Medicalisation of Childbirth in Western Society
Can Women Resist the Medicalisation of Childbirth?

Oddný Vala Jónsdóttir

Lokaverkefni til BA–gráðu í Mannfræði

Félagsvísindasvið
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Abstract
The Western world tends to focus on science, technology and profit which has had a huge impact on the childbirth process. The medicalisation of childbirth seems to have reached a stage in the Western world where the increasing reliance on technology seems to be having a negative effect. Power within relationships, such as between the population and authority, affects the population in a regulatory and disciplinary manner where the population feel the need to conform. Abnormal behaviour, such as resisting medicalisation, is heavily criticized because it creates uncertainty and danger. Childbirth is considered to be a deviant condition whereby women have to conform to the medicalisation of childbirth. If women resist, their behaviour is considered abnormal and risky but should be respected, as the women who find the strength to resist, often do so successfully. They do become part of a power struggle, where the health professionals and women use tactics to try and get what each need. Childbirth should be part of a respectful relationship whereby both views are respected to create a final outcome that empowers the woman, ensures a safe birth for the baby but with the help of the health professional.
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2. Introduction

Childbirth in the Western world can be a very technocratic experience for a lot of women. It has been taken from the social remit of the female environment and put into the sterile walls of a hospital where health professionals seem to control the process. The reason behind this is often said to be safety as childbirth is considered to be dangerous. This essay will look at the medicalisation of childbirth within the developed Western world from the woman’s perspective. It will look at issues such as: discourses of power within modern Western society, resistance to the discourses of power, the power struggle between women and the medical system, risk taking and consequences and whether it is possible for women to resist the medicalisation of childbirth?

This essay begins with looking at childbirth and how it has been medicalised by modern technological innovations. The next chapter looks at how power influences individuals within modern society by looking at the ideas from the philosopher Michel Foucault. His ideas fit well in with the ideas of the norms of medicalisation of childbirth as many women tend to accept what is considered to be normal. This chapter also looks at how people are perceived in the Western society by looking at the ideas from the anthropologist Mary Douglas regarding risk and outcomes of risk. Her ideas fit well with the idea that if a woman challenges the norms of modern Western society, she will often be considered as having taken unnecessary risks because of contemporary ideas on how a woman is perceived. The final chapter will focus more on the woman, the objectification of the woman within the medical system and discuss how women could resist the medicalisation of childbirth.
3. Trajectory

This trajectory will explain why I chose to write about this topic. When I first became pregnant I had originally been programmed to accept what was considered normal in our society regarding childbirth. What was considered to be normal had been advertised in the media and spoken about among my friends. This changed, however, when the independent midwife I had hired started asking me questions about my care and whether or not I knew about and was happy to go along with certain aspects of what was considered normal. She gave me evidence-based information, pointed me in directions I would never have considered and most of all she respected my wishes and made sure that I knew what I was getting myself in to. She made sure that I was making informed choices all the way through pregnancy and during childbirth. In a way she helped me become empowered as a woman in making decisions that were right for me and my family.

My second child was born as an undiagnosed footling breech (where the baby is born with its feet first and head last) at home. He was undiagnosed because I chose not to go for an ultrasound to confirm the status of the baby. In a way an ultrasound will help the medical system prepare for the upcoming birth and to rule out any possible complications but because I knew the midwife personally and I knew what she was capable of. It wasn’t an issue for me or my midwife. A breech birth, in our current medical environment is seen as a problem, because of methodologically flawed research that states that all breech babies should be born via a caesarean. It has been realised since then that breech babies can be and should be born vaginally, but there might be certain complications that all midwives and obstetricians should be aware of. Because of this flawed research I have been criticized for having taken unnecessary risks with my child. For me, it wasn’t about taking a risk but about taking an informed choice, because I trusted myself and my environment and I had the support that was very important in birthing a healthy baby. I don’t speak about his birthing position to everyone because I feel that it is not possible to discuss this impartially as when it comes to giving birth, the mother never seems important.
4. Birth Culture

4.1. Medicalisation of childbirth in the western world

Childbirth stands between the two paradigms of nature and nurture according to Ann Oakley (1980:7). It is a biological process whereby the woman’s body goes through childbirth. The cultural aspects of childbirth are the norms and rules of the society that can affect the outcome of pregnancy and influence the mother in her decision making during childbirth. Wenda Trevathan, Smith and McKenna (2008) suggest that women in childbirth need assistance because of the structural changes that have happened to the body by being upright. The female pelvis seems to make childbirth more difficult and in some cases dangerous, so by having someone to support the birthing mother, it makes childbirth safer. Because of this view, the cultural and social aspect of childbirth affects how women view childbirth. They tend to hand control over to the health profession as they are seen as the specialists that know better and can assist in making childbirth safer. The medical profession seems to believe that birth should take place within the hospital setting as that is the standard norm of the modern society. To do any different would be to go against the standardisation of birth and possibly place the unborn child at risk, according to the views of society.

Robbie Davis-Floyd (1992) believes that the core of Western belief system focuses on science, technology and profit and as such it is not surprising that the medical system reflects this emphasis. Because of this belief system it is no wonder that childbirth has become a more medicalised procedure. The human body in the 20th century is regarded as a machine (Emily Martin, 1989; Davis-Floyd, 2001) rather than a natural being. The process of medicalisation takes what is considered normal and nonmedical and defines it within the remit of the medical environment (Peter Conrad, 1992). Childbirth is a natural process that women have been going through since the beginning of mankind, but because of the view that the body is a machine that is not perfect and that needs assistance it should take place where there is access to specialists. The hospital contains technicians or health professionals who have the proper training and knowledge to help the body as a machine to go through childbirth according to Martin (1989) and Phyllis Brodsky (2008). The labour process has been separated into different stages by these health professionals, whereby each stage should take a certain amount of time, before progressing onto the next stage. If things do not progress normally then the health professional should intervene to help with the process, by using medical procedures. The view has been to understand the uterus as a muscle that should do all the work itself and the mother has nothing to do with this process. This approach completely
ignores the view that childbirth should be respected as a natural process that needs time and should not be rushed to be successful and that childbirth isn’t just about the body but also about the two people involved, i.e. the mother and the baby.

4.2. Technology used in childbirth
Sheila Kitzinger (2005) speaks of childbirth as having been a social process whereby women bonded over the birthing process by nurturing the birthing mother. The birth place used to be a private place often within the remit of the mothers’ social environment whereas today it usually takes place in a medical environment in isolation from the mothers’ social environment. Medicalisation seems to limit personal choice according to Deborah Lupton (1999) and in a way encourages dependency on the medical system. Because the main focus is on the body, Davis-Floyd (2001) states that medical training discourages health professionals from making the birthing process social. Emotional mothers seem to be irrelevant in the whole process. The health professional is there to solve what goes wrong with the body and that is where technology helps. Technology has opened up a whole new way of caring for an unborn baby. What has happened is that women have started to trust the technology available to tell them the progress of the pregnancy and childbirth instead of their own instinctual feelings or the feelings from other women close to them. Even the health professionals have come to rely more on the technology (Brodsky, 2008). The problem with this is that more and more women, according to Richard Johanson et. al. (2002), are being subjected to unnecessary interventions as pregnancies and childbirth are becoming routinely medicalised and stationed within the hospital environment (Brodsky, 2008). There has been an increased reliance on the technology available created to assist childbirth.

