

WOMEN AND MEDICAL KNOWLEDGE IN THE 1950S:
A STUDY OF THE PROCESS OF SOCIAL CONSTRUCTION

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Abstract

This study examines how medical knowledge of women is socially informed in historically specific contexts. The case of obstetric and gynecologic knowledge of the 1950s is the focus of this investigation of the social character of medical knowledge.

There is a prevalent notion that error results when medical knowledge is socially influenced. However, in the present work, social influence is seen as involved in the production of all medical knowledge. Thus, the present study offers an alternative conceptualization to dualist models where the medical and the social realms are considered separate entities. In such models, social influences are posited as factors external to medical knowledge. Rather, it is suggested here that the production of medical knowledge of women is a process consistently informed by its social context.

The social production of medical knowledge is indicated by the ways in which professional concerns, social notions of women and gender relations, and the socio-political context were employed as resources in the construction of obstetric and gynecologic knowledge during the 1950s. The technical distinctions made in that

knowledge of women's reproductive health arose out of the social resources available to the medical profession in that postwar period. Social concepts of femininity and domesticity are resources displayed in the categorizations of medical normality and pathology generated or accepted by 1950s obstetricians and gynecologists.

The form and content of obstetric and gynecologic knowledge, then, reveal how medical, technical terminology acted as a rhetorical strategy. This strategy allowed decisions to be made about norms and to be presented as neutral and asocial. However, the present research suggests that obstetric and gynecologic knowledge was inherently social in its production and maintenance.

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Introduction

Deconstructing Medical Categories

This work examines the question of how the social context of the 1950s influenced the generation of medical knowledge of women during that period. This project falls within the larger realm of the Sociology of Scientific Knowledge. While this study focuses on medical knowledge of women, it also draws upon the broader notion of the social character of scientific knowledge in general. Much of the recent literature on medical knowledge of women suggests that medical knowledge is social, though it is presented as technical and objective on the whole. The present study undertakes a more detailed examination of precisely how medical knowledge of women is informed by social context in historically specific ways. It draws on research in the Sociology of Scientific Knowledge to further investigate the social character of medical knowledge of women.

The specific issue addressed in the present study is whether or not only incorrect medical knowledge is social. This is the prevalent assumption in current approaches to the research on medicine and women. While my project continues the assumption that inaccurate knowledge is socially-informed, it further suggests that the social

character of medical knowledge is not limited to "incorrect" knowledge of women. It is an inquiry which asks about the social "origin" of all categories of medical discourse. Current bodies of literature in the sociology, philosophy and history of medicine fields indicate that medical knowledge is inherently social in its construction, and that there is no such thing as medical knowledge free of social context.¹ My research takes this lead and suggests that error or inaccuracy is not the prime indicator of social influence or context.

Furthermore, this means that the study taken up here attempts revision of the positivist, internalist understanding of medical knowledge which dominates the literature on medicine and women. At present, most works assume that what is taken to be the "rational" explanation or real truth about women's medical conditions, eventually will be revealed. This suggests that the achievement of accurate, non-ideological knowledge is subverted by social influences external to the construction of knowledge itself. For example, although Riessman discusses the social

¹ cf. for example, Michel Foucault, The Birth of the Clinic. An Archaeology of Medical Perception, New York: Pantheon Books, 1973; Roland, Charles G., ed., Health, Disease and Medicine. Essays in Canadian History, Toronto: Clarke Irwin Ltd., 1984; Turner, Bryan S., The Body and Society. Explorations in Social Theory, New York: Basil Blackwell, 1984; Webster, Charles, ed., Biology, Medicine and Society, 1840-1940, Cambridge: Cambridge University Press, 1981; Wright, Peter and Andrew Treacher, eds., The Problem of Medical Knowledge. Examining the Social Construction of Medicine, Edinburgh: Edinburgh University Press, 1982.

construction of science and medicine, her formulation of how medicine is social entails a separation of the medical and social realms. This disjunction is evident in her comment that "medicine is a social enterprise, not merely a scientific one."² There is commonly a divergence conceptualized in the literature between rational, objective medicine and social factors (such as patriarchal interests) which invade presumably "pure" medical knowledge from "out there." "The result," writes Pirie of this assumption,

is a somewhat simplistic causal model which argues that ideological forms of knowledge flow in a more or less undiluted form from patriarchal structures of control and deposit themselves unproblematically on unwitting, passive subjects.³

According to the model Pirie criticizes here, apolitical, value-free knowledge is assumed to be a possibility for medical science.

The present study investigates, rather, how the interests of medical groups may not be "non-medical motives," social factors impinging from without, as is often claimed.⁴ It asks how medical knowledge can be characterized as social knowledge, inseparable from the society within which it is articulated. At issue is how the "reality" of

2 Riessman, Catherine Kohler, "Women and Medicalization: A New Perspective," Social Policy, 14, Summer, 1983: 4-5.

3 Pirie, Marion. "Women and the illness role: rethinking feminist theory," The Canadian Review of Sociology and Anthropology, 25: 4, November, 1988: 631.

4 Pirie maintains this problematic division between medical and non-medical motives. Ibid.: 630.

women's medical conditions, as presented in medical knowledge, is the outcome of a process in which the medical and the social are intertwined.⁵ Concerns about women's changing social position during the 1950s, for example, may not have been superimposed upon factual, correct medical knowledge. Rather, the present study investigates the possibility that the process of construction of that knowledge involved the use of cultural notions of women as a resource for the construction of medical knowledge. It examines, in addition, the various struggles in which factions of the medical profession were engaged over the employment of those resources.

In short, this research asks how, despite an apparently neutral, medical foundation, social concepts were employed as resources in the construction of technical distinctions in medical knowledge of women. The relevance of cultural resources for the formation of scientific categories is basic to the process of knowledge production. As Barnes and Shapin observe of the reliance of science on such resources:

⁵ It is important to remember that knowledge is created by social actors, producing "reality" through the social construction of that knowledge. Knowledge is not simply a passive entity influenced by externals: "...the argument that medical knowledge is an important constituent in the shaping and construction of reality and not just a product of it asks for a degree of reflective thought often absent in the medical sociology field." M.R. Bury, "Social constructionism and the development of medical sociology," Sociology of Health and Illness, Vol.8, #2, June, 1986: 148.

We think and act on the basis of the resources our culture provides...The use of cultural resources to construct scientific theories is an observation of what happens, not the casting of an aspersion.⁶

What this statement suggests is that scientific reliance on cultural resources is not automatically problematic, as it does not necessarily result in error or bias in the scientific knowledge produced; rather, scientific knowledge is consistently reliant upon social resources.

The present study is also concerned, then, with which cultural resources were drawn upon by the medical profession during a specific period of time. The time focused on here is that of the early postwar period, the 1950s. The primary reason for the selection of the 1950s is that this period is characterized as having been one of conservatism and restabilization, a period in which gender behaviours were strongly prescribed. I have thus inquired into the production of knowledge about gender and more particularly about women. The present work looks at medical knowledge of women and those conditions which characterized the decade of the 1950s in examining the question of whether or not the then perceived social conditions of the period became

6 Barnes, Barry and Steve Shapin, "Darwin and Social Darwinism: Purity and History," in Barry Barnes and Steve Shapin, eds., Natural Order: Historical Studies of Scientific Culture, Beverly Hills: Sage, 1979: 138, cited in Cynthia Eagle Russett, Sexual Science. The Victorian Construction of Womanhood, Cambridge, Massachusetts: Harvard University Press, 1989: 185.

resources in the formation of that medical knowledge. For example, my research examines whether or not doctors used the distinctively pronatalist (pro-birth) sentiments accompanying the North American baby-boom of the 1950s (considered herein as social resources) in constructing medical knowledge of women during that period.

Obstetrics and gynecology were selected as the fields for examination of medical knowledge, since they are especially appropriate areas for study of knowledge of female biology and gender. Obstetrics and gynecology are the medical specialties which purport to deal most with women, with their "femaleness." In addition, the unique obstetric and gynecologic concentration on women's reproductive processes invites investigation of the question of how prevailing pronatalist sentiments during the baby boom informed the production of obstetric and gynecologic knowledge.

First of all, it was necessary to specify which female "problems" had been selected for medical attention. The conditions studied (or ignored) by physicians were thought to be socially significant by researchers and doctors, and this significance became part of the foundation upon which medical knowledge of women was constructed. The present research addresses the meanings and explanations these medical personnel used in the construction of knowledge.

Farganis suggests that the focus of medical experts on particular conditions is a process of interpretative selection:

social actors ... choose what the world means from what is, in reality, there or what they have been conditioned or allowed to perceive of as being there.⁷

The thesis argues, then, that the professional and broader social contexts informed obstetric and gynecologic knowledge about female biology and gender by serving as resources for the selective production of that knowledge. The concepts which comprised that knowledge embodied various medical interpretations of the world, through the obstetricians' and gynecologists' own weltanschauungen.

In order to interact in the world, people classify things and processes according to selected criteria specific to their society and historical period.⁸ This constitutes the social basis of the process of technical categorization including, for example, the construction of dichotomies of

7 Farganis, Sondra, The Social Reconstruction of the Feminine Character, Totawa, New Jersey: Rowman and Littlefield, 1986: 20.

8 "Since the world is so full of a number of things, ... we must categorize and simplify in order to comprehend. But the reduction of complexity entails a great danger, since the line between enlightening epitome and vulgarized distortion is so fine. Dichotomy is the usual pathway to vulgarization." Stephen Jay Gould, "Triumph of a Naturalist," Review of Evelyn Fox Keller, A Feeling for the Organism: The Life and Work of Barbara McClintock, New York Review of Books, March 29, 1984: 58-71, cited in Cynthia Fuchs Epstein, Deceptive Distinctions. Sex, Gender, and the Social Order, New Haven: Yale University Press and New York: Russell Sage Foundation, 1988: Preface.

sex and of gender in obstetric and gynecologic knowledge. Of particular interest was how medical thought of the 1950s formulated a distinct female/male, hierarchical dichotomy -- one which included social construction of womanhood in a pronatalist direction. In the case under study, the social conditions of the 1950s favoured an entrenchment of a female/male dichotomy, rather than the presentation of biological sex or gender as part of a continuum of differences. My research examines, then, how obstetricians and gynecologists used the social categorization of sex and gender as a resource in the construction of their knowledge of women.

The present study also asks what the social conditions were in which doctors used this knowledge of women, once it had been produced. In other words, it asks how the technical distinctions that medical practitioners made on the basis of then-existing cultural resources were further employed for normalizing and regulating social behaviour. My study looks at how social concepts of womanhood such as the ideal of femininity, for example, were first used to make biomedical distinctions between normal and abnormal female physiological conditions. Then, the study examines how this newly minted dichotomy of normal/abnormal womanhood and femaleness is presented as a decontextualized medical, technical distinction. Further, my research turns to the issue of the medical profession's use of that distinction to

control social concepts of normality, particularly as applied to the female sex and gender.

The present study, then, examines how, according to its vested interests, the medical profession was able to exercise successfully a surveillance and control over most aspects of what constituted medical knowledge in the 1950s. The fact that this 1950s obstetric and gynecologic knowledge was presented as neutral, technical knowledge with scientific status made it an especially effective discourse. The prevalent distinction medical experts drew upon was that between a social realm on the one hand, and a technical, scientific one on the other. Obstetric and gynecologic knowledge existed in an environment where scientific, technical discourse was very powerful. So my research pursues the issue of how the distinction between social and scientific spheres constituted a resource for obstetricians and gynecologists in arguing for an apparently value-free version of normal, appropriate, gendered behaviour in the 1950s. Medical knowledge was being produced in a context of a growing social reliance on scientific rationality and that spirit supported attempts to define normality and abnormality clearly, according to scientific criteria. However, it shall be argued here that this knowledge demonstrates the wider principle that the content of technical concepts is never context-free; it is, rather, dependent on the human, social context.

My study investigates not only how obstetrics and gynecology identified and defined "disorders," i.e. pathology and abnormality, but also how they monitored women's normal reproductive processes to prevent the development of abnormality. This application of medical definitions to "normal" human conditions, and particularly to the physiological and psychological processes of such socially subordinate groups as women, was part of a general medicalization process.⁹ Medicalization is a process that has certain social implications, as Riessman points out:

Medicalization has resulted in the construction of medical meanings of normal functions in women - experiences the typical woman goes through, such as menstruation, reproduction, childbirth, and menopause.¹⁰

The construction of medical conceptualizations of normal physiology is important because it is often argued in the literature on women and medicine that this process is one of social control. It is considered to be control in the sense that a normative ideal is defined and prescribed which entails selected social assumptions about health and illness, normality and abnormality.¹¹ Mitchinson comments

9 Conrad, Peter and Joseph W. Schneider, Deviance and Medicalization. From Badness to Sickness, St. Louis: C.V. Mosby Co., 1980; Riessman, Catherine Kohler, "Women and Medicalization: A New Perspective," Social Policy, 14: 3, Summer, 1983: 5, 15.

10 Riessman, Catherine Kohler, op.cit.: 15.

11 Conrad, Peter and Joseph W. Schneider, op.cit.: 7, 8.

on this combination of medical description and prescription in the case of the late nineteenth century:

Physicians were attempting to define what the normal healthy woman should be and it is not surprising that she was what they wanted her to be and what society wanted her to be.¹²

My research focuses on instances of that process of definition of the normal woman as existed in the 1950s. It examines how medical experts drew upon the social concept of "femininity," and its achievement through reproduction and mothering, as a resource. The obstetric and gynecologic writings are analyzed to determine how this resource was then used extensively, for example, in categorizing the phases of women's menstrual and endometrial cycles in a manner such that ovulation and reproduction formed the major focal points. The medical literature reveals that, once articulated, these medical and technical conceptualizations of women were then used as resources themselves, to argue that the reproductive state was the criterion of normality for women. My study examines how, in this case, the pronatalist climate of the baby-boom in the 1950s was employed first in the construction of obstetric and

¹² Mitchinson investigates late nineteenth-century medical knowledge of women, but the character of the knowledge as social remains unchanged in the twentieth. Wendy Mitchinson, "Causes of Disease in Women: The Case of Late 19th Century English Canada," in Charles G. Roland, ed., *Health, Disease and Medicine. Essays in Canadian History*, Toronto: Clarke Irwin Ltd. for The Hannah Institute for the History of Medicine, 1984: 392.

gynecologic knowledge. Further, the study considers how, then, in the face of perceived social problems, practitioners used this revised knowledge to reinforce those pronatalist concepts through surveillance of normality.

Specific assumptions about what constituted normal behaviour for women, as opposed to men, are shown to have developed in a social context which was particularly concerned with normalization and the achievement of social stability following the war. Normal women, for example, were expected to take responsibility for "producing fit, healthy children who will grow up to be well-adjusted citizens," a task assumed to contribute to the maintenance of social stability.¹³ Obstetricians and gynecologists were in a particularly central position in the 1950s for advocating this role for women in maintaining stability. It is shown that they could prescribe what was considered normal, through surveillance of the potentially abnormal, often in the form of preventive medicine such as prenatal care.

An examination of obstetric and gynecologic concepts of disorders and surveillance of normal conditions, then, reveals the way in which social resources were employed in the 1950s for certain rhetorical and behavioural ends. The thesis thus argues that there is a historically specific

13 Heidensohn, Frances, Women and Crime, London: MacMillan, 1985: 165-6.

connection between generally available cultural categories of women and their biology, on the one hand, and the technical, medical notions of that biology, on the other. This is indicated by the presence in the technical literature of a closeness of fit between cultural ideas and medical terminology and concepts. For example, an emphasis upon female reproductive capacity in both the social environment of the 1950s and in medical categorizations of menstrual cycles is considered to be a significant connection between obstetric and gynecologic knowledge and its social context.

The present study performs such an examination of the medical knowledge and the context of the 1950s, allowing me to build upon the contributions of other feminist appraisals of medical knowledge of women. The models of social control widely used to characterize medical discourse on women, for example, are based on particular assumptions about the way in which medical knowledge is social. While it is quite widely held that medical knowledge is social, my research addresses the issue of the precise delineation of the manner in which it is so. The present study of obstetric and gynecologic knowledge suggests the need for a revised notion of the social control process from that in much of the feminist work in the area of women and medicine. This revision is based on an alternative way of conceptualizing the social character of medical knowledge. In particular,

it continues the direction begun by those studies which acknowledge the fully social character of medical knowledge of women.¹⁴

Chapter One examines current approaches to the study of medical knowledge about women, highlighting how my own study of the social construction of medical knowledge builds upon previous studies in the area. I've found the recent, socio-historical revisionist literature helpful in addressing the assumption that the construction of medical knowledge about women was directly coercive, a position advanced by some of the previous studies. I provide critical discussion of those studies in which the social character of medical discourse is viewed in a dualistic manner: in which potentially truthful, neutral knowledge is considered to be distorted by such external social factors as professional interests or ideologies. This positivist approach also contains a dualist, non-interactionist model of women as "victims" of social control, a control perpetrated by those agents possessing the medical knowledge. The possibility of a more holistic model of the social character of medical

14 Riessman, for example, in her analysis of medicine, recognizes the social construction not only of illness, but also of science as the legitimator of medical authority to define that illness. She notes that "scientific "facts" themselves are socially constructed." Catherine Kohler Riessman, *op.cit.*: 5; cf. the work of Ann Oakley, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986; cf. Turner, Bryan S., The Body and Society. Explorations in Social Theory, New York: Basil Blackwell, 1984.

discourse on women emerges out of my study of the social resources employed in the construction of 1950s obstetrics and gynecology and contributes to a revised understanding of the social control of women through medicine.

Chapter Two is a discussion of the perspectives in the Sociology of Knowledge and, in particular, in the Sociology of Scientific Knowledge which informed this study. I suggest that the issue of the relation of knowledge to social conditions is most fruitfully addressed by the holistic approach of Gyorgy Lukács and Karl Korsch in the Sociology of Knowledge.¹⁵ Their conceptualizations of the social character of knowledge, as a "processual totality," for example, avoid reliance upon dualist or universalistic models. I also briefly consider aspects of Marx's approach to knowledge, many of which formed the basis for the work of Lukács and Korsch, as Marx's contribution is important in understanding how medical, scientific knowledge is social.

The Sociology of Scientific Knowledge deals more specifically with the social construction of scientific ideas and concepts. I note the general value of this body of literature for my own research question and delineate the applicability of certain approaches within the Sociology of Scientific Knowledge.

15 Lukács, Georg, History and Class Consciousness, Cambridge, Massachusetts: MIT Press, 1968; Korsch, Karl, Marxism and Philosophy, New York: Monthly Review Press, 1970.

Pinch's attention to controversies in science, for example, is one approach to research in the area which makes explicit the process of selection and acceptance of scientific ideas.¹⁶ The social assumptions and resources employed in the construction of scientific, technical concepts and categories can emerge when scientific debates are examined. During the 1950s, for example, obstetricians and gynecologists debated the relative merits of "natural childbirth" and the use of anesthesia in labour and delivery. Consideration of the controversy highlights the social character of the technical distinctions made and how the distinctions were employed in the selection of a solution. In this example, medical experts used pronatalist and eugenicist concepts in their discussions. Some of the problematic aspects of other approaches in the Sociology of Science, such as that of "Interest Theory" are also raised. I discuss these problems because such models have been commonly employed in the literature on the relation of women to medicine and science in a way which perpetuates the same conceptual weaknesses.

¹⁶ Pinch, Trevor, "Towards an Analysis of Scientific Observation: The Externality and Evidential Significance of Observational Reports in Physics," Social Studies of Science, Vol. 15, #1, February, 1985; Pinch, Trevor J. and Wiebe E. Bijker, "The Social Construction of Facts and Artefacts: or How the Sociology of Science and the Sociology of Technology Might Benefit Each Other," Social Studies of Science, Vol. 14, # 3, August, 1984.

Chapter Three is a critical discussion of writings on women and science. This body of literature explicitly addresses some of the problems in current formulations of the construction of scientific and medical knowledge about women. These writings consider fundamental assumptions about the nature of scientific activity and knowledge about gender, including the manner in which such knowledge is social. However, some feminist critics of science, such as the feminist empiricists, tend to eschew any in-depth critique of the usual, "everyday" scientific project itself, a limitation also reflected in the literature on medicine and women. My research into obstetric and gynecologic discourse on women in the 1950s leads to questions about the intent of feminist empiricists and some standpoint epistemologists to produce less-biased science, and hypothesizes instead, that "everyday" science and medicine are socially-constructed. I assess feminist analyses of science and knowledge which move in the direction of postmodernist epistemology, as contributing positively to the beginnings of an alternative vision of medical knowledge of women.

The initial three chapters, then, frame this study of 1950s obstetric and gynecologic knowledge within a critical discussion of the existing literature. Chapter Four goes on to outline the research methodology of the study. It discusses the obstetric and gynecologic texts and journals

from which the data were extracted and the reasons for the selection of these particular sources. It also outlines the bases on which particular material was considered relevant to the issue of the social character of obstetric and gynecologic knowledge; in other words, I show how the medical profession used particular social resources in the construction of medical categories.

The next two chapters present the data on the social and professional context from which these social resources were drawn and the research findings from the obstetric and gynecologic writings. Chapter Five sets out the socio-political context which provided social resources for the construction of obstetrical and gynecological knowledge in the 1950s. This context was one in which attempts were made to overcome the insecurities of the second world war. But the Cold War and the threat of nuclear weaponry, changing family and gender relations, and concern about decline in the fertility rate of white populations were some of the conditions which perpetuated fears of social instability. This was a context interpreted by obstetricians and gynecologists from the perspective of their own social position, informing their constructions of female biology and reproductive health issues.

Chapter Six is an examination of the professional context of the period. That context was one of progressive rationalization of medicine: factions within the profession

struggled over promotion of the "science" of medicine and biomedical concepts, as opposed to retention of the "art" of medicine and inclusion of a psychosomatic approach. Specifically, the dominant social status of scientific medicine was employed as a resource in the construction of particular concepts of women and gender in 1950s obstetric and gynecologic knowledge.

Chapters Seven and Eight present and discuss the textual conceptualizations of female reproductive processes, in light of the context which furnished social resources for their construction. Medical writings are examined for, much as in the case of religion, the texts represent the officially-sanctioned and most powerful body of knowledge of the institution or profession. Chapter Seven addresses the question of which social concepts were embedded in the particular technical constructions that emerged in 1950s gynecologic discourse on sex and gender and on women's gynecological conditions. How intersexuality, for example, was defined in the gynecologic writings of the period was indicative of a strong social norm of two dichotomous genders, accompanied by an intolerance of gender ambiguity. Writings dealing with such gynecological conditions as dysmenorrhea and pre-menstrual syndrome contained the assumption that reproduction constituted normality for women. The chapter also discusses the implications of the medicalization of those "disorders" during this period.

Chapter Eight turns to the obstetrical issues of prenatal care and pregnancy, the management of labour, and fertility and sterility. These issues were technically defined in the 1950s, through reliance on social resources, largely in terms of normal and abnormal categories. This process of categorization entailed surveillance of normal women by the medical profession for detection of the potentially abnormal. Further, this placing of social control on a rational, scientific basis in the form of surveillance took place in a context of strong concern for social stability. For example, the reproductive health of the mother and, particularly, the optimum condition of the fetus were medicalized and controlled through prenatal care and monitoring of the labour process. These last two data chapters, then, deal with how obstetric and gynecologic knowledge drew on social resources from the wider context and how scientific, technical categories were subsequently used to regulate social ones regarding women and gender.

The findings of my study of the process by which medical knowledge and discourse are social in character are summarized in the concluding chapter. The conclusion also indicates some of the implications of these research findings for current discussions on feminist science and on medical knowledge about women.

Chapter 1

Medical Science and Women

Woman as "Victim"

The main questions in the social history of obstetrical knowledge about women have revolved around the issue of control over women's reproductive health care. Researchers in this area have asked, for example, what medical concepts and theories imply about doctors' perceptions of women and how those concepts are employed by the medical profession. An early body of feminist literature, which emerged during the early and mid-1970s, concentrated on (1) the impact of male control of female reproductive experiences and (2) the process of professionalization involved in male acquisition of that control, with the accompanying mystification and monopolization of medical knowledge.¹ These initial studies, which we could refer to as "victimization" studies, laid the groundwork for investigations of medical knowledge of women.

¹ Dye, Nancy Schrom, "History of Childbirth in America," SIGNS, 6 (1), 1980: 98.

