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“Safeguarding Motherhood:”
(De)constructing the Functions of Twentieth-Century Obstetricians

by

Kori Bridget Flower

B.S. (Cornell University) 1993

A thesis submitted in partial satisfaction of the

requirements for the degree of

Master of Science

in

Health and Medical Sciences

in the

GRADUATE DIVISION

of the

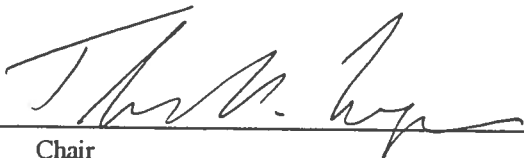
UNIVERSITY OF CALIFORNIA, BERKELEY

Committee in charge:

Professor Thomas Laqueur, Chair
Professor Janet Adelman
Professor Adele Clarke

1996

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Table of Contents

| | |
|---|-----|
| Acknowledgments | iv |
| Introduction | 1 |
| Chapter 1: Methods and Methodology | 6 |
| <i>Part One: Historical Perspectives on The Obstetrician and His Patient</i> | 19 |
| Chapter 2: The Obstetrician Imagines Himself and His Role | 20 |
| Chapter 3: Obstetricians Construct “Womanhood” and “Motherhood” | 34 |
| <i>Part Two: Contemporary Obstetricians’ Narratives</i> | 59 |
| Chapter 4: Contemporary Obstetricians Imagine Themselves | 60 |
| Chapter 5: Constructing Women Patients and Female Obstetricians: 1970 and Beyond | 76 |
| Notes | 94 |
| References | 97 |
| Appendix | 102 |

Introduction

...Who is better prepared than the gynecologist and obstetrician to study and promote investigation in relation to woman from the standpoint of the great field of medicine in all that concerns her development, education, fitness for marriage and maternity, her evolution; and also her degeneracies as a criminal, as a pauper, or as a prostitute.

(Ward 1922, italics mine).

This project has evolved into an exploration of how obstetricians imagine and construct “self” and “other.” Borrowing and altering bell hooks’ phrase about the “representations of whiteness in the black imagination” (Hooks 1992: 166), I have been concerned with representations of women in the obstetrical imagination. So it may seem odd that I will begin by discussing the involvement of midwives in childbirth, but it was through an initial interest in midwives’ work that I came to this project. In 1992, while I was in London interviewing women after childbirth about how they had chosen to feed their infants, I noticed that the circumstances under which childbirth took place there, in a hospital in a poor borough, were quite different from those in a American public county hospital that I had worked in. The presence of the midwives, who were not nurses but were all uniformed graduates of the Royal College of Midwifery, was immediately apparent to me on the obstetrical floor. There, the midwives saw women prenatally, delivered babies, and then visited the women and their babies at home after birth. Obstetricians were rarely seen on the obstetrical floor, and were referred to as “consultants;” I understood that they were involved in pregnancy and childbirth only if complications arose. In contrast, the American hospital that I had worked in utilized primarily obstetricians, who were predominantly men, and who appeared, as far as I could tell, to have the first and the last word on the management of labor and delivery.

Since obstetricians have been the primary childbirth attendants in the twentieth-century United States, I want to review briefly some of the criticisms, by feminists and others, of the way that pregnancy and childbirth have been handled by obstetricians. Where obstetricians supervise pregnancy and childbirth, it has been said that technological interventions into both processes are not far behind. An obstetrical style of management of childbirth has come to be equated with the generous and unhesitating use of technologies such as amniocentesis,¹ chorionic villus sampling, routine ultrasound imaging, pharmacologic relief of pain during labor, and electronic monitoring of the fetus, to name a few (Arms 1994, Mitford 1992). This is not to say that all individual obstetricians practice this way, but rather to suggest that obstetrics as a profession has tended to foster the introduction of technologies of surveillance and manipulation of pregnancy and labor. When high-technology interventions occupy center stage and seem to be the focus of the profession of obstetrics, critics have said that less technological aspects of these processes, such as the advantages of good nutrition, or the psychological bonding of an infant with its parents, recede into the background. The management of pregnancy, labor, and delivery by obstetricians is also widely thought to deemphasize social and experiential aspects of childbirth.

Other critics of the management of childbirth in the United States have focused on the way that obstetrics, and the technologies it utilizes, constitutes a form of social control. William Ray Arney (1982) has argued that the obstetrical approach to childbirth has been characterized by constant and incessant monitoring and surveillance of birth, and that structures of monitoring restrict the behaviors of birthing women. Similarly, Robbie Davis-Floyd (1994) asserts that there is a single, hegemonic birthing model which serves as a means of social control by enacting "principles of separation" which enculturate individuals during their first moments in society. Paula Treichler (1990) has also been

concerned with the establishment of a single, dominant medical ideology of childbirth. She has argued that the discourse about childbearing includes multiple meanings of childbirth, but that “medical linguistic imperialism,” or the monopolization of resources and “linguistic capital,” results in the transformation of a single meaning of childbirth into the official definition. Susan Irwin and Brigitte Jordan (1987) further suggest that obstetrical control over women’s decisions is buttressed by the legal system. Some authors have tended to assume a relatively simplistic power relationship between women and obstetricians: obstetricians have power, women do not, and women are helpless in the face of any challenge to their bodies. Others, in analyzing the actual deployment of obstetrical control over women’s bodies, have emphasized women’s agency and pointed out that women are quite capable of resistance. Emily Martin (1987) claims that women utilize a variety of modes of resistance within obstetrics, such as unstrapping fetal monitors, and Robbie Davis-Floyd (1994) argues that women who give birth at home commit an act of resistance to obstetrical control by giving birth outside the confines of obstetrics.

Many scholars, then, have claimed that the obstetrical management of childbirth has significantly limited the control that women can exercise over the circumstances of childbirth. Such criticism has led Treichler (1990) to characterize American childbirth in the late twentieth century as a “crisis.” In reviewing the existing literature which illuminates the origins of this childbirth “crisis,” I noticed that there were excellent studies of women’s childbirth experiences² and careful examinations of the changing roles of midwives³ but relatively few studies which focused on obstetricians⁴. I thought that an analysis of obstetricians’ perceptions of themselves, their work, and their patients would contribute to this literature on childbirth. In addition, the prospect of making the traditionally male obstetrician an object of research from my perspective(s) as a female

medical student appeared to me to be an intriguing feminist project, and I address methodologic and epistemological issues related to this more fully in Chapter 1.

I chose to examine the ways in which obstetricians have, at different historical moments, constructed their patients, and themselves. Before I turn to my analysis of obstetricians' voices, as I have gained access to them through their writings and through my interviews with them, I want to explain why I begin the story that I am about to tell in about 1920, by briefly reviewing some of the key events in the development of the profession of obstetrics. Judith Walzer Leavitt (1986), in her interpretive chronology of childbirth, has shown that prior to the twentieth century, decision-making around childbirth was negotiated between women, families, birth attendants, and others. According to her interpretation, a balance of power was subtly maintained between women and their physicians until about 1940, when women began to give birth in hospitals in large numbers. Leavitt, along with Richard Wertz and Dorothy Wertz (1977), sees the move from home to the hospital as the key event which enabled the takeover of childbirth by medical professionals. The number of women who gave birth in hospitals jumped from five percent in 1900, to fifty percent by 1939, and to about eighty percent by 1950 (Wertz and Wertz 1977: 133-135). With movement of childbirth into the hospitals came the consolidation of medical control over childbirth; according to Nancy Dye, "since the 1920s, physicians have been the unchallenged birth attendants," and the change in the setting of birth from home to hospital helped physicians to replace midwives as birth attendants (Dye 1980: 106).

While Leavitt, and Wertz and Wertz, have described the change in the location of childbirth as a pivotal one, Dye's analysis suggests that the transition in birth attendants from midwives to physicians was most crucial in transforming women's childbirth

experiences. Other authors have accorded primacy to different events in the history of childbirth. Margarete Sandelowski (1984), for example, argues that women's activity in seeking pain relief from physicians was the most important event in the evolution of obstetrics. Pamela Sumney and Marsha Hurst (1986), on the other hand, have identified events internal to the profession of obstetrics, such as the merger of obstetrics and gynecology in about 1920, and the publication of a single professional journal, as the most critical events in the emergence of obstetrics and gynecology as a medical specialty. While authors differ in the relative importance they ascribe to different changes in childbirth and obstetrics, they seem to agree on one thing: by 1940, childbirth had been radically transformed by the new medical specialty of obstetrics and gynecology.

My analysis, then, is based upon materials written after 1920, since the historical interpretations that I summarized above suggested that modern obstetrics entered the American birthing scene at approximately that time. The chapters that follow represent my attempt to describe and analyze obstetricians' constructions of their female patients, and of themselves. In Part One, my analysis is historical and is based upon obstetricians' writings between 1920 and 1970. In Part Two, I attempt to trace the vestiges of these historical constructions within contemporary obstetrics and gynecology, based upon my interviews with obstetricians practicing in the 1990s. It has been my hope, in attempting this complex interweaving of historical and contemporary narratives, that the evolution of one key figure in the childbirth crisis--the obstetrician--might become clearer.

Chapter 1: Methods and methodology

I want to begin by explaining both the methods and the methodology that I have drawn upon in my attempt to examine the voices of obstetrician-gynecologists during the twentieth century. Here, I distinguish between method and methodology, following Sandra Harding's (1987) distinction between the two. I consider it useful for the purposes of this project to distinguish, as she does, between methods as "concrete techniques of evidence gathering," and methodology, as a "theory and analysis of how research does or should proceed" (Harding 1987:2-3). My choice of particular methods evolved out of the perspective and theoretical framework that I brought to this project, so I will describe first the methodological concerns which underlie and pervade my project, and then the specific evidence-gathering techniques I utilized.

In studying the involvement of obstetricians in pregnancy and childbirth, I have found that I have multiple and simultaneous perspectives on this topic, which occasionally conflict or collide. As a woman who may at some point have a child, many of my concerns revolve around women's experiences of childbirth, which I view through the lens of my own, future, anticipated experience. As a medical student, I carry with me medical metaphors of women's bodies and functions (Martin 1987) and some of the biases, blind spots, and practice concerns of a future practitioner of medicine generally, and as someone who will attend women in childbirth specifically. As a feminist, I recognize and want to take action to change the subordination of women in this society. Later I will explore some ways in which my identities have shaped the information that I have gathered through the

technique of interviewing physicians. For now, I simply want to acknowledge some of the standpoints from which I view this project, for the purpose of acknowledging that my claims are not neutral or objective ones, and with the intention of giving the reader an idea of the kind of lenses through which I view the topic of childbirth.

Initially, it seemed to me that a project on childbirth should attempt to represent women's voices, and should be based on women's experiences, in the spirit of some of the excellent feminist work that has been grounded in women's experiences. But as I realized that excellent work had been done in the area of women's experiences of childbirth,¹ I began to consider whether there might be other ways, from a feminist perspective, to gain an understanding of how childbirth is structured in the United States. As I examined the literature, I found that the role of obstetricians in twentieth-century birthing scenes had been subjected to relatively little scholarly scrutiny in historical and cultural analyses of childbirth. I thought that making obstetricians the focus of study could contribute to feminist work on childbirth by more fully examining all of the actors in twentieth-century childbirth, which include the birthing woman, midwives, obstetricians, nurses, and technologies, to name a few. There may be some important reasons why obstetricians have escaped more attention in historical analyses and cultural critiques of childbirth. While in the collective American imagination, the figure of the obstetrician is hypervisible--my particular version of this ubiquitous figure is a rotund, ruddy-checked, balding Caucasian man in his fifties with a number of white teeth gleaming through his congratulatory smile--the figure of the obstetrician is actually less visible for purposes of analysis because at this particular historical moment, his figure is so entrenched. Midwives, on the other hand, have been less constant figures in childbirth scenes; their appearance and disappearance may have made them more visible and available to scholars for study. The prototypical frantic drive to a nearby hospital to be delivered by an obstetrician is such an entrenched

cultural motif that the very presence of the obstetrician, and his relationship to the birthing woman, seems almost unproblematic. It is precisely because twentieth-century childbirth has become almost imaginable without the mythic sequence that I just described that the obstetrician's place in childbirth is deserving of more extensive questioning and scrutiny.²

To study the position of obstetricians in childbirth is to make visible one component of a hospital-based birthing system that has become so much a part of the cultural fabric as to be taken for granted, invisible, and nearly unavailable for study. To make obstetricians the focus of a study on childbirth is also to "study up." It has been suggested (Nader 1972) that "studying down," in which the researcher is in a greater position of power than those researched, further entrenches a power differential. Laura Nader (1972) has encouraged "studying up" as a way, through the process of research, of redistributing the knowledge and therefore the power that attach to research. And Sandra Harding has suggested that "studying up" has particular relevance for feminists, who in an effort to understand the position of oppressed groups, will need to understand the "sources of social power" (Harding 1987:8). Harding gives the example that "...psychiatrists have endlessly studied what they regard as women's peculiar mental and behavioral characteristics, but women have only recently begun to study the bizarre mental and behavioral characteristics of psychiatrists" (Harding 1987:9). My effort in this project mirrors Harding's example in that I want to suggest that while illuminating women's varied experiences should be one goal of feminist research, another goal of feminist research can, and should be, to scrutinize groups, including physicians, which have been in power over subordinate groups, including women.

In proposing that this project is a feminist one, I want to draw from other feminist researchers in proposing what I think my responsibilities are. Following Sandra Harding

(1987), I want to attempt to locate myself in the same critical plane as my subject matter; therefore, I began this section with an attempt to state some of the beliefs and perspectives that I bring to this project. My goal is, whenever possible, to show how I have actively shaped every step of this project, from the decision of subject matter for study, to the analysis, since I see myself as having a responsibility not to suggest that I am a distanced or neutral knower. A second acknowledgment that I want to make here is that this kind of project, in my mind, carries certain risks that I want to be candid about. Focusing on obstetricians, of course, is a potentially dangerous proposition because it has the possible effect of focusing more attention (mine, and that of my readers) on a group of people who have historically been well-funded and visible, at the risk of making less powerful groups--birthing women and midwives, specifically--seem less important or visible (which is exactly counter to my purposes!) My purpose here is to simply acknowledge that I am aware that this is a risk, and to state that I intend to allow my consciousness of this risk to percolate through this project and analysis.

A word about language

So far, I have used the word "obstetrician," and I want to explain my rationale for using this word to mean "obstetrician-gynecologist" in the remainder of my paper. Obstetrics and gynecology were distinct medical specialties until the 1920s and 1930s, when medical schools created combined departments of obstetrics and gynecology (Speert 1980: 88), and specialists began to be referred to as "obstetrician-gynecologists." Since my interest, in this paper, is in childbirth and in physicians as attendants of childbirth, I have used the word "obstetrician" only, for brevity and clarity, and generally avoided the lengthier "obstetrician-gynecologist." But I just want to note briefly that some obstetrician-gynecologists are more allied with obstetrics, as a specialty that attends to pregnant women,

or with gynecology, as a specialty of the diseases of women. In fact, some obstetrician-gynecologists practice only gynecology while others practice both obstetrics and gynecology. The distinction between identifying mainly as an obstetrician or as a gynecologist may be a meaningful one; for example, in Dorothy Fadiman's film *When Abortion Was Illegal*, a woman seeking an abortion before *Roe v. Wade* describes how she went through the phone book looking for names of gynecologists who were not obstetricians, who she thought might be more sympathetic to her situation. In fact, the woman seeking the abortion found this to be the case, and she found a gynecologist willing to perform an abortion. Therefore, while I refer to "obstetricians" for simplicity's sake, I have attempted to pay attention to the language that obstetrician-gynecologists use in describing themselves; when they have self-identified as "gynecologists," or described themselves as practicing "gynecology and obstetrics," I have taken note of this and reproduced their language in its original form.

I frequently use "he" or "him", rather than the more awkward "he/she, him/her" construction in referring to obstetricians. This is not meant to suggest that the male pronouns are the "default" option or that they are used unconsciously, but rather to reflect the fact that, historically, obstetrical discourse has been dominated by men, and when I use "he," I mean deliberately to conjure up the figure of the traditionally, historically male obstetrician. My use of "she" or "her" is also significant and conscious; I have used these pronouns when I discuss the discourse that is produced by female obstetricians, regardless of whether or not it is different from the traditional discourse of obstetrics that is gendered male.

Evidence-gathering techniques

I have attempted to collect the public voices of obstetricians by several means. To analyze what being an obstetrician meant in the early part of this century, from about 1920 on, I analyzed obstetrician's writings. I examined closely the annual addresses in the *American Journal of Obstetrics and Gynecology*, the main professional journal, between 1920 and 1970 to capture obstetricians' voices in their professional communication. To find out how obstetricians talked, in their writings, to women directly, I analyzed guidebooks to pregnancy and childbirth that were written by obstetricians from about 1920 on. For sources of career narratives, I turned to several autobiographies by obstetricians. The historical component of my analysis, then, is based on these three types of materials: journal articles, health guides, and autobiographies.

My objective was to analyze the voices of obstetricians in these historical materials side-by-side with contemporary obstetricians' voices, in an effort to trace continuities and discontinuities in obstetricians' goals, philosophies of practice, and relationships with women. To capture contemporary obstetricians' public voices, I elicited career narratives through interviews with obstetricians. I interviewed twenty-four obstetrician-gynecologists who ranged in age from their early thirties to their mid-seventies. Most of the obstetricians were white, but one was African-American and two were Asian. The interviews took place in two cities: thirteen of the interviews were conducted in "Westview" (a fictional name), a large, liberal West Coast city with a strong midwifery presence, a history of consumer activism, and significant involvement in "managed care" health plans. Eleven of the interviews occurred in "Newborough" (also a fictional name), a conservative, medium-sized, "Rust Belt" city which has few midwives and little involvement at this time in "managed care" health plans. In each city, the settings of obstetricians' practices included solo and group private practice, academic positions in university hospitals, clinics, and health-maintenance organizations. Two of the eleven obstetricians in Newborough were

women, as were five of the thirteen obstetricians in Westview. My goal, in talking with obstetricians of different ages, ethnic backgrounds, and practice settings in these two very different cities, was to gain a sense of the spectrum over which currently practicing obstetricians' voices and philosophies vary.

Obstetricians were recruited for the interviews in several different ways. In Westview, physicians with whom I am in contact gave me names of their colleagues, and at times facilitated setting up an interview appointment. I contacted the obstetricians first by letter, then by telephone to arrange an appointment, usually through a secretary. The physicians who referred me to their colleagues were sometimes acknowledged that they were referring me to their favorite obstetrician, and sometimes to their least favorite, so it was my hope that by being referred to potential interviewees in this way, I was encountering the range of obstetricians that a woman might encounter while seeking care during pregnancy. In Newborough, the recruitment of physicians was entirely random; I sent letters to fifty obstetricians whose names I found in the telephone book, and followed up with telephone calls to each obstetrician. Of the fifty obstetricians I called, I was able to schedule appointments with eleven. Many of the obstetricians' offices did not return the telephone calls, so there is certainly room for a non-response bias in the group of physicians I interviewed in Newborough. Any characteristics which might separate the "nonresponders" from the "responders" are not known to me, but it does not seem likely to me that those who responded simply had a more communicative style; the obstetricians I eventually interviewed ranged, in communication styles, from terse to quite verbose.