Health professionals according to Davis-Floyd (2001) are taught how to exert authority. Their dress code, i.e. white coat and titles, and medical vocabulary give the signal that they are the authority on health related issues and most people don’t feel comfortable in contradicting this authority. Western culture also dictates that those that are in authority tend to know what they are talking about and therefore should be respected. So it isn’t surprising that women do as they are told when it comes to childbirth. Furthermore the media plays a big part in promoting the views of the professionals as being the expected norm for childbirth in society. In 1996 and 2001 (see Kitzinger, 2005) obstetricians in the US and in the UK were asked how they would birth their babies. In the UK, about 31% of those asked said they would choose a c-section. In the US, about 46% of those asked would also choose a c-section. These figures were portrayed on the front pages of local newspapers and give the impression
that c-sections are a safe and easy option, which they aren’t. Marion Hall et al (1999) state that an elective c-section has a 2.84 times greater risk of maternal death than does a vaginal birth, whereas an emergency c-section has a 6.22 times greater risk of maternal death. These are almost always down to complications connected with caesareans, but when the health professionals are so open about their choice in childbirth, the implications can be that mothers see these as safe options. The discussion is no longer about the complications but about the fact that this is an easy, relatively safe option and it becomes part of normal choice (Wendy Savage, 2002).

The technology that is available for use in childbirth by health professionals ranges from simple things such as the forceps and suction cup to consistent use of induction drugs or manual techniques, anaesthetics, to electronic foetal monitoring to caesareans. These were all created so as to help in childbirth to make the process more manageable for the mother and to be able to save both mother and baby during complications of childbirth. In many cases they do certainly help save babies but they can also create even further complications as they interfere with personalized care (Brodsky, 2008). When the technology is in use, it takes attention away from the birthing mother which in itself can create problems as it makes childbirth impersonal and technical. Normal pregnancies are being induced around 40 to 42 weeks of pregnancy, using manual techniques, such as stretching the cervix, breaking the amniotic waters surrounding the unborn baby or using drugs such as pitocin, a synthetic version of the oxytocin hormone. After 42 weeks there is a risk of the unborn baby dying, but according to A Metin Gülmezoglu et. al. (2006) the risk is small but they do suggest monitoring the baby with yet another technology, the ultrasound, which can see the unborn baby within the mother and make judgements based on what is seen with the ultrasound. Induced pregnancies can often be very painful as they are stimulating contractions, so the mother needs access to anaesthetics or epidurals to stop the pain, which in turn often has a negative effect on the baby, by which point a caesarean is often the only way to solve the problem (Stephenson, et.al, 1993; Barbara Kiesewetter & Lehner, 2011). What is interesting is that in 1993 a study was started by Thorpe et. al. that looked at whether epidurals would have any connections with caesareans and found that in first time mothers it was more than 11.4 times more likely that the birth would end with a caesarean. This study was stopped due to ethical reasons when they realised the possible outcome (Thorpe et.al, 1993) but this is still perceived as a normal analgesic that is offered routinely to women in childbirth. Women who do not require assistance are routinely being strapped to electronic fetal monitoring (EFM), which was originally developed to minimize damage to the unborn baby but according to
many studies (Freeman, 1990; Zarko Alfirevic, Devane & Gyte, 2006) it doesn’t really prevent anything. The technology allows midwives and obstetricians to follow the baby’s heart rate more easily than by using a stethoscope but does not seem to prevent anything negative from happening. Caesareans are on the rise in many western countries with figures as high as 40%, which according to the World Health Organisation (WHO) goes against their recommended 10-15% figure (World Health Organisation, 1985). There are also continuous discussions on whether there are correlations between higher c-section rates and a higher maternity mortality rate (Hall et. al, 1999; Vicky O’Dwyer et. al, 2012; Fernando Althabe et. al, 2006).

4.3. Problems with medicalised childbirth

Hall et al (1999) state that an elective c-section has a 2.84 times greater chance of maternal death. O’Dwyer et. al. (2012) and Althabe et. al. (2006) find that there is no correlation between maternal mortality rate and higher c-section rates because of access to modern technology and access to care. Maternal mortality has been significantly reduced according to the World Health Organisation [WHO] et. al. (2010) since 1990, but this is part of a strategy to reduce maternal mortality agreed upon by 189 countries. According to WHO et. al, (2010) the worldwide number of maternal deaths in 2008 was 358 000 which is a 34% decrease from 1990 with a higher percentage in the developing countries. Most of these deaths seem to occur during the third trimester of pregnancy and the first week after childbirth (according to Carine Ronsmans and Wendy J. Graham, 2006). The leading causes, according to Kahlid S. Khan et. al. (2006), seem to be excessive bleeding after birth in developing countries, hypertensive disorders in Latin America and the Caribbean and complications from anaesthesia and caesarean sections in developed countries. There seems to be a need for more specific care for different countries, but in the developing countries there is a higher need for more skilled care and access to that care, that can save women from problems such as bleeding.

The leading causes of maternal death in the western world are according to Ronsmans and Graham (2006) from complications from caesareans and from anaesthesia. Previous causes in the Western world according to Loudon (see Ronsmans and Graham, 2006) were the same as in the developing countries but because of improved access to health care, lower infection rates and improved surgical skills these rates have dropped, although the rates of certain Western countries are becoming higher. The maternal mortality rate for developed countries is 14 per 100 000 live births which is low but the fact that the current causes are because of modern technological innovations that are promoted to help childbirth is quite frightening. In the last two centuries obstetricians seem to have taken over the care of normal
births as well as complicated births in countries that focus on private medical care, such as the US according to Johanson et. al. (2002:892). This seems to be having an effect on caesareans and instrumental births. The maternal mortality rate within the US has risen from 12 per 100 000 live births in 1990 to 24 per 100 000 live births in 2008. Canada seems to be heading in the same direction but the UK seem to have steady rates of 12 per 100 000 live births between 1990 and 2008. The difference in figures may be due to the fact that in the UK most women are still being taken care of by midwives during pregnancy and in childbirth and women also receive postnatal care. Obstetricians in the UK only see the special cases when things go wrong. Could it be that the medicalisation of childbirth is promoting increasing maternity mortality rates?