More recently, revisionist studies have been conducted which build upon that earlier work.² The revisionist research has examined more of the complexities involved in the issue of women and medicine. This chapter is an examination of both of these bodies of literature and their contributions to our current understanding of the character of medical knowledge of women. Further, the discussion points to the issues which need to be addressed and which my research attempts to develop.

The main focus of the initial "victimization," socio-historical research on women and medicine has been the shift of childbirth from the domain of female midwives to that of male obstetricians, particularly in nineteenth-century America. Feminist writers depicted this process as one in which obstetricians' professional interests were the driving force, combined with thinly-veiled hostility toward women and envy of their reproductive capacities.³ Those studies argued that although male-midwives and obstetricians initially attended only difficult births, their interests as men and as doctors drove them to take control of normal births as well. This medical takeover from female midwives

² Lewis divides the interpretation of the relation between the social history of family and that of childbearing into two categories - the "orthodox feminist argument" and the "alternative, or revisionist, explanation." Lewis, Judith Schneid, In the Family Way. Childbearing in the British Aristocracy, 1760 - 1860, New Brunswick, N.J.: Rutgers University Press, 1986: 2.

³ Sandelowski, Margarete, Women, Health, and Choice, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1981: 85.

is characterized in much of the feminist literature of the 1970s as a misogynous development instituted by doctors, who reflected the patriarchal society of which they were a product. That literature largely viewed the exploitation involved in this process and the medical knowledge which emerged as having been unilaterally imposed upon women who were defined as victims or "unwitting accomplices."⁴

Further, these victimization studies saw the obstetricians' development of interventionist, technological knowledge as resulting from a masculine propensity for domination and control (also characteristic of western science), rather than from humanitarianism. This, to many, was the beginning of a process of medicalization of women's experiences which persists into the present, and which has resulted in medical knowledge which is oppressive to women. Some researchers, such as Ehrenreich and English, have perceived obstetric and gynecologic interpretations of women's problems in terms of a conspiracy theory. For example, they write:

...doctors and therapists organized to flush out the millions of women who must be "rejecting their femininity" in one way or another.⁵

4 Ibid.: 138, 147; Ehrenreich and English also argue that during the 1950s in America, science was "misogynous" in supporting the belief that the "over-protective" mother was a danger to the development of her son's sense of masculinity and "manhood." Ehrenreich, Barbara and Deirdre English, For Her Own Good. 150 Years of the Experts' Advice to Women, Garden City, N.Y.: Anchor Books, 1979: 241.

5 Ehrenreich, Barbara and English, Deirdre, For Her Own Good. 150 Years of the Experts' Advice to Women, Garden City, N.Y.: Anchor Books, 1979: 273.

This use of the concept of patriarchy as a universalistic, causal explanation for the medical knowledge constructed about women results in a portrayal of women as passive victims of the medicalization process. This portrayal denies to women a role as social actors. The victimization approach may be partially related to the type of evidence Ehrenreich and English use to support their argument. They draw on popular writings of the time, obstetrics and gynecology texts and journals (such as Obstetrics and Gynecology), and texts of psychoanalysts. These they combine with secondary sources. The main difference between the sources drawn on in their work and later writings on the subject is that the medical literature Ehrenreich and English use is primarily psychologically-oriented. The selectivity this reveals supports their perception of a strong link between obstetric and gynecologic knowledge of women and psychiatry. This perceived link becomes part of the basis for Ehrenreich and English's main critique of medicine, which is of medicine's errors regarding women's reproductive conditions.

This picture of obstetricians developing their knowledge in order to achieve social control over women tends to be highly romanticized by feminist authors.* The

6 Laws notes that many feminist writers have posited social control of women as the major objective of nineteenth-century male doctors' treatment of women. Laws, Sophie, "The Sexual Politics of Pre-Menstrual Tension," Women's Studies International Forum, Vol.6, #1, 1983: 24.

victimization studies do not address the issues of the complexity of physicians' stances and evidence, in earlier centuries, of women's strong fear of disability and death in childbirth. Woman-centered birthing may have been valuable as a bonding experience in "female culture." However, childbirth was also frequently a dangerous ordeal. As Nancy Schrom Dye writes:

Because we know so little and because the midwife is so closely associated with female-controlled childbirth, it is easy to romanticize her and to see her solely as a persecuted female protoprofessional.⁷

The problem, then, is the particular way in which the social control process is characterized in the "woman as victim," feminist literature. In other words, in the research I allude to here, medical knowledge is assumed to be free of ideology and error most of the time, or at least ideally. This leaves the only explanation for social ideas about women in medical knowledge being that research is poorly done and biased by social influences. Hence, the feminist work of the seventies caricatures some of the more psychogenic medical ideas as absurd error.

This approach focuses upon critiques of "bad" or poorly-done science, rather than analyses of "science as

⁷ Dye, Nancy Schrom, op.cit.: 99. Dye states this with reference to Barbara Ehrenreich and Deirdre English, Witches, Midwives, and Nurses: A History of Women Healers, Old Westbury, New York: Feminist Press, 1973.

usual."⁸ Yet, such a critique of all ongoing "science as usual" could have been culled from the Sociology of Knowledge literature. As early as 1973, feminist writers referred to the Sociology of Knowledge as a framework for examining gynecological perspectives on women's health, but the framework was utilized only in a narrow way. These researchers suggested, for example, that the Sociology of Knowledge implied that gynecological texts were constructed from a male viewpoint. This is an interpretation which may be sound, but it is only one of the many aspects suggested by the Sociology of Knowledge.⁹ The interpretation made in victimization studies led to the development of a dichotomy between science or medicine as objective, though susceptible to distortion, and external social influences such as masculine interests and viewpoints. Scully's comments serve as an example of this approach:

Medical and surgical judgment, as these documents reveal, is influenced by personal and cultural values as well as by scientific proof.¹⁰

⁸ See Harding regarding the terminology of "bad science" and "science as usual." Harding, Sandra, The Science Question in Feminism, Ithaca and London: Cornell University Press, 1986.

⁹ Scully, Diana and Pauline Bart, "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks," American Journal of Sociology 78 (4), January, 1973: 1048.

¹⁰ Scully, Diana, Men Who Control Women's Health. The Miseducation of Obstetrician-Gynecologists, Boston: Houghton Mifflin Co., 1980: 41.

The cultural values referred to above are deemed to undermine science. Ehrenreich and English assert, in reference to scientific experts:

But science, in their hands, is weirdly distorted and finally debased beyond recognition...¹¹

So attempts are made to explain the errors of nineteenth-century physicians' views on women's reproductive health. Bullough and Voght, for example, assumed that poorly conducted science was the cause of such error:

A[n]...explanation of the error was that physicians had not based their conclusions upon accurate evidence.¹²

Ideology and social beliefs are separated from science by these scholars. Ehrenreich and English even refer to nineteenth-century medicine as patriarchal ideology, not science.¹³ There is no sense of scientific or medical knowledge being consistently socially constructed. Hence, no critique of "science as usual" ensues. The solution to the problem of scientific knowledge of women as suggested by these theorists involves, in the view of Lennane and Lennane,

11 Ehrenreich, Barbara and Deirdre English, For Her Own Good. 150 Years of the Experts' Advice to Women, Garden City, New York: Anchor Books, 1979: 28.

12 Bullough, Vern and Martha Voght, "Women, Menstruation, and Nineteenth-Century Medicine" (originally 1973), in J. W. Leavitt, ed., Women and Health in America, Madison, Wisconsin: University of Wisconsin Press, 1984: 35-6.

13 Ehrenreich, Barbara and Deirdre English, For Her Own Good. 150 Years of the Experts' Advice to Women, Garden City, New York: Anchor Books, 1979: 5.

the application of normal objective scientific methods to these topics...in a properly rational and critical fashion.¹⁴

In other words, it is assumed that a more rigorous application of science to the study of women's health problems would avoid the error and distortion produced by social influence. Bullough and Voght base their research on medical texts and journal articles, as well as on historical writings on women's education. Their studies lead them to argue concerning improvements in the use of science that

...[they] ought to make the physician a little more cautious in distinguishing his biases from his objective findings.¹⁵

Such a perspective entails numerous problematic assumptions about the nature of the scientific enterprise, and more particularly about the social character of knowledge production.

These initial studies of medical knowledge of women, then, contained a "woman as victim" model of social control, control which emerged with the medicalization of women's conditions. These writings inspired research into medical knowledge of women, but the writings were limited in that they were typically exposés of the "woman as victim/doctor as oppressor" relation. Ehrenreich and English's works are

14 Lennane, K. Jean and R. John Lennane, "Alleged Psychogenic Disorders in Women -- A Possible Manifestation of Sexual Prejudice," New England Journal of Medicine, Vol. 288, Feb. 8, 1973: 291.

15 Bullough, Vern and Martha Voght, op. cit.: 36.

the prototype of this approach to analysis of the historical record.¹⁶

One of the problems with this first group of studies is the way in which it uses the concept of "patriarchy" as a universal explanation for the social control of women by the medical profession. Underlying this use is the notion that patriarchal interests bias medical knowledge about women. A second problem is that these victimization studies entail analyses of poorly-done, biased medical science. They use a sociology of error to examine the development of the medical profession's faulty views of women. This creates a disjunction between medical knowledge that is in error because it is socially-influenced, and potentially untainted medical knowledge. The issue of the character of medical knowledge implied by this disjunction in the literature was not addressed, and it is this issue in particular which is taken up in my research on obstetric and gynecologic knowledge of women.

Some revisionist authors have since pointed out that doctors' views of nineteenth-century women's conditions could also have contained an element of truth, rather than being completely in error. Women's nineteenth-century

16 Their most developed writing on this subject is: Ehrenreich, Barbara and Deirdre English, For Her Own Good. 150 Years of the Experts' Advice to Women, Garden City, N.Y.: Anchor Books, 1979.

hysteria, for example, could have been a form of women's attempts at self-expression and power.¹⁷

A number of issues were not addressed, then, by the "woman as victim," faulty science approach to researching medical knowledge about women, particularly obstetrical knowledge. This victimization literature, however, did contribute to the development of revisionist social histories of medicine which acknowledge the complexity of historical processes, such as those processes influential in the social construction of medical knowledge of women.

Developing the Contextualization of Medical Knowledge

Attempts to revise initial, victimization studies of medicine and women emerged out of the important questions raised by those studies. The later, revisionist research examines the broader social context in which medical knowledge about women was constructed. It attempts to flesh out the details of women's roles and the portrayals of doctors as social control agents in the process of knowledge construction.

17 Carroll Smith-Rosenberg has made this point in "The Hysterical Woman: Sex Roles in Nineteenth Century America," Social Research, 39, Winter, 1972: 652-78, cited in Barbara Ehrenreich and Deirdre English, For Her Own Good. 150 Years of the Experts' Advice to Women, Garden City, N.Y.: Anchor Books, 1979: 138. See also Judith Walzer Leavitt, Brought To Bed. Childbearing in America, 1750 to 1950, New York: Oxford University Press, 1986: 73.

This revisionist work on medical knowledge of women continues to acknowledge the importance of male-dominated culture and the professionalization of medicine in the social construction of that knowledge. However, the concentration of earlier work on patriarchal motives, as an explanation of medical control of knowledge about women, has been broadened considerably.¹⁸ The process of professionalization has also come to be viewed as more complex, relative to the contributions of the original research. Studies of professionalization now include analyses of women's own part in the process, as well as the consequences of internal dissensions within the medical

18 Some of the recent literature contends that it deals with more than the dual factors of patriarchal ideology and professional motives of the medical profession. Yet, upon close examination, the basic argument again revolves primarily around those dual explanations. Rothman, for example, examines two models of medicine -- the patriarchal and the midwifery, holistic models. Beneath an analysis of medical models lies her answer to why women's health issues became more "medicalized": patriarchal ideology (characterizing the medical model) and the needs of the profession of obstetrics as it was developing. It is argued that many obstetrical interventions were accepted in the 1930s, for the gaining of teaching material, prestige, centralization and routinization of patients. Rothman, Barbara Katz, In Labor. Women and Power in the Birthplace, New York: W. W. Norton & Co., 1982: 36, 58.

A further example is the work by Oakley on prenatal care. While she provides a broader contextualization of the issues, she also continues to emphasize dual patriarchal and professional motives. In her work, not only the medical profession is misogynous, but the state as well. Explanation of how this is the case, in terms of the fully social and/or patriarchal character of medicine and the state, could now be developed further. Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 254, 255.

profession. In addition, the significance of the historical rise of science and the general social reliance on "experts" for the construction of medical knowledge of women are issues raised in the victimization literature and developed further by revisionist researchers. Finally, the participation and choices of women as patients are acknowledged more frequently by revisionist researchers as crucial factors in the historical development of women's relation to the medical profession.

These revisionist conceptualizations, then, can be divided into four categories through which the contributions of revisionist research can be illustrated: (a) Professionalization (b) Socio-political Context (c) The Rise of Scientized Medicine and (d) Women's Participation and Choices.

Revisionist studies are an important influence on this thesis research, as it builds upon the revisionist work. In particular, my research focuses upon the question of the socially-constructed nature of all obstetric and gynecologic knowledge about women, an issue not yet fully addressed in revisionist studies. The character of the social construction process, as currently delineated, contains many of the same assumptions that underpinned earlier conceptualizations of that process. The separation of social influences from medical knowledge, for example, is an assumption which requires more thorough examination. Some

studies, such as those of Oakley and Martin, have already moved some distance in that direction.¹⁹ The major contributions of the body of revisionist literature on medicine and women are examined here, beginning with the issue of professionalization.

(a) Professionalization

Professions have the ability to wield authority, as occupational status plays an important part in distinguishing stratification and class.²⁰ Professionalization is the process by which this power is attained. The concept of a profession includes an occupational group's requisite claims to legitimate authority, exclusive knowledge and skills, autonomy, control over working conditions and professional training, and self-regulation.²¹ Revisionist studies of medical knowledge of women suggest that the process of gaining social control, through claims to exclusive, professional knowledge, is a more complex one than was previously acknowledged. Some argue for the recognition of the increasing importance of

19 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986;
Martin, Emily, The Woman in the Body. A Cultural Analysis of Reproduction, Boston: Beacon Press, 1987.

20 Morantz-Sanchez, Regina Markell, Sympathy and Science: Women Physicians in American Medicine, N.Y. & Oxford: Oxford University Press, 1985: 355-6.

21 Freidson, Eliot, Professional Powers. A Study of the Institutionalization of Formal Knowledge, Chicago: University of Chicago Press, 1986.

knowledge as power, contending that the two should not be conceptualized as separate entities. Hence, the close relation of power and knowledge is suggested by these researchers in their references to power/knowledge.²²

The professionalization of obstetrics and gynecology, during the eighteenth and nineteenth centuries, involved attempts to eliminate major competitors, in order to obtain status and rights to a clientele. In this case, the chief competitors were female midwives. However, this process of struggle against competition was not only aimed at women and midwives; for example, homeopathic medicine was eliminated partially through the efforts of the "regular" physicians in the nineteenth century. Through their research into the professionalization of medicine, revisionist writers suggest that obstetricians and gynecologists were not necessarily conspiratorial villains in this historical process.

Rather, the revisionist literature examines the complexities entailed in professional control and at times suggests that socialization into the medical profession is an important influence on the construction of medical knowledge. Revisionist writers note that doctors are socialized into

a cultural system whose ideas and
practices pervade popular culture and in

²² See, for example, the use of Foucault on this point in Ann Oakley, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986.

which, therefore, we all participate to some degree.²³

There is evidence that all professions go through this process. In fact, revisionist studies suggest that:

once a given professional group exists, it is in the interests of that group to promote its own occupational welfare and identity.²⁴

In other words, it is simply nonsensical to expect that a profession would act against its own interests and this holds true for the medical profession, just as for any other profession.

Hence, it is not surprising that obstetricians attempted to move from intervening in difficult births to attending all births, ousting midwives in the process. Since midwives were often working-class and unorganized, they did not have the strength to form an effective pressure group on their own behalf.²⁵

Previous interpretations of these medicalization and professionalization processes claimed that women generally were losing some of the status which they had enjoyed prior to industrialization and the accompanying relegation of women to the domestic sphere. However, "a more complex

23 Martin, Emily, op.cit.: 13.

24 Oakley, Ann, "Feminism, Motherhood and Medicine - Who Cares?," in Juliet Mitchell and Ann Oakley, eds., What is Feminism. A Re-Examination, N.Y.: Pantheon Books, 1986: 136.

25 Donnison, Jean, Midwives and Medical Men. A History of Inter-Professional Rivalries and Women's Rights, London: Heinemann, 1977: 177.

picture of social relations" emerges from recent, revisionist research. The revisionist literature suggests that prior to the nineteenth century, women performed a wider range of economic tasks, but that these were domestically-oriented and women did not necessarily benefit socially from this work. Its economic value to the household was not correlative with high social status, which implies that women may not have lost status following that period.²⁶ Further, revisionist studies also indicate that women have not necessarily lost social status with the increasing medicalization of pregnancy during the twentieth century.²⁷ These research findings suggest that the relation between medicalization and women's social status is a complex one.

Still, it is recognized in the literature that the professionalization of medicine contributed to and reflected the limitation of women's roles to the domestic and maternal ones in the nineteenth century.²⁸ But a crucial point made in this revisionist research is that obstetrics and gynecology possessed low status and power in the eighteenth century. This meant that obstetricians and gynecologists were controlled, to some extent, by their aristocratic clientele and the families of their patients. These men-

26 Morantz-Sanchez, Regina Markell, op.cit.: 12-13

27 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 253.

28 Morantz-Sanchez, Regina Markell, op.cit.: 203, 205.

midwives or accoucheurs were dependent upon their patients for success in their profession, and so

lacked the professional autonomy necessary to the imposition of a medical orthodoxy. Instead, medical theory and practice emerged out of the complexity of relationships between accoucheur, patient, and aristocratic family.²⁹

Lewis, for example, affirms the view that accoucheurs were not particularly powerful, based upon her research on fifty British aristocratic women's experiences with childbirth from 1760 to 1860. She examined private collections of papers on the subject, including diaries and letters. In addition, she bases her argument on information gleaned from archival and record offices and writings by the obstetricians who attended the aristocracy.³⁰

Revisionist studies, then, offer a broad contextualization of the development of the professional authority of obstetrics. This results in interpretations of professionalization in which obstetricians are not viewed as one-sidedly and forcibly taking control of childbearing. Some revisionist writers suggest that for the aristocratic class in Britain, at least, patriarchal power did not become more consolidated with the growing emphasis upon private domesticity. The reasoning is based on historical evidence that these women had always been subject to patriarchal

29 Lewis, Judith Schneid, In the Family Way. Childbearing in the British Aristocracy, 1760-1860, New Brunswick, New Jersey: Rutgers University Press, 1986: 3-4.

30 Ibid. passim.

control of their reproductive capacities for property and lineage purposes. Such research suggests that only by examining the development of obstetrics in the context of wider changes in social and family relations, and concepts of women, children and motherhood, is it possible to draw out these socio-historical trends and their meanings.³¹

According to revisionist studies, the medical profession capitalized on public concerns and demands in enhancing the profession's development. Those concerns included state aims of controlling the population's health and fertility rate. These aims of the state, along with the professional concerns of physicians, were addressed through the development of preventive medicine, including prenatal care of women. Oakley expresses this point in her investigation of the development of British antenatal care:

...antenatal care obtained its final mandate, a mandate written by the medical profession in alliance with the population-controlling interests of the state, and one giving an unprecedented degree of licence over the bodies and approved life-styles of women.³²

Hence, it seems that, in this case at least, the state's interests coincided with the professional concerns of physicians.

31 Ibid. *passim*.

32 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 2, 34.

During the pronatalist times of the 1950s, the profession again drew on public concerns. For example, women who were searching for more satisfying birthing experiences encouraged obstetricians to provide "natural childbirth," in one form or another. The profession capitalized on such social concerns about obstetric practices and, as Sandelowski notes:

The trend toward psychosomatic medicine and women's increasing demand to be satisfied in childbirth converged in the Natural Childbirth movement.³³

Yet, after 1915 in the United States, the use of drugs such as anaesthesia had also helped obstetrics to gain professional prestige. This acceptance was aided by years of women's strong demands for pain relief.³⁴ The professional prestige which resulted was particularly important because obstetrics and gynecology have traditionally been low-status specialties within medicine.³⁵

Revisionist research indicates that, essentially, an amalgamation of both approaches to pain relief occurred in North American obstetrics; natural childbirth was reinterpreted and subsumed under a more medicalized form of

33 Sandelowski, Margarete. Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960. Westport: Greenwood Press, 1984: 136.

34 Leavitt, Judith Walzer. Brought To Bed. Childbearing in America, 1750 to 1950. New York: Oxford University Press, 1986: 122.

35 Sandelowski, Margarete. Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960. Westport: Greenwood Press, 1984: 33-4.

childbirth practice. Obstetrics responded to perceived demands by women for pain relief and benefitted professionally by accommodating them. Physicians themselves acknowledged the professional benefits that accrued from incorporating social concerns, according to one revisionist writer:

Although physicians believed that women's demands were compelling them to use drugs, often against their better judgment, they also suggested that their own desires to make obstetrics as modern, scientific, and prestigious a specialty as surgery warranted the use of the latest techniques in the care of childbearing women. . . . Moreover, physicians equated the use of drugs and instruments with progress toward the goal of scientific obstetric care. Consequently, any physician practicing obstetrics who was interested in pleasing his patients and committed to modernizing the specialty so that it would never again be confused with mere midwifery could hardly avoid using these drugs, no matter how reluctant he might have been to do so.³⁶

This portrayal of changes in obstetrics has a different slant from the image of professionalization in the victimization studies of medicine and women. In the victimization studies, obstetrics was depicted as effecting direct control for misogynous reasons with women as passive victims of medical interests. In the revisionist literature, the discussion has shifted to a view in which

36 Ibid.: 33-4.

social control of women is a more complicated, indirect process.

A further element in the professionalization of obstetrics, considered in both revisionist and initial, "woman as victim" studies, is that of medicine's use of science. Science, knowledge, and expertise came to command high social value, and hence, became valuable resources for the medical profession.³⁷ According to both groups of studies, doctors believed that science would allow for the emergence of pure medical knowledge and expertise. Such a process could contribute to physicians' professional aims and ideals. But that aspect of professionalization was also taken to be neutral by the medical profession, as Morantz-Sanchez points out:

Supposedly objective, rational, and gender-free, professional values were assumed to be informed not by narrow self-interest but by concern for social and democratic ends. It was the expert who would interpret the benefits of disinterested science for the social good.³⁸

The importance of this rise of a presumed objective, value-free science and its incorporation into medicine will be discussed further later in this chapter. It is important to note here, however, that many revisionist studies follow

³⁷ The licensing movement in medicine stressed major social values in promoting the development of expertise and scientific management. Ludmerer, Kenneth M. Learning to Heal. The Development of American Medical Education. N.Y.: Basic Books, Inc., 1985: 237.

³⁸ Morantz-Sanchez, Regina Markell. op.cit.: 280-1.

on initial, victimization ones in attending to the strong medicalization and technological, interventionist trends which developed. The literatures show that these trends emerged partially out of this emphasis on the link between science and expertise, both in the wider society and within medicine.

The revisionist literature emphasizes that medical interventions per se were not necessarily seen by women as negative, either in the past or currently. Presented by medicine as purely technical, non-social interventions, some obstetric practices were apparently accepted as enhancing the safety of childbirth. But medicalization and intervention are also seen to have contributed to the scientization of motherhood. As doctors claimed expertise to speak about the correct way to mother, women themselves lost their status as experts in that realm.³⁹ The medical profession's claim to authority is held to include the right to define concepts such as "motherhood." As Riessman points out:

In order for the occupational strategy of this emerging professional class to succeed, it was necessary to control the meaning of things, including interpretations of symptoms and beliefs about health care.⁴⁰

39 Oakley, Ann, "The trap of medicalised motherhood," New Society 18, Vol. 34, #689, Dec., 1975: 641.

40 Riessman, Catherine Kohler, "Women and Medicalization: A New Perspective," Social Policy, 14, Summer, 1983: 4.

Riessman argues here that professional obstetrics has hegemony over the construction of particular conceptions of childbirth and of the meaning of female reproductive processes. This necessarily places considerable power and control in the hands of medical practitioners.⁴¹ The medicalization process has also made such conditions as pregnancy a legitimate part of medical discourse, and hence, brought those conditions under medical jurisdiction and control.⁴²

A potential implication is that the social control which accompanies the medicalization of conditions, is part of medical knowledge, even when that knowledge is not in "error." However, most current, revisionist studies assume that professionalization entails ostensibly "social," non-medical influences separate from and infecting medical knowledge. Hence, revisionist research has not focused on the issue of the social character of that knowledge which is currently considered correct.