The interviews with obstetricians lasted from twenty minutes to two hours in length, depending upon the amount of time each would give me. The obstetricians chose the time and place that was most convenient for them to be interviewed; consequently, the

location of the interviews varied. Most took place in the obstetrician's office, but two took place at the home of the interviewee, one in a hospital call room, and two in cafeterias. When the interviews took place in the obstetrician's office, I was able to observe and take notes on the atmosphere and decor, although that was not possible for all interviewees. The interviews consisted of a set of standard questions, and I frequently used minimal prompting to encourage the interviewees to elaborate upon their answers. All interviews but one were tape-recorded, with the interviewee's explicit permission. After each interview, I tape-recorded my own impressions of the interviewee and made notes on the ways in which I might have shaped the interview. Later, I transcribed all of the interviews. My analysis of the interviews consisted of a close reading of the transcripts for comments related to the following themes: their ideas about their role and relationship to women, and their perceptions of their female patients.

In gathering and collecting the textual materials that I have relied upon in my analysis, I actively shaped them, as I have shaped this project at every stage. That is, this work was generated from a constructivist epistemology in which knowledges and findings are created within and by the interaction of the researcher (me) and the subjects (obstetricians and texts) (Guba and Lincoln 1994). Feminists, philosophers, and others have pointed out that researchers are not disinterested and neutral, as positivism has claimed, and the knowledge produced by research is not free of the values of the investigator (Harding 1991; Keller 1992; Haraway 1991). In keeping with that spirit, I want to turn now to considering the ways in which I saw, and was seen, as a consequence of the identities, perspectives, and beliefs that I, as a specific and engaged person conducting research, brought to this project on the voices of the obstetricians of this century. My public identity as a medical student enabled me to have access to certain obstetricians, and allowed me to be privy to certain kinds of conversations (and not others). For example, my recruitment of obstetricians in Westview was entirely dependent on my

personal contacts, as a medical student, with physicians. In Newborough, when I recruited physicians by letter, I always identified myself as a medical student, and I was aware that my claim to membership in the club of medicine was more likely to provide me with entree into the fraternity-like community of obstetricians. Newborough was also my birthplace, and there I had an additional layer of identity as a student returning “home.” My childhood ties to the city, in addition to my present training in medicine on the West Coast, probably contributed to some obstetricians’ willingness to be interviewed. I sensed that obstetricians in Newborough agreed to participate in the interview because I was someone who had ties to and familiarity with the area, but also because they were somewhat curious about my medical education in a distant geographic location.

My identity as a medical student seemed to affect which obstetricians agreed to talk with me, but also shaped the content of the interviews. I imagine that certain assumptions were made between myself and my interviewees, some of which I am probably not aware, about the legitimate topics and the proper language for conversation. I think that there was a tacit understanding within the context of the interviews that the obstetricians could speak their own language, including profession-specific jargon, and that I, as a novice speaker of the same language, would understand them. As a result, there was probably less clarification of terms, and fewer explanations of the taken-for-granted disease states, than there might have been in a different kind of researcher/researched dynamic. Because I have internalized certain biomedical constructions of bodies and disease, I am probably limited in my ability to interrogate certain deeply entrenched concepts held by physicians generally, and I may have missed opportunities to challenge such concepts that a different researcher would have been able to capitalize upon.

Often, I was seen by the obstetricians I interviewed as a future colleague or partner, a potential competitor, a younger version of themselves, or as one of their own students. Since many of my interviewees were two to three times my age, I think that my young age in combination with my identity as a student encouraged many of the interviewees to take on the role of teacher/lecturer during the interview. I recall several instances when an interviewee truncated his answer to a question in order to find a textbook and demonstrate the anatomy or pathology of a condition he had mentioned. So, within the context of the interview, my position as a student in the same profession, and as a younger person, made it easy for the interviewees (and me, with them) to slide into a teacher/student relationship.

In several cases, it seemed to me that interviewees envisioned me more as a prospective colleague. I think they may have interpreted my project, to some degree, as an exercise in “shopping around” for training and practice opportunities for the future. While such a purpose was far from my mind, I think that some of the obstetricians sought to create a good impression. Several of the obstetricians spoke at length to me about the advantages of their particular kind of practice; they may have been eager to convey the positive (and, in some cases, the negative) aspects of their practice settings because they saw the interview as an opportunity to provide advice to and influence a younger trainee.

Sometimes I sensed that it was primarily my identity as a woman that the interviewees were responding to. One of my male interviewees, for example, asked during the interview if I took vitamins, and claimed that he would be able to convince me to by the end of the interview. I sensed that, to him, I had temporarily slipped into the role of his imagined patient, and as such, I received a lecture on the importance of vitamins that a different researcher might not have been privy to. At other times, I was aware that my identity as a woman was intersecting with that as a medical student to cause the

interviewees to respond to me in certain ways. When I spoke with women obstetricians, for example, I often sensed that they saw me as a younger version of themselves. And, in response, I know that I participated in identificatory moments with them, at times, laughing at the recognition of similar experiences as women in medicine, or nodding in understanding about the challenges of balancing career and motherhood. In general, the female obstetricians seemed to see me as a potential ally, and assumed that I would sympathize with the challenges they faced as women, mothers, and physicians. Certainly, the identificatory process that occurred during the interviews, especially with the women obstetricians, shaped the interviews; the women were probably much more likely to talk about sexism in medicine, and career/family conflicts, than they would have been with a researcher they perceived as less sympathetic. I must add that, certainly, there were identificatory moments with the male obstetricians also, and that the extent to which I identified with different obstetricians certainly affected the kind of information that was generated in each interview.

The methodology and epistemology that I have described here led me to adapt the specific method or evidence-gathering technique of interviewing to my own purposes. My awareness of "studying up," and of the power differential between myself, a young female interviewer, and primarily older, male, physician interviewees, caused me to construct a specific kind of interview. Whereas different methods might be useful when interviewing women--for example, I would be much more likely to consider open-ended interviews or focus groups as a technique for gathering information from and with poor women--the fact that my interviewees possess a certain amount of power and privilege in society (most as men, and all as physicians) made it desirable for me to structure the interviews in such a way that did not merely recapitulate the interviewees' accustomed social position. As a young, female researcher, I wanted to be sure that my interviewees did not take the

opportunity to reinforce, within the context of the interviews, hierarchies of age, professional experience, and gender which separated me from them. My decision to use a structured interview grew out of these concerns. My efforts here have been in the spirit of egalitarianism which has characterized other feminist work (Reinharz 1992:27) but whereas feminists who interview women have sometimes turned to "interviewee-guided" interviews (Reinharz 1992:24), my own methodological choices were intended to foster a more egalitarian relationship by providing a structure which enabled *me*, the less powerful person in the research dyad, to guide the interviews. As Reinharz notes, feminists engaged in research on persons and institutions of greater social power "...must find ways to increase their status and credibility" (1992:30). While interviewing physicians, I found it necessary to bolster my credibility by indicating to my interviewees, through the format of a structured interview, that I was a competent, confident investigator.

In spite of my efforts to set the terms of the interviews, it was apparent to me that my interviewees were accustomed to occupying the position of "investigator," and possessing the power to ask questions. Many of the obstetricians I interviewed responded cooperatively to the idea of a structured, taped, interview. I felt, however, that there were many subtle maneuvers by my interviewees which served to turn the tables of the research dynamic, and return the interviewees to the position to which they were accustomed. A small number of the interviewees gave advice, at the end of the interview, on how to analyze and interpret the results of my work; I would imagine that such advice-giving, in a "between-us-researchers" way, would not occur in research contexts where the subjects felt less empowered to comment on research design. Some of the obstetricians I interviewed appeared to require a certain amount of personal information about me before the interview began. My comment here is not so much that their questions were unusual or unwarranted, but rather that I had a sense that they felt entitled to such information, as a result of being

part of a profession that ordinarily requires people to divulge personal information in a one-way informational flow. In the most dramatic example, one obstetrician insisted, as a condition of the interview, that I send him my curriculum vitae. I experienced this request as his attempt to regain some of the power to interrogate that I had taken on in the researcher/researched relationship.

It is my hope that, through these reflections on feminism, method, methodology, and epistemology, I have communicated some of the excitement of the issues that are central to my work on obstetricians and childbirth. For I have found that, nearly as intriguing as the materials that I gathered for analysis, were the questions that have hovered in and over this work about social research generally and feminist research specifically. I have barely touched on the former, and have only skimmed the surface of the latter. My aim here has been to attempt, through a certain degree of reflectiveness about the origins and genesis of one project on childbirth, how I have become concerned with considering *what can constitute feminist research* . In conclusion, keeping “feminist research” dynamic and open to continual redefinition may offer stimulating possibilities for studying the operation of gender in society, and working for change.

Part One:

Historical Perspectives on The Obstetrician and His Patient

Chapter 3: Obstetricians Construct “Womanhood” and “Motherhood”

In the previous chapter, I described obstetricians’ constructions of their roles and relationships with patients. Such constructions rely upon, and require, certain constructions of women. So in this section, I turn to the following question: who is the woman who is the imagined patient of the obstetrician? Using obstetricians’ guidebooks on pregnancy, journal articles, and autobiographies, I will explore here how women have historically been constructed by obstetrical discourse. I don’t mean, in doing so, to suggest that the imagined or constructed woman bears any resemblance to real, actual women, or to perpetuate the seeing of women through the eyes of traditionally male obstetricians. But I think that tracing the way in which obstetrics has comprehended women and their bodies can be helpful in ultimately determining the meaning and relevance of obstetrics as it has been traditionally practiced for real and actual women today.

Translating “woman” into “mother”

Even prior to the consolidation of obstetrics and gynecology as a medical specialty, obstetricians presented “motherhood” to their female patients as the pinnacle of “womanhood.” Obstetrician Frederick Irving’s description, in his 1932 guidebook *The Expectant Mother’s Handbook*, exemplifies the eagerness with which obstetricians of the late nineteenth and early twentieth centuries sought to equate true womanhood with motherhood. Irving suggests to the woman reader that she should:

face motherhood with an easy mind, secure in the knowledge that she is fulfilling her highest physical function as a woman and that in bearing children she is doing the normal thing.

(Irving 1932: 3-4)

Irving and other obstetricians contributed their voices to a larger chorus that proclaimed that bearing children was the greatest achievement of a woman's life. Other voices, including those of women writing on pregnancy and childbirth, certainly also embraced the notion that motherhood represented the ultimate fulfillment that a woman could hope for.

Obstetricians, however, had a unique position in reinforcing the importance of motherhood for women. Because of their intimate relationships with women, obstetricians were in a special position to help women internalize the construction of motherhood as the pinnacle of womanhood. Their constructions of "womanhood," and "motherhood," then, acquire added importance.

Irving's particular version of the construction of motherhood as the ultimate form of womanhood carries two additional messages. First, bearing children is to be faced with an "easy mind;" that is, women are encouraged to discard any ambivalences and hesitations about the meanings and physical realities of motherhood, and make a smooth psychological adjustment to the physical state of pregnancy. The author assumes that any specific, individual responses to the idea of pregnancy will be subsumed by the inevitable and powerful appeal of pregnancy to all women. The individual, pre-pregnant woman (if in fact she ever existed) becomes the generic, faceless mother, whose fulfillment is guaranteed. Second, the normalization of childbearing accompanies the translation of the individual woman into the generic mother; motherhood for women is not only the ultimate goal, in Irving's mind, but also the "normal thing." The normalization of women's bodies and physical functions is pervasive in the history of obstetrics, and an example will serve to illustrate that the representation of the "normal woman" as a mother was part of a larger construction in obstetrics of the "average woman." George Gellhorn, in his 1932 address to his professional society, pretended to discard the concept of "normal," or "average,"

saying, "Nobody can tell accurately just what is a 'normal' woman" (Gellhorn 1932: 491). But in fact Gellhorn has a very specific idea of who the "normal" woman is; he continues, "We can only have a sort of intuitive conception. Rafael's Sistine Madonna, and so does, in the plastic art, the Venus of Medici [*sic.*]." With these women as prototypes, the spectrum of normality envisioned by Gellhorn is very narrow indeed! Gellhorn continues, quoting another obstetrician: "The perfectly normal woman 'glides, it were, insensibly, from the reproductive age into the menopause,' practically without any physical or psychological upheavals" (Gellhorn 1932: 493).

The example of Gellhorn's image of the "normal" woman is dramatic, but through many subtler and more pervasive expressions of normality by obstetricians, a monolithic WOMAN is constructed. This woman who is the product of obstetrical discourse has universal and predictable characteristics and responses. She is middle-class and white; the texts that I have analyzed convey that these are the characteristics of the imagined reader by including white infants on the cover (Castallo 1944), and assuming that the reader will have the benefit of a private obstetrician rather than the public clinic care that is the recourse of poor women. When women do not fit within the monolithic WOMAN that obstetrics both constructs and addresses, they are treated entirely differently. For example, James McCord, in his 1941 presidential address to the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, was concerned with "obstetric deaths in colored women" and explicitly defines them as a separate category:

The colored obstetric patient is most often stoical and likely to give one a false sense of security. Too often they do not have what it takes for a comeback after a long, hard labor..."

(McCord 1941: 358)

African-American women are seen as a unified group, subject to little variation, and to whom a set of universals can be easily applied. As this excerpt shows, the characteristics

of African-American women are quite different from those that characterize “women generally,” or really, middle-class white women, in obstetricians’ minds.

In addition to emphasizing motherhood as a woman’s sole identity, obstetricians insisted that women were complete only when mothers. Obstetrician Mario Castallo, for example, regarded the woman who had borne children as the “complete woman” (Castallo 1944: 4) and told women that a marriage without children was “incomplete” (Castallo 1944: xii). Other authors of advice on pregnancy and childbirth also contributed to the construction of the childless woman as the incomplete woman. Eve Featheringill, a woman who wrote advice based on her own three pregnancies, warned other women that a marriage without children was incompletely consummated:

...the childless couple have an incomplete and in many respects immature relationship which, while it may be real, balanced, and fruitful, may not be regarded with quite the same attitude as the marriage which establishes a family...
(Featheringill 1951: 123)

Women were pressured by both obstetricians and other advice-givers, to be fully inducted into womanhood by undergoing pregnancy and birth, and to make their marriages more complete and socially legitimate by producing children. Through these texts, becoming a complete woman is tantamount to becoming a mother. A corollary to the construction of mothers as complete women is the pathologization of the childless woman; I imagine that the logic in operation is that if pregnancy and childbearing lead to completeness, then the failure to bear children can be construed as a condition of incompleteness with consequent flaws and pathological conditions. Obstetrician Willard Cooke, in 1945, wrote:

Since woman is primarily a reproductive organism, the frustration of this essential function leads to the protean physiologic and psychologic aberrations, especially after the age of 30 years...
(Cooke 1945: 460)

Women who failed to bear children, by choice or by chance, risked mental and physical derangements. Cooke drew upon psychiatry to explain that women’s “psychosexual

status” was inherently unstable and contained an “urge to reproduce the species” and “the maternal instinct” (Cooke 1945: 458). The derailment of the urge and instinct to mother was sure to lead, in this author’s mind, to pathology.

Accompanying the vision of pregnant women as complete women was the notion that pregnant women were healthier than nonpregnant women. Curiously, obstetricians were able to invert the traditional notion of pregnancy as an illness, a disease state (Hahn 1987) when their desire to help women see the advantages of pregnancy was strong enough. Obstetrician Mario Castallo, in his book *Expectantly Yours*, provides an example of how motherhood could be conceived of as a woman’s healthiest state:

If anything, she’s healthier since pregnancy stimulated many dormant glands and in other respects she is functioning--now that she’s had her baby--as a complete woman for the first time in her life.

(Castallo 1944: 4)

So in Castallo’s view, women’s physiology performed at its peak during pregnancy. Pregnancy was also a time when a woman made use of her sex-specific glands and organs and ensured that these tissues did not go to waste. Since pregnancy roused a woman’s glands and organs from a sleep-like state, it enabled her to become a physiologically more complete female. In addition, the birth of her child, the entrance into motherhood, made her a “complete woman.” Physiologically functioning as a complete female during pregnancy, and then socially functioning as a “complete woman” after childbirth, the woman who has undergone both processes can properly be called complete.

When true womanhood was equated with motherhood, women and their bodies were perceived as inevitably and uniformly prepared for pregnancy. Women’s bodies lay dormant, waiting and yearning for pregnancy, as Mario Castallo illustrates when he describes menstruation as “ever hopeful housecleaning” in which the uterus gives a “big

gesture of welcome” by “throwing out the stale tissues intended for an earlier fertilized ovum which never arrived, and readying up fresh ‘linen’--or more tissues for the new visitor” (Castallo 1944: 9). Castallo’s pronatalist description implies that women’s bodies were always ready to host a new pregnancy, and by extension, that women were invariably prepared to become mothers. Invoking a metaphor of “housecleaning” to describe menstruation, Castallo invites his female reader, who is herself always engaged in some gender-specific domestic activity, to see the parallel between her own activity and that of her uterus. As the woman herself is forever dusting the already-decorated nursery, longing for an inhabitant of it, her anthropomorphized uterus is repeatedly cleansing itself, forever anticipating pregnancy.

‘Women-as-mothers’ in historical context

I have sketched an outline of the woman who appeared in obstetricians’ discourse: the normal woman was imagined to be a happy mother. Now I want to introduce a parallel narrative to suggest that the equation of womanhood and motherhood was inflected differently within particular historical contexts. In texts of the 1920s and 1930s, obstetricians imagined their female patients as always mothers, but perhaps not *only* mothers. In one of several examples, obstetrician Joseph Brettauer, addressing the American Gynecological Society in 1928, appears to be concerned with considering women in a capacity other than as mothers. He says:

Within the last few decades great changes have taken place; with the political, economic, and educational freedom of women, the world is open to them. The family is no longer the only and absorbing interest in their lives; it has become fashionable to have a career.

(Brettauer 1928: 459)

While Brettauer certainly exaggerates the scope of women’s opportunities, his remarks reflect a willingness to consider women as actors in the public sphere. The author’s

decision to devote his annual address to the challenges women face in combining career and family suggests that he found women's work outside the home to be a legitimate matter for discussion by obstetricians. His suggestion that obstetricians have a role in helping women to assume new roles in the world, suggests that this author, like other obstetricians of the 1920s and 1930s, was at least occasionally capable of envisioning women as other than mothers.

The outbreak of World War II seems to have invited obstetricians to reflect publicly on women's rightful place in society. World War II required women's efforts in two capacities: they were needed for the reproduction and maintenance of a populous democratic nation, and they were simultaneously called into service in public arenas previously reserved for men. Obstetricians' writings around World War II suggest that they initially felt compelled to support women's participation in wartime jobs, but eventually sought to underscore the importance of motherhood for women. For example, obstetrician George Kosmak's 1944 presidential address to the American Gynecological Society, "Woman in This Changing World," is a "plea for the conservation of motherhood" (Kosmak 1944: 753). Worried that "maternal influences" were disappearing from the home and that there would be a postwar decline in the birthrate, Kosmak made an emphatic statement about the role of women in society: "...women must continue to function as the mothers of the nation" (Kosmak 1944: 759). Other obstetricians similarly engaged in discussion about the place of women in society, only to restate the importance of motherhood with new emphasis. Obstetricians James King's 1940 address, a "discourse on woman, herself" is devoted to the social position and psychological characteristics of women. King confronts a dilemma because he perceives that women's societal roles are changing, yet believes that women are destined to carry out their reproductive functions, emphasizing in the end that "Woman is definitely a reproductive machine" (King 1940:

186). Similarly, Willard Cooke in 1945 was forceful in asserting that women exist essentially to reproduce:

Reproduction is the central physiologic *raison d'être* of woman, marriage is normally her goal and lifework, and the disappointments and annoyances of the menstrual and reproductive cycles keep her constantly reminded of the necessity for planning all of her activities in relation to this basis.

