyrology is obsessed with chastity, and female martyrs all renounce their femininity in some way and behave 'like men' themselves, inspiring and perpetuating fear of women's bodies. By the late 3rd century, the divine female was mother and virgin, her opposite the old testament Eve. Mary was by grace, unsexual (1.*Timothy*.2.15). However, through her motherhood she revealed the way for those tainted by sexuality to redeem themselves from Eve's sin by pain, childbirth, and motherhood, and by aspiring to a life of chastity. Although a woman could find salvation in childbirth (if her issue were testimony to her faithfulness, holiness and sobriety), less merit was attached to marriage and motherhood than in antiquity. For those who abandoned the trappings of their sexuality, the Virgin was also icon and protectress.

[19] A feminist account of the persistence of cult observance in the early Middle Ages can be found in Ehrenreich and English, 1973a; and Rich, 1984, pp.129ff.

[20] The surgeon, Guy de Chauliac, describes the midwife dispensing aphrodisiac potions and advice, and counselling couples (for a few days) about their relations, and then reporting to a physician who would pass on his opinion to the judiciary (Jacquart and Thomasset, 1988, pp.115, 170-2).

orders of women were considered capable of breaking the bonds of love and loyalty - the midwife contributed to life, but like the prostitute, she belongs also to the domain of possible sterility, distributing contraceptive advice and procuring abortions. The schism that came to be driven between sex and childbirth had ancient origins. In antiquity, promiscuity and sexual excess were linked with barrenness in ritual, while chastity and abstinence were associated with fecundity.[21] In the Christian ethic, such qualities came to be associated with spiritual rather than physical fertility.

Midwives continued to minister to, or preside over, many aspects of family life; courtship, marriage, friendship, conception, contraception, fertility, diet, childhood ailments, childcare, pregnancy and parturition. These areas of life were in practical terms, ignored by university physicians, so midwifery remained outside university control. The medical discourse that came to challenge the power of the midwife, contributed to, and exploited existing fears, rationalising superstitious belief. University training and theory was valued above practice, and surgeons were regarded as 'craftsmen'. While surgery began to be included in Italian university curricula, an increasing array of marginal medical practitioners, continued to attend the majority: barber-surgeons, apothecaries, midwives, and their ancillaries. These 'paramedics' gradually became subject to professional physicians. The institutionalisation created by the examination in higher education, and the

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[21] In the festivals honouring Aphrodite's lover Adonis there was symbolic small scale planting of short lived crops (Just, 1989, p.239). This is not as paradoxical as it first appears if it is remembered that sexually promiscuous women were not the bearers of legitimate children. Also of significance in antiquity is the fact that sexually active goddesses are not entrusted with the care of children. Artemis is given this responsibility because she is unaffected by Aphrodite (Lefkowitz, 1986, pp.123-4). This dichotomy of the role of the whore and the madonna is restated throughout the mariology of the Middle Ages and in the creation of philanthropic objects of the nineteenth century and the containment and discursification of social evil.

subject specialisation it encouraged, was epitomised by the different branches of medicine. Medicine was jealously professionalising, guarding and judging its own standards, competing and setting itself aside from others. There was increased segmentation and fragmentation in other occupational groupings and elsewhere. The qualifications of midwives became very slowly a matter of public concern. The experienced midwife was only a threat when she encroached upon areas dominated or appropriated by other organised, educated, male-dominated groups. Among the communities where they worked, the midwives lack of training was barely relevant, as they were often the only recourse. The control of medicine by qualified physicians depended upon their access, legitimate influence over, creation and assimilation of these borderline groups.[22]

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[22] Bullough (1966, pp.101-2) details the movement against 'quackery' by the universities, and cites the case in the Charter of the University of Paris, of Jacoba Felicie de Almania, brought to trial in 1322, for illegal practice. Jacoba specialised in the care of women, who, she claimed, came to her rather than a man, from a sense of propriety and shame. She could safely elicit their secrets and gain their confidence. She called her patients as witnesses to testify as to the efficacy of her cures and treatments. Her popularity had spread via kinship and friendship networks, and she had not charged her patients until her cures had taken effect. On both counts she was an obvious danger to the hierarchy of organised professionals. She had an unofficial source of patients, that was promulgated by the patients themselves in a random if close-knit manner, and she challenged the worth of legitimate practitioners by the sort of individualism she exhibited concerning fees. Links to efficacy would not be a welcome development to professionals. However, the midwife also testified to the inescapability of the prevailing paradigms with her emphasis upon propriety and modesty. There are parallels with the professed priorities of Christine de Pisan, and the conventionality of other women writers and professionals seeking legitimate status. All the prejudices linked to clandestinity, are reinforced here. Women and poor families having been constrained to a single recourse; to find the best and most affordable, experienced if untrained help available via word of mouth. This placed midwives and the like outside the concerns of the mainstream or of university medicine, which had largely, and to a practical extent, ignored, denigrated or degraded them. However, out of sight was not necessarily out of mind. The fear of women, and the concomitant fear of clandestine practices associated with them (whether justified or not), still persisted. Incursions into this satellite world of illicit practices was necessary in order to justify and ratify professional legitimacy. There was also the need to preserve the differential created by the maintenance of such marginalisations. Although many of Jacoba's patients and witnesses were openly hostile to the Parisian medical faculty, and despite her own cogent defence, she was found 'guilty', and was threatened with excommunication and pecuniary penalties if she

All social classes traditionally summoned friends and relatives to attend to give their support and experience, but these gatherings also guaranteed that mothers were protected from accusations of abortion if a child died, and if it lived, from accusations of substitution.[23] What could previously be regarded as an element of the midwife's power, now became a different type of professionalising tool and burden upon her - she was still

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continued to practice medicine in Paris. Thus the right of the university to set standards was upheld. Efficacy was not a legitimate criterion for practice. The new criteria were educational qualifications, recognised and examinable training, the acknowledgement of the necessity of specialised membership and organisation of both personnel and knowledge.

[23] As late as 1722, the *Memorandum Book* of Titus Wheatcroft, a schoolmaster, notes that that a Derbyshire midwife's oath of 1686 bound her to promise never to allow a birth to take place in secret but to ensure that two or three 'honest women' were present and that the scene was sufficiently illuminated. (Donnison, 1977, p.3) This is similar to Gardner's description of ancient practice (1986, p.52). The effect of later hospitalisation was to de-intimacise these proceedings and thus ensure that such deceits could not pass unnoticed, and that birth took place more publicly, and under the 'disinterested' eye of strangers. In a copy of a midwife's license of 1686, there is evidence to suggest an inquisitorial role for the midwife herself. She was admonished to be wary of witchcraft, crime and extortion, and also to ensure that a woman correctly named the 'true' father of her child. The midwife: "shall not suffer any woman to pretend, feigne, or surmise herselfe to be delivered of child, where not so indeed, nor to claim any other woman's child for her own" (Donnison, 1977, p.229). Dead infants were to be buried safely and the midwife was to be vigilant about the behaviour of other midwives. Males were not welcome at the birth, other than if they were doctors, which helped to facilitate the move from domestic birth to the hospital. The parturient and child were the possession of the experts and professionalisation further promoted by the status seeking midwife who placed herself and her colleagues under surveillance. Ecclesiastical requirements also placed the burden of moral policing of herself, her colleagues and her patients, and her patients' relatives, neighbours and friends, for their chastity and honesty. Not only must she prevent the destruction or concealment of infants, but she must enjoin the mother to 'confess' the paternity of her child, particularly if illegitimate. Tale-telling was a feature of all historical infiltrations, either as transmission or as confession, submission to interrogation. All examples are formulaic, linked with clandestinity, close gatherings, and the pluridisciplinary aspects of religion and medicine. This links them to childbirth from antiquity. The historical strictures concerning pain-relief, drugs, potions and alcohol are linked to this insofar as intoxication might loosen the tongue, but not increase the individual's capacity for truthfulness.

required to baptise infants thought likely to die, but she must do so according to the approved and codified form, on pain of deprivation of her livelihood (Donnison, 1977, p.4). In England, following France and Germany, the first formal arrangements to police midwifery were made under an Act of 1512, to control and license medical activity implemented by ecclesiastical authority. The Church's preoccupation with witchcraft and childbirth brought midwifery under its auspices. The Bishops licensed curates, surgeons and schoolmasters, thus demonstrating the interrelation of these spheres, and the range of the Church's influence and interest. Character references were essential to ascertain moral status, and midwives required six matrons to testify to their technical skills (Donnison, 1977, pp.5-6). The encouragement of self-policing, of confession to authority, and of submission to the interpretation and mediation of others was evident.

The history of midwifery would be profoundly affected by inquisitorial paradigms. From the late fourteenth century, there was an increase in the information available even to untrained village practitioners, particularly relating to the numerous and diverse topics connected to health and disease. As knowledge became more compartmentalised, and medicine itself was developing its specialisms and hierarchies; medicine became an essential part of a 'liberal' education. This was due to a number of interrelated factors combining the exigencies of new forms and organisation of knowledge, and the discourse of professionalisation. Ordinary men and women continued to be essential to everyday healthcare, but moves towards exclusivisation were taking place.[24] There is evidence of aggressive and interventionist practices in both Guainerius and in Beryl Rowland's fifteenth century English gynaecological handbook, which implicated both males and females.

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[24] For example, there were attempts in the first quarter of the fifteenth century to bar non-trained people from practice, and many such legislative measures would follow. Talbot details evidence of such moves taking place in Europe in 1421 (1967, pp.186-196)

Midwives were considered practical authorities, and they were observant of the proprieties demanded and the liberties allowed, by the societies in which they lived.[25]

The interrogation of unorthodox practice guaranteed its continuing marginal status, and facilitated the monitoring of the activities and dispersal of recruits and clientele. It also provided a venue for the legitimation of orthodox power to organise marginal practice and to penetrate and exert control over productive and potentially dangerous relations, making them the objects and tools of power and knowledge. Such relations were part of the legitimating process in the burgeoning organisational hierarchy of education and medicine. The control of women and childbirth as an aspect and corollary of intervention in private life, was both fortuitous and essential. Childbirth was at the centre of family life - its purpose and its fate; its outcomes generating relations with society at large. It was at the fundamental axis of interaction between private and public life.

The gleaning of religious confessions caused communities to turn in upon themselves, with collective introspection, and as individuals against each other. Such upheavals disrupt the usual patterns of kinship behaviour, and new alliances develop both within the family and outside it. In this process of fearful and futile self-examination, withdrawal into the confines of the family was made possible, as was the journey into the confines of the self, where the very foundations of the self were to be 'tortured' with enquiry. Here we see the possibility of the entry of the expert into the heart of familial, personal, and self-conscious relationships, perhaps even the beginnings of the creation of a modern self-consciousness. Not only were wise women suspect accordingly with the illegitimate powers they exercised, but within their communities, there were secrecies to be exposed, interpreted and gradually to be given up to the 'neutrality' and safety of the 'professional'.

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[25] Helen Rodnite Lemay (1985, p.326) notes that there was a "willingness on the part of medical practitioners of both sexes to subject women to painful, often debilitating, treatments."

The new form of self-policing begins a pattern of control and manipulation in its roughest and least subtle form - but from it would grow the complexities of examinatory and disciplinary procedures, which stemmed from the earliest strictures of behaviour moderation. These included the self-examining practices of antiquity, developed in the revelatory discourses of Christianity, and undergoing further changes with the coming of the universities and their continuation of the rhetorical principle via the oral examination. Such practices had an over-all impact upon learning and knowledge itself, and the rigours of the disciplinary schema are in turn exacerbated by the regimenting action of writing techniques, and the questioning of the intentionality of the subject that takes place in the later Christian era. Again, these changes devolve in varying practices and mores, through the 'Enlightenment' and into the nineteenth century and beyond. The possibilities of coercion, repression and the inculcation of fear, diminished in relation to the dispersal of authority, and what came to be regarded as legitimate knowledges.

The refinements of the Renaissance were developments rather than replacements for the interrogatory techniques of the late Medieval period. In part, the necessity for the revelation of self and the incessant examination of conscience is part of a rigorous search for 'truth'. Not until the Enlightenment did the religious dimension of these techniques of self begin to be dispelled in their direct configurations. Similar disciplinary techniques also develop within a medical and scientific context. In late fifteenth and early sixteenth century Europe, thousands of witches were condemned, many of these were women.[26]

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[26] The German inquisitors, Sprenger and Kramer claimed in their *Malleus Maleficarum* of 1484-6, that in all matters of witchcraft and abomination: "witch midwives cause yet greater injuries, as penitent witches have often told to us and others, saying: No one does more harm to the Catholic faith than midwives." and that according to confessions: "the greatest injuries to the Faith as regards the heresy of witches are done by midwives" (Kramer and Sprenger, 1971 (trans.1928), part I,qn.XI, p.161; part II, ch.XIII, p.305).

This cannot be explained simply as the result of misogyny or religious fervour, these purges have also to be seen in the context of reflexive paradigmatic conditions. Men appeared morally and intellectually superior to women; they had access to education and training which was itself framed in the terms of a phallogocentric discourse. They appeared to therefore be on the side of legality, theology and rationality. They were professionalising and organising. Women lay healers, on the other hand, were seen to be on the side of an arbitrary justice, evil, darkness and sorcery. Their operations were ill-equipped, random, haphazard, disorganised, and at the behest and mercy of unfathomable circumstance.

The disapprobation of female practitioners was also an oppositionary tactic of the growing imperatives of moral policing that were integral to hierarchisation. The character of the pedagogue and the physician, their behaviour, diligence, modesty, discretion, self-restraint and sobriety (Talbot, 1967, pp.136, 140). Significantly, notions of personal hygiene were instigated, embellished and codified around the pregnant and parturient woman. Ideals of hygienic practice which were to have resonance in the modern era, began for the individual with life itself. The unborn child was to be protected by the policing of the eating habits and mode of existence of the mother. Type, quantity, and regularity of intake of digestible foods and drink were prescribed. As were the avoidance of stress and strenuous activity. There was a general advocacy of cleanliness, calm and gentle exercise. Preparation for the new infant's birth and early days also becomes the object of medical guidance. The general cleanliness of the midwife, parturient and the birthing environment were evident in Medieval directives for birthing practice, and for maternal and child care (Jacquart and Thomasset, 1988, pp.120-3). Medical hygiene, and echoes of ritualistic practice are clearly combined in a religious and secular conjunction.[27]

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[27] The widest circulated treatise on the subject was that of John of Burgundy in 1365, who advocated temperance in regimen. *In De Secretis Mulierum*, Albertus Magnus expressed fears concerning the balance between pleasure and preservation; analogies between 'natural' demand and over-indulgence in

Despite the lack of knowledge about the transmission of infection, and despite the lack of 'effectiveness' of the measures employed, there was early evidence of regimen of behaviour, diet, and hygiene in hospitals and institutions. Midwives were increasingly regarded as the potentially abusive arbiters of life and death, as the advocacy of male midwifery gained pace. Obstetrical textbooks proliferated from the sixteenth century and they included much practical advice to midwives as well as information on issues ancillary to parturition.[28] The range of areas for which information was available is exemplified by the work of Ambrose Pare (1510-1590), who was the resident surgeon at the Hotel Dieu. Pare, Jacques Guillemeau (1550-1612) and Riolans (1538-1608), all wrote treatises on conception, pregnancy, gynaecology, diet, and care of the newborn.

