BLOCK 1 INTERFERING IN PEOPLE'S LIVES?

INTRODUCTION TO BLOCK 1
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UNIT 1 IN THE BEGINNING
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The Open University Press
Introduction

Block 1, as an introductory block to the whole course, is concerned with the creation of social problems and the interventions designed to solve them. In this block we will be concentrating on problems that appear to be ones that are a part of the human condition and thus affect every individual, before going on in later blocks to explore more specific problems that surround particular families, communities and social structures. Although our choice of topics has been determined by our focus on individuals, you will find that few of their problems can be explored at that level alone. Society impinges in all sorts of ways on all of us and it is rarely possible to say, in a non-controversial manner, that this is an individual problem while that is a problem for society. Similarly when we examine the causes of problems, sometimes the reasons why individuals suffer particular problems may be traceable to their own unique characteristics, but the reason why such problems exist at all can often only be explained at the level of society.

Take unemployment, for example. It may be possible to explain on an individual level why it was Jane who, on leaving school with six ‘O’ levels and with a very good interview manner, got the job in the insurance company’s office rather than Jill, who had done less well at school, had turned up for her interview in clothes that appalled the personnel manager, and who is currently unemployed. But that does not explain why the levels of unemployment in the town where Jane and Jill live are currently over 50% for school leavers, so that Jill will not have many other chances to learn from her previous mistakes. When Jane’s and Jill’s parents were young in the early 1960s they had little trouble finding jobs. Indeed the problems of youth discussed in the media in those days were about how much money they had to spend and how irresponsible they were with it. Jane’s mother had been a mod, was employed and spent her money (which never seemed so much to her) in ways which sometimes got her into trouble in quite different ways from Jill’s mother who had been a student involved in political protests, which also occasionally landed her in confrontations with the police. Again, these two were individuals and what they were like as individuals affected the particular problems they faced. But the range of such problems was, as today, affected by society as a whole and the particular times and difficulties society was going through then.

So when we say that the focus of this block is on problems which appear at the level of the individual, we have to be aware that this means that the creation of individual problems also rests on the interplay between each individual and wider social concerns and constraints. It is that interplay which we shall be using in our examination of the central themes of the course. In particular, we shall be examining four key questions which in various ways form the underlying agenda for the rest of the course.

1 What is social about a social problem?

Many of the problems that people have seem at first sight to be natural and obvious, such as the problems caused by ageing, breaking the law or a physical impairment. But when we come to examine them more closely we realize that they have important social dimensions too. Different societies treat old people in very different ways – for example, the high status accorded to old people in China is in stark contrast to the way they are treated in Britain today, similarly, illegal drinking during the days of prohibition in the United States in the 1930s was not seen as a problem at all in other periods of American history. Problems also affect people differently according to their position in society. Physical disability is quite a different problem for a widowed pensioner living on her own than it is for a middle-class professional man able to call on support from his wife at home, his secretary at work and who is mobile through access to a car and other aids.

Society also plays its part in the causes of problems. For example, particular occupations have a much higher incidence of industrial accidents. The incidence of nearly all social problems – whether they are related to ill-health, unemployment,
inadequate housing, crime, disabilities or whatever – is also unequally distributed across social classes, genders and ethnic groups. This suggests that social factors have a role to play in the development of even those problems that appear to be most individual.

So the question of what is social about a social problem is a question partly about causes and partly about effects. Even when problems appear to be naturally given and to be basically the problems of individuals (as the problems associated with particular stages in the life-cycle appear at first sight to be), we have to ask a number of questions about the way in which societyimpinges upon them. How has the type of society in which we live today contributed to particular natural or individual characteristics becoming problems? And how has the way society is structured affected both the incidence of such problems among different groups in society and the effects which such problems have on them?

2 When does a matter of private concern become a social problem?
We all have to face problems every day, but not all of these become problems in which society takes an interest. Some seem to be just private matters, such as the question faced in households of what to prepare for an evening meal. But many private problems have a social dimension too: nutrition and health in general are matters of social concern and the inadequate diet of some groups in this country is seen by many people as a social problem which requires intervention. Others, on the other hand, would see it as a private matter, to be solved within the family where parents should be providing themselves and their children with an adequate diet. Such questions are inevitably political ones and debate about them is often highly charged, perhaps particularly because issues concerning the allocation of blame and responsibility seem to be at stake should we blame particular families or should health authorities and governments take responsibility?

There is also a related issue which is not so much about the responsibility for social problems as about how and in what circumstances they get taken up. Thirty years ago black people suffered from as much, if not more, abuse and discrimination as they do today, but prohibitions against ‘coloureds’ were not defined as key social problems. So why is racism acknowledged as a major social problem today when previously it was not? To raise this question is not to dismiss the real misery and suffering that may lie behind the issues that society does take to be its problems, but to note that there is also the question of why particular problems become perceived as such at some times and not at others, and for some sections of society and not others. One of the classic examples of this is the problem of ‘mugging’—sociologists have shown that media interest in the activity, particularly in the early 1970s, effectively defined the crime in such a way that in a relatively short period of time an epidemic of it seemed to have broken out. Of course, the reality was that some people did get mugged. However, the social problem of ‘mugging’ was created not simply by the occurrence of such incidents, but by media interest and social reaction to them.

But what do we mean by social reaction? Is it everybody’s view or the view of particular groups in society? When we talk about the problem of teenage delinquency, for example, we do not tend to mean problems faced by teenagers but the problems they cause for an ‘us’ that seems to exclude them. We have to consider the questions of whose views are those which are represented in public opinion and how that public opinion is formed.

3 What is the appropriate level of intervention?
Just as the cause of social problems is a disputed matter so is their solution. Should intervention to cure unemployment be directed at improving individuals’ skills and interview techniques or should it be directed at the conditions in society as a whole which have resulted in there being few jobs available? And what forms should intervention take? It can range from the giving of advice, the provision of welfare benefits (both of which in theory people can take or leave as they choose), through
controlling forms of intervention which are in some sense compulsory for their recipients, to full-blown institutionalization of the people who have, or are perceived to be, problems

4 What are the consequences and outcomes of intervention?
This might seem to be a relatively simple issue of whether the problem to which intervention was directed has got better. But interventions may have consequences other than those that were intended and in areas beyond the problems they were designed to solve. In particular, interventions designed simply to be forms of care may end up acting as forms of control too. For example, the provision of money to single women on social security is so hedged about with checks that no man is supporting them, that this can be seen as a form of policing of their sexual behaviour. Not only is this an intrusion into the lives of women themselves but it also has wider consequences for society as a whole, reinforcing and giving official endorsement to the idea that women are or should be financially dependent and that a man with whom they have a sexual relationship should support them.

These are the main questions this block has been designed to explore. They were chosen in order to introduce you to the range of issues tackled in the other blocks of the course. But discussing such questions at an abstract level is never a good way to start. We need to have some concrete social problems to use as examples. The examples we use in this block are all of a particular type: they are the social problems which are seen as applying to people as a result of being within a specific age-group. We have chosen to focus on such ‘critical’ life stages because growing up and growing older and having to cope with the problems associated with being of a particular age is often seen to be a purely biological and individual process. After all, none of us can stop ourselves physically growing older. But, in practice, as you will see, the biological processes associated with growing older hardly figure in this block. Instead we are looking at groups of people who are defined by all being at a similar stage in their lives and by the problems which surround them within society at large. This will inevitably bring in that interplay between the individual and society talked about above, and give us a chance to explore our four key questions in more detail.

We start, in Unit 1, with the problems of the very young and their mothers. The relative safety of childbirth today for both mothers and babies is often seen as one of the great successes of modern society. Childbirth has been effectively transformed from a dangerous process, which both mother and child were lucky to survive, into one that, with the help of medical intervention, is more than likely to bring parents a healthy addition to their family. However, how far have such advances been achieved at the expense of devaluing the experience of giving birth? Has it become just another routine medical operation in which the role of the mother is minimized?

In Unit 2 we ask why today we have come to accept ‘childhood’ as a period in which young people should be both educated in and protected from certain types of knowledge? Not all societies have such a notion of the specific needs of children. Some, indeed, may have no preconceived ideas of children as having needs different from adults and expect them to work and behave much like their elders. Why does our society view children in the way it does? Is that view changing? And what problems does society impose upon children by adopting particular views about them?

The next unit looks at adolescence, a stage of life which was ‘discovered’ much more recently, along with its attendant social problems. Coupled with the discovery of the problems young people are supposed to have came explanations for their behaviour. Is youth depraved or deprived? And what are the implications of different ways of viewing the social problems that are seen to surround adolescence? What role do the media play in creating stereotypical images of adolescents and how have these stereotypes served to create and reinforce the problems of adolescence?
The next unit of this block, Unit 4, moves to another group of people for whom being a particular age is seen as a problem in itself that of the elderly. Here we examine why the problem of dependency has become such a characteristic of old age in our society. Is it an inevitable result of the physical deterioration of our bodies that happens with ageing, or is dependence caused or exacerbated by particular features of capitalist society? And for whom are the old a problem – for themselves, for those who care for them or for society as a whole?

Finally, every week you will be asked to do some other activity besides studying the unit text, and you should allow time for this. Linked with this block introduction is an audiocassette which introduces the course as a whole. Unit 1 also has an audiocassette tape exercise associated with it, which analyses regional, class and ethnic variations in perinatal mortality rates. You will need your copy of the unit with you while you listen to the tape. The tape runs for less than half an hour, but you should allow one hour for this exercise, because you will be asked to stop and answer questions at various times during the tape. There is a specific point in the unit, roughly two thirds of the way through, where the audiocassette exercise comes, but if it is not possible to use a cassette player at that time, you can do the exercise later.

Unit 2 has two television programmes associated with it. One of these will be transmitted at the end of your first week of study, the other one late in the second week. These television programmes are essential to your work in that week, because Unit 2 is ‘media led’. This means that the main argument of the unit is given in those television programmes, with the unit text providing the framework into which this needs to be put. The two television programmes run for twenty-five minutes each, but you should allow yourself plenty of time before and after each programme to ensure that you have done the necessary preliminary reading and the subsequent exercises. You should look at the Introduction to Unit 2 now to ensure that you are able to plan that week’s work around the television programmes.

Unit 3 has no associated audiocassette, television programmes or readings. However, it does contain some quite substantial exercises and you should devote the necessary time to doing these. It is a relatively short unit, so you should have plenty of time for doing these activities. One of them involves looking through a week’s supply of one newspaper. The choice of newspaper (national or local, serious or popular) is up to you. Whatever your choice you should have six copies at hand (Monday through to Saturday) before starting work on this unit, so it would be a good idea to start collecting them now.

Unit 4 has a reading associated with it; this is Chapter 3 by Alan Walker in the course Reader. You should allow about three hours for reading, thinking and making notes about this chapter, which forms an essential and integral part of your study for the week.

Finally, Unit 5 which is a half-length unit provides a short review of the block, in which we shall return to the four questions posed in this introduction to see how much further the units have taken us in answering them. Chapter 1 of the Reader by Nick Manning is essential reading for your study of Unit 5. The rest of the time in this week is for the writing of your first TMA, which will be on the questions raised in this block.

Before you go on to Unit 1, have another look at those four main questions which run through this block. If you bear those in mind throughout the next five weeks, we hope you will – whatever your age – find our excursion through the problems of different age-groups illuminating.
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There are no associated readings or television programmes with this unit. You will find, however, that in section 4.3 you are asked to listen to an audiocassette programme which should help you with some data analysis and the assessment of evidence. If it is not convenient for you to listen to it when you reach section 4.3, do not feel that you have to stop your study of the unit but do listen to the audiocassette as soon as you can. The tape itself runs for less than half an hour, but you should allow an hour for this section because of the time it will take to work through the section answering the questions.

The remainder of your study time for this week should be devoted to reading, thinking about and taking notes on the text of this unit. There are four main sections in this unit but they are not of equal length. Sections 3 and 4 will take more of your time than sections 2 and 5.

**Aims**

Using childbirth as an example, this unit aims to show that:

1. ‘Natural’ events do not occur in isolation from their social setting, they are therefore always socially constructed too. There is no natural state of non-intervention (though critiques of intervention sometimes propose a ‘return’ to more ‘natural’ methods).

2. Change tends to come about through organized groups:
   (a) constructing the perception of problems whose solution requires change, and
   (b) agitating for particular solutions.

Their success depends not only on their own efforts, but the power they have and the extent to which proposed changes are in accord with more general social trends.

3. The professions constitute one example of such organized groups, consumer groups, asserting individual rights to choose, are another.

4. Only certain specifiable types of problems are considered appropriate for intervention while other more structural social factors, even if demonstrably more significant, remain untreated.

5. Evidence used to support the effectiveness of particular interventions needs to be assessed with caution. In particular, it is important to see what other social changes have been happening simultaneously.

6. Social problems and social interventions may affect different groups in the population differently.

7. Formulating policy involves having a theory about causes. Such theories cannot be proved by statistical evidence which can only show how variables are associated. To go further, we need to have a theory of how a causal connection, if it exists, would work.

8. Whether theories affect policy-making depends as much on whether the implied policies necessitate structural change and the interests they favour as on the validity of supporting evidence (see points 2 and 3 above).

9. Different participants within the same event may have widely different views as to what constitutes a problem or intervention, and when the latter is desirable and/or necessary.

10. Different views may turn around different perceptions of the public/private distinction and the appropriate location of specific problems.

11. Intervention creates its own institutions and expectations, which may in turn create their own problems necessitating further intervention.
1 INTRODUCTION

Birth is a universal experience. And it is undoubtedly a natural event. No society has evolved any other method for bringing new human beings into existence, we have all been born. But birth is not only a natural event. Society constructs it too. Different societies view and construct birth in different ways.

This unit, like the others of Block 1, is designed to introduce you to some of the ideas, themes and skills that will be useful to you throughout this course. To do so, it uses birth - the most universal of all experiences - as an example of a natural event in which society inevitably intervenes to discuss some of the problems and controversies which surround social intervention. One reason why birth is a good example to use in this way is that the practices surrounding childbirth have become highly controversial and are currently in a state of flux. This means that fundamental issues to do with the role of professionals, the benefits and problems of the forms of intervention they practise and the rights of individuals to choose the 'treatment' they receive are raised for all of us by the debates surrounding childbirth, even though for most of us it is an event in which - after that most significant event of all, our own birth - we participate infrequently, if ever.

This unit will examine the way in which our British society, an example, but a particular example, of a western capitalist society, copes with and manages birth. I use the word 'manage' here on purpose, partly because that is the way a whole set of people - the medical professionals concerned with birth - have been taught to see it, but also because for society as a whole it is something that has to be managed so that society can run in an orderly way. In that sense it is like the production of goods, which we all accept needs some organization in order that they are produced in a way that meets the demands and needs of society.

We tend, however, to see the production of human beings in a somewhat different light from the production of things. We think of birth as a specifically biological process and see ourselves as being at our closest to nature when involved in such existential processes as birth. This is true not only for mothers but for fathers too, those who have been present at their child's birth often describe the experience in terms which stress the unversality of the experience and thus implicitly its natural basis 'looking back into the beginning of time' is how one friend of mine described his daughter's birth.

This makes birth rather a good starting point for this course and not only for the obvious reason that it comes at the beginning. But because birth is so easily perceived as a natural process, its regulation by society is often seen as 'intervention' in what should be, though in practice never is, a purely natural process. For there are no such purely natural processes. Society, by its very existence, shapes and moulds everything that goes on within it. However much the idea may at the same time be created that it does not, or should not, intervene.