(Cooke 1945: 457)

Like King earlier, Cooke emphasizes the centrality of woman's biology, her "menstrual and reproductive cycles," to her life, and draws attention to her biological distinctiveness. During and after World War II, textual attempts to underscore sexual difference and return reproduction to the center of women's lives can be read as one expression of a generalized anxiety that women would not continue to reproduce democratic citizens, and that they would displace men in the realm of paid employment.

During the 1940's, an optimistic pronatalism accompanied the renewed emphasis on women's reproductive functions. Not surprisingly, then, glorification of motherhood became more prominent during and after World War II. For example, William Carrington, in his 1944 book *The Expectant Mother's Handbook*, advocated motherhood for young women, saying, "Today young women enter life's most wonderful adventure with calm confidence, safe and secure" (Carrington 1944: 9). He and other authors sought to convince young women that the dangers of childbirth were being eradicated with the same zeal that fueled the war for democracy. With the safe environment provided by modern obstetrics, young women, in Carrington's mind, had no reason to remain childless. In fact, childlessness was to be pitied: "It is no longer pregnancy that excites sympathy and solicitude, but barrenness" (Carrington 1944: 9). As the nation needed women to evacuate the workplace and return to the home to produce children, and as obstetrics became more entrenched as the medical specialty that facilitated childbearing, obstetricians' voices became more insistent as they articulated the value of motherhood to women. Similarly,

while obstetricians had, in the 1920s and 1930s, attempted to consider women as both workers and mothers, their discussions of women's roles became more constricted after the war, and obstetricians seemed willing to consider women as only mothers.

In equating "women" with "mothers," obstetricians accomplished an essentially reductive move which limited the variety of emotions and experiences of female existence to a single emotion--happiness--and a single experience--motherhood. Beginning in about 1940, an additional reductive move in the construction of women was made: women-as-mothers became women as fetal environments. With the expansion of obstetrics as a research enterprise as well as a clinical medical specialty, obstetricians began to construct women as the "fetal environment." The female body, as a container or vessel for the fetus, appears in illustrated forms in many advice books to women. In one widely printed illustration, a woman's outlined figure has notches on her belly, as if to resemble a measurement gauge. The woman's body, in this illustration, becomes the background against which progress in fetal growth can be better visualized (Eastman 1957: 23). Some texts contained explicit references to the woman as the fetal environment. In treating "habitual abortion," or repeated miscarriage, obstetricians strove to "render the womb an incubator in which the fetus can develop and grow without trauma or outside stimulation and in a tranquil atmosphere"(DeLec 1949: 80). The woman, through the medium of her body, is able to provide the peaceful, protected atmosphere that a fetus requires. Her body parts are machine-like, with her uterus being compared to an "incubator." Extending the technoscientific metaphor, the woman is important in this excerpt because she can provide a fetus with the proper "culture medium" for optimal fetal growth.

Nicholson J. Eastman's 1954 address to the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons provides a rather dramatic example of the

construction of women as primarily “fetal environments.” His speech, entitled “Mount Everest In Utero,” put forth the widely influential hypothesis that the amount of oxygen available to a fetus was very low. Eastman and his disciples wondered: “How does the fetus manage to live and grow in such an environment?” and posited that the woman’s uterus provides a challenge to the growth of the fetus (Eastman 1954: 706). Eastman’s question and odd metaphor reflects a concern with women as primarily environments for fetal growth. In this construction, women are relegated to the background, and the fetus occupies the foreground of obstetricians’ imaginations as they consider the “adaptations” of this wondrous creature to the strange environment of the woman’s uterus. Through the comparison of a woman’s uterus to Mount Everest, Eastman constructs the woman’s body as a strange, foreign, and inhospitable, albeit interesting, place. The fetus receives Eastman’s kudos for managing to survive in spite of the challenges posed by such extreme, foreboding territory.

Eastman’s fascination with, and wonder at, the fetal environment was shared by an obstetrician-researcher, Nicholas Assali, who gained prominence during the 1950s for his investigations on pregnant women. In Assali’s autobiography, women nearly disappear from his account of obstetrics and are replaced by the placenta and uterus, which are presumably sufficient to furnish the fetus with its needs. Assali demonstrates that his primary interest in obstetrics is in “intrauterine life”:

We were the first group of scientists to show that the human placenta does indeed produce ACTH-like substances. This discovery had an enormous impact on later research...This led us into research for the next twenty years on the many fascinating aspects of intrauterine life and the adaptation of the infant to the external environment after birth.

(Assali 1982: 160-161)

While a metaphor between these scientists’ research and explorations of outer space, is not explicitly drawn here, I think such a metaphor is in operation. The fascination that Assali

describes with “intrauterine life,” parallels the fascination in the 1960s with life on other planets, and space travel. Others have even suggested that the fetus began to be represented as a tiny astronaut, floating freely in the atmosphere of the womb (Petchesky 1994). The quest to find out what life is like for what Rosalind Petchesky (1994: 405) calls the “tiny man, a homunculus” can be read as an identification of the researcher with this miniature astronaut-like creature. Identifying perhaps with astronauts who explored the foreign territory of the moon, tethered to their spaceship, Assali and others sought to understand the atmosphere experienced by the fetus. In the construction of the uterus as a sort of “last frontier,” a strange, unknown, unseen territory, the woman becomes only the surface to which the fetus is tethered, and therefore, quite unimportant. She is important to the obstetrical research enterprise primarily as a source of research material, and, as an excerpt from Assali’s book will demonstrate, some women are more likely than others to provide research material appropriately:

We selected a young black girl, pregnant for the first time and close to term gestation. We took her to the laboratory and had her recline in bed...We then turned the machine on and were thrilled to see on the rolling paper the first tracing of uterine activities ever recorded. The resident and I stepped out of the room for a moment to savor this extraordinary event....

(Assali 1982: 128)

It is the “uterine activities” that the researchers are primarily interested in, not the woman herself. Disenfranchised patients, and in this case African-American patients, are constructed in and through this excerpt as being especially available for the conduction of research that might lead to “extraordinary events” and lead to moments of personal pride for the male obstetrician-scientists.

Constructions and consequences: Implications for reproductive choice

Women were, to the obstetricians whose views I have described, complete, healthy, real, and inevitably grateful when pregnant. For such obstetricians, the healthy

woman *was* a willing mother. Women-as-mothers dominated obstetricians' thinking to the point that they had difficulty, ideologically and practically, envisioning and treating women any other way. The language of obstetricians' writings from the early to middle years of the century suggests that they were happiest in helping women to become mothers. The unplanned or undesired pregnancy did not exist or was ignored when obstetricians considered the issues of their profession, or when they advised women about their pregnancies. Leonard Biskind in his 1954 book *Having Your Baby: Modern Instructions for Expectant Mothers*, states this starkly when he writes, as part of a numbered, point-by-point instructions on mental state during pregnancy:

6 Since many pregnancies are not planned and some not desired, it is important, not only for you, but for the sake of your expected baby, to adjust yourself emotionally to your new status.

(Biskind 1954: 14)

Biskind begins his advice with a nod of recognition to the fact that not all women are equally prepared, at all times, to become mothers. Curiously, Biskind begins, "Since many pregnancies are not planned and some not desired..." but he does not then suggest that a woman might therefore opt out of pregnancy through birth control or abortion. If there is an inconsistency between the physical state of pregnancy for a woman, and her mental or emotional preparedness, she ought, in Biskind's estimation, to change her mind. Emotional adjustment to pregnancy is, as Biskind communicates it, the normal and correct response. The pregnant woman is, then, effectively already a mother; the only thing that separates her from the world of "expectant motherhood" is emotional adjustment.

Biskind does not stop by recommending that unprepared or unwilling women adjust emotionally to pregnancy. He continues, in his point-by-point list of statements about "Your Mind," to explain why anything but a smooth adjustment to pregnancy is unacceptable:

8 In most instances, the chief factor in the unwillingness to have a baby is the economic one, in which the patient and her husband will worry over their ability to care for the expected child and to provide education and other facilities for it.

9 Another, though less common cause of the rejection of a pregnancy, is the attitude of the husband, who, for one reason or another, wishes to delay acquiring a family.

10 However, the greatest source of rejection toward a pregnancy is stimulated by attitudes developed early in childhood; chiefly the attitude of selfishness.

11 Rejection of a pregnancy, no matter the cause, often reveals itself as a sense of disgust in being pregnant, manifested in the so-called morning sickness.

(Biskind 1954: 14)

Just as the healthy woman is a willing mother, the unhealthy woman must be an unwilling mother. Biskind and other obstetricians interpreted nausea and vomiting during pregnancy as a manifestation of a woman's ambivalence about pregnancy. Both psychological pathology (selfishness) and physiological pathology (morning sickness) are attributed to the woman who fails to successfully adjust to pregnancy. Biskind does attribute some of the responsibility for rejected pregnancy to the father. But while Biskind describes the father in more neutral terms, as someone who "for one reason or another, wishes to delay acquiring a family," the woman receives the brunt of Biskind's invective: she is selfish and has other negative psychologic attributes. Motherhood is thereby constructed as an event so central to a woman's life that rejecting it is indicative of psychopathology, whereas fatherhood is treated as something of an accessory function of men, who can opt out "for one reason or another" (Biskind 1954: 14). Finally, even though Biskind describes financial difficulties as one of the reasons that pregnancy may be unplanned and undesired by a woman and her husband, the subtext of his recommendations is that emotional adjustment will compensate for financial difficulties. Biskind does not overtly criticize people who find themselves without sufficient resources to raise a child, but he refrains from furnishing any suggestions about how a couple might cope with the financial strain of an unplanned child. In his eagerness to dictate a woman's emotional response to

pregnancy, and his simultaneous lack of support for people who face the real, material limitations of parenthood, Biskind practices what I will call “absentee paternalism.” Biskind simply tells the woman to adjust, without offering any real, practical guidance about the material difficulties of raising a child.

Biskind’s model of “emotional adjustment” for addressing unplanned and undesired pregnancies was not unusual among obstetricians whose texts I encountered. Commonly, obstetricians encouraged women to shed any negative or ambivalent reactions to pregnancy, and embrace the notion of motherhood. Sol T. DeLee, in the section of his book entitled, “Mental Attitude and Beliefs,” exuded enthusiasm for pregnancy when he intoned:

The prospective mother should take cheerfulness as her motto. Cheerfulness will work wonders for her, her baby and her home. She should keep in mind the overflowing happiness that a delightful, lively, rosy-cheeked baby will bring in a few months’ time.

(DeLee 1949: 34)

The pile of dirty diapers and the infant squalling at 3 a.m. notwithstanding, DeLee sees childbearing as an unequivocally satisfying experience for a woman. Addressing “the prospective mother,” he assumes that women are homogeneous in their emotions, and will respond to one-size-fits-all psychological advice. Regardless of her individual hopes, aspirations, dreams, or disappointments, she is expected to adopt a mental state of cheerfulness, or at least a facade of one.

Obstetricians such as DeLee acted as the enforcers of psychological norms, and indicated that calm, peaceful, happy emotional states were the only ones that were normal for pregnant women and mothers. He advises women: “Adopt a safe and sane attitude toward your condition. Nine months will slip by quickly if you check any tendency toward emotional upset” (DeLee 1949: 2). Obstetrician-authors such as DeLee seemed to see their

female readers as being in special need of emotional guidance; they were likely to deviate from the ideal feminine norm of serenity and cheerfulness at precisely the time when obstetricians felt that such emotions were especially important. If a woman did not adhere to her obstetrician's prescription for her psychological state, she and her child were likely to suffer untoward consequences. Obstetrician-author Frederick Goodrich says of the postpartum period:

...the wrong kind of emotions at the wrong time may affect the infant the rest of its life. This emotional susceptibility is like a contagious disease which the infant catches from its mother.

(Goodrich 1966: 140)

While the obstetrician-author does not explain what the "wrong kind of emotions" are, it is clear from the remainder of his text that any sadness and disappointment associated with the postpartum period would be among them. Warning that women were likely to spoil their infants' lives by displaying un-motherly emotions, the obstetrician-author coopts some principles of psychiatry to justify the widespread prescription of cheerfulness for pregnant women and mothers.

The ideological underpinnings of obstetrics during the middle of the twentieth century, then, included a conflation of "healthy woman" with "willing mother." Obstetricians were most comfortable in helping women make the transition to become mothers; as I showed in the first section, they were eager to take an active role in the moment of childbirth, and as I have shown here, they also saw it as part of their function to facilitate a woman's emotional adjustment to pregnancy. The dominant ideology in obstetrics, as well as in some places outside of it, that pregnancy is an inevitably joyous and unambivalent moment for generic "women," seems to have precluded many obstetricians' consideration of unwanted pregnancy, and certainly prevented most obstetricians from publicly discussing solutions to unwanted pregnancy. That is, the

eagerness of obstetricians to help women become mothers, and the historical unwillingness of obstetricians to become involved in the widespread provision of birth control and abortion, are not unrelated phenomena. James Reed (1979) has proposed that, until 1960, physicians in general participated infrequently and reluctantly in the provision of birth control services, because birth control was inconsistent with the social order that physicians sought to preserve. Reed suggests that physicians, including those who sought to specialize in the female body, eschewed involvement in birth control because they shared the larger society's belief that a healthy woman was a willing mother; like J. Marion Sims, they were happiest in helping women to become mothers (Reed 1979: 125-126).

Physicians, including obstetricians, were also either conspicuously silent about abortion, or worked to outlaw it, until the late twentieth century. James Mohr (1979) has noted that the emergence and consolidation of the profession of obstetrics coincides with a major shift in the regulations and practices regarding abortion. Although physicians in general had previously been active in helping women to abort unwanted pregnancies, they changed their tune in the late nineteenth and early twentieth centuries. Many physicians, especially those in power in the American Medical Association, began to advocate the virtual elimination of abortion, a stance which Mohr attributes to physicians' ideas about the rightful place of women, and their desire to completely eliminate midwives. Mohr summarizes why the elimination of abortion services was a goal that physicians could rally around: "In short, the abortion issue combined for many nineteenth-century physicians both their ideological world view and their professional self-interest" (Mohr 1979: 119).

In keeping with the analyses of Mohr and Reed, abortion and birth control were topics that were conspicuously absent from the obstetricians' texts that I examined. When obstetricians did discuss such matters, it was only grudgingly; the author of a 1920 address to the American Gynecological Society admitted: "Another of the distasteful subjects we

naturally shirk is contraception” (Dickinson 1920: 6). Surely, the topic of contraception was tainted in obstetricians’ views partially because of its association with quack healers and midwives, to whom the task of preventing unwanted pregnancy had fallen because of the lack of interest on the part of “regular” physicians. But it may be that the prevention of pregnancy was “distasteful,” as Reed suggests, partially because it was not consistent with obstetricians’ interest in helping women to become mothers and assume traditional feminine and domestic roles. The fact that contraception was a “distasteful subject” for many obstetricians meant that it did not appear often in their otherwise detailed and inclusive instructions to women on reproductive and domestic life. Obstetricians’ instructions to women about sexuality, and simultaneous silence on contraception, placed women in an uncomfortable double bind. Mario Castallo, advising women on sex after childbirth in his 1944 book *Expectantly Yours*, recommended that a woman “be wise in her sex life” and suggested that she needed eighteen months to recover from childbirth before becoming pregnant again. Castallo then adds, “But fear of pregnancy should never be allowed to isolate her from her husband (Castallo 1944: 96). Women were expected to be sexually available to their husbands, and at the same time space their pregnancies, without any guidance from their obstetricians regarding birth control.

Whereas most obstetricians were silent in their texts about birth control, several openly discouraged women from considering abortion as a solution to the perceived problem of unwanted pregnancy. Mario Castallo, for example, was overtly unsympathetic to the unwilling “mother” who sought an abortion; he told women, “...thank your stars you’re having your baby in security, not getting rid of it in the squalor of an abortionist’s hideout” (Castallo 1944: 1). Such women, in Castallo’s view, are “confused and mistaken;” their attempt to end unwanted pregnancy constitutes an unsuccessful emotional

adjustment to the pregnant state. Sol T. DeLee, writing in 1976 on the recent legalization of abortion through *Roe vs. Wade*, is ambivalent at best about the availability of abortion:

There are many individuals and groups which firmly believe this decision is wrong and have organized to reverse it, but as of this writing, the decision stands...Only time will tell about the far-reaching effects and the significance of this attitude--what good or evil (if any) may come of it.

(DeLee 1976: 81)

DeLee's cautiously worded statement suggests that he is reluctant to say anything too negative about the availability of abortion, in the highly politicized reproductive rights arena of the 1970s. At the very least, it is clear, in DeLee's statement, that he does not interpret the legalization of abortion as providing him with an option for his unhappily pregnant patients. Instead, he seems to linguistically ally himself with those who "firmly believe this decision is wrong," for it is their viewpoint that he chooses to represent.

So when DeLee later implored, "**Let him** [the obstetrician] **safeguard your motherhood!**" (1944:3, bold type in original) his call can be interpreted, through the silences on birth control and negativity about abortion, as an appeal for the safeguarding of all pregnancy, regardless of whether or not women desired "motherhood."

The traditional constructions of healthy women as willing mothers, and of motherhood as an unconflicted and nearly automatic function of women, have pervaded obstetrics as it has developed as a specialty. I have suggested that one of the implications of these constructions is that obstetricians have been most eager to offer their services to certain women ("expectant" mothers) in the pursuit of certain reproductive ends (happy childbirth). With such limited constructions of women, and of reproductive life, obstetricians seem to have become advocates of "motherhood," and consequently were not well-equipped to consider the greater variety of emotions and experiences which characterize women's lives.

Safeguarding the individual mother, safeguarding society

So far, I have discussed the way in which the promise to “safeguard” the health of pregnant women was articulated by obstetricians in contractual and paternalistic terms, and I have also shown that “safeguarding motherhood” was a goal that was consistent with the ideas that obstetricians held about women and mothers. In this section, I want to show that obstetricians’ professional goals were not limited to facilitating the transition of individual women into motherhood. Obstetricians have also been eager to supervise pregnancy because of the importance that they perceived the institution of “motherhood” had for a larger society and nation. As I will describe, obstetricians articulated a role for themselves as safeguards of the health and quality of the nation, and this formulation of their role depended heavily upon an ideology that equated healthy women with willing mothers.