41 Foucault states, in reference to psychology: "It was the emergence ... of a new type of supervision - both knowledge and power - over individuals who resisted disciplinary normalization. ... But the supervision of normality was firmly encased in a medicine or a psychiatry that provided it with a sort of 'scientificity'; ... a carefully worked out technique for the supervision of norms has continued to develop right up to the present day." Foucault, Michel, *Discipline and Punish: The Birth of the Prison*, New York: Random House/Vintage Books, 1979: 296.

42 Oakley, Ann, *The Captured Womb. A History of the Medical Care of Pregnant Women*, Oxford: Basil Blackwell, 1986: 145.

Recent studies have suggested that medical control can take the form of a general monitoring and surveillance of female patients.⁴³ Some researchers stress that this professional power of obstetrics was particularly strengthened with the shift of childbirth to the hospital during the twentieth century.⁴⁴ Coincident with this structural change, labour and delivery moved into the domain of obstetricians.⁴⁵ This permitted a greater degree of monitoring of normal labours and deliveries for any development of abnormal tendencies, as the obstetricians came to view pregnancy as "potentially pathological."⁴⁶ Others emphasize that the trend towards surveillance has included a monitoring of doctors themselves, with the medical profession now losing some of its professional control to hospital administrations and the state.⁴⁷

43 This point is particularly emphasized in works which draw on the ideas of Michel Foucault. cf. Oakley, Ann, "Feminism, Motherhood and Medicine -- Who Cares?," in Juliet Mitchell and Ann Oakley, eds., What is Feminism. A Re-Examination, N.Y.: Pantheon Books, 1986: 127; Martin, Emily, op.cit.: 145; Arney, William Ray and Bernard J. Bergen, Medicine and the Management of Living. Taming the Last Great Beast, Chicago and London: University of Chicago Press, 1984.

44 Leavitt, Judith Walzer, Brought To Bed. Childbearing in America, 1750 to 1950, New York: Oxford University Press, 1986: 5.

45 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 145.

46 Ibid.: 2

47 Martin, Emily, op.cit.: 145-6; Arney, William Ray and Bernard Bergen, op.cit. passim.

Overall, the revisionist literature on the professionalization of obstetrics and gynecology brings out the interrelation of this historical process with social conditions and attitudes.⁴⁸ This research is more in-depth than previous studies and has given rise to alternative interpretations of the effect of the professionalization of obstetrics on knowledge about women's reproductive processes. The examination of multiple factors which has been conducted by revisionist researchers suggests that professional obstetrics was not simply imposed upon women. Rather, revisionist studies point to the existence of a social context which in the past was conducive to the professionalization of scientific expertise. Those studies also note that women themselves called for the benefits of scientific and medical "progress," benefits that they saw as part of the process of obstetric professionalization. So in terms of professionalization, this revisionist literature on medical knowledge about women recommends changes to the model of social control of women which portrayed women as passive victims of medicine's patriarchal, direct control. The revisionist work considers the tensions within the medical profession, ambivalence about changes in medical views and practices, and the broader, social contextualization of knowledge construction. Attention to

48 Kobrin, Frances E., "The American Midwife Controversy: A Crisis of Professionalization," in J.W. Leavitt, ed., *Women and Health in America*, op.cit.: 325.

all of these aspects results in a complex picture of the nature of the social control process. To be developed further, however, is the notion of professionalization as inherent in knowledge construction. This is therefore a major theme addressed in my research on obstetric and gynecologic knowledge.

(b) Socio-political Context

Increasing attention to the broader context of the development of obstetrics, including its professionalization, has highlighted various aspects of the relation of obstetrics to women and gender. Revisionist researchers have investigated, for example, the contribution of transformations in medical ideas and practices to women's power and status in the family. More studies are attending to, among other projects, what Morantz referred to as the nineteenth-century

relationship of industrialization to changes in the family structure, and how this larger development altered attitudes toward sex roles and practices.....It is with questions like these that we can move beyond accusation to deeper understanding.⁴⁹

The revisionist focus upon the broader socio-political context of changes in the relation of medicine and women,

49 Morantz, Regina Markell, "The Perils of Feminist History," in J.W. Leavitt, ed., op.cit.: 242.

then, aims to question why changes occurred and what their implications were, rather than to demonstrate direct victimization of women.

A number of social influences have been identified by revisionist historians as contributing to the nineteenth-century shift from midwives to male accoucheurs and obstetricians as birthing attendants. This is a shift which formed a major basis for the twentieth-century medical developments in this area. The original rise of obstetrics, changes in childbirth practices and alterations in gynecological views of women have been found to be linked with changes in social relations both within and without the family. Revisionist studies have examined how childbirth practices altered in the cities, with increasing urbanization both in Britain and in the north-eastern United States. For example, these studies have found that change in practices began with the upper classes in the late eighteenth and early nineteenth centuries. Birthing gradually became less of a communal happening and more of an intimate family event. The changes taking place in urban centres, writes Scholten,

reflected the increasing privatization of family life, and they foreshadowed mid-nineteenth century attitudes toward childbirth, mother, and woman.⁵⁰

50 Scholten, Catherine M., " 'On the Importance of the Obstetrick Art': Changing Customs of Childbirth in America, 1760-1825," in J.W. Leavitt, ed., op.cit.: 150.

The changing meaning of "the family" for aristocratic British women was connected primarily to the privatization of the nuclear family and the rise of domesticity. There was therefore a lessening of concern for family as a means to ensure inheritance and a trend toward more individuality, emotionality and family relationships. Some revisionist researchers suggest that women's status may actually have increased during this period, when childbirth became demystified and childbearing and rearing became blurred. No longer was childbirth imbued with meaning as a "rite de passage," as childrearing became the focus of domesticity and motherhood. While class reproductive needs apparently continued to be important for the British aristocracy throughout this period, there was also increasing concern that these needs not interfere with the well-being of individual women of that class.⁵¹

Revisionist research has found that the rise of the companionate marriage, based upon the notion of the moral influence of the woman in the domestic sphere, accompanied a change in views of children. Women's role in childrearing was emphasized as children came to be romanticized and considered malleable. This led to the development of the woman-supervised, nuclear family as the ideal for the middle class during the nineteenth century. Yet women's domestic, so-called, "private" role was politicized in America, where

51 Lewis, Judith Schneid, op.cit.: 121, 218, 226.

the "virtue of its people" was deemed crucial.⁵² For example, Morantz-Sanchez argues that:

American democracy gave a central place to motherhood, now defined as a device to insure the perpetuation of a responsible citizenry. ⁵³

Hence, women's child-rearing tasks were, in actuality, political, public tasks.

Revisionist writers relate these alterations in familial relations and women's position to the employment of midwives and obstetricians. For example, revisionist studies point out that midwives were often poor immigrants. So, in order to distinguish themselves as upper or middle class, women in these classes were motivated to employ obstetricians rather than midwives. Decreased immigration to America also contributed to a reduction in the clientele for midwifery and to the rise of obstetrics, as it was most frequently immigrants themselves who looked to midwives as birthing attendants.⁵⁴

According to revisionist studies, as geographic mobility and urbanization increased, a resulting breakdown of communal ties meant that women's traditional social networks for birthing support disappeared.⁵⁵ In addition, expectations of enhanced standards of obstetrical care

⁵² Morantz-Sanchez, Regina Markell, *op.cit.*: 19, 36, 45.

⁵³ *Ibid.*: 21.

⁵⁴ Kobrin, Frances E., *op.cit.*: 324.

⁵⁵ Leavitt, Judith Walzer, *Brought to Bed. Childbearing in America, 1750 to 1950*. New York: Oxford University Press, 1986: 174, 176.

accelerated this process of diminishing reliance upon neighbours, female relatives, and midwives.

Socio-historical shifts in social and family life are connected by revisionist researchers to new attitudes toward childbirth. The "natural" way, for example, was decreasingly considered the best way to give birth. This change in social attitudes allowed for the development of the view that some intervention in the process would be beneficial to women.⁵⁶ The companionate form of marriage and the rising importance of emotional ties in the family seem to have played some part in the desire for intervention on women's behalf. As Lewis writes:

This growing resistance to the notion of the inevitability of maternal suffering is perhaps the key to understanding the changing meaning of childbearing in this period. And that can be best understood by a review of how domesticity transformed family life.⁵⁷

In other words, revisionist writers such as Lewis, frame changes in the relation of obstetrics to women in the broader socio-political context.

According to revisionist researchers, these transformations in social relations, attitudes, and the meaning of motherhood and childbirth allowed obstetricians to gain greater control over women's reproductive experiences. Greater obstetric intervention, such as pain

56 Kobrin, Frances E., op.cit.: 324-5.

57 Lewis, Judith Schneid, op.cit.: 223.

relief, became accepted and even welcomed, a change which opened the door for obstetricians to effect social control of women. But the revisionist literature presents social control as the result of a historical process in which a number of trends intersected, including changes in women's expectations and gender relations.

For example, revisionist studies examine how an increasing proportion of middle class women began to perform wage labour during the twentieth century. This was a transformation from the situation in the nineteenth century which, in the light of concepts of domesticity and motherhood, created a degree of social anxiety. The concern for maternal and infant mortality during the 1920s and 1930s led some policy makers to recommend the abolition of women's work outside the home as a way to lower the mortality rates. This approach probably had some of the same roots as did calls for better medical care of pregnant women prior to childbirth: fear of the falling birth rate and a parallel desire to encourage women to have more children.

Research on this concern for maternal and infant mortality shows that the concern also expressed a perceived need to enhance the "raw material of the race."⁵⁸ During the late 1930s and the 1940s, debate raged regarding the "population problem." According to recent studies, this

58 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 124.

debate included questions about the meaning of maternity to women, families and the nation. Further, revisionist research suggests that the ideas involved in the debate influenced obstetrical and antenatal care during and following that period.⁵⁹

Revisionist studies also point to how this process of change in obstetrical and prenatal care was enhanced by the twentieth-century emergence of a professionalizing new middle class. This was a class which looked to the profession of medicine as a suitably upwardly-mobile occupation.⁶⁰ This class of professionals had to ensure themselves a clientele, while dealing with changes in the family and gender relations within their own class. Increasing medical interventionism, as with the advocacy of prenatal care, was one way in which a clientele could be assured.

Revisionist researchers have also examined changes in the gendered division of labour, at least as it relates to alterations in obstetric knowledge and practices. They have noted, for example, that the proportion of married, middle and upper middle class women in the labour force has increased since 1940, relative to the proportion of working

59 Ibid.: 74-5, 129, 131.

60 Morantz-Sanchez, Regina Markell, *op.cit.*: 240.

class wage earners.⁶¹ Women's increasing educational levels and labour-force participation could have been construed as a social threat during this period when women were viewed as the cause of domestic strife and guardians of American democracy. The renewed emphasis upon maternity and the rise in the birth rate during the 1950s were the result of attempts to compensate for the disruptions of the second world war and the threat of the atomic bomb. Private, family life was avidly sought, for example. Further, women's role as "guardians of the race" was posited as a solution to the problems of North American society, including that of confrontation with the dangers of communism.

During this era of the "feminine mystique," particular obstetric and gynecologic ideas emerged or were supported which paralleled more general social concerns. Natural childbirth methods discussed during the 1950s in North America could be interpreted as an attempt to make pregnancy and birth more satisfying and, thereby, more attractive to women. It has been suggested that the natural childbirth movement involved the social aims of reinforcement of the

61 Evidence for this is taken from secondary sources on women's work and on general women's history (from William Chafe, *The American Woman*, N.Y.: Oxford University Press, 1972: 218-9; and Robert W. Smuts, *Women and Work in America*, N.Y.: Columbia University Press, 1959: 36-7, 63-4). Morantz-Sanchez, Regina Markell, *op.cit.*: 352.

"feminine mystique," including its emphasis upon motherhood, and the consequent creation of "better" people.⁶²

Revisionist studies also portray gynecologic concepts of the time as expressive of social concerns of the 1950s. Those studies note, for example, that women's reproductive problems were interpreted by medical practitioners, at times, as reflecting women's "rejection of femininity." As one author suggests:

Evidently, though rarely explicitly, rejection of femininity entails, and is entailed by, working or wanting to work outside the home.⁶³

In other words, gynecologic knowledge of women's conditions can express much broader social concerns.

Extensive examination of socio-political concerns, such as those regarding population issues and eugenics, has added to our understanding of obstetric and gynecologic knowledge. Revisionist research has provided the contextualization necessary for more in-depth analyses of the socio-historical processes entailed in the construction of that knowledge. While the revisionist literature maintains concerns that were prevalent in victimization studies, the resulting findings and arguments have shifted. Revisionist studies consider patriarchal social relations in a broader context

62 Sandelowski, Margarete, Pain, Pleasure and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960, Westport, Connecticut: Greenwood Press, 1984: 115-6, 74.

63 Oakley, Ann, "A Case of Maternity: Paradigms of Women as Maternity Cases," SIGNS, Vol.4, #4, Summer, 1979: 618.

of change, for example, and the medicalization of women's conditions is considered in the light of interrelated social trends. The analytical emphasis on women as passive "victims" of social control has diminished as a consequence.

The contributions of revisionist research to discussion of the relation of social context to the construction of medical knowledge about women have moved some way towards consideration of the fully social character of medical knowledge and practices.⁶⁴ However, the literature does not completely develop the theme as yet. For example, Morantz-Sanchez uses what is essentially a reflection model to depict the relation between the rise of obstetrics and the political and socio-economic changes involved in the emergence of commercial capitalism. Morantz-Sanchez writes:

In many respects, changes in the management of childbirth merely mirrored more profound shifts in society at large.⁶⁵

This revisionist writer, then, views the rise of obstetric knowledge and practice as socially-driven, in the sense of being a passive reflection of external social forces. My thesis suggests that there are alternative ways to conceptualize the relation between knowledge and its context and attempts to investigate this issue further.

64 See, for example, Martin's recognition of this and the problematic aspects of conducting research with that in mind: "It is difficult to see how our current scientific ideas are infused by cultural assumptions...." Martin, *Emily*, op.cit.: 27.

65 Morantz-Sanchez, Regina Markell, op.cit.: 18.

(c) The Rise of Scientized Medicine

Medicine is just one of many occupations which have been scientized over the past century. This is a process which, not surprisingly, has accompanied an increase in the social estimation of science.⁶⁶ The scientization of medicine was held to be problematic by victimization studies and still is by some revisionist writers. Both literatures are concerned about use of the image of science on the part of medical specialities like obstetrics and the potential for medicalization of social problems.⁶⁷ The reasoning behind this concern is that when problems are medicalized, they are removed from public debate in the process. Those problems are inserted into the mystified realm of the expert,⁶⁸ where there is an obfuscation of the moral issues

66 Shorter, Edward, Bedside Manners. The Troubled History of Doctors and Patients, N.Y.: Simon and Schuster, 1985: 130-1.

67 Leavitt, Judith Walzer, Brought to Bed: Childbearing in America, 1750 to 1950, New York: Oxford University Press, 1986: 174; Riessman points out that the image of science plays a role in medicalization. This occurs through the assumption that medicine is based on objective, scientific evidence and knowledge, an assumption that neglects the social construction of scientific "facts." Riessman, Catherine Kohler, op.cit.: 5.

68 While science has contributed to more medical advances and health benefits, there has been a further separation of the expert from the layperson. Riessman, Catherine Kohler, op.cit.: 174.

involved in decision-making.⁶⁹ Revisionist writers consider not only how medicalization affects the content of the resulting obstetric and gynecologic notions, but also the socially-sanctioned power which science provides to the medical profession. For example, Morantz-Sanchez suggests that the ideas of nineteenth-century male doctors regarding women's reproductive health may say less about the doctors than about the power of science. She emphasizes:

the cultural component of scientific assumptions and the power that those who are recognized interpreters of scientific theory began to exert in the social realm.⁷⁰

Morantz-Sanchez refers, in particular, to the power which the medical profession was able to wield as the profession laid claim to a scientific basis. Martin further suggests that claims about "natural," biological facts regarding women and new medical metaphors evolved through the scientization of medicine. According to Martin, these were claims which were used to justify gender stratification and other forms of social organization. Martin bases this

69 Riessman makes reference, on these points, to P. Conrad and J. W. Schneider, Deviance and Medicalization: From Badness to Sickness, St. Louis, Mo.: C.V. Mosby, 1980 and Zola, I.K., "In the Name of Health and Illness: On Some Socio-political Consequences of Medical Influence," Social Science and Medicine, Vol. 9, 1975: 83-87. Riessman, Catherine Kohler, op.cit.: 4.

70 Morantz-Sanchez, Regina Markell, op.cit.: 208.

conclusion on a late nineteenth-century monograph about the "evolution of sex," as well as on secondary sources.⁷¹

Social faith in practical science has its roots in the emergence of seventeenth-century mechanistic science (which many writers describe as the expression of masculine domination over nature⁷²) and the instrumentalism of Protestantism. In the mechanistic approach, which came to dominate medical views of women's bodies, there is a Cartesian separation of the body from the mind. This is a model in which machines are expected to produce scientific, medical answers to medical problems.⁷³ In fact, the entire body is conceptualized as a machine, with doctors acting as mechanics and technicians. This mechanistic science in medicine, then, is seen to have contributed to the medical development of interventionist technologies - technologies with which the body as machine can be "fixed."⁷⁴

The history of childbirth management is presented by some revisionist writers as one of opposition between the holistic midwifery model and the rational model of

71 The book is that of Patrick Geddes and J. Arthur Thompson, The Evolution of Sex, New York: Scribner and Welford, 1890; Martin, Emily, op.cit.: 17, 32.

72 See, for example, Merchant, Carolyn, The Death of Nature: Women, Ecology, and the Scientific Revolution, San Francisco: Harper and Row, 1980.

73 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 287, 293; Wertz, Richard W. and Dorothy C. Wertz, Lying-In. A History of Childbirth in America, N.Y.: The Free Press, 1977: 234.

74 Martin, Emily, op.cit.: 21, 54.

science.⁷⁵ Even at the end of the nineteenth century, for example, the debate surrounding childbirth included the issue of whether childbirth should be considered a pathological or a natural process. But revisionist research suggests that doctors were not aligned only on one side of the issue. Rather, research findings indicate that obstetricians stood on both sides of the debate.⁷⁶ The victimization literature on this question would lead us to believe that doctors jumped at the chance to use science for their own purposes. In contrast, the revisionist literature suggests that women and their medical attendants were ambivalent about science and that, in fact, the ideology of scientific medicine was initially ignored by doctors. Revisionist studies contend that some time passed before the notion of scientific medicine was accepted by physicians. The suggested reason for this is that the medical profession accepted science only when the profession believed that the use of science could improve its status and promote social progress. The image of science was closely linked with belief in societal "progress."⁷⁷

More than one revisionist author has found evidence to suggest that obstetricians were pressured from many

75 Leavitt, Judith Walzer, *Brought to Bed. Childbearing in America, 1750 to 1950*, New York: Oxford University Press, 1986: 208.

76 Morantz-Sanchez, Regina Markell, *op.cit.*: 222.

77 Leavitt, Judith Walzer, *Brought to Bed. Childbearing in America, 1750 to 1950*, New York: Oxford University Press, 1986: 208; Morantz-Sanchez, Regina Markell, *op.cit.*: 241.

quarters, including female patients themselves, into using interventionist measures. As noted, doctors may have initially been reluctant to provide anaesthesia for the relief of pain in labour and delivery. However, for a number of reasons, including women's demands, physicians intervened in the process of childbirth to provide pharmaceutical means of pain relief.⁷⁸ The need for expertise in administering anaesthesia, such as the scopolamine and morphine which comprised early-twentieth century "Twilight Sleep," allowed for the provision of pain relief while it simultaneously encouraged the medicalization of labour. And by the 1930s, most American obstetricians were giving labouring women some form of pain relieving drugs. In addition, that medicalization process included the shift of the site of labour and delivery to the hospital, so that anaesthesia could be more safely administered. Revisionist studies suggest that through their demands, women were attempting to control decision-making regarding pain relief. However, they also argue that women ultimately lost control of birthing in the process.⁷⁹

78 Wertz, Richard W. and Dorothy C. Wertz, op.cit.: 116; Sandelowski, Margarete, Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960, Westport, Connecticut: Greenwood Press, 1984: 6.

79 Sandelowski, Margarete, Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960, Westport, Connecticut: Greenwood Press, 1984: 17, 18; Leavitt, Judith Walzer, Brought to Bed. Childbearing in America, 1750 to 1950, New York: Oxford University Press, 1986: 134, 135, 140.

The influence of mechanistic science on gynecologic knowledge of women has recently been described in the revisionist literature. Studies of the mechanical model note its multiple appearances in antenatal literature and in general medical texts. Further, such studies examine the embodiment of notions of the feminine woman in medical uses of that model.⁸⁰ What this research suggests is that medical views in which women's gynecological problems are taken to be expressing "rejection of the feminine role" or rejection of their reproductive functions⁸¹, are partially a product of the mechanistic (and, to some, patriarchal) science.

Revisionist studies are also linking psychoanalytic and psychological theories, drawn upon by obstetrics and gynecology, to the use of a particular scientific medical model. This particular medical model is one which conceives of "psychological states as epiphenomena of physiological ones...."⁸² Revisionist writers have pointed to the social nature of the mechanistic, scientific basis of this medical approach to the psyche.

This recognition of the influence of the scientific paradigm upon knowledge construction can contribute to investigation of the traditional, theoretical disjunction between medical and social knowledge. Hence, some

80 Oakley, Ann, "A Case of Maternity: Paradigms of Women as Maternity Cases." SIGNS, Vol.4, #4, Summer, 1979: 613.

81 Ibid.: 614-617.

82 Ibid.: 621.

researchers are at present investigating the social character of medical knowledge by inquiring into the more precise forms which medical models took during the 1950s. Revisionist studies are also examining, for example, the effects of shifts in the medical paradigm upon obstetric and gynecologic ideas about women.

Throughout the 1970s, feminist historians and sociologists of medicine alluded to the "medical model" in general as playing an important part in the construction of medical ideas about women's femininity and biology.⁸³ Those historians and sociologists emphasized that women's reproductive functions were considered pathological, according to that medical model. The main objectives of obstetricians during the 1950s, according to those researchers, were efficiency, speed, and "standardized, production-line methods" for controlling the optimization of childbirth. As Wertz and Wertz write:

During the 1940s, 1950s, and 1960s, birth was the processing of a machine by machines and skilled technicians.⁸⁴

Such studies imply that labour and birth may have been treated in that way, not only because the medical profession viewed delivery as a pathological process, but also because

83 For example, cf. Barbara Ehrenreich and Deirdre English, *For Her Own Good. 150 Years of the Experts' Advice to Women*, Garden City, New York: Anchor Books, 1979: passim.

84 Wertz, Richard W. and Dorothy C. Wertz, *op.cit.*: 164-166.

such a view of delivery was in accord with the mechanistic standards of the prevailing medical model. Recent studies also continue to pinpoint the shifting of childbirth to the hospital setting as a crucial development in the reinforcement of this mechanistic, technological paradigm of birth management.⁸⁵

Attention of revisionists to the details of the medical paradigm has indicated that, from the 1950s on, obstetrics increasingly concentrated on the issue of infant mortality, and hence, on the fetus. After maternal mortality had been substantially reduced, obstetricians came to regard women as requiring monitoring, as containers of a fetus.⁸⁶ Oakley

85 By 1950, 88 per cent of American births took place in hospitals. Sandelowski, Margarete, Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960, Westport, Connecticut: Greenwood Press, 1984: 72. In fact, Leavitt argues that doctors did not gain substantial control over birthing practices until delivery moved into the hospital. Leavitt, Judith Walzer, Brought to Bed. Childbearing in America, 1750 to 1950, New York: Oxford University Press, 1986: 87 & 98.