The focus of this unit, then, is on an event which is often considered natural and highly personal, yet where society is involved so that controversies about social problems and social intervention inevitably take place. My main aim is to use birth as a vehicle to raise more general issues which will come up throughout this course. Although these issues will be discussed in this unit around social problems and intervention in childbirth, they are not unique to childbirth and as you study the unit you should try to think of other areas in which similar issues might be relevant.
One form of intervention which you will meet throughout this course is the giving of advice. Childbirth is no exception: any woman giving birth today is subject to a barrage of advice as to how to behave during her pregnancy and how to prepare herself for giving birth.

We are going to examine two examples of the sort of advice available in books to pregnant women today. The first extract is an example of the advice which doctors tend to give their pregnant women 'patients'. The second comes from the natural childbirth movement, which is generally fairly critical of medical intervention in childbirth. After you have read each extract, I would like you to think a little about the assumptions it embodies and in particular what it says about intervention in childbirth.

### 2.1 Advice on how to be a patient

Our first extract comes from *Pregnancy*, a book by an eminent gynaecologist and obstetrician, Gordon Bourne. This book became, for a period, almost the bible for pregnant women and has been reprinted at least sixteen times since its first publication in 1972; it is still widely used today. Like most doctors, Mr Bourne thinks it very important that a pregnant woman should receive medical advice throughout her pregnancy. This is how he writes about such 'antenatal care'.

#### Antenatal care

Antenatal care aims at maintaining the good health of the mother during pregnancy which will enable her to produce a healthy, normal infant and remain so herself. It is greatly concerned with health education during pregnancy to ensure the maximum preparation of each individual for her labour and the role of motherhood. One of its outstanding features is the early detection of any condition which might adversely affect the health of the mother or her baby.

#### The history of antenatal care

Antenatal care is a comparatively new approach to childbirth and has only developed since the beginning of this century. Before 1900 women had no care during pregnancy and were seen for the first time by a doctor or midwife when labour had become established so that complicating factors were never discovered until late in labour. The results were disastrous: Women died in childbirth and their babies were fortunate to survive.

The serious study of pregnant women began in 1901 in Edinburgh and has been developed throughout many countries. Advances in the care of pregnant women are still continuing and today in this country it is difficult to realize the situation of the past. Today women have nothing to fear from pregnancy and labour, the outcome of which is a happy event in any family unit.

Very few aspects of medicine have changed so dramatically and radically as the care of the pregnant woman over the past forty years. The introduction of antibiotics and the consequent control of infection have affected all branches of medicine, not least of all women during and immediately after childbirth. However, the complete antenatal care as we now know it is an entirely new concept not even dreamed of forty years ago. It has moved most of the responsibility for the pregnancy from the woman herself to her professional adviser, be that doctor or midwife. The maternity services, as represented by the doctor and midwife, have cheerfully and gladly accepted the responsibility of looking after the pregnant woman. The history of antenatal care is one which will stand repeated examination.

Forty years ago antenatal clinics as we now know them did not exist. The pregnant woman either wrote to or went to see her doctor, midwife or hospital in order to book a place for her confinement. When she had done this she returned home and awaited the onset of labour, or some complication which might befall her during her pregnancy. If the pregnancy proceeded normally and labour duly arrived, the doctor or midwife was summoned at a time determined by the pregnant woman and her husband, or other members of the family brought in to give appropriate advice.

Complete antenatal care is the ideal type of preventive medicine for which doctors have been searching for many generations. Complications can be recognized sufficiently early to be corrected. Tests and other investigations can be performed to detect those patients in whom a complication might arise so that treatment can be given to prevent its occurrence. Even for those who are destined to have a perfectly normal pregnancy,
labour and delivery, helpful guidance, reassurance and instruction will help to make their pregnancy a pleasure rather than a duty

The importance of antenatal care cannot be over-emphasized nor can the benefits that good antenatal care bestows upon the pregnant woman be overstressed

During the past ten to fifteen years women have become more inquisitive concerning the process of labour and their delivery and their seeking for information is to be encouraged. Even so, some women are frequently screened from some of the true or more unpleasant facts if these might disturb them.

Many pregnant women today want to know more about the process of pregnancy and what they can do to ensure its success. Their questions should be answered honestly and sympathetically and they in turn must accept the honesty of the answers they are given. If they enter into a phase of grey depression when they are told that a certain risk is present and do not accept that the risk is not a finality, doctors will refuse to disclose information to their patients.

The majority of doctors and midwives recognize that only knowledge can eliminate fear and depression. They are now attempting to remove the mystique which has always surrounded pregnancy and labour so that pregnant women and their husbands will understand not only the physiology and anatomy, but also the signs and symptoms of complications as well as the methods of dealing with them and their prevention. The effort to replace ignorance with knowledge and understanding is gaining momentum from the combined efforts of midwives and doctors as well as from women themselves.

The vast majority of maternity units under the National Health Service in Great Britain have a course of classes for patients who are attending the antenatal clinic of the hospital. Similar antenatal classes are run by many local authorities for women who are having their babies at home. The majority of these courses include lectures and discussions on pregnancy, labour, delivery, the care of the new-born baby, clothes required during pregnancy and for the new-born infant, as well as visits to the wards and delivery room, instruction and practice in the use of gas and oxygen machines and other simple equipment that may be required during labour. Relaxation classes are usually run parallel with the courses of instruction. A dietician is available to give advice on diet during pregnancy and a social worker to offer advice and help to those who need it. The majority of units also encourage husbands to attend one or more of these discussions or lectures.

The whole concept of this type of antenatal care and instruction is to offer helpful information and to create trust, confidence and understanding between the patient and the people who are going to look after her. Fear and misunderstanding are replaced by knowledge and a confident appreciation of the reasons behind the meticulous care that is taken of a woman during pregnancy.

Many changes through the years have been responsible for the progress in obstetric practice. Their effect has been cumulative since no single factor could have changed pregnancy from the days of ignorance, disease, damage and death, to the present haven of knowledge, safety, happiness and health of the mother and her child.

Obstetricians, doctors who specialize in midwifery, have had an immense amount of training. Midwives have advanced training and they too are experts in the care of women in normal pregnancy, labour and the puerperium. The midwives and obstetricians cooperate to achieve maximum benefits for all under their care.

The pregnant woman herself, however, is the most important factor in the management of pregnancy. She must learn to look after her unborn baby during the nine months of her pregnancy with the same amount of care that she will take of him after he is born, and to do this she must know all about her pregnancy. (Bourne, 1979, pp 121-5)

Q. Having read this extract, think about some of the assumptions it embodies. For example:

1. What view does Bourne take of the effect of medical care?
2. What view does he take of pregnancy and childbirth without medical care?
3. What is seen as the ideal way to avoid the complications that occur in some pregnancies?
4 Who does he say is in charge of a pregnancy?

5 What should pregnant women know about their own condition?

6 What is seen as the best source of advice about pregnancy, and who is seen as in need of such advice?

Bourne’s view is that pregnancy and childbirth are naturally risky processes, with potentially ‘disastrous’ results for both mother and child. Medical care can, however, prevent such disasters provided the ‘complicating factors’ which cause them are discovered early enough ‘to be corrected’. To make this possible, it is important that all pregnant women are given the appropriate tests and other investigations. Even for those who will have a normal pregnancy and delivery, the tests are considered to be of benefit in providing reassurance.

Medical knowledge is seen to have been very effective in reducing the risks from a situation in which ‘women died in childbirth and their babies were fortunate to survive’ to one today where ‘women have nothing to fear from pregnancy and labour’. It is midwives and obstetricians, particularly the latter with their immense amount of training, who are the purveyors of that medical knowledge and who therefore now take over most of the responsibility for ‘the pregnancy’ from the pregnant woman.

On the other hand, because women are now more ‘inquisitive’, Bourne does think it is important that women should understand more about their own pregnancies, not so much that they get worried, but enough that they are reassured (and this provided they behave well and do not show they are upset when given bad news!). It is assumed that they have husbands, who should also be encouraged to learn part, though not necessarily all, of what their wives are taught at their antenatal classes. Such classes are provided in most areas by the NHS or local authorities (two branches of the state) and while some of what is learnt there is medical, much of it is about how to fit in with the institutions of modern maternity and child care. Equally, pregnant women need to be prepared for the ‘role of motherhood’ for it is assumed that she will be the one taking care of the baby after he (sic) is born.

2.2 Advice on how to be ‘natural’

Besides books by obstetricians, pregnant women today have a fast-growing alternative literature to which they can turn. The advocates of ‘natural childbirth’, who believe that much of modern medical intervention is unnecessary in pregnancy and childbirth, degrading to women and sometimes downright dangerous, have written their own handbooks in response to those of the orthodox medical profession. Sheila Kitzinger has been a proponent of this more ‘natural’ approach to childbirth for many years. Here are a couple of extracts from her recent book, The New Good Birth Guide, a consumer guide to the practices of a large number of hospital maternity wards throughout the country.

What are antenatal clinics for?

In most societies there are rules about pregnancy, strict regulations about what the woman may and may not do and what she must eat and avoid. In this way each culture stresses the marginal nature of the pregnant state and surrounds it by rites de passage. We have always done this in the West, and our ‘old wives’ tales’ are vestiges of a complicated network of beliefs which controlled the behaviour of the pregnant woman. Today new elements of social control have replaced those imposed by older women, grannies and aunts, and these have to a large extent even taken over the power and aura previously invested in the priesthood.

The new system is controlled by doctors. They lay down the rules and a woman looks to medical experts to tell her how she should behave. If she attends antenatal clinics early in pregnancy, keeps on going regularly and obeys the doctors, it is implied that she has done everything she possibly can for a safe childbirth and for the benefit of her baby. If she breaks the rules she is a ‘defaulter’, a term used to describe women who do
not turn up for clinic appointments, the penalty for which, it is suggested, may be a
difficult labour, and a deformed, handicapped or dead baby.

In fact, we have only just started to investigate the cost-effectiveness of antenatal
care. We do not really know how soon or how often a woman ought to go to an
antenatal clinic, or even whether a healthy woman need go at all (Kitzinger, 1983, p
15).

Much of the technology used in obstetrics today has been introduced, and become a
routine part of clinical practice, without adequate research and without strong evidence
of its advantages. It is difficult for a woman who is told ‘this is done for the benefit of
mother and baby’ to query the use of, for example, electronic fetal monitoring or an
oxytocin infusion. Moreover, many hospital rites are taken for granted by members of
staff and performed as a matter of course, so that to question them seems almost
insulting. If putting women to bed during labour, the assumption that a woman will be
down when she is on the bed, breaking the bag of waters artificially, not letting a
woman eat during labour, urging her to push and to hold her breath in the second
stage, and performing an episiotomy are all examples of routines which are so much an
accepted part of our Western way of birth that the woman who prefers to do something
different may have a label of ‘neurotic’ pinned to her or be castigated as a
‘troublesome’ or ‘one of those women’s hibbers’. Because childbirth is something that
only happens to women, their concerns about it, what they want, their hopes, fears and
anxieties, are often explained away as either irrelevant to the only criteria of success, a
live, healthy mother and a live, healthy baby’, or are seen as parts of a pathological
process in the female psyche.

Women in labour usually do not want to be thought ‘rude’ or aggressive, and as a
result when they feel trapped in situations which are entirely out of their control, on
territory over which power is exercised by professionals, they become passive and
placating. Sometimes they are frightened into obedience because they fear that non-
compliance will result in worse things being done to them or their babies. I know that
some obstetricians and midwives, giving of their energy, time and skills without stint, to
do the best they can for their patients, will urge a gentle approach to change, a
willingness to ‘co-operate’. Women having babies, too, may warn us ‘not to rock the
boat’, even those who stand beside us in wanting to create the conditions for informed
choice between alternatives.

But the evidence is that change does not come, or does not come for enough women,
when an expectant mother has a quiet talk with the obstetrician, but only when there is
open and public protest. There is a place for quiet talks, but we need more than that if
our Western culture of birth is to see any radical transformation. The task calls for
knowledge and understanding, the courage to question assumptions and the energy to
work together to create a way of birth in our society in which women are recognized as
adults and active birth-givers (op. cit., pp 7–8).

Q. Look back now over the questions you answered about the Gordon Bourne
extract, and think what answers Sheila Kitzinger would give to them.

Sheila Kitzinger is clearly far more critical of the forms of medical care given to
pregnant women today. She sees them as the rituals and ‘rites’ of ‘our western way
of birth’ rather than practices which are known to be of benefit to either mother or
child.

The value of the whole system of antenatal care is questioned, at least for healthy
women. In contrast to the idea that all women should be tested and monitored to
discover those who are more likely to need medical intervention, she sees the whole
process as a set of rules, which, if broken, will result in the woman being threatened
with a difficult labour or a less than healthy baby as punishment. Kitzinger would
like a distinction to be made between healthy women and those who might need a
doctor’s attention, a distinction Bourne would reject on the grounds that one only
knows which labours turn out to be ‘normal’ after the event.

Kitzinger regrets that doctors (or hospitals) are largely in charge of the process of
giving birth because this results in women’s own wishes being ignored or treated as
neuroses. She talks of herself as part of a movement ‘to create a way of birth in our
society in which women are recognized as adults and active birth-givers’. Advice
and knowledge is an important part of making this possible, because she feels women have to be able to make their own 'informed choice between alternatives'. But such choice is not currently available to most women who feel trapped in a situation out of their control, on territory over which power is exercised by professionals. Professional expertise, she claims, is used to intimidate women. But this is a situation that she hopes will be rectified if more women read books like her own and put pressure on the medical establishment to change.

Another criticism Kitzinger has is of the medical establishment's view of fathers.

The assumption is often made by labour ward staff that a man is there to witness the delivery of his child and that he has no positive function before then except, perhaps, to do a bit of hand-holding. These professionals are out of touch with social changes in the last fifteen years or so which are drawing couples to want to experience the whole of childbirth together, not just its grand climax. The sharp divisions of labour between men and women, differentiated male and female roles, the ignorance that many have about women's bodies, the guilt and hidden conspiracy about 'female complaints', menstruation and childbearing are fast giving way to a new openness and sharing between a man and woman in partnership together. Pregnancy is often a time when such partnership, sharing of information and awareness of each other's psychological needs, acquires a firm basis (1983, pp. 93-4).

2.3 Summary

In this introductory section we have looked at two views of antenatal care and the advice women are given before giving birth. We saw some important differences between the views of an orthodox obstetrician and those of a campaigner for an alternative way of giving birth. Their views differ on the following points:

1. The control of birth and who knows best

   Bourne's view is that it is the development of medical science that has made childbirth immensely safer for women and children. This means that it is the medical profession who now knows most about these matters. It is therefore obstetricians, as those doctors with the greatest specialist training, who, with the help of midwives, are now in charge. Nevertheless, it is important for women to inform themselves about the processes involved.

   Kitzinger would reverse this order of priority. She thinks it is most important that women know as much as possible about the processes of pregnancy and birth, so that they can make their own informed choices. She regrets that doctors have stepped outside their proper role of coping with illness to intervene in the essentially natural and normal process of childbirth.

   So, tied in with the two different views of what knowledge is for and who should be in charge are related views about nature and its control. For Kitzinger, and the natural childbirth movement, childbirth is a natural process with which it is best not to interfere in most cases. For Bourne, it is also a natural process but nature is fraught with danger and therefore best controlled or at least monitored so that appropriate intervention may be made to prevent potential problems.