Borrowing from eugenics

In the early part of this century, obstetricians’ articulations of why they found “motherhood” such a compelling issue for their profession are not at all subtle. Writing to women, obstetricians suggested that pregnant women were of interest because they occupied a special place in society. Frederick C. Irving, in his *The Expectant Mother’s Handbook* (1932), hinted at this when he announced to his readers that the “well-being of expectant mothers is of infinite importance to themselves, their unborn children, their families, *and the nation*” (Irving 1932: v, italics mine). Pregnant women were therefore of national importance, and it is intimated that they are a kind of national resource. Accordingly, the state will have a clear interest in the “well-being” of “expectant mothers.” Brooke M. Anspach, president of the American Gynecological Society in 1935, echoed the importance of motherhood to the whole nation:

Although to the life and health of the individual the reproduction function is not essential, it is the very source of the *life of the nation*. . . .
(Anspach 1935: 459, italics mine)

Pregnant and birthing women, in obstetricians' eyes, were important for maintaining the vitality of the nation.

In the historical materials that I have examined, when pregnant women/ "expectant mothers" are constructed as essential to the "life of the nation," pregnant women's bodies become a route to bettering the future of the race, an idea that borrows heavily from eugenics. Obstetricians were mouthpieces, in the 1930s, for eugenic ideas, and the legacy of eugenics can be seen in obstetricians' writings even into the 1960s. Consider, for example, an obstetrician's 1932 speech on "The Constitutional Factor in Gynecology and Obstetrics." The "constitutional factor" that the author speaks of is a set of vaguely defined characteristics that are not explicitly genetic in the author's mind. He writes:

Much more important than the therapy of inferior constitutions is their prophylaxis. We must bear in mind that the law of natural selection no longer applies universally to mankind, and that civilization tends to preserve the unfit. Something should be done to check the endless stream of these ill adapted individuals and to improve the constitutional quality of the race...

(Gellhorn 1932: 495)

Here the importation of eugenic thinking into obstetrics is clear. The idea that natural selection no longer operates to eliminate undesirable characteristics has circulated into obstetrics. Artificial selection must replace natural selection in order to maintain the quality of the "race," and the implication in George Gellhorn's speech is that obstetricians are in an ideal position to exert influence on "constitutional quality." Women, through their actions during and after pregnancy, could also contribute to evolutionary progress:

Will our young men of tomorrow, our young women of the day after be taller, stronger, smarter than their forbears? The answer is there in your baby while he develops in the womb, while he fills his lungs with air at birth, while he grows and grows and grows before your very eyes. If you give him the right start, you will benefit untold generations.

(Castallo 1944: xi)

By providing an optimal uterine environment for the fetus, women had an opportunity to help to create a superior society with “taller, stronger, and smarter” offspring.

Obstetricians could facilitate the creation of a society composed of more fit individuals in two ways: by devising means of eliminating the less fit, as in Gellhorn’s vision, and by simultaneously encouraging women to extrapolate from their individual infants to the larger society, and make the connection between their own healthy pregnancy, and a more fit society.

Peter Bowler (1989:295) has said that the influence of eugenic thinking waned in the 1930s. But in 1954, even after World War II had clearly illustrated the dangers of eugenics, Leonard Biskind’s book *Having Your Baby: Modern Instructions for Expectant Mothers* still proposed a eugenic basis for obstetrics. The foreword, by obstetrician Fred Adair, is an abstruse discussion of how the acquisition of knowledge about reproduction can lead to the betterment of the race. It is an odd way to begin a book that is intended to provide advice to pregnant women, for this discussion has no apparent relationship to the individual woman’s experience of pregnancy and childbirth. The foreword, although its relevance to the reader is not clear, offers a window on how the obstetrician-author conceived of the relationship between a pregnant woman, society, and the profession of obstetrics. Adair recycles eugenic thinking from pre-war days in the following excerpt from the preface; he says that the end of previous civilizations took place because of the

...survival of undesirable traits in the human race. If these can be removed it will only be by progressive improvement in human beings, and one of the most important means to that end is a better comprehension of the laws of human propagation and development...

(Adair 1954: xi)

The disappearance of natural selection thus necessitates tampering with human reproduction in a way that will facilitate the survival of the race. “Motherhood” provides a key moment

for intervening in production of tomorrow's race; the mother becomes a key figure who can be manipulated in order to realize evolutionary progress:

In such an evolutionary advancement, parenthood becomes of paramount importance and the mother is the most important factor in the creation and development of human life.

(Adair 1954: xii)

Here, the mother is foregrounded i.e. she is a highly visible figure, because she is the figure through whom the betterment of society can be accomplished. But while her figure is visible, she is not necessarily central; the "creation and development of human life" is, and a woman acquires importance merely as a contributing "factor" in such a central and important process.

The quality of the race could be most readily and efficiently improved, in the minds of obstetricians, if "expectant mothers" were under constant obstetrical supervision. Beginning in the 1930s, obstetricians talked about the benefits of obstetrical care not only for the individual woman and her future child, but also for society at large, as when Adair wrote:

Maternal Care is thus of the greatest value not only for the mother herself but also for her offspring and for the human race which one must regard not only in the present but also for the future.

(Adair 1954: xii)

Obstetricians, through looking after the well-being of pregnant women, saw themselves as having an important function in shaping the larger society. The more extensive the supervision of pregnant women was, the more completely the quality of the race could be controlled. Obstetricians' notions of their functions therefore expanded from monitoring the process of childbirth, to supervising the health of the woman before and after birth. Adair (1954), for example, defined "complete maternal care" as:

...preconceptional care, prenatal care, delivery care and continuing postpartum care for the mother and postnatal care for the infant. All of these are directed not

only to safeguarding the health and the lives of mothers and their infants but also contemplate the eventual improvement of human beings....

(Adair 1954: xiii)

Obstetricians' attention is thus directed to women-as-mothers; they have a role in "safeguarding" the health of women not *as women*, but *as mothers*. The function of obstetricians here is to optimize the health of women, from before conception to after childbirth, in order to foster evolutionary progress in the human race. Explicitly through Biskind's words, and implicitly through other obstetrician's writings, obstetricians sought to give comprehensive care to women-as-mothers because it enabled them to intervene more frequently, not only to improve the health of individual women and their infants, but also to effect changes in society.

That obstetricians were most interested in what women-as-mothers could contribute to society is even more explicit when the infant is foregrounded. Mario Castallo, author of *Expectantly Yours*, wrote:

Consider these facts about your child...Your baby will be entirely unique...He is the link from which the perpetuation of the species depends.

(Castallo 1944: xi)

In Castallo's writing, the infant is at the center of the obstetrician's concern, and it is the infant--here, autonomous and alone--who represents a future society. In fact, most of Castallo's book is written with the infant as the focal point: the Caucasian infant's face fills the cover of the book, and the title (*Expectantly Yours*) reflects the infant's perspective.

Reproducing happy, healthy democratic citizens

Particularly during and after World War II, obstetricians had a specific idea of what the society whose growth they wanted to foster would look like. There is a sense, in their writings, that they thought that they were participating in creating a society that was

composed not only of biologically fit and healthy members, but of civilized people who were happy democratic citizens. Mario Castallo, in his 1944 book *Expectantly Yours*, conveys this in an especially explicit way;

Upon that mite [the fetus] rests our whole system of government. Nowhere is it so important as in a democracy that its citizens should be capable of shouldering their share in a 'government of the people, by the people, and for the people.' The procreation of healthy children and the protection of the mother-to-be and her unborn child is of vital importance to your country. And to you. After all, it's your baby.

(Castallo 1944: xii)

In the climate of World War II, this obstetrician-author is concerned with the perpetuation of democracy. In his advice book, pregnancy and childbirth are constructed as matters of national importance, to be safeguarded by both the state and the obstetrician. Children, and by extension, the "mothers" who give birth to them, deserve national interest and attention because they are vital to maintaining a democratic society. Mothers, but not necessarily women generally, are valued for their reproductive capabilities and their role in the "procreation of healthy children." Motherhood becomes a patriotic activity, and its safeguarding by obstetricians becomes a national duty, because the fetus is constructed as already a democratic citizen. He shoulders the responsibility for the continuation of democratic society, and presumably, is accorded the rights and privileges of citizenship because he is so crucial to democracy. The obstetrician, in Castallo's view, has an important role in helping to maintain democracy through protecting the mother-to-be, and overseeing the production of democratic citizens. With the lives of many U.S. citizens being lost abroad during World War II, and with the combined strength of the Axis powers threatening many democratic governments, Castallo's text may be read as encouragement to women to shore up democracy on the home front by assuming a role in the production of democratic citizens.²

Obstetricians pictured the society that they were involved in creating as a democratic one, and also as a civilized, cultured one. Castallo (1944) tells his female reader that she has important role to play in creating this kind of society:

You have the privilege of conceiving, nurturing, and bringing forth into the world a being with the capabilities of thought, abstract reasoning, and ingenuity which no other living creature may possess; a being who has harnessed the elements, conquered the air, built cities, created music, and stemmed epidemics.

(Castallo 1944: xii)

In this excerpt, Castallo endows the unborn child with civilizing potential. Although it is not explicit, Castallo's passage suggests that the "privilege of conceiving, nurturing" is the domain of women, and that the activities of a conquering nature most likely belong to men. "Conquering" the air and "harnessing" the elements, for example, are human accomplishments most frequently and publicly attributed to men, and women's participation in motherhood enables these activities. The female reader of Castallo's book is therefore important to society because she produces the men who create Western culture.

The creation and continuation of civilized democratic societies was dependent upon women eagerly joining the ranks of mothers, as in the excerpts from Castallo's book above, but also depended heavily upon the proper obstetrical supervision of women. In obstetricians' writings after World War II, a link is forged between good obstetrical care and the integrity of a democratic nation. James R. Bloss, writing in 1950, urged his colleagues to extrapolate from the health of their patients to the health of democracy:

He [the obstetrician] must keep before him always that the health of our nation, of all nations, is in great measure dependent upon good obstetrics...Healthy and happy babies, cared for and reared by mothers who are not mental and physical wrecks as the result of childbearing, will become happy and healthy citizens. Happy and healthy citizens will be sane ones and will not become Communists, Fascists, or Nazis.

(Bloss 1950: 1187)

According to this author, the obstetrician should consider himself to be a vital component of the national armamentarium, and recognize the evil forces he faces: Communism,

Fascism, and the Nazi regime. With the nation no longer openly at war, but always on the brink of infiltration by enemies, obstetricians' skills become valuable weapons which can be silently stockpiled in defense of democracy.

What is remarkable about the excerpts that I have cited above is not simply that obstetricians sought to make connections between the health of women and children and the health of a larger society. Such a connection is not unique to obstetrics, and similar claims have been made in fields such as public health. Instead, I want to call attention to obstetricians' concerns about the reproduction of happy, healthy democratic citizens. Such anxieties about the health and integrity of the individual mother/child pair reflect, I think, concerns about the integrity of the national body which were especially pervasive following World War II. When obstetricians discuss their profession's role in improving the quality of the race and in protecting democracy, they reveal that their concerns were not entirely, or even primarily, about the "motherhood" of the individual woman. Obstetricians' interest in "motherhood," then, was to a large extent an investment in the social institution of "motherhood," and not necessarily an interest in the experience or meaning of "motherhood" to individual women. Perhaps it was the magnitude of this gulf in the meanings of "motherhood" to women and to their obstetricians that led first-wave feminists (Rich [1976]) to raise their voices in favor of motherhood as experience rather than as institution. It is the interruption of traditional obstetrical ideas and constructions by similar feminist voices that I turn to exploring more fully in Part Two.

Chapter 2: The Obstetrician Imagines Himself and His Role

Earlier, I mentioned that by 1920, physicians had replaced midwives as the primary birth attendants in the United States (Dye 1980). Increasingly, the physicians who were ubiquitous in childbirth scenes were specialists in obstetrics and gynecology, or obstetrician-gynecologists. While physicians in general sought to make childbirth a medical matter, obstetrician-gynecologists sought increasingly to make it a *specialists'* matter. Specialists in the separate fields of obstetrics and gynecology had existed since the mid-nineteenth century, but until the early twentieth century, there was little agreement about or regulation of who was qualified to practice obstetrics and gynecology (Wertz and Wertz 1977). With the formation of the American Board of Obstetrics and Gynecology in 1930, and the development of certification in obstetrics and gynecology by examination (Wertz 1983), specialists attempted to restrict supervision of childbirth, as well as the responsibility for other areas of women's health, to themselves. Obstetricians, then, increasingly made themselves the prototypical birth attendants, so that by the late twentieth century, they dominate childbirth scenes. In this section, I want to present the public voices of obstetricians as they appear in advice manuals between 1920 and 1980. My focus in this chapter is on exploring obstetricians' conceptualizations of their role in pregnancy and childbirth during this time--by this, I mean what they consider their professional responsibilities to encompass, and how they describe their relationships with women.

The publication, in 1920, of the first volume of the *American Journal of Obstetrics and Gynecology*¹ marked the official alliance between the previously separate specialties of obstetrics and gynecology (Sumney and Hurst 1986). This newly-formed field began to

struggle to define itself and demarcate its parameters. It was within this context of professional self-definition that individual obstetrician-gynecologists attempted to articulate what they perceived their roles to be in pregnancy and childbirth. In the 1920s and 1930s, the professional territory of obstetrician-gynecologists was still threatened by the practices of midwives and general practitioners; the presence of an obstetrician-gynecologist at the hospital bedside of the birthing woman was not a predetermined certainty. Not yet having been granted a secure position at the bedside, obstetrician-gynecologists still had to prove that they had unique contributions to offer.

Obstetrician-gynecologists were also faced with the dilemma of reconciling their position that their expertise was needed and crucial to the health of women and babies, with statistics that suggested that their involvement in pregnancy and childbirth had not dramatically improved maternal or child health. There was widespread public concern, buttressed by reports by the New York Academy of Medicine in 1933 and the White House Conference on Child Health and Protection in 1933, as Wertz and Wertz (1977) have noted, that both infant and maternal mortality were unacceptably high and had not been significantly affected by physicians' intervention. In addressing women, and in their professional communication with each other, obstetricians felt compelled to respond to this public concern. Mario Castallo, in his 1944 book for women, *Expectantly Yours*, says: "Childbirth should have no terrors for the woman who has put herself in the hands of a capable obstetrician. His science has progressed in an unwavering line *not reflected in the mortality statistics*" (Castallo 1944:1; italics mine). Obstetricians attempted to explain the apparent discrepancy between increasing medical intervention in childbirth and essentially unchanged mortality rates using a variety of tactics; for example, in 1930, the president of the American Gynecological Society suggested that obstetrics and gynecology did not yet have enough influence: "At the present day the infant and maternal mortality has shown but

slow improvement, largely due to the fact that the majority of women are delivered by the general practitioner or the midwife” (Norris 1930: 297, italics mine). Sol T. DeLee², in his book *Safeguarding Motherhood*, shifts the blame to women: “a good share of the blame for these fatalities may be attributed to the unfortunate prospective mothers themselves” (DeLee 1949: vi). Another obstetrician warned women that they should not heed the mortality statistics because they unfairly included women who had sought abortions from illegal practitioners:

They [the figures on death in childbirth] suffer under the injustice of including in maternity statistics deaths which result from abortions. This is the regular statistical practice, misleading to the layman who doesn't know that one out of every three deaths in the total should be laid at the door of the illegal practitioner--the criminal who batters on confused and mistaken women. If you've encountered any figures on the subject lately, cut the total by at least one-third in the interest of accuracy, and thank your stars you're having your baby in security, not getting rid of it in the squalor of an abortionists' hideout.

(Castallo 1944: 1)

One president of the American Gynecological Society felt compelled to take partial responsibility for poor obstetrical results, saying that “[our] interference is our greatest factor in the loss of mothers and children” (Hamilton 1937: 191). Obstetricians were put on the defensive by public concern over their apparent ineffectiveness in improving the health of women and children, and some responded by attempting to promote themselves as indispensable figures in pregnancy and birth, in spite of statistics that suggested otherwise.

Contracts of paternalism

The rhetoric of advice books to women that were written during the 1920s and 1930s offers a glimpse into the role that the obstetrician-gynecologist was beginning to carve out for himself. In *The Expectant Mother's Handbook* by Frederick Irving (1932), women are introduced to the notion that they require constant “watchful supervision,” and

that obstetricians are uniquely qualified to provide that service. That is, obstetricians like Irving began to identify themselves as “guardians” of pregnancy, and they advanced the benefits of the new practice of prenatal care, which became one of the arenas in which they exercised their guardianship. With their insistence upon “supervising” pregnancy and childbirth, obstetricians extended to birthing women a paternalistic hand. “Watchful supervision” is a service, however, that is not extended to women for free; according to Irving:

This watchful supervision over the welfare of the expectant mother is called *prenatal care*. Its service to women through the preservation of life and health has proved incalculable. It requires a full cooperation with the doctor and demands from the patient that she should see him as early and as often as he desires and, furthermore, that she should follow his directions to the letter. Once having placed herself unreservedly under the care of a physician in whom she has confidence, she may set her mind at rest. The responsibility is now his; not hers.

(Irving 1932:4, italics in original)

In this passage, the obstetrician-author strikes a bargain with the patient-reader: He promises (though, as I have previously discussed, cannot always deliver) protection from the widely feared dangers of childbirth, and in return, the pregnant woman must relinquish control over her body and submit to his rules and regulations. In this obstetrician’s conceptualization of his own role and that of the pregnant woman, an unofficial contractual relationship is created: the obligation of the obstetrician is to guard the woman in her pregnant state, and it is the woman’s obligation to cooperate with and participate in any rituals instituted by the obstetrician. While this is a contract that is tinged with paternalism, its existence is important because it presupposes that both parties have the subjecthood and agency required for contractual relationships.

The notion that both the woman and her obstetrician must both fulfill their responsibilities in order to achieve results that are satisfactory to both is echoed by Claude

Edwin Heaton in his 1935 guidebook, *Modern Motherhood: A Book of Information on Complete Maternity Care*. Heaton writes:

Omission of proper prenatal care constitutes negligence on the part of both patient and doctor. No other one factor is so important in securing a successful outcome for the mother and baby. Constant supervision is the keynote of good prenatal care; the closer the supervision, the more successful the results. Failure by a doctor to make a general and pelvic examination, to take the blood pressure and analyze the urine at frequent intervals should warrant a patient's going to another physician. The patient and her family, on the other hand, should give the doctor full co-operation; ignorance or indifference on their part will also result in failure to obtain adequate care.

(Heaton 1935: 16)

What is particularly interesting about this passage is that unlike later material, it contains an explicit concession that either the woman or the obstetrician may potentially fail to fulfill the responsibilities required in the relationship. Furthermore, the author offers the suggestion that a woman might want to exercise agency and autonomy by extracting herself from a relationship in which the obstetrician does not fulfill his responsibilities. As I will discuss below, later guidebooks take on a much more confident tone in assuming the competence of the obstetrician. Heaton's admission, then, that not all obstetricians provided equally good "supervision" probably reflects a characteristic of the period in which he wrote: the new field of obstetrics and gynecology had not yet fully professionalized and developed widely standardized and rigorous training programs and licensure, a fact much lamented in the meetings of the annual societies of gynecology and obstetrics.³ Obstetricians such as Heaton therefore found themselves having to adopt an apologetic tone about the fact that doctors who attended women in childbirth, including general practitioners fresh out of medical school, were not universally well-qualified for practice.⁴ Heaton's caution to women may also reflect the fact that, in 1935, women were not universally convinced of the benefits of hospital-based obstetrics, and obstetricians writing to them needed to adopt a somewhat concessionary stance and admit that women, who still shared some power with

obstetricians over the circumstances of birth, just might back out of their obligations if the obstetrician failed to live up to his.