86 Oakley extracts a quotation to this effect from Beard, R., "Changes in Obstetrics: an interview with Professor Richard Beard," British Medical Journal, July 23, 1977: 251, in Ann Oakley, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 213. See also *ibid.*: 253.

Armstrong also notes this change and criticizes the epistemological assumptions of medical research for assuming that techniques uncovered the invariant nature of the "infant." He suggests that medical researchers have not seen that their analysis and the object (fetus and infant) are "mutually constitutive." According to Armstrong, this "discovery" of the fetus meant that the mother was viewed as the one who was pathological in the event of premature birth, owing to prenatal causes. Armstrong, David, "The invention of infant mortality," *Sociology of Health and Illness*, Vol.8, #3, Sept., 1986: 216, 217, 225-7.

suggests that this shift in focus during the 1950s was related to increased general social concern for the fetus as the future of the nation and "the family." In addition, she situates this, essentially mechanistic, model of women's reproductive biology within a social context of changing views of women in general. Oakley argues that the monitoring of the mother and fetus, such as through prenatal care, involves covert social control of women. She draws on the work of Foucault in suggesting that medical knowledge of women can't exist outside social relations of power, relations which give rise to phenomena like prenatal surveillance.⁸⁷

The 1950s stand out as a significant period of alterations in medical views of women's reproductive conditions. These changes in medical knowledge were part of larger shifts in the mechanistic medical model inherited from modern science. The debate surrounding the interpretation of these shifts falls into two main camps: that view which emphasizes increased scientization of medicine after 1950, and the other, which perceives an increasingly ecological approach in medicine. Both point to important considerations on the issue of how changes in scientific and medical models influence medical knowledge

87 Oakley, Ann, *The Captured Womb. A History of the Medical Care of Pregnant Women*, Oxford: Basil Blackwell, 1986: 252.

about women. Shorter and Martin are representatives of the first group, while Arney and Bergen represent the second.

Shorter argues that since the second world war, medicine has paid less attention to psychosomatic influences on patients and has correspondingly increased its disease-orientation. He claims that the more holistically-oriented general practitioners lost status in America during the 1920s and 1930s, when medicine was dividing into specializations. The high-status specialization of internal medicine emphasized the need for "chemistry-oriented sciences" in medical practitioners' education. This led, Shorter argues, to an emphasis upon basic medical sciences in the medical school curriculum of the 1950s, though they had initially been instituted in that curriculum by the late nineteenth century.⁸⁸

During the 1950s, this situation was also facilitated by the "drug revolution."⁸⁹ Drug-based therapy became especially important, according to Shorter, because disease was explained in biochemical terms, as based on "molecular changes." This definition contains a generally organic conceptualization of disease, one which omits the influence

88 By the first decade of the twentieth century, "There was no longer any doubt that the scientific subjects and the laboratory belonged in the medical curriculum." Ludmerer, K., op.cit.: 107, 102-4.

89 This "drug revolution" refers to the development primarily of sulfa drugs during the 1930s and early forties, penicillin and antibiotics in 1941, and anti-inflammatories in the early 1950s. Shorter, Edward, op.cit.: 180, 183-4.

of the psyche and which promotes a view of doctors as scientists.⁹⁰ Along with the increased number of factions and specialization within medicine, the period following the second world war was characterized by great expansion of biomedical research.⁹¹ This expansion facilitated entrenchment of a biomedical model of disease.

Martin's recent exploration of metaphors in obstetric and gynecologic knowledge confirms the general trend perceived by Shorter. Martin claims that a view of the uterus as machine (a mechanistic concept) still predominates. She found that this medical metaphor portrays the mother as "a passive host" and "laborer" producing the child (with passivity and labour being a contradiction in images not noted by Martin). She argues that the twentieth-century development of scientific medicine has precluded the emergence of environmentally-oriented medical imagery. Rather, Martin suggests, scientific medicine employs a biochemical metaphor. This is a metaphor in which physiological processes are perceived as analogous with the division of labour in a factory, in which there is central control of hierarchical information flow. For example, 1950s obstetric texts explain cessation of labour contractions physiologically and view such cessation as involuntary.⁹² Martin also found that the texts pictured

90 Ibid.: 23, 24, 183, 184, 185, 202.

91 Ludmerer, K., *op.cit.*: 261-2.

92 Martin, Emily, *op.cit.*: 61-2, 36-7, 40-1, 63.

women's reproductive functions as part of a signal-response, hierarchical communication system, not a feedback loop. One example Martin chooses to demonstrate this metaphor is that of the medical assumption that menopause is pathological. She writes that this conceptualization of menopause as pathological is:

a logical outgrowth of seeing the body as a hierarchical information-processing system in the first place.⁹³

In other words, Martin suggests that the scientific, biomedical model plays an important part in producing obstetric and gynecologic knowledge of women.

Such recent studies of medical metaphors and models in the construction of medical knowledge about women suggest the need for a revision of the traditional model of woman as victim of patriarchal, medical control. The contributions of these revisionist studies also lead to the question of how that medical knowledge is socially-constructed, since the studies often view the scientific, medical model itself as a social product.

Shorter's discussion of the organic, disease-oriented paradigm and Martin's revelation of a biochemical, information-systems model indicate a 1950s trend of increasing scientization of medicine. According to Shorter, this trend exacerbated factionalization within the profession. He states that:

93 Ibid.: 42.

Before World War II, considerable emphasis had been placed in medical schools on "treating the patient as a whole," or on "holistic views of disease." By the early 1950s medical education stood at a crossroads. An old guard continued to maintain that medicine should focus on "the patient as a whole and on the patient as an individual human being."⁹⁴

Shorter is suggesting that there was conflict over change of medical models. The resolution of the problem of competing models or emphases in medicine is significant here, for it influenced the knowledge about women's reproduction that was deemed acceptable. For example, even when a so-called "natural" alternative to scientized obstetrics arose, the disjunction between the two models was resolved by incorporation of the "natural" approach into scientized obstetrics. This, in turn, encouraged an approach to obstetric knowledge which promoted the use of technological, interventionist measures.

In addition, the "natural childbirth" alternative to the biomedical model, as the Read and Lamaze methods were referred to in the 1950s, was somewhat of a misnomer. It was hardly a "natural" approach, since all modes of birthing are social and cultural products. Oakley believes that

94 Shorter, Edward, *op.cit.*: 185. Shorter refers in this quotation to the examples of George S. Stevenson, "Why Patients Consult the Gastro-Enterologist," *JAMA*, 1 February 1930: 334-335 and George Canby Robinson, *The Patient as a Person: The Study of the Social Aspects of Illness*. New York, 1939: 410-414.

trends like the natural birthing movement and holistic antenatal care were consumer movements, but ones whose purposes were also absorbed into biomedical obstetrics in the form of " 'psychological' preparation for childbirth."⁹⁵ Oakley argues that obstetrics and gynecology did not absorb natural childbirth methods solely out of concern for women's "general well-being."⁹⁶ Rather, obstetricians and gynecologists saw any negative mental attitudes on the part of pregnant women as hindering what they called "the mechanics of reproductive performance."⁹⁷

Since what were referred to as "natural childbirth" methods were not clearly defined, interpretations could emerge which would support the biomedical effort to improve "reproductive performance." So, as Sandelowski discovered, the meanings attributed to the term "natural childbirth" and to the notion of "pain" when imported into North America were ones which suited the prevailing obstetrical practices and beliefs. Sandelowski describes how pain was considered to contain more than just a physiological component and how American obstetricians interpreted natural childbirth as psychological preparation for a hospital birth, a birth which would still include drugs for pain relief. The management of pain, she argues, just as in the case of birth

95 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 264.

96 Ibid.: 264.

97 Ibid.: 264.

in general, was retained as the responsibility of the medical profession, not of the woman herself.⁹⁸

The significance of the natural childbirth movement then, as conveyed through the work of these revisionist scholars, is that even this attempt at wresting control from obstetricians became scientized. These studies even suggest that scientization is one of the primary reasons that Read's "metaphysical" method failed, while the Lamaze method is still popular today. While the approaches of both Lamaze and Read threatened obstetricians' control of the domain of childbirth, the Lamaze method was at least seen as more scientific and hence became more integrated into biomedicine.⁹⁹ A related reason for this integration was that both methods used metaphors similar to those found in the biomedical model. This is demonstrated by Grantly Dick Read's explicit use of a mechanistic analogy to describe his own natural childbirth method. Read wrote:

Since when have repair shops been more important than the production plant? ... we almost forget the relative reliability of the modern machine if it is properly cared for... the mother is the factory, and by education and care

98 Sandelowski, Margarete, Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960, Westport, Connecticut: Greenwood Press, 1984: xii, 107, 110, 113.

99 Ibid.: 129 & 131.

she can be made more efficient in the art of motherhood.¹⁰⁰

With the same mechanistic metaphor prevalent in Read's alternative model as in biomedical obstetrics, it is not surprising that his model simply became a subordinate part of scientized obstetrics.

Arney and Bergen represent the second group and offer a slightly different interpretation of the 1950s shift in medical paradigms. Many of the trends to which they refer complement the first interpretation of medical models and of how those models have influenced obstetric and gynecologic conceptualizations of women's reproductive issues. For example, Arney and Bergen note, as did Shorter, that there was initial reluctance on the part of obstetricians to accept natural childbirth methods. But Arney and Bergen argue that such methods were soon accepted and reformed. Arney and his co-authors also contend that the medical profession "embraced" natural childbirth owing to the profession's increasing attention to environmental concerns.¹⁰¹ They argue that social and emotional factors, considered with regard to pain for example, became part of

100 Reference to Dick-Read, Grantly, Childbirth Without Fear. London: Heinemann, 1942, in Oakley, Ann, "A Case of Maternity: Paradigms of Women as Maternity Cases," SIGNS, Vol.4, #4, Summer, 1979: 628-9.

101 Arney, William Ray and Bernard J. Bergen, op.cit.: 51, 59, 68; Arney, William Ray and Jane Neill, "The location of pain in childbirth: natural childbirth and the transformation of obstetrics," Sociology of Health and Illness, Vol.4, #1, 1982: 10-13.

medical discourse - a discourse that subsumed such social and psychological factors as "technical matters."¹⁰² In other words, Arney, Bergen and Neill concur with other researchers that natural childbirth was integrated into scientific medicine, but they place less emphasis upon the trend toward scientization. Rather, they focus upon expansion of the medical domain as the means by which childbirth alternatives became subsumed.

Arney and Neill explain the difference in interpretations as the result of feminist scholars having researched only the first, mechanistic stage of medical paradigms.¹⁰³ Rather than the content of the second stage being further scientization, as Shorter and Martin claim, Arney and Neill conceptualize a more holistic, ecological and systems-theory model as comprising that stage. Further, Arney and Bergen suggest that:

Mechanistic relationships in the body lost their prominence to relationships mediated by information flows in a broader ecology. The domain of the doctor expanded.¹⁰⁴

Arney and Bergen contend that this ecological and systems-theory approach, which excludes the notion of causality and its "explanatory logic," grew out of the disjunction between medical models in the 1950s. They note, however, that this

102 Arney, William Ray and Bernard J. Bergen, op.cit.: 57.

103 Arney, William Ray and Jane Neill, op.cit.: 7 & 8.

104 Arney, William Ray and Bernard J. Bergen, op.cit.: 60-1.

ecological, systems-theory model did not become prominent in medical education until the late 1960s and 1970s.¹⁰⁵ In contrast, Martin also found that a systems-theory model was prevalent in obstetric and gynecologic texts, but did not find this model to be ecological and holistic.

It seems that there has been a long-standing faction in medicine which has attended to the psychological and emotional aspects of obstetrics and gynecology, in an attempt to take a more holistic approach. Perhaps one way, then, that we can make sense of the variation in accounts of medical models provided by these two groups of researchers is that there have been two simultaneous, yet contradictory trends. Ann Oakley suggests that antenatal care, as obstetrics generally, may have been experiencing both trends. According to Oakley, obstetrics has been moving:

towards a more social and user-sensitive agenda on the one hand, and in favour of mushrooming new technologies on the other.¹⁰⁶

Oakley implies that both these trends existed simultaneously.

The existence of these two trends may have been part of a process of legitimation in medicine, a process in which the medical profession merged the more holistic agenda into scientific discourse. Gynecologists, for example, drew upon

105 Ibid.: 63, 70, 73.

106 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 204.

scientific, endocrinological discourse, on the one hand, as a theory of the etiology of menopause and other reproductive processes during the 1930s and 1940s. While this use of science and biomedicine helped gynecology to appear more objective, many physicians thought, on the other hand, that science needed to be combined with more holistic, clinical judgment. The science of endocrinology led gynecology to focus on physiological, hormonal aspects of women's reproductive health. This trend also meant that gynecology made an apparent separation between biological aspects, and psychological and environmental influences. At least in the case of menopause, the emphasis in research remained on the biological aspects, especially the "cessation of ovarian function."¹⁰⁷ Yet physicians stressed the need to maintain clinical skills in their work, as that would keep them from becoming totally dependent upon laboratories for diagnosis of patients' conditions. They hoped that the clinical skills would also enhance medical authority and the doctor-patient relation.¹⁰⁸ So any attention that was directed at psychosocial aspects of women's obstetric and gynecologic conditions during the 1950s tended to be subsumed under biomedical, more apparently scientific, explanations.

107 Bell, Susan E., "Changing Ideas: The Medicalization of Menopause," Social Science and Medicine, Vol.24, #6, 1987: 537.

108 Ibid.: 537.

These recent studies of medical models move some way towards addressing the issues taken up in this dissertation. However, some aspects of medical social control of women remain unexplored. Arney and Bergen's position, for example, is that medicine's own "logic" is creating changes in the medical model, such as an increase in attention to the subjectivity of female patients. These authors present medicine as offering a more ecological model to patients, rather than being pressured towards accepting that approach.¹⁰⁹

While Arney and Bergen are drawing upon Foucault, their rendition downplays Foucault's analytical assessment and notion of surveillance as power. For Foucault, the concept of "knowledge as power" has a critical edge. But Arney and Bergen's statement that, "The patient's psychology was a new entree to patient control," instead notes a positive transformation.¹¹⁰ In contrast to Foucault, they view enhanced medical control of patients as a positive social achievement.

There is also no sense of women's power or that of patients in Arney and Bergen's interpretation; in other words, there exists no active subject. Medicine is interpreted as simply allowing the whole human being back into medical discourse. Finally, their work takes a very

109 Arney, William Ray and Bernard J. Bergen, *op.cit.*: 27-8, 46-7, 97, 90, 165.

110 *Ibid.*: 68.

idealist and internalist approach, entailing little discussion of the social context of the medical discourse and of how the broader context could have influenced shifts in medical paradigms. Arney and Bergen's work, then, does not develop a sense of medical knowledge as social. Medicine is treated as if it existed in an autonomous sphere and is assumed to be separate from social influences.

The revisionist literature dealing with changing medical paradigms and how physicians translated their concepts into ideas regarding women's reproductive health has contributed some knowledge of the nature of medical control of women. This literature provides some critique of "normal" science and analysis of the construction of "medicine as usual," in terms of the influence of medical and scientific models or paradigms. However, as the revisionist analysis of medical and scientific control at times takes the form of opposition to "incorrect" science, exploration of the social character of medical knowledge could be developed further.

(d) Women's Participation and Choices

Some of the victimization literature is premised on an assumption of women's oppression, a stance which can lead researchers to dismiss women's own choices as part of the

socio-historical process.¹¹² This gap in the research creates an ironic situation. As Riessman points out, feminist analyses haven't always

noted the fact that women actively participated in the construction of the new medical definitions, nor discussed the reasons that led to their participation. Women were not simply passive victims of medical ascendancy. To cast them solely in a passive role is to perpetuate the very kinds of assumptions about women that feminists have been trying to challenge.¹¹³

Riessman and other revisionist writers are attempting to rectify this problematic situation in the research on medicine and women.

This dissertation does not concentrate upon the part women played in the social construction of medical ideas, but it is important to acknowledge the findings of revisionist studies that examine women's role. Such studies suggest that medical practices and knowledge were influenced throughout history by women's demands, even if women's choices were limited by their social and cultural milieu. Revisionists make a valuable contribution to our understanding of medical knowledge of women by pointing out, for example, that one cannot assume *a priori* whether women's

112 Martin's research question, for example, is that of whether women, in their oppression, are "mystified" about their reproductive health processes. She conducted interviews with women of different age groups and social classes in the United States to ascertain the meaning of these reproductive processes to women themselves. Martin, Emily, *op.cit.*: 23, 202.

113 Riessman, Catherine Kohler, *op.cit.*: 3.

decisions about childbirth were in the interests of a patriarchal medical profession or in women's own interests.¹¹⁴ Rather, each specific situation must be examined in order to determine the extent to which women participated in decision-making processes.

Studies perceive women's participation in the construction of obstetric and gynecologic knowledge and practice as varying in degree. This participation has been expressed in the literature as: women "acquiescing" in a biomedical view of birth as pathological,¹¹⁵ women "allowing" medicalization to occur,¹¹⁶ women having "consented" to the shift of childbirth to the hospital,¹¹⁷ and - the strongest version - women having "invited" male doctors into the experience of birthing.¹¹⁸ Yet women do not, of course, make decisions in a vacuum. While research has revealed that women participated to some degree in obstetric and gynecologic changes, researchers also acknowledge the influence of the medical profession upon the decisions made by women.

Revisionist studies indicate that, in many cases, women accepted medical developments because they perceived new

114 Lewis, Judith Schneid, op.cit.: 17.

115 Wertz, Richard W. and Dorothy C. Wertz, op.cit.: 236.

116 Oakley, Ann, "Feminism, Motherhood and Medicine -- Who Cares?," in Juliet Mitchell and Ann Oakley, eds., op.cit.: 135-6.

117 Sandelowski, Margarete, Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960, Westport, Connecticut: Greenwood Press, 1984: 71.

118 Leavitt, Judith Walzer, op.cit.: 39-40.

medical ideas as resulting in benefits for themselves. Women were not immune to the general social view of science; they too accepted obstetrics as associated with science and, therefore, with progress.¹¹⁹ Women turned to obstetrics, and eventually also to hospitals, for example, for the progress in the areas of potential safety and pain relief that they promised.¹²⁰ Revisionist researchers suggest that considerations such as safety were prominent in an age when there was pervasive fear of death in childbirth.¹²¹ This is one example of a historical, social situation which some authors argue had a significant impact upon women's acceptance of obstetric ideas and practices.

Turning to the cases of natural childbirth and early twentieth-century Twilight Sleep, it seems evident that women's decisions were again motivated by concern for relief of pain and the threat of death. Women's own concerns permitted some social acceptance of natural childbirth practices, such as Grantly Dick Read's method. Read's approach spiritually glorified motherhood but possessed aims similar to those of women. Both women and Read aimed at

119 Morantz-Sanchez, Regina Markell, *op.cit.*: 18.

120 *Ibid.*: 38; Sandelowski, Margarete, *Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960*. Westport, Connecticut: Greenwood Press, 1984: Introduction; Wertz, Richard W. and Dorothy C. Wertz, *op.cit.* *passim*.

121 Leavitt, Judith Walzer, *Brought to Bed. Childbearing in America, 1750 to 1950*, New York: Oxford University Press: 38.

pain relief for women giving birth, according to Wertz and Wertz:

Read wished to free women from fear, but not from family and home. And American women of the 1950s largely agreed.¹²²

Women not only agreed with Read on obstetric aims, then, but also on the larger social question of women's ideal "place" in society.

The acceptance of Twilight Sleep in North America is an instance of an obstetric practice resulting largely from women's demands and pressures. Women were demanding the right to available anaesthesia and, thereby, pain relief in childbirth. Following the debate, in the early twentieth century, women had generally acquired that right.¹²³

One of the effects of women's demands in different periods was that doctors were forced to make their gynecologic and obstetric practices acceptable to women. This was particularly the case with upper class women who have been able to wield more power over their obstetric attendants than have working class women. The findings of revisionist research indicate that upper class women were capitalizing on the status of their obstetrical attendants. Leavitt, for example, finds evidence for this view in archival sources, such as diaries and family papers.

122 Wertz, Richard W. and Dorothy C. Wertz, *op.cit.*: 185.

123 Sandelowski, Margarete. *Pain, Pleasure, and American Childbirth. From the Twilight Sleep to the Read Method, 1914-1960*, Westport, Connecticut: Greenwood Press, 1984: 28.

biographies of obstetricians, and secondary sources on the history of women and obstetrics.¹²⁴

The questions being asked by revisionist researchers about women's role in the construction of medical knowledge are becoming increasingly important. Even when a project is not directly focused on women's input into obstetric and gynecologic knowledge, as in the case of the present dissertation research, awareness of women's participation contributes to a balanced analysis of medical concepts.

Overall, then, revisionist scholarship provides more in-depth understanding of the social construction of medical knowledge of women. The specific contributions of this research have been outlined in this chapter in terms of four specific categories.

This revisionist literature deemphasizes the focus on patriarchal interests as directly coercive, an orientation characteristic of victimization studies. Morantz is one revisionist scholar who criticizes feminist historians for their "woman as victim" theme, noting that these historians are

often too willing to distort historical evidence and lay blame, while missing a larger opportunity to explore the immense complexities which lie at the

124 Leavitt, Judith Walzer, Brought to Bed. Childbearing in America, 1750 to 1950, New York: Oxford University Press, 1986: 39-40, 85.

root of Victorian attitudes toward
women.¹²⁵

The revisionist research deals with the problems of oversimplification and blaming, as characterize the victimization literature, by attending to the complexities involved in the medicalization of women's conditions and in social control by the medical profession. This focus on complexities entails a broadened contextualization of the relation of medicine to women, an approach which contributes to the framework used in my study of the social construction of medical concepts of women's reproductive health.

Revisionist analysis of the complexities and broader contextualization of medical knowledge and practice has led to fruitful new approaches. For example, the Sociology of Science has become an indirect influence on some historical studies of the management of childbirth. This influence can be detected in revisionist studies which are analyzing:

the history of obstetric theories in
their social context, studying
innovation and its diffusion as a social
process, and the philosophical and
social assumptions on which obstetric
theories are based.¹²⁶

This trend towards use of the Sociology of Science is one direction in the revisionist literature which encourages

125 Morantz, Regina Markell, "The Perils of Feminist History," in J. W. Leavitt, ed., Women and Health in America, Madison, Wisconsin: University of Wisconsin Press, 1984: 239.

126 MacIntyre, Sally, "The Management of Childbirth: A Review of Sociological Research Issues," Social Science and Medicine, Vol. 11, #8/9, 1977: 478.

further exploration of the complexities involved in the construction of medical knowledge of women.

Some revisionist writers on medicine and women, then, have drawn on aspects of the Sociology of Knowledge and the Sociology of Science in developing the frameworks for their research. However, the way in which these approaches have been applied to research on the social construction of medical knowledge of women tends to be limited.¹²⁷ More specifically, revisionist researchers focus at times on the problem of sexist "bias" in medical knowledge, while the issue of the value-ladenness of everyday medical science requires further exploration. The existence of a realm of social influence, on the one hand, and a realm of potential "truth" about women's reproductive health, on the other, is implied in the ongoing search for error or bias. This division leaves undeveloped the possibility of medical knowledge being consistently social.

An example of this division in revisionist research can be found in Martin's work. She contrasts a medical text's teleological view of menstruation to the rest of that text, contending that the latter contains "extremely objective, factual descriptions."¹²⁸ She clearly assumes the existence

127 See, for example, Ann Oakley's reference to Kuhn regarding "science as ideology." Kuhn, Thomas S., The Structure of Scientific Revolutions, 2nd ed. Chicago: University of Chicago Press, 1970, in Ann Oakley, "A Case of Maternity: Paradigms of Women as Maternity Cases," SIGNS, Vol.4, #4, Summer, 1979: 608.

128 Martin, Emily, op.cit.: 45.

of a neutral, objective medical science, rather than the consistent, social construction of normal science. At another point, Martin argues that not all medical texts use negative terms to describe women's reproductive functions. She then goes on to state:

But unacknowledged cultural attitudes
can seep into scientific writing through
evaluative words.¹²⁹

Martin's approach implies that only negative terms, not all medical discourse, are socially-constructed. However, the existence of values and attitudes in scientific knowledge becomes less problematic if one examines "science as usual." What is more problematic than the influence of cultural attitudes, then, is the issue of how normal science is socially and culturally constructed.