2. The effects of intervention

   Bourne states that medical intervention has been effective in reducing the risks for women. Kitzinger questions this view even over antenatal care, as we shall see later, the natural childbirth movement is much more critical when it comes to medical practices during childbirth itself, claiming that medical intervention can do positive harm, so that doctors end up having to use all their skills saving the lives of babies they have themselves put at risk.

3. About the people and institutions involved

   The two writers share some views about the importance of fathers' involvement. They assume men are also involved and that childbirth is the beginning or growth of a family, although Bourne does not expect as much involvement by fathers as Kitzinger does.
Bourne sees hospital routines as having been developed in order to promote the safety of both mother and child. Kitzinger thinks of them as more like rituals or *rites de passage* that women in our society have to suffer in order to be allowed to have a baby, rituals which may be convenient for doctors but can have very bad effects on both women and their new-born children.

I hope that this brief introduction has given you some flavour of the debates surrounding intervention in childbirth today. In the remainder of the unit, we are going to look at certain areas of these debates in more detail, areas chosen because they have something to say about 'intervention' more generally.

### 2.4 Overview of the rest of the unit

In section 3 we shall examine three perspectives in the childbirth debate – the two you have met examples of already and a third perspective, that of feminism, which shares some of the criticisms already examined of medical practices, but also has its own criticisms of the natural childbirth movement. We shall examine the ideologies underlying each approach and the different ways they would approach the history of the development of modern techniques of childbirth management. We shall also look at the social organizations through which the debate takes place, the medical profession and the variety of consumer organizations campaigning for change in current practices from a natural childbirth or a feminist point of view.

Section 4 will attempt to assess some of the evidence for and against the effectiveness of modern methods of childbirth. We shall look at mortality statistics both for women in childbirth and new-born babies, over different periods of time and in a number of different ways, to see whether childbirth has become safer because of – or perhaps despite – modern medical intervention. We shall also consider whether other forms of intervention might be more effective and the process by which certain types of intervention come to be adopted rather than others. An important aim of this section is to introduce you to some techniques of statistical analysis, which should be helpful to you later in this course and in any further studies in the social sciences.

Section 5 raises a number of controversial issues about intervention in general. What criteria are to be used for assessing the outcomes of intervention which are used? Can such interventions be considered singly or must they be seen as part of the whole experience of childbirth? Who should be in control? All these issues are explored around the question of the choice of where a woman gives birth – at home or in hospital – a decision which legally is in the woman's hands but one which few women feel they actually make. Finally, we shall consider one of the main themes of this unit – when does help become seen as intervention? – an important issue for the rest of this course.

The conclusion will then look at some of the more general points about intervention which can be taken from this unit. For remember, its main purpose is to introduce you to some of the themes of the course as a whole and questions which relate to social intervention in general. Childbirth is just one way of bringing them to life. May you have a happy and trouble-free delivery!
Figure 1

Even the techniques of 'natural childbirth' have to be learnt: a typical syllabus for a course of classes run by the National Childbirth Trust

Source: Beets, 1978, pp. 94-5
Pregnant women have never been short of advice. For example, they have been told what to eat and how much to eat, though what is considered correct has varied within very short periods of time. Just over the past few years in Britain, for example

The view used to be that every woman should ‘eat for two’. Then everything changed about and pregnant women were led to believe that something dreadful would happen if they gained a little extra and that any extra weight would stay with them for ever. Now the pendulum is swinging back again. (Phillips, 1983, pp. 25–6)

The advice given varies across cultures too. In his huge Comparative Study of Reproduction, Ford reported in 1945 that 38 of the 65 cultures he studied gave dietary advice, while 35 recommended or discouraged other types of behaviour prenatally. The advice was not consistent across cultures, while most cultures encouraged pregnant women to rest at certain times in their pregnancy, others recommended heavy exercise and some prohibited intercourse while others encouraged it. The nineteenth-century anthropologist, Englemann, in his Labor Among Primitive Peoples published in 1883, uncovered some customs he thought particularly bizarre such as the weekly changing of pregnant women’s shoes in Estonia to throw the devil off her scent (Ford, 1964)

The way childbirth practices have varied between societies and over time must lead us to the conclusion that there really is no such thing as ‘natural’ childbirth. In all cultures, social customs and practices play their part. Even though these may be in dispute at any point, no woman giving birth can do so outside the cultural influences of the society in which she lives. She may be able to exercise some choice between alternative methods, but all such methods are themselves shaped by ideas and customs formed within society, in that they are no more or less natural than each other and childbirth always involves intervention by society in some form or other. It is no more natural to give birth with husband and midwife in attendance encouraging the use of breathing techniques to control pain, than to have obstetrician and anaesthetist there using a drip to administer pain-killing drugs. In both cases, the attendants are there because of their socially sanctioned roles – marriage partners just as much as medical attendants – and the techniques used are ones that have to be learned and are taught in specific social settings – natural childbirth classes or medical schools. See Figure 1

Recognizing that childbirth can never be a purely natural event but is inevitably the result of social intervention has a number of implications. First, it means that childbirth has a history in which the people and practices involved have changed. Secondly, because practices surrounding childbirth are socially constructed, they are the subject matter of much dispute. It is such dispute which leads to change. At any one time in a particular culture, one set of practices may constitute the dominant form of intervention in childbirth, but many others may challenge it.

The dominant form which social intervention in childbirth takes in Britain today is that of medical intervention. Thus means that it comes from a specific social organization, an institutionalized, hierarchical profession, accorded recognition for its expertise both by society as a whole, and more specifically, backed and protected by the state. To become members of the medical profession, people have to pass through its entry procedures, become a doctor one has to go to the sort of school which enables one to study for the required A-levels, be allowed to stay on at school long enough to do so, spend six years at medical school and then further years training in hospital if one wants to specialize in obstetrics, passing all the requisite examinations on the way. There are other routes to other positions in the health service dealing with pregnancy and childbirth. Midwives, for example, have their own rather different training. And each has its specific role in the profession. Midwives deliver women having normal labours, general practitioners can deal with minor complications, but obstetricians take charge as soon as any greater difficulties are encountered or anticipated.
Medical practice also has its own ideology, that is, a set of linked assumptions about its own practices, based on the idea that science can be used to understand nature and control its dangers. Practitioners therefore see themselves as part of a tradition of scientific rationalism, in which the application of a growing body of medical knowledge has led to better treatment of illness and thus greater health and safety for all people, including pregnant women and their babies.

There are a couple of effects of this medicalization of childbirth that are worthy of examination. First, it means that knowledge about childbirth forms part of a body of knowledge developed primarily to deal with illness. The hierarchy of the profession reflects this greater status and salary are accorded to obstetricians than to general practitioners, and to general practitioners than to midwives. This can result in pregnancy being treated as if it were a sickness and the pregnant woman a patient. Not surprisingly, given their training, doctors are sometimes accused of being more interested in pathological cases than what turns out to be unproblematic pregnancies and births.

Secondly, it means that the higher ranks of the profession are largely male, since women historically and today have not become doctors in the same numbers as men and within the profession, have not entered the specialism of obstetrics at the same rate as men, though midwifery remains a female occupation. The tendency of any profession to protect itself by claiming to be the only source of skill and reliable knowledge in its field, coupled with the fact that most obstetricians have no direct experience of childbirth themselves, results in a denial of the role of personal experience in the construction of knowledge about pregnancy and childbirth. (You may have noted that nowhere in the extract you read did Bourne suggest that a doctor might have anything to learn about a pregnancy from the woman herself rather than the other way round.)

Critics of medical intervention in childbirth have focused on these two effects. Natural childbirth advocates criticize particularly the treatment of pregnancy as an illness. To scientific rationalism and the desire to control nature, they counterpose the idea of pregnancy and childbirth as natural processes which are usually best left alone to take their own course. Underlying their criticisms is an alternative ideology, one based on the idea of the ‘natural’ as a desirable state to which a return could be made if only women were freed from unnecessary forms of intervention being imposed on them.

Another set of criticisms of the medical profession have come from feminists. Their criticisms have focused more on the way a male-dominated profession appears to have taken the control of childbirth out of the hands of women, and in particular away from the woman giving birth. Its criticisms are based on an ideology of women’s rights, adapting the slogan ‘A Woman’s Right to Choose’, first coined over the right to abortion, to a woman’s right to choose how and in what manner to give birth.

These two movements share some of their criticisms of dominant medical practice. Both, for example, tend to prefer the way midwives treat women in childbirth to the approach of doctors. Because their training is in the management of normal labours, midwives are seen as less inclined to interfere and, as women, perhaps less likely to attempt to take control from the labouring woman herself than doctors. But natural childbirth advocates and feminists are not always in agreement, as you might imagine from their different starting points.

In order to explore further the different ideologies underlying each approach, we shall look at the way they explain the history of childbirth practices in this country. Just as the description of present practices is a matter of dispute between competing ideologies, so historical description and explanation of the past is disputed too. In the previous section you compared two examples of writing—by an orthodox obstetrician and an advocate of natural childbirth, in this section, we shall look at an account of the history of childbirth in this country, from the third of our perspectives, a feminist point of view.
At this point, it would be a good idea to stop and devise a strategy for taking notes on the childbirth debate. We have identified three main perspectives in the debate - medical, 'natural' and feminist - so a good way would be to draw up a chart in which each perspective gets a column and the various ways in which they can be compared are listed down the side. We have noted that the three perspectives stand in different positions with respect to current practices in Britain today, one, the medical approach, is dominant, while the other two approaches are defined by their criticisms of that approach. So you could start by drawing a chart which looks something like this:

**Approaches to childbirth**

<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>'Natural'</th>
<th>Feminist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position with respect to current practices</td>
<td>dominant</td>
<td>critical</td>
<td>critical</td>
</tr>
</tbody>
</table>

However, I would suggest that you draw your chart much larger, so that there is plenty of room for filling in your notes. (None of the other boxes will be able to be filled by just one word.) You will find you need space to add more rows of boxes, corresponding to further points of comparison, and you will also find that you have more to add within previously filled boxes as you read further through the unit.

The subsection which you have just read discussed the different ideological bases of the three approaches, so before you go on to the next subsection add a row labelled 'ideological basis' to your chart and fill in the appropriate boxes with a description of the ideological basis underlying each approach.

### 3.1 The male takeover of childbirth: a feminist account

History as recounted from different perspectives varies not only in the answers given, the explanations of why things happened in the way they did, but also in the questions to be asked. Particular features of the present will seem to be worthy of note and therefore particular aspects of the past will be highlighted as relevant to their explanation. To a feminist what has to be explained is how childbirth has become the area of medical - and thus male - expertise that it is today.
To H R Spencer, a famous obstetrician writing more than fifty years ago, it seemed obvious that men were introduced into the management of childbirth because they were better educated than women in the scientific foundations of obstetrics. It was a result of the march of scientific progress.

By 1800 a great advance had been made in the science and art of midwifery. This was due chiefly to the introduction of male practitioners, many of whom were men of learning and devoted to anatomy, the groundwork of obstetrics (Spencer, 1927, p. 175 quoted in Oakley, 1980, p. 11).

Feminists have, however, challenged this view, arguing that other issues to do with attempts by men to limit and supplant women's powers were at stake. The first stage in this process was the development of the medical profession itself and the suppression of female healers. As a consequence women were restricted to practising only in the female domain of childbirth. The second, much later stage, was the incorporation of midwifery itself into the range of medical specialisms, thus turning childbirth into an area of, by then, male medical expertise.

**The suppression of female healers**

In early mediaeval times, most healing was done by women and most communities would have had their 'wise-women' to whom people turned in times of illness. These healers were largely women because caring for the sick was simply an extension of the wide range of roles that 'housewives' in pre-industrial society needed to perform in the absence of the range of market- and state-provided services with which we are familiar today. The care of women in childbirth was part of this role.

European medicine developed as a secular science between the eleventh and thirteenth centuries borrowing much of its 'scientific' content from commercial contact with the Arab world. Barber-surgeons, physicans and apothecaries formed guilds which barred non-members from the right to practise medicine. The membership of such guilds was exclusively male, so their success in monopolizing formal medical practice meant the demise of the educated, urban, female healer. Her more traditional rural counterpart, the community 'wise-woman', was also suppressed with the help of the medical profession. From the fourteenth to the seventeenth century throughout Europe, vast numbers of women were accused, tried and punished for being witches in trials organized by the church. Members of the medical guilds were called in as experts to determine whether women should be deemed to have practised witchcraft for, according to the 1484 treatise on witches, *Malleus Maleficarum*, 'If a woman dare to cure without having studied, she is a witch and must die' (quoted in Inch, 1982, pp. 19–20).

The problem with witches was thus not that they failed to cure, but that they did so outside the conventions and social institutions of medicine of the time. And these social institutions were ones set up to protect particular interests (those of the medical guilds) in such a way that they did not challenge dominant ideas about the running of society and people's roles within it. Women with powers, such as those of the healer/midwife/witch, were a direct threat to male secular power, to the church and to the scientific rationalism which supplanted traditional medicine. As a result, it was not only the healers themselves who were destroyed, but a whole system of female-controlled health care.

The male takeover of medicine did not in itself imply changes in the practices concerning pregnancy and childbirth, for these became excluded from the province of the physicians, apothecaries and barber-surgeons who made up the medical profession. Childbirth and midwifery remained 'women's business' practised within a female sub-culture with little or no male interference. It was seen as a natural event which occurred frequently to most women, and a social event for the women of the community in which female neighbours and kin could participate and at the same time gain valuable skills for future use (Versluysen, 1981) see Figure 2.
To keep childbirth as a separate woman’s domain represented one way to control female power, albeit a more indirect way than the direct control of women’s reproductive abilities exercised by male-dominated medicine today. It was also a form of control, however, in that it limited women’s powers to the domain of childbirth, and therefore did not threaten male power within the increasingly important and prestigious medical profession. This mirrored other changes in society whereby women were increasingly excluded from the public sphere of political and commercial life and restricted to a homebound existence focused around child-rearing and domestic pursuits (Oakley, 1976, 1980).

**Men-midwives and the medical takeover**

Nevertheless ‘men-midwives’, as they were known, first began to make an appearance in the early seventeenth century: see Figure 3. There is some debate as to whether their origins can be directly traced to the invention of obstetric forceps, or whether they constitute a simple example of men attempting to take over a field previously exclusively female. Certainly forceps were a remarkable invention, because prior to their use an obstructed delivery meant certain death for either mother or child; their use, however, was restricted by law to barber-surgeons, the precursors of modern obstetricians (who are consequently classified as surgeons rather than physicians and do not use the title ‘Dr’). But the number of cases which were helped by their use was small, the risk of infection and death through their use enormous and the literal cloak of secrecy under which they were kept by their inventors meant that their use cannot have been widespread. (See Figure 4.)