Despite an impressive bibliography of gynaecological works between 1540-1600 which might be regarded as an indication of an increased concern with the condition of women, the central tenets of ancient authority, while diminishing, are still residually inscribed in medicine, ethics, politics, law and public life. Childbirth manuals were obviously only

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either food or sexual activity. Medical and Scholastic treatises, such as the Salernitan *Regimen Sanitatus*, and civic decrees and statutes, all evidence a concern with hygiene and sanitation, from the early Middle Ages (Talbot, 1967, pp.145, 167-9; Jacquart and Thomasset, 1988, p.71).

[28] Among the works available were an English translation of Roesslin's *Rosegarten* (1513), under the title *De partu Hominis* which was an influential guide in which presentation and delivery were discussed; the *De Puerperio Tractatus* of Percivall Willughby (1596-1685) which was an adaptation of translated texts, including that of Fabricius (1537-1619) whose work on the anatomy of the uterus was influential; Lazarus Riverius' (1589-1655) *The Practice of Physick*, (1678), an example of the many medical anthologies of the sixteenth and seventeenth centuries, which includes information on disorders of the womb and dystocic therapies. The first English writer to make a significant contribution to midwifery was William Harvey (1578-1657) with his *De Generatione Animalium* (1651). He describes his own and other cases betraying a conversancy with practice unusual hitherto (Cutter and Viets, 1964).

available to the literate and to those who could afford them. They were predominantly available to men and to urban dwellers. However, in the 1545 preface of Roesslin's *Byrth of Mankynde*, it was noted that, "many ryght honourable ladyes, and other Worshipfull Gentlewomen" would take it upon themselves to read aloud from the Byrth to midwives and the assembled company at labours (Donnison, 1977, pp.7-8). This may have been publisher's hyperbole but demonstrates how class, literacy and regulation create a self-policing disciplinary hierarchy reinforcing professional paradigms.

The scientific and prescriptive texts of obstetricy which from the seventeenth-century *De Puerperio Tractatus* of Percivall Willughby (1596-1685) continued to proliferate in England and the rest of Europe from the eighteenth century, enhancing the prestige of the field while stimulating new areas of debate and dissent.[29] The world takes on an increasingly textual aspect from the late eighteenth century; both the known and the knowable is vulnerable to schematisation as the old order is 'challenged' and rearranged.[30] Ordering and hierarchisation had extended into every area by the beginning of the new era, from 1800 on. It had consequences for women, parturients, for childbirth itself, as they

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[29] Influential "midwives companions" included those of W. Sermon, 1691; R. Barret, 1699; H. Bracken, 1737; B. Pugh, 1754 and W. Smellie, 1752-64 (3 vols.), and examples of midwifery critique which proliferated alongside them include J. Maubray, 1724; W. Clark, 1751; P. Thicknesse, 1751 and S. W. Fores, 1793. Women writers such as Jane Sharp (1671) wrote confident guides, and later came to emphasise the status of midwifery according to professionalising exigencies, either as 'Science' and/or 'Art' (Nihell, 1760).

[30] Similar imperatives of ordering, schematising and synthesising had been the preoccupation of antiquity; Galen had been one of the first to attempt to systematise knowledge. From Ramus to Bacon, there was a diagrammatic impulse, to map, outline, spatialise, and encyclopaedise. Aquinas's *Summa* was also an earlier attempt to encyclopaedise, but the exigency itself came to to represent, cause, expose, epistemological anxieties. D'Alembert, a prominent encyclopaedist, deplored the 'Dark Ages', and subscribed to the highly historiographically influential 'Great Man' view of history (Darnton, 1984, pp.193-7). Systematisation itself carried its own truth and implications.

became objects of systematisation. Childbirth was imperfect because of its blurring of boundaries; physical, sexual, medical, moral, temporal, and spatial. It was clearly a case for containment, categorisation and control. Gradually, childbirth becomes demystified as an event. It moves out of the province of Marianism, as reciprocal iconography declined. It becomes a medical event from which empirical knowledges can be derived. It becomes the object of medical interventionism in a very much more definitive, unafraid and overt way. It is dehumanised as it is demythologised.

Two other elements helped to create the conditions for the redefinition of childbirth and its attendants. Cartesian oppositionism was all-pervasive and integral to prevailing paradigms.[31] Second, The middle-class flourish in the post-revolutionary Enlightenment, and their status is confirmed by literature and philosophy.[32] The old style midwives, and barber-surgeons, like the Rabelasian 'rabble', were specific examples of the phenomenon of division and divisiveness. They lost their old venues and strongholds, and achieved a hybrid status.[33] Throughout the eighteenth century, licensing was far from an enforceable necessity, and did not yet directly make an impact upon the everyday practices of the

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[31] The Renaissance celebrated Bacon, Descartes, Newton and Locke, who broke with Aristotle and Aquinas, exposing the limitations of truth and reason, thereby reinforcing them as paradigms. Religion splits from philosophy as the arena of non-empirical knowledge, and new boundaries are set.

[32] See Darnton, 1984, pp.107-9.

[33] There were some channels of instruction for European midwives, and in France in 1631, at the Hotel Dieu, some midwife pupils were taken in and lying-in provisions made. In 1688, Elizabeth Cellier, a midwife, proposed the foundation of lying-in wards in London, but standardisation of practice was slower than elsewhere in Europe. Episcopal licensing was renewed during the Restoration, but this did not guarantee medical standards. Municipal licensing based on the continental system was instituted in Scotland from 1694, and lasted for around 100 years. Midwives continued to be a popular choice in France to attend the bourgeoisie, but in England they continued to be refused any form of self-regulation. (Donnison,1977, pp.17-20)

majority, but it placed an underlying pressure upon practices, sounding the death knell for informal arrangements rather than the practices in themselves. New configurations of time, space and personnel, and new modes of organisation and accountability were the changes of paramount importance which were being forged in this period of transition.

Women practitioners were not the exclusive purveyors of superstition, neither were they entirely in thrall to the male practitioner with his armoury of instruments. Loysa Bourgeois (1563-1636), a famous female midwife, published a work on obstetrics (1609). She included details in her autobiography (1627) of her own formidable achievements; 34 years of lauded service, certification "after various examinations", and translated works running to several editions. In her *apologia* for a death by puerperal sepsis at a royal confinement, she defends her diagnosis, and somewhat disparagingly refers to "men of science who are such experts in the diseases of the childbearing woman." She reveals the possibilities for a woman, though she obviously ranks as unusual in having attained such status, as she is in her belief in her right to defend herself, and to criticise male authority.[34] She reveals herself as conscious as any male of the need to exclusivise, and to share the fruits of observation and experience with discretion. Perhaps she was particularly conscious, as a woman, of the fact that certain forms of knowledge were closed to her. Nonetheless, she joins with others of her profession to use the object of knowledge to her advantage, aware that a rapport between parturient and deliverer was the surest way to develop knowledge, and produce the best results.

The Hotel Dieu, a prestigious school in Europe for surgeons; was also to become a major venue for the training and subordination of the female midwife. By the mid-eighteenth century, surgeon Guillame de la Motte records that 3-400 women were at the hospital,

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[34] *Les Six Couches de Marie de Medicis* (Paris, 1875, pp.24-27, trans. Richard Howard).

most of whom were delivered by women pupils (Cutter and Viets, 1964, p.83). The combination of professionalising interests was manifest much earlier in the history of the Hotel. Pare, for example, claimed to have been inspired to undertake his experimentation in obstetrics at the Hotel Dieu, because of the 'abominable practices' of the midwives he saw there. Later Francois Mauriceau (1637-1709), also at the Hotel Dieu, displays some of the earliest signs of professional 'paranoia' when he describes some of the midwives as those: "who do maliciously put such a terror and apprehension of the Chirurgeons in the poor Woman, comparing them to Butchers and Hangmen that they chuse rather to die in Travail with the Child in their Womb, than to put themselves into their hands." (Cutter and Viets, 1964, pp.69-71, 80).

The prescription for the suitable midwife comes increasingly to sound as if she should be the accomplice of the doctor rather than companion to the parturient. In Dr.William Sermon's *The Ladies Companion, or The English Midwife* (1671, p.5), there are these guidelines: "As concerning their minds; they must be wise, and discreet; able to flatter, and speak many fair words, to no other end, but only to deceive the apprehensive women, which is a commendable deceit, and allowed, when it is done for the good of the person in distress" (Donnison, 1977, p.16).

The traits traditionally associated with the 'wise woman', and rustic midwifery, which had inspired both fear and derision from the earliest times, appear here to be openly and positively recognised; and rather than being simply condemned and eradicated, channelled and exploited to specific ends.

In the discourse of professionalisation, women were just as subject to the phallogocentric paradigmatic framework as male surgeons. The latter were as likely to be committed, according to prevailing possibilities, to the aid and improvement of obstetric services. Renowned female figures in obstetrics, such as Justine Siegemundin (1650-1705), Louise

Lachapelle (1769-1821), and Marie-Anne-Victoire Boivin (1773-1841), if typical of their professional type, did as men did; that is: they raised the profile of the pregnant and parturient woman by writing and illustrating exhaustive case histories, they pursued related scientific and academic studies, and generally objectified the parturient body as the focus of benign but nonetheless invasive treatments and technologies (Cutter and Viets, 1964, pp.195ff.). In the moves of professionalism, women, where able, were inevitably subscribers and perpetrators of the establishment in obstetrics of a model of elitism and expertism. In this field they were particularly able to exert an influence, as they continued to take the primary practical role as legitimate childbirth attendants, even for the wealthier classes, despite the fact that men monopolised every other area of medical practice.

It is clear that the drive towards professionalisation was not simply a case of male appropriation. The myriad of effects which combined to create the shift towards professionalisation, had been spurred and facilitated by the refinements of logocentric pedagogy, but their resonances would reverberate in the chambers of the parturient, long before the doctor was as a matter of course, courtesy, and legitimacy invited in as overseer and principal player. In the historical movement from the consulting midwife to the 'surgeon-*accoucheur*', there was the belief and fear that midwifery was not for men of honour. Women too were aware of the competition and threat the male obstetrician posed. Despite the persecution they were to experience in the seventeenth century in Europe and America, they continued to be at the forefront of parturial delivery, and to resist the interference of male obstetricians. They fostered the idea that it was indelicate and improper for a man to attend a woman in childbirth, and had prolonged success in maintaining their preserve. Male surgeons tended to respond by developing obstetric curricula, scientising and refining childbirth technology, cerebrating concerning its status as an 'art', and generally disseminating authoritative texts (Cutter and Viets, 1964, pp.143ff.).

The increased use of instrumentation following the 'secretive' development of the midwifery forceps from around 1720, accelerated the acceptability of male intervention (Radcliffe, 1947). Young surgeons and apothecaries were attracted to midwifery - as it could be regarded as a step towards more general practice. The training of women continued to be a matter of discord as each area of medical practice began to stake its claims and position. The latter half of the eighteenth century saw the introduction and growth of lying-in wards, and the intake of pupil midwives in for example, Scotland and in London. The medical establishment required the hospitalisation of the parturient woman at least partly as legitimate clinical material for study. The wards attracted philanthropic and demographic interest. Most had some limited training provision for women (Donnison, 1977, pp.21-41).

It is perhaps to be seen as remarkable that women became, even under the new auspices of direct male authority and intervention, 'reinstated', and were able to fashion for themselves along the lines of the masculine model, a profession from the metaphorical ashes of old regime practices, and the literal ashes of centuries of mistrust and persecution. Or perhaps not so remarkable, but rather inevitable, given the productive, disciplinary and utilitarian paradigms that emerged with the refinements of educational and training techniques, such as the written examination and grading systems, and all that those strategies imply.

Philip Thicknesse, a journalist writing in 1764, details the evidence of supposed ancient fears concerning the weakening of wifely fidelity and the collapse of family and societal values, as male midwifery gained in fashionability. Much of this writing appears to have been prurient and such anxieties generated a wealth of pseudo-moralistic proselytising.[35]

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[35] Jean Donnison (1977, pp.27ff.) details the self-interested polemic surrounding the prejudices and fears on both sides of the male midwifery question.

The best midwife referred and deferred to the male physician. Male interventionists began 'normalising' and extending processes to 'speed up' the progress of birth.[36] Although men such as Manningham, Ould, Smellie and Hunter increased the credibility of all male practitioners amongst the wealthier classes, the obverse side of this was that in popular mythology the male appears to an extent to take the place of the female in popular ambivalence. In an illustration from S.W.Fores (1793), the male-midwife is depicted as a 'monster', an absurd and grotesque figure. His female counterpart is homely and primitive, while the male, although ridiculed with his array of potions and aphrodisiacs, has the 'tools' and equipment associated with childbirth at hand. Inspired by more than a simplistic misogyny or an exaggerated sense of propriety, such representations display a complexity of attitudes about the associated effects of childbirth; the fear and superstition, the ambivalence regarding faith and continuity, the possibility of pain and death.

The evangelically inspired 'delicacy' of the middle classes on such matters led to a seeming polarisation yet collusion of those social commentators who adopted a high moral tone and who could barely, although they increasingly and with vehemence did, speak the name of childbirth, and those who took a prurient interest, retailing similar details and a high tone, but in order to shock and titillate their readership (Bland, 1982). 'Science' fed journalism and vice versa, both linked to a developing code of morality. Taboo, euphemism and circumvention merely reinforced and added to the resonances of the discursive explosion around sex. Sensationalism prevailed, and while such prudery may have had an adverse effect upon the parturient, it also placed her body at the centre of scientific and moral concern. As the search for origins continued to intrigue the Victorians, the body of the parturient (the giver of life), and the body of the corpse (anatomically revealing the sources and nature of death) became the loci of investigations, and the matter of medical discourse.

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[36] For example, by stretching the neck of the womb; a procedure advocated by such as Mauriceau, Bracken and Clark. (Donnison, 1977, p.16)

Although these bodies did not have a 'voice', their conditions spoke and engendered volumes.

By the nineteenth century, women had come increasingly to associate their sexuality with compliance in phallogocentric expertise. A masculinised eroticism is apparent in the compulsion to confess and confide; in the admission of oneself to specialist and purposeful structures, accepting the ethos of masculine environments, in the measuring of behaviours in the light of the masculine gaze. From around 1800, new areas of visibility begin to open up, and a certain structure, based on the notion of man as an historical *a priori* and the focus of empiricism and 'objectivity', begin to impose new structures on both language and objects.

The early attempts by Cuvier and Lamarck to structure science into evolutionist models, foster the historical principle of continuity, while the systematisation of these notions by Darwin, reinforce the axiom of successivism.[37] In the institution of these new theories, the focus upon reproductive models of linearity and succession, reinforces the concern with human reproduction as a primary object of science, and legitimises in terms of natural hierarchy, the masculinisation of all areas of scientific concern. Both aspects of these epistemic developments have their obvious implications for the discourse that devolves upon childbirth practices.

Men were becoming increasingly more 'expert' on all aspects of domestic life. Traditionally female areas such as infant feeding and training become the province of male authority. The common assumption was that men could manipulate nature, while women could only surrender to it. The arguments for and against both lay and medical regulation

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[37] See Foucault, 1970, pp.132, 152-3, 334-5.

continued, female midwives favouring the possibilities of autonomy permitted by the former. Training was largely informal or private, though it did increase in the second half of the eighteenth century. Continental instruction was more established than in England; improved service, state recognition and better funding was available in post-Revolutionary France. The English midwife declined more rapidly though regulation was sparse and uncoordinated, which reveals the power of the paradigms that lay behind the drive for professionalisation. Just as practices are always more than legislation might allow, practices are also as much a result of the discursive conditions which prompt campaigns for legislation, as of legislation itself.