Morantz-Sanchez is another scholar who falls into the revisionist category and who also separates the medical, scientific enterprise from social influence and construction. She states, for example, that ideas about women's health were not "empirically-verified" in the nineteenth century. Morantz-Sanchez suggests that such ideas were instead:

cultural assumptions that had a
particular non-medical use in ordering
social and power relationships.¹³⁰

129 Ibid.: 48.

130 Morantz-Sanchez, Regina Markell, op.cit.: 208.

Here she conceptualizes social influences as located externally to medicine and, hence, as part of a "non-medical" realm. Undeveloped, again, is a sense that correct, empirical science and medicine could also potentially entail cultural assumptions that are outside the strict definition of medical expertise.

This issue could also be explored further, following on Oakley's *The Captured Womb*, in which she discusses the increasingly scientific, technological character of obstetrics and gynecology.¹³¹ Oakley sets the medical knowledge of women that has evolved out of this scientific, medical paradigm in the context of broad social trends. She supplies a valuable discussion of the obstetric and gynecologic aim of exposing the fetus to view, the concepts of pregnancy to which that aim led, and the social control of women that was entailed in that medical knowledge. She also links changes in obstetrics and gynecology to the impetus provided by social influences such as the professional aims and interests of obstetrics, needs of the state, and concepts of womanhood.

However, in places, Oakley focuses on an internalist history of developments in medical research and practice, containing a technocratic emphasis. When Oakley discusses the "scientific discovery" of a drug, for example, she

131 Oakley, Ann, *The Captured Womb. A History of the Medical Care of Pregnant Women*, Oxford: Basil Blackwell, 1986.

neglects the social aspects of the initial process of discovery.¹³² In her work, medical practice and technological developments are conceptualized, at times, as products of a duality in which social factors influence autonomous scientific process. For example, Oakley states that:

Technologies do not simply emerge or exist; they frequently imply a transformation in social relations by acquiring identities of their own. ... A central problem of technology everywhere is its overloading by commercial interests and the vested interests of particular professional groups. ... Scientific evidence as to the effectiveness of this or that technical procedure is not the main criterion used either by the technology manufacturers, or by obstetricians, in deciding how to treat their patients. ... Only by mapping these informal relations between doctors could the process of drug innovation be understood; the notion of individual scientific appraisal of the drug's benefits and hazards did not provide an adequate explanation (Coleman, et al., 1966).¹³³

Oakley's attention to social factors external to the scientific or medical process, such as interests, supplies some understanding of the social basis of that process. Oakley builds upon more traditional, victimization studies through her consideration of the socially-constructed quality of medical technology. The issue of how science and

132 Ibid.: 106.

133 Ibid.: 287-8. The final part of this quotation contains a reference by Oakley to Coleman, J.S. et al., Medical Innovations. a diffusion study, N.Y.: Bobbs-Merrill, 1966.

medicine are consistently social is one still to be addressed in the literature.

The need for development of an analysis of the consistently social character of medical knowledge is also evident in Oakley's use of extra-medical influences as explanation for what she considers to be incorrectly done medicine or science. She attributes errors made in the early development of X-rays, for example, to unusual intrusions into medical research. Oakley claims:

The evil effects of X-rays and radium on animal and plant life were also established early. . . . At the same time, the investment of those who worked with the new method of seeing inside the human body was so great that harmful effects were often strenuously denied. . . . But warnings of damage were counterbalanced by the attractiveness to the obstetrician of the information gained.¹³⁴

That this is a debunking approach to the construction of scientific knowledge can be deduced from Oakley's bracketing of the word scientific, as in, "so-called 'scientific' development."¹³⁵ Such bracketing implies that recognition of the social character of science requires consequent rejection of its existence as science. In other words, there is an assumption in Oakley's position, that science or medicine ultimately should not be socially-influenced. This

134 Ibid.: 102.

135 Ibid.: 3.

results in some ambivalence, considering Oakley's view that science is

at least partially, a culture of ideas
influenced by the social relations of
individuals and groups.¹³⁶

So while revisionist studies have developed the notion of obstetric and gynecologic knowledge about women as socially-constructed, the issue of possible alternatives to dualist assumptions about the way in which this knowledge is social has not been a central focus. Rather than acknowledging that medical knowledge is social and/or ideological, for example, Oakley voices opposition to the positivist assumption of medical or scientific autonomy through a quote from Figlio. Figlio writes:

'That is, it [the positivist approach to medical history] neither examines the non-intellectual contingencies which mould ideas, nor does it look at the use of scientific or medical concepts as cultural, social, religious or ideological tools.'¹³⁷

Here, Oakley acknowledges the social construction of medical ideas, but not the possibility of an integral unity of intellectual and non-intellectual, social, or ideological aspects. This possibility is a concern of the present study of medical knowledge of women.

136 Ibid.: 3.

137 Ibid.: 3. The reference Oakley uses is: K. Figlio, "The Historiography of Scientific Medicine: an invitation to the human sciences," *Comparative Studies in Society and History*, 19, 3, 1977: 262-286.

Thus, in examining these revisionist studies of medical paradigms and knowledge, we see that they have moved in the direction of addressing the sociality of medical knowledge. They build upon early "woman as victim" studies, focusing primarily on incorrect medicine as problematic and doctors' interests as a primary factor in the construction of medical knowledge.¹³⁸ The present study of obstetric and gynecologic knowledge during the 1950s raises the question of whether that focus on incorrect medicine could be broadened. My dissertation research emphasizes the unresolved issue of how the social character of medical knowledge should be formulated and attempts to contribute to further developments on this subject. The present research operationalizes that issue by investigating how social conditions in the 1950s became resources in the acceptance and production of obstetric and gynecologic knowledge of that period.

138 of. William Ray Arney's use of Barnes' Interest Theory as the prime example of the Sociology of Knowledge. William Ray Arney, *Power and the Profession of Obstetrics*, Chicago: The University of Chicago Press, 1982: 1, 244, Reference Numbers 11-13.

Chapter 2

The Social Character of Medical Knowledge

The Sociology of Knowledge

Medical ideas and beliefs about gender and biology, like all other ideas, are constructed within particular social conditions. So to fully understand how specific medical knowledge about women was constructed in the 1950s, we could ask which beliefs about feminine gender and femaleness were prevalent at that time, which social conditions formed the context for the construction of those particular beliefs, and about the nature of the relation of those ideas and beliefs to that context.

The Sociology of Knowledge is one approach to addressing those questions. It provides a useful theoretical framework for analyzing the problem of how to characterize the relation between social existence and knowledge, despite this perspective only recently being applied to ideas about gender and biology. The Sociology of Scientific Knowledge, in particular, aids in the analysis of the medical construction of femininity and female biology. Some studies of scientific knowledge, as well as formulations in the Sociology of Knowledge, effectively

express the way in which medical knowledge about women is social. Hence, this chapter first examines the aspects of the Sociology of Knowledge applicable to this study and then moves on to discuss aspects of the Sociology of Scientific Knowledge.

While it has not always been the central focus, the nature of knowledge and consciousness¹ has been an underlying issue in all major sociological theories. The Sociology of Knowledge perspective can be broadly defined as the study of "relations between knowledge and society" or "existentially connected" thinking.² Since the Sociology of Knowledge is not one cohesive theory, this definition does not specify the type of relation which exists between social existence, and knowledge or thought. However, many forms of the perspective assume that the world is constructed by actors (individuals, or groups such as social classes or occupations). The choice of meanings which these social subjects give to the world is influenced by the social conditions of their existence.³ This means that those social

1 No finer distinction will be made here between knowledge and consciousness, assuming that all forms of consciousness are ways of knowing. Hence, the terms are used interchangeably. cf. Marx, Karl and Friedrich Engels, *The German Ideology*, New York: International Publishers, 1970, on consciousness always being conscious existence.

2 Stehr, Nico and Volker Meja, eds., *Society and Knowledge. Contemporary Perspectives in the Sociology of Knowledge*, New Brunswick: Transaction Books, 1984: 7.

3 Farganis, Sondra, *The Social Reconstruction of the Feminine Character*, Totowa, New Jersey: Rowman and Littlefield, 1986: 20.

actors construct the changing meanings of concepts which form their knowledge of the world. We will see that in fact the conditions of obstetricians' and gynecologists' lives during the 1950s did inform the meanings they attributed to aspects of women's biology and reproduction. For example, the seemingly unstable political conditions of the 1950s influenced the content obstetricians and gynecologists gave to their categorization of "normal" female cycles, through the pronatalist climate which prevailed.

A problematic issue for sociologists of knowledge is that of "specifying the way in which thought is related to its alleged existential basis."⁴ Certain social factors are said to be entailed in knowledge, but, much as we found in the women and medicine studies, the question of how this relationship can be characterized is more contentious. Some Sociology of Knowledge theorists have argued that knowledge and its social basis are two isolated factors. They are then connected through a causal relationship of determination (one or two-way), or with a reflection theory, whereby thought reflects or mirrors reality. These are the models most commonly used to characterize the relation of medical knowledge about women to its social basis.

⁴ Hartung, Frank E., "Problems of the Sociology of Knowledge," in James E. Curtis and John W. Petras, eds., The Sociology of Knowledge: A Reader, London: Gerald Duckworth and Co. Ltd., 1970: 686.

The relationship between knowledge and being has, alternatively, been conceptualized as a non-causal one. In this approach, knowledge is taken to be an "expression" or an "excrecence" of particular social conditions. It is this latter, European strand, which is supported by this study of obstetric and gynecologic knowledge. This more holistic approach best expresses the contextuality of medical knowledge about women during the 1950s and the nature of the correspondence of the social context with specific obstetric and gynecologic concepts. It also suggests how those concepts embodied general characteristics of the conditions of existence of the obstetricians and gynecologists constructing the knowledge, without relying upon a causal, deterministic model.

The growing power of "knowledge" in our highly technological and rationalized society is one of the important themes in this sociological approach and is one that we have already encountered in the research on women and medicine. This concern focuses on the increasing importance of specialized forms of knowledge and the corresponding increase in power of these specializations.⁵ Hence, the Sociology of Knowledge is a particularly appropriate perspective for research dealing with the creation and dissemination of specialized knowledge. Scientific and medical knowledge are highly valued and,

⁵ Stehr, Nico and Volker Meja, eds., op.cit.: 11-12.

therefore, powerful forms of specialized knowledge. One aspect of the existential basis of the production of obstetric and gynecologic knowledge about women is that of the power relations embedded in that knowledge. This is particularly the case as knowledge about women's biology and reproduction has increasingly come into the domain of specialized medical "experts."

Such power relations are part of the existence and practical life-activity emphasized by Marx, Korsch and Lukács in their non-causal approach to the production of consciousness. It is useful to examine their strand of the Sociology of Knowledge, since their approach comes closest to the characterization of the social nature of knowledge which arises out of this study of obstetric and gynecologic ideas about women. The European tradition, represented here by Korsch and Lukács, was influenced by all of Marx's basic principles, including the Hegelian aspects and the labour theory of value.⁶

Marx, Lukács, and Korsch

Marx held a Hegelian notion of society as an integrated, changing whole, with being and consciousness

⁶ Ibid.: 2.

forming aspects of that society.⁷ This approach stands in contrast to Mannheim's neo-Kantian separation of consciousness and being. For Marx, consciousness was related to being through "the social mediation of the human relation with nature."⁸ This meant that human beings act upon their environment to produce and fulfill their needs. Through this process, human subjects create a particular form of social labour and social relations, as well as forms of consciousness. This practical life-activity, however, is always historically specific and, hence, is also accompanied by historically specific forms of thought. As Marx himself expressed it in Part One of The German Ideology:

The production of ideas, of conceptions, of consciousness, is at first directly interwoven with the material activity and the material intercourse of men, the language of real life. Conceiving, thinking, the mental intercourse of men, appear at this stage as the direct efflux of their material behaviour. The same applies to mental production as expressed in the language of politics, laws, morality, religion, metaphysics, etc. of a people. Men are the producers of their conceptions, ideas, etc. -- real, active men, as they are conditioned by a definite development of their productive forces and of the intercourse corresponding to these, up to its furthest forms. Consciousness can never be anything else than conscious existence, and the existence of men is their actual life-process.⁹

7 Hadden, Richard W., The Social Origins of Early Modern Mechanism, Unpublished Ph.D. Thesis, Hamilton, Canada: McMaster University, 1984: 47.

8 Ibid.: 48.

9 Marx, Karl and Friedrich Engels, op.cit.: 47

Marx critiqued both Hegelian idealism and Feuerbach's materialism in the course of developing his own views of consciousness and being.

As early as the Correspondence of 1843[with Ruge] he conceives of consciousness as immanent in history. Consciousness does not lie outside the real process of history.¹⁰

And as seen in Marx's and Engels' writing in The German Ideology, the "real process of history" consists not only of social class as contributing to forms of thought, but the whole of human practical life-activity.¹¹ Marx posited no mechanistic link between thought and class position (particularly as he was in fact critiquing such determinism), and was opposed to any conceptualization of that relation in terms of universal laws.

This can also be seen in Marx's analysis of the fetishism of capitalist commodity production. In Capital, Marx argues that political economy consists of reified concepts - universalized concepts, unable to penetrate the essence underlying the immediate appearance of social relations in capitalist production.¹² However, Marx's critique of this reified thought does not necessarily imply negation of the value of political economic concepts:

10 Lukacs, Georg, History and Class Consciousness, Cambridge, Massachusetts: MIT Press, 1968: 77.

11 Marx, Karl and Friedrich Engels, op.cit. passim.

12 Marx, Karl, Capital, Volume 1, edited by Frederick Engels, New York: International Publishers, 1967: 76.

The categories of bourgeois economy consist of such like forms. They are forms of thought expressing with social validity the conditions and relations of a definite, historically determined mode of production, viz., the production of commodities.¹³

In fact, then, political economic analysis may be an accurate indicator of the actual presentation of categories to human beings in any particular society. Marx points out that the political economists were incapable of going beyond this superficial analysis because in the society itself, "The characters that stamp products as commodities. ... have already acquired the stability of natural, self-understood forms of social life...."¹⁴ Not only are the concepts taken to be "natural" and universal, but they contribute to a fragmentation of the social whole into seemingly independent parts. The underlying unity is lost.

This work of Marx's emphasizes the importance of analyzing the social context of thought and knowledge. The problems which emerge, if one doesn't begin with an analysis of the social context, is evident in the work of many Marxists, such as that of Althusser. The Althusserian, structuralist emphasis upon the relative autonomy of ideology subordinates the historical aspects involved in the construction of ideology or knowledge. It also means that

13 Ibid.: 76.

14 Ibid.: 75.

little attention is paid to the fruitful aspects of Marx's original texts.

all those texts which generate knowledge of the societal context of cultural production. ...Althusser's theory of semi-autonomous practices not only licenses but enjoins specialisation in the understanding of particular practices in their specificity *before* they can be studied in their articulation with the remaining practices of the social formation. Inevitably the second task is postponed to a last instance which never comes.¹⁵

A strand of the Sociology of Knowledge which extends Marx's own approach, instead, is that of Lukács and Korsch. Their formulation emphasizes the relation of ideas to their social context, beginning with that context itself. Both Lukács and Korsch were members of the early phase of the Frankfurt Institute of Critical Theory.¹⁶ They employed Marx's concepts of reification and fetishism to examine bourgeois and Marxist thought. Korsch and Lukács opposed the correspondence theory of truth of the bourgeois positivists, who assumed the existence of an independent reality "out there," to which categories of consciousness correspond.

The naively metaphysical standpoint of sound bourgeois common sense considers thought independent of being and defines truth as the correspondence of thought

15 Lovell, Terry, Pictures of Reality. Aesthetics, Politics, Pleasure, London: BFI Publishing, 1980: 5.

16 Morrow, Raymond A., "Critical theory and critical sociology," Canadian Review of Sociology and Anthropology, 22: 5, December, 1985: 711.

to an object that is external to it and 'mirrored' by it.¹⁷

Korsch also aimed his critique at the economistic school of Marxism (for their economic reductionism and relegation of the rest of social existence to an ephemeral category of ideology). He criticized those Marxists who took "a general empirical and positivistic method" towards consciousness and being.¹⁸ This approach, Korsch argued, transforms materialism as a method into "co-ordinated 'sociological' sciences," lacking in historical content and any penetrating critique of the social whole.¹⁹

Korsch and Lukács extended Marx's critique of political economy to an analysis of all thought.²⁰ The influence of the concepts of reification and fetishism can be seen in Lukács' formulation of the relation between consciousness and being. In contrast to Marx's stress on the importance of relations of production, Lukács drew more on the Hegelian categories of totality and mediation.²¹ Lukács referred to

17 Korsch, Karl, Marxism and Philosophy, New York: Monthly Review Press, 1970: 95.

18 Korsch, Karl, Karl Marx, New York: Russell and Russell, 1963 (originally 1938): 218-9.

19 Ibid.: 218-9.

20 Lukács includes the notion of interests and motives, but in the sense of being related to "reified" or "false consciousness." He is aiming thereby at an historical analysis of inferred thoughts which would be appropriate to the particular social situation of any group, not a mere description of what they did think at any specific historical moment. Lukács, Georg, op.cit.: 51.

21 Levitt, Cyril, The Sociology of Knowledge of Georg Lukács and the German Idealist Tradition, Unpublished M.A. Thesis, Waterloo, Canada: University of Waterloo, 1972: 78.

the notion of a "totality"²² of consciousness and social being: a totality which does not allow for the reduction of all its parts to one unity, yet pierces the apparent total autonomy of those elements -- the way in which they are presented to us in everyday life. Lukács argues that:

For, as far as *method* is concerned, historical materialism was an epoch-making achievement precisely because it was able to see that these apparently quite independent, hermetic and autonomous systems were really aspects of a comprehensive whole and that their apparent independence could be transcended. This semblance of independence, however, is no mere 'error' simply to be 'corrected' by historical materialism. It is rather the intellectual and conceptual expression of the objective social structure of capitalist society.²³

In contrast to a simplistic notion of false consciousness, then, Lukács views thought as an expression of social being. Similarly, Korsch held that forms of consciousness co-exist with social existence. Both being and consciousness are conceived of as "reality." To Lukács, Marx's notion of fetishism contributes to a method which can

22 The notion of "totality" implies that, "The greater the understanding of the context within which the individual exists, the greater our knowledge." It refers, for Hegel, to a dialectical development of internal mediations, whereby the movement of the whole occurs through the opposition of its elements. The specific nature of those elements gives rise to the particular relation between them which comes to be. It is not a one-way deterministic process, however, as the elements which develop through the totality actually determine the nature of that totality at the same time as they are determined by it. Levitt, Cyril, *op.cit.*: 36-7.

23 Lukács, Georg, *op.cit.*: 230.

get to the essence of thought and situate it historically in its broader context. The notion of a totality allows Lukács to present ideas and categories as interrelated with their context, so that they no longer appear autonomous.

The second major aspect which Lukács and Korsch revive is that of mediations in the totality of consciousness and being. Korsch pointed out that it isn't possible to explain philosophical thought directly by its "earthly kernel." Mediations are used in a dialectical way by Lukács, to refer to an indirect relation between thought and being. This is important, as it avoids the positing of a direct relation, a position which has led to economism and a reflection theory of consciousness. Rather, in Lukács' view, consciousness is active and thus, able to transform its own historical situation.²⁴ In History and Class Consciousness, Lukács makes it abundantly clear that he rejects any one-way, causal relationship as characterizing consciousness and

24 This is particularly true for Lukács when the theory and practice come to be in a dialectical relation (e.g. in revolutionary situations). Theory and practice become elements of a historical totality through the "identical subject - object," the revolutionary class of the proletariat. This is a central aspect of Lukács' work, though not directly relevant for the subject matter of this research problem. Lichtheim, George, Lukács, London: Fontana/Collins, 1970: 64-5.

being, favouring instead the Hegelian notion of a mediated totality.²⁵

Lukács' work provides a more complex and integrated picture of the relation of consciousness and being, than do the prevalent positivist or Marxist approaches, through a revival of the Hegelian aspects of Marx's writings. Thus, it continues to have value in spite of the fact that Lukács was not always consistent in adhering to his own principle of historical specificity. Lukács tended to create abstractions of the notions of reification and totality,²⁶ rather than treat them in their historically-specific contexts.²⁷

Korsch's approach is useful in overcoming Lukács' abstraction. Korsch notes that a holistic relation of social existence to consciousness cannot hold in all instances. Rather, he posits no general law, preferring to

25 "If by interaction we mean just the reciprocal causal impact of two otherwise unchangeable objects on each other, we shall not have come an inch nearer to an understanding of society. This is the case with the vulgar materialists with their one-way causal sequences (or the Machists with their functional relations)." Lukács, Georg, *op.cit.*: 13.

26 Levitt, Cyril, *op.cit.*: 84.

27 This is partially related to the coalescence Lukács' effects between objectification and reification, blinded to the fact that objectification alone was a necessary part of the human condition in the metabolic interrelation with nature. Reification, on the other hand, varies by social class and the relations of production (for example, reification of the class of social labour in capitalism). Hence, reification takes a historically-specific, concrete form in human thought. Levitt, Cyril, *op.cit.*: 76; Krader, Lawrence, *Dialectic of Civil Society*, Assen/Amsterdam: Van Gorcum, 1976: 8-9.

emphasize the need for historical specificity and the importance of research in determining the character of the consciousness/being relation in any particular case.²⁸

These epistemological and methodological concepts, particularly that of the historical specificity of the consciousness and being relation, inform the framework of the research problem addressed in this thesis. The theoretical possibility of a mediated totality allows us to move away from the dualist model of knowledge and social existence that characterized the women and medicine literature. It suggests how obstetric and gynecologic ideas about women arose out of the historically-specific context of the 1950s and, hence, were social. It does not assume that the content of the medical knowledge of women was a direct reflection of that social context.

This Sociology of Knowledge approach is used here to emphasize that obstetric and gynecologic knowledge was not generated by value and context-free medical research in a scientific vacuum. For that reason, no differentiation can be made between the social context of medical research and writing, and definitional categories of women that constitute scientific medical knowledge.²⁹ It is suggested

28 cf. Korsch, Karl, Karl Marx, N.Y.: Russell & Russell, 1963 (originally 1938): 214.

29 Rouse notes the power involved in creating classifications. Rouse, Joseph, Knowledge and Power. Toward a Political Philosophy of Science, Ithaca and London: Cornell University Press, 1987: 217.

that medical knowledge of women is not an apolitical, neutral entity which may at times be contaminated by external factors, resulting in distorted, ideological knowledge about women. Rather, the obstetric and gynecologic knowledge of the 1950s was not unusually distorted or in error. In fact, it may have frequently expressed aspects of gender relations and women's existence that were problematic for women themselves at that time. The main point, however, is that all of the medical knowledge can be viewed as social knowledge, not only those aspects which are now considered to have been in error.

Nor does the fact that social relations of power were involved in producing obstetric and gynecologic knowledge mean that power was merely an external influence which might distort the content of that knowledge.³⁰ Power was consistently an integral part of that knowledge production, an aspect of the social character of medical knowledge about women.

The Sociology of Scientific Knowledge

It is essential to turn to an examination of how scientific knowledge, specifically, is constructed. This issue is crucial for a project on obstetric and gynecologic knowledge of women to address, as medical knowledge has

30 Ibid: 255.

increasingly come to entail applied scientific knowledge. It is useful to investigate how the production of scientific knowledge generally proceeds, if we are to understand how medical researchers in any specific historical time and place constructed particular views of women. While the area of the Sociology of Science rarely deals with scientific knowledge about gender or women specifically, it is an area of study which is, potentially, theoretically and methodologically useful for such research.³¹

If we wish to examine the social construction of any form of scientific ideas, then the Sociology of Scientific Knowledge becomes a special case of the, more general, Sociology of Knowledge. Sociologists of scientific knowledge have taken up the Sociology of Knowledge question of which social processes are involved in the existential conditioning of thought, through the "production and acceptance of knowledge claims."³² What is the rationale for the connection between the Sociology of Knowledge and the study of scientific knowledge in particular? Collins expresses the relation between the two:

I see the mainstream concern of the sociology of scientific knowledge as being the *sociology of knowledge* and I see the concentration on science as

31 Studies of science and gender are found more frequently in the feminist literature, studies which are discussed in the next chapter.