It seems more likely that the gradual fashion for the wealthy to employ male medical practitioners to supervise female midwives came about as part of a general denigration of female knowledge. The main justification for male presence at childbirth was the need for surgical intervention should complications arise. But midwifery attendant on the upper and ascendant middle classes had become a lucrative business and men were keen to claim a role in normal childbirth too. In doing so, they had to contend with the sexual mores of the day which allowed them very limited experience of female anatomy, the view that childbirth was a natural female process and therefore not an appropriate domain for either medicine or men, and the hostility of both female midwives, who saw their own livelihood being threatened, and of much of the medical profession itself who saw no place for midwifery within its ranks. They feared that if medical men were to do women’s work then the status of the profession as a whole would be lowered.
The Presidents of each of the Colleges of Physicians and Surgeons expressed the hostility of their professions towards men-midwives in 1827. The former saw them as carrying out a manual operation ‘foreign to the habits of Gentlemen of enlarged academical education’, for the latter they were ‘invading a natural process for pecuniary gain’ (Carter and Duriez, 1986). This remained the attitude of the medical profession until late in the nineteenth century, and ‘proper’ doctors did not concern themselves with childbirth. But by the 1850s lectures in midwifery were being given in British medical schools and by 1886 proficiency in it became a necessary qualification for a medical practitioner. Restrictions of female midwives to the management of normal labours followed, and the midwife increasingly became relegated to the position of medical aide or nurse, under the supervision of a male doctor.

Again, the reason for doctors taking over could not always be justified on health grounds. In the mid-nineteenth century up to a quarter of women giving birth in hospitals, where they were most likely to be attended by doctors, died of puerperal fever, an infection most frequently transmitted by doctors from their other cases – and in particular from their dissection of dead bodies – to women in childbirth (Rich, 1977). Even those delivered at home were more likely to become infected if attended by a doctor rather than a midwife, since even though midwives’ antiseptic precautions were no better than those of the doctors, they did not deal with illness or dead bodies.

However, despite the increasing use of male doctors to attend childbirth among the upper and middle classes, working-class childbirth remained largely under female control. The Midwives Act of 1902 set up the Midwives Board, dominated by doctors, to register midwives. Nevertheless uncertified midwives, or ‘handywomen’ as they became known, continued to practice (See Figure 5). This meant that a clear hierarchy developed of doctor, midwife and handywomen in decreasing order of status, fees commanded and control they were permitted to exercise.
With the development of the National Health Service handywomen disappeared and the certified midwife’s autonomy was steadily eroded. Today midwives may attend both home and hospital births but cannot perform certain parts of the process, such as the repair of any cuts or tears that occur. Although many women may never see a doctor during the course of their labour, they will almost invariably have been under the charge of a doctor, indeed usually a whole hierarchy of consultant obstetrician and junior doctors, under whose supervision, however distant, the midwife must work.

3.2 The technology of childbirth

Remembering that different perspectives will ask different questions of the past and having read the above brief account of the history of childbirth constructed from feminist texts, consider for a moment what differences you think using accounts from the natural childbirth movement or from a conventional obstetrics textbook would have made. Think first about what questions each would be concerned to answer in their histories.

Although the natural childbirth movement is also concerned with the way doctors have replaced midwives, it is not so much because of their respective sexes. Instead midwives, because of their different training, are seen as being more prepared to let nature take its course and less likely to intervene than doctors. A historian sympathetic to the movement would therefore be looking for answers as to how childbirth began to be treated as an illness rather than a natural event and how the techniques of medical intervention developed.

Obstetricians, on the other hand, would stress the benefits that scientific knowledge has brought to childbirth, making it a much safer process both for mothers and their babies, as Spencer did in his history from which you read a quotation earlier. Their
histonians would therefore be interested in questions about which scientific discoveries led to changes in obstetrical techniques and the effects these had on the safety of childbirth.

Both groups would stress the *technology* of modern childbirth more than our feminist history has. For advocates of natural childbirth the reliance on technology is the main way in which medicine has dehumanized and interfered with the natural process of birth. For obstetricians technological innovation is one of the ways in which scientific knowledge has been put into practice to increase the safety and comfort of childbirth.

A list of such innovations would start with the instruments that were used in mediaeval times to cut up and remove babies whose delivery was obstructed, thus saving the mother's life in a few cases at least. We have already seen how the subsequent introduction of obstetrical forceps allowed men into the delivery room for the first time in the early seventeenth century. Anaesthetics began to be used from the 1840s both for pain relief and to enable operations, in particular Caesarean sections, to be performed. Although first discovered in 1847 the use of chloroform to relieve pain in childbirth met widespread opposition until used by Queen Victoria at the birth of her seventh child in 1853. (See Figure 6.) In the later years of the nineteenth century, aseptic surgical procedures for the first time gave a woman undergoing a Caesarean section a reasonable chance of survival, opening up the possibility of performing the operation in circumstances where the dangers of non-intervention were probable rather than certain.

The 1930s and '40s brought blood transfusions for women who haemorrhaged after childbirth and sulphanamides and penicillin to cure infections. Again, these innovations could be used not only after 'natural' methods had failed, but also enabled a more interventionist approach to be taken by doctors in cases where they feared problems might arise.

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*Figure 6*

James Young Simpson, the discoverer of chloroform, experimenting on himself with it. Sir Walter Scott later suggested that an appropriate coat of arms for Simpson would be 'a wee naked bairn' with the motto 'Does your mother know you're out?' Even when expertly administered chloroform presented dangers because of its toxic effects.
The development of a whole host of techniques since the Second World War has led to the medical profession seeing itself as actively 'managing' childbirth, to the despair of its natural childbirth critics. These new techniques have included methods of monitoring pregnant women and their foetuses before and during labour by ultrasound scanning, cardiology, methods to sample blood from the scalp of the foetus and to monitor the foetus' heartbeat electronically. Such monitoring techniques are not, of course, themselves life-saving, rather they give an indication of what it might be advisable to do, leaving plenty of room for argument as to the circumstances in which the monitoring needs to be done as well as the interpretation of its results.

Another set of techniques are basically precautionary measures, such as giving a woman in the last stages of labour an 'episiotomy' (a small cut to prevent tearing as the baby's head emerges), injecting her just before delivery with a drug to ensure that her womb contracts properly and even not allowing her to eat throughout labour, just in case she needs an emergency Caesarean section. These precautionary measures have led to controversy between those who believe that they are unnecessary, unpleasant and sometimes harmful and those who, on the basis that no labour is ever proved normal until after the event, feel that all possible precautions have to be taken.

Further developments in anaesthesia have also become controversial, in particular the introduction of the epidural block which can give women complete pain relief but may restrict her movement and impair her ability to push out her baby unaided, A woman may be grateful for pain relief but may regret losing out on the experience of having actively participated in childbirth.

Finally, the management of labour by doctors has in some cases meant the induction, speeding up or, in rarer cases, the delaying of labour, by the use of appropriate drugs. It is around this set of techniques that the greatest controversy has raged, since it is claimed that they have resulted in control passing from mother to obstetrician. An increasing proportion of labours were induced until 1974, when evidence of the dangers of mistakenly causing premature babies to be born led to the use of induction declining in some but not all hospitals (Beard, 1981).

Having read accounts of both the change of personnel and the introduction of obstetric technology into childbirth, the time has come to add some more notes to your chart. The first issue we considered was the different questions each perspective would want their historical accounts to explain. We then found that their different histories would pick out particular changes as significant in answering such questions.

I would therefore suggest that you now add two more rows to your chart – one labelled 'questions for history' and one labelled 'significant changes' – and fill in the appropriate boxes with notes on what you have just read.

3.3 Organized consumers: natural childbirth and a woman's right to choose

The medical profession is not the only organized body concerned with childbirth. Since the 1950s a number of pressure groups have been set up to campaign for improvements in the ways in which women give birth. In this section we shall consider some of the forms of social organization of the critical perspectives on childbirth.
The Natural Childbirth Association (now the National Childbirth Trust or NCT) was founded in 1966 with the aim of promoting knowledge about childbirth and, in particular, about methods of relaxation and breathing in labour as alternative forms of pain control to medically administered drugs. The emphasis was put on methods in which the mother retains control. Initially, the association stressed that its work was 'complementary' to the work of 'the great professions' of obstetrics and midwifery, and it behaved essentially as a consumer group which put special emphasis on the 'feelings' of mothers. Recently, however, its approach has become more militant, and it has functioned more as a pressure group for change within the practices of the medical profession itself.

The Association for Improvements in the Maternity Services (AIMS) was founded in 1960 with a broader brief: the improvement of antenatal care and of the treatment of pregnant women in general. (It was originally proposed that it be called 'The Society for the Prevention of Cruelty to Pregnant Women'.) AIMS puts a particular emphasis on women's rights to be informed and consulted about all aspects of their care. Interestingly, although initially it tended to welcome new forms of medical treatment, in recent years it too has come to stress non-intervention. In 1981 the Association pledged itself to the promotion of the 'right of the mother to experience normal physiological birth without interference unless she wants it or there are clear indications that it is needed'.

Other organizations dealing with various aspects of birth have been established. These include the Society to Support Home Confinements, set up in 1974 to campaign against the trend towards universal hospital births, the Association of Radical Midwives, campaigning to reverse the declining role of midwives, the Maternity Alliance, founded in 1980 to provide better services (including maternal benefits) for mothers and babies, and the Active Birth Movement, which since 1982 has been campaigning for the right of women to give birth in whatever position they choose, rather than the horizontal position preferred by most obstetricians, and organizing exercise classes to train women for such 'active births'. (The addresses of these organizations are given in the appendix on p. 64 for anyone who requires further information.)

All these organizations, whatever their initial aims, have come, with various degrees of radicalism, to hold positions critical of the medical establishment's handling of labour, in favour of less intervention and more active control by the woman herself. In each case this has meant that even if the starting-point has been a straightforward pro-woman's choice position, they may now seem to be promoting an alternative orthodoxy — that 'natural' childbirth is best and that women have failed if they allow doctors to administer drugs to them or intervene in any way. Indeed, this has been felt so strongly in some quarters that a counter-organization, the Association for the Advancement of Maternity Care, was formed in 1986 to promote the right of women to have drugs for pain relief, epidurals, Caesareans and other forms of medical intervention if that is what they want.

All but one of the 'consumer groups' concerned with the treatment of pregnant women and promoting pro-choice positions have favoured 'natural' childbirth methods. Attempting to readjust the unequal balance of power between professionals and consumers has meant questioning the benefits of modern technology, since this is so much in the hands of the professionals. For women to exercise the power of choice, there have to be some choices available that are in their own control, choices which can be argued to be at least as good as those which rely on the medical profession's tools.

It is on these grounds that feminists in the women's movement have also been critical of the medical management of childbirth. The women's movement's position on childbirth developed from its stance on women's reproductive rights in general and in particular on the right of women to control their own bodies and choose whether to bear children or not. The slogan 'A Woman's Right to Choose', although
now applied more widely, initially meant a woman's right to choose whether or not to have an abortion, and the local groups campaigning for women to have more control over childbirth often grew out of groups campaigning for better abortion and contraceptive facilities. In turn, the women's movement has been critical not only of the medical establishment, but of the natural childbirth movement too.

What criticisms do you think feminists might have of the natural childbirth movement? (You may find re-reading the extracts from Sheila Kitzinger helpful in this.)

Feminists have voiced the same criticisms we raised earlier in the unit of the notion of the 'natural', claiming thereby that the benefits that technology has brought to large numbers of women who used to die in childbirth have been ignored. The NCT has also been criticized for being middle-class, both in its own organization, which works largely through coffee mornings and afternoon teas in members' houses, and in promoting the interests of 'predominantly healthy, well-nourished, white, middle-class members. There is a danger that if the NHS is pushed into meeting their demands for non-medicalized childbirth, there may be a failure to pick up the minority of working-class women at risk who do require medical intervention during labour' (Caroline Langridge speaking at a Birth Rights rally in April 1982). As we shall see in section 4 of this unit, there are clear class differences in the outcome of pregnancy, and modern obstetric methods may therefore be of more benefit to working-class than middle-class women and babies.

The natural childbirth movement has also been criticized on more specifically feminist grounds for failing to question the role of women in society. Natural childbirth advocates tend to talk, as did the extract from Sheila Kitzinger that you read, of the family as a partnership between men and women, stressing its private nature and the importance of the father's involvement. Although these notions may be seen as an improvement on unquestioned, rigidly divided sex-roles, they remain ones of which feminism is critical, since they can be argued to reinforce traditional ideas that women cannot manage without men and are naturally tied to the family and having children.

This wide variety of pressure groups has been having effects on the practices of some hospitals. Some obstetricians too have become critical of the orthodoxy of their own profession, and have shown themselves to be concerned to give women whatever freedom of choice they consider safe in the conduct of their labours. It is in recognition of such changes that natural childbirth advocates have published such books as The New Good Birth Guide from which we quoted in the first section of this unit. Some hospitals are beginning to become places to which Sheila Kitzinger would give three stars for their treatment of women in labour, though others still get no praise. However, some of the natural childbirth movement's critics are concerned that some of its methods may be being adopted, in the face of government cuts, for reasons of their cheapness. For example, husbands may be used instead of trained attendants to avoid increased investment in personnel. In that case those most in need of expert help would be deprived of both choice and medical care.
You are now in a position to add another row to your chart. In this subsection, we have been discussing the organization of movements in support of the critical perspectives on childbirth. We said a little about the organization of the medical profession at the very beginning of section 3. So, if you add another row labeled 'social organization', you should be able to fill in the appropriate boxes with notes now.

We have also noted some of the ways in which organizations critical of the management of childbirth by obstetricians may be having an effect on current practices. You may therefore want to make some addition to the boxes in the row of your chart labeled 'Position with respect to current practices.'

3.4 Review

This is a good point to stop and review where we have got to. Your chart should by now provide a reasonable summary of the issues discussed in section 3, the underlying ideologies of the three different perspectives, the way they look at the history of childbirth, their forms of social organization and the relative effect they have had on current practices surrounding childbirth in this country.

When comparing different perspectives, it is important also to look at the criticisms each perspective has of the others. Such criticisms are relatively easy to find from perspectives which are defined by their criticisms of dominant practices. However, the criticisms that obstetricians have of natural childbirth advocates and of feminist positions on childbirth are more implicit in their overall stance than explicitly laid out. Similarly, natural childbirth advocates and feminists have implicit criticisms of each other.

So as a final exercise, you should now add another row to your chart labeled 'Criticisms of the other perspectives.' In order to fill it in, you will need to look back not only over this section but also over section 2. In doing so, you may well find that there are additional points you want to add in some of your existing boxes.

Your chart should now give you a good and well-organized summary of the main points about childbirth raised in the unit so far. But this unit has a dual purpose: not only to introduce you to the controversies surrounding childbirth, but also to raise some more general issues about social problems and interventions which will arise throughout the course.

The following is a list of some of those issues which have arisen so far. As you read it, try to remember how each issue has arisen in the discussion of childbirth so far.

1. The main issue we have explored so far is the way even apparently 'natural' events, such as childbirth, take place in society. As a result, they are inevitably subject to social intervention, so in that sense are never purely natural.

2. This can be seen by looking at how social practices vary across different societies and have changed through time.

3. Social practices are often controversial, leading to different ideas about which types of intervention are desirable and who are the appropriate people to carry them out.
4 Such different ideas about social practices and appropriate intervention reflect different underlying ideologies, which in turn will influence the way past and present events are explained and described, thereby forming different overall perspectives.

5 Different perspectives will also have their own forms of social organization some may be accorded recognition by the state, others may see themselves more as critical pressure groups arguing for change.

6 Such controversy between different perspectives and the forms of organization to which they give rise is the process whereby practices change.