The midwife was 'reincarnated' as the creature of masculine authority, something she had always tacitly been. A superstructure of training, education, supervision and examination developed to which the aspiring midwife must conform. These rigours and procedures were imposed upon most areas of skill and knowledge in the process of disciplinisation and in the devising of modes of access and accountability. These had been the underlying principles of practice in varying ways since Classical times and through the exigencies of Christianity, and they informed the refining strategies upon which the creation of modern professionalisation depended.

Midwives were constrained to a new conformity of practice and to the rigours of scrutiny. The medical profession came increasingly to rely on a formalised and consensual knowledge, and on unity and homogeneity in training and learning.[38] By the nineteenth century, midwives in France were able to serve an apprenticeship within the auspices of the hospitals. One example was the midwifery department of L'Hospice de la Maternite, Paris, where they were systematically taught over a certain period during which time they were

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[38] Unlike France, state involvement with training and licensing in Britain and America, remained minimal and midwifery resisted systematic standardisation for longer (Gelfand, 1980, pp.190ff.).

resident in the hospital and were expected to abide by strict rules of conduct. They had examinations and they received diplomas to enable them to practice. They had daily instruction and were expected to write clinical reports of the cases they witnessed and assisted (Cutter and Viets, 1964, pp.92-3). Here they had the opportunity to legitimise their practice by fulfilling the requirements of logocentricity, but they also imbibed the essence of the tutelary process and were saturated with the exigencies of the new professionalising discourses - the need to display expertise in certain forms of standardised and elite knowledges. Obstetrical textbooks, both moral and didactic, continued to proliferate alongside the many debates which centred on childbirth during the nineteenth century, ensuring the elaboration of the discourse surrounding it.[39]

Men-midwives were the hybrids of the medical hierarchy. Throughout the nineteenth century, attempts to be elected to the College of Physicians or Surgeons failed, and they were often held in contempt. They were regarded as the perpetrators of manual rather than the cerebral activity that the educational system valourised and rewarded. The Obstetrical society, instituted by Augustus Glanville in 1826, formed to initiate and consolidate further reform, was also largely unsuccessful. The perceived opportunities for corruption in obstetric practice engendered a wealth of polemic; a discursive explosion which accompanied its institutionalisation. While the parturient faded into obscurity, shrouded head to foot in discreet coverings, the wraps came off the debate surrounding childbirth and midwifery, often lapsing into arguments based on aggressive self-interest, as the different interest groups battled for recognition and status, or into prurience as the

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[39] One William Read (1820-1889) set a standard of meticulous research, having access to a huge library of obstetric cases. He was reputed not to quote unless the original was before him (Cutter and Viets, 1964, p.214). Such rigidities inscribed the obstetric discourse and gave it the immutable power and permanency of written authority.

arguments were pushed to extremes. Far from distaste dissolving into silence, a whole range of arguments and interests came to be addressed[40].

As middle class women were increasingly pathologised and enjoined to leisure by men to preserve their reputations (this had been important since antiquity as women were representatives of men in their homes) - midwifery became an unsuitable occupation for poorer genteel women who could no longer 'decently' support themselves except as poorly paid governesses and nannies. Pro-midwife pamphleteers of the 1820's were concerned with the lack of employment for respectable if impoverished women. Prostitution was regarded as the great social evil as deviance became the creation of a prolific discourse (Harrison, 1977). In such an atmosphere, the work of the 'accoucheur' was considered 'odious' and unfit for either men or women of reputation. Male-midwives were accused of haste, over-use of instruments and lechery, and women were denounced as incompetents, drunkards and procuresses (Porter, 1987). As sexuality began to be inscribed in discourse, there was much prurient interest in midwifery and an accompanying phallocentrism in practice. *The London Practice of Midwifery* first published in 1803, a popular though critically targeted manual, ran to several editions until 1832, and contained advice to the *accoucheur*, suggesting that digital penetration of the parturient during the early stages of labour reassured the woman, especially if the man was about to leave her in the hands of an assistant, and accomplished a display of 'skill' to both mother and nurse' (1803, pp.139, 157-8, in Donnison, 1977, pp.210-11).

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[40] Dismissed as a 'dishonourable vocation' by Sir Anthony Carlisle, a member, later president, of the Council of the College of Surgeons in a letter to *The Times*, the implication was that the natural province of women was beneath men of reputation: "the humiliating events of parturition" and the seeking to profit thereof, was not a job for men of honour" (Donnison, 1977, p.47).

James Blundell of Guy's, observed in men, "a sort of instinctive impulse to put the lever and the forceps into the vagina." (1834, p.21). Around 1830, a new British Ladies Lying-in Institution was established for the instruction of midwives, but by 1858, the 'Consulting midwife' became the male 'Surgeon Accoucheur', and women were increasingly subordinate to men. Part of the problematisation of etherisation or other forms of pain relief was their association with the incitement of the parturient to sexual excitement (Youngson, 1979, pp.97-123). In a discourse that professed itself shocked by such possibilities, a literature grew around the phenomenon of the possible metamorphosis of pain into passion. The disciplinary discourses of the nineteenth century sexualised every aspect of existence in the will to knowledge, while having historically been associated erroneously with silence and repression.

By the mid-nineteenth century, departments of midwifery in American medical schools had instituted academic titles such as 'professor of obstetrics', 'professor of the diseases of women and children and midwifery', thus enhancing the academic and professional status of obstetrics, while inscribing childbirth practices in a broader panoply of concerns which implicated women in the disciplinary discourses of expertise, including gynaecology and paediatrics. This also had the effect of deepening and normalising the problematisation and pathologisation of childbirth by association with childhood and gynaecological diseases. Also, childbirth comes to be regarded as a part of an observable and measurable continuum, part of the panoply of a woman's biological life which would bring her to the attention and guardianship of a number of related experts[41].

In 1847, when James Simpson published the results of his (dangerous, often personal) experimentation with chloroform, he deplored suggestions of impropriety and danger in

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[41] See Arms, 1975; Donzelot, 1980; Rich, 1984.

the use of childbirth anaesthesia (Youngson, 1979, pp.55-69). Like Semmelweis, and many other celebrated and high profile obstetricians to the present day, Simpson appears to have had a charismatic and risk-taking reputation for his zealous, often aggressive pursuit of his crusades. However, Simpson was also aware of the susceptibilities of his day, and displayed sensitivity to the erotic potentialities of the childbirth scenario.[42] In his lecture notes *Natural and Morbid Parturition* (1843-4), Simpson records the prevalent obsessions of the time, that is; with the poeticising of the woman/nature theme, and the desire to measure, time and quantify, preferably in a complex relation of observance and tutelage with the object of attention[43].

The 1858 Medical Health Act still did not recognise midwifery as part of medicine, but obstetricians themselves could be Fellows of the College of Physicians, and a new Obstetrical society was formed. The male obstetrician gained in social acceptibility, as the female midwife appeared unless under explicit tutelage, to be incompetent, even sinister. There was a new category of the 'unprofessional', into which the midwife could fit if she did not conform. It could be argued that without her, and other empirics the category itself could not exist, and therefore a remaining elite would not be formed.

The exigencies of timing and intervention were increasingly the paramount factors of male obstetrics. Midwives had quickly to learn these priorities in order to survive

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[42] Youngson (1979, p.61) suggests that in searching for his career niche, Simpson had married rather than be prey to 'indelicate' suggestions as to the suitability of an unmarried man as a childbirth attendant.

[43] Some of these aspects are encapsulated in his synopsis of a secret attendance upon a woman in labour, by a Parisian doctor, M. Sacombe, who watched everything unnoticed: "attentively, and determined to leave everything to nature as much as if my patient had been alone, in the midst of a forest. Thus, with if I may so say, a pair of compasses in my eye, a watch in one hand, and a pencil in the other, I witnessed the truly ravishing spectacle of a natural labour." (Youngson, 1979, p.233).

professionally. This was not a sudden change of priorities. Nor was it such a huge imaginative leap for the midwife. She was herself complicit in bringing in the doctor, and had herself been historically instrumental in intervening to speed up the birth process, particularly in dystocic cases where a baptism was necessary. She had begun to attend such lessons. Failure to comply with the dominant phallocentric mode had had consequences long before the more sophisticated strategies of the professionalising discourse became fully developed. The midwife was not then the victim of a sudden intentional takeover. The organisation of midwifery under masculine authority which entailed a homogenisation of practices and a redefining of its objects, simply encoded a process that had been implicit in the relations of tutelage which thrived in antiquity, and in the refining of that discourse in Christianity, culminating in the exigencies of interpretation and expertise which permeated practices and paradigms into the present era.

That midwives came inevitably to police themselves should be no surprise, as they internalised the messages of the tutelary relation which permeated every other aspect of existence. It could not be the case that they were simply everywhere and at all times scrutinised and repressed by a permanent staff of male obstetricians. The changes were more subtle than that. Even on male terms, women also participated in the race to organise and professionalise. They were eventually as susceptible as any other group, who at varying speeds and in disparate conditions, came also to absorb the requirements of differentiation and homogenisation, and to involve themselves in a permanent relation of tutelage in which they needed no overt pressure or supervision.

It seems that the demise of the village midwife was a creative subsidiary of the differentiating practices that ensued from the inquisitive and individuating discourses of theology and medicine. It was a consequence of the drive to professionalisation, informed by the compulsion to 'profess'. The uneducated midwife was the repository and embodiment of centuries of accumulated fears, mistrust and prejudice, the need and

justification for which, was fast diminishing. Her time was gone. It was the attitudes towards her that by the nineteenth century, had become, like her, anachronistic and impossible to sustain. Certainly, the uneducated midwife was maligned and harried into the nineteenth century, where she was the figure of documented, serious, and often deserved disapprobation, rather than as the target of largely literary ridicule she had hitherto remained. But the object of revile both of medicine and literature were extremes, both of example and revulsion.

The chronicle of polemic, detailed in *The Lancet* during this period, surrounding the entry of the female into the medical profession, as helpmeet rather than competition for fees, was as complex and drawn out as that surrounding male-midwifery (Donnison, 1977, pp.72-74). The need for women to be attended by women was an ostensible reason, though there were several vested interests for the establishment of a 'Female Medical Society and Ladies' College' in 1862, which would advocate the rehabilitation of midwives[44]. The College was encouraged by the opponents of male-midwifery, and by those concerned with the rights of women, and with general philanthropic concerns. Dr. William Farr of the Registrar-General's Office, welcomed the idea of educated women again espousing 'this old business of their sex', replacing 'ignorant old women', and in co-operation with male authority.[45] From 1870, the Obstetrical Society campaigned to prohibit all

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[44] It was largely inspired by general practitioner and consultant, Dr. James Edmonds, who had been involved with the Royal Maternity Charity. He was later involved in the foundation of the London Temperance Hospital and the British Medical Temperance Association. Edmonds was also concerned with temperance reform, as were many others involved with women's rights and issues (B.Harrison, 1971, pp.174-5).

[45] *The Lancet* (1865, 2, p.435). Farr, reporting again in the Registrar General's Annual Report for 1876, (p.250) concluded that outside the more wealthy areas of the capital, 70% of all births were attended by inadequately trained midwives.

unqualified midwifery practice, male and female. In 1872, it set up its own Examining Board and Diploma as a hopeful prelude to government legislation. The requirements were rigorous but still disbarred midwives from anything other than 'normal' births, and still kept midwifery out of the mainstream of medical practice. It was in opposition to the Female Medical Society's aim to provide highly skilled midwives. At the same time, Dr William Acland, Regius Professor of medicine at Oxford, headed a sub-committee to investigate the possibilities of the Registration of midwives, nurses, and dispensers. The development of the mechanisms of control, rather than incorporation appeared to be the aim, though the medical establishment questioned the suitability of its involvement with such schemes. D.J.H.Aveling (1872) also made the case for midwife registration. An obstetric specialist, he was among those men who, represented by the Obstetrical Society and by the General Medical Council, wanted reform to include proper parameters of female midwifery practice. This should of course be subordinate to their own professional expertise; preserving, hierarchising and outlining their own role. Further support for such action came also from the Select Committee on Infant Life Protection who wanted regulation to prevent baby-farming, abortion and infanticide, they believed that regulation could be achieved by the surveillance and control of those most likely to perpetrate such inimical activities, that is, mothers and midwives. (Donnison, 1977, pp.75-81)

The General Medical Council began to award annually revocable licences, which were withdrawn if men were not called for in abnormal circumstances. The debate was always framed in terms of the dominant discourse - women attempting to enter male enclaves on the terms they thought acceptable to male authority. Where they had organised separately, it was on the lines of existing male organisation. The slight shifts in the debate that took place were part of the fine honing of the professionalising discourse. The hyperbole of the public debate probably reflecting the extreme polarisation of the different factions, whereas much of practice went on largely unhindered.

The women's movement opposed the Obstetrical Society's proposals for the registration of midwives because it officially relegated women to a subordinate position in terms of skills and remuneration. This frustrated the aims of the society who claimed that registration would disadvantage the poor, particularly those living in rural areas who had hitherto relied upon a 'neighbourly' network of assistance. The women's movement opposed the curtailment of any women's work on principle, which exasperated those, mainly men, who whatever their own interests, claimed that women were neglecting the rights of the poor to safe childbirth. The indigent were at the same time blamed for creating their own circumstances, and it was felt that the availability of unofficial midwifery simply provided an excuse for the poor to avoid calling in the doctor. The practices and condition of the poor could be invoked as evidence to support any rendering of the case at random. There was the two-fold fear that the community networks, that threatened to depress the earnings of rural doctors, might however break down and leave an unfillable gap for the majority who needed cheap effective provision. A fine balance was achieved by a tacit deference to the legitimate authority of the doctor, who could nonetheless avoid the 'drudgery' of childbirth without threat to his income. Men like Aveling saw the role of the midwife as one of relieving the doctor from an arduous task, and if cooperation could be achieved, the doctor could still preserve his place in the family, and in general practice. This ensured that everyone willing and able to implicate themselves in this complicity of relations had some place in the order of things.

However, even by the latter quarter of the nineteenth century, few women were seeking formal training. The professionalising midwives aimed for the recruitment of educated women, and the founders of the Midwives Association of 1880, later to become the Royal College of Midwives, advocated cooperation with obstetricians, and the summoning of male assistance in anything other than what was considered to be a normal birth. Strict codes of competence, character and conduct were required, with particular scrupulousness

with regard to the use of alcohol, and the keeping of professional confidences (Donnison, 1977, pp.99-106, 116ff.).

As late as 1898, one contemporary estimate was that far from losing influence, the female midwife still attended around three-quarters of all births (Donnison, 1977, pp.89-90, 146). The nature of the professional transition, given the historical prevalence of masculine-orientated paradigms, was not the new and overt male acquisition of a hitherto wholly female preserve, but rather a change in the operation and scope of midwifery itself as it professionalised, and its members came to take seriously their membership of an elite group, creating conditions whereby such definitive parameters can be enhanced and maintained.