32 Knorr-Cetina, Karin D. and Michael Mulkay, Science Observed. Perspectives on the Social Study of Science, London: Sage Publications, 1983: 9.

being a consequence of its suitability
as a social laboratory for the
exploration of ideas about knowledge in
general....it is the canonical
knowledge-producing institution.³³

Hence, the Sociology of Scientific Knowledge is
considered here, not as a project aimed solely at the study
of science for its own sake, but rather as entailing a wider
aim of discovering "*in what sense and to what degree we can*
speak coherently of knowledge as being rooted in social
life."³⁴ Some sociologists of science actually express the
hope of establishing "a new empirical foundation" for the
Sociology of Knowledge.³⁵

Acknowledgement of the social construction of science
implies that there is no epistemological privilege given to
the scientific form of knowledge.³⁶ It is no longer
considered particularly contentious to argue that scientific
knowledge is connected in some fashion to the social order,
rather than being autonomous, or that "statements of

33 Collins, H. M., "An Empirical Relativist Programme in
the Sociology of Scientific Knowledge," in Karin D. Knorr-
Cetina and Michael Mulkay, eds., *op.cit.*: 87.

34 Knorr-Cetina, Karin D. and Michael Mulkay, eds., *op.*
cit.: 14.

35 *Ibid*: 6.

36 Pinch, Trevor J. and Wiebe E. Bijker, "The Social
Construction of Facts and Artefacts: or How the Sociology
of Science and the Sociology of Technology Might Benefit
Each Other," *Social Studies of Science*, Vol. 14, #3, August,
1984: 401.

scientific fact may be theory-laden."³⁷ The main task for sociologists of science has now become the demonstration of *how* scientific knowledge is social.³⁸ This is precisely the question addressed in this research on the obstetric and gynecologic knowledge formulated about women during the 1950s.

There have been a number of studies of the work of scientists (e.g. Merton's *Sociology of Science*). However, there have been fewer research studies of the *Sociology of Scientific Knowledge*, meaning the social construction of scientific knowledge -- "what comes to count as scientific knowledge and how it comes *so* to count."³⁹ For some time it has been contended that the origins, and acceptance or rejection, of scientific knowledge are social processes.

However, the assertion that, additionally, the content and

37 Shapin, Steve, "Homo Phrenologicus: Anthropological Perspectives on an Historical Problem," in Barry Barnes and Steve Shapin, eds., Natural Order: Historical Studies of Scientific Culture, Beverley Hills: Sage, 1979: 42, cited in Steve Woolgar, "Interests and Explanation in the Social Study of Science," Social Studies of Science, Vol. 11 (1981): 365-94; Shapin, Steven, "History of Science and its Sociological Reconstructions," History of Science, 20, 1982: 157-211.

38 Shapin, Steve, "Homo Phrenologicus: Anthropological Perspectives on an Historical Problem," in Barry Barnes and Steve Shapin, eds., Natural Order: Historical Studies of Scientific Culture, Beverley Hills: Sage, 1979: 42, cited in Steve Woolgar, "Interests and Explanation in the Social Study of Science," Social Studies of Science, Vol. 11 (1981): 365-394; Shapin, Steven, "History of Science and its Sociological Reconstructions," History of Science, 20, 1982: 157-211.

39 Collins, H. M., "The Sociology of Scientific Knowledge: Studies of Contemporary Science," Annual Review of Sociology, 9, 1983: 265-85.

form of that knowledge are social products, is a more recent development.⁴⁰

This literature is particularly important to consider here, because some sociologists of scientific knowledge suggest how scientific and medical knowledge is social. Their central focus is on *how* science is conducted, particularly in laboratories, rather than on explanations of *why* particular constructions of scientific knowledge come about.⁴¹ This thrust contributes greatly to our understanding of the construction of knowledge about women. It analyzes the process by which all scientific knowledge is inherently social, as science is "done," and the resulting knowledge is constructed. This is not to say that all approaches to the Sociology of Scientific Knowledge overcome the problems involved in attempting to characterize the social nature of scientific knowledge. Some strands in this area of study take up a form of explanation that exhibits many of the same problems as are found in the women and medicine literature. Those that maintain a dualist explanation of the sociality of scientific knowledge fail to overcome the problem of a separation of science from social being, and hence, of focusing only upon "erroneous science." In fact, this problem is common to both literatures, partly because these dualist formulations in the Sociology of

40 Mulkay, Michael, Science and the Sociology of Knowledge, London: George Allen and Unwin, 1979: 2.

41 Knorr-Cetina, Karin D. and Michael Mulkay, op.cit.: 7.

Scientific Knowledge are precisely those which feminists apply to the study of science and medicine. This section, then, is a critical examination of some of the research done in the Sociology of Scientific Knowledge. It considers formulations of the construction of scientific knowledge that could help develop the literature on women and medicine, and contrasts them with those that reflect the existing problematic approaches to studying knowledge construction.

One of the fundamental assertions in recent studies of the social construction of scientific knowledge (e.g. the ethnomethodological, ethnographic and discourse analysis models) that is expressed in medical knowledge about women, is that scientific observation and interpretation are not separate moments. Rather, they are considered to be one process of construction of facts, in which interpretation inherently plays a part. This contrasts with the assumption of scientific method, that observation of facts comes

directly by way of the senses.⁴² Rather, observation necessitates interpretation of the meaning of a phenomenon, particularly as that meaning is removed from its original context and made general scientific property. The meaning of pain in childbirth, for example, was not directly observed by obstetricians during the 1950s. Its significance and implications, such as those that were discussed in the natural childbirth debate, varied according to the individual obstetrician and the particular nation into which a system of natural childbirth was imported.

While ethnomethodology has been primarily influenced by Garfinkel's work, discourse analysis of scientific accounts has utilized literary criticism and semiotics.⁴³ Overlapping with the ethnomethodological approach, discourse analysts in science concentrate upon uncovering *how* versions of scientific accounts are produced. Scientific discourse becomes the focus of analysis, rather than a tool for

42 Kuhn had stressed the point that theoretical paradigms consist of shared assumptions, supported by relations of power and authority. Kuhn, Thomas S., The Structure of Scientific Revolutions, 2nd edition, enlarged. Chicago: University of Chicago Press, 1970, cited in Donald A. MacKenzie, Statistics in Britain 1865-1930. The Social Construction of Scientific Knowledge, Edinburgh: Edinburgh University Press, 1981: 217. These paradigms, which are to be tested, in fact also influence what is considered to be proper evidence in any particular case. Knorr-Cetina, Karin D. and Michael Mulkey, op.cit.: 4-5; Lécuyer even refers to Kuhn's notion of "paradigm" as a <<forme cognitive de l'autorité.>> Lécuyer, Bernard-Pierre, "Bilan et perspectives de la sociologie de la science dans les pays occidentaux," Archives europeennes de sociologie, xix, #2, 1978: 311.

43 Knorr-Cetina, Karin D. and Michael Mulkey, op.cit.: 9.

examining "action and belief in science."⁴⁴ Hence, in our examination of obstetric and gynecologic texts, it is profitable to turn to these other analyses of how scientific texts are produced. Discourse analysts of scientific writing, for example, have indicated the social character of the construction of both content and form.

Through the processes of interpretation and negotiation, both within the scientific community and in the larger society, scientific claims come to be considered "adequate" by a "specific group of actors in a particular cultural and social context."⁴⁵ The values of that group of actors are developed in a particular sociocultural context and, in turn, influence the meanings attributed to concepts and objects.⁴⁶ These more micro-level studies in the Sociology of Scientific Knowledge, then, assume historical and cultural variability in the content of that knowledge, including its interpretations or meanings. It follows, then, that there cannot be any separation of the content of

44 Mulkay, Michael, Jonathon Potter, and Steven Yearley, "Why an Analysis of Scientific Discourse is Needed," in Karin D. Knorr-Cetina and Michael Mulkay, *op.cit.*: 195; Yearley, Stephen, "The Relationship Between Epistemological and Sociological Cognitive Interests: Some Ambiguities Underlying the Use of Interest Theory in the Study of Scientific Knowledge," *Studies in the History and Philosophy of Science*, 13, 4, 1982: 386.

45 Mulkay, Michael, *op.cit.*: 35, 43-6, 49, 54, 58, 61, 95. cf. Karin D. Knorr-Cetina and Michael Mulkay, *op.cit.*: 3-5, on the "theory-ladenness" of observation.; Knorr-Cetina, Karin D., *The Manufacture of Knowledge. An Essay on the Constructivist and Contextual Nature of Science*, Oxford: Pergamon Press, 1981: 2.

46 Pinch, Trevor J. and Wiebe, E. Bijker, *op.cit.*: 428.

science from its context.⁴⁷ Scientific knowledge is viewed as a constructed, social product, an integral part of wider social life and experience.⁴⁸

Yet this social character, integral to the production of science, is erased from the presentation of scientific writing in textbooks and journal articles. Discourse analysts suggest that the formal language in which scientific or medical knowledge is couched has usually had any modalities or qualifiers removed by the time it reaches the texts and journals. This means of presentation obscures the active negotiation that goes into the construction of facts and concepts of nature⁴⁹, including concepts of female nature.

In fact, the more dissent a debate entails, the more the literature drawn upon and generated becomes scientific and technical. The writing becomes increasingly dense and apparently non-social, as material (such as scholarly references) is employed as rhetorical resource against other

47 Bruno, Latour, *Science in Action*, Cambridge, Massachusetts: Harvard University Press, 1987: 4,6.

48 In dealing with scientific knowledge and "facts," it is important to remember that, as Latour has pointed out, the word "fact" means "that which has been made," coming from the Latin *facere*, "to make." Noted in Knorr-Cetina, Karin D., *The Manufacture of Knowledge. An Essay on the Constructivist and Contextual Nature of Science*, Oxford: Pergamon Press, 1981: 3.

49 Pinch, T. J. and H. M. Collins, "Private Science and Public Knowledge: The Committee for the Scientific Investigation of the Claims of the Paranormal and its Use of the Literature," *Social Studies of Science*, Vol. 14, #4, November, 1984: 522, 523.

anticipated, rhetorical attacks. Yet this material is in fact composed of associations among researchers and authors of journal articles and texts, in other words, the resources and their usage possess a social content.⁵⁰

Medical science, of course, also obscures its social character by wrapping its content within technical writing. The Sociology of Scientific Knowledge studies provide clues as to the manner in which medical observations and facts contain interpretations and how those social processes result in particular forms of medical writing about women.

These recent studies in the Sociology of Scientific Knowledge differ in their formulations of the social character of science, relative to earlier studies. For example, Kuhn had demonstrated the historical and social elements involved in scientific change. But sociologists have since looked to more than paradigms and internal revolutions to explain such change. There has been a dissatisfaction with Kuhn's divorcing of the *content* of scientific knowledge from its context of institutional and wider social processes, and his lack of formulated connections between various conceptual, social and institutional levels.⁵¹

50 Latour, Bruno, *op. cit.*: 15, 30, 31, 46.

51 Mendelsohn, Everett, Peter Weingart and Richard Whitley, eds., *The Social Production of Scientific Knowledge*. Dordrecht: D. Reidel Publishing Co., 1977: 7.

Mannheim, for example, completely exempted science from the realm of social influence. The assumed asocial character of the content of science, in particular, has been a significant component of the Sociology of Science of Merton and Ben-David. Ben-David allowed that the social context can influence science, but only in a delimited fashion. Usually this was conceptualised as entailing a negative influence, in that science was thrown off its normal, progressive path.⁵² Such a sociology of error and Merton's separation of science and ideology contrast with the recent studies which are used here.⁵³ The micro approaches in the Sociology of Scientific Knowledge emphasize their difference from the reflective epistemology of modern science.⁵⁴ They dispute scientists' own claim that scientific accounts reflect any fundamental, material reality "out there." The accounts given by scientists are considered by these sociologists of science to be the only reality that exists.

These micro approaches also do not separate social context from scientific account or knowledge. Scientific knowledge is not conceptualized as containing social

52 MacKenzie, Donald A., op.cit.: 2.

53 Mulkay, Michael, op.cit.: 10; O'Neill, John, "Marxism and the Two Sciences," Philosophy of the Social Sciences, 11, 1981: 293.

54 cf. Mendelsohn's anatomy of science as including "a way of knowing" comprised of rationalism, empiricism, and an underlying belief in a material reality. Mendelsohn, Everett, "The Social Construction of Scientific Knowledge," in Everett Mendelsohn et al., op.cit.: 6.

influences or components (such as interests or mediations). Rather, these studies contend that all scientific processes that contribute to the construction of knowledge are inherently social.

This approach is a valuable foil against reflection theories and dualistic formulations wherein social being is considered an entity autonomous from consciousness and knowledge. Laboratory and discourse studies can also provide detailed interpretations of the processes involved in scientific construction. However, their analyses are narrowly restricted to the scientific community itself and provide little consideration of the links between that community and the broader social sphere. Although they have attempted to overcome Kuhn's explanatory internalism, the ethnomethodologists are methodologically consistent with Kuhn's emphasis upon the scientific community itself.⁵⁵

Knorr-Cetina offers a constructivist and ethnographic model of scientific knowledge in an attempt to bridge the gap between the micro and macro levels of analysis. She continues the micro concentration upon the experimental construction of science in the laboratory, but broadens the scope of study of the scientific community to a number of

⁵⁵ Methodological internalism consists of an analysis of the internal workings of scientific practice, whereas explanatory internalism refers to the notion that factors "internal" to science itself are adequate to explain the development of scientific knowledge. Hence, the latter excludes social influences from its analysis. Knorr-Cetina, Karin D. and Michael Mulkay, op.cit.: 6-7.

"situational contingencies," including the role of funding agencies and the availability or scarcity of technical resources, among others. Local resources are seen to play an "opportunistic" role in the selection and development of scientific ideas.⁵⁶

The earlier Sociology of Science approach, which emerged out of Mannheim's exclusion of the natural sciences from a Sociology of Knowledge analysis, neglects study of how scientific concepts and theories are actually socially constructed as "science." It also leads to dualist research on the effect of "extrascientific," social influences upon science, resulting in the sociology of error approach.⁵⁷ Essentially, science is posited in a realm of the non-social, a realm of the non-rhetorical.⁵⁸ Hence, the realist calls upon the category of "Nature" as the ultimate judge of the error or truth of scientific knowledge. Past failures⁵⁹ in science are explained from a contemporary standpoint, as the result of error (basically a Whig history approach).⁶⁰ As we have seen in the women and medicine literature, this is essentially the problem which emerges there as well. Many analyses of the construction of medical knowledge about women do not entirely overcome the sociology of error

56 Knorr-Cetina, Karin D., *op.cit.*: 33-5, 46-7, 83, 87-94.

57 Brannigan, Augustine, *The Social Basis of Scientific Discoveries*. Cambridge: Cambridge University Press, 1981: 63, 79.

58 Latour, Bruno, *op.cit.*: 21, 61.

59 *Ibid.*: 100.

approach, as the social character of all the knowledge produced is not completely acknowledged.

These problematic aspects are found in the schools of thought which emphasize "interests" as a social component of medical or scientific knowledge. This is frequently the approach taken in the women and medicine literature, when the construction of medical knowledge is dealt with. The notion of particular interests is given primacy particularly in the "mediative constructivist" accounts of the Strong Program of the Edinburgh School, of which Barnes, Bloor and MacKenzie are the primary representatives. The mediative constructivist approach considers the broader social context of scientific knowledge to a greater extent than do the ethnomethodological and discourse analysis studies, an aspect consistent with the intent of this research on the construction of a body of medical knowledge. In fact, it is also more akin to the traditional Sociology of Knowledge, although the mediative constructivist model posits a *weaker* link between social factors (such as interests) and ideas.

than do sociologists of knowledge.⁶⁰ The micro studies were formulated partially as a response to the inadequacies of this more macro approach in dealing with the social construction of scientific knowledge. As we shall see, the mediative constructivist model contains aspects which have been identified as problematic in this study of medical knowledge, including in the form in which they have been carried over into the literature of the construction of medical knowledge about women.

Interest Theory views cognitive, instrumental interests as mediating factors between an object and the construction of the scientific account of that object. This is not, as is claimed by proponents of this theory, a wholly relativist stance, as Barnes' usage of "reality," for example, implies

60 This is not the case in the broad sense, but rather in the narrow sense of the imputation of social interests or goals to a particular social group, whose beliefs have an affinity with those interests. Knorr-Cetina refers to the example of a link made by Marx between an individual's economic or philosophic ideas and "bourgeois" interests, in his *A Contribution to the Critique of Political Economy*. It should be noted, however, that Marx did not posit this relation as a universal one, nor as a case of causal determination of beliefs via "interests" of any sort. This point is particularly important to note in the following discussion of Interest Theory in the Strong Program. Marx, Karl, *A Contribution to the Critique of Political Economy*. New York: International Publishers, 1968 (originally 1859), in Karin D. Knorr-Cetina and Michael Mulkay, eds., *op.cit.*: 115.

a strong realist aspect to this approach."⁶¹ Strong Program adherents, in fact, are confronted with the problem of justifying their own claims while relativizing all others. Bloor and Barnes' solution is not completely convincing, as they argue that reflexivity regarding their own sociological position is sufficient, and that the truth-value of any belief is irrelevant to their study. The Strong Program adherents do not utilize Lukács' argument that the knowledge claims of subordinate social groups should be privileged. Rather, Bloor and Barnes take a traditional positivist stance in response to opposition to their relativism (opposition which they characterize as partially owing to academics' penchant for "moralizing"). They see their form of relativism appealing to sociologists doing more "disinterested research."⁶²

While Barnes appeals to Lukács as a resource in his work, their two epistemologies are, in fact, contrasting.

61 Woolgar, Steve, *op.cit.*: 506-7; cf. also: Woolgar, Steve, "Irony in the Social Study of Science," in Karin D. Knorr-Cetina and Michael Mulkay, eds., *op.cit.*: 252-3. Here Woolgar explains that (as in the ethnomethodological approach) if it's assumed realities are "entirely equivalent to the way they are accounted," then one can't see an object's nature as unchanging. However, in the case of the Strong Program's "relativism," nature is seen as incapable of influencing accounts of itself and it is assumed that diverse interpretations of that "same (unchanging) thing" can result, i.e. there is an underlying stance of "epistemological realism."

62 Barnes, Barry and David Bloor, "Relativism, Rationalism and the Sociology of Knowledge," in Martin Hollis and Steven Lukes, eds., *Rationality and Relativism*, Oxford: Basil Blackwell, 1982: 47.

As we saw in our discussion of the Sociology of Knowledge, Lukács holds a notion of a holistic totality, within which is contained mediations, as moments of that whole. Barnes misinterprets Lukács, however, and uses Lukács' concepts in a positivist, dualistic fashion. Barnes and others in the Strong Program treat mediations, such as interests, as intervening between two autonomous realities - the object of analysis and the scientific account of that reality. There is no notion of a potentially cohesive, intertwined totality. Other critics have noted that this dualist conceptualization exempts aspects, particularly interests, from social construction. They are taken, rather, as an *a priori* given. In fact, there is lacking an acknowledgement of the social character of all scientific thought and practice. This notion of scientific practice as having "social components" assumes a non-socially influenced aspect and "ignores the processes of construction whereby scientists themselves manage and attribute interests."⁶³ A concept like that of "interest" implies that only some

63 This notion of scientific practice as having "social components" assumes a non-socially influenced aspect and "ignores the processes of construction whereby scientists themselves manage and attribute interests." This reference is to Bruno Latour and Steve Woolgar, *Laboratory Life: Social Construction of Scientific Facts*, New York: Sage, 1979, in Yearley, Stephen, *op.cit.*: 387; Woolgar, Steve, *op.cit.*: 375.

beliefs may be socially-influenced and/or ideological."⁶⁴
 In the analysis of a particular case, then, the socially constructed nature of the interests involved in the production of scientific or medical knowledge would itself be exempt from examination.

This conceptualization of a duality is logically linked with the Strong Program's aim of producing causal explanations, rather than understandings of scientific constructions. Barnes, for example, claims to be a relativist, holding no criteria to be absolute. Yet he in fact assumes the autonomy of different phenomena. This leads him to rely on "a causal-type explanatory scheme. Interests can be used to *explain* knowledge generation."⁶⁵ Barnes puts forth no general theory of the nature of the relation between particular interests and social groups. Yet he posits interests as *the* universal causal factor in the construction of scientific knowledge, despite viewing the form of that construction as variant by historically-specific instance. Barnes ignores the larger question of

64 Yearley, Stephen, "The Relationship Between Epistemological and Sociological Cognitive Interests: Some Ambiguities Underlying the Use of Interest Theory in the Study of Scientific Knowledge," Studies in the History and Philosophy of Science, 13, 4, 1982: 387.

65 Lécuyer notes Barnes' debate with Lukes on such fundamental notions as causal analysis and rationality, and then states that: <<Barnes semble vouloir rejeter tout critère absolu, univoque et universel de rationalité et de scientificité...tout en se défendant d'être contraint pour autant de verser dans un relativisme ruineux pour l'analyse causale qu'il entend défendre.>> Lécuyer, Bernard-Pierre, op.cit.: 325; Woolgar, Steve, op.cit.: 368-9.

the historical specificity of interests themselves as a factor.⁶⁶

Barnes' own perspective strongly informs his reading of Lukács, so that Barnes is unable to recognize the difference between his own conception of interests as a mediating factor and Lukács' Hegelian notion of class interests as part of a dialectical totality. Barnes does allude to Lukács' holism when discussing the partial consciousness of social classes, as being restricted by the particular interests of each. He notes that for Lukács, "We can only properly understand an aspect of reality by considering it in context, in relation to everything else...."⁶⁷ Yet Barnes goes on to interpret Lukács in a non-Hegelian sense, as holding deterministic views and a correspondence or reflection theory of knowledge. This is precisely, as Barnes himself notes, the contemplative type of position which Lukács vehemently opposed! Barnes contends that,

It follows that the particular
restricted interests of a class set
limits upon the whole of its thinking.

66 See Barnes' statements regarding historical specificity and general theory. Barnes, Barry. Interests and the Growth of Knowledge. London: Routledge and Kegan Paul, 1977: 58.

67 Ironically, Barnes accuses Lukács of neglecting "the fact that men's thinking is always an extension of earlier thought...and that consciousness is to this extent always the product of history." Barnes is implying that Lukács is not paying sufficient heed to the original tracts of Hegel. This is a problematic aspect of Barnes' critique, since Lukács was attempting to follow Marx in moving *beyond* Hegel's idealist formulation (and beyond reflection theory and contemplative materialist approaches). *Ibid.*: 11-12.

and *logically determine* the most that it can hope to produce in the way of knowledge. To every class there corresponds an ideal class-consciousness. ...Without in any way addressing the problematic question of what Lukács's own views were on the subject, it is worth noting that his account is readily intelligible if we assume that the knowledge which men generate in the course of their practice is in some sense a copy, reflection or picture of an aspect of reality.⁶⁸

Barnes argues that Lukács ignored the influence of past knowledge upon new, and states regarding Lukács' approach:

It assumes instead an unproblematic interaction between men and reality, with a third variable, interest, effectively doing no more than accounting for the restricted scope of that interaction. ...And, accordingly, interest can no longer determine consciousness by restricting it to involvement with some section of the whole of reality.⁶⁹

Lukács' original sense of historical specificity and mediated totality are lost, as can be seen in this transformation of his stance, as effected by Barnes. This allows Barnes to read Lukács in such a way that Barnes could posit interests as factors, universally determinant of consciousness and knowledge. In addition to Barnes' own perspective, Lukács' internal contradiction on the point of

68 Ibid.: 11-12.

69 Ibid.: 11-12.

historical specificity, may have contributed to this particular interpretation.⁷⁰

Barnes, and Interest Theory as a whole, take a more universalistic stance, one already widely disputed by Marx's notion of "ideology," Mannheim's "perspectivism," and Kuhn's "paradigmatic" science. Barnes and the Strong Program proponents posit interests as predominant and universal social influences. This contributes to their neglect of the point raised by contemporary critics, as well as by Lukács, Marx, and Korsch, that social influence on knowledge must be considered in a historically-specific manner.

The same problems, not surprisingly, arise in the application of Interest Theory to historical study. MacKenzie, for example, studied how social (class) interests, through the mediation of eugenics beliefs, influenced the development of statistical theory. His research has been criticized for *assuming* the primacy of socio-political interests. There is also inadequate definition of "interests" or consideration of the influence on beliefs of the "conflicting interests" of a group.⁷¹ MacKenzie notes that such conflicting beliefs can exist, but argues that "tendencies" of social influence on a particular group can still be uncovered. MacKenzie identifies this

70 See the discussion on the Sociology of Knowledge in the first part of this chapter for elaboration of this problem in Lukács' work.