4 ASSESSING THE EVIDENCE

In the previous sections we have opened up some of the controversies surrounding childbirth both today and in the past. When views differ, turning to the facts to sort out which view is correct may seem a good idea. But from your previous studies in the social sciences you will undoubtedly know that facts can rarely be used to claim certainty for any particular view, though they may provide useful evidence in support of some theories rather than others. In this section we are going to look at some of the ways data about the changing mortality rates of mothers and new-born babies can be used to assess the claims of the various schools of thought on childbirth. You should treat this as an exercise in the use of statistics as evidence, a skill you will need to practise throughout this course and use with care and discretion.

There is little or no dispute that childbirth in Britain today is a much safer process for both mother and baby than it either was in Britain before the development of modern medical techniques or is today in those countries where women have little access to doctors and their skills. Although medical science does claim some of the credit for this, social factors, including the improved nutrition and health of women generally and warmer and more sanitary housing conditions, are acknowledged by all sides of the debate to have had at least as important an effect. And we have already seen that the possibility of a third type of factor – iatrogenic (doctor-induced) illness – has to be considered too. However, sorting out the relative contributions of each of these factors is impossible for changes over such a long period of time as that considered in section 3, especially since reliable figures are not available.

Instead in this section we shall concentrate on two more recent periods and the present. The first is a relatively short period, before and during the Second World War, when childbirth became very much safer for women. The second, the 1960s and 1970s, is the period in which the techniques of ‘modern management’ of childbirth focused on the health and safety of the child, were applied with greatest enthusiasm in this country. In the third part of this section there is a cassette exercise in which you will be asked to look at and assess explanations of the current differences between the mortality rates of babies born in different parts of the country and to parents of different classes and ethnic groups. Finally, we shall consider the ways in which such evidence has been used in the shaping of policy.
In taking notes on this section, you may like to think about what sorts of evidence each of the three perspectives, considered in the last section, would be eager to use in support of its case. Which perspective is most likely to stress factors which are medical in origin, which social, and which the iatrogenic ones? And which parts, if any, of the evidence we consider would each perspective use to support their case?

But this is not the only aim of this section, it is also designed to introduce you to some more general techniques for assessing statistical evidence, which should be useful to you later in this course. It would therefore also be a good idea to make a list of these techniques and how they are used as you read through this section.

4.1 *Maternal mortality 1935–50*

The graph in Figure 7 gives trends in maternal mortality, that is the number of women who die in childbirth per thousand giving birth, since 1881 when the figures were first collected on a systematic basis.

**Figure 7**
Trends in maternal mortality, England and Wales, 1881–1981
Source: Macfarlane and Mugford, 1984, p 197

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**Q** In which of the periods did maternal mortality rates fall?

There were a number of periods in which they fell unevenly, such as the period around the turn of the century. But none of these falls were sustained and the maternal mortality rate in the early 1930s was higher than that for 1905. Maternal mortality fell sharply in the mid 1930s and continued to do so until about 1950, when the rate of decrease slowed down to eventually tail off by about 1975.

One of the explanations that has been given for the sharp improvement in the late 1930s and '40s is the spread of antenatal care. The first antenatal clinics were set up in the early years of this century as part of an attempt to reduce acceptably high mortality rates, particularly maternal ones, partly as a result of pressure from mothers themselves. Before the development of antenatal care, most women received no professional help at all in connection with their pregnancy until they were
actually in labour. When the Ministry of Health set up a Departmental Committee on Mortality and Morbidity in 1932, there were 700 antenatal clinics operating throughout Britain. By 1944 the number of clinics had risen to nearly 2000 and when the National Health Service started in 1948 free antenatal care became available to all pregnant women.

Q Looking at the evidence above, do you think that antenatal care has made a contribution to lessening maternal mortality?

There is no way that this question can be answered from statistical evidence alone. We can see that there is an association between two variables: the maternal mortality rate and the number of women receiving antenatal care. As the number of women receiving antenatal care went up, the maternal mortality rate went down. But that in itself says nothing about causation. It could be pure chance that the two variables changed at the same time or it could be that they were both the results of some other third factor. We always have to look at data cautiously with such possibilities in mind. In particular, we always have to consider if there were other simultaneous changes in society at large, which could explain the changes in which we are interested.

Q In this particular case, can you think of other changes over the period in question (1935 to 1960) which could explain the fall in the maternal mortality rate?

Incomes also rose over that period. Higher incomes enable pregnant women to live in better housing and to eat better food, both of which may contribute to a safer outcome of their pregnancies. Of course, a higher personal income is not the only way to achieve an improvement in such “social” factors; welfare benefits can be provided by the state too. But looking at the rise in personal incomes raises the question of how far the decrease in maternal mortality might be attributable to social factors instead of, or as well as, the medical care provided through antenatal clinics.

The 1932 Committee on Maternal Mortality and Morbidity set up to consider the high maternal mortality rates of the early 1930s, endorsed the view that poverty was one of the most important factors when it found that the safety of childbirth was most closely related to the general state of the mother’s health, and a leader in The Lancet of 1934 saw poverty as “perhaps the most potent influence tending to counteract the benefit of antenatal care.”

If income is a significant factor in improving mothers’ survival rates, then one would expect women of the higher income social classes to have lower mortality rates than those from the manual working class. Table 1 shows figures from the 1930s which baffled observers at the time who were well aware of the association between poverty and mortality for all other groups of the population.

Table 1: Mortality from puerperal causes per 1000 live births, of married women, according to social class of husband, England and Wales, 1930–32.

Q What is unusual about the figures in Table 1?
Childbirth resulted in a greater death rate for the wives of men in Professional classes I and II than for the wives of manual workers (III, IV and V), reversing the usual association of poverty with poor outcomes of childbirth. This negative association was particularly marked for death from puerperal fever, that is childbirth infection, but was present to a lesser extent for all causes of death in childbirth except haemorrhage, which, at the time, prior to the introduction of blood transfusions, was a life-threatening emergency doctors could do little about.

Q Can you think of any explanation for the negative association between poverty and maternal mortality rates in the early 1930s?

Two related causes have recently been suggested by government statisticians to explain this unusual social phenomenon as well as the rising overall maternal mortality rates of the early 1930s (see Figure 7)

In retrospect, a number of factors which might have played a part both in this social class pattern and in the overall rise in mortality can be identified. Firstly, middle-class women may have been more likely to be able to afford to have their babies in nursing homes and other institutions where they were probably at a higher risk of developing puerperal fever than at home.

Secondly, the reports on maternal mortality during the 1930s all carried warnings of the dangers of obstetric intervention and the Registrar General’s reports pointed to increases in mortality from this cause. Middle-class women were more likely to be able to pay to be attended by doctors rather than midwives and thus put themselves at increased risk of unwarranted and sometimes inexpert intervention. Midwives attending difficult births were increasingly likely to send for doctors, who in some cases had inadequate training and experience (Mactaraine and Mugford, 1984, p 205).

The Lancet, in the leading article of 1934, previously quoted, returned to the two factors of poverty and antenatal care to explain the rising mortality rates of the 1930s.

It would be possible to argue that in the view of the hard times we have come through, a maternal mortality rate which has not risen seriously is an achievement, some of the credit for which is due to antenatal work. Supervision at an antenatal clinic will not by itself save life (The Lancet, 24 November 1934, p 379).

But one would hardly expect The Lancet, the house journal of the medical profession, to comment on any contribution the profession itself made to maternal mortality, which did start to fall in the mid 1930s. Although some contribution must have been made by the introduction of both anti-bacterial drugs as a treatment for puerperal sepsis and blood transfusions for women who haemorrhaged, the decrease in the death rate from each of those specific causes had begun to fall before the introduction of the relevant medical advance. Similarly, the overall mortality rate continued to fall after the new techniques had become general practice. It continued to fall throughout World War II, a time when there was a severe shortage of doctors, midwives and maternity beds but the wartime national food policy provided cheaper milk and extra rations of appropriate foods for pregnant women.

Finally, the Working Party on Midwives in 1949 put forward another factor which it thought had contributed to the fall in maternal mortality.

As the risks of death are controlled, to some extent, by the age of the mother, the number of previous pregnancies and the interval between pregnancies, any changes since 1935 in the respective influence of these factors, such as fewer sixth or subsequent births of elderly worn-out mothers, could well reduce the overall death rate (quoted in Huntingford, 1978, p 239).

In other words, smaller families may also have contributed to the fall in the maternal death rate.
Q. Given all this evidence, what policy do you, with hindsight, think should have been followed in the 1930s to improve maternal chances of survival?

You may have a number of suggestions. Perhaps you suggested looking at the medical care women received to develop better forms of antenatal care, perhaps focusing more on nutrition and hygiene, with less subsequent intervention by doctors in childbirth. Or you may have thought more could be done by helping women before they became pregnant, extending contraceptive services so that women could choose to have fewer children. Alternatively, you may have suggested solutions that went beyond the individual and the choices they could make – policies for directly improving the nutrition of poor women by supplementing their diet or improving their living conditions. Yet wider changes would involve trying to do something about the general incidence of poverty, perhaps by redistribution or changing the economic system altogether.

The figures we have looked at, like any other statistics, do not actually prove that any of the changes that happened in the 1930s were responsible for the fall in maternal mortality. That a change happened at the same time only shows that it can be statistically associated with the drop in maternal mortality; it does not in itself imply a causal connection. To assert a causal connection, we have to have a theory about why the two factors show a statistical association. And, as we have seen, there are a number of such theories, each of which gives support to a different variable.

We did see that by looking at evidence in more detail we can reject some of the more simplistic theories. For example, we saw that the exact timing of the falls in maternal mortality make it unlikely that the two main medical innovations of the period – the use of anti-bacterial drugs and blood transfusions – could have been alone responsible for all the improvements in maternal mortality. This technique of looking at evidence in more detail is sometimes useful to judge between different theories asserting different causal connections. Although the evidence still does not prove any one theory to be right, it may enable us to rule out some others.

We used another way of looking at the data in more detail, breaking down the total maternal mortality rate into rates for women of different social classes, to provide more evidence. We found that women whose social conditions were likely to be the most favourable – those married to middle-class men – suffered the worst mortality rates. This unexpected result led us to surmise that something must have been unusual in the way other factors impinged. We considered one hypothesis supported by this evidence that middle-class women were more likely to be subject to iatrogenic factors, because they were more likely to give birth in institutions and more likely to be delivered by doctors.

In an area like this, which theory is believed and thus how the problem is defined is not just an academic matter. It has important consequences if it informs the makers of policy, or the people and interests who put pressure on them. Those who believed that it was the ignorance and life-styles of pregnant women themselves that caused their high mortality advocated antenatal education. Others felt poverty was the root cause, but saw little that could be done about it within the depressed economic situation of the time. Others believed that medical science would provide the answers, these joined with the previous groups to set up clinics which were precursors of the National Health Service. Beliefs are not held irrespective of the interests they support, however. The alternative view that obstetric intervention was dangerous and contributed to maternal mortality, although suggested in a number of official reports during the 1930s and endorsed by the Registrar General, had little effect, except perhaps on the choices made by a few pregnant women. There was no specific lobby to take up this view, but an increasingly powerful one entrenched against it the medical profession itself.
Before reading on, it would be useful to make two sets of notes

1. Additions to your chart list which parts of the evidence, if any, that we have considered could be used in support of each perspective and the parts of the evidence which it is difficult for each to explain (It is important that you label these notes as being about the period 1935–50, because we shall now go on to consider more recent evidence)

2. A list of the statistical techniques used and what they helped us to sort out

4.2 Perinatal mortality in the 1960s and '70s

In the post-war years, when childbirth had become very much safer for women, attention switched to the health of their babies. It was in pursuit of lower rates of mortality and morbidity (death and illness) for babies that many of the techniques of modern obstetric management of childbirth were introduced in the 1960s and 1970s.

The measure most frequently used of the dangers of childbirth to the baby is the perinatal mortality rate which adds the number of stillbirths — babies born dead at or after 28 weeks of gestation — to the number who die in the first week of their life. The measure is used because one week is thought long enough to include most of the immediate after-effects of birth, but is a sufficiently short period to exclude most subsequent causes of death.

The graph in Figure 8 shows how perinatal mortality rates have fallen since the 1930s. Compare this with the graph in Figure 9 which charts the increased use of the main techniques of obstetric intervention from 1955 to 1978. (If you need to remind yourself what these techniques are, look back at section 3.2 where they are described.)

Figure 8
Trends in perinatal mortality rates, England and Wales, 1928–84
Source Huntingford 1978, p 240
Q What evidence do these graphs give to support the claim that modern obstetric techniques have been effective in improving the safety of childbirth for babies?

Perinatal mortality rates did fall markedly in the 1960s and 70s, the period in which the use of all the above techniques increased greatly (except for a drop in the number of labours induced after 1974). However, we have to be careful in jumping to conclusions as to what caused that fall. All we can safely say as yet is that we have a positive association between the increased use of obstetric techniques and the fall in the perinatal mortality rate throughout the 1960s and 1970s.

Doctors have long been aware that factors other than their own skill and expertise affect the survival rates of new-born babies. George Newman, who was Medical Officer for Health for Finsbury, lamented in 1906 that:

... though the general death rate is decreasing the infant mortality rate is not declining. This means that whilst during the last half-century, a time of marvellous growth of science and of preventive medicine, human life has been saved and prolonged, and death made more remote for the general population, infants still die every year much as they did in former times. Indeed, in many places it appears that they die in greater numbers, and more readily than in the past. (Newman, 1906, quoted in Macfarlane and Mugford, 1984, p. 27)

Newman investigated the possible contribution to infant mortality of a number of factors including 'antenatal influences', domestic and social conditions, and the employment of women.

Today a large number of such 'social' factors are known to influence the chance of a baby being born alive and surviving the first week of life, still by far the most dangerous period of any person's life. These include the mother's age, her parity (the number of previous children she has borne), her ethnic origins, and the region of the country in which she lives, whether she is married and, if she is, her husband's occupation and various aspects of her life-style including whether she smokes, though not, in fact, whether she is employed. These factors have, of course, been subject to considerable change. So assessing whether they or medical improvements have been responsible for falls in the perinatal rate over the past thirty years or so is a difficult matter.

The babies most likely to figure in the perinatal mortality statistics are those of 'low birth weight'. These babies, defined as those weighing less than 2500 grams (about 5½ lbs) at birth, account for nearly two-thirds of perinatal deaths, even though they form only around seven per cent of all births. So the most important factors in
explaining why some babies die must be the factors which can explain why some babies are born small and why some of those babies consequently die.

Babies who are born small can be classified into two types: those that are full-term but 'small for dates', that is, those whose growth rate has been low, and those who are born prematurely, that is, their period of growth in the womb has been short. Both causes of low birth weight can be affected by social factors, but the growth rate more than the length of gestation. The effects can be direct or indirect, for example, directly through maternal nutrition during pregnancy, or indirectly if malnutrition in childhood has left the mother unable to support a foetus of normal growth rate. But some social conditions, for example, insanitary housing leading to maternal infection, can affect both the foetus's growth rate and its length of gestation.

Most babies born small today spend much, if not all, of the first week of their life in intensive care, and mothers giving birth prematurely or expecting a baby which is known to be 'small for dates' will be under full medical supervision. Under these conditions the social circumstances of the parents will cease to matter directly, though indirect effects may, of course, continue to operate. It is in these circumstances that medical factors would seem to be paramount, both in ensuring that babies in the womb known to be at risk are born safely and that all small babies are helped to feed and kept free of infection and respiratory problems.