The handbooks by Irving and Heaton, and other guides to pregnancy and birth by obstetricians, serve in part a pedagogic function. Particularly between 1920 and 1945, when obstetrician-gynecologists struggled to make themselves appear indispensable to pregnancy and childbirth, these manuals contained an implicit aim of introducing women to the practitioners of the newly-formed field of obstetrics and gynecology, and instructing them as to what the role of both the obstetrician and the pregnant woman should be. For example, Irving, who instructed women about what they could expect from their obstetricians during pregnancy, as I described above, also sought to teach women how the role of the obstetrician during birth was to be regarded:

The care of the patient during labor is the province of the doctor. He will decide whether it is best for her to be up and about or in bed. The nurse, acting under his instructions, will see that the patient's bowels and bladder are kept empty and will arrange her diet.

(Irving 1932: 127)

The requirement that the pregnant or laboring woman relinquish control of her body reappears in this passage. In addition, it becomes apparent to the woman reader that the setting of childbirth is to be structured by the obstetrician, and that the most minute details of her physical condition will, in keeping with the contractual agreement, be arranged by him.

Throughout the 1920s and 1930s, obstetricians' writings reflected the fact that their position in pregnancy and childbirth was not yet a secure one. Having defined unsupervised pregnancy as a problem, they found the solution, and a niche for themselves, in the concept of prenatal care.⁵ By World War II, obstetrics and gynecology had emerged as a specialty, consolidated, and begun to mature (Sumney and Hurst, 1986). The more

secure footing that obstetrician-gynecologists found themselves on in birthing scenes, which now largely took place in the controlled environment of the hospital, may explain why obstetricians seemed to begin to articulate their role with more confidence and fewer apologies. Sol T. DeLee's guidebook for women, *Safeguarding Motherhood* (1949), is an example of the more authoritative manner in which obstetricians began to express themselves to women from about 1940 onward. By the time that DeLee wrote his book in 1949, the balance of power in the relationship between a woman and her obstetrician had shifted such that DeLee no longer finds it necessary to be as solicitous toward the female reader as the earlier authors did, and he can afford to adopt a more authoritative tone. For example, writing about perinatal mortality, he states that

...a good share of the blame for these fatalities may be attributed to the unfortunate prospective mothers themselves. Thousands of women fail to be examined by a physician during their pregnancy because of ignorance, negligence, financial difficulties, territorial inaccessibility or other reasons.

(DeLee 1949:vi)

His assignment of responsibility for the negative outcomes of pregnancy solely to the woman contrasts with the more equitable sharing of responsibility that was articulated by the earlier authors. Part of the contractual relationship envisioned by earlier obstetricians does persist: the pregnant woman is still obliged to relinquish control over her body, as when DeLee says "...it is important that the patient place herself in the care of her physician early in pregnancy in order that any complications that might otherwise develop may be foreseen and averted..." yet the contractual relationship has begun to disintegrate since the woman no longer shares responsibility for the outcome of her pregnancy with her obstetrician (DeLee 1949:4). DeLee does not hesitate to relieve the obstetrician of responsibility, and in his representation, the obstetrician no longer emerges as a fallible figure.

A shift from the earlier guidebooks is captured in the transformation of Irving's 1932 promise of "watchful supervision" into DeLee's 1949 plea: "**Let him safeguard your motherhood!**" (DeLee 1949: 3). This more forceful message sets the tone for the more authoritative, confident, and inflexible manner in which obstetrician-gynecologists address women in their writings from the postwar years onward. I do not want to suggest that obstetricians writing prior to World War II did not have or communicate a sense of authority to their women readers. But I do sense a difference in the degree to which such a tone permeates their writings; contrast, for example, consider the less dogmatic approach of Samuel Bandler in his 1921 book *The Expectant Mother*: "The patient should lead the sort of a life as before, if it has been a sensible kind. She should eat whatever agrees with her and what she likes, whatever is nutritious" (Bandler 1921:47). This approach contrasts with DeLee's later and less compromising advice: "Housework is desirable for it keeps the mind occupied, but there should be no lifting of large children or heavy furniture" (DeLee 1949:38) and "The mind should be kept busy--by reading light literature, perhaps, but this must not develop into a whole-day occupation..."(DeLee 1949: 35). In other words, it is as if an earlier obstetrician like Bandler had to take a more tentative tone in advice-giving, allowing that a pregnant woman still had a certain amount of power in negotiating the relationship with her obstetrician--the result is a text with more movement and allowance for *the pregnant woman as a subject* and subsequently, higher regard for her ability to make decisions regarding lifestyle and hygiene. Texts from about 1940 through 1970 provide dictums on every aspect of a woman's physical, mental, emotional, and social existence, and the guidelines are relentless in their level of detail. Little or nothing is left to the individual woman's judgment, quite possibly as a consequence of the fact that it is no longer as much in the authors' interest to regard her as a subject.

Scientist or counselor?

What were the factors that permitted obstetricians, after approximately 1940, to feel more confident that they had a secure place in the management of childbirth? I think that part of the answer lies in DeLee's epigraph to his introduction: "*Guided by modern medical science, childbirth is no longer a miracle but a safe and satisfying, if somewhat tedious, experience*" (DeLee 1949: 1; italics in original). With the development of a firm scientific basis for their practice, obstetricians now could make a contribution that they regarded as unique. The promise, if not the actual fact, of limitless progress and advances in childbirth as a result of the new scientific basis of obstetrics, enabled obstetricians to make claims about their indispensability to women and babies. Obstetricians perceived themselves as beneficiaries of the explosion in scientific knowledge and capability that effected, and was inseparable from, changes in fields outside of obstetrics, such as weapons technology, and genetics. The perceived scientific basis of obstetrics resulted in an altered self-image for obstetricians; they began to see themselves as scientists, as in DeLee's sketch of "modern obstetrics":

She [the pregnant woman] has the assurance today that little unforeseen can occur because she is in the hands of a *scientist* who has spent long years of preparation, by study and practice, in order to bring her safely through her ordeal and to crown it with the delivery of a fine healthy child.

(DeLee 1949: 89, italics mine)

The scientific basis of his practice has endowed the obstetrician with new capabilities, and has resulted in the foregrounding, in DeLee's imagination, of the obstetrician's activities in the birthing scene. The obstetrician, in this passage, is the main actor; it is his activities (and indirectly, scientific progress) that count, and make childbirth possible. That the obstetrician-author has begun to view himself as central to childbirth and to the process of reproduction generally, is apparent in Castallo's promise that "...some research man may someday hit upon a method for fixing you up with a boy if that's what you want--or a girl" (Castallo 1944: 12) and his self-important comment on the centrality of the obstetrician's

skills: "An incision here or there, some tidy stitching, the right tools, and, above all, a pair of wise and gifted hands are employed by the trained man to bring your child into life--with a minimum of wear and tear on the pair of you (Castallo 1944: 73). Scientific research was especially important in enhancing obstetricians' practical capabilities in one area that was especially important to birthing women themselves: the relief of pain during labor. A feeling of obstetrical omnipotence is conveyed in the promise to women that they can "face the pains of childbirth with equanimity, even with nonchalance" because if she is lucky "perhaps he [the obstetrician] will send you off with a magic pill to some distant country of dreams" (Eastman 1957: 134).

The new image of the obstetrician as a medical scientist, and therefore a distanced, white-coated, authority figure was not, however, without contradictions and tensions. As Sumney and Hurst (1986) describe, there was an "expansionist" quality to the discourse of obstetricians during the postwar period. Obstetricians were optimistic about what their roles could encompass, and they increasingly saw themselves as experts and voices of authority on "woman's entire reproductive system in all its physical and psychological aspects (Sumney and Hurst 1986: 104). This "expansionist" ideology is characterized, for example, by James Bloss' statement to the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons⁶ that "The obstetrician must be an internist, a surgeon, a pediatrician, a psychosomaticist, as well as an economist, eugenist, and sociologist" (Bloss 1950: 1187).

In particular, obstetrics and gynecology began to forge a link with psychiatry, and made claims using concepts and language borrowed from that specialty. Obstetricians saw the insights gained from psychiatry as especially relevant to a profession that dealt exclusively with women; for example, an obstetrician addressing his professional society in

1945 argued that psychotherapy was crucial to solving the gynecological problems of most women (Cooke 1945: 457). Perhaps as a result of obstetricians' interest in psychology and psychiatry, and their eagerness to be seen as experts on what they perceived as the unique psychological make-up of women, many obstetricians attempted through their writings to establish positions as counselors and friends. For example, DeLee, in *Safeguarding Motherhood* regards the role of the obstetrician:

...not only as an operating technician for the delivery, but prior to this for many months as a friend, a person to turn to for emotional comfort and assurance. Instead of brooding in uncertainty and breeding more anxiety, she should share any such feelings with her physician. It is then his responsibility to remove these fears and apprehensions, regardless of what the source may be.

(DeLee 1949: 35)

The obstetrician promotes himself in this excerpt as a capable psychological helper, a "medically knowledgeable friend;" the psychological well-being of his female patients is within his professional repertoire. The obstetrician's new image and identity as friend and counselor does not, however, in any way diminish the authoritative quality of his voice. The previously established hierarchy within the relationship between a woman and her obstetrician is maintained, as is expressed in DeLee's statement that "Most doctors respect the idea that a woman has the right to have her baby according to her own desires and beliefs...But the patient must always keep in mind that her wishes must remain secondary to her doctor's judgment" (DeLee 1949: 105).

The strength of the "natural childbirth" movement from about 1940 onward, and women's demands for this birthing method (Wertz and Wertz 1977), may have helped to fuel obstetricians' desires to play the role of confidante and to have warm, intimate relationships with their patients. Unlike other popular strategies for managing childbirth and pain relief at the time, "natural childbirth" actually relied upon and required the conscious presence of the birthing woman. In the minds of obstetrician-gynecologists, the potential success of this method depended on the birthing woman's willingness to place her

full confidence in the obstetrician's abilities (Goodrich 1966: 8). This vision of the obstetrician-patient relationship is really an extension of the image I discussed earlier in which the pregnant woman is required to relinquish her body and her responsibility for it. With the influence of the "natural childbirth" movement, this relationship was rearticulated with an added twist: the obstetrician was now also to be a "medically wise friend" (Eastman 1957: 156). So it might be said that it was in obstetricians' best interest, at this particular historical moment, to articulate a conception of the relationship that included elements of friendship and intimacy, which were central to the philosophy of "natural childbirth." Nicholas Eastman's 1957 discussion of the method of "natural childbirth" is especially interesting because the very presence of this topic is a tacit acknowledgement of a woman reader who possesses agency, and to whose demands for information the obstetrician-author must respond. But Eastman presents "natural childbirth" to the reader in such a way that the principles of the method are coopted. The reader is presented with three simple rules: put your complete confidence in your doctor; acquaint yourself with the changes that will take place in your body, and learn what will happen in labor as well as how to relax. Eastman says that if women follow these three rules they "will secure all the advantages of Natural Childbirth and need not bother further about it" (Eastman 1957: 156-157). His strategy appears to be to pacify the woman reader's curiosity by distilling a whole philosophy of natural childbirth into a few rules, so that the obstetrical management of childbirth, and the obstetrician's role, do not have to change significantly in order to accommodate women's demands.

With the infusion of psychology and psychiatry into obstetrics, the obstetrician is called upon to exercise his patriarchal role in a slightly different way. The language of the call for a psychologically-oriented obstetrics invites the obstetrician to become not only a friend, but almost a family member. For example, one address to the American

Gynecological Society suggested that the role of obstetrician is one of “father-confessor” (Cooke 1945: 458). This metaphor follows nicely on the heels of a tradition of obstetrical discourse that has been both patriarchal and paternalistic. Now, the obstetrician is to be a gentle, listening kind of paternalistic figure, rather than a firm, gruff, and distant one. Additionally, with the obstetrician called upon to become a psychological helpmate, and the birthing woman’s husband increasingly brought to the bedside, there was potential for confusion of the roles of obstetrician and husband. Leonard Biskind, in his 1954 book *Having Your Baby: Modern Instructions for Expectant Mothers*, provides an example of how on occasion the husband’s and father’s roles are made linguistically synonymous. He tells the reader, “Nothing gives you a better ‘lift’ during pregnancy than good grooming, and your husband and physician will appreciate this” (Biskind 1954: 37). The pregnant woman is reminded of her ornamental status, which is important to both her husband and physician, who become effectively in this sentence the same person. Even though obstetricians do not, in their official language and public voices, recognize the subject matter of their work as sexually charged, in this sentence, it is as if the author has “slipped,” and acknowledged the connection between a husband’s sexual intimacy with his wife, and the obstetrician’s familiarity with her sexual and reproductive organs.

By the 1950s and 1960s, the figure of the obstetrician assumes a stable form and has become a seemingly permanent figure in childbirth scenes. He has established a professional domain that includes both medical and psychosocial aspects of childbirth. What remains is for the obstetrician to defend, in the 1970s, this professional domain against threats such as the women’s movement. Obstetricians indeed began to adopt a defensive posture, as illustrated in this 1970 address to the American Association of Obstetricians and Gynecologists:

As men of today, we have established a territory, a specialty of obstetrics and gynecology. We have defined its scope and marked its borders...We recognize the

territorial rights of others. We have struggled to possess and defend this territory...
(Brewer 1970: 957, italics in original)

In a later section, I discuss how obstetricians practicing after 1970 responded to the women's movement and other challenges to obstetrics. For now, I will just mention briefly that two of the texts that I have discussed so far, Nicholas Eastman's *Expectant Motherhood*, and Sol T. DeLee's *Safeguarding Motherhood*, were published in successive editions as late as 1979 with only minimal changes from the original editions in the 1940s. The fact that these authors did not find it necessary to change most of their texts during this forty-year period reflects the stability of the figure of the obstetrician, and the essentially unchanged nature of his relationship to women, during that time.

Part Two:
Contemporary Obstetricians' Narratives

Chapter 4: Contemporary Obstetricians Imagine Themselves

In this chapter, I attempt to trace the themes that emerge in contemporary obstetricians' descriptions of their role and relationship to birthing women, based on my interviews with twenty-four obstetrician-gynecologists. In Part One, I used historical materials to demonstrate that obstetricians drew upon concepts and technology that were increasingly made available to them as a result of scientific research in order to construct a more scientific basis for their practice. As representatives of scientific progress, obstetricians could occupy a more central position in birthing scenes. Here, I will trace this theme to argue that some obstetricians continue, in the late twentieth century, to picture themselves and their roles as the focal point of birthing scenes. In order to develop this theme, I want to introduce someone who has, unknowingly, served as a catalyst for these thoughts. I met "Peter" (a pseudonym) in 1990 while we were both working for the same family planning agency. Peter was twenty-one, a devout Christian, and destined from birth, he thought, to become an obstetrician. As a college student, Peter spent his spare moments as an "embryo doctor." By that I mean two things: first, that Peter acquired a long white coat and a laboratory setting that permitted him to function as a doctor-in-training; and second, that he spent his summers shepherding tiny embryos, through his *in vitro* fertilization work, to maturity. By the same age, Peter had also acquired a fast, sporty red car, and a personalized license plate that read "STORK 2B." To say that Peter's conceptualization of his role in childbirth captured my attention would be an understatement. His lifelong fantasy of becoming an obstetrician, and its expression via his license plate, have figured prominently in my imagination as I have attempted to explore the figure of the twentieth-century obstetrician. In Peter's vision, his role as obstetrician would be central: he would have the ability, with the help of technology, to create new life, and then he would generously share that ability with infertile women. He also imagined

himself as the “stork,” or agent of delivery, foregrounding his own role in pregnancy and childbirth.

The obstetrician takes center stage

Peter’s emphasis on the importance of his presence and contributions to childbirth were mirrored in the career narratives of several obstetrician-gynecologists I interviewed. When I asked Walter Morris, an obstetrician in his fifties in Newborough, what he liked about doing obstetrics and gynecology as a medical student, he responded:

I liked delivering babies. The few I delivered, it was really fun. I used to get up and try to beat the resident into the delivery room. I thought it was fun, and I liked the patients, and I liked the immediate gratification of ‘here, lady, seven-and-a-half pounds, it’s yours.’

Walter Morris’s initial statement, that he “liked delivering babies,” was very typical of the obstetricians I interviewed; most of them expressed some version of this description of pleasure in being able to be present at the moment of birth. Some aspects of this brief excerpt from my interview with Walter Morris, however, merit more discussion. Walter Morris expresses here that the opportunity to be present at birth represented something of a contest between himself and the resident who supervised him. He seems drawn to the drama of being woken in the middle of the night, and rushing to compete with the resident to be the main actor in the delivery room. When he gets there, his role is a curious one: he presents the birthing woman with her baby much as a waiter hands a restaurant customer his salad. In this case, the principle of the satisfied customer is reversed, and the pleasure or “gratification” belongs to the obstetrician, who has provided the service. Now, my objective here is not to vilify Walter Morris, but instead to use his words to illustrate that medical students do their learning from early on, in a context that permits them to develop a conceptualization of their own activities and presence as central to the process of birth. And, in Walter Morris’s case, his activities are quite central indeed; in the passage, the baby

is *his*, it in some way appears to belong to him, since he can exercise his prerogative of presenting the woman with her baby, as a sort of gift, and he has the power to tell her “it’s yours.” As he informs the woman, “it’s yours,” he accomplishes a literal reversal of what would be seen, through other perspectives, as the woman’s activity in presenting the world with the baby she has birthed.

In some cases, the obstetrician’s self-image as agent of delivery, or Peter’s stork, was more subtle; Bruce Hinton¹, a forty-nine year-old male obstetrician in Westview explained that:

It’s a joy to walk into a restaurant and have a patient come up with her children and say, “You know, you delivered these two” and even the children’s response: “This is the doctor who delivered me?” “Yeah this is the doctor who delivered you.” I mean, what greater gratitude than to be valued to people.

As Bruce Hinton imitates this dialogue between his patients and their children, he clearly takes pleasure in the part that he sees himself as having played in creating the “extended family” that expresses public appreciation to him. His use of the word “delivery,” a term typically used by physicians but not common parlance among midwives, hints at a particular kind of relationship that Bruce Hinton and other obstetricians perceive between themselves and their work. “Delivery,” as others have pointed out (Hahn 1987) is a term that reflects the perspective of someone external to the birthing woman, and suggests an agent who accomplishes “delivery;” “birth,” on the other hand, assumes the woman’s perspective, as only she can “give birth.” As the children in the excerpt echo back that they were brought into the world by the activity of the obstetrician, their voices confirm that his figure is an active and central one.

A more dramatic example of childbirth as a dramatic event with the obstetrician as its central figure is provided by someone who was not a respondent of mine in the same sense as Walter Morris and Bruce Hinton. William Sweeney is an obstetrician who wrote

an autobiographical account of his career at the encouragement of one of his patients, who was a writer and assisted him with the book. Sweeney's book, written in 1983, contains a more detailed career narrative than I had been able to gain access to in my interviews, so I include it in my discussion here. Sweeney begins by anticipating that the (probably female) reader is curious about his career and his daily life:

I have often wondered whether people really know what it's like to be an obstetrician and gynecologist. To be so chronically exhausted that you literally fall asleep in the middle of dinner. To be so conditioned to crises that you jump whenever a phone rings...