71 Yearley, Stephen, *op.cit.*: 373-5.

approach with that of Lukács and Lucien Goldmann, yet goes on to develop an antithetical functionalist and reflection theory in his historical work.⁷² Again, in the name of Lukács, an Interest Theory is promulgated which has little affinity with that original work's fundamental assumptions and conceptualizations. Owing to this theoretical confusion, it is necessary to differentiate between Lukács' work, as it forms part of the framework of this research on medical knowledge, and the interpretation of it by the Strong Program in the Sociology of Scientific Knowledge. Only through that exercise, is it possible to clarify why such a model as Interest Theory is unsatisfactory as a framework for socio-historical research, when uncritically taken up as a whole. As it stands now, such sociologists and historians of science frequently rely on the "coercive model" of the Sociology of Knowledge, rather than availing themselves of more complex and potentially more fruitful approaches.⁷³

72 MacKenzie, Donald A., *op.cit.*: 6, 5.

For examples of MacKenzie's functionalist and reflection theories, see pp. 50-2 and 72. For example, he concludes that, "the needs of eugenics in large part determined the content of Galton's statistical theory."; "And Galton's eugenics reflected the social interests of the groups of elite professionals...."

73 Shapin defines the "coercive model" as one which assumes that most individuals in any social situation will take up a particular intellectual position, and that the character of the relation between social situation and belief is one of "determination." Shapin, Steve, *op.cit.*: 194-5.

An examination of the Sociology of Scientific Knowledge, then, conveys the basis for some of the problematic assumptions found in the women and medicine literature, assumptions being contested by this research on the construction of obstetric and gynecologic knowledge. But some approaches also inform this study regarding the relation between socially constructed, scientific knowledge and social existence. These recent studies suggest what characterizes this relation and how this social construction comes about, in a specific form, and at any particular point in time. On a general level, the social nature of even the content of scientific knowledge is highlighted by the Sociology of Scientific Knowledge. Kuhn's points, that science is paradigmatically-based and that scientific observations are theory-laden, emphasize the socially-constructed nature of observations and interpretations. As the historian Charles Rosenberg comments, society can affect the "particular texture of scientific thought," as

scientists have -- especially in
medicine and certain areas of biological
research -- incorporated social
perceptions into the formal texture of
their work.⁷⁴

As we have seen, these notions have recently been supported by other scholars in the area. Ethnomethodological studies.

74 Rosenberg, Charles E., No Other Gods. On Science and American Social Thought. Baltimore and London: The Johns Hopkins University Press, 1976: 19.


for example, bring to light the construction of scientific facts and their decontextualization in texts.

Such studies point to the fact that the influence of social factors are not the only, or perhaps even the primary way, in which science and medicine are social. For example, scientific and medical discoveries are socially developed categorizations, tied to their context and interpretations.⁷⁵ The associations created by scientists and employed as resources in ongoing controversies, are social aspects in what comes to be accepted in science as "fact," or is relegated to the status of "artefact."⁷⁶ This dissertation research on medical science is a case example in which the relation of obstetric and gynecologic content to its context is examined. The Sociology of Scientific Knowledge suggests a manner in which the construction of medical knowledge about women is an inherently social process, rather than a dualist one in which external social influences produce incorrect knowledge. How that medical knowledge comes to be considered medical fact at all, is the question which needs to be addressed. What is accepted as medical fact about women's biology is itself a social process, even though this is difficult to discern in the obstetric and gynecologic texts, as they become increasingly

75. Mulkay, Michael in the introduction to Brannigan, Augustine, *op.cit.*: ix; Brannigan, Augustine, *op.cit.*: 63, 77.

76 Latour, Bruno, *op.cit.*: 7-9, 25, 62.

"technical." Inquiry into how it becomes defined as technical knowledge frames the issue in terms which avoid setting up medical knowledge as social only when in error or ideological, and as social only in the sense of being influenced by external social factors. Hence, this allows the possible social character of all medical knowledge to be explored.



Chapter 3

The Construction of Scientific Knowledge of Women

Some approaches in the Sociology of Scientific Knowledge point to ways in which scientific knowledge is fully social. If we apply these approaches to the study of medical knowledge, we move towards overcoming the problem of a separation of medical from social knowledge. We do not have factually correct, objective knowledge about reproductive physiology over here, for example, and socially-influenced, incorrect and ideological medical knowledge over there. Such dualist models still exist in the Sociology of Scientific Knowledge, as we have just seen, and are drawn upon in studies of medicine and women. As the Sociology of Scientific Knowledge does not deal directly with science's construction of women, however, other studies have emerged which examine the relation of science more specifically to gender. This dissertation concentrates upon the formation of "women" in and by a scientific, medical culture during the 1950s. Hence, it is important to consider how studies of gender and science conceptualize the social construction of women.

What we find in this, predominantly feminist, research on science and gender is a trend in the direction of

analyzing the social character of all scientific knowledge about women. Studies are moving away from critiques of only gender constructions by biased, erroneous science. This entails a growing focus upon the effect of prevailing gender systems upon the construction of scientific knowledge about biological sex. No longer is research concentrated solely on construction of gender in scientific knowledge, based on findings about biological sex. However, ambivalence about this direction of critiquing science as fully social results in the same problem identified in the two previous chapters. It is a phenomenon which is partially rooted in the limited interaction the Sociology of Knowledge and of Scientific Knowledge have with feminist work on scientific knowledge.

As noted earlier, sociologists of scientific knowledge have raised the issue of the relation between science and society, yet haven't considered gender as part of that relation. In noting that this body of literature is not particularly "gender sensitive," Harding comments that "the usual array of androcentric gaps and distortions appear in these recent studies too."¹ Harding is claiming that this literature contains "bad" or incorrect science due to the application of androcentric interests. She believes that "post-Kuhnian" Sociology of Science continues the treatment

¹ Harding, Sandra, *The Science Question in Feminism*. Ithaca: Cornell University Press, 1986: 198.

of gender "as a biological given rather than as a social construct."²

On the other hand, feminist theorists have brought attention to the relation of gender to society, without considering science in the relation.³ Little research in the Sociology of Scientific Knowledge is considered, other than occasional references by feminist scholars, such as to the work of Kuhn.⁴ Two exceptions to this are writings by Dorothy Smith and Sandra Harding. Smith, for example, refers to Lynch's work on science and to Latour and Woolgar's ethnomethodological research.⁵ Harding refers to ethnomethodological laboratory studies as well, and draws on the work of David Bloor.⁶ As Bloor is a member of the Strong Program, the conceptual problems discussed regarding that approach, are also found in Harding's work. Smith⁷ and

2 Ibid.: 201.

3 Keller, Evelyn Fox, *Reflections on Gender and Science*, New Haven: Yale University Press, 1985: 4.

4 Kuhn, Thomas S., *The Structure of Scientific Revolutions*, 2nd edition, enlarged, Chicago and London: The University of Chicago Press, 1970.

5 Lynch, M., "Discipline and the Material Form of Images: An Analysis of Scientific Visibility" (Paper Presented at the Annual Meeting of the Canadian Sociology and Anthropology Association, Vancouver, 1983 and now published in *Social Studies of Science*, Vol.15, 1985); and Latour, B. and S. Woolgar, *Laboratory Life: Social Construction of Scientific Facts*, New York: Sage Publications, 1979, cited in Smith, Dorothy, "Textually mediated social organization," *International Social Science Journal*, Vol. 36, #1, #99, 1984: 65.

6 Bloor, David, *Knowledge and Social Imagery*, London: Routledge and Kegan Paul, 1977, cited in Harding, Sandra, *op.cit.*: 34.

7 Smith, Dorothy, *op.cit.* passim.

Farganis⁸ both utilize mainstream Sociology of Knowledge studies. Yet, again, the tendency in these studies is to cite Mannheim⁹ as the prototype sociologist of knowledge, and then to move on to the researcher's own immediate concerns. This results in a neglect of major advances in research on knowledge and science which could contribute to the development of feminist analyses. I would suggest that feminist researchers studying gender in both knowledge and science need to selectively consider the work done in the fields of the Sociology of Knowledge and of Scientific Knowledge, avoiding the perpetuation of the problems of the dualist approaches in these other literatures.

Critiques of Erroneous Scientific Knowledge of Gender

We can see, in following the development of feminist studies of science and gender, that the general trend is parallel to that in the Sociology of Scientific Knowledge - towards a study of science as usual, of science as fully social. However, the limited range of the Sociology of Scientific Knowledge used contributes to the continuation of some problematic elements from the earlier work on gender and science. Feminist investigations of knowledge and

8 Farganis, Sondra. *The Social Reconstruction of the Feminine Character*. Totawa, N.J.: Rowman and Littlefield, 1986.

9 Mannheim, Karl. *Ideology and Utopia*. New York: Harcourt, Brace and World, Inc., 1936.

science previously centred around the question of the social origins of distorted, ideological beliefs about women in scientific knowledge. Of particular concern was the notion in science that these social beliefs about women had been brought about by forces external to human society. This can be seen, for example, in the frequent scientific references made to "nature." Nature, in this case, referred to biological sex and was used as a basis, in science or medicine, for the construction of gender. According to Allen and Wiggins, this is

a fallacy endemic to human consciousness and society: human beings overlook the human origin of their social constructs and misconceive them as things. Thus women have been victimized by the fallacy of reification.¹⁰

A major theme in feminist studies of science is that early modern science and medicine associated women with "passive nature." Femininity has been symbolized as naturally passive, creating a disjunction with the reality of women's lives:

the lack of fit between ideas and experience clearly points to the ideological function of the nature/culture dichotomy as applied to gender. This ideological message was

10 Allen, Annette and Osborne Wiggins, "The Feminist Critique of Self and Society: a Phenomenological Metacritique," *Catalyst*, #10-11, Summer, 1977: 46.

increasingly conveyed in the language of medicine(p.42).¹¹

The concern is that medical and scientific beliefs regarding the nature of women have taken the form of essentialist thought and developed into assumed universal truths - truths purported to be based on biological difference.¹² However, any study of the social construction of female nature by medicine or science must consider the historically and culturally-variable meanings of concepts like "nature" or "the natural." There has arguably been no absolute, universal symbolic equation made between nature and female, culture and male.¹³ Still, concern for maintaining social stability and order tends to lead to efforts to maintain a distinct separation of the sexes and their social roles.

11 Jordanova, L. J., "Natural Facts: A Historical Perspective on Science and Sexuality," in C. MacCormack and M. Strathern, eds., *Nature, Culture and Gender*. New York: Cambridge University Press, 1980, cited in Harding, Sandra, *op.cit.*: 118.

12 Messing advocates that we regard scientists and their claim to objectivity skeptically and examine "what scientists have to say about the nature of women." Meanwhile, Bleier is concerned about biologically determinist ideas used as scientific explanations of the origins of gender differences and inequities, particularly the dominance of such ideas during times of social unrest. Messing, Karen, "The Scientific Mystique: Can a White Lab Coat Guarantee Purity in the Search for Knowledge about the Nature of Women?," in Greta Hofmann Nemiroff, ed., *Women and Men. Interdisciplinary Readings on Gender*. Toronto: Fitzhenry and Whiteside, 1987: 113; Bleier, Ruth, *Science and Gender. A Critique of Biology and Its Theories on Women*. New York: Pergamon Press, 1984: vii, viii, 12, 164; Schiebinger, Londa, "The History and Philosophy of Women in Science: A Review Essay," *SIGNS*, Vol. 12, #2, Winter, 1987: 323.

13 Carol P. MacCormack and Marilyn Strathern, eds., *op.cit.*: 20-1; Jordanova, L. J., *op.cit.*: 45.

particularly during periods of rapid social change.¹⁴ Some studies interpret this concern for differentiation of the sexes as an historical attempt to use science and medicine for social control of women. This control includes the countering of women's strivings beyond what is deemed, at any particular time, to be their biological destiny or nature. Such attempts at social control may be expressed in terms of medical concern about women's rejection of their reproductive and mothering roles, which, it was feared, would potentially lead to race suicide.¹⁵ However, when such notions have arisen, gender must already have been considered a general social problem and a matter for medical debate. Only then could the very question of the biological nature of gender be taken up by science.¹⁶ Otherwise, it is unlikely that the question of the nature of women would have been considered an important part of the research agenda.

That question became part of medical and scientific research, particularly because it existed in a scientific-

14 One way in which this was expressed was through medicine: "At certain times (perhaps times of perceived rapid change), physicians were deeply concerned about the feminization of men, for which homosexuality could be adduced as evidence, and the masculinization of women, which they believed could result from excessive physical or mental work." Jordanova, L. J., *op.cit.*: 43, 44.

15 Bleier, Ruth, *Science and Gender. A Critique of Biology and Its Theories on Women*, New York: Pergamon Press, 1984: 2.

16 Bleier is paraphrasing Margaret Osler here. Osler, M. "Apocryphal Knowledge: The misuse of science," in M. Hanen, M. Osler, and R. Weyant, eds., *Science, Pseudo-science and Society*, Calgary: Wilfrid Laurier University Press, 1980; Bleier, Ruth, *op.cit.*: 195.

technological culture. Scientific discourse participates in the social construction of gender, as frequently, "the grounding of social roles in biological differences takes a scientific form in our society."¹⁷ Appeals to science abound in this culture, providing a semblance of authority even to popular culture writings.¹⁸ Feminist scholars' attempts to understand the process of the scientific construction of women first gave rise to an analysis of the social construction of knowledge about gender in general. More recently, these scholars have developed critiques of the construction of gender within the social and natural sciences.

The Social-Constructivist Critique of "Normal" Science

Many of the same themes which appear in feminist work on knowledge in general, appear in the research on science's views of women. Essentially, feminist theorists view the relation of science to women as a political question, in that the power relations involved are of major interest. Many of these theorists contend that gender is constructed as part of an inherently political act. Some argue that the fact that science itself is socially-situated and influenced

¹⁷ Hubbard, Ruth in Marian Lowe and Ruth Hubbard, eds., Woman's Nature. Rationalizations of Inequality. New York: Pergamon Press, 1983: 2.

¹⁸ Harding, Sandra, op.cit.: 16.

by its socio-historical context, means that science is political, as are all human enterprises.¹⁹

Critiques of the claim in science, that gender is based on biological sex differences, eventually led feminist researchers to question the development of knowledge about biological sex differences as being based on social constructs of gender as well. No longer is it only bad science or biased medical research on gender which are being questioned, but also the ongoing production of all scientific knowledge (for example, about biology) and the deeper construction of science. The basis of scientific knowledge about biological sex is being investigated, for example, in terms of the gendered character of that process of knowledge production. It is argued that one of the reasons knowledge and science construct feminine gender and biological sex in certain ways, is that the theoretical and methodological bases of those constructions are themselves highly gendered (in a predominantly masculine direction).²⁰ Evelyn Fox Keller notes that it has become imperative to inquire into

how ideologies of gender and science
inform each other in their mutual
construction, how that construction
functions in our social arrangements,

19 Fausto-Sterling, Anne, Myths of Gender. Biological Theories About Women and Men, New York: Basic Books, Inc., 1985: 207.

20 Harding, Sandra, op.cit.: 200; Farganis, Sondra, op.cit.: 184; Bleier, Ruth, op.cit.: 206.

and how it affects men and women,
science and nature.²¹

Feminist scholars have begun to examine the construction of gender and nature in concrete instances, in order to reveal how science and medicine are used to maintain male dominance and the specific ways in which this is translated into scientific research and knowledge. One study, for example, examined the idea that concepts of nature, biological sex in this case, provides the basis for ideals of womanhood. A historical study of the metaphors used to describe women during the historical development of biomedical science was conducted. This study suggested that the ideal biomedical stereotypes of women that resulted were related to the particular characteristics of the group which generated them - middle class professionals who gained status from their possession of exclusive knowledge and who saw scientific and medical knowledge as the key to progress.²²

Essentially, the problem at hand has become not only how gender and biological sex are constructed by science, but simultaneously, how science is influenced by gender and sex.²³ Yet science and sex/gender need not be considered wholly distinct categories, autonomous of each other. Harding points out that

21 Keller, Evelyn Fox, *op.cit.*: 8.

22 Jordanova, L.J., *op.cit.*: 42 & 64.

23 Harding, Sandra, *op.cit.*: 57.

the scientific beliefs of different eras bear the distinctive marks of the social relations through which they were produced.²⁴

And these social relations include gender relations. As Harding notes, historians have not studied "how real and threatened changes in social relations between the genders have affected the history of science."²⁵ Generally, the social relations which form the context for the production of scientific knowledge have been neglected. Smith, however, has developed an approach to the study of texts and discourse, including scientific discourse, which emphasizes

actual ongoing practices and sites of practices, the material forms of texts (journals, reviews, books, conferences, classrooms, laboratories, etc.), the methods of producing texts, the reputational and status structures, the organization of powers intersecting with other relations of ruling in state agencies, universities, professional organizations, and the like....specific forms of social relations, accomplished in determinate socially organized practices.²⁶

Investigation of the construction of gender and sex in science requires understanding the initial construction of scientific knowledge through particular social relations - gender relations, for example.

24 Ibid: 69.

25 Ibid: 80.

26 Smith, Dorothy E., The Everyday World as Problematic. A Feminist Sociology, Toronto: University of Toronto Press, 1987: 214.

Feminist work, in considering the gendered context of the production of scientific knowledge about women, has moved away from a consideration of patriarchal social relations as being primarily external influences upon the construction of knowledge. Rather, much knowledge is conceptualized as being fully patriarchal or "male-stream."²⁷ Scholars have indicated that this situation is partially the result of women's lack of power, traditionally, to participate in the construction of such knowledge.²⁸

This direction has further contributed to the project of developing an alternative mode of knowing to that which gave rise to past scientific knowledge about women. The creation of a new epistemology and even a "feminist, successor science" are being pursued. This would involve a

27 The use of discourse theory by Dorothy Smith, for example, brings out the importance of decontextualising the construction of texts of knowledge and science. Smith, Dorothy E., "Textually mediated social organization," International Social Science Journal, Vol. 36, #1, #99, 1984. Others, such as Margrit Eichler, discuss this progression in feminist thought on the Sociology of Knowledge. Eichler specifically brings out the points on the patriarchal basis of most knowledge in the social sciences, the possibility of an alternative women's standpoint of the production of knowledge, and also the questioning of positivist, "value-free" science. Eichler, Margrit, "And the work never ends: feminist contributions," Canadian Review of Sociology and Anthropology 22:5, December, 1985: 631-3. cf. the work of Mary O'Brien on "male-stream thought," The Politics of Reproduction, Boston: Routledge, Kegan and Paul, 1981.

28 See, for example: Tancred-Sheriff, Peta, "Women's Experience, Women's Knowledge and the Power of Knowledge: An Illustration and an Elaboration," Atlantis, Vol.10, no.2, Spring, 1985: 108.

reconceptualized notion of the relation of knowledge to social experience. It is a project and a debate which is a general one, going beyond the areas of science and medicine. There seems to be a consensus that the current, mainstream scientific paradigm is overly empiricist and positivist. Additional suggestions are that feminist science would include "decentered knowledge-seeking,"²⁹ more contextual science, fewer dualistic separations such as those between subject and object, more use of empathic understanding in research, and so on. This is an aspect of the feminist critique of science which supports the direction taken by phenomenology and Critical Theory.³⁰

Some argue that a fundamental critique of science will develop out of the inclusion of women in the scientific process.³¹ The implications of this critique might go beyond merely providing an alternative, women's approach. Evelyn Fox Keller warns that complementary masculine and feminine perspectives in scientific knowledge are insufficient. Rather, she recommends a "gender-free science" which would

29 What Harding means by this is that it is a way to knowledge opposed to "androcentric" science where knowledge claims are evaluated in comparison to the "one true story" of reality. Harding, Sandra, *op.cit.*: 55; See also Evelyn Fox Keller's rejection of scientific hegemony or claims to "universal truth." Rather, she states, we should aim for "diverse conceptions of mind and nature" and diverse methodologies. Keller, Evelyn Fox, *op.cit.*: 178.

30 Farganis, Sondra, *op.cit.*: 183.

31 Eisenstein's view is that inherent in feminist empiricism is a radical challenge to traditional empiricism. This is mentioned by Sandra Harding, *op.cit.*: 162.

represent "a transformation of the very categories of male and female, and correspondingly, of mind and nature."³²

Problems in Achieving a Feminist Critique of "Normal" Science

There is a disjunction, though a very blurred one at this point, however, between noting that current social and scientific theories are masculinist and inquiring as to how this came about in the construction of science.³³ Labelling all current scientific knowledge male-stream or patriarchal tends to obscure the complex issues involved in determining how that knowledge may be patriarchal. While they may be adequately descriptive in some ways, the concepts, "patriarchal" and "male-stream," do not clarify the historical and cultural issues at stake. Application of these terms to knowledge has also contributed to the problem of patriarchal knowledge being associated primarily with ideology and error. Problematically, the patriarchal character of knowledge is usually considered to be ideological, in the sense of being distorted or in error. Hence, while recent studies have acknowledged the social character of scientific knowledge about women, they stop

32 Keller, Evelyn Fox, *op.cit.*: 19-20, 178.

33 Longino, Helen and Ruth Doell, "Body, Bias, and Behavior: A Comparative Analysis of Reasoning in Two Areas of Biological Science," *SIGNS: Journal of Women in Culture and Society*, 9, #2, Winter, 1983: 208.

short of completely overcoming the earlier analysis of erroneous science. Conceptualizations of feminist epistemology and science range from the defined task of unearthing erroneous, biased science that has given rise to "myths" of gender, to a more in-depth critique of scientific methods and fundamental assumptions. The former project is one which Harding and Hintikka term the "deconstruction of masculinity in supposedly gender-neutral sciences."³⁴ This is taken to imply a need to "root out sexist distortions and perversions in epistemology, metaphysics, methodology, and philosophy of science."³⁵ Here we see a separation made between ideology and knowledge, with an emphasis upon locating erroneous science.

One of the difficulties with this approach is evident in the internal contradictions in Harding's own position. While aware of the need to go beyond simply pointing to biased, incorrect science, she still wants this critique to be effected within the framework of science itself - to produce a more scientific science, one might say.³⁶ Harding and Hintikka deduce that this can be achieved through the inclusion of women's social experience in scientific research (both as scientists and the targets of study),

34 Harding, Sandra and Merrill B. Hintikka, Discovering Reality. Feminist Perspectives on Epistemology, Metaphysics, Methodology, and Philosophy of Science. Dordrecht: D. Reidel Publishing Co., 1983: ix.

35 Ibid.: ix.

36 Harding, Sandra, op.cit. passim.

thereby achieving a more "representative" science. Their ultimate acceptance of current scientific standards is revealed in their comment that alternatives to masculine, distorting experience can allow for the development of "maximally scientific human understanding."³⁷ There is also the problem here that the notion of masculinist science and knowledge as biased ignores the full social construction of that knowledge within its specific socio-historical context. The concept of patriarchy, in other words, is universalized here, in its application to scientific knowledge.

What we have in the feminist critique of knowledge and science, is an uncertainty about the validity and implications of erroneous science as opposed to those of science as usual. The current ambivalence around this issue can be seen in Fausto-Sterling's work. Fausto-Sterling states that her aim is to go beyond erroneous and even good science, to feminist science. Yet, she takes a traditional approach to biological theories of gender, challenging their evidence and framing the issue in terms of poorly done science. Fausto-Sterling posits that science as usual, what she terms "conventional science," omits and distorts feminine gender, and she thus produces an elision of the two

37 Harding, Sandra and Merrill B. Hintikka, op.cit.: x. See also for definitions of a feminist science as a science which includes women and therefore is considered to be a "better" science: Bleier, Ruth, op.cit.: 205 and Rosser, Sue V., Teaching Science and Health From a Feminist Perspective, New York: Pergamon Press, 1986: 16.

approaches.³⁸ Yet she fears that all science will be viewed as "corrupt" and rejected if the problem is taken to be one of social influence on science and scientists (on science as usual).³⁹ That is a misconception of the implications of the critique common among feminist scientists.