Medical intervention may in a few cases be able to prevent or delay premature birth, and antenatal care may have some effect in preventing those social factors which reduce growth rates over which a mother has control, such as smoking. On the other hand, medical intervention may actually increase the number of babies born small, through early inductions, though in some cases this may, of course, save the baby's life.

Q The distinction made above between medical and social factors cannot always be neatly drawn. Can you think of examples where it cannot?

One example in the discussion above might have struck your attention. I talked about antenatal care, a medical factor, possibly having an effect on the number of low birth-weight babies if it reduced the number of mothers who smoked, a social factor. Medical and social factors interact, so to make a distinction between them as potential causes does not always make sense, especially when one is talking about matters over which mothers have some control and doctors some power to influence them.

Despite these difficulties we can make some broad distinctions between the two types of factors and, by looking at what has happened over the past thirty years, begin to assess from which type the greater improvement has come.

Q What data would be useful in making such an assessment of whether medical or social factors had been more important in reducing perinatal mortality?

Since broadly social factors seem to affect whether a baby is born of low birth weight and medical factors whether a low birth-weight baby then survives, it would be useful to know what has happened over the period in question to both the proportion of babies born who are of low birth weight and the subsequent mortality rates of these babies. Figure 10 gives this information.

From this graph we can see that from the mid 1960s the mortality rate of low birth-weight babies declined markedly in the first day of their life, less so for the remainder of the first week and hardly at all for the remainder of the first month. This does mean a considerable improvement overall, however, since the latter two mortality rates will include babies surviving past the end of their first day who would not previously have done so. On the other hand the proportion of babies of low birth weight has hardly changed over the same period, as Figure 11 shows. Indeed for some years, like those of the late 1960s, it actually rose.
What conclusions do you draw about the relative importance of medical and social change in improving the perinatal mortality statistics since the 1960s?

Medical care certainly seems to have been effective in lessening the mortality rate of those babies most at risk. But the proportion of such babies born has remained constant. This would suggest that improvements in social factors have been less marked or less effective.

So although the crude evidence of trends could not sort out which of the changes that have happened over the past thirty years has been responsible for the declining perinatal mortality rate, by looking at the proportion of babies of low birth weight born we can make a broad distinction between the effects of medical advances and of social changes. This is because social circumstances tend to have most effect on the proportion of babies born of low birth weight, while medical science can on the whole claim the credit for improvements in their survival rate. In this way, the proportion of low birth-weight babies was used as a 'proxy variable' to measure the effect of the social circumstances in which babies are born. This technique of finding a variable which is subject to some of the factors under consideration but not all of them, is useful for giving support to one causal theory rather than another.
But sorting out which factors have been responsible for reducing perinatal mortality in the past does not necessarily indicate what would be the most effective policy in the future. One could argue that the success of medical improvements over the past thirty years in improving the survival chances of low birth-weight babies points to the need for more medical intervention. (Note that the evidence we have looked at says as much, if not more, about the effects of modern methods in the care of babies after birth (paediatrics) as before and during it (obstetrics).) On the other hand, one could use the evidence that little improvement has taken place over the past thirty years in the proportion of babies born who are of low birth weight to indicate that now we should pay more attention to social factors which could influence that proportion.

The incidence of low birth-weight babies and infant mortality rates for a number of countries are plotted in Figure 12. (Comparable perinatal rates are not available so I have had to use infant mortality rates, that is, the mortality rates of babies in their first year of life.) Such a chart is called a ‘scatter diagram’ on which points are placed according to two variables, one measured along the horizontal axis and one measured along the vertical axis.

**Figure 12**
Infant mortality rates and the incidence of low birth weight for selected countries, 1972–77
Source: Macfarlane and Mugford 1984, p. 239

![scatter diagram]

**Q** What can you tell from the scatter diagram in Figure 12 about the experience of other countries which might be useful to the policy-makers of this country?

A number of points are worth noting from this scatter diagram:

- Britain does relatively badly compared with most other western nations on both counts
- There is a large range in the percentage of low birth-weight babies born. In Sweden less than four per cent of babies are born small, compared with more than eleven per cent in Hungary
- The points on the graph are not randomly scattered. They cluster around a line which runs diagonally from bottom left to top right. This means that the variables plotted on the two axes tend to go together; countries with a high incidence of low birth-weight babies have a high infant mortality rate. In other words, the diagram shows the two variables are positively associated. Of course, as we noted before, this
does not necessarily prove anything about a causal connection. But in this particular case, because we already have good reason to believe that there is a causal connection, we can see the graph as further supporting evidence.

The association between the incidence of low birth weight and the infant mortality rate is not exact. If it were, all the points plotted would lie on a single upward sloping line. This means that other factors, such as variations in medical care, are needed to explain why, for example, there are more than twice the proportion of infant deaths in West Germany than in Denmark even though the incidence of low birth weight in the two countries is rather similar.

**Q** What does the evidence of other countries’ achievements suggest might be the most effective way to improve Britain’s perinatal mortality rate?

The points for both Scotland and England and Wales lie on or just below that general upward sloping line around which most points lie. This suggests that, given Britain’s incidence of low birth-weight babies, our medical services do rather well in saving them. But countries such as Sweden and Finland have an incidence of low birth-weight babies only about half that of Britain, and correspondingly lower infant mortality rates. This suggests that improving social conditions to match those of Sweden, for example, would have a great effect, possibly resulting in even lower mortality rates than the Swedish ones, if our existing medical facilities were used to cater for a much reduced number of low birth-weight babies.

Now stop and make notes on this section

1. List on your chart evidence for and against each perspective’s case. Remember that, because we are getting nearer the present, we have also considered policy options for the future, which may require a different answer than the question of what has proved most effective in the past.

2. Note the statistical techniques used and the ways in which they were helpful.

### 4.3 Choosing the right parents

This section consists of an audocassette exercise to examine and explain variations between the perinatal mortality rates of babies born in different parts of England and Wales and to parents in different social classes and different ethnic groups. You will need a pencil and paper to make some notes on the following tables, maps, and diagrams to which the tape refers. When you are ready switch on the tape, stop it whenever it asks you a question and continue when you have considered your answer. When you have finished the tape, make notes as it suggests and then go on to the next subsection of this unit. If you cannot listen to your cassette now, move on to section 4.4 and return to this section as soon as you can.
FRAME 1

Copyright material removed
OpenLearn

Source: Macfarlane and Mugford, 1984, Figure 3.13, p. 55

FRAME 2

Copyright material removed
OpenLearn

Source: Macfarlane and Mugford, 1984, Figure 3.12(b), p. 59
Copyright material removed

Source: Macfarlane and Mugford, 1984, Figure 3.12 (d), p. 54
FRAME 4

(a) Special care cots and low-weight births, in English Regional Health Authorities, 1980

Copyright material removed

OpenLearn

Source: Macfarlane and Mugford, 1984, Figure 7.2, p. 145

(b) Intensive care cots and very low-weight births, English Regional Health Authorities, 1980

Copyright material removed

OpenLearn

Source: Macfarlane and Mugford, 1984, Figure 7.3, p. 146

Q Does the availability of special equipment and medical care for tiny babies match the need for it in different parts of the country?
Q. Did social class differences in perinatal mortality rates improve in the 1970s?

Source: OPCS Mortality Statistics, reproduced in Macfarlane and Mugford, 1984, Table 5.2, p. 97
Q Which measure would you expect to pick up social factors most clearly?

Source Office of Population Censuses and Surveys, OPCS Monitor, DH3 87/1, p 6 and DH3 87/3, p 5

Q For which measures are class differences greatest? How can this be explained? Can social class differences in perinatal mortality rates be explained by differences in birth weight? Have social class differences changed from those of the 1970s?
Q. What can one say about ethnic differences in perinatal mortality rates from this table? Is there a consistent pattern across different birth weights? Should low birth weight be defined the same way for all groups?
FRAME 10

Q: What possible explanations can you think of for such differing mortality rates?

<table>
<thead>
<tr>
<th>Class of travel</th>
<th>Mortality rate for women</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>3</td>
</tr>
<tr>
<td>Second</td>
<td>16</td>
</tr>
<tr>
<td>Third</td>
<td>45</td>
</tr>
</tbody>
</table>

Source: Ann Oakley, lecture to the British Association for the Advancement of Science, Bristol, September 1986

Make sure before you go on that you have made notes as suggested on the audiotape.

4.4 Government responses

Throughout the 1970s there was concern among those involved in health policy about the relatively poor perinatal mortality rate in this country. Over the decade, a series of government reports and consultative documents on the perinatal health services were published, culminating in July 1980 with the Short Report, the second report from the Social Services Committee on Perinatal and Neonatal Mortality.

This committee, chaired by Renee Short, MP, was concerned, as we were in the previous section, to identify the factors which caused babies not to survive and to suggest ways of reducing perinatal mortality rates. It concluded that:

Factors causing perinatal and neonatal mortality and handicap broadly divide into two categories
(a) Socio-economic factors such as lack of education, poverty, poor housing, possibly poor nutrition, unplanned pregnancy, smoking, drinking alcohol to excess, etc.
(b) Medical factors such as lack of antenatal care, low birth weight, asphyxia during delivery or afterwards, congenital malformations, cerebral haemorrhage, etc.
(DHSS, 1980a, p. 158)

Q: It is clear that in our terms, some of these factors cannot be considered 'causes' so much as associated variables. Can you think of any examples?

As we have seen, there is little evidence to suggest that antenatal care has any direct effect on maternal health. There is an association between the amount of antenatal care received and decreased perinatal mortality, but this may arise because those women who are most likely to attend antenatal clinics regularly are the same ones who would anyway give birth to healthy babies. If this is the case, campaigns to encourage women to attend clinics earlier or more frequently will have little effect. This is how one critic of the whole debate puts it:

There is however mounting evidence, both clinical and epidemiological, to suggest that most of the major causes of perinatal mortality are not affected by antenatal care but lie outside and are independent of this period. Perinatal mortality cannot, therefore, be seen
as caused by lack of antenatal care, although it is likely to be related to it, because non-attenders at antenatal clinics are at higher risk of losing their babies through other factors such as economic deprivation, high parity and extremes of age (Russell, 1982, p 306)

Q Look back again now at the Short Report's list of factors. Can you suggest ways in which those factors termed 'socio-economic' and those termed 'medical' might be interrelated?

We have already noted that 'antenatal care', the first of the Short Report's 'medical' factors, does not in itself save lives. But one of the functions it may perform is an educative one, and it may influence thereby those 'socio-economic' factors, such as smoking, alcohol consumption and nutrition to the extent that these are in the control of an individual woman

Low birth weight was one of the factors which we noted was most closely associated with the social conditions of the parents. And this is true of nearly all the remaining 'medical' factors on the Short Committee's list. They are strongly associated with the poorer geographical regions of the country and with being born to parents of social classes IV or V or of non-white ethnic groups. They are 'medical' only in the sense that it might be hoped that medicine could mitigate their effects, not in the sense of being of medical origin. 'Socio-economic' factors in contrast therefore would seem to be those factors for which doctors are not considered to have any professional responsibility, because their cause lies elsewhere in society. In other words, the division made was between those factors in which there was a belief doctors could be effective agents in bringing about improvements and those which, by implication, formed part of an unchangeable background structure, upon which such agents could not be expected to have any effect.

Although the Short Report recognized the interrelation of its socio-economic and medical factors, it structured these lists in such a way as to justify a concentration of policy on the medical, leaving thereby an almost total silence with respect to policy for improving social conditions. It suggested that medical intervention, for example foetal monitoring of all deliveries, could largely remedy the effects of adverse social circumstances.

Pernatal and neonatal mortality are twice as high in the lowest socio-economic classes as in the highest. We recognize that in the long term raising the standard of living is the best remedy for overcoming the problems of babies of socially disadvantaged mothers but suggest that much of the death and handicap suffered by [these] babies can be overcome by well applied medical intervention (DHSS, 1980a, pp 158–9)

An alternative approach would have been to concentrate on the social factors so as to obviate the need for medical intervention. This is what the National Prenatal Epidemiology Unit advocated.

Firstly, the medical care during the child-bearing period isn't going to eliminate the causes of many deaths. Secondly, reducing social disadvantage is not a very different issue from the issue of improving perinatal mortality and morbidity, but the same issue. Those who concern themselves with how good our maternity services are should also concern themselves with the health and social position of women in our society, and with the extent and consequences of class inequality (Oakley, quoted by Russell, 1982, p 307)

The government echoed this criticism, though for different reasons, in its reply to the Short Committee, when it insisted that 'wider policies of economic and social progress have an essential part to play alongside improvements in health care' (DHSS, 1980b, quoted in Russell, 1982, p 307). But at the same time it made clear that if medical reforms were to be rejected on the grounds of cost, then 'economic and social progress' was even more unlikely to find government financial support.
If the evidence as to the benefit of further concentration of medical intervention to improve perinatal mortality rates is so unclear, why do you think more policy initiatives have been directed towards that end than to improving social factors?

You may have answered this question by looking at the relative power of the different interest groups involved. Those who benefit from an increased concentration on medical resources include the medical practitioners themselves, by now, as we have seen, a very powerful professional lobby. On the other hand, those who would benefit from an improvement in the social factors which contribute to perinatal mortality are the poor, and not only those specifically at risk, since many of the improvements would be hard to target on those pregnant women whose babies are in most danger. The poor are not a notably effective pressure group.

An alternative answer would focus on the way society as a whole works, and point out that some aspects of society are so fundamental that to intervene in them would mean effectively changing its whole structure. One of the main planks of a capitalist society such as ours is the idea that people have to provide the basic essentials of life for themselves and their families, usually by earning wages. To provide food and other essentials directly seems to hit at the very foundations of such a system in the way that the provision of medical care does not. In times of war or other national emergencies such ‘rules’ can be broken, as they were with the provision of special rations for pregnant women during the Second World War, because everyone knows that they are temporary measures, and the normal ‘rules’ will be reapplied after the emergency is over.

If you have met the terms ‘structuralist’ and ‘pluralist’ in your previous studies of the social sciences, you may have noted that one of the above explanations was a structuralist one and one a pluralist one. Which was which?

The pluralist explanation focused on the working of competing interest groups, whereas the structuralist one looked at how the structure of society as a whole works. Of course, neither answer is really adequate because the rules of society themselves are the subject of debate and political struggle in which different interest groups participate. When family allowances were first introduced, opponents argued that they would shake the very foundations of family life by relieving men of the responsibility to provide for their wives and children. In practice this has not happened, although it can be argued that similar fears restrict such benefits to levels that provide no serious alternative for many women and children to dependence on a male wage-earner.

As a concluding exercise for this section, think about the following questions and note down your own views:

1. What changes, if any, should there be in the notion of what type of care it is appropriate to give to pregnant women?

2. What in practice do you think will happen? Will the state be ‘rolled back’ so that the provision of medical care becomes the responsibility of families too? Or will state intervention be extended to encompass more of the social circumstances in which women give birth to babies?

3. Which interests would be involved in shaping and contesting such policy changes?

Finally, make notes on your chart of the views, if any, you would expect each of the three perspectives on childbirth to have on the above questions.
4.5 Review

The notes you have taken should provide you with a good summary of the explanations of why maternal and perinatal mortality rates have fallen overall and why they still vary between different parts of the country, different social classes and different ethnic groups. You should also have a good idea of the way evidence can be used to sort out whether social or medical factors have been the more significant in explaining variations and historical changes in these mortality rates.

