WOMEN, HEALTH AND MEDICINE

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Until pregnancy and childbirth were defined as medical events, midwifery was in no sense a branch, area or interest of medicine as a profession. The expansion of scientific medicine converted normal physical changes of pregnancy and others into medical problems devoid of their larger socio-emotional content. The displacement of the midwife by the male obstetrician resulted not from any ideological struggle or 'scientific' advancement but from the control that physicians exercised through their professional associations. The treatment of the body as a machine and the lesser functional importance assigned to women constituted a basis for exercising the overt social control over women through the surgical removal of her various sexual organs and by creating physical deformities in her. The author argues that the alternative to the mechanical model of taking the female system as a complication of so-called biological stability of the non-cycling male, is to take the female as working norm for the female system.

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Women are not only people: *woman* is a subject one can study, even specialize in within medicine. Obstetricians and gynecologists are medicine's and perhaps society's generally recognized "experts" on the subject of women, especially women's bodies: our health, reproductive functioning, and sexuality.[1] Obstetrics is the branch of medicine concerning the care of women during pregnancy, labor, and the time surrounding childbirth,[2] similar in some ways to midwifery. Gynecology is the "science of the diseases of women, especially those affecting the sex organs."[3] There is no comparable "science" of the study of men, *their* diseases and/or reproductive functions. An attempt by urologists in 1819 to develop an "andrology" specialty came to nothing.[4]

At its simplest, we can think of a medical specialty as arising out of pre-existing needs. People have heart attacks: the medical specialty of cardiology develops. Or the amount of knowledge generated in a field grows so enormously that no one person can hope to master it all: physicians "carve out" their own areas of specialization. Increasing knowledge about cancer thus led to the specialty of oncology, and subspecialities within oncology.

But the development of a medical specialty is not necessarily the creation of a key for an already existing lock. Medical "needs" do not necessarily predate the specialty, even though the specialty is presumably organized to meet those needs. This has been made quite clear in the work of Thomas Szaz on the relatively recent expansion of medicine into such "social problem" areas as alcoholism, gambling and suicide.[5] Medicine doesn't have the "cures" for these problems but by defining them in medical terms, as sickness, the physician gains political control over the societal response: punishment becomes "treatment", desired or not, successful or not. Similarly, medical control over childbirth, lactation, menopause, and other women's health issues was not based on superior ability to deal with these concerns.

The case of Jacoba Felice de Almania, a woman tried for the illegal practice of medicine in 1322 illustrates this point. In her defense Jacoba Felice de Almania had witnesses who testified that she never charged unless she cured, and that her cures were successful where other "legal" (male) practitioners had failed. However, since she had not attended a medical school (medical schools being closed to women) she was not licensed to practice medicine. That she saw women who did not want to go to a male practitioner, that she was successful did not matter. "Efficacy of treatment was not the criteria for determining who was or was not a legitimate medical practitioner, but the educational requirements and membership in the faculty of an organized group were the most important factors."[6] In essence, what professional control over medicine says is, "We may not be able to help you, but we are the only ones qualified to try."

Vern Bullough, in his analysis of the development of medicine as a profession, writes that during the middle ages, "One obvious group outside of the control of the university physician was the midwife, but during the period under study the university physician generally ignored this whole *area of medicine*. Midwives might or might not be qualified, but this *was not a matter of public concern*. (emphasis added)".[7] More accurately, one might state not that physicians ignored this "area of medicine," but that midwifery and its concerns were outside of medicine, just as matters that were

undoubtedly of concern *to women* existed outside of the "public" concern. Until pregnancy and childbirth were defined as medical events, midwifery was in no sense a branch, area, or interest of medicine as a profession.

Medical expansion into the area of childbirth began before the development of asepsis, surgical techniques, anesthesia; any of what we now consider the contributions of obstetrics. And yet, even without the technology, by the beginning of the nineteenth century medicine had begun the redefinition of childbirth from a family or religous event to a medical one, needing medical presence for its safe conduct.[8]

Midwives treated childbirth in the larger context of women's lives. Midwives did not and do not deliver babies. They teach women how to give birth. Brack has called the role of midwife "total" —she helped in the socialization of the mother to her new status, both as teacher and as role model. "The midwife's relation to the woman was both diffuse and affective, while the physician role demanded specificity and affective neutrality".[9] Midwives taught how to birth babies, how to nurse them, how to care for the babies and for the mother's own body. Physicians deliver babies and move on. The physician "isolated the laboring woman and her delivery of the infant from the rest of the childbearing experience, and defined it as a medical and surgical event which required specialized knowledge."[10] As one modern nurse—midwife has said of obstetrics residents : "They want us to stay with the woman in labor and just call them when she's ready to deliver. To them, that's the whole thing."