The medical profession of course fought off competition, such as they perceived that emanating from females to be. University training was not only instrumental, but elemental and integral to the elevation of the doctor above the empiric. The attitude among the Victorians that women of the wealthier classes were too delicate to train as doctors and professionals, but that women of the sturdier, poorer classes were suited to the menial hands-on tasks of administering to the sick, attending labours, laying out the dead, points up the dichotomy of class certainly, and it highlights certain tenacities and hypocrisies. However, these were not paradigms based on a conspiracy of intention despite the obfuscations and perambulations of the law and higher professionals, but were easily perpetuated in practice by the assimilation of those values and the techniques for preserving them, by all involved.

By the end of the nineteenth century, midwifery was given status by its inclusion as part of the qualification in medicine. Unqualified practice was not prohibited, but women were further disadvantaged by the prohibitive expense and exclusivity of training and the examination system. The extensive support for registration from the various groups despite the opposition from general practitioners, resulted in the Midwives Act of 1902.

This Act gave midwives some limited status.[46] The path to legislation was full of the obstacles created by the variety of vested and contrasted interests. Those representing the midwives wanted to enhance the status of midwives, by encouraging training, examination and social elitism, while the medical profession welcomed any curbing and regulation of the midwife's activities, and what they saw as a ratification of her subordinate role. Registration, examination and discipline were to become the accepted province of a single authoritative body, in this case local boards advised by the G.M.C. Certainly, the disciplinary and surveillance aspects of proper training provision for midwives were not lost on advocates and critics of midwive's registration.

Donnison (1979, p.179) writes: "...the Board's disciplinary powers were more extensive than those granted to the regulatory body of any other profession. It was the Board's duty to lay down a strict and comprehensive code of conduct governing the midwife's practice. The rules made by the Board outlined in minute detail the midwife's duties to mother and child at the birth and during the ensuing ten days, even laying down requirements as to the dress she was to wear, the appliances she was to carry, the records she was to keep, the number of times she was to visit the mother, and in what circumstances she was to send for a doctor."

These recommendations are still the essence of childbirth and post-natal practice today, though in England the duties are further polarised except in exceptional circumstances where efforts have been made to ensure some continuity of care. Normally, duties are divided between the midwife who, distanced from the mother-to-be, her family and community, usually delivers the child in the hospital, often having not previously encountered the parturient, and the community nurse who provides post-natal care and

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[46] It laid the ground for the more comprehensive 1951 Act. The Midwives Act of 1936, finally made local health authorities responsible for the provision of midwife training, so that even rural areas came to be serviced by legitimate practitioners.

attends to record keeping, by very much the same guidelines that were operating at the turn of the century[47].

While it had been the argument of those who were for professionalisation, that the poor, uneducated midwife was more likely to seek pecuniary advantage by diversifying into the procuring of abortions, those who were most flagrantly anti-female midwifery, protested that in fact the better trained midwife would have more facility in procuring safe abortions. There were other seeming paradoxes. The trained midwife was a necessity, and yet she was a danger. If educated and literate she might be in a position to breach the confidences of the families she came into contact with. Yet, without formal acknowledgement, she was the greatest asset to the discourse of perpetual policing, and would come to align herself with the forces of expertise, taking her place among the panoply of those who perpetrated a benign societal surveillance.

The organising midwives hoped to promote godliness and good behaviour in the families they came into contact with by the example of their manner of fulfilling 'natural' and 'sacred' duties, which come once again to be the stuff of eulogy and respect. In their endeavours to become respectable the midwives found allies among well-to-do obstetricians, as they posed more of a threat to ordinary general practitioners. The shaping of the profession of midwifery, was achieved by the resolving of the various interests. Not only were some opponents of independent registration in favour of a class of obstetric nurse under the medical jurisdiction of the doctor, but nurses themselves in their struggle to organise and achieve recognition, resisted attempts at merger, or association with the

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[47] For example, *The Lancet* (1903, 2, pp.616-7 in Donnison, 1977, p.179) details the support for the view of the controlling Board's members of that year, that midwives should not be taught the treatment for haemorrhages, nor the management of infant feeding beyond the first ten days. The *laissez-faire* idealism of public pronouncements, was undermined by the fierce protectionism of the professionalising discourses.

midwives, carving for themselves a distinct entity. Thus, they proved themselves as susceptible as any other group to prejudice about childbirth and its historically ambivalent ethical and medical record.

The majority of the clientele of the midwives continued to remain largely unmoved by these arguments and counter-arguments. Although the interests of the parturient poor are much mooted in these debates, they themselves had little to gain. Childbirth, from being an intimate and integral family affair, was fast becoming a medical event. This was of course achieved in part by hospitalisation, which would come to 'complete' and normalise the job. However, for the majority of women who still gave birth at home; the untrained friend or trusted neighbour, who would cook, clean and tend to other children and family needs, was not replaced in this host of roles, by the trained midwife. She was often an 'incomer', a woman not otherwise known to the family, and usually of a more genteel class. She brought different values of her class and profession to the childbirth proceedings, which had hitherto while always maintaining an anomalous status was nonetheless 'organic' to the organisation and activity of the family. The historical associations of class and gender permeated the changing relations, but were themselves dictated by the prevalent paradigms which forged unusual alliances that did not clearly divide or polarise along strict class or gender lines.[48]

The trained midwife strained emotional and financial resources, she injured the pride of those who could not always provide her with the appropriate conditions and wherewithal to perform her professional duties, forcing the 'confession' of inadequacies hitherto unacknowledged, and reinforcing the need for the universal institutionalisation of childbirth as the norm. However, such fundamental change was only achievable according to the

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[48] See Woodward and Richards, 1977; Donzelot, 1980; Hirst, 1981.

new paradigms of individual accountability enhanced by improved recording technologies and exigencies. Not only was the parturient a calculable entity in terms of her own conformity to the requirements of the medicalising discourse, but so also were the habits and demeanour of the midwife. Held perpetually to scrutiny, she was responsible not only for the behaviour of her clients but for her own standards of private morality. The midwive's organisations themselves welcomed such restrictions.

The exigencies of professionalisation furnished a certain welcoming of disciplinary restrictions which enabled a further narrowing of the emergent elite group, and the marginalisation of non-conformity, lending further definition to the parameters of legitimate group membership, and empowering them to define and punish misconduct in others and to set benchmarks for self-regulation. Their power in the now almost separate sphere of childbirth was instrumental in normalising submission to humane interrogation and expertise. The general accountability of oneself to oneself and others, gradually implicated the parturient who internalised these requirements. It was as much the activities and values of the professionalising midwife, as those of the hospital, that implicated the parturient in the medicalisation and objectivisation of her pregnant and birthing body.

In the discourse of professionalisation it is partly oppositionary factionalism which has an effect upon ensuing practice, and partly the intensity of the debate itself. the latter brings the object of scrutiny to conscious examination and creates a focus for enquiry that expands the discursive framework, reinventing the paradigmatic agenda. The discourse surrounding midwifery took place within a broad framework of concerns. The British Medical Association and other interested bodies would, had it not been for practical exigencies, have been prepared to forbid all unqualified practice. As interest grew in the welfare and disciplining of the individual, and of the population, there was developing philanthropic concern with both mortality and morality, and the domain of human rights and civil liberties which derived from this discourse. There was a perceptible need to

permit limited self-determination, reflected in the tenets of free trade at the time - and culminating in the modern self-help discourses of the later twentieth century.

The combined effect of social surveys such as Booth's, and the exigencies of warfare brought the health of the poor into public focus, as the object of the drive towards greater efficiency in public management facilitated and reciprocally generated new types and forms of information and social documentation presented as expose and comparison. Reports were compiled in such a way as to be more than simple descriptive commentary; they were prescriptively preparatory to action and reform. A cautious discretion was employed to create the new exigencies of individual privacy, and to preserve the 'dignity' and self-motivation of those subject to, and object of, scrutiny. Observation and intervention without overt disciplinary overtones and interference seemed to be the impossible requirement of the new policies of gentle but insistent incursion. The 'for-your-own-good' complicity-seeking discourses of the late nineteenth and twentieth centuries, become a feature of the Western democracies.

Increasingly, the need for constrained but collusive conduct was paramount. Disciplinary concerns were expressed in the changing fortunes of 'good conduct' clauses, which came to apply only to non-certificated women, and in the measures to enforce annual licensing which did not reflect any real local power of jurisdiction, but supplied information about the whereabouts of midwives who came under local 'supervision'. By 1905, although a half of births were attended by registered midwives, only half of these had any certification. Most women still continued to be delivered at home. The enforcement of the strict codes was spasmodic and irregular, despite their minute detailing. The bigger the authority, the better qualified the inspector, but a less well defined administration went on in more rural areas. Abuses and vendettas were facilitated as the struggle to standardise took place. However, as certificated midwives increased in number and became the norm, petty or vindictive disciplining began to decline. The vices for which a midwife might be

struck off ranged from 'disinfection' offences highlighted in the hysteria which came to attend the tackling of puerperal fever, through the wearing of improper dress or poor record-keeping, to the more serious lapses of 'virtue'.

Although the advent of the trained midwife was slow, registration was the first and paramount step. The banning of unqualified practice was also of importance. Again a balance of requirements and exigencies had to be achieved. All new midwives were constrained to take the Board's examination, which again, if it were not to deprive rural areas of legitimate practitioners, could not be too difficult or beyond the capabilities of the woman who would be likely to service such areas. The certificated midwife was constrained to submit herself to examination, which gave her a certain status. However, she was educated only to a level which could not threaten the superiority and domination of existing medical practitioners. The three months training initially required was extended to two years by 1938, and eventually the majority of practising midwives were also trained nurses (Donnison, 1977, pp.181, 183). The burgeoning of such exclusivising and hierarchising requirements was typical of a professionalising discourse. The outward appearance of the midwife had to conform to current standards of female respectability (virtually unchanged since the exhortations of Soranus), and the confessorial and examinatorial aspects of human intercourse formed the hallmark of the developing profession.

The course of obstetric history is rather one of assimilation and normalisation. Its accommodation as an area of medical prestige is testimony to the power of professionalising discourses, and the struggle for recognition of childbirth practices and their incorporation into the mainstream, and the fervency of the debate surrounding them, facilitated rather than retarded the process of professionalisation. Just as the creation of the categories of madness and deviancy facilitated respectively the discourses of

rationality, and legitimated the creation of normative categorisation.[49] Similarly, the witch-midwife had been the creation of the paradigms attendant upon the upheavals of the Reformation, and of new priorities and organisation of the discourse of medicine. The aim was production and proliferation, rather than eradication.

The influence of polarised female practice, was integral to these discourses. The transmission of privileged knowledges derived at least in part from the closed and intimate world of women epitomised by childbirth practices. Midwives were not the only group of practitioners to undergo these transformations. Interestingly, the drive for specialisation within the medical establishment, with the various interest groups vying for position and status, had a long unofficial pedigree in the irregular practices of empirics such as those who attended specifically to bones, teeth, ears and eyes, and particular organs, or specialised in herbal remedies and restoratives. While legitimate doctors regarded themselves as the best placed purveyors of every type of treatment, there was a simultaneous drive towards specialisation, in a dual movement, which saw the incorporation of diverse fields into the sphere of legitimate medicine, where once 'normalised', there was a concurrent move towards specialisation by legitimate practitioners (Youngson, 1979). This phase of professionalisation gave credence to the 'part-body' services recognisable in current medical practice, where ironically, it is the more marginalised alternative practitioners who are regarded as the purveyors and advocates of a 'whole-body' approach which has become the antithesis of Western allopathy.

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[49] See Foucault, 1967; 1979; Scull, 1979; Evnine, 1989

5.2. Paradigmatic dysjunction: the treatment of puerperal fever

As hospitalisation altered conditions for the parturient poor, a concurrent increase in the desire and capacity to measure and categorise aided in the assessment of mortality rates. The 1836 Registration of Births and Deaths Act provided the information that six in one thousand mothers died each year; many of puerperal fever. In the Registrar General's Annual Report for 1841 (pp.185-6), Dr.William Farr deplored the maternal mortality figures, the lack of midwife training and useful occupation for the genteel (Donnison, 1977, p.54).

It is worth looking in some detail at the case of the treatment of the most devastating parturient illness which was epidemic during the period of childbirth professionalisation, as it provides an example, not only of the result of historical continuities coupled with epistemological change; but also of the phenomenon of paradigmatic dysjunction which appears to be a feature of professionalising discourses. In the latter half of the nineteenth century, the highest maternal mortality figures were claimed by the contraction of puerperal fever in the Lying-in hospitals, as invasive techniques in childbirth were increasingly normalised. Epidemics of puerperal fever since the establishment of these hospitals, had been recorded from the mid-seventeenth century.[50] The rate amongst the rich and well-attended, where 'interference' was at its most unnecessary and intense, was also high. The aetiology of puerperal fever long remained a mystery. Some obstetricians correctly assumed its connection with other septic conditions, and therefore regarded it as similarly transmissable. Fever as a result of wound infection or surgery was known to

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[50] Hirsch, in his seventeenth century *Handbuch der Historisch-geographischer Pathologie*, enumerates 288 epidemics, 187 occurring exclusively in Lying-in hospitals. He quotes Lefort who shows a 3.4% death rate in hospitals, a greater number than those delivered at home, of whom 0.47% died (Cutter and Viets, 1964).

many seventeenth and eighteenth century writers.[51] Others, as documented by the Obstetrical Society, preferred to believe that the fever could 'spontaneously arise from the 'combustible' nature of the parturient herself. (Donnison, 1977, p.94) In the discussions surrounding the fever, women's feebleness, vitiation, delicacy and dysfunction are all emphasised. William Harvey (1651) describes the placental site as a "vast internal ulcer" which exposes women "to disorders and perils immediately after birth." (Cutter and Viets, 1964, p.99). Whatever the disparity of belief, doctors were not generally held to be culpable for high parturial mortality. One late eighteenth century medical commentator, Margaret Stephen (1795, p.43) remarks: "people are more reconciled to the event, because there is no appeal from what a doctor does, being granted he did all that could be done on the occasion."

Management was advocated as the key to prevention by those involved in male midwifery, and later these ideas were refined in the work of Louis Pasteur (1822-1895), and Joseph Lister (1827-1912). However, there was a time lapse or what might be called a paradigmatic dysjunction, between the understanding of the condition and measures set in train to combat it. Cutter and Viets (1964, p.101) point out: "The wonder of it all is that such outstanding progress in preventing puerperal fever, all but providing the complete etiology, should have been within the grasp of so many widely scattered observers with so little effect upon the practice of midwifery of the time or that of the two or three generations immediately succeeding.".

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[51] These included Thomas Willis (1621-1675), Hermann Boehaave (1668-1738) and Thomas Kirkland (1722-1798). Auguste Cesar Baudeloque (1795-1851), William Harvey, James Blundell, William Campbell and Charles Waller, also testify to the problem of manual transference of infection via the parturial canal. James Simpson, influential in the debate about inhalation analgesia, amongst others advocated antisepsic cleansing and isolation of the parturient (Cutter and Viets, 1964, p.104-115).

Such a lapse is in part to do with the age-old belief in the errant and ulcerous womb, but cannot be simply the conspiratorial intention of the obstetricians who debated the causes and cures of the puerperal fever phenomenon.