Birth statistics in the UK published by HESonline (2011) show how and where childbirth takes place there. In the year 2010 24.8% of births were caesareans, while 51.1% took place in consultant wards, 37.1% took place in combined consultant/midwifery/GP wards, 2.5% took place at home and 9.3% took place in unknown places. Consultant wards are where most women with high risk pregnancies give birth, whereas the combined wards are for women classed as low to medium risk. The caesarean rate is very similar to the previous years, but what is interesting is that more women are giving birth within a high risk maternity ward with the possibility of raised instrumental births.

Is it possible to turn this around so as to refocus on the whole birthing process as a social process rather than focusing solely on the body? Ontarios Womens Health Council (see Johanson et. al. 2002) did a study on how to lower caesarean rates. The outcome was that there were twelve factors that helped in lowering caesarean rates. Among those factors were having the right attitude and support. To lower the rates staff at hospitals had to be proud of lowering caesarean rates and promote birth as a normal physiological process that had to be respected. This is a process that is already being focused on in Scandinavia but in the UK birth seems to be looked at as a process that evolves without the input of any cultural or social values and therefore very open to medicalisation.

This as well as the reliance on technology may be influencing the birthing process where women seem to be constrained by the birthing culture within their environment. Johanson et.al. (2002) believe that to change the current medicalisation of birth, the culture of childbirth within each society needs to be readdressed. Training of the medical profession needs to be less on the bodily aspect of childbirth but more on the holism that consists of both mother and child.
5. Power, Resistance and Risk within the Western culture

The relationship between the health professional and the pregnant woman, according to Iris M. Young (2005:59), tends to be that of a superior to a subordinate, where the health professional seems to have power over the woman. This is a normal power relationship that is part of the medicalisation of pregnancy and childbirth (Lupton, 2002:100). Health professionals in the Western world appear to have the exclusivity of defining and treating illnesses in a way that society seems happy with. Patients accept this more often than not because it is the norm and to be expected due to normalising factors within society. There are, however, some that might wish to resist and will do so, but those who are vulnerable might not feel that they have the power or knowledge to contradict the health professionals or to take control over their own bodies so as to feel empowered (Lupton, 2002).

5.1. Power and its effect on society

Power can be seen as part of a relationship within the social system that operates at every level within society. It is found in everyday practices of any institution belonging to or controlling society, such as medical institutions (Denise Gastaldo, 2002:111). This type of power can affect people when used by the regulatory control that is used to intervene in the lives of the population and through focusing on the individual body as a machine. By managing the health of the population it is possible to create social policies that control and create normality. By focusing on each individual it becomes possible to integrate the individual into the economic and social life of each society (Gastaldo, 2002:116).

Medical science according to Michel Foucault (see Bryan S. Turner, 2002:37) can be seen as the link between the discipline of individuals by professionals and the regulation of the population by what Foucault calls panopticism. This is where individuals within a society are regulated through institutions such as schools and hospitals. Foucault (see Patrick H. Hutton, 1988:126) believes that the individual mind is formed through the regulating or policing of society, which defines what is considered to be normal behaviour. It is through this policing that individual behaviour becomes either accepted or not, and acceptable boundaries are set for each individual within modern society, whereby abnormal behaviour is heavily scrutinized and criticized. Foucault believes that this policing regulates individuals within the society and that the individuals become part of the environment by conforming to it. The self of the individual becomes more real through this policing because of the need to conform to a normality, which plays a huge part in the power relations with others in the society.
The individuals do not seem to be important to Foucault, because they are considered objects of knowledge that influence the power relationships within society that guide what is known as governmentality (Gastaldo, 2002). Governmentality regulates and controls the population within modern society according to Lois McNay (1992:68), not by imposing laws but by using the power relationships to create a balance between the governing bodies and individuals. This balance guides governmentality into creating what is known as the medical gaze, which is the process of identifying and collating information on disease and their underlying causes so as to be able to identify and normalise a healthy population. It is through the power of the medical gaze, that guidelines are established that guides individuals to self-regulate or police themselves (Hutton, 1988). The people who live in society require “intervention, management and protection” according to McNay (1992) so governing bodies and institutions are able to control the welfare and health of the population. Techniques such as observations, examinations, measurements and comparisons are considered normal as they create what is known as normalisation. These techniques also allow the governing body and institutions to discipline the individual into conforming to normalisation (Turner, 2002).

Normalisation is a technique used to see what is normal within the behaviour of the population and used to compare amongst the population to be able to control it. Normalisation uses disciplinary power to help individuals self-regulate so as not to go outside the boundaries of what is considered normal, as well as to create an environment that does not harm the individual. If something goes wrong, the population is encouraged to seek out someone with more knowledge. If someone goes outside the boundaries or does not seek this help, they are classed as high risk and therefore subjected to advice and regulation so as they can go back to normality. Individuals seem happy to consent to this because they have been persuaded that this is appropriate by the health professionals or governing body, whose goal it is to create a healthy population (Gastaldo, 2002). Self-regulation according to Gordon (see Jane M. Ussher, 2007) becomes a replacement for the panoptic, institutional surveillance because of the disciplinary powers governmentality and normalisations have.

5.2. Resistance and reaction to resistance

McNay (1992:12) worries that the individual has become too impassive in Foucault’s ideas of self-regulation and normalisation. Individuals seem to have no say in what happens to them but are part of an automatic process. The idea seems to be that by not looking at each individual, but seeing them rather as part of a power relationship and as objects of knowledge it is possible to see that each individual is like an empty canvas that will develop depending
on what is thought to be normal. The power relationship between the individual and the
governing body can become more fluid and change according to what goes on in each era.

There is nothing that is taken for granted, so in the instance of childbirth, a woman who
decides to learn more about certain aspects of childbirth should in theory be greeted with
respect so that she and the health professional can reach an agreement that both are happy
with, but founded on what is considered normal. For Foucault, resistance happens
automatically within the creation of the power relationship because of its fluidity, whereby
power will become shared (Lupton, 2002). McNay (1992:41) finds this is a simplification
because this idea of an automatic process belittles individual experiences in the power
relationship, especially within the medical environment where the health professional almost
always becomes the all knowing superior and the pregnant woman the subversive individual
who becomes objectified and finds resistance ineffective due to the normality of
medicalisation.

The medical system has according to Foucault (see Ussher, 2007) for a long time
scrutinized the female body, subjecting it to surveillance and positioning it as a potential site
for “madness, badness or weakness”. This is to make the female body passive and docile so
that it becomes possible to treat it in a normalised way. Pregnancy according to Ussher (2007)
is regarded as an illness and the body a mechanical object so open to surveillance and
intervention by use of modern technology. Illness according to Turner (2008:154) can be
classed as deviant behaviour, but it is down to the culture to accept this deviant behaviour as a
medical condition. To understand illness it becomes important according to Turner (1995:5)
 to position the ill patient within his/her social and personal environment to understand how
society defines the deviant behaviour. The categorization of deviant behaviour determines
social memberships, as they determine access to resources whereby power is the most
important part. The boundaries of society are governed by those in power or those who have
the knowledge, who in turn give or take away permission to certain social groups through
uses of surveillance and governing of resources.