At the time that physicians were taking over control of childbirth, it is virtually unarguable that the non-interventionist, supportive techniques of the midwives were safer for both the birthing woman and her baby. The physicians' approaches included bleeding to "syncope" (until the woman fainted), tobacco infusion enemas, frequent non-sterile examinations, and other surgical and chemical interventions.[11] In the 1910's and 20's, as American physicians successfully ousted midwives, the midwives' safety records remained better than the physicians. In Newark a midwifery program in 1914-16 achieved maternal mortality rates as low as 1.7 per thousand, while in Boston, where midwives were banned, the rates were 6.5 per 1000. Similarly, infant mortality rates in Newark were 8.5 per 1000 contrasted with 37.4 in Boston.[12] In Washington, as the percentage of births reported by midwives shrank from 50 percent in 1903 to 15 percent in 1912, infant mortality in the first day, first week, and first month of life all increased. New York's dwindling corps of midwives did significantly better than did New York doctors in preventing both stillbirths and post—partum infection.[13]

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The physician's separation of the "delivery" of the baby from its larger socio-emotional context has its roots as far back as Rene Descartes concept of mind-body dualism. To Descartes, the body was a machine whose structure and operation falls within the province of human knowledge, as distinguished from the mind which God alone can know. Though even the Hippocratic principles state that the mind and body should be considered together, "Experience shows that most physicians . . . irrespective of their professional activites and philosophical views on the nature of the mind, behave in practice as if they were still Cartesian dualists. Their conservative attitudes are largely a matter of practical convenience."[14]

The medical models used for convenience are that diseases are the bad-guys which the good-guy medications can take care of; that the body breaks down and needs repair; that repair can be done in the hospital like a car in the shop; and that once "fixed." the person can be returned to the community. The earliest models were largely mechanical; later models worked more with chemistry; and newer, more sophisticated medical writing describes computer-like programming; but the basic points remain the same. It was a useful model when dealing with the problems facing medicine at the turn of the century : primarily bacterial and viral disease-causing agents and simple accidents and trauma. It has never worked well for understanding the problems that women face in dealing with doctors, including the experience of childbirth. While midwifery was learned by apprentice, doctors were instructed in the use of forceps, as well as techniques of normal delivery, by "book learning," by discussion, the use of wooden models, and infrequently by watching another doctor at work. Wertz, in her study of the development of obstetrics, has pointed out that "By regarding the female body as a machine, European doctors found that they could measure the birth canal and predict whether or not the child could pass through."[15] Stories of women delivering while their doctors scrubbed for a Caesarian section were told, probably

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with much relish, and similar stories continue to be part of the lore of midwifery. Among the stories midwives tell each other are the tales of women who were told that they could never deliver vaginally, and then went on to have normal births of oversized babies.

In the nineteenth and early twentieth centuries midwives and physicians were in direct competition for patients, and not only for their fees. Newer, more clinically oriented medical training demanded "teaching material," so that even the immigrant and poor women were desired as patients.[16] The displacement of the midwife by the male obstetrician can be better understood in terms of this competition than as an ideological struggle or as "scientific advancement." Physicians, unlike the unorganized, disenfranchised midwives, had access to the power of the state through their professional associations. They were thus able to control licensing legislation, in state after state restricting the midwife's sphere of activity and imposing legal sanctions against her.[17]

The legislative changes were backed up by the attempt to win public disapproval for midwifery and support for obstetrics. Physicians accused midwives of ignorance and incompetence, and attacked midwifery practices as "meddlesome." Rather than upgrading the midwives and teaching the skills physicians thought necessary, the profession of medicine refused to train women either as midwives or as physicians.[18] Physicians argued repeatedly that medicine was the appropriate profession to handle birth because "normal pregnancy and parturition are exceptions and to consider them to be normal physiologic conditions was a fallacy."[19] Childbirth became redefined as a medical rather than a social event, and the roles and care surrounding it were reorganized to suit medical needs.[20]

Once professional dominance was established in the area of childbirth, obstetrics rapidly expanded into the relatively more sophisticated area of gynecology. The great obstetricians of the nineteenth century were invariably gynecologists[21] (and of course all men). Among other effects, this linking of obstetrics and gynecology further reinforced the obstetrical orientation toward pathology.