Chlorine began to be used as a disinfecting agent. Robert Collins (1801-1896) experimented with its use for the prevention of puerperal fever, with successful results. Before the Viennese physician, Ignaz Semmelweis (1818-1865), publicised his belief that the fever was caused by the manual introduction of cadaverous or putrid organic material, and that the increased use of forceps had enhanced the spread; these ideas had wide currency among obstetricians (Cutter and Viets, 1964, pp.99-143). Puerperal fever had constituted an epidemic in Europe for two centuries before Semmelweiss investigated its cause and cure in the nineteenth century. He regarded the advent of the doctor onto the childbirth scene to be a harbinger of death. Having observed in his own hospital that the section run by doctors and students had three times the mortality rate than that run by midwives and nuns, he concluded that unhygenic interventions were the cause. In 1861, he published the result of a five-year study of two sections of the Lying-in Hospital in Vienna, which revealed that those attended by male physicians whose work was diverse, were more likely to die. Post-mortems, and the handling of cadaverous material caused infections, while the use of chlorinated lime for cleansing quickly produced positive results (Semmelweis, 1861). The notion of the doctors' responsibility and failure was greeted with hostility. He met with professional antagonism and vilification.

Lister's work on antisepsis twenty years later, also encountered some resistance. He introduced the principle of asepsis in surgical operations, and Pasteur demonstrated the reality of bacterial infection. Asepsis was used later in midwifery and gynaecology when J.J.Bischoff (1841-1892) made the principles applicable to childbirth. The adoption of cleaner practice such as the carbolic washing of dressings and linen saw a drop in mortality rates. The greater provision of lying-in wards increased the likelihood of the disease, but

obstetricians remained reluctant to acknowledge their part. Action against the fever was delayed by the adversarial debate that surrounded the origins of the disease.[52] Simultaneously, the debate upon the use of anaesthetic and analgesics in childbirth was beginning, heralding the onset of technologised childbirth. Ironically, the alleviation of the terrors of childbirth, many of which were created or exacerbated by growing scientisation, coincided with the increased technologising of natural processes; the two elements went hand-in-hand. While puerperal fever was gradually brought under control, it was not the doctors and hospitalisation that attracted most suspicion. Something quite different occurred. The hospital was regarded as the venue where such problems could be resolved, and the doctors were regarded as those who could bring about a resolution. The experimental nature of hospital practice, with its strategies of trial and error, were in some way accepted while at the same time an aura of ultimate infallibility settled both upon the institutions and their personnel. The hospital was a microcosm hermeneutically devising its own dialectical processes, an interactive reflection of the sealed hierarchical and professionalising modern discourses.

Far from bringing the doctor and his milieu under suspicion, the incidence of puerperal fever confirmed the pathologisation of childbirth and its connection with disease and contagion. The hospitals were not seen to create this phenomenon, but rather to contain it. It was the problem of the dying parturient, not of the doctor fresh from the post-mortem with unwashed hands. That general hygiene improved was a matter highlighted by the need to reduce such obvious and damning mortality rates in childbirth. This was not so much a matter of wilful neglect, or a collective intellectual failure to make the right connections, rather it was the result of a certain paradigmatic combination arising from the exigencies of the professionalising process, and the historical prejudices and pressures

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[52] In England and Wales in the 1840's, approximately 3,000 women a year died from puerperal fever, which accounts for around 1 in 210 confinements (Youngson, 1979, pp39-40).

which surrounded childbirth anyway. Most importantly, these factors meant that different priorities were pursued and the problematisation of childbirth pain entailed the adoption of certain approaches which took as their starting point its developing pathology and its possible alleviation by timely and appropriate interventions. This required the organisation of its processes into manageable proportions, a grading and hierarchising of the experience to bring it into line with the other progressive tabulations of disease and to echo the professionalising process itself.

In this schema, the growing concern and discoveries associated with hygiene and antisepsis, can be regarded as a corollary of medical investigative procedures which were increasingly about observation and cross-referencing, and not necessarily as an urgent and independent course of enquiry and clear catalyst for change. The findings of Semmelweiss and of Lister, took place within a discursive framework which was making efforts, but had not yet succeeded in, making normal and axiomatic the improbable divorce of medicine and philosophy. Therefore the seeming 'slipped' connection between invention or discovery and implementation or utilisation, is sometimes simplistically interpreted as a matter of concerted intention or inattention, perhaps even a question of wilful neglect. Rather it was a particular ordering of concerns, permeated not only by the modern expediencies of the advancement of both individual and profession, but by persistent age-old dogmas concerning both physic and sexuality.

Despite the work of Semmelweiss on antisepsis, it was not until Lister's findings were recognised as valid by reforming obstetricians that the conditions and mortality rates improved. It was the middle of the twentieth century before the fever was virtually eliminated in the West. Those obstetricians who preferred to disbelieve that they themselves could be transmitting the disease, did so, not necessarily out of ignorance, nor

out of preconceived negligence.[53] Rather, their oversights and indignation arose from a combination of forces which included the fear of damaging personal reputations and the mystical ethos of the profession as it was establishing itself. The simultaneously developing medical concern with psychiatry with its heavy reliance on mythic symbolism, accentuates the probable impact of preconceptions about the nature of women's sexuality which informed the emergent experts via Classical texts and Christianity.

The discourse of hygiene, with its record of failure in regard to the lives of thousands of women between the seventeenth and nineteenth centuries, is presented historically as the triumph of great men such as Lister and Pasteur, and this version is supported historically by attitudes towards women as the great contaminators, who are themselves particularly vulnerable to contagion. The debate remained in the realms of masculine, ancient and Christian prejudice about the fatal flaws of women, even when it became apparent that people other than the parturient could contract the disease and die.[54] There was still a residual notion of self-infliction and something that was only to be expected if not in some way, perhaps under the terms of Eden, an unfortunate but deserved retribution. This has echoes of the current popular debate about AIDS, which, again, because of the nature of its transmission, has become fixed upon the worthiness or otherwise of the victims of the disease, rather than upon the disease itself.[55]

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[53] During 1869, James Simpson, although apparently confused by the ideas of Lister and Semmelweis, described those who continued to practice where they knew infection was spreading, to be guilty of "professional murder" Detailed in the *Lancet*, Vol ii, 1869, p..296,332,432 (Youngson, 1979, p.169).

[54] Semmelweiss died of the disease himself in 1865, having conducted extensive and seminal research into its causes. (Youngson, 1979).

[55] With the advent of Aids in the medico-sexual discourse, the historically derived anxieties which linked and pervaded sex and death, need no longer rely upon the hollow resonances of ancient voices, or the shadows of terrors past. The scientifically unsophisticated and technologically untenable model of conception as deleterious for men, and childbirth as potentially destructive for women (the latter still

The epidemic of puerperal fever in European hospitals from the seventeenth to the nineteenth century, was regarded as telluric, atmospheric, cosmic and inexplicable, something that was part of the 'curse' of women, and therefore preordained. Medical standards of clinical cleanliness appear to have relied on taboos of impurity based on gender, which placed great moral and physical stress upon the bodies of fertile women. The matter of cleanliness and hygiene does not emerge as a necessary aspect of medical practice distinct from moral ramifications or judgemental agenda, until the late nineteenth century. The risks for the poorer classes giving birth, were increased by the high incidence of puerperal fever in the hospitals. The *Lancet* reported in 1862, (II, p 423), that hospital midwifery was ten times more dangerous than home delivery. (Duffin, 1978, p.35)

It was a long time before the reasons for the contagiousness of the fever were acknowledged. In the system of checks and balances, the advantages of doctor-supervised institutionalised childbirth under the auspices of science were still, despite the evidence to the contrary felt to be the parturient's best chance. In the mid-nineteenth century, American obstetrician, Oliver Wendell Holmes followed up the work of Alexander Gordon (1765), with the influential if much maligned *The Contagiousness of Puerperal Fever* in 1843. This was attacked in the 1850's by Charles.L.Meigs and others, who appeared reluctant to admit the obstetrician's culpability. Holmes, on the other hand, wrote: "Let it be remembered that persons are nothing in this matter; better that twenty pamphleteers

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informing much of precautionary obstetric practice), is replaced by a much more plausible *fin-de-siecle* image. The spectre of debilitating disease becomes material; an effective and imaginable embodiment of human fear about the body. The connected and cogent prospect of maternal transmission of the virus to the foetus is an aspect of contagion accounted for by typical saturation tactics with moves towards routine HIV testing in pregnancy. The disciplinary potential of what appears, historically, to be a perpetually recyclable maternal image of chastity, integrity and nurture; does not prevent the simultaneous rehashing of the old taboos of childbirth contamination, which has come to inhabit the discourse of AIDS.

should be silenced, or as many professors unseated, than that one mother's life should be taken. There is no quarrel here between men, but there is a deadly incompatibility, and exterminating warfare between doctrines." (Stern, 1941, p.193).

The treatment of puerperal fever is a clear case of paradigms defying the evidence of the mortality figures of the hospitals. Just as the midwifery forceps had taken a disproportionate time to become part of the childbirth practitioners armarium; the delayed use of asepsis to combat puerperal fever displays similar elements of paradigmatic dysjunction. Those who 'progressively' began to acknowledge the need for professional hygiene, were prefigured by the example of antiquity. The ritualistic requirements of any exacting regime and organisation incorporated notions of both moral and physical cleanliness and purification. The time to embrace new practices, was as much determined by these exigencies, as was the desire to discredit or ignore them. The debate itself was fashioned in the same discursive framework, diminishing the credibility of the idea that the experts somehow divided neatly into idle and entrenched misogynists wantonly purveying destruction, and far-sighted, progressive humanitarians willing to admit to mistakes and take on the 'establishment' singlehandedly, against the tide and in the sole interest of the parturient. Though of course in terms of individual careers and reputations such heroism cannot be denied. What should be questioned is the overall efficacy of individual intention and action as a foremost instigator of change. After all the embracing of new practices began to have a momentum which overtook all the apportioning of blame, and overwhelmed the superficialities of the debates that had surrounded and legitimated them. Retrospective analyses can fail to take into account that at the time of imminent and ongoing change, the impetus is largely balanced on the side of the 'innovators', while the outward manifestation of the developing discourse; the polemic that surrounds impending upheaval, tends to be couched most vociferously and vehemently in traditionalist terms by those who have most to protect. The balance almost imperceptibly swings when conditions permit a normalising of what has created contention. The professionalising

discourse makes the arguments its hermeneutic own, and the collective dynamism of the experts is, to both paradigmatic and practical purposes, the dilemma's most recollectable trace.

Despite the evidence that the expedition of birth by the use of instruments, and the lack of basic hygiene procedures by obstetricians and their students, were increasingly regarded as significant factors in the transmission of disease, and although high mortality rates could not be regarded as entirely the burden of the untrained midwife, members of the General Practitioner's Union insisted that women who attended fatalities should be investigated and reprimanded by coroners (Donnison, 1977, p.130-1). This kind of precaution fuelled the cause of the pro-registration lobbyists. It was far from a foregone conclusion that conditions automatically improved when the certificated midwife began to hold sway. For it was this midwife, steeped in the training and ideals of a masculinised profession, and used to behaving in collusion with those who could both threaten and preserve her new-found status, who was more likely to seek the aid of the doctor.[56] In this way she limited her own now-increased vulnerability and liability, while showing the appropriate deference to the medical profession which out-ranked her.

Part of the seeming male compulsion to act with regard to childbirth had been their general lack of experience of the process of normal childbirth. Each birth was seen as a potential problem and a sequence of potentially dangerous events to be resolved as quickly as possible. The handling of birth testified to their expertise and professionalism. The doctor was the last recourse of the difficult labour, yet obstetric experience gained by the hours of

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[56] The protectionist attitudes of midwives and nurses, who did not wish their roles to coalesce, have continued into the latter part of the twentieth century (Robinson, 1990). This reveals a general impetus to professionalisation. The status of the midwife in other European countries, particularly France where they have a more specialised training, has always been higher than in England (Donnison, 1977). Nonetheless, the professionalising and specialisation process has produced similar effects across Western civilisation.

patience and observation obtained by the experienced midwife was closed to the doctor even if he had been prepared to acquire it. The prevailing paradigm was that he did not need to spend time on such drudgery, in fact no-one need waste their time when processes could be advantageously speeded up with manipulation, intervention and instrumentation. Hence the midwife, fearful of her own reputation, would stand aside for the magician.[57]

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[57] During the first third of the twentieth century, as doctors salaries became secure, and there was less professional opposition to the trained midwife. The birthrate fell, the Poor Law infirmaries came under local authority control and with the removal of stigma, the number of women having hospital births more than doubled to 34% between 1927 and 1937. The mortality rates, still high, began to stabilise. General mortality fell by a third, and infant mortality by a half (Donnison, 1977, p.187).

6. Conclusion: The History and Currency of Childbirth Practices

6.1. The demystifying process

The more recent history of childbirth can be seen in the broader context of Western overkill. The creation of modern civilisations has depended on the process of production, over-production and dismantling of what has been produced, and the creation of objects and subjects to facilitate this process. Just as certain forms of representation came in the refinements of alphabetic cultures to have a 'life of their own', so too did the processes they engendered. Hence it has been necessary to manufacture certain enmities and alliances in order to justify particular responses, or to perpetuate historical anachronisms. Similar charges can be attributed to professional medicine, which has sought its objects and developed as subjects, conditions and clients who have furthered the differentiating and hierarchising process. In the case of childbirth, strategies have been developed which encompass the whole of the parturient body and process, and implicate every woman who gives birth. These measures operate, not with much-vaunted technological precision, but crudely and collectively (in a climate of contrived equality of opportunity and purpose), so that a 'safety net' is provided in the face of the 'worst-case scenario'. This pertains for the few at the expense of the many, in an obsessive covering of every eventuality, resulting in overkill and anomaly.

This is the climax of a process which has sought to perform the spectacular in every field and failing the production of what might be perceived as real 'advance', each 'advance' (if economically feasible) is distributed indiscriminately like a net which not only breaks the fall of those at risk, but entangles and ensnares those who should be free of its suffocating safeguards. It is not however that the majority are somehow accidentally trapped by these fail-safes. Far from it, these blanket policies create not only a homogeneity of purpose and

the illusion of consensus, but fulfil a disciplinary and divisory function also. A function in which even the dismantling of practices can have a role, as other complementary or supplementary practices are set up which do not threaten but rather reinforce prevailing paradigms. Such imperatives, far from being simply a misogynist plot, are examples of procedures and strategies that are the mainstays of the development of the practices and principles of Western civilisation.

Also, it would be erroneous to suggest that somehow, men appropriated existing structures of power that 'belonged' to women. The institution and occupation of hierarchies is a more complex phenomenon. Women without the means or voice to professionalise, were able to subvert the processes and outcomes by organising themselves on the lines of, and against the regulatory bodies. They used their language and organs of authority; their learning strategies and modes of entry, and eventually, in modest numbers came to inhabit levels of the new hierarchies. Speculation as to whether or not they might have done things 'differently' presupposes paradigmatic choices that were unavailable. Changes are dictated by conditions of possibility. The organisational shifts that took place, were not essentially about keeping midwives in their place, still less about improving the lot of the hard-pressed parturient poor, they were rather about a self-interested drive towards professionalisation, as an expression of differentiating and hierarchical paradigms, by people who were by those very processes favoured and empowered to do so. Women did not initiate these changes because they need not and could not.