By being portrayed as an illness, pregnancy can be considered dangerous, so pregnant
women have to go through certain checks and are given guidelines to follow. It is made clear
that they have to keep the unborn baby safe. They are warned of dangers if they do not do
what they are told and so the docile and passive pregnant body become objectified by the
medical gaze. This undermines women’s sense of power and control over their bodies. Most
women submit to this, because of the normality of medicalisation of childbirth. What is
interesting is that in a lot of self-help books that help in the self-surveillance of their bodies,
women are encouraged get to know themselves during this period (Ussher, 2007) as if this gives them the right to control the process. They are also told that emotions are normal but that they are to control the emotions. This is a very good example of the self-regulation of modern society where the woman is encouraged to gain power through knowledge but within the remit of norms of the society, so as to keep the female individual docile and passive. What also tends to happen is that the body somehow becomes public property whereby everyone has a say in what the mother does to her body. The bodily boundaries change completely so as to welcome others into the boundaries, without respect for the pregnant woman.

When someone goes against what is considered to be normal within the medical environment, how do others react? There is always the question of “what if something goes wrong?” A mother who decides to do things differently to the normality of medicalisation of pregnancy is believed to be a danger to her unborn child according to Tsing (see Lupton, 1999a) and could be prosecuted for endangering her child if the risks are high. The problem is that with all the technology available to predict the outcome of the unborn baby, there is always a level of risk as none of the technology used is perfect in its level of diagnosis. The mother is told what these risks are and has to calculate what they mean to her so at a certain point she comes to realise that everything she does in the pregnancy has a calculated risk factor. Some women seek advice from the health professional so as to gain knowledge of the meanings of the risk factors, whereas others search out their own information so as to be able to get a different perspective. This is almost always done for the sake of the unborn baby but not for the sake of the mother (Lupton, 1999a).

Society according to Mary Douglas (1984) has a right to control. It has external boundaries and internal structure and has power to reward conformity as well as power to ward off any attack on normality. Douglas (1984:5) states that the universe is “moralized and politicized” so it is quite normal to want to blame someone if something goes wrong. Societies tend to be organised by the nature of seeking blame for whatever goes wrong. Douglas (1984) says that the social limits are defined by what is thought to be “out of place”. It is by containing and controlling what is deviant that it is possible to maintain social order or normalisation. The pregnant female body is deemed deviant from the illusion of a normal, rationalized and controlled body and therefore threatens stability or social order. A pregnant female who decides to behave out of the social norm is therefore always wrong, cannot be taken seriously and needs to be contained and constrained. Childbirth represents a significant difference between males and females that must be kept away from social order so as not to upset it.
5.3. Risk

What is defined as risky or not can be discussed by amateurs and experts. There is a lot of information available on what is defined to be risky but the expert tends to be the one most listened to. Lupton (1999a:63) mentions two types of risks that can be connected to pregnancy; clinical and epidemiological risk. Clinical risk is concerned with case studies of individuals whereas epidemiological risk is based on patterns of disease and identification of risk factors. The results from both create what is thought of as normal and abnormal. The pregnant mother is compared to this and anything that is thought to be abnormal is classified as high risk. A mother who decides to go against the normal procedures of childbirth will be encouraged to rethink her actions and do what is expected of her.

Douglas (1992) says that people don’t tend to take risks if it has any great implications because risk, according to Douglas (1990), is connected with what is considered to be dangerous. People normally don’t take risks that go against what is considered culturally acceptable in their own society because of the possibility of being scrutinized by others within the society. Douglas (1992) believes that if someone decides to do something that is classed as risky by others, it is not because of ignorance, it is because of preference, and that should be respected, not criticized. Choosing to do something risky almost always makes people of authority take notice because of its connections to danger. When a woman decides to become pregnant she already has some notions of what is expected of her because of normalising factors within the medicalisation of birth. The health experts according to Lupton (1999a:64) advise women to be careful and think of their unborn baby, give advice on vitamins, prenatal care, antenatal care and so forth. Any book that a mother reads will tell her what is expected of her as a mother and that she has to eat carefully and not consume any harmful substances. Women are also expected to turn up to regular antenatal appointments, where it is normal to have blood and urine tests, as well as other tests such as amniocentesis (used to diagnose Down’s syndrome) or ultrasound (taking images of the baby) dependant on risk factors decided upon by the medical profession. The message given to the pregnant mother is to get through the pregnancy by playing it safe and to accept what is on offer as a no risk pregnancy doesn’t seem to exist because something might happen to the unborn baby. Tsing (see Lupton, 1999a) says that a normal pregnancy doesn’t seem to exist, because of all the possible risks that could have a negative effect on the baby.

What is considered to be risky seems to be controlled by the society the woman lives in and what is considered to be normal. Douglas (see Lupton, 1999a:3) believed risk to maintain cultural boundaries in the West between individuals, social groups and between communities.
Society decides what is risky and therefore dangerous and there is an expectation that the woman accepts this and complies. By defining risk, society can identify those individuals who could be potentially dangerous because they go against what is considered to be culturally normal. Ulrick Beck (see Lupton, 1999:59) says that the modern Western world is a society filled with risk and that it could be called a “risk society” where the main focus is on minimising risks. When someone does something outside the norm he or she will be assumed to be behaving in a risky fashion. If something falls outside what is considered normal then everything is done to try and restore normality (Lupton,1999a).

A pregnant woman, who decides to go against what is considered to be normal, will not make decisions by herself. She will most likely seek advice from others around her, to see if what she is thinking of is too risky (Douglas, 1992:30). This is because of the idea of “mutual accountability”. This idea holds that individuals within a society will hold each other accountable for the outcome of their risk taking, but the level of accountability is different for each individual. The pregnant woman, who takes a risk, by going against normality, has a different idea of accountability than others and her idea of accountability is based on her knowledge, her background and her experience.
6. Empowered women

6.1. Women as emotional, natural objects

Women have always been considered a part of the birthing experiences through most of human life, either as the birthing woman, the wise woman or in a supporting social manner. Even though men were not allowed to be part of this natural part of reproduction, women have always had problems in making midwifery professionally accepted in modern society. Midwives tend to the normal births but as soon as there is a problem, the higher ranking, most often, male obstetrician is called upon to assist (Turner, 2008) as if he is saving the day. A book on women’s health since the 1930s states that women are to reproduce and a woman who can’t is a pathetic one (Turner, 2008:187-188). This view has changed within modern society whereby women are found in the work place with equal rights to men, single parent households are growing, and women seem to have control over their reproduction rights, although this may be changing with the current changes in abortion and contraception legislation within the US (Alastair Gee, 2011; Janice H. Tanne, 2011).