One of the earliest uses of the developing field of gynecology was the overt social control of women through surgical removal of various of her sexual organs. Surgical removal of the clitoris (clitoridectomy) or less dramatically, its foreskin (circumcision) and removal of the ovaries (oopherectomy or castration) were used to check women's "mental disorders." The first gynecologist to do a clitoridectomy was an Englishman, in 1858.[22] In England, the procedure was harshly criticised, and not repeated by others after the death of the originator in 1860. In America, however, clitoridectomies were done regularly from the late 1960's through till at least 1904[23] and then sporadically until as recently as the late 1940's.[24] The procedure was used to terminate sexual desire or sexual behavior something deemed pathological in women. Circumcisions were done on women of all ages to stop masturbation up until at least 1937.[25]

More widespread than clitoridectomies or circumcisions were oopherectomies for psychological "disorders". Interestingly the female gonads were removed not when women were "too female" — i.e., too passive or dependent, but when women were too masculine—assertive, aggressive, "unruly." Oopherectomies for "psychiatric" reasons were done in America between 1872 and 1946.[26] (By the 1940's perfrontal lobotomies were gaining acceptance as psychosurgery.)

The developing medical control of women was not limited to extreme cures for psychiatric problems. The physical health and stability of even the most well-adjusted, lady-like women was questioned. Simply by virtue of gender, women were (and are) subject to illness labeling.

One explanation for women's vulnerability to illness labeling lies in the functionalist approach to the sociology of health. Talcott Parsons has pointed out that it is a functional requirement of any social system that there be a basic level of health of its members.[27] Any definition of illness that is too lenient would disqualify too many people from fulfilling their functions and would impose severe strains on the social system. System changes, such as war, can make changes in standards of health and illness generally set for members. This works on an individual level as well, standards of health and illness being related to social demands, a mild headache will excuse a student from attending class, but not from taking final exams. A logical extension of this is that the less valued a person or group's contribution to society, the more easily they are labeled ill.

Women are not always seen as functional members of society, as people doing important

things. This has historically and cross—culturally been especially true of the women of the upper classes in patriarchal societies, where it is a mark of status for a man to be able to afford to keep a wife who is not performing any useful function. A clear, if horrifying example of this is the traditional Chinese practice of foot-binding. By crippling girls, men were able to show that they could afford to have wives and daughters who do nothing. It is a particularly disturbing example of conspicuous consumption. But we do not have to turn to faraway places to see women defined as useless. In Ehrenreich and English's historical analysis of the woman patient *Complaints and Disorders*, they speak of the late nineteenth and early twentieth century "lady of leisure." "She was the social ornament that proved a man's success; her idleness, her delicacy, her childlike ignorance of 'reality' gave a man the 'class' that money alone could not provide."[28]

The practice of creating physical deformity in women can be seen in our history as well. A woman researcher who studied menstrual problems among college women between 1890 and 1920 found that women in the earlier period probably were somewhat incapacitated by menstruation, just as the gynecologists of the day were claiming. However, she did not attribute the menstrual problems to women's "inherent disabilities" or "overgrowth of the intellect" as did the male physicians. She related it to dress styles. Women in the 1890's carried some fifteen pounds of skirts and petticoats, hanging from a tightly corseted waist. As skirts got lighter and waists were allowed to be larger, menstruation ceased to be the problem it had been.[29] In the interest of science, women might try the experiment of buckling themselves into a painfully small belt and hanging a fifteen pound weight from it. One might expect weakness, fatigue, shortness of breath, even fainting: all the physical symptoms of women's "inherent" disability. And consider further the effects of bleeding as a treatment for the problem.

It follows from Parson's analysis that in addition to actually creating physical disability (the bound feet of the Chinese, the deforming corsetry of our own history), women were more easily *defined* as sick when they were not seen as functional social members. At the same time in our history that the upper class women were "delicate", "sickly" and "frail," the working class women were well enough to perform the physical labor of housework, both their own and the upper classes as well as to work in the factories and fields. Because "...however sick or tired working class women might have been, they certainly did not have the time or money to support a cult of invalidism. Employers gave no time off for pregnancy or recovery from childbirth, much less for menstrual periods, though the wives of these same employers often retired to bed on all these occasions."[30] The working class women were seen as strong and healthy; and for them, pregnancy, menstruation, and menopause were not allowed to be incapacitating.

These two themes: the treatment of the body as a machine, and the lesser functional importance assigned to women, still account for much of the medical treatment of women.

Contemporary physicians do not usually speak of the normal female reproductive function as diseases. The exception, to be discussed below, is menopause. The other specifically female reproductive functions—menstruation, pregnancy, childbirth, and lactation—are regularly asserted in medical texts to be normal and healthy phenomena. However, these statements are made within the context of teaching the medical "management," "care," "supervision," and "treatment" of each of these "conditions."