On the other hand, do people understand the sheer joy of delivering a baby, or the pride and accomplishment you feel when you know your operation was well done and your patient will be healthy because of you? Do they know how great it is to look forward to going to work?

(Sweeney 1983: 1)

In Sweeney's account, the obstetrician has become the centerpiece of the drama; his figure is so central to the action that he must "jump whenever a phone rings," although he simultaneously attempts to marshal some sympathy for his hectic lifestyle. I don't intend to suggest that Sweeney is not as busy or harried as he suggests; on the contrary, I think that Sweeney is every bit as "conditioned to crises" as he says that he is. But what underlies this passage is a certain construction of birth and the obstetrician's role in it: every moment in pregnancy and birth contains a potential drama, and the obstetrician is the heroic figure who intervenes. Since the process of birth exists just on the brink of disaster, in Sweeney's imagination, he is always potentially heroic. For Sweeney, childbirth represents not only impending disaster but inevitable surgery. In the above excerpt, and elsewhere, he moves from the joys of attending birth to the pleasures of the operating room without distinction, and in the process he conflates childbirth with surgery, making childbirth a proto-surgical condition.

In imagining that all roads that lead to childbirth also lead to surgery, Sweeney finds it possible to present himself as an indispensable and central figure. The possibility of being called upon to perform heroic acts, the “drama” inherent in birth, is what makes his role exciting. “Drama” is his own term, not mine, and he has a rather extensive metaphor of birth as a theatrical production:

I always feel labor is like the greatest drama in the world--like somebody must be standing in the background beating a drum slowly and then faster and faster as the excitement builds and the climax is coming. *Nine* months we got ready for this, and finally we're here and this woman must think, 'I'm center stage.' In England the delivery room is called a theater. The birth itself is a big drama. There's a large white light shining down on the woman. The doctor is in there with his mask and gloves; the nurses are waiting on him, and he's a big ham, anyway. Most of us are. Time after time we're thrilled when we deliver a baby, and it must be the most joyous and profound moment in a woman's life.

(Sweeney 1983: 52, italics in original)

Although Sweeney later denies any “sexual feeling” for the unclothed women he sees in his office (Sweeney 1983: 72), the metaphor he creates here is a covertly sexual one, with a feverish drumbeat coming to a climax. And there are a number of ambiguities within Sweeney's “drama:” he says that the woman must think she is center stage, but it's not clear whether he thinks she is, or whether she is just under the naive impression that the scene revolves around her. The remainder of his description suggests that Sweeney is more inclined to think that the birth is the obstetrician's show: the nurses attend to *his* needs, and he is a “big ham,” suggesting that he finds ways of focusing attention on himself. Sweeney develops this theme further when he says:

But we get phone calls from women all the time. Letters and flowers and gifts arrive. We're little gods. And we get to be spoiled. It's not just that we're idolized by our patients. We also work in offices and hospitals where we're waited on.

(Sweeney 1983: 97)

So Sweeney's patients and staff apparently play a part in creating a role for him that he is more than happy to play, and although he perceives that obstetricians can become “egotistic” (Sweeney 1983: 98) from being catered to by staff and patients, he does not see

anything fundamentally wrong with this organization, but instead asks the reader to indulge him by granting him a little sympathy for having an inflated self-image. Obstetricians' emotions, too, are placed at center stage when he says that "we're thrilled when we deliver a baby" and adds, as if an afterthought, "and it must be the most joyous and profound moment in a woman's life."

The tension that Sweeney conveys through his narrative, between wanting to be the indispensable hero in the drama that the telephone call promises, and desiring sympathy for some of the dilemmas of being such a central figure, mirrors another central tension in the narratives that I have explored: obstetricians wanting, as Sweeney does, to see themselves as center stage and rationalize their presence and activities, but simultaneously perceiving that more often than not, birth occurs uneventfully without acts of obstetrical heroism. Sweeney himself expresses such a contradiction when he includes the following dialogue between himself and a patient in his autobiography:

'I'm going to start an infusion now. We'll put it in the back of your hand so you can move around.'

'An infusion,' Jean said, her attention suddenly riveted on me. 'I thought with natural childbirth I wouldn't need anything like that.'

'I'd rather you had it,' I replied, thinking that one thing wrong with obstetrics is it's really a surgical specialty but it's not approached as one. Nobody in his right mind would start an operation without an infusion running, yet babies are delivered without them every day.

(Sweeney 1983: 33)

Against Jean's wishes, Sweeney makes the decision to start an "infusion," or a means to deliver medications and fluids directly into her veins. Sweeney has interpreted his responsibility to the pregnant woman to mean that he should decide what is best for her; her only remaining responsibility is to comply with his advice. The irony in this exchange is that Sweeney presents the "infusion" as a necessary part of surgery (which, to him, includes childbirth), and yet manages to recognize that most babies are born without the

assistance of the “infusion.” The obstetrical technology, and the obstetricians who wield it, are invoked as necessary and indispensable, but this rationalization clashes with the common-sense observation that “babies are delivered without it every day.”

The obstetrician de-centered

The obstetricians’ voices that I have described so far, which constructed the obstetrician as a central and heroic figure, and childbirth as a dangerous drama which required surgical intervention, were interrupted in the 1970s and 1980s by a new set of voices that were influenced by the women’s health and childbirth movement and other forces. When I asked Sandra Levinson, a thirty-five year old female obstetrician practicing in Westview, if she would describe her role in pregnancy and birth, she responded:

I see myself as a member of the team, and I consider myself an expert in certain aspects of health care, and an educator. But I see that she’s an expert of her body, and her husband or partner is an expert of that relationship, so I sort of see myself as a contributor to the team, and someone to provide information and options to a patient. I let patients make a lot of choices themselves about things. I try not to tell people what to do in many instances that doctors would probably otherwise say ‘this is your only option’. I like to give lots of options and let people make decisions, and sort of, help to give people the information to make decisions. A supporter. Sometimes I need to be fairly directive in order for things to progress in a way that I think will be safe. But I’m also very flexible. Like, I tell people when they go for their birth, that I don’t have an agenda of what their birth is going to look like. And I’m interested in hearing their preferences. And I just consider both me and the couple going on a journey together, and we’ll sort of see what happens, and we’ll navigate together. And I have some skills and resources to provide interventions if they’re needed, but if they’re not needed, then they don’t need to be there.

Sandra Levinson’s narrative contrasts dramatically with the previous narratives I present, in which the obstetrician emerges as dominant or central. In Sandra Levinson’s imagined birthing scene, there is a group of people who participate in decision-making around pregnancy and birth, and she is just one of the “team.” Each “team member” has an area of expertise that is to be respected, and power is diffusely spread among those people in the

birth scene. It isn't that Sandra Levinson downplays her own role in pregnancy and birth so much as that she limits her expertise to a clearly circumscribed area. And, compared to a narrative such as Sweeney's, her position makes more modest claims and promises; she aspires primarily to educate, help, and support. Her metaphor of traveling on a journey *with* the birthing couple suggests that she envisions a more equitable relationship between herself and her patients.

But Sandra Levinson's narrative suggests that the role that she envisions for herself is not always an easy one. She faces challenges that never arose when the obstetrician was clearly cast in the roles of director, producer, and star in a theatrical production of childbirth. Her language is fraught with contradictions and tensions, which suggest that she walks a fine line between being directed by her patient's desires, and relying upon her medical knowledge. Her language initially emphasizes choices, information, and options, and adopts a non-interventionist, non-directive stance. But then she contradicts herself, saying that sometimes she must be directive in order to fulfill the promise of safety that originated in the contract with the pregnant woman. In this sense, Sandra Levinson appears to want to retain portions of the contract between a woman and her obstetrician that I have claimed characterizes twentieth-century obstetrics. At the same time, her statement of her role is a rejection of the paternalism advanced by earlier, and primarily male, obstetricians. Other portions of my interview with Sandra Levinson suggested that she had been drawn into gynecology and obstetrics as a result of interest in "women's rights and women's health care," and in the wake of the feminism of the early 1970s. So when she tells me that she doesn't have "an agenda of what their birth is going to look like," she is speaking partly in reaction against the heavy-handed paternalism that was never seriously questioned in medicine generally before the consumer rights movement, and in obstetrics specifically before the women's rights movement. And I will

mention just briefly that the pregnant woman who appears in Sandra Levinson's birthing scene is also a new kind of woman. Now recognized as an "expert of her body," she is a woman who can be envisioned only after the widespread reading of books such as *Our Bodies, Ourselves* (1984). Like Sandra Levinson's narrative itself, the family of books that includes *Our Bodies, Ourselves* constitutes a reclaiming of women's knowledge about their own bodies, which had been submerged under the heavy hand of paternalism.²

Obstetricians such as Sandra Levinson appear to have been influenced, in their conceptualization of their roles, by the women's health movement. A rekindling of interest in midwifery accompanied the women's health movement (Ruzek 1980:44). Two of the obstetricians I interviewed in Westview invoked the practice and philosophy of midwifery in their descriptions of their role in pregnancy and birth. Cindy Jacobs, a woman in her fifties, said:

I would say that, you know, as a physician you hold a certain amount of expert knowledge on aspects of pregnancy, be it nutritional, medical, whatever. But that my role--one would be to monitor the health of the infant medically, but also to be a sort of guide to a woman's pregnancy, much more in a midwifery sense of helping people sort of take care of their health, you know, helping them understand the importance of good nutrition or not using drugs, that the health of their baby starts with the pregnancy, or even before the pregnancy.

In Cindy Jacobs' imagination, the obstetrician retains a certain "expert" status, as she does for Sandra Levinson. But Cindy Jacobs also borrows from midwifery the ideal of being a more experienced peer, who can travel "with woman" as a helper and educator.³ Teresa King, another female obstetrician in her fifties, also wants to be a guide and educator:

I used to feel, it was really nice to get many of your patients, and, you know, follow them through the whole pregnancy and go into the hospital...and I actually changed my views on that after working with midwives. That the pregnancy is an experience of the family, and that I was there to be sure that they had the information that they needed and that nothing went wrong... I no longer feel it's absolutely necessary for a woman to have her doctor there in the delivery room, as long as you have properly prepared them, made them feel comfortable with you and the caretakers that will be there, and understand that it is *their* experience. *We're* not having the baby, *they* are [laughs; emphasis hers].

Here, Teresa King expresses that, like Cindy Jacobs, her philosophy and practice have been influenced by midwives. And the influence of midwifery has actually resulted in Teresa King's de-centering of her own role. In opposition to obstetricians such as Sweeney, who worries all night since the pregnancy and birth experience (and the responsibility for it) is as much his as anyone else's, Teresa King emphasizes that birth and pregnancy belong to the family. She rejects an aspect of her role that obstetricians such as Sweeney have clung to: that the personal characteristics of the obstetrician have much to do with the success of the birthing process, and that, without him, the show (that is, the birth) cannot go on. Having downplayed the importance of her role at the moment of birth, Teresa King concludes that she is not an irreplaceable figure, and feels confident in allowing the family a central position in the birthing scene.

Teresa King's narrative shows evidence of another kind of influence, the alternative and holistic health movements, which have been especially vigorous in Westview. Teresa King referred to her former private practice: "...we had yoga classes twice a week for our prenatal patients, herbs, herbal medicine..." and Sandra Levinson spoke of using massage during pregnancy. In other words, Teresa King and Sandra Levinson were quite willing, in a departure from earlier obstetrical discourse which exclusively emphasized Western scientific knowledge, to incorporate non-Western techniques into their practices. In addition, Teresa King voiced her dissatisfaction with the resistance in U.S. medicine to holistic approaches, saying:

I think that medical school has very little focus on integrating the whole patient, dealing with them from the top of the head down sort of thing. It's very much segregated into these small physiologic units...

While obstetricians such as Teresa King and Sandra Levinson clearly draw from and respect midwifery and alternative medicine, I would maintain that they still mark themselves as physicians through their language in many ways. For example, Teresa King

said, during the interview, "My goal is that no patient leaves my exam room without a new piece of information." Her statement contains elements of the same kind of rigidity in the expectations of the doctor and patient that characterized earlier advice books on obstetrics. That is, the physician still dictates the terms of the relationship, and there is a sense that the relationship is not supposed to be an entirely equitable one, because the physician still articulates what is required and what is permitted of the patient. Similarly, while she respects midwives and remains open to practitioners other than physicians, Teresa King talks about "mid-levels" and "usage of midwives." This reflects a traditional perspective of physicians, in which nurse-midwives and nurse practitioners, rather than being seen as having unique kinds of skills and qualities, are seen as having a quantity of knowledge that does not measure up to that possessed by physicians. They therefore reside in a kind of imaginary "halfway house" in physicians' minds, possessing just enough skills to be useful as resources which can be utilized in "extending" the physician's reach.⁴ I would argue, then, that feminism and the alternative and holistic health movements collide to produce a new set of discourses in obstetrics about pregnancy and childbirth, and these discourses draw from, but can be distinguished from, those that characterize midwifery and the women's health movement.

The influence of feminist voices

The three female obstetricians whose voices I have just discussed represent a strand of obstetrics that has been most influenced by the women's health movement. However, many of the male obstetricians' ideas and language also revealed the influence of the women's, and other, movements. For example, Gordon Dubois, a male physician in his forties practicing in Westview, said:

I think we have a very non-interventionist approach to childbirth in this hospital, which is largely due to the very powerful influence of the midwifery service. I like

very much their ethos, and their style of practice, and they have a very beneficial effect on all of us. So our job is to give help, give comfort, and to give pain relief, knowledge, and information. To make sure that things are going safely and smoothly, and according to the mother's wishes, to the extent we can.

Still invoking the "safety" promised by the obstetrician-woman contract, Gordon Dubois also credits midwifery with providing a philosophical basis for his practice, and this is a significant departure from the emphasis on scientific progress in mainstream obstetrics. Midwifery leads Gordon Dubois, like the three female obstetricians I discussed earlier, to make his own activities less of a focus of the childbirth scene; this is expressed by Gordon Dubois when he prides himself on a "non-interventionist approach." Non-interventionism is also valued by Ken Andrews, also in his forties in Westview, when he says that "...the person doing the delivery should relax and let as much go naturally as possible and not intervene," and Nancy Jordan, in her forties in Newborough when she says, "They go into labor and deliver, most of the time, just fine. So our job's just to sit there and say, 'It's okay! You're supposed to feel that way!'" These obstetricians, sometimes due to the influence of midwifery, value a "hands-off" obstetrical approach, deemphasize their own roles, and tend not to envision themselves performing heroic acts, as some obstetricians I discussed earlier do.

Other narratives showed, to varying degrees, the influence of the women's movement and other factors on obstetricians' ideas about their role. Robert Sloan, a male obstetrician in his seventies practicing in Newborough, captures a shift in his views of his role in the following excerpt:

Well, I used to think that we managed the pregnancy, we took care of the pregnancy, we took care of the delivery...But now, I think that I'm there more to guide, assist, and educate. And that it's really a pregnancy dominated by the mother, and we should be there as helpers. I can't have the baby for any particular patient--it's really her baby, it's her pregnancy, it's her event, I'm there to help her. I used to think that I managed everything. (laughs)

“Guide, help, and educate” has apparently become the mantra of these obstetricians practicing in the 1990s. These goals are articulated by the obstetricians who I earlier identified as closely allied with feminism, and then echoed even by male obstetricians who had begun their practices when it was still politically feasible to give orders and expect not to be questioned. Robert Sloan’s voice sounds as if he has been a pupil of the women’s movement; he dutifully recites what he now knows to be the popularly accepted version of the obstetrician-patient relationship. He recognizes, and even laughs about, his earlier visions of his role, in which he was the active and prominent figure, and recognizes the shift in his own thinking that re-positioned the birthing woman as the central figure.

In Robert Sloan’s narrative, it is not only the influence of the women’s movement, but also the consumer movement which caused him to adapt his conceptualization of his role. He believes that his patients have a different perception of their role, too, than they did earlier in his career:

People are more demanding now, you know. They want to spend more time with you. If you were seeing obstetrical cases in the past, I would say you spent five or six minutes with a routine visit, not the initial visit, not a problem visit, but just somebody coming in with no problems. You listen to the lungs and heart, measure the uterus, said, ‘How are you, Mrs.,’ and that’s five or six minutes. Now, you can’t do that anymore. Patients demand more of your time. And they have a list of questions now, not only about their own case, but about their sister’s case, or their daughter’s case. You’re doing more education...They’re getting more educated in medicine, they’re not accepting what you say on blind faith, they say, ‘why?’ And before, you just said, ‘here’s your prescription.’

In Robert Sloan’s mind, the obstetrician’s shift to an education-oriented approach was forced by the newly curious and educated female patient. Instead of the passive patient, who can be examined cursorily and who unquestioningly accepts the word of the omniscient physician, he believes that he faces a more assertive and questioning patient. The questions of his patients may be taxing and place more demands on him, but Robert Sloan sees himself as adapting to this challenge by becoming an “educator.”

Bruce Hinton, a male obstetrician in his fifties practicing in Westview, perceives, like Robert Sloan, that as a male obstetrician practicing after the women's movement, he needs to distinguish his approach from the heavy-handedness of his predecessors:

I think that if male physicians show in general respect and see the relationship as one of exchange of information, or in many instances of teaching, as opposed to a power relationship, power struggle, where I'm the doctor and I'm autocratic, and I tell you what to do, just listen, and your role is one of passivity and dependence, I think that then develops a relationship with your patient that's interdependent. And your role as a professional is to assist her, to help her make the decisions that are in the best interest of herself and her child.

Bruce Hinton articulates the ideal obstetrician's functions of education and assistance, as other obstetricians do, and he knows that he must reject an overtly hierarchical relationship in favor of a more equitable one. He wants to grant the woman a certain amount of "expert status," which allows her to exchange information with him, and at the same time, his reference to the "best interest" of the woman and her child suggests that it is the obstetrician who really has access to knowing what is in her "best interest." Mary Mishler, a female obstetrician in her fifties practicing in Newborough, revealed through her narrative a combination of the sentiments of Robert Sloan and Bruce Hinton:

The women are very intelligent now, they ask a lot of questions, so it isn't like, I'm the doctor, you're the patient. We are responsible for your care together. If they want to have a natural delivery, fine, I encourage them, I encourage them to do what they want as long as it's in the realms of correctness.

In other words, Mary Mishler, like Robert Sloan, perceives a shift to more assertive and questioning patients, which results in a more equitable relationship between woman and obstetrician. But for Mary Mishler, as for other obstetricians, there is always a qualifier ("as long as it's in the realm of correctness") and there are always limits to what the obstetrician will allow since it is pregnancy that is at stake. Rules that are made by obstetricians, then, have become more flexible; they stretch, and they are enforced by a gentler (and more frequently female) hand, but these narratives make it clear that the rules still exist.