The view of women, however, hasn’t changed a great deal within the medical system where women are still being viewed in a condescending, paternalistic and sexist manner as can be seen in Scully’s and Bart work (see Turner, 2008:188) when they surveyed gynaecology texts over a thirty year period before 1973. The reason may be that fewer women have been employed in the higher positions within the medical profession, with women being relegated to the assisting roles of midwifery that see to the normal births. The traditional hierarchical relationship between men and women in the household can also often be seen in the relationship between health professional and patient according to Gamarnikow (see Turner, 2008:189).

Women have been the target of various social practices that restrain them and survey their reproductive capacities according to Turner (1995:87). They have always been seen as lacking in self-restraint and been considered emotional and irrational and because of this are in need of medical surveillance, guidance and advice (103). Sherry Ortner (see Henrietta Moore, 1988) believes that to men, women are regarded as subversive because of their association with nature. Since most cultures place nature at a lower level to culture, women can then also be placed at a lower level. Culture according to Moore (1988:14) will try to “socialize” nature so as to be able to regulate it which is very similar to what has been happening to women over the centuries. Jennifer Harding (2002) mentions that sex hormones have global significance because they can identify the woman’s emotional state. A woman’s
sex hormones are supposedly able to alter her behaviour and appearance and this becomes important within the discourse of childbirth which will affect how women are often treated during childbirth.

A pregnant woman is in a difficult position because she, according to Lupton (1999a) has in a sense become two bodies; the body that belongs to the woman and then the body that belongs to the unborn baby. The state of being pregnant does not seem to belong to the woman according to Young (2005:46) because she is only a container for the unborn baby. Pregnant women experience themselves as being split into two, between themselves and the baby that they carry. Women according to Martin (1989) often feel as if they are fragmented where they lack autonomy and are carried along by forces that they have no say in. The pregnant female is a good example of this fragmentation because she feels that she is both herself and yet not herself because there are movements that are within her that do not belong to her but yet she finds that her body reacts to these movements and changes accordingly. She also becomes responsible for the unborn baby, but she in a sense becomes unimportant.

The pregnant body becomes objectified both by the health professionals and the mother as a condition that needs to be taken care of. Their bodies are seen as being in production when going through childbirth. According to Martin (1989) if birthing is only seen as production then it should be managed by the health professionals with the assistance of technology. There have been breakthroughs in technology to access what was once a very private world. Ultrasounds are used to check the baby’s state, size and pregnancy age so as to assess the state of pregnancy. With increasing technological advances, there is better access to the unborn baby, making it more difficult for the woman to be subjectified as an important individual. Lorna Weir (see Lupton, 1999a) states that with the emerging technology it is no longer the woman's own innate experience of childbirth that influences the medical opinion, but technology with the interpretation of the health professional. As such the mother’s experiences carries less weight. The changes that happen to the mother are physical and she experiences the changes, but what also happens is that the more pregnant she becomes the more she loses her own identity. Others seem to have a strong opinion on what she should do and what she shouldn’t do (Lupton, 1999a). The focus of concern is not the mother, but the baby and its health. The mother becomes an incubator and has to make sure that she doesn’t do harm to the baby in any way. She is not allowed to take any risks and the discussion of risk and self-surveillance due to the normalisation of pregnancy and childbirth is greatly connected with this sense of being two bodies. What women tend to want to feel is a sense of wholeness during childbirth where they are perceived as being one body, so in a way they
should be allowed to feel this wholeness. It becomes difficult when the primary goal of childbirth is a healthy baby that is apart from the emotional, passive and objective body of the mother.

Objectification of the body can be done according to Foucault (see Liz Eckermann, 2002) with the idea of normalisation and through the modern medical gaze. Modern scientific methods use statistics and epidemiology to register information about the population and pregnant women can be especially vulnerable to this because of the ideas of their social standing. Women were at one point looked upon as emotional natural beings whose place was in the home. As such their knowledge didn’t fit into the rational environment of clinical knowledge. This has somehow followed women into the 20th century where women are still being treated as if their workplace is in the home rather than being equal to men. Foucault (see Gastaldo, 2002:125) also states that by using power through discipline it is possible to create socially accepted individuals that are acceptable to the medical system. The disciplinary process is done through the regulation of the smallest part of their lives, so in the case of the pregnant woman, it would be by regulating the baby that would make the mother do as she is told. The pregnant woman takes part in a medicalised system that is considered normal.

Childbirth is advertised in Western society as being dangerous and difficult. If women watch television programs and movies where childbirth is depicted as painful what tends to happen is that this becomes normality in regard to expectations for most women. Foucault (see Harding, 2002) states that discourse within society influences how individuals relate to experience. When a woman regards the depiction of childbirth on television as something to embody as a frightening experience, then this in turn becomes a normal social phenomenon. When expectations are of this nature, it can take a lot of courage and effort to step away from that to change what is conceived as being normal especially if normality is connected with the health professional’s authority and power. Martin (1989) states that by changing the discourse within society that creates the normal social phenomenon it is possible to change embodied expectations of pregnant women.

Foucault (see Harding, 2002) perceives that different discourses in connection with power relationships and subjectivity within the society can affect society and individuals. The discourses in the environment of the pregnant woman can create what is perceived as a social phenomenon that can change and develop depending on what is going on in her environment. Each era has different ideas about what is perceived to be normal and what women should do regarding childbirth. The plethora of information can be overwhelming and frightening but
yet at the same time be uplifting, empowering and wonderful. A mother only has to turn on the television to realise how frightening and real childbirth can be, i.e. One Born every Minute (Dragonfly Productions, 2010-2012) or movies that have scary birthing scenes where the women scream and swear out with pain in the lithotomy position (on their back), i.e. Knocked up (Judd Apatow, 2007), but can then go to a yoga class to be told that her body is her temple and that she can do anything she wants to or reads books by midwife Ina May Gaskin where labour pains or contractions are described as “rushes” and that having an orgasm during birth is just fine (Martin, 1989). These do not necessarily add up to her final experience within the hospital settings or they might actually help the woman have a wonderful birthing experience.

6.2. Reaction to medicalisation of childbirth

According to Emily Abel and Browner (1998:315) women tend to use embodied knowledge that draw on their own experiential world and often that of other women’s experiences when deciding to accept or refuse medical advice. They gain information from the medical environment as well as from social sources, such as books, television, websites and previous experiences, so as to adhere to the best interest of themselves, their families and often their communities. Women seek medical advice so as to know what to expect from pregnancy and childbirth and the advice they are given is then transformed into embodied knowledge. They also use their embodied knowledge to disregard medical advice, because they have had experiences where previous medical knowledge wasn’t helpful. What these women tend to do is seek out what they feel is relevant to their situation so as to feel a sense of empowerment (Mary Nolan, 2011) and control.