Understood in limited mechanical terms, each of these normal female conditions or happenings is a complication, stress on an otherwise normal system. Medicine has fared no better than any other discipline in arriving at a working model of women that does not take men as the comparative norm.

For example, while menstruation is no longer viewed as a disease, it is seen as a complication in the female system, contrasted to the reputed biologic stability of the supposedly noncycling male.[31] As recently as 1961 the American Journal of Obstetrics and Gynecology was still referring to women's "inherent disabilities" in explanations of menstruation:

> Women are known to suffer at least some inconvenience during certain phases of the reproductive cycle, and often with considerable mental and physical distress. Woman's awareness of her inherent disabilities is thought to create added mental and in turn physical changes in the total body response, and there result problems that concern the physician who must deal with them.[32]

Research on contraception displays the same mechanistic biases. The claim has been made that contraceptive research has concentrated on the female rather than the male because of the sheer number of potentially vulnerable links in the female chain of reproductive events.[33] Reproduction is

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clearly a more complicated process for the female than the male. While we might claim that it is safer to intefrere in a simpler process, medicine has tended to view the number of points in the female reproductive process as distinct entities. Reproduction is dealt with not as a complicated organic process but as a series of discrete points, like stations on an assembly line, with more for female than for male.

The alternative to taking the female system as a complication of the "basic" or "simpler" male system is of course to take female as the working norm. In this approach, a pregnant woman is compared only to pregnant women, a lactating breast compared only to other lactating breasts. Pregnancy, lactation, etc. are accepted not only as nominally healthy variations, but as truly normal states. To take the example of, pregnancy, women *are* pregnant; it's not something they "have" or "catch" or even "contain". Pregnancy involves physical change; they are not, as medical texts frequently call them, "symptoms" of pregnancy. Pregnancy is not a disease; its changes are no more "symptoms" than the growth spurt or development of pubic hair are "symptomatic" of puberty. There may be diseases or complications of pregnancy, but the pregnancy itself is neither disease nor complication.

In contrast, the working model of pregnancy that medicine has arrived at is that a pregnant woman is a woman with an insulated parasitic capsule growing inside. The pregnancy, while physically located within the woman, is still seen as "external" to her, not a part of her. The capsule within has been seen as virtually omniscient and omnipotent, reaching out and taking what it needs from the mother-host, at her expense if necessary while protected from all that is bad or harmful.

The pregnancy, in this medical model, is almost entirely a mechanical event in the mother. She differs from the nonpregnant only in the presence of this thing growing inside her. Difference other than the mechanical are accordingly seen as symptoms to be treated, so that the woman can be kept as "normal" as possible through the "stress" of the pregnancy. Pregnancy is not necessarily inherently unhealthy in this model, but it is frequently associated with changes other than the growth of the uterus and its contents, and these changes are seen as unhealthy. For example, haemoglobin (iron) is lower in pregnant women than nonpregnant, making pregnant women appear (by non-pregnant standards) anemic. They are then treated for this anemia with iron supplements. Water retention, oedema, is greater in pregnant women than nonpregnant, and they are treated with limits placed on their salt intake and with diuretics. Pregnant women tend to gain weight over that accounted for by the fetus, placenta and amniotic fluid. They are treated for this weight gain with strict diets, sometimes even with "diet pills". And knowing that these changes are likely to occur in pregnant women, American doctors have tried to treat all pregnant women with iron supplements, limits on salt and calorie intake, and many with diuretics, in the name of "preventive medicine".

What is particularly important to note is that these "treatments" of entirely normal phenomena are frequently not perceived by the medical profession as interventions or disruptions. Rather, the physician sees himself as assisting nature, restoring the woman to normality. Bogden, in her study of the development of obstetrics, reports that an 1800's non-interventionist physician, as opposed to a "regular" physician, would give a laboring woman a catheter, some castor oil or milk of magnesia, bleed her a pint or so, administer ergot, use poultices to blister her, and "Any of these therapies would be administered in the interests of setting the parturient up for an easier, less painful labor and delivery, while still holding to the belief that the physician was letting nature take its course." [34] Wertz says that currently medicine has redefined "natural childbirth" in response to consumer demand for it to include any of the following techniques : spinal or epidural anesthesia, inhalation anesthesia in the second stage of labor, forceps, epesiotomy, induced labor. [35] Each of these techniques increases the risk of childbirth for mothers and babies. [36] Under the title "Normal Delivery," an obstetric teaching film purports to show "the use of various drugs and procedures used to facilitate normal delivery." Another "Normal Delivery" film is "a demonstration of a normal, spontaneous delivery: including a paracervical block, epesiotomy . . . ."