This change in perspective, permits the examination of the same historical material, and does not need to deny, for example, that part of the answer to the question as to why women managed to maintain their hold on midwifery, must be that women traditionally did work that was considered lowly and menial, and have continued to occupy in greater numbers, the lower echelons of most professions, in terms of status and remuneration. Also, that the reasons for this can be expressed with reference to women's biologically

determined commitments, which of course inhibit their economic and political power. On the other hand, this cannot be regarded as the story entire.

Is the narrative of women's history purely one of oppression and repression, coming from nowhere, a purposefully detrimental exercise of superiority perennially perpetuated, to which all other interests are in thrall, always intentionally perpetrated, always done to them, essentially unproductive and negative, in which women never exercise power or judgement, however circumscribed? And is this the lived experience of all women, and is it only ever men who endeavour to uphold the existing system? For whichever the system that exists, it appears to privilege men in real terms. If they do act, are women so perpetually gullible or altruistic that they always comply in strategies which disadvantage them? If the answer to these questions is simply affirmative, then it would seem that they can never then be, even at the level of operations, the authors of their own successes. It is traditional analyses which point up these deadlocked and contradictory scenarios, and which leave the answers suspended in some metaphysical rendering of the past, as if women existed, and can exist, somehow outside discourse, and not subject to the same conditions of possibility as those which govern men's behaviour. This, far from defeating change, is what makes change paradigmatically possible and strategically achievable or even likely.

The same might be said of the position of the midwife. While in her ignorant and dangerous incarnation, she serves her purpose by attracting and allowing the intrusion of both old and new imperatives, she then becomes the casualty of the resulting discourse, displaced at the bedsides of her former clients, and in the company of her former colleagues. This is not to the total disadvantage to either group in the course of time, though that is not to deny or make light of the fact that individuals are sacrificed in this process. For the rest, their historical implication in the maintenance of the status quo, already in place, far from weakening their position and laying 'their' profession open to

appropriation, proved to be their strength, as new opportunities for collusive and combative configurations, however hierarchically inscribed, presented themselves.

The dangers of sexual activity are accentuated in every age, and the links with reproduction are particularly strong in the ethics of antiquity, and subject to recurrent historical emphases, as in middle-class Victorian society. However, in the Christian era, a binary fragmentation appears to occur whereby sex and reproduction come to occupy parallel discourses, as do parturients and midwives; their histories separate since antiquity, diverging from the medieval era and polarising from the end of the eighteenth century. This occurs again to some extent in the problematisation of sex and birth in the twentieth century, when, as Foucault (1988, p.10) claims: "sexuality seems to be a question without direct relation with reproduction. It is your sexuality as your personal behaviour which is the problem."

During the Classical era in which the groundworks for these technologies were developing, women were not considered capable of the necessary powers of self-contemplation and control. The authoritarian model preached by late classical monasticism was more within their compass. The later Puritanism expounded by Calvin, deriving from Pauline and Augustinian doctrine, was even more severe upon the self, propounding the impossibility of self-salvation (Paden, 1988, p.64). In some ways, these notions propounded an equalising force; neither men nor women could attain complete self-knowledge. To know oneself one must reveal oneself, providing further justification for the objectification of the body. However, the balance tipped against women. In the masculine-dominated world of consultancy and expertise, the key to unlock the self was in phallocentric control. For men it was necessary to reach a certain state of grace in order to surrender themselves entirely to God, but for women, this achievement entailed the unquestioning acceptance of humiliation and pain and the absolute need to submit to the authority of men. By implication, female subservience to husbands, priests, doctors and authors, was a necessary

pre-requisite for the full expression of their inability to save themselves either spiritually or materially, in other words, their lack of personal instrumentality.

The epistemic changes which took effect from the thirteenth century, brought a gradual acceptance (and compartmentalisation) of observational and practical skills, while still privileging as 'academic' theoretical and rhetorical abilities, by virtue of the prevailing examinatory codes. What is probably more puzzling than the much-mooted 'appropriation' of childbirth, is the longevity of its existence 'intact' in the increasingly penetrative discourses that were developing elsewhere. It is likely that the disparate exigencies of religious and social taboo, came to bear in the past upon the discourse of childbirth, 'protecting' it, paradoxically, from direct masculine interference. It is also likely that resonances of the same prejudices, distorted by historically circumstantial anomalies, came also to hinder and prevent, those aspects of medical technology that would, properly employed sooner, have saved the lives of many women. Those women who, by the time of Lister, Simpson and Semmelweiss, often unnecessarily confronted unaided the hazards of dystocia, and unhygenic conditions. Parturient women died through ignorance and incompetence at the hands of both male and female attendants. The historical conditions which caused first the apparent scientific boycott of childbirth then its invasion, also prompted then delayed the application of research and technology. This diminishes the paradox that the very same transmuted prejudices, long-unquestioned, and historically redundant, underlie much of the revolt against the practices of modern medicalised childbirth.

Childbirth appears historically resistant to changes brought about by objectifying and individualising practices. The reasons reside in the developing discourses of hierarchical differentiation central to the most fundamental techniques of learning, reinforced by the highly visible, evocative and analogous distinction of the sexes. This comes to be variously explicated and perpetuated, via devotional, medical, cultural, literary and

domestic mythologies, truisms, and practices, which came also to reinfect educational methods and axioms, in a gathering, transmuting and transmitting arrangement which permeated the thinking, doing, and saying of successive generations.

In its female specificity, childbirth is the realm of the 'other' upon whose existence the discourse of hierarchical differentiation depends for its visible, lived experience of such an ordering and organisation. It had been created as a mystery, it had come to cloak itself with clandestinity. Its characters and practices had always been at the centre of moral ambivalence and disapprobation. It took place in the domestic heartland, it connected in the most complex of ways with the integrity of personal and formal relationships, and it represented the human resolution of fears about mortality, and obsession with immortality. It had potential for mythmaking, metaphysics, and magic. It attracts the use of drugs, therapy and pathology. It is a unique, shared short-term condition reflecting eternal exigencies, it ruptures the constitution of otherwise 'healthy' bodies, and permits the on-going and inter-discursive debate about disease to focus upon post-natally related pains and fevers.

So here is an arena for centuries superficially impervious to the direct ministrations of men, which was always nonetheless permeated by the exigencies of masculinised discourses. It became problematised and organised by the developing professionalising discourses. These discourses deprivileged the old practitioners from the outset. The type of learning and knowledge reified and inculcated by university teaching and assessment, marginalised certain skilled groups and led to some individuated, inward-looking and protection-oriented moves. One example were the barber-surgeons, who had begun to found guilds in Europe in the fourteenth century (Donnison, 1977). These guilds at first were concerned principally to secure conditions, and the supervision and control of practice. Homogenisation ensured a certain status which then required preserving. The actual focus on activities themselves and the individual and collective responsibilities that the new

status conferred, came later as a natural consequence of the new mode of organisation. This pattern was similarly established elsewhere, and brings into question the idea that changes in the medical discourse were somehow inspired by the objects of science and enquiry on humanitarian grounds, or that the drive for professionalisation was something intentionally pursued in all its aspects, in a particular sequence from a specific date as a matter of moral urgency, and a concern with standards collectively realised.

The further compartmentalisation of medically related discourses, the forming of externally differentiated, but internally homogenised groups, who tended to territorialise rather than combine, further exclusivised medical disciplines, and pushed further to the margins of practice and tolerance, the unorganised, uneducated and non-standard practitioners. These included lay-healers and midwives, who had never before appeared so distinct within the auspices of medical practices in general, though their presence and significance, as, for example, the purveyors of potions, the summoners of dieties, the procurers of contraception and abortion, within discourses closely related to childbirth had been of perpetual fascination. It is almost as if those who fell prey to the inquisitorial exigencies of the fifteenth and sixteenth centuries were the exhausted rump of an entrenched but informal, now dying mode of life, who facilitated the incursion of organising principles into what could be considered areas of darkness and/or privilege. They underwent a dredging for the last vestiges of their productivity tortured into acceptable truths in the manufactories of religious and cultural orthodoxy; a sort-of making safe, before they fell silent forever.

Of course in reality the maverick practitioner never went away, and until the principle of public health reform became established in its different guises throughout the developed world, they remained often the only recourse for the poor and indigent, who they either saved or exploited according to their talents. The 'independent' practitioner appears to have had a fashionable if ersatz reincarnation in the more recently publicised panoply of

'alternative' therapists, who have a certain current vogue, and have found some support among orthodox practitioners. Paradoxically, better, more advanced care, and the resultant impact on lifestyles, and the potential for increased longevity; have heralded the advent of new diseases, and the greater distribution of known ones. This, and other changes in health expectations, such as shifts in focus in obstetric practice predicated on the near-eradication of parturial mortality, have entailed a moving away from redundant preoccupations with aspects of safety, to a new emphasis on quality of experience. Hence, a certain crisis of faith in the old orthodoxies and their exponents has become evident. However, the new gurus also struggle for recognition amongst the practitioners of mainstream medicine, and within existing conditions have developed their own hierarchies of acceptability.

With technological developments in surgical techniques came the refinement of other, new practices and skills; with a concomitant preoccupation with timing, hygiene, observation, detailed recording, comparison, and the use and development of instrumentation. This of course, had its impact on childbirth. The linkage of childbirth in specific ways to sexuality, death, misogyny, fear, mistrust, and the pedestalisation of women, both highlighted the richness and ripeness of childbirth as developable site, yet also reined in those possibilities. The parturient body and her special circumstances were saturated with medical and ethical potentialities to be exploited. The growing concern with parturition was a natural concomitant of the interest in the health of individuals and populations.

Philanthropy in the nineteenth century cannot be taken at face value, or as the servant of capitalism. It both devolved upon and removed certain responsibilities regarding the family. It instituted a type of subordinate domestication that could be internally and privately instituted and regulated, and at the same time externally and publicly examined and policed. The good wife policed and disciplined her husband and her children. Her alliance with the doctor created new and powerful roles for her. This was particularly true

in relation to infant management, for example, and the institution of the figure of the good mother and the creation of the rights, responsibilities and vocation of mothering. This, in turn, becoming (like monasticism) an institutionalisation of women's power.

The notion that women are helpless, oppressed and powerless in these processes has to be questioned. Although circumscribed by their roles, they were also conduits of power; and should be regarded historically as productive and instrumental rather than as the passive and coerced victims of patriarchy. The family relinquished whatever independence it might have been said to possess in the process of becoming the project and product of medical ethics.[1] While it was promoted as the pedagogic centre of the life of the individual, the agencies of expertise come to manage the family via the tutelage of the mother. Hence she is promoted as an agent of social management - and her roles within the family are then increasingly under the scrutiny of the experts, and this phenomenon, involving aspects of both the investment and disinvestment of power, is increasingly normalised.

Some feminist writers have taken issue with the notion of female collaborativeness.[2] However to deny the mother any role other than a passive one, in the development of the social, via the family, is to yet again cast her in the role of victim and martyr; as someone who has had little historical impact. It is also to exaggerate and overstate the case of patriarchy as a conscious male-led conspiracy. Women cannot anyway be the independent authors of their fate. It would be inaccurate to overstate the possibilities of the intentionality of the subject, whether constituted as female or male. The subjectivity of both are constructs forged under the same patriarchal exigencies. Women are implicated in the perpetuation of phallogocentric culture whether or not they subscribe to it. They are

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1 See Lasch, 1977; Shorter, 1977; Poster, 1978.

2 Ehrenreich and English, 1979; and Bennet et al., 1981.

functioning within it, dealing with its negative aspects in a productive and ongoing dynamic that is itself permeated by rupture, and characterised by negotiation and dissent.

Contrary to feminist methodology since de Beauvoir, it is the privileging of the notion of the subject that has made women appear simply as contingent, and should that premise be challenged, other beneficial changes in historical perspective might also be made.[3] Feminist defensiveness can stifle the analysis of gender relations. It is clear that there has been a non-coercive if at times uneasy alliance between the 'helping' professions and middle-class mothers, whether or not this is seen to have been the result of pressurising, persuasion and the raising of unrealistic expectations. The notion of correctness and acquiescence permeates most aspects of consumer materialism: health, diet, image of self and domestic environment, family regimen and childrearing. Even the pressure upon the middle-class parturient to be self-determining in their mode of childbirth reflects middle-class fears about being seen to have forsaken autonomy and to have countenanced intrusion. The condition of modern technologised childbirth might be said to be as much to do with the imposition of choice as of control. The privacy and 'freedom' to be self-motivating and self-determining has been upheld as a human 'right'. Paradoxically, the very groups who have been led to believe that such rights must everywhere be vociferously and rigorously defended, have been those for whom the invasion of external management has probably been most effective and unchallenged.

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[3] Feminist debates since the seventies have centred largely upon the possible compatibility of feminist aims and materialist analyses. Examples include R. Harrison and R. McDonough, 1978; and E. Hicks, 1981. More recently, feminism has addressed the significance of the 'new' philosophies, and a greater coalescence has occurred between them in what might be described as the post-modern, post-feminist era. Relevant texts include T. Modelski, 1986; C. Weedon, 1987; A. Nye, 1988; C. Pateman, 1988; J.W.Scott, 1988 and S. Bordo, 1990.

The process of overwhelming the subject with the detail of existence has been a process of power strategies which began in the eighteenth century and developed in the nineteenth. The twentieth century has seen the fine-honing of the valourisation of the detail to an art. The over-technologisation of childbirth may have been falsely regarded as a process of the infantilisation of women, whereas, in fact, it increases her range of responsibility and choice, and creates a new domain of decision-making and stress. The vogue for 'natural' childbirth entails the reassessment of effective time-consumption, and a conscious disruption of what has come to be regarded as institutional timing, or the exigencies of professionalism and mass care programmes. This does not necessarily mean a realignment of the middle-classes away from their traditional alliances with the professionals of their own class. Systems are created from a mixture of complicity and dissent. Strategies are played out in relation to the dominant discourse, reshaping it and shaped by it.

The current middle-class affectation of disdain for the 'convenient', has entailed a concomitant revalourisation of time-consumption, and a different evaluation of what constitutes time and effort well-spent. Part of the effect of a return to time-intensive and expensive activities, has been to increase the time spent by women upon the domestic environment, and an increased investment of time in planning the lives of her children from birth on, whether or not she actually intends to be the main perpetrator of the programme she devises. The complexity of the discursive exigencies upon which these strategies are founded mean that explanations which are approached purely from psychoanalytical, ideological or sociological premises cannot be adequate. It is not the repressive aspects of reproduction and mothering that should gain exclusive attention, rather it is that, however circumscribed, women are, in reproduction and elsewhere, spoilt for choice; as to whether to conceive, whether to abort, whether to accept pain relief in childbirth. They are inundated with responsibilities, and as one author describes it, they are continually under "the chronic pressure of decision-making." (Kickbusch, 1981, p.158)

The technologising of childbirth has also presented women with a new range of options. This phenomenon has too often been regarded as the negative and coercive *fait accompli* of medical men, the only benefit of which for women was the dramatic reduction in maternal and infant mortality, when it should perhaps be seen as another means of exploiting potential. With its original insistence upon maternal complicity, the advent of birthing technology followed a classic path to normalisation and integration. However, it was equally inevitable that the 'exclusive' knowledges of the parturient body would also excite the interest of the parturient, long held to have a privileged knowledge which had been overshadowed by technology. Not surprisingly, the questions the middle-class woman and her newly created birth partner (usually male), asked about her pregnancy and birth generated dissension, debate and new choices. It also created new quasi-professionals, experts and gurus. Hence, the process can be regarded discursively as a positive and productive one, rather than as negative and repressive.