The mother is an individual that will most likely do what she can to make sure that her baby is as safe as possible, but governed by her own embodied knowledge of what she finds safe rather than by accepting the views of the medical profession. She most likely wants to be treated as an equal in the relationship with the health professional and to take part in the process that relates to her body and that of the unborn baby (Savage, 1986:xv-xvi). Wendy Savage’s experience as a gynaecologist and obstetrician is that women want to be seen as equals and not as some subordinate person within a power struggle. It matters to most women that they have a say in the process of pregnancy and childbirth. When something during childbirth doesn’t go as planned the result may be insecurity, fear and a feeling of loss of power, to name some of the more emotional reasons (Brodsky, 2008) and the more the woman knows about what is happening the more chances are that the birth will be more successful.
Savage (1986) is afraid that if women are not seen as equals and are continually put in a subordinate position, there might be an urge for woman to bypass the medical system altogether by freebirthing or having an unassisted homebirth. Beech (see Nolan, 2011) feels that the number of women freebirthing might grow if they continue to feel unsupported and bullied. In the UK this is allowed because there is nothing that makes it illegal (Nolan, 2011). In the US, it is illegal in some states whereby a mother could be prosecuted for putting her unborn baby into harm’s way.

To assist women in resisting the feeling of being subordinate during childbirth, it is necessary to understand which particular forms of self-surveillance resulting from medicalisation makes them feel objectified (Ussher, 2007). This is so that they can challenge the unwritten rules and normalisations of childbirth with the hope of changing them. Foucault (see McNay, 1992:68) mentions that the individual can fight the power of the regulated society by using the same ideas of power as the health professional. By policing themselves through self-surveillance women are able to stand up against the social normalities by using knowledge which can then assist them in feeling empowered. One way of creating empowerment is through education. Gastaldo (2002:129) states that health education gives information to patients so as to enable them to make informed choices. This gives them an opportunity to use their own experience alongside the given information to exercise self-regulation and freedom to make their own choices. However, health education can also cause the pregnant woman to lose control of her body because of how the health professionals perceive themselves in the relation to the patient. The health professional may decide not to give the pregnant woman all of the information. So for Foucault (see Gastaldo, 2002:129) health education can either empower women or discipline them so that they conform to the norms.

Women aren’t always on their own when it comes to resisting medicalisation as there are health professionals that respect women and will often assist them in making decisions so to make them feel empowered (Ussher, 2007). According to Ussher (2007) women are not always passive in the process of normalisations that come from surveillance and regulation of society. They do have the power to take control and can resist the notion of their body being a site of illness and deviant behaviour. There are movements that try and create a different view of childbirth and regard it not as an illness where the mother is objectified, but takes her into account. There are prominent figures within the birthing environment that have had a profound effect on the Western birthing culture so as to respect and subjectify the mother, such as Sheila Kitzinger, Ina May Gaskin, Michel Odent and Ann Oakley. Their view has
been to empower women to take control over their own situation so as to be able to choose what is right for them with the assistance of the health professionals. A book search on natural birth on Amazon.com will find many books that talk about different natural empowered ways of childbirthing.

If women have lived through a bad experience with their first child, they will often choose something different for subsequent childbirths. Homebirths are often chosen for subsequent children because women are trying to make the experience more social by stepping away from the technocratic birth that they already been subjected to (Brodsky, 2008; Barbara Rothman, 1982:101). Homebirths are also often chosen as a form of resistance to the medicalisation of childbirth according to Patricia A. Kaufert (1998). Women have gone through the medical process whereby staff ignore them, treat them as objects and rely completely on the technology used in childbirth rather than listen to and watch the birthing mother. The woman may tell the staff about what she feels is happening and feel that she is completely ignored because the charts and the technology are saying something completely different. Some women become disillusioned by the medical management of previous births and feel that they need to take control and give birth in the way that they feel empowered and supported. It is through being disillusioned that organisations such as La Leche League, a breastfeeding support organisation, was started so as to support mothers from the mother’s perspective. Their work has influenced mothers to think about their choices and made them aware that medical knowledge can be incomplete and in some cases incorrect (Rothman, 1982).

6.2.1. Societal reaction when fighting medicalisation

The pregnant woman will most likely be criticized for going against medical advice but what isn’t realized is that what one woman finds safe another woman doesn’t. The women who choose to go against what is considered normal often find the knowledge they need to make an informed decision and will often be more accepting of the final outcome even if it is negative (Nolan, 2011). Health professionals will most likely try to get the woman to change her mind because it goes against what they consider to be normal. The woman is often spoken to in a derogative manner because she is considered to be a lay person rather than a specialist, but the woman only wants to be spoken to so that she can possibly empowerment during the process. Good communication between health professionals and a birthing mother more often than not, leads to a positive outcome (Kitzinger, 2005), for both mother and baby. Nolan (2011) states that for a mother to make the right decision for her there has to be cooperation
between the health professional and the woman. This means sitting down with the woman, talking to her, discussing different scenarios, research and possible outcomes and to help find a solution that is both acceptable to the health professional and the mother. This is probably very uncomfortable for the health professional as this transfers power from the professional, who is the specialist, to the woman or the lay person, who might go completely against their advice. In some situations it can happen that the health professional takes control by ignoring or by pressuring the mother just to fulfil protocols or certain medical processes that are deemed to be normal.

Rothman (1982) decided to homebirth her baby, but found it difficult to get the support she needed, both from the health professionals and from her environment, because it was deemed unsafe. She was told horrible birth stories of babies that could have died if the mothers hadn’t gone to hospital to give birth. She was also accused of being irresponsible for wanting to take a risk with her unborn baby, but what she found interesting was that if a woman decides to take control of her situation, she is deemed irresponsible whereas if she submits to the norms of the medicalisation of childbirth she is deemed responsible. Society has deemed childbirth to be dangerous and therefore only safe in the hands of the health professionals (Apatow, 2007; Michele L. Crossley, 2007; Nolan, 2011). This is despite all the possible complications that technological interventions can cause that are used within a hospital during childbirth (O’Dwyer et al., 2012; Ronsmans & Graham, 2006; Thorpe, 1993). During a homebirth, the woman is in her own environment, where intervention is almost nonexistent, all is calm, she has control to do what she pleases, and there are no protocols to follow (Kitzinger, 2005; Rothman, 1982). A homebirth takes the birth away from the medical world back into the social remit of the woman’s environment according to Kitzinger (2005). If there are any problems there are usually early indicators that tell the midwife or assistant that the woman needs to get to hospital and women usually listen to the advice of their assistant because even though they have decided to go a different route, their main concern is also for the safety of the baby.