The use of estrogens provides an even better example of how medicine views the body as a machine that can be "run" or "managed" without being changed. Estrogens are female hormones; in medicine they are seen as femininty in a jar. In the widely selling *Feminin Forever*, Dr. Robert A. Wilson,

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pushing "estrogen replacement the rapy" for all menopausal women, calls estrogen levels as detected by examination of cells from the vagina, a woman's "femininity index." As estrogen levels naturally drop off after menopause a women is according to Dr. Wilson, losing her "femininity. Interestingly, estrogen levels are also quite low while a woman is breast-feeding, something not usually socially linked to a "loss of femininity."

Menopause remains the one normal female process that is so overtly referred to as a "disease", in the medical literature. To some physicians, menopause is a *deficiency disease*, and the use of estrogen restoring the woman to her "normal" condition. Here we must reconsider the question of women's functional importance in the social system. Middle-aged housewives have been called the last of the "lady of leisure," having outlived their social usefulness as wife-mothers, and having been allowed no alternatives. While oopherectomies and clitorectomies are no longer being done on upper class women as they were a hundred years ago, to "cure" all kinds of dubious "ills," older women are having hysterectomies, (surgical removal of the uterus) at alarming rates. [31] Much more typical of modern medicine, however, is the use of chemical rather than surgical "therapy." Because the social changes and demands for readjustment of middle age roughly coincide with the time of menopause, menopause becomes the "illness" for which women can be treated.

Estrogens have been used in virtually every stage of the female reproductive cycle, and usually with the argument that they return the woman to normal. or are a "natural" treatment. Estrogens are used in puberty, to keep girls from getting "unnaturally" tall; to treat painful menstruation; as contraception, supposedly mimicing pregnancy; as a chemical abortion in the "morning after" pill; to replace supposedly missing hormones and thus to prevent miscarriages; to dry up milk and return women to "normal" nonlactating state and in menopause to return women to the "normal" cycling state. For all the claims of normality and "natural" treatment, at this writing approximately half of these uses of estrogens have been shown to cause cancer. The use of estrogens in pregnancy was the first to be proven carcinogenic: daughters of women who had taken estrogens (notably DES, a particular synthetic estrogen) are at risk for the development of a rare cancer of the vagina [10] The sequential birth control pill was taken off the market as the danger of cancer of the lining of the uterus (endometrial cancer) become known, and similarly estrogens taken in menopause have been shown to increase the risk of endometrial cancer by as much as fourteen times after seven years of use. [21]

The model of the body as a machine, which can be regulated, controlled, and "managed" by medical treatments, is not working. "Femininity" or physical "femaleness" is not something that comes in a jar and can be manipulated.

Nor are women accepting the relegation to secondary functional importance, as wives and mothers of men. In rejecting the viewpoint that we bear men's children for them, we are reclaiming our bodies. When pregnancy is seen not as the presence of a (man's) fetus in a woman, but as a condition of the woman herself, attitudes toward contraception, infertility, abortion, and childbirth all change. When pregnancy is perceived as a condition of the woman then abortion, for example, is primarily a response to that condition.

The women's health movement has grown as an important part of the women's liberation movement. In some of its work, the movement has been geared toward consumerism within medicine, seeking better medical care and a wide range of services for women. While better trained, more knowledgeable and more *humane* physicians are a high priority, what the self-help and lay midwifery groups are doing goes much deeper than that. I believe that these women are reconstructing the pre-obstetrics and gynecology model of women's health. They are redefining women's health in fundamentally women's terms.

Women's self-help groups and clinics are teaching women how to examine their own bodies, not in the never-ending search for pathology in which physicians are trained, but to learn more about health. Medical technology and physicians are clearly useful in treating illness, but do we really want physicians to be "treating" health? It is entirely possible for a woman to fit herself for a diaphragm, do a pap smear and a breast examination (all with help and instruction if she needs it) and never adopt the "patient" role. It is also possible for a woman to go through a pregnancy and birth her

baby with good, knowledgeable, *caring* help, but without becoming a "patient" under the "supervision" of a physician.

Redefining normality within the context of the female. reproductive sytstem will take time. We have all been imbued with the medical model of women's bodies and health and it is hard to work past that. Redefining women in women's terms is not a problem unique to health. It is an esential feminist issue.

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