As a result of the women's health movement and the consumer movement, then, many obstetricians no longer see it as desirable or feasible to present themselves as central and heroic figures in pregnancy and childbirth. Because of involvement in feminist movements themselves, or because of the percolation of feminist ideas and language throughout mainstream obstetrics, the obstetricians I interviewed most frequently aspire to more modest roles as guides, helpers, and educators. Obstetricians' construction of their role in these terms relies upon a newer (or really, recycled) construction of childbirth as an event that ordinarily proceeds without heroic intervention. In addition, the way that obstetricians imagine themselves and their patients in the post-1970s era depends upon new constructions of women. I have suggested here that women are constructed by the obstetricians I interviewed as educated, active, and assertive participants in the processes of pregnancy and childbirth. In the next chapter, I explore more fully how women are constructed by obstetricians in the wake of the women's health movement.

Chapter 5: Constructing Women Patients and Female Obstetricians: 1970 and Beyond

In Part One, I suggested, based on historical materials, that obstetricians, through about 1970, were effusive in their encouragement of women to become mothers. Through discourse that openly glorified motherhood, but that also contained silences about contraception and abortion, obstetricians communicated that they were happiest and most comfortable in assisting women in becoming mothers. I want to turn now to the voices of obstetricians I interviewed to trace this thread into the late twentieth century, and ask if helping women become mothers is still the primary goal of obstetricians, and one that is still consistent with the ideologies of the profession.

The fate of unambivalent pregnancy and the monolithic WOMAN

Most of the obstetricians I interviewed, whether they were generally satisfied with their careers or not, commented that theirs is a “happy specialty.” It is not difficult to understand why obstetrics is widely perceived as a happy field, for, compared with other medical specialties, the patients are younger and healthier, and tend to suffer from fewer long-term illnesses, and have better recoveries. Most obstetricians I interviewed also expressed that delivering babies is one of the most satisfying aspects of their careers. But what is it that experienced obstetricians find satisfying and enjoyable about “delivering babies,” particularly when they have practiced for twenty or thirty years?¹ Oddly enough, this is not a question that is easy to answer based on obstetricians’ narratives, because many were not specific about why they found delivering babies enjoyable. Some obstetricians described being involved in “new life” and “creation” as part of their

motivation; others wanted to “change people’s lives with a new baby,” or liked being involved in “happy-type situations.”

Irrespective of these reasons, do obstetricians’ expressions of the joy that they describe in attending childbirth, in helping women to become mothers, mean that they are necessarily less equipped to help women with other aspects of reproductive life? In other words, when obstetricians are called upon by women in less happy circumstances--such as when pregnancy is unwanted, or when miscarriage occurs, do obstetricians find similar personal satisfaction in helping women to *not* become mothers? Anecdotally, one woman, Florence Johnson, who I spoke with in Newborough told me that, during her pregnancy in 1969, she had been satisfied with the care provided by her obstetrician until she miscarried. She said that her obstetrician was “insensitive” when he met her at the hospital, and that he complained that it was an inconvenient hour for him to perform the surgical procedure that would empty her uterus. While obstetricians generally often describe rushing to the hospital to deliver babies as exciting, if inconvenient, it appeared that meeting this woman as her pregnancy ended did not offer the obstetrician enough excitement and personal satisfaction to compensate for the inconvenience. Similarly, issues around abortion and contraception were not what had drawn many of the obstetricians I interviewed into their careers. In my interviews, the obstetricians who were most enthusiastic about the joys of delivering babies were also the most silent about contraception and abortion--a silence mirroring that in the speeches and texts of obstetricians earlier in the century. Jack Hurst, in his thirties in Westview, was enthusiastic about his role in delivering babies, but unenthusiastic about the pregnancy that ends in abortion. A section of the interview, in which he expressed pessimism about teenage pregnancy, included the following remarks:

If you look back at the ‘70s when abortion legalization took place, abortions are going up, unwanted pregnancies are going up, everything is going up. It’s going up. So I think the system is not working. Do I have an answer? I don’t have a good answer.

Jack Hurst and the other obstetricians who expressed most strongly their pleasure in delivering babies, were either negative, or silent, about abortion and contraception. One obstetrician in his seventies in Newborough who gave a poignant description of his joy at “seeing that first crying, bright eyes of the baby,” is well-known among his colleagues for refusing to prescribe contraception to his patients. Similarly, William Saunders, also in Newborough, commented that he enjoyed his profession because “You deal with life and creation more than death and dying, which was not something I cared to deal with.” This remark, when considered along with his waiting room, which contained many Christian magazines, would suggest to me, and perhaps other women frequenting his office, that William Saunders was not eager to participate in pregnancies that did not enable him to “deliver babies,” and specifically, pregnancies that ended in abortion. So, if obstetricians have invested most of their personal satisfaction in delivering babies, they may be less eager to be involved in a woman’s pregnancy when a baby welcomed by a grateful family is not the outcome.

I have spoken of the silence about contraception and abortion that exists in many of the obstetricians’ narratives, particularly those who most enjoyed “delivering babies,” and I mentioned that these narratives are most clearly marked with a legacy of equating women with willing mothers. I want to turn now to several of the obstetricians’ narratives which, in the wake of the women’s movement in the 1970s, are structured around alternative conceptualizations of women. Contraception and abortion occupy prominent places in several of the obstetricians’ narratives. In fact, providing contraception and abortion services is so central to some obstetricians’ satisfaction in their careers that it is as if their career narratives had been written in direct opposition to those I described earlier, in which “delivering babies” was a key theme. Gordon Dubois described the highlights of his career

as a public-health oriented obstetrician in Westview as follows, and mentioned nothing about “delivering babies:”

I’ve had a rather eclectic career, I think, almost ten years at the Institute doing public health and ob/gyn. That was fun, to be able to make important contributions that rapidly changed practice--with regards to abortion and family planning.

Gordon Dubois not only mentions contraception and family planning in his narrative, but cites them as being among the aspects of his career that are most gratifying.

Two other obstetricians whom I had interviewed, Dennis Pherson and Scott Graham, both in Westview, devoted considerable portions of their careers to work on contraception and abortion. The satisfaction of “delivering babies” is a theme that occupies these two obstetricians’ narratives marginally, if at all. When I asked Dennis Pherson what he had enjoyed most about his career, he responded,

I’d say the most enjoyable aspect of it has been the opportunity for me to pursue what I saw as one of the most important social--and later, from the point of view of my patients, personal, issues, that is, contraception.

He added later that he felt he could make a contribution through his career by making contraception and abortion widely available. Similarly, it was a concern about the adequacy of contraception and abortion, along with other “public health” issues, that propelled Scott Graham into obstetrics. Scott Graham recalled his experience overseas in the Peace Corps, saying that his concern about children’s malnutrition had eventually led him into obstetrics and gynecology, and that family planning issues were a second factor:

And the second part was dealing with problems of the young women I met who were in the Peace Corps at the time. There were significant numbers of reproductive issues that I had to deal with at that time, including abortions, illegal abortions, septic abortions, and family planning issues that people didn’t deal particularly well with, it seemed to me.

While the opportunity to deliver babies was a key motivating factor in some of the other obstetricians’ careers, it was the opportunity to help with the prevention of pregnancy that

led Scott Graham into obstetrics. This portion of his narrative also suggests that his ideas about “women” deviate from those traditionally held in obstetrics and gynecology. Scott Graham experienced women around him as colleagues in the Peace Corps; it seems that it would have been more difficult for him to sustain the traditional construction of “woman=willing mother” in the face of the experiences of his female colleagues, who apparently were not universally prepared to become mothers.

Another set of narratives disrupts the traditional construction of the announcement of pregnancy, and the birthing scene, by suggesting that these are not always uplifting events involving “life and creation.” In this way, the “motherhood” of the earlier books by obstetricians becomes a more fragmented and varied experience. Cindy Jacobs, in her fifties in Westview, talked about “the profound nature of everything in ob/gyn--delivering babies, life, death, childbirth...” For her, there were no concrete divisions between the aspects of obstetrics that involved life and joy, and those that involved death, loss and pain; all were intimately intertwined. Bruce Hinton’s description of his work contrasts with the overwhelming happiness in obstetrics that many of his colleagues described:

In obstetrics and gynecology, we deal a lot with loss--for example, women who are infertile are constantly dealing with loss...So we deal a lot with depression, loss, mourning, death...And the beauty of obstetrics and gynecology...is that you deal with the whole gamut of emotions, all day. And you can, in one instance, deliver a baby and have absolute joy and elation--the start, the beginning, of one family--and then you leave and come back to the office and there’s a patient who has been trying to conceive for five years, and she finally succeeds and she’s in your office, and she’s bleeding, she’s having a miscarriage, and then you go from elation to despair in fifteen minutes.

In Bruce Hinton’s narrative, the “joy and elation” of delivering a baby become just one component of obstetrical practice. Death and loss are not invisible, and are inevitable, in his narrative, and he finds the “gamut of emotions” in obstetrics rewarding.

I have suggested in an earlier section that women appeared in obstetricians' writings in predictable ways: they were forever "expectant mothers," either happily expecting, or expecting to be expecting. Some of the obstetricians' narratives that I have described here disrupt this narrative, either by suggesting via references to contraception and abortion that women need not always be mothers, or by proposing that death and loss go hand-in-hand with reproductive life for women. I want to turn now to suggesting that many of the contemporary obstetricians' narratives work to dismantle the traditional construction, within obstetrics, of the uniform, monolithic WOMAN. Many obstetricians took pains to describe differences between the women they saw in their practices, and they rarely made sweeping statements or generalizations about "women." For example, when talking about how he addresses issues about weight gain, Paul Garrison, in his fifties in Newborough, said, "Patients are different--you don't treat them all the same way." That his patients are "different" from one another is something that Paul Garrison also expressed in other portions of his narrative. When I asked him to describe the patient population that he sees, his lengthy answer included the following description of the differences he sees between patients at his three private practice sites:

The Centreville patients are suburban kind of people, but even far suburbs--rural. They're into tennis and horses, you know, gardens, things like that...We see farm people. You tell someone not to lift after they have their new baby, and it's calving season, and when they see a calf being born out the kitchen window, they have to go out and pick the calf up and put it in the barn. And they just had a baby last week [chuckles]...

Downtown Newborough, a lot of elderly well-to-do women who live in the towers across the street, a lot of women who work downtown, they work for Blue Cross, Blue Shield, they themselves are professional people, attorneys, accountants, um, real estate women, and they come to our office, and then we draw from the suburbs. A lot of university people, nurses from the hospitals, researchers and PhDs...

And then, this office is probably a more typical suburban office. The people are forties, fifties, successful, kids raised, finished college, building their new smaller home in the suburb, or the successful young couple, you know, he's a lawyer, she's a schoolteacher, they're both schoolteachers, working couples, and they've been in their starter home or their flat, and they're building their development home in Lakeview...

In the above excerpt, Paul Garrison appears to think of his patients primarily as “patients” or “people;” it is not at all apparent from the above excerpt that he sees only women in his practice. In addition to the fact that “women,” as a category of people, are not especially conspicuous in his narrative, women-as-mothers is not a prominent theme in his description of his patients; he seems to focus more on his patients’ identities as middle-aged or elderly people, or as part of a “successful young couple.” Paul Garrison is clearly aware that the women who see him have identities other than as mothers; in his imagination, they also lift calves, train horses, argue cases in court, and flip burgers. What I am trying to suggest is that, in a narrative like Paul Garrison’s, where differences between women are narrated with exquisite detail, the themes of motherhood and sex-specific reproductive biology that I showed were so prominent in earlier obstetricians’ writings, drop into the background. Emphasis on sexual difference is replaced by emphasis on social and economic differences--although this shift is not an unproblematic one, as I will show later.

Like Paul Garrison, other obstetricians frequently described differences between their patients, and they were often especially attentive to ethnic and economic differences. Gordon Dubois, based in a public hospital in Westview, noted the following about the patients he sees:

It’s a very heavily immigrant population. The major ethnic groups include Hispanics, Asian-Americans, a small proportion of Caucasians. Among the most common languages spoken will be Spanish, Cantonese, and Mandarin. We also have a very large Russian population in the city, and a very diverse cultural makeup, both patients and staff.

What Gordon Dubois found most compelling to communicate to me, then, were the ethnic and cultural differences among his patients. As in Paul Garrison’s description of his patients, in Gordon Dubois’s narrative, it is not especially apparent that his patients are “women,” and the differences within this category are given much more attention by this obstetrician than the similarities. Other obstetricians tended to focus on the uniqueness of

different patients' reactions and emotions. A Newborough obstetrician in her fifties, Mary Mishler, for example, said, "I can deliver someone four times and it's a different reaction, four times." Inherent in her statement is an appreciation for the possibility of varied emotions in response to pregnancy and childbirth, rather than these being experiences of women that can be characterized in universal terms. Walter Morris, also in his fifties in Newborough, expressed a similar understanding of women's varied experiences with pregnancy:

Different women want different kinds of support, anywhere from very independent women who are sure it's okay and they're in and out in twenty seconds, they want to go back to work, or there are some people who are very dependent or intellectual, and they have all these thoughts or questions that can't be answered. Or they're kids, who don't even know they're pregnant, who have no concept of what's happening to them or what will be happening to them. It's quite dependent on the individual.

Especially in terms of their needs and what they will ask of him, Walter Morris perceives his patients as quite different from one another, and he is reluctant to generalize about how he interacts with them.

I want to point out briefly that obstetricians' articulations of difference, while they tend to fragment the monolithic WOMAN constructed by earlier obstetricians, are not entirely unproblematic. I am unable to give this topic the fuller treatment that it deserves, but I want to mention that obstetricians' constructions of the race, class, gender, and financial status of their patients intersect in complex ways. For example, some obstetricians tended to characterize their indigent Hispanic and African-American patients as "lazy" and "uneducated," while private-practice white patients were praised for having exceptionally valuable health behaviors. But a shift by obstetricians, from emphasizing the similarities among women to the differences between them, doesn't necessarily mean retreating to negative stereotypes. Several obstetricians' articulations of difference seem to be consciously formulated in response or reaction to negative stereotypes of race, poverty,

and class. For example, one obstetrician was eager to shift the responsibility for health problems away from poor women and onto the system that serves them, saying that it is “our challenge” to serve them well.

To summarize, statements in which women are perceived by obstetricians as unique and varied, contrast with a monolithic conceptualization of women held by an earlier generation of obstetricians. This contrast can best be appreciated by recalling the words of one obstetrician, William Sweeney, whose autobiography *Woman's Doctor* I discussed in an earlier section. Sweeney represents this previous generation and is much more willing to see women and their pregnancy experiences as uniform:

It's a happy specialty. The patients are happy people to work with. And at the age of fifty I still get a bang out of delivering a baby. It's just a gorgeous, glorious thing. And honest to God, the greatest worry these ladies have is about their child, and this is what makes women beautiful.

(Sweeney 1983: 29)

Here, the patients are inevitably happy, undeniably female, and have a shared set of concerns, ie. they are most worried about the baby. Sweeney easily generalizes about women as a group--women are beautiful because they put their children first--and he doesn't communicate any differences that he sees among them. The articulation of differences among women by the obstetricians I interviewed suggest a shift in obstetricians' narratives, from concerns with the general, the sex-specific, to concerns about the unique and the particular.

Constructing the “woman-obstetrician” and the “lady urologist”

I have already remarked that, in contemporary obstetricians' narratives, the construction of women as mothers is not nearly as prominent as it was in obstetricians' texts from earlier in the century, nor are women generally constructed in a homogeneous

and totalizing way. In addition, there is a new kind of construction of women that appears in the narratives of obstetricians I interviewed: the construction of women as physicians and specifically as obstetricians, and the attempted construction of another new figure, the “lady urologist.” In this section, I will trace the constructions of these two figures, and the relationship between them.

As I noted earlier, the obstetricians who appear in all of the advice books and annual speeches that I have studied are overwhelmingly male. None of the advice books were written by female obstetricians, and none contained so much as a passing reference to the possibility that an obstetrician might be a woman (or vice versa). Since the 1970s, women have, however, entered the specialty of obstetrics and gynecology in increasing numbers.² I asked the obstetricians I interviewed whether or not they had noticed changes in the practice of obstetrics as women had entered the field in significant numbers, and this question elicited lengthy narratives and diverse emotional responses to the presence of women as practitioners in obstetrics. Most of the obstetricians’ narratives centered around an argument about whether or not women made better obstetricians than men. I want to sidestep proposing that there is an ultimate answer to this question, and describe instead, how the woman obstetrician is constructed in and through these arguments.

Some obstetricians, especially the women, felt that being a woman endowed an obstetrician with favorable qualities. Mary Mishler, the first female obstetrician in Newborough, said, “In general, I think that women physicians in ob/gyn care more about their patients.” Women were sometimes described as more caring or more sensitive. Sandra Levinson, a woman in her thirties in Westview, compared the greater sensitivity of women obstetricians to some men. She recalled:

I was in residency and I remember a male physician doing an endometrial biopsy without anesthesia. The woman was in complete pain, and he was telling her, this doesn't hurt you. For the most part, I would say a woman wouldn't do that.

Women are not likely, in Sandra Levinson's view, to display such crass insensitivity to their female patients' pain.

Frequently, though, obstetricians depicted the women among them as not significantly different from the men. Scott Graham, in his fifties in Westview, thought that change was on the horizon in obstetrics, but that it would not necessarily result from a difference in the gender of those who provide obstetrical care:

I think change will happen if more people give thought to what their direction will be. That probably will be led by women, but it won't be led by women obstetrician-gynecologists, necessarily...I think the problem with many women in the field is that they are trained by, they learn to think like, and they become just like each other...I think that radical change will have to come from another place, and I think not just because of women, but because of public health thinking, it's really non-ob/gyn thinking.

In Scott Graham's mind, gender alone is not sufficient to lead to dramatic shifts in perspective within obstetrics. According to him, other factors, such as the type of training and the theoretical basis of practice, have at least equal influence in determining who will be capable of effecting change within the field. Cindy Jacobs, a woman in her fifties in Newborough, added that, during her residency, "...a lot of the women may as well have been men." Michelle Harrison, family practitioner and author of *A Woman in Residence*, concurred that the training for obstetrics and gynecology overwhelms bonds that are based on gender similarity:

Carol, Jackie and Joan had all come to OB wanting to change the way that women were treated. For women physicians with such a perspective, the daily assault on female patients they have to watch and take Part One is painful, confusing and isolating. It is often difficult for women to make the transition that is required of them: from identifying with a sister to seeing her impersonally, as a patient. Unfortunately, most often they do not make the transition, and the attitudes of female obstetricians and gynecologists are indistinguishable from that of their male colleagues.

(Harrison 1982: 92)

Harrison elucidates how the same kind of training results in the same kinds of practitioners, regardless of their gender. Her point of view, as well as that of others that I described here, might be described as follows: obstetrics is a huge machine-like apparatus which draws potential practitioners in and homogenizes the differences between them so that, in the end, they practice alike. The female obstetrician who is required to act upon other women's bodies in the same way that male obstetricians traditionally has, apparently can inherit his perspective and attitudes as well as his technical skills.