We also saw that it was in practice difficult to make a separation between medical and social factors and showed how the division was drawn would affect the policy conclusions arrived at, as it did in the Short Report. Despite acknowledging the importance of social factors, the Short Report’s recommendations concentrated on changes in medical policy alone. We examined two possible explanations of why this might happen – a pluralist one based on interest groups, and a structuralist one based on the nature of capitalist society – and noted that in practice there is an interaction between interest groups and the ‘rules’ of capitalist society which constrain policy options.

One aim in taking you through the statistical analysis was to introduce you to some statistical techniques which may be useful to you later on. We saw that the existence of an ‘association’ between two variables does not in itself imply any particular explanation for that association. The techniques we used to assess explanations were:

- To analyse data in more detail (for instance on a year-by-year basis) to see if an association that appeared to hold at a more general level continued to hold when looked at in more detail.
- To break down aggregate data into subgroups (for example by class, region or race) to see whether any unexpected associations occurred (like the higher mortality of middle-class women in the 1930s) and to examine variations between groups, which might be better explained by one theory than another.
- To choose a ‘proxy variable’ which can pick up variations in the factors important to one theory, but is relatively independent of those important to an alternative explanation.
- To draw a ‘scatter diagram’ to examine how exact an association between two variables is. An exact positive association will result in all points lying on a straight line running diagonally upwards from bottom left to top right. Deviations from such a line will point to the need for explanations in terms of other factors.
Of course, every pregnant woman wants to survive the experience of giving birth and wants to produce a healthy baby. But, as childbirth has become safer, women have begun to demand that the experience of childbirth be assessed in terms other than those represented by mortality statistics. The success of the natural childbirth movement in questioning doctors' attitudes shows how many women have begun to see birth itself as a rare event in their lives which they want to have the chance of experiencing in particular ways. Some want it to be as painless as possible, others as natural as possible. Most want to feel in control themselves and few want to be treated as if the subject of a medical emergency rather than actively exercising their natural female powers. A key issue seems to be whether the help given is perceived as 'intervention' and who is thereby in control.

Graham and Oakley found in studies of antenatal care carried out at two different hospitals, that the mothers and obstetricians they observed had different 'frames of reference' or 'ideologies of reproduction', one part of which were their differing criteria of success. They contrast the obstetrician's 'restricted' view with the mother's 'holistic' frame of reference.

Criteria of success

**Obstetricians**

The obstetrician's frame of reference gives a particular and again restricted meaning to the notion of 'successful' reproduction. Here the reference point is perinatal and maternal mortality rates, and to a lesser degree certain restricted indices of morbidity. A 'successful' pregnancy is one which results in a physically healthy baby and mother as assessed in the period immediately following birth, i.e. while mother and child are still under the obstetrician's care.

**Mothers**

Because of the holistic way in which women view child-bearing, the notion of successful reproduction is considerably more complex than the simple measurement of mortality and morbidity. Though in almost all cases the goal of the live birth of a healthy infant is paramount, success means primarily a satisfactory personal experience. This applies not only to the pregnancy and birth but to the subsequent mother-baby relationship and to the way in which motherhood is integrated with the rest of a woman's life. Unlike the obstetrician's criteria of success, these criteria — pregnancy/birth experiences, experiences with the mother-baby relationship, and experiences with integrating motherhood into a woman's life-style — are not separable or easily observable, but can only be assessed in the weeks, months or even years following birth. 

(Grantham and Oakley, 1981, p. 54–5)

Q What do you think is meant by saying that the mothers' frame of reference is a 'holistic' one?

A 'holistic' approach is one which looks at the matter under consideration as a whole, rather than breaking it down into its constituent parts. The obstetrician's frame of reference looks for certain measurable criteria, such as the perinatal mortality rates we considered in the last section, which from the mother's point of view may be only part of the picture. Childbirth for her is also the beginning of a new relationship, with her baby, and a new or changed way of life for herself, as a mother.

If a woman has a different frame of reference from her obstetrician, she may make different choices — if she is allowed to — as to the way in which she gives birth. In this section we are going to examine the following related issues:

1. Which criteria women might use in making choices about childbirth?
2. Under what circumstances women do or do not feel in control
3. When professional help becomes seen as 'intervention', or even 'interference'

These are the main themes of this section and it is on them that you should be making notes after reading each subsection. They will be explored by looking at one particular choice that faces every pregnant woman: where to give birth, at home or in hospital?
5.1 The state and its institutions

In this country, where the majority of medical care is provided under the National Health Service, the state is involved not only regulating but also providing maternity services. Even at times when medical care was largely private, state regulations affected childbirth practices.

Q Can you think of instances where the state is or was involved in regulating practices around childbirth?

The state is involved in the certification of people allowed to practise midwifery. In the past it supported the right of the medical guilds to monopolize the practice of medicine and was involved, through the church, in the persecution of 'witches' for practising their form of medicine. Later it registered doctors and midwives, limiting the practice of midwives to normal childbirth and placing on them the responsibility for calling doctors in cases of difficulty. In this way the state was actively involved in defining the roles of both doctors and midwives with respect to childbirth.

Today the state is involved in a much wider sense because it provides antenatal and childbirth facilities as well as regulating their use. But provision, because it takes certain forms and not others, becomes in itself regulatory. An example where this distinction between the state as regulator and the state as provider becomes blurred is around the choices available to women as to where they can give birth.

Every woman has the legal right to choose where to give birth. And every local authority has the statutory obligation to provide a midwife to attend a home delivery. Conversely, a woman who gives birth in hospital has the right to stay there up to ten days. Any woman who gives birth at home or is discharged before the ten days is over – many stay forty-eight hours or less – must be visited by a midwife once a day until ten days after the birth, and, if her family is unable to provide it, is entitled to some home help.

In practice these rights may be difficult to enforce. Any doctor can refuse to authorize a home birth, and, as we have seen, midwives rarely practice without medical authorization. Finding and obtaining the agreement of another doctor may be difficult. It is illegal to give birth without a qualified attendant, except in an emergency, and unqualified attendants have been prosecuted. The safety of home births depends on the existence of local obstetric emergency units – 'flying squads' – which can give pregnant women in difficulties the care they need as they are moved to hospital. In some areas these units no longer exist, even though where they do operate they are more frequently called to attend women who had planned to give birth in hospital but find themselves unexpectedly in advanced labour, than those in difficulties during a planned home confinement.

In practice, then, although the state's role in this area is in theory an enabling one, and one which gives women the freedom to choose where to give birth, they may have difficulty exercising that choice. This is for three reasons. First, there may be great pressure put on women to go into hospital, including the belief that they may be putting their baby at an unnecessary risk even though, as we shall see, the evidence that exists to support this is questionable for most women. Secondly, people may not know about their rights. Without this knowledge, few women would be able to insist upon a home delivery or, conversely, on their right to stay in hospital for the full ten days. Finally, the practical obstacles to enforcing one's rights may be so great as to be beyond the reach of all but the most determined, most articulate and those with sufficient time available to devote to the task.

Q Do you think many women feel they have a choice as to where they are going to give birth?
5.2 The ‘cascade of intervention’

One of the problems for some women with being in hospital is that it is the doctors’ territory and it is they rather than the woman who appear to be in control. One basis for such a fear is that medical interventions may not come singly: having accepted one form of intervention a woman may be letting herself in for a whole ‘cascade of intervention’ whereby one form of intervention leads to the need to use another, even to the extent, their natural childbirth critics claim, that doctors may eventually end up using all their skills and technology to save the life of a baby their intervention has itself endangered.

One of the most controversial of the techniques of modern obstetrics is the use of artificial induction of labour, that is, starting a pregnant woman’s labour off by some artificial means, usually in the first instance rupturing the membranes surrounding the amniotic sac in which the foetus lives. This technique has undoubtedly saved many babies’ lives and avoided the alternative of Caesarean sections for some mothers, but it does have its dangers.

The direct danger of induction is that the baby is delivered prematurely. Since prematurity and consequent low birth weight is by far the greatest cause of perinatal mortality, this is a danger which needs to be taken seriously, and is one reason why the induction rate has now fallen in many hospitals from the high rates of the early 1970s; then inductions were often done routinely whenever a mother’s blood-pressure was raised, a baby was thought to be ‘late’ or even, in some cases, to help plan the use of hospital beds and staff shifts (Huntingford, 1978).

Even when labour is induced for sound medical reasons, when, for example, the mother is showing dangerous signs of toxaemia or the baby of post-maturity, it may lead to the need for further intervention. Figure 13 illustrates a possible subsequent cascade of intervention. Running down the cascade, if rupturing the membranes does not succeed in inducing labour, other forms of induction will be needed. This is because the baby cannot safely remain long in the mother’s womb once the amniotic sac has been broken. She will therefore be put on a drip through which drugs to induce labour will be fed into her. The problem with being on a drip is that it means that she has to remain horizontal, which is not a good position for labour and giving birth, because gravity is not able to help the process and her pelvis has a smaller diameter than it does in other more ‘natural’ positions.

Figure 13
One possible cascade of intervention
Source: Inch, 1982, p. 36

Babies being born in such circumstances have frequently shown signs of ‘distress’, which would show up on a foetal monitor. If this happens, or if subsequent attempts at induction fail, a Caesarean section will be necessary. Like any major operation this has risks for the mother and consequently possibly also for the child. Even where the induction works, it often leads to a more painful labour and thus greater
likelihood of drugs being used, which as we saw above, can have detrimental consequences for the child. In particular, since the woman is already confined to her bed because of the drip, the most effective method of pain-killing to use is an ‘epidural’ which numbs the whole pelvic area, but usually also results in her not being able to push the baby out unaided, thus in turn may mean that forceps would be needed to deliver the baby. This rarely has any harmful effects on the baby, but almost invariably means that the mother needs an ‘episiotomy’, a small cut to widen the opening where the baby comes out. This can contribute to the total blood loss of the mother, which, though usually small, can result in a ‘post-partum haemorrhage’, a large and uncontrollable loss of blood which, in rare cases, can still be fatal.

Leaving aside such cases, the end-point of this possible cascade of intervention is the effect that surgical procedures and the use of drugs can have on the development of a close relationship between mother and child, or ‘mother-baby bonding’. A drugged baby may be less responsive, as indeed will a mother semi-conscious or in pain from the after-effects of an operation.

Of course, not every step in this cascade will occur in every case, and certainly their opponents would claim that the natural childbirth movement exaggerates the likelihood of many of the steps being necessary. Sally Inch, from whose book the diagram is taken, would not agree. Indeed she sees that as just part of a whole complex of possible steps that make up the full cascade of intervention shown in Figure 14. It is not necessary for you to follow through every possible step on this chart. It is reproduced here simply to show how interventions cannot be considered singly, because they may lead to the need for more intervention.

Q If such a cascade of intervention is initiated, but a healthy baby results, how would the experience of childbirth be assessed in (a) the mother’s and (b) the obstetrician’s frame of reference?

5.3 The institutionalization of birth

Nearly all births in Britain today occur in hospitals, a few in GP units in smaller cottage hospitals and less than 2% at home. This is, of course, a recent development, since it was only in 1948 with the formation of the National Health Service that all women expecting difficult births could hope to be delivered in hospital. In 1946 half of all births took place at home, by 1958 only 36% did, and the trend towards hospital confinement continued through the ‘60s and ‘70s until in 1970 just over 12% and by 1979 only 14% of all births took place at home in England and Wales (Beels, 1978, and Macfarlane and Mugford, 1984).

One recommendation of the 1980 Short Report was a phasing out of home births altogether. This was consistent with its general support for more rather than less medical intervention as a way to lower perinatal mortality. But as with all forms of medical intervention, the benefits of requiring all mothers to give birth in hospital has come under considerable fire. The evidence on safety has been much disputed, because, as we shall see, it is not just a question of comparing two sets of mortality statistics. The evidence from other countries’ experience shows that a greater or lesser proportion of hospital births may have little overall effect on the safety of childbirth. Both Holland and Sweden have considerably better perinatal mortality rates than Britain, though in Sweden almost all babies are born in hospital, while Holland has a quite different policy which means that a relatively large proportion of babies are born at home (Huntingford, 1978).

Advocates of home deliveries point out it is four times safer in this country to give (planned) birth at home than in hospital. Indeed, that the mortality rates for babies born at home are lower than for those born in hospital is not in dispute.
Can you think why the perinatal mortality rate of babies born at home is likely to be lower than of those born in hospital?

Any woman expecting problems, for example any woman knowing her baby is small or giving birth prematurely, will, except by accident, give birth in a hospital so that the baby can be given hospital treatment immediately after birth. This means that babies born at home will be, on the whole, larger and healthier than those born in hospital. So a straight comparison of the mortality rates says little about the relative merits of each place of birth.

More detailed statistical analyses by Marjorie Tew divided babies into different predetermined groups of low, medium, and high risk, and showed that within each category babies still did better if they were born at home. Although perinatal mortality has decreased as the proportion of hospital births have increased, that is that they appear to be associated variables, she also showed that the association does not fit at a detailed level when one looks at year-by-year changes (Tew, 1978).

On the other hand, mortality rates are currently rising for babies born at home, while falling for those born in hospital. But this can easily be countered by looking again at which babies are born at home. Some who are born at home are low-risk babies whose mothers have had excellent antenatal care and have chosen to give birth at home, but others are those who have received little care or are born at home by accident. As fewer home births are planned, the latter group begins to outweigh the former, and so worsens the mortality figures for home births on average. Conversely, taking more of the low-risk babies into hospital to be born improves the hospital figures.

Women receiving antenatal care are especially heavily discouraged from planning to give birth at home if they are subject to one or other of what are called ‘risk’ factors, factors which statistically are more likely to require medical intervention, such as having a small pelvis, and those which, whether or not intervention can do anything about them, are statistically associated with greater than average mortality rates, such as being over 35 years old. Although the list of what such factors are varies in practice, there is little dispute that there is such a group of women who would benefit from giving birth in hospital. The dispute is about how to identify such a group, how large it is and whether it would still be better for the remainder to be in hospital ‘just in case’.

5.4 Home or hospital?: the pros and cons

For natural childbirth advocates the reasons for giving birth at home are not primarily to do with safety. As advocates of natural methods Doctors Andrew and Penny Stanway are not followers of orthodox medical teaching on many matters. In their book, Choices in Childbirth, they give the following list of reasons why a woman might want a home birth (incidentally they give no corresponding list of ‘cons’).

Of those women who have experienced births both at home and in hospital, the majority say they would like to have their next baby at home. The reasons women give for wanting a home birth include:

- It feels more natural to have a baby in the familiar environment of the home.
- It becomes a family affair.
- They fear that by going into hospital they’ll be overtaken by the system of medical intervention and won’t be able to control what happens to them.
- They fear they’ll be treated impersonally on a kind of conveyor belt.
- They fear that they’ll be unable to have their partner with them in hospital and that they’ll be alone for at least some of the time.
- They are concerned that their babies will be removed from them with resulting damage to bonding and breastfeeding.
- They want the continuity of care that a home birth team can give.
- They want sympathetic postnatal care.

(Stanway and Stanway, 1984, p 49)
Contrast this with Bourne’s views on the reasons for giving birth in hospital

**Hospital or home?**
The argument on the rather difficult subject of whether a mother should have her baby in hospital or at home has continued ever since maternity hospitals were first instituted well over fifty years ago. Hospital delivery provides the essential medical and nursing care, as well as the facilities to deal with any eventuality. Domiciliary, or home, confinement provides social advantages and is convenient for the mother who has a young family. Gradually, however, more and more women are having their babies in hospital at present more than 90% are delivered in a maternity unit.