If something goes wrong at the birth and a baby dies, the chances of litigation tend to be quite high and courts do not distinguish between unavoidable and preventable death. So the health professionals are in a bit of a dilemma. They are in a position where they are meant to save the life of the baby but often in disregard of the mother. Would a mother sue for unnecessary intervention if the baby she has given birth to is healthy? Probably not, but there are cases where mothers have been sectioned because the health professionals felt the mothers were endangering the life of the unborn baby (Rosamund Scott, 2002). There are seven
known cases in the UK (Savage, 2002) where mothers have been sectioned and the babies taken by caesarean. In most of these cases, these mothers have had these court decisions overturned with the effect that in 1997 (Clare Dyer, 1997) the courts decided that a mother could not be sectioned unless there was extremely strong evidence to suggest that she was incapable of making rational decisions. An unborn baby is not deemed to be a legal subject that has rights over the mother and to force a mother to have a caesarean with the risks associated, is considered very serious. Unfortunately, it depends on which state the mother lives in, within the US (Scott, 2002) whether the unborn baby is considered a legal subject or not and therefore has rights that override the rights of the mother. This is a very complicated moral and legal issue that makes it hard to truly justify whether a woman can be judged unfit to make a decision when it comes to her unborn baby.

A mother (Nolan, 2011:68) gave a speech about her negative interactions with the medical service in the UK. She wanted a homebirth but the medical team was against the idea and the mother discusses the negative impact, having to fight a system that should support women, can have on women. The problem is, is that women who are constantly looked at as objective bodies rather than subjective bodies, lose contact with themselves. They no longer recognize their own bodies and become disempowered. The message they get is that health professionals know more than they do and if the women dare contradict the health professionals they are often deemed irresponsible and often treated as such. A power struggle can begin between the woman and the health system, whereby the health system tries to get the woman to behave and comply but the woman might want to do something different that goes against the advice of the medical system (Francoise Baylis and Sherwin, 2002). She in a sense can be likened to a child by the medical system that isn’t behaving rather than a competent adult who has a right to make choices that suit her own body.

When a mother decides to go against the norms of her society (Rachel Westfall, 2006) she will often say yes to the health professional and lie to them, but often more to placate the professionals so as to not have to fight them. Women, who do not have the energy or a need to confront, will also tend to go down a route of avoidance according to Nolan (2011). They tend to agree to appointments, but do not turn up. They agree with the health professionals but then quietly do something else. The problem is that the health professionals use the same tactics to get what they want as well by avoiding an issue until a later date or by delaying discussions on important matters until it is too late to do anything for the pregnant mother. They coerce the mother to conform by using certain tactics such as using powerful specialist words the mother probably doesn’t understand.
A mother pregnant with twins (Nolan, 2011:76) wanting a homebirth ended up having one, because she persisted and resisted the system, but what is interesting is that she felt that she had been duped into believing that she lived in a society whereby she could choose, but in reality that wasn’t the case. She was unusual in this situation, because she resisted the bullying and in the end received the care that she fought for. To have to fight the social system so as to be able to choose in her mind wasn’t in fact choosing, it was fighting and to women who have to fight the system, it does not feel like it was a choice at the end of the day. Women who end up fighting with the health system are often branded as trouble-makers according to Stapleton et.al (see Nolan, 2011:78), because the reality is, that most women conform to the routine medical care that pregnant women receive.

Derber and Graebner (see Davis-Floyd, 1992) and Wendy Kline (2010) talk about the fact that women are raised to do as they are told and to conform and to be good instead of complaining about something they don’t like or know nothing of. If they do dare complain, they are often belittled or made to feel inferior or they might be told off for talking about something they know nothing of. The women who fight the system or go against what is considered to be normal never feel as if they are on equal footing with the health professionals. It is as if because of the background of the health professionals and their knowledge that they have accumulated an amount of power that they become too superior to be able to listen to the subordinate amateur or in this case the woman who is in their care for only a few months. The woman will probably be ignored instead of being treated with respect. A woman might also not want to jeopardise the relationship she has with her midwife as it might have a negative effect on the relationship already in place (Rebecca Shaw, 2007). On the other hand, these same professionals are often trusted by the majority of women, because of the medicalisation of pregnancy and childbirth that has become normality in Western society. Most women believe that the health professionals are working in their best interest and don’t believe that they need to fight.

6.2.2. Should women fight medicalisation of childbirth?
Crossley (2007) depicts what can happen when births become medicalised and talks about her own decision of wanting a natural normal birth and how things rapidly changed when there was an inkling of something going wrong. She started worrying about everything that could possibly happen, as is normal during pregnancy because of the “what if” syndrome of worrying about everything that could go wrong and in the end decided on a hospital birth. What is interesting is that everyone surrounding her became relieved that she had opted for a
hospital birth because of its safety. She showed signs of possible pre-eclampsia, a complication of pregnancy, during a routine check and she ended up having a cascade of interventions that started with an induction technique of stretching the cervix to encourage contractions without actually being asked whether she wanted it done or not and ending up having a c-section to deliver the baby. From the way she talks of her birth, it sounds like the health professionals treated her as an object that needed supervising, checking and re-checking. She had a birth-plan that no-one looked at. Because of her expectations of a normal and natural birth, she felt like a failure as a woman which is not a unique experience of women in the modern world of childbirth. She asks why she didn’t put up more resistance, why she didn’t fight what happened to her and resisted the medicalisation of her birth. In her view it wasn’t possible to fight the system, as how could she fight something she knew nothing of? She wasn’t medically trained so couldn’t argue with the health professionals on the chances of her having pre-eclampsia or any of the other interventions that she was subjected to. She felt that she couldn’t make an informed choice because she didn’t have the knowledge in this situation or wasn’t given the knowledge. It seemed that her opinion didn’t matter and that she was told that everything that had happened was deemed necessary for the sake of herself and the baby. The only way to be able to gain true choice in this situation is to read up on the matter before getting into it, which is why a lot of women tend to become experts (Nolan, 2011) when they know that they can possibly do something different. The other option is to just accept the process as is expected of them by the health professionals.

The technocratic discourse of birth (Davis-Floyd, 1994) is a dominant one which tends to control values, beliefs and behaviours of the population within society. Childbirth policies according to Heather Cahill (2000) have resulted in complete medicalisation of childbirth whereby almost all women give birth within the hospital environment, as it is considered safest. While obstetricians believe that a birth should only take place within the four walls of the hospital because of safety, then it will be very difficult for individuals to see birth as a more social and personal experience that doesn’t need help unless there is a problem. The problem with this view is that if looking at the maternal mortality rates in the US and in the UK and the reasons behind them, then hospital births do not seem to be as safe as one would hope. This doesn’t seem to deter women away from these so called safe places to give birth because of the dominant view that hospital births are safe. Another issue is that what is considered normal and abnormal is in the hands of the obstetricians which often view pregnancy as an illness and deviant condition that requires assistance and women tend to accept their view.
Feminists over the last 30 years have criticized the medicalisation of birth according to Crossley (2007). They would like to allow women the freedom of having power over their bodies and being allowed to choose what happens to them, but by doing so can be criticized because female choice goes against the idea that a woman should be docile and impassive. To shift power to the woman sounds like an anomaly according to Rothman (1982) because of the power of the medical system. Homebirth can be seen as a reaction to the medicalisation of childbirth according to Rothman (1982) whereby it can be seen as an arena where women can feel empowered and in control of childbirth. The medical system is an established system whereby the population trusts their authority in regards to pregnancy and childbirth which makes it hard to criticize and fight against. The health professional usually has the final say in what happens during childbirth. Women, who challenge the system, are challenging a system that has authority and most women do not feel that they have the knowledge or power to challenge this system.