Certainly, there has been a period during which there appeared to be little choice. Women who entered hospitals to have their babies underwent an entirely institutionalised experience, manipulated by doctors and attendants, seemingly in the service of the available equipment and machinery. This is doubtless still the case for a number of women. However, the choices are becoming increasingly evident and where even a minority of women have taken the opportunity of choice, new configurations of power have evolved. Women's difficulties in childbirth, as in menstruation, menopause, and infertility, have all been pathologised and made subject in the main to drug therapy and sometimes to surgery. The instances of abuse have been and continue to be the subject of much debate and research concerning childbirth (Enkin et. al., 1989). Recent discursive attention has appeared particularly to emphasise the problematic of artificial fertilisation, and genetic manipulation (Corea, 1985).

It is important to note that just as families and family problems are created and not just highlighted by the activities of the panoply of relational expertise that is 'available' to them, so too are the women who challenge the predominant modes of parturial practice. Their expectation of choice and wide-ranging decision-making powers have grown out of the same discourse that has appeared to relieve them of choice. One might point out that before technologised childbirth the choices were pretty limited anyway. It would be erroneous to suggest that the constellation of experts that form a therapeutic ring around the family, and the medical expertise which surrounds the parturient woman, were somehow invading a field of instinctive and primitive innocence, an unchanging 'given', which existed in an untouched and unchanging form prior to invasion.

Childbirth technology has not been the liberation it might have been thought to become given the undeniable relief from parturial mortality it has ensured. Neither was it the result of a reversal of biblically inspired *laissez-faire* towards childbirth pain, thus providing further evidence of modern medical enlightenment. But it has not either entirely stifled and homogenised the process of birth - it has in fact been a productive disciplinary process, which has generated a myriad of related arguments, ethical and technological debates, and new subjectivities to objectify, manage and maintain. The problems of technologised childbirth in the West are not diminished by a more positive appraisal of their origins and process. Certainly in this century, as conditions began to improve, mortality rates to fall, and a technological answer began to be found to the questions posed by dystocic birth; the notion of an overt operation of superior and repressive power seems to be inaccurate. Although the possibility of a more equitable balance between the needs of the parturient, whatever she may discover them to be, and those of the expert discourse, may appear to exist; certain obstacles, which are beyond the intentionality or desire of any party, still remain. A value laden and hierarchical ordering of the different aspects of obstetric discourse determine patterns of relations and activities, some according to age-old contingencies that no longer obtain.

The problematic of childbirth is devised in the way in which questions are formulated and how responses are framed. It is a problematic concerned with the formation of objects and the creation of subjectivity. The prevailing dialecticism of rational logocentric ordering and codification requires that a hierarchical split is created, recognised and normalised in the relations between the parturient and the establishment of practices. Existing practice has historically deprivileged women, so that their role in the negotiatory processes of discursive activity has an axiomatic rather than a deliberative status. This creates the situation whereby it is the possible and probable dysfunction of the female body and its biological processes that preoccupy the obstetric establishment. Although this establishment is predominantly male in its upper echelons, the values it began with are those that filter through in the arena of practice which is still largely the province of women. It is women also, who supply an objectivisation of themselves generated by the conditions of discursive process. They provide of themselves as objects new demands, directions and information. They accept these practices from conception, through delivery and nurture.

It is the historical expectation of the body's failure, that has determined that it is this and not the quality or consequences of interventions that are examined first and foremost. Bryan Turner (1984) in his work on the history of diet and the historical management of the body, suggests that we are culturally embodied, just as we are enselved, and that the regulation of the body has served its construction within our thinking. The 'disorder' of the body, whether reproductive or alimentary, is regarded as an indication of a failure of control. A problematic of personal behaviour which can be righted by experts, is established in both cases. Far from deterministic and unchanging, childbirth is an overlapping dynamic, which apart from some distinguishing physiological features, is variously experienced, and as much a creation of circumstance as any other discursive object. Also, the parturient's subjectivity is as much a cultural phenomenon as the

experience itself.[4] The paradox culturally is having and being bodies. Hence our sense of self has been constructed to consider that a 'failure', such as disease, disablement, disorder, or inordinate desire, constitutes a threat to the self. From the eighteenth century, the 'explanation' of the body has been increasingly a medical rather than a theological one, as the concern for populations has entailed the management and distribution of bodies both collectively and individually. Medical paradigms of the body have come increasingly to be defined by what can be done to them. The differentiation of bodies comes to dictate life choices, and decision-making becomes the crux of control.

In the pressure to ensure the correction of the dysfunctional body, and the perfection (however that is paradigmatically defined) of the process and outcome of birth, the chronicles of technologically created dysfunction serve mainly to reinforce uncertainties about the integrity of the body in relation to treatment, and the latter tends to be discontinued or otherwise on that basis. There is much at stake in the preservation of interventionary activity, the reciprocal tendencies of treatment and effect create the conditions whereby the obstetrical discourse can continue to exist. Hence, the negative long term view that the ultimate intervention of 'elective' caesarean section might become the norm, has recently been substantiated by rising figures.[5]

Jean Astruc regarded the obstetric forceps as the "last step to perfection" in childbirth practices (Cutter and Vietts, 1964, p.87). In modern terms, the caesarean section might well be considered the ultimate intervention. It has been suggested, for example, that the

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[4] See O'Brien, 1982, pp.104-5 and Morgan, 1985, pp.236-7. The work of Turner, Foucault and others follow the Nietzschean principle that the notion of the body is language and perception dependent, and is therefore a social construct our experience of which as a corporeal entity does not predate classificatory systematisation (Nietzsche, 1968 (1901-11), p.347; Stern, 1978, pp.22-4, 121, 146).

[5] Arms, 1975; McIllwaine et. al., 1985.

vaginal delivery might come to be regarded as exceptional and selectively permitted.[6] The normalisation of the elective caesarean might be seen to elide the need for other methods of birthing.[7] However, as a measure of last resort, the caesarean does not preclude other obstetrical practices such as induction, monitoring, and the use of analgesics. There would perhaps be insufficient justification for the medical establishment to routinise caesareans, though the guarantee of safety and the avoidance of unwanted pain and responsibility might woo the prospective parturient, if already uncritically attuned to the deployment of childbirth technology. The fears that have been expressed by the critics of childbirth technology, are that the caesarean birth, as an example of the ultimate in terms of 'safe' delivery, and likewise in terms of medical intervention, could become common practice. Recent evidence suggests that while caesareans are on the increase, this unadorned fact obscures the entire picture.[8] A percentage of mothers, need caesarean sections to ensure

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[6] See Arms, 1975, pp.93-4; Sutherist and Case, 1975, pp.241-161; Corea, 1985, p.97. Also, recent figures suggest that the incidence of caesarean section has risen steadily in most developed countries since 1980, quadrupling in America over the past two decades (Placek and Taffel, 1988, pp.562-3), but at lower rates of increase elsewhere (Boyd et.al., 1983; McIllwaine et.al., 1985, pp.301-5; Hillan, 1992, pp.157-75).

[7] The caesarean itself has latterly become the focus of elective procedures, and does not necessarily involve general anaesthesia. Interventions involving epidural anaesthesia, which include caesarean sections, constitute a medical breakthrough in terms of pain relief and also in relation to enhancing the possibilities of unimpaired consciousness for the parturient in cases of dystocia. However, recent research suggests that this type of anasthesia may also involve negative long-term effects on mental and physical health (Birmingham University Medical School, 1991). These practices implicate the mother in other configurations of medical power. These might include, for example, the discourse of psychiatry which has problematised post-natal psychology, and that of pregnancy and parturition (Brown and Harris, 1978; Dalton, 1980).

[8] For example, caesarean sections rose from 9% to 10.5% of total deliveries in England between 1980-5; however, fewer than half were elective, and these births were at less than 2/3rds the rate of overall increase (Donnithorne, 1990, p.15).

safe delivery in cases of cephalopelvic disproportion, placenta praevia, malpresentation, diabetes or toxaemia, and also in cases where other interventions have led to parturial inertia and foetal distress. The proposition that it may become routine rather than the exception has some credence if the experience of America, which has a high incidence of caesarean birth was copied more generally in the West. This might occur either as a natural concomitant of existing techniques or as an exigency created by increased litigation. Litigation has in itself, and as part of the proliferation of expertise, been encouraged by the very results produced by modern interventionism which has generated a discourse of unnatural guarantees and expectations.

Resort to caesarean section is also based on the length of labour and its stages, though these too are difficult to determine with any precision. What is imposed on childbirth is an ideal of timing and progress which does not exist as a generality. One of the few advantages of this strategy is that by casting the net for contingencies so wide, those mothers who are at risk are likely to be fully screened and accounted for, though this is not always the case. The problem with otiose routines is that they can breed complacency, both about the routines themselves which are infrequently reviewed, and about giving sufficient credence to real anomalies when they present themselves. For those that this system does implicate unnecessarily, the price is often unnecessary distress, humiliation, trauma, and sometimes needless physical hurt. These mothers will comprise the vast majority who would otherwise undergo normal births.[9]

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[9] See Kitzinger, 1992. In America in the mid-seventies, for example, it was estimated that with adequate pre-natal care, approximately 70% of pregnant women in America might be expected to deliver safely without intervention, while another 20% with complications might also do so. Pro-'natural' childbirth studies have put the figure as between 93-6% (Arms, 1975, p.48).

However, it is not, as we have seen simply a question of clinical and societal ideals being fulfilled. It is a plethora of effects and interests that determine the course and nature of interventionism. There is some evidence to support the idea that in Britain, it is the so-called alternative postures of the natural childbirth movement that have held sway in determining the adoption of new strategies in the hospital (Kitzinger, 1990). A more collaborative position vis-a-vis the parturient, her family, and childbirth mentors whoever they may be, might after all be the more productive and profitable of the power-knowledge configurations available. Such contradictions push at the parameters of change more certainly than the routine subjection of a fully anaesthetised parturient to a completely controlled medicalised event. The latter notion, if implemented, could effectively sever major routes to further collaborative conjunctions of personnel and practice. These conjunctions have shifted and differed in terms of power and practice, but have functioned similarly, providing a bridge between the parturient and society at large.

The caesarean may continue to function as a worst case scenario. In terms of its discursive potential, it appears to operate best as a distant possibility, an ultimate failsafe against the dystocic birth, a promise rather than a threat to the prospective parturient. Whatever the exigencies, the age-old horrors of which the technologised version of childbirth functions as a permanent reminder, these are far from the parturient's range of expectations. She frustrates the malevolent plan of nature by placing herself in the hands of the professionals, who are willing not only to intercept the natural processes at every juncture should they deem it necessary, and should she so desire, but will also as a matter of negotiation, relinquish some of their technological power to permit a measure of what might still be regarded as a primitive autonomy. That is, as long as that switch of control pays the dividend of cooperation and the generation of new and expanding data on which to exercise new refinements of expertise. The bargain might also include at its least imaginable (but nonetheless imaginable) extreme, the acceptance of the possible necessity

of a caesarean should a situation develop whereby the all-important guarantees might be threatened by a failure to intervene.

There is another tacit guarantee that has developed with this discourse of subtle disciplinarity. The rewards of complicity are not exclusively those of relieving the parturient of mortal fear, or even of providing her with a healthy infant to take from the hospital. Under compulsion, what appear to be the obvious objectives of parturial desire would clearly lose their priority. They are the expectations engendered by the technological possibilities (Minkoff and Schwarcz, 1980, pp.594-7). The seeming paradox is that what has most disciplinary effectiveness is the guarantee that no measure will be a matter of imposition. The assimilation of some of the messages of anti-technology, have enhanced rather than diminished the disciplinary potential of childbirth, and generated a multiplicity of possible interactions. The most recent signs are of a movement away from homogeneity and routine, with the notion of negotiable and individualised packages, and of a developing reciprocity of explanation based on new and trusting alliances. Childbirth management may increasingly display a willingness to supply the form of childbirth desired by the prospective mother, who will gradually be reinvented as a 'client' whose interest in her own processes should be encouraged, and properly channelled and utilised.

The binding of the parturient to the offices of the expert are expressed in the old symbols of coercion; the straps and cuffs of the delivery table are incongruous apparatuses to recreate old fears and anxieties. But the image of the "willing prisoner" of the hospital is perhaps too simplistic, or even too loaded to be fully accurate (Arms, 1975, p.99). Such devices provide what Nietzsche would describe as a "mnemotechnic" (1969 (1887), p.61) of the past which underlines the persuasion of the parturient to obey her own best interests, and to obediently don the vestiges of coercion. A process which Nietzsche would suggest is in itself a function and manifestation of the will to power (Deleuze, 1983, p.63). The use of restraining devices in and after childbirth labour are also the subject of

enquiry and resistance. They are an instrument of the fragmentation of experience essential to modern disciplinary discourses. As they limit the participation of the parturient by immobilising her, their use produces not only a fortuitous mnemonic, but simultaneously a reminder of the anachronistic interrogatory techniques of an 'uncivilised' past in which mothers and babies died, and human life was somehow therefore 'cheap'. So, not only is the evocation of this past a necessity for the operations of the current discourse of technologised childbirth, but this past, and those who peopled it must somehow be presented as ignorant, careless, uncultivated and lacking in humanity. Such is the historical arrogance that shamelessly conjures the past, while censuring its lack of 'civilisation'.

The hospital system that presents itself as the safe and obvious venue for the mother, breeds its own criteria for regard and dependency, by a process of disorientation that makes the routines and technology the familiar, normal, and universal, and that to which it feels most safe to adhere. The broken contacts, the discontinuity of care, the fragmentation of the stages of labour, the variety of treatments and the venues in which they take place, the strangeness of proceedings for which even the best informed cannot be fully pepared, and the enforced reliance upon strangers, all this has the effect of disorientation. Following upon which, the complicity that is requisite, is established almost imperceptibly. Ways of combatting such disorientation, include the generation of dialogue between the parturient and those who attend her or have an interest in the progress of her birth, such as midwives, doctors, therapists, radicals, mavericks and 'experts'. This element of participation has grown to the extent that it has pushed at the paradigmatic parameters that operate within the existing system. For example, the negotiated birth plan can become the benchmark whereby 'success' or 'failure', no longer a question of a live child, or the recovery of the mother, can by adjudged by the extent to which the plan is observed or from which it is deviated. The ignorance of the mother-to-be can certainly be exploited, but the effects of this are limited. A more certain, varied and productive result can be evinced if compliance is sought via controlled and mutually ratified information,

negotiation and cooperation. The movement which advocates a return to home birth for the majority of 'normal' cases has stimulated the debate in those countries where hospital birth is the norm.[10] However, the take-up rate is unlikely to be high while the main criterion for childbirth remain feasibly the safe and perfect result.

In order to compete with this movement, however, the hospital has gradually begun to dispense with the more redundant depersonalising features and procedures of childbirth. For example, some provide more relaxed and homely environments, with low beds and less uniform decor, for the parturient. She may be able to complete the entire process in this one space. She may also be encouraged to bring artefacts and audio tapes to personalise the experience further. The advent of the male partner in the birthing room is an accepted feature of modern childbirth, and he is largely welcome everywhere. Continuing research advocates that redundant procedures be abandoned, and the more overtly unpleasant preparatory measures for labour are disappearing from the new user-friendly agenda (Enkin et. al., 1989).