Harrison's description also constructs what I will call the "woman-obstetrician;" that is, in her imagination the female practitioner of traditional obstetrics is a hybrid of two entities which can never be completely reconciled with one another. For Harrison, being a woman and practicing obstetrics by United States standards are inherently irreconcilable--so much so that Harrison eventually dropped out of the obstetrical training program. Being both a woman and an obstetrician requires practicing two kinds of seeing simultaneously, an impossible task. The hybrid of "woman" and "obstetrician" must "identify with a sister" in addition to "seeing her impersonally, as a patient," a feat of double vision not required of her male colleagues. The strain of simultaneous objective and subjective experience of other women leads either to the woman-obstetricians becoming indistinguishable from their male colleagues, or, as in Harrison's case, to leaving obstetrics. The opposition and antagonism between the two realms of being and seeing of the woman-obstetrician is a theme that runs throughout Harrison's writing. Other obstetricians presented, in practical and concrete terms, the identities of woman and obstetrician in conflict with one another. As I described in a previous section, several of the women described a difficult juggling act of trying to raise children and be available at all hours for their patients. They felt that the practice of obstetrics was not set up to be accommodating to persons who occupied identities in addition to that of obstetrician (for example, "parent" or "mother").

In some cases, the woman-obstetrician was constructed as a physician who not only lacked any advantages related to having the same gender as her patients, but she might actually have less to offer than her male colleagues. Paul Garrison, in his fifties in Newborough, sounded somewhat resentful as he described female obstetricians in the following way:

I think people perceive--they have misperceptions--that a female would be more understanding, she'd know more, she'd know what having a baby is like because she's a female. If she's just getting out of medical school and out of her training, and she's never had a baby, then she doesn't know much more...

Paul Garrison went on to say that men who have had experience by proxy, ie. they have watched women give birth, may actually be more qualified for practice than women who have less personal experience with birth. Ideas about the qualifications of women that are based on their gender are classified by Paul Garrison as "misperceptions." He sees women as no more understanding, and possibly even less so, as a result of being women. Other obstetricians, particularly some of the men, intimated that the popularity of female obstetricians sometimes substitutes for skill. Samuel Chandler, in his seventies in Newborough, for example, said, "I've seen female doctors, with very poor training and very poor skills, gain huge numbers of patients in a very short time, because they were female." Samuel Chandler and other male obstetricians, tended, in the interviews, to cast a suspicious eye on the female obstetrician. The possibility that she was unqualified, and simply popular--an impostor, really--hovered over the interviews. Some saw the desire of women patients to have a female physician as a trend or a fad, much like a style of shoes or a haircut, and was something that would pass or fade eventually. Lloyd Alcott, for example, in his forties in Westview, thought that while some women wanted a female obstetrician for "legitimate" reasons, such as a history of sex abuse, other women, he thought, wanted female obstetricians to be chic and gain the approval of their friends. The popularity of women physicians among women patients seems to have triggered questions,

particularly by the men, about the competence of female obstetricians generally, perhaps because the male obstetricians have felt financially threatened by the prospect of more popular female colleagues. A number of the male obstetricians commented that having to compete with female practitioners has had a detrimental effect on their practices.

Female obstetricians sometimes seemed to represent, in the imaginations of male obstetricians, a decline in the practice of medicine generally. Often, when they talked about female obstetricians, male obstetricians lamented what they saw as the deteriorating standards of the practice of medicine. ("There goes the neighborhood!") William Saunders, in his sixties in Newborough, for example, said:

They [female obstetricians] don't want to work as hard in terms of putting in the time and the hours...They are not as interested in or needing of so much money, because they generally have a husband who's a professional of some sort. It causes a change in the way that medicine will be practiced in general, women willing to deal with the salary-type jobs...

Here, women are constructed as always married, likely to be supplementing a professional husband's wage with "pin money," and not terribly hard-working. William Saunders's statement about "salary-type jobs" represents the loss of autonomy and proletarianization of physicians that have embittered many older physicians; women are perceived as willing to accept less autonomous jobs that would never have been acceptable to professionalized, male physicians. Sometimes obstetricians I interviewed seemed anxious not to appear to disparaging of their female colleagues, but they nonetheless expressed opinions that the changes that women brought to the field were not beneficial ones. Paul Garrison, for example, in his fifties in Newborough, said, "It's not that they're not reliable, but they have other priorities that compete with medicine...A male is likely to practice obstetrics for ten years longer than a female..." Female obstetricians were thus perceived as not as likely to contribute as much to the field as men. Finally, constructing the female obstetrician through these interviews also involved re-constructing the male obstetrician, whose gender

is now apparent and brought into the light. For example, comparing male and female obstetricians, Andrew Kushner, in his fifties in Newborough, said, "I think some of the males tend to be more aggressive in terms of forceps use and surgical scheduling, maybe." Nancy Jordan, in her forties in Newborough, said, "I have two male partners. They [patients] complain, men don't talk to them, they don't listen. They see more patients an hour, in general, than most women physicians." With the female physician constructed as caring and sensitive, the male obstetrician is co-constructed as terse and efficient.

For some reason, discussion of the figure of the "woman-obstetrician" seemed to invite several male obstetricians to construct the additional figure of "lady urologist." Robert Sloan, in his seventies in Newborough, said, "I think great openings exist for the lady urologist, because most urologists are men right now." After I had finished the formal questions in another interview, with Samuel Chandler, also in his seventies in Newborough, he and I had the following informal conversation, which was tape-recorded. I think it illustrates another attempt to construct a "lady urologist," and also illustrates how the dynamic of the interview was occasionally reversed by the interviewee:

Samuel Chandler: Would you, as a woman, go into urology?

KF: I guess right now, I can only speculate, having never done urology--

Samuel Chandler: The only reason I'm turning the tables on you and asking you that question is because it's pretty much the same as, in my day, when a man went into gynecology, because you dealt mostly with females, whereas a woman going into urology would deal mostly with males.

KF: Hmm.

Samuel Chandler: Think about that, whether you're psychologically able to make that adjustment. That's put you in the place of a male making the adjustment to deal only with women.

KF: Hmm.

Samuel Chandler: You never thought of it that way, did you?

KF: No. I guess I haven't felt a particular draw toward urology, that I've had no exposure to it, I suppose--

Samuel Chandler: Right. It's almost been a male domain in which very few women get to see how it works, so they don't choose it. I mean, there's nothing wrong with a woman doing urology, and nothing wrong with a woman doing it well, and most men would accept a woman doing urology as well as a man. But there's this perception that they wouldn't. And there's this perception that women shouldn't be doing urology. 'Cause it's

too forward a field for women. You never thought about that, heard about that?

KF: I think my lack of exposure at this point--

Samuel Chandler: If you go around and look at the training programs and see how many women are in them. And you see that there are very few. And you to say, why is that? I mean, women go into radiology, women go into surgery, women go into neurosurgery, dermatology, everything. Why not urology? [emphasis his]

KF: I don't know. I'll keep my ears open, though.

In this portion of the interview, I attempted to respond to Samuel Chandler's questions with answers that reflected my perspective as a medical student, but that did not divulge very much about my biases regarding different subfields of medicine. I wanted to give him an opportunity to say as much as possible about what was troubling to him about the absence of women in urology. Using Samuel Chandler's and Robert Sloan's comments, I want to explore why they and other obstetricians may want to talk about urology in the same sentence as obstetrics and gynecology, and what underlies their construction of the "lady urologist." Obstetricians such as Samuel Chandler and Robert Sloan presumably want to offer urology as a parallel to obstetrics and gynecology; their logic is, as Samuel Chandler says above, that obstetrics addresses the health of women, and urology addresses the health of men, so that a female practitioner of urology is in a situation parallel to that of men in obstetrics. My interpretation is that this is a false parallel for two reasons: first, my perspective as a medical student tells me that urologists have primarily, but not solely, male patients, since about 20% of patients in a typical urology practice are female.³ In obstetrics and gynecology, on the other hand, the patients are always female. So a urologist actually sees patients of both genders, while an obstetrician is assured of seeing only women. Second, my perspective as a woman and a feminist leads me to think that a female urologist could never occupy a position comparable to that of a male obstetrician, since historically men have always been in power in obstetrics, but women have never occupied positions of similar power in institutionalized medicine, and certainly not in urology specifically. But why do obstetricians such as Samuel Chandler and Robert Sloan offer this parallel, and

even persevere on it? As older, male obstetricians whose positions appear to be threatened by the influx of women into medicine, Samuel Chandler and Robert Sloan seem to recognize that the very presence of men as practitioners of obstetrics and gynecology is being questioned by female patients. Constructing the "lady urologist" may be a way of defending their own positions as male practitioners in a women's health field. These two obstetricians seem to fear that the absence of women from urology is an implicit critique of the presence of men in obstetrics. Samuel Chandler appears to want desperately to see more women in urology, and it is as if their presence in urology would legitimize his own position as a man in obstetrics and gynecology. I felt quite certain that both obstetricians would have been relieved and enthusiastic if I had expressed a desire to become a urologist! The construction of the "lady urologist," then, may serve to reassure these practitioners that it's possible to be a gender-blind practitioner in a gender-specific medical specialty.

As women are constructed by obstetrical discourse for the first time as practitioners, and not just as patients, tension, hostility, and ambivalence surround some of the constructions of this new figure. The figure of the woman-obstetrician is perceived, in some ways, as a threatening one, and not only in the relatively private context of my interviews. A recent Wall Street Journal headline queried: "The Male Gynecologist: Soon to Be Extinct?" (Gerlin 1996). Behind this headline is the same fear that was expressed by so many of the male obstetricians I interviewed: the woman-obstetrician is taking over the field. Many of the interviewees cited, in support of this sentiment, a fairly well-known statistic, that fifty percent of resident obstetrician-gynecologists in 1996 are female. At the same time, another statistic--72% of practicing obstetrician-gynecologists are male--draws little attention. The idea that the "woman-obstetrician" may *someday* appear in numbers equal to those of their male colleagues seems to have been interpreted as the *present takeover* of the field by women. Such anxieties about the disappearance of the male

obstetrician, and the emergence of the female obstetrician, seem to underlie obstetricians' constructions of the both "woman-obstetrician" and the "lady urologist."

Notes

Introduction

1. I want to briefly explain these technologies. Amniocentesis is a procedure in which a needle is inserted through a woman's abdomen, and fluid is drained from the amniotic sac surrounding the fetus, for the purpose of detecting genetic problems in the fetus. Chorionic villus sampling is also a procedure which detects some genetic defects in the fetus, and it entails removing a small sample from the placenta. Ultrasound is a technique of using sound waves to produce a visual image of the fetus within the woman's uterus. Electronic monitoring of the fetus involves the insertion of an electrode into the fetus' scalp during labor, in order to assess the fetus' heart rate. These brief descriptions are adapted from Felicia Stewart et al. (1987) *Understanding Your Body: Every Woman's Guide to Gynecology and Health*, and Neville F. Hacker and J. George Moore (1992), *Essentials of Obstetrics and Gynecology*, 2nd Edition.
2. See, for example, Ellen Lazarus (1994) and Emily Martin (1987).
3. Jane Donegan (1978) and Jean Donnison (1977) provide two examples.
4. Exceptions include the work of Diana Scully (1980) and Robbie Davis-Floyd (1987).

Chapter 1: Method and Methodology

1. See, for example, Adrienne Rich (1976); Barbara Katz Rothman (1982); Robbie Davis-Floyd (1992); Ellen Lazarus (1994).
2. This is not to suggest that this myth represents the actual experiences of women; women's actual childbirth experiences are shaped and constrained by an enormous number of factors, including women's varying economic circumstances and access to health resources (Lazarus 1994). I am suggesting that there is a dominant cultural narrative, which is widely available to women and is often re-represented and re-entrenched through television and films, of obstetrician-attended, hospital-based, childbirth.

Chapter 2: The Obstetrician Imagines Himself and His Role

1. The first volume of the *American Journal of Obstetrics and Gynecology* was published in 1920. It had been preceded by the *American Journal of Obstetrics and the Diseases of Women*, and there was a brief hiatus in 1919 between the publication of the two journals.
2. Sol T. DeLee's book contains a dedication to the prominent Chicago obstetrician of the late nineteenth and early twentieth century, Joseph B. DeLee, who was his uncle. Joseph B. DeLee was well-known for, among other things, his paper on prophylactic forceps operations.
3. For example, Frank W. Lynch (1934), in a presidential society address entitled "The License to Practice Medicine," argued that the medical school training for obstetrics was

inadequate and that licensure should be required of practitioners of obstetrics and gynecology.

4. When the profession of obstetrics and gynecology agreed upon the standards for certifying its practitioners through the American Board of Obstetrics and Gynecology, certification as an obstetrician-gynecologist was only available to a select few. Sumney and Hurst (1986: 109) cite census data which showed that, for example, there were 2000 obstetrician-gynecologists nationwide in 1946, for three and a half million births. They also say: "In 1954, there were 158 general practitioners and 17 specialists for each 10,000 births." In other words, while my discussion in this paper is devoted to the specialists of obstetrics and gynecology, in actuality, a large number of births have been attended by general practitioners.

5. Obstetricians adopted, but did not originate, the concept of prenatal care. Prenatal care appears largely in the twentieth century, and was begun by the nursing profession. Obstetricians and life insurance companies then co-opted the concept and practice of prenatal care. For a brief treatment of this topic, see Speert (1980: 143-145).

6. The American Association of Obstetricians and Gynecologists was originally founded in 1888. In 1920, the group changed its name to the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons in 1920. In 1954, the name was changed back to the original form (Speert 1980: 121).

Chapter 3: Obstetricians Construct "Womanhood" and "Motherhood"

1. I have not included constructions of fatherhood in my main discussion. It is not that fatherhood is *unconstructed*, but that it is constructed by obstetricians as a minimal and accessory function of men. Fathers are often considered in the very last sections of obstetricians' advice books, as if to convey that fatherhood is something of an afterthought. When fathers are finally discussed, they are subject to some of the same paternalistic intonations to which women are subjected, but in a less exaggerated form. For example, Frederick Goodrich, in his 1959 book, *Maternity: Guide to Prospective Motherhood*, adds onto his text a list of "do's and don'ts" for fathers (p. 120-121) that is not unlike the laboriously detailed instructions given to women. While frequently women are constructed as being potentially irreponsible and guilty of harming their relationships with their husbands and children, men are not necessarily free from obstetrician's harsh criticism and blame. Frederick C. Irving, in *The Expectant Mother's Handbook* (1932), wrote:

A man who has had gonorrhoea should undergo a careful examination before marriage. If it is found that he is free from all evidences of the disease and has been so for some time, he may marry. On the other hand, should it be discovered that traces of the infection still linger, he must postpone marriage until such time as he will cease to be a menace to his wife and future children. (p. 95)

Fathers also appear as potential allies in the obstetrician's goal of "safeguarding motherhood." The father, in Sol T. DeLee's mind, is the ideal enforcer of the rules of pregnancy: he can help his wife cooperate with the obstetrician and instruct her on how to handle pregnancy--for example, by enforcing early bedtimes. In the next section, I discuss DeLee's mimicry of the intimacy of husband and wife in his formulation of the relationship between a woman and her obstetrician. In general, there is less unanimity when obstetricians discuss fatherhood, and they do not attempt to speak about it in a single, unified voice.

2. Castallo's emphasis on the importance of motherhood to society finds a parallel in the glorification of motherhood in Nazi Germany. At roughly the same time that Castallo's book was written, the Nazi regime bestowed medals upon Aryan women who produced more than five children, and saw the childbearing woman as a key piece of constructed a populated Aryan nation. For the Nazi regime, there was a clear link between the production of healthy and fit Aryan citizens by women, and the success of an Aryan society.

Chapter 4: Contemporary Obstetricians Imagine Themselves

1. Walter Morris is a pseudonym. Where other obstetricians' names appear, they are also pseudonyms to protect the confidentiality of the people I interviewed.
2. Sandra Levinson also said "I always give people a mirror during the exam to let them see themselves..." This is a gesture which Sandra Levinson borrowed directly from the women's health movement, and it further strengthens my claim that she represents a cluster of mostly female obstetricians (and other physicians, too) who were directly influenced by the language and philosophy of this movement. One of my medical school professors, an internist in her thirties, once joked in an all-female setting about a practice of hers that was a carryover from "the *Our Bodies, Ourselves* days."
3. It is helpful here to recall the etymology of "midwife." The American Heritage Dictionary gives the derivation of "midwife" from the Old English *mid*, or "with," and *wif*, or "woman," so that the word literally means "with woman."
4. In the 1990s, midwives, nurse practitioners, and physician assistants often appear in popular discourse as "physician extenders," and have attracted attention within health policy circles because they are seen as a less expensive alternative to physicians. The focus tends to be on their "inexpensive labor," rather than on any special skills that these groups of practitioners have. See, for example, Kathleen Doheny's article in the Los Angeles Times (March 6, 1996): "A Sign of the Times in Health Care--the Doctor Extender Is In."

Chapter 5: Constructing the Woman Patient and the Female Obstetrician: 1970 and Beyond

1. Most ob/gyns don't practice obstetrics for their entire careers. They generally quit practicing obstetrics, and restrict their practices to gynecology, on the average, at age forty-eight, according to one of my informants. The physically exhausting and time-consuming nature of the practice of obstetrics are commonly cited as reasons for quitting obstetrics.
2. For example, as noted in a recent article by Andrea Gerlin in the *Wall Street Journal* (February 6, 1996), the percentage of female residents in obstetrics and gynecology rose from about 30% in 1980 to 60% in 1995.
3. This statistic is based on information given to me by one of my interviewees.

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Appendix

Interview Questions

Characteristics of practice

1. Tell me about your practice. Do you presently practice obstetrics, gynecology, or both?
2. How long have you practiced? When did you train in ob/gyn?
3. Do you practice in an academic center, public hospital, private hospital, private practice, HMO, etc'?
4. How would you describe the patient population you generally see?

Motivations for entering medicine and choosing obstetrics/gynecology

1. At what point in your life did you decide to become a physician? An ob/gyn?
2. Can you think of experiences (personal or professional) that influenced your decision to go into ob/gyn?
3. If you had to name 3 or so things that you have enjoyed most about your career, what would they be?
4. Can you describe some of your frustrations with ob/gyn during your time in the field?
5. If you could change something about your present career, what would it be?
6. In spite of any frustrations, what has motivated you to keep practicing?
7. Thinking back to your training in ob/gyn, were there any aspects that you found challenging and frustrating? How would you change the medical school preparation and/or residency in ob/gyn?
8. Would you choose the same specialty again? Why/why not?
9. How much, if at all, do you find that your practice infringes on your life at home? To what extent does your daily practice shape your life at home? Or to what extent do aspects of your home life and personal experience shape your professional practice? Can you discuss the relationship between your home life and work life?

Narratives in obstetrics and gynecology

10. Would you describe how you perceive your role in childbirth?
11. Suppose that you wanted to use anecdotes from your clinical experience to illustrate to a medical student:
 - a) a satisfying moment in your career
 - b) a disappointment.

Can you relate those anecdotes?

12. Would you describe your general approach to a patient with the following psychosocial issues:
 - a patient who is using crack when she finds out she is pregnant
 - a patient who is reluctant to gain weight because she wants to remain slim
13. Can you describe how your patients, in general, react to you?

Priorities and changes in obstetrics/gynecology

14. If you personally had the power to change 2-3 things in the lives of your clients/patients, what would you change?
15. In the 1990s, what areas within obstetrics and gynecology would you see as most deserving of attention or research money?
16. Some people have suggested that many changes will occur in obstetrics and gynecology with increasing numbers of women entering the field. Do you agree? Why? Why not? What kinds of changes would you predict?