The discussion so far has been quite negative because of the discussion surrounding the objectification of the female body during childbirth. A lot of women, however, seem happy to hand control over to the health professionals and embrace the technological advances available according to Davis-Floyd (see Crossley, 2007). Their reasoning is that they are afraid of the biological process of childbirth and they find it empowering that they don’t have to take part in the process by using everything possible to make labour pain-free. These women have every right to decide this because it is at the end of the day about choice, the freedom to choose what is best for each and every woman instead of inflicting on women something they themselves do not desire. The downside to choice is how to choose and how to choose correctly so that the outcome does not become negative as in increased maternal mortality rates or injury to the woman.

Crossley (2007) says that if women are to have real choices then they should be warned of what they might experience within the hospital setting. Women are told to write birth plans so as to be able to predict what type of care they can expect, but the problem with these is if something happens that goes completely against the birth plan. What should be done is to prepare women for the fact that not all births are natural and wonderful, some are difficult and disempowering. Birth can be empowering for any women open to true choices, whether it is a choice of intervention free and natural birth to the extent that it isn’t dumbed down with external technology or a choice of complete intervention so as not to feel anything during childbirth and their empowerment is to have actually gone through the process without feeling anything.
A different viewpoint comes from Clare Stockill (2007) where she feels that it is the health professional’s duty to inform the mother of what is being recommended and then explain the risks involved in these recommendations so that the mother can make an informed choice. Clare experienced a highly medical birth for her first child where she was left disempowered and bullied. Her birth-plan was ridiculed as whimsical and laughed at. She felt that she was informed of what was going on, but that nothing was explained to her as to the possible risks of each intervention. She feels that the interventions she received were unwarranted and unnecessary and that the health professionals that cared for her only deemed birth safe when it is over. All subsequent births that Stockill (2007) went through were completely different because she decided to make them intervention free by becoming informed as to what should be done and what should not be done during childbirth and taking control. What is important in every situation is the level of support a woman gets during childbirth and no matter whether childbirth goes to plan or not, to respect that there is a woman giving birth to a baby and that she needs to feel as if she is in control. Kitzinger (2005:46) says that what needs to be done is to build bridges between the medical environment of birth and women. The health professionals who want to give women-centred care that is based on informed choice need support to do so. The birthing environment needs to improve so women feel supported in birthing their babies.
7. Conclusion

Childbirth stands between the paradigm of nature and nurture as it is a biological and cultural process according to Oakley (1980:7). It is biological because of the way babies are born but cultural because of the impact technology, science and politics can have on the process. The process has become medicalised whereby the human body is regarded as a machine that needs controlling and normalising. As such childbirth has been moved from the social remit of the woman’s environment, where women bonded over the birthing process, into the sterile medical environment because it is viewed as deviant condition that is considered to be dangerous and in need of assistance. The mother doesn’t seem to fit into the medical picture of childbirth as she is just an objectified container for the baby and the main goal of childbirth seems to be that of giving birth to the baby as safely as possible.

Women seem to trust this environment and accept the medicalisation of the childbirth process, which is not surprising if the process of power, normalisation and risk is looked at. Foucault believes that power can be seen as part of a relationship between various institutions and individuals in the modern society. This relationship should be fluid so as to create a normality that can change depending on individual needs. What tends to happen, however, is that the governing body tends to create social policies and guidelines that control and regulate the lives of the population so as to create a sense of normality that is guided by the governing body and not the individuals. Mary Douglas (1984) feels that society has a right to control, as without this control it would be difficult to create external boundaries or internal structures. Social limits or normality are defined by what is out of place and by controlling what is out of place, abnormal or deviant it becomes possible to maintain social order and to create what is considered normal. The individuals feel that they have to conform to this idea of normality as otherwise the sense of being criticized becomes too overwhelming. This is what tends to happen within the technocratic and medicalised environment of childbirth. Women do what they are told and follow the rules and protocols that the health professionals have informed them of. Because this is considered normal, few women resist, but those who do get criticized by both the health professionals and often other women.

What is considered to be risky is often defined by the society that individuals live in and the main goal of society is to minimize potential risks and danger. Women who do resist the medicalisation of childbirth tend to be criticized because their behaviour is considered risky, abnormal and dangerous. Pregnant mothers who go against normal procedures are often
classified as high risk and are encouraged to rethink their actions. A woman who does this will often be deemed irresponsible by the society she lives in as Barbara Rothman (1982) felt, but a woman who submits to the normalities is deemed responsible. Mary Douglas (1992) feels that the people who do take risks do not do so out of ignorance, but out of preference. Their need to resist does not stem from a need to create chaos but to regain power over their own bodies so they feel empowered. A pregnant woman who goes against normality does not do so in isolation but will most likely seek advice from others so as to gain confidence in doing so. Her ideas of risk taking are also probably very different to that of others and therefore she will probably be more accepting of the outcome of her so-called risk taking.

A lot of women find empowerment in the medicalisation of birth and are happy to accept the normality of this, as they find the biological aspect of birthing frightening and disempowering and there is nothing wrong with that. Quite a few women do not feel they have the knowledge to oppose the medicalisation of birth because of its supposed power and authority. These women accept the normalities within the medicalisation of birth but may find that they become disillusioned with the process, because they tried to control it but lost control because of the authority the health professionals had. If women do decide to go against the medicalisation, they often do find the strength to become experts on their own situation. They gain embodied knowledge from their own experiences and from other relevant sources, but as a result can often become part of a power struggle where women are encouraged to conform to the medicalisation of childbirth. This is a true shame as childbirth should not be part of a power struggle, but part of a respectful relationship whereby both views are respected to create a final outcome that both empowers the woman and ensures a safe birth for the baby but with the help of the health professional, who can provide assistance, support and intervention in the case of actual rather than perceived risk to the mother or baby.

To answer the question posed as the title of this essay, women can resist the medicalisation of childbirth, but it is difficult because of the structures of power, risk and normalisation. Sheila Kitzinger (2005) says that what needs to be done is to build bridges between the medical environment of birth and women. The health professionals who want to give women-centred care that is based on informed choice need support to do so. The birthing environment needs to improve so women feel supported in birthing their babies in all forms, whether it be at home, within the hospital, with assistance of technology or without it. This is the fluidity that Foucault spoke about in regards to the relationship between authority and the individual so as to create a normality that everyone agrees to.
8. Bibliography