The modern ethos is increasingly one of negotiation, one in which birth plans and programmes initiated by the birthing clients themselves are likely to be increasingly respected (Kitzinger, 1983). To an extent this does not threaten existing structures of obstetric practice. In fact, it is an indication that the parturient is beginning to codify and arrange her own experience. Perhaps the most extreme examples of this can be found in the self-determined use of TENS machines for pain relief. Further evidence is to be found in the more recent experimentation with self-administered epidural 'top-ups' which allows the parturient some mobility. In such processes, it is the role of the hospital to offer advice, support, availability and access. As in any transitional process, there will be voices raised against such 'non-professional' interference (Kitzinger, 1992, p.65). However, these

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[10] See Oakley, 1976; Kitzinger, 1978, pp.135ff; Richards, 1978, 1982; Faulder, 1985; Tew, 1989.

only serve ultimately to reinforce and underline the changes that are in fact being set in train and becoming normalised.

TENS has obvious advantages insofar as it permits the parturient a measure of control over the administration of her own pain relief in accordance with her own assessment of both the level of her pain and how she should respond to it. The highly localised effectiveness of TENS has two distinct outcomes. One, it has little more to offer in term of actual pain relief than the more readily available 'gas-and air' (entonox) which is also self-administered. Secondly, for the same reason, it does not induce the same soporific side-effects which can impair judgement and render the parturient both incapacitated and docile, and therefore a more likely and willing candidate for interventions. So, on the one hand, the effectiveness of the pain relief may be limited, and only provide therefore an insufficient safeguard against the need for more conventional analgesia (though it must be said that fear of the loss of self-command can itself produce muscular tension and psychosomatic pain, and this might be countered by introducing an element of control). On the other hand, the relative lack of contra-indications involved in the use of TENS can interrupt the 'knock-on' effect of technological interference, thus reducing the need for intervention. The effectiveness of this method will depend largely upon the relative importance the individual parturient places upon self-prophylaxis, and on the avoidance of pain, and these things in turn will be determined by what sort of psycho-social influences are experienced or have been brought to bear, and on what the prevailing paradigms happen to be that govern the need for self-control/self-fulfilment. Paradigms which will define pain and its parameters.

The rather more recent experiments with the personal administration of epidural top-ups have rather different implications. It appears to be an innovation which will release the patient from the constraints of supine horizontality which have previously been the result of epidural anaesthesia, while also guaranteeing a more effective form of pain relief. Also,

it appears to release the parturient from her dependency upon outsiders while permitting her to partake of the benefits that technology has to offer. All this is certainly innovative and will enhance the repertoire of choices that are available to the birthing woman, and should perhaps be welcomed. However, it is also necessary to be aware that such innovations are developed within the scope of the prevailing paradigms of childbirth practices, and are derived from a multiplicity of historical precursors and contemporary requirements, both lay and professional, and will therefore have a complexity of outcomes and effects which can only be guessed at here, and exemplified by simple observations. For example, the 'top-ups' themselves will obviously be strictly controlled so that the parturient does not exceed the maximum dosages that would anyway have been administered. This seems to be a sensible precaution where it can be certain that a standard dosage has universal effectivity. Also, in order that this prescribed dosage is not used up too quickly, self-administration is strictly and *automatically* controlled into pre-defined amounts and time-slots. This too is an obvious precaution. However, apart from the possibility of mobility, which is an improvement not to be underestimated, the avoidance of arbitrariness in the setting of limits necessarily requires the same standardised and universalised approach. The implications are far-reaching.

The control of pain represented here is an anonymous extension of existing authority. This merely but portentously, offers the parturient what can only be described as *control simulation*. If a predetermined allocation of relief released over preset periods of time is administered by the recipient herself, giving a semblance of control enhanced by increased mobility, there is a possibility that not only will such forms of control simulation become normalised, but that greater numbers of women will opt for epidural anaesthesia than would have previously considered it as an option. Certainly the possibility of mobility can alleviate some of the problems associated with epidurals which have formerly been resolved by resorting to further technological intervention - but not all of the side effects can be negated simply by mobility. Sensation is still necessarily and deliberately impaired.

Unlike the pain relief afforded by TENS, this type of anaesthesia still at present requires hospitalisation, and will certainly, in its early stages of experimentation, promote hospitalisation. As surely, the parturient will become a stronger partner in the historical alliance of women and the medical profession.

While this does not necessarily have negative implications, it is inevitable that such innovations will be sold or rejected according to inaccurate criteria. Respectively; welcomed, perhaps as further evidence of women wresting control of their bodies from masculined technological institutions and thereby returning to a (suitably modernised, modified and sanitised) female-dominated natural primitivism which never existed. Conversely, it may be rejected by professionals as retrograde for the same spurious reason; and similarly, by natural childbirth lobbyists as a new and devious method of institutionalised control. Ultimately however, it is likely that such procedures will form part of the strategic framework whereby: firstly, such notions as pain, control, the progress of science, and the realisation of self will themselves be restructured and redefined. Secondly, a fusion of requirements will be satisfied and incorporated into the embrace of the developing professional ethic which is contemporaneously infused with a *fin-de-siecle* eclecticism and caution.

Professional dissent is set against the new criteria being formulated and guided by the prevalent forms of expertise, which, of course, include that of the once 'maverick' practitioners, whose message is modified and moderated into acceptability. This, of course, is what occurred with other professionalising groups, such as surgeons, midwives and obstetricians. Far from being 'free' of the 'tyranny' of the expert, the parturient has extended the range of experts from whom she will sift and combine advice. She will choose from a wider range of options than ever before, increasingly with the blessing rather than the discouragement or opposition of the medical and obstetrical establishment

(Richards, 1982; Faulder, 1985). This makes the notion of tyranny somewhat inappropriate to these developing discourses.

It must not be overlooked that despite the fact that these changes are manufactured from within the exigencies of the existing discourse, they are indeed in terms of practice having an effect upon the experiences of many women, even those who do not themselves militate against the status quo. They too, will inevitably be affected by changes that are wrought in principle and practice, just as women who might expect a normal and straightforward delivery have been caught in the 'safety net' of the guaranteed secure and perfect delivery, where mistakes and wrong outcomes are anaethema and abnormality in themselves. Part of the effectiveness of the complicity seeking discourse of modern childbirth, is that it is impossible to judge whether or not a certain procedure was entirely necessary, when the outcomes are almost always, according to the criteria that have developed, as one would hope and expect. No-one knows or dare risk, or indeed should risk, waiting to see what the outcome might be given time in an uncertain circumstance. The parturient woman feels herself to be 'singled out' by technological marking, moulding and mending, yet paradoxically complies in a form of subjectivisation which undermines her individuality. It is the distinguishing feature of modern discourses that they involve a simultaneous process of homogenisation and differentiation.

Within the hospital, the parturient is surrounded by the fail-safe mechanisms which can still ensure results. If she has elected to experience childbirth pain and this has been properly negotiated, then this too has become a permissible feature of labour. It has even become a disciplinary feature itself insofar as the parturient can be regarded as having set her own parameters for success or failure. Exacting standards of endurance are inspired by those other arbiters of obstetric good taste, the childbirth dilettantes, who, as surely as any other disciplinary factor, assert their influence over the birthing woman. She can rest assured that even should she 'fail' these negotiated tests, the hospital will be there with all its

trappings to rescue her. Either scenario does the established regime no harm. The client can be satisfied that her plans were accommodated by the hospital, thus justifying her collusion with the system. Otherwise, she is grateful that common sense and good offices prevailed to save her and her child when personal judgement might be thought to have failed.

The 'alternative' childbirth lobby has little to lose either. Its battle with the hospital having culminated in a negotiated truce in which the faith of the parturient is the tacit hostage; both gain credibility and kudos from their association with the other. The hospital gains because it is seen to have updated and modified its attitudes and procedures, demonstrating the open-mindedness of the obstetricians. The natural childbirth lobby gain respectability and their 'flat earth' status diminishes. If their adherents 'fail' to produce babies by their exacting standards, then despite their protestations to the contrary, it is to be regarded as the failure of the parturient herself, whose threshold of pain and integrity has been tested and found wanting. There is little of fundamental alteration here, despite the outward manifestations of change. Certainly the parturient appears to have more autonomy, and her range of choices has extended. Indeed, it might be thought that the quality of her experience today in the wealthy West offers the best of both worlds, as a more enlightened system of obstetric practices becomes the norm rather than the exception, and the realm of possibilities broadens.

All this so far has positive connotations, and much in it to satisfy all parties. However, the basic structuring of disciplinary and examinatory organisational strategies of modern phallogocentric discourse, which privileges the principles of division and hierarchy remain intact in all areas of human interaction, whether educational, economic, punitive, or medical. Where the latter is concerned, this can be most thoroughly and paradoxically masked and demonstrated by the psychiatric and obstetric discourses, both of which have had especial significance for the experience of women. By the time the woman comes to

the hospital to give birth, the safety network, technologically, emotionally, and paradigmatically is in place around her. What she does or does not achieve within these parameters and within the parentheses that mark off the process of her labour, is really her own fleeting affair. The only requirement is her commitment to an uncompromised outcome. Therefore it is where her 'freedom' occurs within the network of effects that is crucial. Its location must be an area of containment (as, for example, with the use of TENS), and the maximum that can be produced from the encounter of the parturient with the obstetric system must be ensured and sustained. Much of this is assured before the woman enters the hospital. With the intensification of scientific interest in the realms of what might be dubbed 'pre-genetic', or 'super-genetic' material and information, this could be said to occur even before the fertile woman conceives.

Women are implicated in the procreative discourse from their own conception. How they fared in the wombs of their mothers may go some way to condition the outcome of their own offspring's birth, procreation, and death. Whatever the extent of the impact of lifestyle, it is clear that the delineation of what used to be rigidly classified as either nature or nurture, has fallen into the melting pot of the modern research idiom. Therefore the incursion into the lives, histories and intentions of prospective parents, and particularly, but by no means exclusively, the female line, has become increasingly justifiable. The experts have appropriate props for every step of the way. The fact that one cannot counter or reinvent ones own history, pushes further the alliance with the experts in what can best be described as a damage limitation exercise.

The woman who has conceived under the auspices of these exigencies will surrender information about herself long before she fills out a form at an ante-natal clinic. She is involved in a perpetual personal audit. She has been accountable and recordable in every aspect of her existence, and further implicates herself in a reciprocal web of information, examination, advice and assistance, once her child is born. The discourse of parenting is

expounded in every doctor's surgery, in each clinic and school, and in every media outlet. The modern relation of tutelage unleashes, with her avid complicity, its subsuming power. Neither neutral nor repressive, the paradigmatic family - "...appears in childcare manuals, in advertisements for cars and insurance policies, in the formal and 'hidden' curricula of schools, ...in the catalogues of Mothercare and the brochures of travel agents." (Barrett and McIntosh, 1982, p.28).

What follows is an immersion rather than coercion, in the codes and practices that comprise the prevailing syllabus of parenthood that has undergone perpetual self- and 'expert' appraisal.

In the modern discourse of accountability, the individual is imbued with the rudiments of expertise, in a culture where everyone is an expert. The individual cultivates, and mistrusts an inner spy; increasingly asked by both medicine and media to measure up, to rate themselves on a score of one to ten, and to make decisions based on multiple choices which can facilitate further categorisation. Aspersions are cast on the perspicacity and judgement of the individual even while he or she is enjoined to tell the truth and make honest assessments. In these tasks, the individual is aided by cure-all homilies as to what future behaviours might produce the desired if arbitrary outcomes.

The late twentieth century has produced the 'entertainment' end of the disciplinary discourse - the media phenomenon of the celebrity as expert. The self-styled expert is endorsed as mentor, who, via books, tapes, videos, articles and interviews, peddles the ancient dream of perfection, offering advice on every aspect of existence, whether the aim is to form new 'good' habits or to relinquish old 'bad' ones. As of old, the invitation is to shape up before the icon, to seek redemption and make the appropriate sacrifices. This is similarly true of established and 'unorthodox' childbirth celebrities; and the panoply of their

disciples and devotees, who proffer their particular precis of parturition; their programmes, plans and prescriptions.

Successful examinees are the parents and parturients who become their own examiners, who have internalised the appropriate criteria to such an extent that they are able and practised enough to ask themselves the most searching questions and adopt the most suitable strategies. They espouse the right causes and purchase the best products. They supplement their own learning with the appropriate professional advice, in order to achieve the correct and acceptable result. The middle-class parturient and parent who best adapt to such regimes, in childbirth practices as elsewhere, are also of the class that motivate, ideologise, problematise and staff the institutions that perpetuate them. A state safety net is provided for those who do not or rather cannot break the codes which give the clues to conformity. Thus the experts serve both the successes and failures in a tutelary complex which depends upon both adherents and deviants for its continuing legitimation.

The discontinuous trace of changing power practices in medicine can be discerned from the illicit use of the cadaver in the furtherance of anatomical study in the sixteenth and seventeenth centuries, through the objectification of docile bodies in the eighteenth and nineteenth, to the engagement of the object in the testimony of themselves in more recent examinatory discourses. These devolve upon and culminate in: "the personal history...the interrogation, the exacting questionnaire..." (Foucault, 1981, p.65): the dual process of refinement and impairment of the structures of domination and repression. A process evolved in the confessorial and revelatory strategies whereby the human sciences have defined their objects and created their professionalisms. Outcomes are increasingly assured without recourse to coercion or repression; but on the contrary, as a result of persuasion, negotiation and assimilation. The exigencies of phallogocentric discourses which privilege all division remain. They are particularly manifest in the hierarchisation of gender relations, especially in the discourses of reproduction, and clearly also in the

practices of childbirth. They ensure that *via* the conduits of power represented by institutions, practices and persons, the male is still the prime authority. However, the constitution of the truth and therefore of knowledge and knowledge acquisition is increasingly negotiable within these constraints. The expanding and expansive frame of paradigmatic reference, is composed of an increasingly devolved and fragmentary power. This augurs rapid change and discursive diversity rather than either the unified progressivism or stagnation forecast in the discredited doctrinalisms of the twentieth century.

The decentring of the intentional instrumentality of the pre-given human subject is not to deny either the motives or activities of individuals - it is rather to question the very constitution of the subject and the paradigmatic conditions which determine the devolution of power. In this process, women may be historically deprivileged, but they are not absent, nor are they inevitably passive victims of circumstance. Equally, the possibilities for the constitution of subjectivity and experience are neither static nor preordained. The childbirth 'heroes' of the nineteenth and twentieth centuries require debunking, but so too do the childbirth 'heroines' of the mythic past. In the West, such fictions operate like the creationist fantasies represented by the notion of omnipotent monotheism and of a virgin mother inseminated by the *logos*. They sustain and are sustained by the simultaneous devaluation and valourisation of human generative processes; a dialectic which from antiquity has characterised the reconciliation of fear and necessity. Historically imbued with these images and resonances, childbirth has no definition which can be free of the attentive calculations of science or the physiological oversimplifications of humanism; of the rational assumptions of progressivism or the obfuscations of metaphysics. Whatever has been, is or will be, thought or said to constitute for both the parturient and practitioner the conglomerate of experience known as childbirth, must be revealed and recognised as definitions based on interpretations and not as unchanging truths.

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