This increase is due to several factors. Modern obstetric care is designed not only to prevent complications occurring but also to recognize and treat them promptly when they arise. Since it is impossible to predict that a pregnancy, labour, delivery and puerperium (as well as the progress of the new-born infant) will be normal until after the events have occurred, most obstetricians prefer to look after their patients in hospital, because it is only there that they have all the facilities and ancillary services that they may require.

All doctors and midwives, as well as the majority of women, now regard antenatal care as being an essential part of pregnancy. The safety of the mother and the safety of her unborn child are their prime considerations. In other words, safety has taken the place of convenience. All the evidence points to hospital confinement as being safer than home confinement since skilled nursing, obstetric, paediatric, and anaesthetic staff are available both day and night. Most women prefer hospital delivery because they have complete and absolute confidence, so essential for the pregnant woman, that everything is prepared for them and only in hospital are they assured adequate rest after delivery (Bourne, 1979, p 134).

Finally, look at the following list of the comparative advantages of each place of birth, which comes from *Your Body, Your Baby, Your Life*, written by the feminist journalist Angela Phillips (The book is described on its cover as ‘A non-patronizing, non-moralizing, non-sexist guide to pregnancy and childbirth’).

**Hospital or home**
Here is a comparative list showing the medical and social advantages of hospital or home birth.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Contact with other mothers can be very reassuring if this is your first baby</td>
<td>1 You don’t have to suffer separation from people you love. The experience will be shared</td>
</tr>
<tr>
<td>2 Trained staff on tap can be a relief when everything is new</td>
<td>2 You will have fewer professionals caring for you and less conflicting advice</td>
</tr>
<tr>
<td>3 Domestic chores will not be added to difficulties of coping with a new baby</td>
<td>3 Your sleep will not be disturbed by other people’s babies</td>
</tr>
<tr>
<td>4 Visiting will be regulated by the hospital. You won’t be inundated</td>
<td>4 Visiting can be regulated to your routines not the hospital’s</td>
</tr>
<tr>
<td>5 You have time to get to know your baby without pressures from other family members</td>
<td>5 Your partner will be fully involved with the child from birth and probably more willing to share care</td>
</tr>
<tr>
<td>6 Your labour can be followed electronically if you are at risk</td>
<td>6 One person usually cares for you throughout labour. She is more likely to know you and, without technological equipment, may be more wary and spot problems before they get serious</td>
</tr>
<tr>
<td></td>
<td>Modern equipment is available to deal with a crisis for you or your baby</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8</td>
<td>A special care baby unit may be available if your baby is in trouble</td>
</tr>
<tr>
<td>9</td>
<td>Immediate treatment is available if your new baby should get ill</td>
</tr>
</tbody>
</table>

(Phillips, 1983, pp 29-30)

Q: Now looking over these extracts, think about what types of advantages and disadvantages of hospitals are most important to each.

For Bourne the issue is straightforward: safety is the most important consideration and he claims that 'all the evidence points to hospital confinement being safer than home confinement', though this, as we have seen, is questionable. But you may have noted that it is obstetricians' preferences for hospital delivery which are cited first. It is only in hospital that 'the facilities and ancillary services that they may require' (emphasis added) are to be found. But he also claims that 'most women prefer hospital delivery' because they need 'complete and absolute confidence, that everything is prepared for them', a view that I suspect does not take much account of their desire to remain in control.

For the Stanways, one important reason for not having a baby in hospital is to avoid medical intervention, loss of control and the impersonality of hospitalization, including separation from one's partner.

Angela Phillips sees some emotional and social benefits attached to either place, she sees time to develop a relationship with the baby and contact with other mothers as a potential benefit of hospital birth. Later in her book she talks about the isolation mothers at home with babies feel, ‘Friendships in hospital can be as important as the time a partner can put in’. She does see the medical back-up available in hospital as important, partly in case there are problems, but also for the reassurance that she recognizes many women, not fully confident that they ‘naturally’ know best, may need.

Q: Now look over these extracts again, thinking about what 'home' stands for in each of them.

Going through the Stanways' list of reasons gives a pretty clear picture: home represents nature, the family, non-intervention, personal attention, being with one's partner, the chance to bond with one's baby, love and sympathetic care. Bourne also sees social advantages in the home, particularly for women who already have young families, but for him safety considerations massively outweigh these factors.

For Phillips home is the place where one can best share the experience of childbirth with those whom one loves. But she also recognizes that the home is the place of work for women, so that being in hospital can give a break from domestic chores. She sees the partner's role rather differently too, as being enabled to take a better share in childcare right from the start with a home birth, or implicitly forced to take over domestic chores if the mother is in hospital, rather than just involved in emotional support and the creation of the new family as in the Stanways' view.

Indeed Angela Phillips questions whether the desired 'privacy' of a home birth is achieved in reality by including the following cartoon...
The views of the Stanways and of Bourne reflect a desire to keep separate public and private domains, an idea which exists very strongly in our culture. It is an important distinction which will come up many times in this course. Which aspects of life do you see as part of the public and which are part of the private domains?

I expect your list put most things to do with employment, politics and the state into the public domain, while the family, love and personal relations stayed in the private. You may also have noted that the private domain also involves work – housework and childcare – both of which are largely women’s work.

Despite the apparent ‘naturalness’ of the private domain, in contradistinction to the clearly ‘man-made’ (sic) public world, the separation between the two is in fact a social construction, an effect of the development of industrial capitalism. Prior to the Industrial Revolution, the home was the place of work for most people, and the separate public sphere of political life involved relatively few people. The development of wage-labour for capital, by giving men, in particular, jobs outside the home, forced that separation into everyone’s life by and large. Men’s roles became those in the public arena, while women were supposed to keep the home fires burning in the private domain.

It is because of this identification of men with the public and women with the private domain that feminists think that the separation between the two is to be questioned rather than reinforced, unlike both natural childbirth advocates and the implicit assumptions of the medical profession. And feminists would point to the rather traditional attitude of much of the natural childbirth movement to the roles of men and women in childcare as evidence of the dangers to women of accepting those notions of the ‘private’ and the ‘natural’ unquestioningly. It is perhaps not surprising that one of the greatest successes of the natural childbirth movement in changing medical practice has been in getting nearly all hospitals to allow fathers to be present at their child’s birth, at least when things are going smoothly.
It is also perhaps this attitude to the proper location of childbirth in the private domain, which explains why so much that doctors do in this area is seen as 'intervention'. Though doctors, like other state 'welfare' workers, are criticized for intervening in other areas, the loudest complaints — as you will find throughout this course — are those about interference in the private domain of family life.

Now is the time to go back to your chart of the different perspectives. Make notes under each perspective for each of the following three questions

1. Which criteria should women use in making choices about childbirth?
2. Who should be in control?
3. When should professional help be considered 'interference'?

5.5 Review

The questions at the end of the last subsection are not exactly the same ones you were asked to consider for section 4 as a whole. Those were not so much about what the different perspectives thought 'should' happen, but how these 'shoulds' are formed.

We saw that women and obstetricians may have, for good reasons, different criteria of success or 'frames of reference' by which to assess experience of childbirth. Women's tend to be more 'holistic', taking account of the subsequent development of their and their babies' lives as well as their health immediately after birth.

Control for women was a key issue but women may not feel able to exercise the control they legally have over where to give birth because

(a) provision by the state takes particular forms, which in practice regulate the choices available,

(b) moral pressure and lack of either knowledge of their rights or time to fight for them may restrict their control.

We also saw that intervention may lead to further intervention or even a whole cascade of intervention. This also can leave a woman feeling out of control and the experience of childbirth less than a success for her, even if the outcome is still a healthy baby. Interventions cannot therefore be assessed singly.

We then examined different views on where it is best for women to give birth, seeing that the statistics on safety do not support the view that hospital is best for all women, even using the obstetrician's frame of reference. Resistance to the overwhelming trend towards hospitalization has come from both natural childbirth advocates and, to a lesser extent, feminists. There is a fear that control is more difficult to exercise in a hospital setting and that there is more danger of unwanted medical intervention.

Finally, we saw that a key issue was the boundary between the public and private, help often becomes seen as interference if it transgresses that boundary. If childbirth is seen as a private, family matter taking it out of that setting into a hospital may seem inappropriate.
Childbirth was chosen as a starting point for this course because, through looking at intervention in this particular area, we can consider some general points about intervention to solve problems, a theme which will reappear throughout the course.

At the beginning of the unit there is a list of some of the aims of this unit. Look back over that list now and at the reviews at the end of each section. They are all general points concerning practices which are socially constructed, disputes about them and how ideas about appropriate forms of intervention are formed. There are also some skills and techniques for assessing evidence that you have met in this unit. You may be able to think of other such general points which have been raised in your mind by the discussion of childbirth in this unit, in which case please add them to your list. As a final exercise you should now go through the list of aims, the review sections and your additions, making notes as to where examples of each point have come up in this unit. If you do this carefully, you will then have made yourself a useful summary of the unit.

Birth was chosen as the subject matter for this unit because it is an event which it is easy to see as a purely natural event. It does have a very clear biological basis after all. But you saw in this unit that even 'natural' events like birth do not occur in isolation from their social setting.

This was shown in section 2 by examining briefly the way the advice of different cultures as to how pregnant women should behave varies and how, in this country, practices surrounding childbirth have changed over time. On this basis, we rejected the idea of there being any such thing as 'natural' childbirth. It is always managed or intervened in by society in some way or other, and it must be so, because it always takes place within some society or other.

Nevertheless there can be and is controversy over how such intervention should take place and which people should be involved. We saw in section 1 that obstetricians tend to view childbirth as a potentially hazardous event which the advances of medical science has made safer for both women and children. They consider that the only safe course is for women to put their trust in their medical attendants and leave them to make what are essentially scientific decisions as to the best course of action. The natural childbirth movement, on the other hand, sees birth as primarily a part of nature in which intervention is often unnecessary, can even be harmful and inevitably interrupts the desirable natural flow of events. They see intervention and its technology as part of a ritual developed by the medical profession rather than of clear benefit to most women. Feminists stress the woman's right to choose and criticize medical practice, in the past and the present, for taking over from women, both as mothers and as traditional midwives, what had been primarily a woman's domain.

These different ideologies each have their own priorities for assessing current practice for doctors it is safety measured by mortality rates, for natural childbirth advocates it is the extent to which practices are in tune with their view of nature and natural relationships, such as the family, and for feminists it is to do with the extent to which women, and in particular the mother herself, feel in control. These differences also lead each school to ask their own questions of the past, to see different changes as significant and to explain those that have happened in different ways.
We saw in section 4 that disputes between different ideas could not be settled simply by looking at statistical evidence because a number of changes have taken place concurrently with the drop in maternal and perinatal mortality rates. In other words, a number of possible factors are associated variables. We divided these variables roughly into social and medical factors and could then give more support to some causal explanations than others, even if our evidence could never be totally conclusive. The techniques we used to do this included looking at the data in more detail, breaking it down by regional, class and ethnic variations, the use of scatter diagrams by which the extent of an association of two variables could be visualized, and the choice of a proxy variable, which allowed us to separate social and medical effects.

However, we then saw that sorting out what has happened in the past will not determine what policy options should be followed in the future. First, because concentrating on those factors which have led to improvements in the past may not be the right thing to do now. It might be important to work on those which have been neglected in the past. Also, policy decisions are rarely made on the basis of evidence alone. To a pluralist this is because different interest groups are involved, some more powerful than others. In particular, professional groups may have an interest in defending and extending the forms of intervention on which their professional interests are based. A more structuralist account, however, would look at this problem in a slightly different way and see that some types of remedy involve more structural change than others. Those involving change which might threaten fundamental aspects of society would be less likely to be adopted, though even those aspects themselves can be contested.

In section 5, we saw how the issue of whether a woman should give birth at home or in hospital was again a disputed area. One reason some prefer not to be in the institutional setting of a hospital is because they feel that having some measure of control is important. Unlike their obstetricians who believe that a hospital birth is safest ‘just in case’ anything turns out not to be straightforward, women tend to have a more ‘holistic’ frame of reference of which safety is only one aspect.

One particular worry is that intervention may itself lead to problems, necessitating further intervention and that such a ‘cascade’ of intervention may be less likely to get started at home than in hospital.

Finally, we saw that different views about where to give birth also said something about underlying views about the home and the boundaries of a private arena. One reason among others that medical intervention tended to be perceived as interference by natural childbirth advocates was a belief that home and the family are essentially private areas.

The disputes about childbirth which we have examined in this unit are political ones in the sense that they have involved organized groups agitating for change in the practices of another group, the medical profession, agitation which has in some cases been successful. In such disputes, all groups have constructed their own perceptions of the problems which need to be solved as well as the methods of their solution. Disputes about how problems should be perceived and how to solve them is really what this course is about. We hope that this introductory unit has given you some feel for some of the ways in which such debates can be analysed.
Appendix

Addresses of Organizations Referred to

Active Birth Movement
18 Launier Road, London NW5 1SG (01–267 3006)

Association for Improvements in the Maternity Services
Hon Subscriptions Secretary, Elizabeth Key, Goose Green Barn, Moss House Lane, Much Hoole, Preston, Lancs PR4 4TD

Association of Radical Midwives
88 The Drive, Wimbledon, London SW20

Association for the Advancement of Maternity Care
Sycamores, Chilbolton, Stockbridge, Hants

The Maternity Alliance
59 Camden High Street, London NW1 7JL (01–388 6337)

The National Childbirth Trust
9 Queensborough Terrace, London W2 3TB (01–221 3833)

Society to Support Home Confinements
Lydgate, Lydgate Lane, Wolsingham, Bishop Auckland DL13 3HA (0388 528044)
(Note: If you write to one of these organizations for further information, please enclose a stamped addressed envelope as many of them run on a shoestring.)

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Grateful acknowledgement is made to the following sources for permission to use material in this unit.

**Text**


**Figures**

Figure 1 Beels, C., *The Childbirth Book*, 1978, Turnstone Books, Figure 2 Mansell Collection, Figure 3 from John Blunt, *Man Midwifery Dissected*, 1793, Figure 4 from G. J. Witowski, *Histoire des Accouchements*, 1891, photo Thérèse Durex, Figure 5 Royal Society of Medicine, Figure 6 Mansell Collection, Figures 7, 9, 10, 11 and 12 Macfarlane, A and Mugford, M., *Birth Counts*, 1984, HMSO, Figure 8 Huntingford, P. 'Obstetric practice past, present and future' in Kitzinger, S and Davis, J. A (eds) *The Place of Birth*, 1978, Oxford University Press, Figures 13 and 14 Inch, S., *Birthrights – A Parents’ Guide to Modern Childbirth*, 1982. Century Hutchinson.

**Tables**

Table 1 Macfarlane, A and Mugford, M., *Birth Counts*, 1984, HMSO

**Frames**

Frames 1, 2, 3, 4, 5 and 6 Macfarlane, A and Mugford, B., *Birth Counts*, 1984, HMSO, Frame 7 OPCS Monitor, DH3 87/1 and DH3 87/3, HMSO, Frames 8 and 9 OPCS Monitor, DH3 87/1, HMSO

**Cartoon**