The influence of the Sociology of Scientific Knowledge can be discerned in this distinction between erroneous, biased science and science as paradigmatic and value-laden (i.e. the fact that science is always related to its social context).⁴⁰ Yet despite acknowledgement of some research in the Sociology of Scientific Knowledge, feminist critiques still hold to many mainstream scientific values. Harding discusses the critique of patriarchal science as being an analysis of science as usual (owing to the "fundamental value-ladenness of knowledge-seeking").⁴¹ She views this as one particular research program in the feminist studies of

38 Fausto-Sterling, Anne, op.cit.: 9.

39 Ibid.: 208.

40 Eichler gives a brief explanation of Kuhn's notion of paradigms and "normal science," the latter containing a "taken-for-granted" paradigm. She argues that it is a time of crisis for the assumed scientific paradigm, giving rise to the search for an alternative, feminist one. Eichler, Margrit, "The Relationship between Sexist, Non-Sexist, Woman-centred and Feminist Research in the Social Sciences," in Greta Hofmann Nemiroff, op.cit.: 22-5.

41 Harding, Sandra, op.cit.: 22.

scientific knowledge. Ultimately, however, she takes the position that both critiques are essential.⁴²

Acceptance of mainstream scientific values is one of the hazards of the feminist critique of erroneous science as responsible for inappropriate constructions of gender and biology. A number of theorists who pursue this approach, such as biologists Fausto-Sterling, Lowe, and Hubbard, as well as neurophysiologist Bleier are "scientists" in their own right who evaluate bias in science in scientific terms.⁴³ Unfortunately, this leads to an attempt at providing a basis for the social equality of women, on the grounds that biological sex differences are minimal.⁴⁴ This means that feminist scientists end up responding to assertions about women in mainstream science, in the same terms in which they are put forth. Feminist critics then accept concepts of sex and gender as ultimately reflecting an objective, neutral biology, as had originally been asserted. In addition, this position entails the assumption that it is possible and preferable to pursue truth, as an existent realm of value-free knowledge. This demonstrates a lack of questioning of traditional scientific values, including the ingrained assumption that there is neutral

42 See Harding's discussion of the approach to science studies which emphasizes the social contextualization and construction of all scientific undertakings, a notion based on the Sociology of Knowledge and the Sociology of Scientific Knowledge. Ibid.: 22, 246.

43 Schiebinger, Londa. op.cit.: 326-7.

44 Ibid.: 326-7.

knowledge which can be pursued through science.. In other words, there is no conception that the production of science as usual is a paradigmatic or value-laden and contextual one. This makes it exceedingly difficult to go beyond the critique of erroneous science maintained by these feminist scientists. Science as usual is assumed to be the ideal goal, of which erroneous science is a distorted product.

Even those who recognize that acceptance of a particular scientific theory is dependent upon the social context in which it is advocated, maintain faith in scientists' ability to perceive a neutral thing called nature. Thus, for example, while Keller criticizes the "objectivist ideology" of mainstream science, she simultaneously desires the retention of objective inquiry, though in a different form.⁴⁵ This approach limits her to a critique of erroneous science and a deemphasis of science as a socially-constructed enterprise. It also leads to a type of interest theory which is reminiscent of that of Barnes⁴⁶ and Bloor⁴⁷ in the Sociology of Scientific Knowledge.

Keller discusses how commitments to the scientific enterprise are "subverted, by the more parochial social, political, and emotional commitments (conscious or not) of particular individuals and groups."⁴⁸ She sees these as

45 Keller, Evelyn Fox, *op.cit.*: 12, 178.

46 Barnes, Barry, *Interests and the Growth of Knowledge*. London: Routledge and Kegan Paul, 1977.

47 Bloor, David, *op.cit.*

48 Keller, Evelyn Fox, *op.cit.*: 11.

determining the "priority" of interests and criteria of success of theories.⁴⁹

Postmodernism is a recent epistemological development which refers to a position of skepticism regarding traditional notions of science, reason, progress, and the subject in science. The postmodernists assume that there is no "original unity" that "knowers" can draw upon, but rather that there is a need to rely on "our nonessential, nonnaturalizable, fragmented identities."⁵⁰ This is a category which has links with other intellectual movements such as semiotics and structuralism.⁵¹ Postmodernism is posited by Harding as a third major feminist program in the critique of science's construction of gender and gender's influence on science.

The first two programs are feminist empiricism (critiquing science with science) and feminist standpoint epistemology. The latter entails the view that women form an "interested social location," one which is socially subordinate to the position of men. This fact, and the experiences of women in the division of labour which prevails in our society, are believed by some to give women a privileged standpoint for understanding social life

49. Ibid.: 11.

50. Harding, Sandra, op.cit.: 193.

51. Flax, Jane, "Gender as a Social Problem: In and for Feminist Theory." *American Studies/Amerika Studien*, Journal of the German Association for American Studies, 1986: 3, cited in Harding, Sandra, op.cit.: 27-8.

through scientific investigation (a notion partially derived from aspects of the work of Lukács which I do not use in the present study).⁵² It is a somewhat problematic position, as it views the feminist perspective as indeed partial, yet claims a greater truth-value for it, relative to masculine-based understandings. This requires the assumption that there still exists "one true story" of reality in some form, a viewpoint which is eschewed by postmodernist epistemology. The proponents of standpoint epistemology do recognize, however, the mystification involved in the dominant group's assertion that it provides the objective version of reality by standing outside that world. Therefore, standpoint epistemologists do not make the same claim.⁵³

Further, standpoint epistemology fails to acknowledge that the very concept of two distinct sexes and genders is a social creation. Consideration of this postmodernist contribution would imply that to advocate a feminine or women's view of social reality is in fact to accept a "masculinist conceptual scheme."⁵⁴

Feminist post-modernism is the perspective which is most similar to the analysis of scientific knowledge of

52 Lukács, Georg, *History and Class Consciousness*. Cambridge, Massachusetts: MIT Press, 1968.

53 Miles, Angela, "Sexuality, Diversity and Relativism in the Women's Liberation Movement," *Resources for Feminist Research*, Vol. XIV, #3, November, 1985: 9.

54 Harding, Sandra, *op.cit.*: 27-8, 155, 173, 191, 193, 195; cf. also Riley on this point. Riley, Denise, "Am I That Name?" *Feminism and the Category of 'Women' in History*. Minneapolis: University of Minnesota, 1988.

women which acknowledges the fully social character of that knowledge. Yet theorists who discuss feminist postmodernism still, too frequently, remain concerned with the level of "distorted thought" in the construction of sex and gender. This is partially a function of the acceptance of science as necessarily based on notions of causality and traditionally-defined concepts of rationality.⁵⁵ This is problematic, for example, in the work of Harding. On the one hand, she comments on the western, masculine purposes which underlie the methodological emphasis on "law-governed behavior and activity."⁵⁶ On the other, however, she claims that in spite of the negative gender metaphors in science, scientific theories "extend our understanding of the regularities of nature and their underlying causal tendencies."⁵⁷ In other words, scientific theories have produced beneficial knowledge, though some social groups may have profited more than others.⁵⁸ In fact, Harding conceptualizes the relationship between forms of consciousness and social being in terms of causal determination:

55 Though she is not a postmodernist, Bleier, for example, refers to the need for feminist science to allow for a plurality of views and "multifaceted causal forces." Evidently she does not question the notion of causality, which is part of the "taken for granted" scientific paradigm. Bleier, Ruth, *op.cit.*: 206.

56 Harding, Sandra, *op.cit.*: 229.

57 *Ibid.*: 239.

58 *Ibid.*: 239.

we need to look at the complex and two-way causal influences between all of a culture's social forms and the kinds of cognitive structures it favors.⁵⁹

So although feminist theorists searching for a new epistemological framework and science are critical of the positivist thrust of mainstream science, they remain, on the whole, ambivalent. They continue to rely, in many respects, on the "traditional positivist-empiricist perspective." Some, such as Jill McCalla Vickers, in her work on "methodological rebellions," however, are discussing the need to reject notions of laws, linearity, inevitability, and unity in science, in favour of notions of "multiformed regularities" and anti-positivist epistemological pluralism.⁶⁰ The prevalent ambivalence, though, has far-reaching implications for the way that these theorists are conceptualizing the social, scientific construction of biological sex on the basis of gender. It tends to result in a deemphasis of the fully social character of science as usual, for example.

This ambivalence toward the issues of causality, rationality, and positivism, may be partially the result of the widespread feminist rejection of relativism. Attempts

59 Ibid.: 231.

60 Vickers, J. McCalla, "Memoirs of an Ontological Exile: The Methodological Rebellions of Feminist Research," in A. Miles and G. Finn, eds., *Feminism in Canada*, Montreal: Black Rose Press, 1983; Poff, Deborah C., "Feminism Flies Too: The Principles of a Feminist Epistemology," *Resources for Feminist Research*, Vol. XIV, #3, Nov., 1985: 7.

by feminist scientists to maintain that much previous knowledge about women is "mythical."⁶¹ imply lack of consideration of the social construction of all knowledge, not just knowledge of gender. In turn, this leads to a contradictory position being taken. Mannheim's⁶² and Kuhn's⁶³ works from the Sociology of Knowledge and the Sociology of Scientific Knowledge are used to critique science as usual, while their own position is exempted from the same standards. This lack of reflexivity may be related to the fact that most feminist theorists are non-relativists. It is feared that to accept relativism would eradicate any special epistemological privileges for the feminist position and that total rejection of rationality and objectivity would ensue. Feminist theorists cannot hold to relativism because they want to argue that a non-sexist theory is superior to a male-biased one.⁶⁴

Certainly some relativism is implied in Kuhn's⁶⁵ assertions that observation is value and theory-laden and that paradigms are culturally influenced. It is also implied in the feminist critique of the social construction

61 Lowe and Hubbard, for example, refer to "the myth of the nature of white, middle class women as passive, nurturing, and focused on motherhood and domesticity." Fausto-Sterling even titles her book, *Myths of Gender. Biological Theories About Women and Men*. Lowe, Marian and Ruth Hubbard, eds., op.cit.: xi; and Fausto-Sterling, Anne, op.cit.

62 Mannheim, Karl, op.cit.

63 Kuhn, Thomas S., op.cit.

64 Poff, Deborah C., op.cit.: 7.

65 Kuhn, Thomas S., op.cit. passim.

of science and scientific methodology. Yet, ironically, feminist scholars continue to try to convince others, on "evidential grounds," that their account is more factual.⁶⁶ They do not wish to assert that their account is simply "differently culture-laden."⁶⁷ This problem could be expressed as one of how feminists can criticize both erroneous science and science as usual,⁶⁸ when the latter, in particular, implies a relativism which feminist theorists reject. Yet the critique of science as usual is needed for the development of any new epistemology or alternative science. This contradictory position is partially what comes across in Harding's work, as she advocates postmodernist epistemology, yet rejects relativism.⁶⁹

The current stage of theorizing, then, focuses on finding a resolution to the problem of characterizing the social construction of scientific knowledge about women. However, most writers on gender and science hope that this can be achieved without giving up the scientific goal of rationality and the pursuit of truth in its various forms. Farganis suggests that the equation in Western societies

66 Longino and Doell recognize this "paradox" and make this point. Longino, Helen and Ruth Doell, "Body, Bias, and Behavior: A Comparative Analysis of Reasoning in Two Areas of Biological Science," *SIGNS: Journal of Women in Culture and Society* 9, #2, Winter, 1983. See the discussion by Sandra Harding, *op.cit.*: 102.

67 Longino, Helen and Ruth Doell, *op.cit.*: 102.

68 Harding, Sandra, *op.cit.*: 138.

69 At one point, Harding states that the aim of feminists is "gender-free hypotheses," not "subjective relativism." *Ibid.*: 138.

between the domination, objectivity and rationality deemed to be part of masculinity and of science, points to the problem as well as a possible solution. She sees it as an important step in that direction,

to retrieve the idea of reason from its equation with a form of rationality held to be particularly male, that is, functional and instrumental.⁷⁰

In other words, a process of reconceptualization and redefinition of knowledge, epistemology, and science would provide the potential for a greater understanding of the social construction of scientific knowledge, including ideas about sex and gender. Meanwhile, further studies of the social construction of that knowledge can help build such a reconceptualization.

We now turn to the study of 1950s obstetric and gynecologic knowledge in this dissertation. Analysis of how this medical, scientific knowledge about women was social contributes to a furthering of the project begun by feminist researchers of the gender and science relation. The results of this particular case study help to overcome a dualist separation of medical and social knowledge. Development of a more adequate conceptualization of the social character of such knowledge about women was sought in this study, through examining the discourse produced by science as usual. The

⁷⁰ Farganis, Sondra, *op.cit.*: 185.

methodology used to pursue this research on obstetric and gynecologic discourse is outlined in the following chapter.

Chapter 4

Research Methodology

Previous chapters have outlined the general problem pursued in this dissertation. As noted, the problem is one of how to interpret the social character of scientific, medical knowledge about women. The present study examines, therefore, social conceptualizations of women lodged in seemingly "timeless" obstetric and gynecologic discourse, ideas which contained socially and historically-specific meanings.¹ Ideally, the issue of the social character of medical knowledge of women should be examined through a comparative study of how medical knowledge of women during the 1950s varied from that of other periods. While some comparison with later periods is included in this study, the comparative analysis is limited in scope. The present research focuses solely upon the 1950s in order to investigate the medical knowledge of that period as fully as possible and to circumscribe the size of the research project. This means, however, that the design of the research limits the implication of the findings. One way in

¹ See Smith regarding textual discourse. Smith, Dorothy E., "Textually mediated social organization," International Social Science Journal, Vol. 36, # 1, #99, 1984: 60.

which these limitations could be overcome is through future research which takes a comparative approach.

The specific questions used to investigate the problem under study in the present research are highlighted through the selection of 1950s obstetric and gynecologic discourse as the object of analysis. The major questions addressed in this research are:

- 1) What were the most prominent characteristics of the social climate of the 1950s, as revealed in historical and sociological studies of the period? Which aspects of the social context would have had the greatest impact upon members of the medical profession, considering their social class, race, and other attributes? Which aspects of the context of the 1950s were employed as resources for, and hence, were evident in obstetric and gynecologic knowledge?
- 2) In what particular ways were aspects of the social context of the 1950s apparent in obstetric and gynecologic knowledge? Were the contextual aspects evident only in the content or also in the form of the discourse? Were the categorizations, language (including metaphors), and illustrations used, socially-informed? What were the "taken for granted" assumptions underlying concepts and categorizations of female biology and gender?

- 3) Which women's reproductive conditions were given particular attention during that period? What were the themes which repeatedly emerged in obstetric and gynecologic discourse on women's conditions? Which portions of obstetric and gynecologic texts were revised and what sections were added to texts in their 1950s editions?
- 4) What versions of obstetric and gynecologic knowledge about women's reproductive conditions were available during that period? Which particular journals, and obstetricians and gynecologists, represented each viewpoint?
- 5) Were debates resolved in favour of one dominant position, as revealed in the major obstetric and gynecologic texts? How was the medical knowledge rendered a "factual" and uncontentious reality? What social resources informed the dominant views?

Text Selection and Sampling

To address these questions, obstetric and gynecologic textbooks were selected as the main objects of investigation. The texts were chosen to most adequately represent accepted obstetric and gynecologic knowledge of the period. The texts are particularly important, as textbooks were more influential during the 1950s than they

are in the 1980s, their authors having had more impact on doctors' attitudes than did journals.²

A listing of those texts in most frequent use in medical schools during the 1950s would have been ideal for the purpose of selection, but no records were available. An initial scanning of medical school calendars of the 1950s yielded no results. For example, calendars from the University of Toronto and the University of Western Ontario were inspected for lists of texts used during that period. Unfortunately, the texts were not included in their course lists.

The decade under study is not recent enough for records still to be held, but neither is it sufficiently historical for such documentation to be considered worthy of preservation. Therefore, libraries and medical schools have destroyed many documents from the 1950s.

This situation created difficulties in locating major texts of the period. Precise figures on the general circulation of texts in medical school libraries were also sought, but found to be unavailable. Requests for 1950s circulation figures were sent to the publishers of all texts. Unfortunately, the publishing companies were unable to supply this information.

² Interview with Dr. Murray Enkin, Department of Obstetrics and Gynecology, Health Sciences Centre, McMaster University, Hamilton, Canada, July 10, 1986.

However, the listings of medical libraries' holdings were helpful, as they contained the texts which had been used during the 1950s. The final list for the research was based on a selection, from library holdings, of those texts which went through several editions, on the basis that this represented their widespread influence. Many of those chosen, in fact, are still in use in the 1980s. Several of the texts had already gone through a number of editions by the 1950s, so were not written during that period. However, others were written during the 1950s and subsequently went through multiple editions.

All the texts selected were prominent in that period, whether their editions were prior to or were subsequent to the 1950s. The fact that these textbooks went through several editions is an indication that the knowledge they contained was accepted obstetric and gynecologic knowledge, widely read and used. Further, the 1950s editions selected for examination indicate accepted knowledge for that specific period. Hence, one can assume that the times were at least congenial to the maintenance and dissemination of the particular obstetric and gynecologic ideas contained in those texts. However, the restriction of the research largely to examination of 1950s texts does not permit us to make a full assessment of changes in the content of obstetric and gynecologic knowledge over time.

The list of obstetric and gynecologic texts from which the data were culled does not pretend to be totally comprehensive or exhaustive. However, the fact that this was a representative list was confirmed by examination of the content of the texts themselves. Obstetricians and gynecologists cross-referenced each other's texts, and the major textbooks were repeatedly mentioned.

Reviews of textbooks on the list served as additional criteria for the purpose of determining which texts were prominent during the 1950s.³ The content of the book reviews noted the central place of particular works in the obstetric and gynecologic community and the extent of revisions in the 1950s editions, relative to previous editions. The texts eventually selected, then, were ones reviewed as being important contributions to the field. For example, Williams Obstetrics was evaluated in one review as being "the premier obstetric textbook of the Americas."⁴ The tenth edition of this text was also said to have been largely revised: "Over half of the text and nearly one-

3 For example, see the reviews of (1) Greenhill, J. P., ed. (originally by Joseph B. DeLee), The Principles and Practice of Obstetrics, 10th edition, Philadelphia and London: W. B. Saunders, 1951, in American Journal of Obstetrics and Gynecology, Vol. 62, #6, Dec., 1951: 1390-1.

(2) Eastman, Nicholson J., Williams Obstetrics, 10th edition, New York: Appleton-Century-Crofts Co., Inc., 1950, in American Journal of Obstetrics and Gynecology, Vol. 61, #4, April, 1951: 943-4 and in Obstetrics and Gynecology, Vol. 2, #5, November, 1953: 553-6.

4 Review of Eastman, Nicholson J., op.cit., in Obstetrics and Gynecology, Vol. 2, #5, Nov., 1953: 556.

third of the illustrations are new."⁵ New sections in this edition, the first edited by Eastman, included recent knowledge on toxemias of pregnancy, ovarian and placental hormones, estimation of pelvic size and shape, forces of labour, analgesia and anesthesia.⁶ Another text, edited by Greenhill, was called "a standard classic in obstetrics" and was considered, in 1951, to have "been completely rewritten."⁷

Book reviews, then, were useful in providing clues about the extent to which a particular text was prominent during the 1950s. Reviews were used to locate major obstetric and gynecologic texts of the period which had gone through multiple editions, as well as to confirm their widespread use. The final list of obstetrics and gynecology texts which emerged is as follows:

- (1) Atlee, H.B. The Gist of Obstetrics. 1st edition. Springfield, Illinois: Charles C. Thomas, 1957.
- (2) Baird, Dugald. Combined Textbook of Obstetrics and Gynaecology. 5th edition. Edinburgh: E. & S. Livingstone Ltd., 1950.
- (3) Beck, Alfred C. Obstetrical Practice. 5th edition. Baltimore: The Williams & Wilkins Co., 1951.

⁵ Review of Eastman, Nicholson J., op.cit., in American Journal of Obstetrics and Gynecology, Vol.61, #4, April, 1951: 944.

⁶ Ibid: 943-4.

⁷ Review of Greenhill, J. P., ed., The Principles and Practice of Obstetrics, 10th edition, Philadelphia: W. B. Saunders, 1951, in American Journal of Obstetrics and Gynecology, Vol. 62, #6, December, 1951: 1390-1.

- (4) Dick-Read, Grantly. Childbirth Without Fear. The Principles and Practice of Natural childbirth. 2nd revised edition. New York: Harper and Row, 1959.
- (5) Eastman, Nicholson J. Williams Obstetrics. 10th edition. New York: Appleton-Century-Crofts, Inc., 1950.
- (6) Greenhill, J.P. Principles and Practice of Obstetrics. 10th edition. (originally by Joseph B. DeLee) Philadelphia and London: W.B. Saunders Co., 1951.
- (7) Jeffcoate, T.N.A. Principles of Gynecology. 1st edition. London: Butterworth & Co., 1957.
- (8) Moir, J. Chassar. Munro Kerr's Operative Obstetrics. 6th edition. London: Balliere, Tindall and Cox, 1956.
- (9) Novak, Emil and Edmund R. Novak. Textbook of Gynecology. 5th edition. Baltimore: The Williams and Wilkins Co., 1956.
- (10) TeLinde, Richard Wesley. Operative Gynecology. 2nd edition. Montreal and Philadelphia: J.B. Lippincott Co., 1953.

The texts selected for examination were all authored by academic obstetricians and gynecologists, located in university medical schools and holding hospital appointments. They were clearly leaders in their fields and were also the obstetricians and gynecologists who would experience the greatest degree of influence by scientific medicine, owing to their institutional affiliations. It was also important to note the national and institutional affiliations of the obstetricians and gynecologists in order to take into account the slant of each of their academic departments.

The approaches in the texts tended to be in line with the general British-American difference in emphasis in

medicine. Few medical works were published in Canada during that period, so Canadian obstetricians and gynecologists relied primarily on American and British texts. While the American texts were often more scientifically-oriented, the British ones displayed greater acceptance of psychological and other factors as integral aspects of health and medicine. This split reflected the emphasis on medical practice considerations in Britain, and the greater focus on biomedical research in the United States. This difference was not an absolute split, but rather a tendency. For example, those authors located at Johns Hopkins (Eastman,⁸ the Novaks,⁹ and TeLinde¹⁰) tended, on the whole, to stick to the mainstream of biomedical obstetrics and gynecology. But there were other North American obstetricians and gynecologists who promoted alternative, more psychological interpretations. One of those was Atlee (Head of Obstetrics at Dalhousie University, Halifax), who was well-known in Canada, but definitely not considered part of the medical establishment.¹¹ Another was J. P. Greenhill of Chicago and Cook County Graduate School of Medicine.¹² He was one of

8 Eastman, Nicholson J., Williams Obstetrics, 10th edition, New York: Appleton-Century-Crofts, Inc., 1950.

9 Novak, Emil and Edmund R. Novak, Textbook of Gynecology, 5th edition, Baltimore: The Williams and Wilkins Co., 1956.

10 TeLinde, Richard Wesley, Operative Gynecology, 2nd edition, Montreal and Philadelphia: J. B. Lippincott Co., 1953.

11 Atlee, H. B., The Gist of Obstetrics, 1st edition, Springfield, Illinois: Charles C. Thomas, 1957.

12 Greenhill, J. P. op.cit.

the leading figures in obstetrics and gynecology in the United States, and did not take a strictly biomedical approach. Two of the major British authors, Sir Dugald Baird¹³ of the University of Aberdeen and T.N.A. Jeffcoate¹⁴ of the University of Liverpool, also considered more extra-physiological issues in their obstetrics and gynecology texts, relative to many of the American academic physicians. As all but one of the texts examined were British or American, containing relatively little Canadian content, it was necessary to include the socio-political situation of Britain and the United States in the present study's examination of the social context of medical knowledge.

Selection and Sampling of Journals

Scientific and medical texts tend to present accomplished "truth," decontextualized from the process of its creation. Knowledge is presented in obstetric and gynecologic textbooks through a form of discourse which disguises its disputed nature. For example, this is the case with the development of uniform classifications of women's biology and reproductive conditions in the 1951

¹³ Baird, Dugald., Combined Textbook of Obstetrics and Gynaecology, 5th edition, Edinburgh: E. & S. Livingstone Ltd., 1950.

¹⁴ Jeffcoate, T.N.A., Principles of Gynecology, 1st edition. London: Butterworth & Co., 1957.

edition of Greenhill's text.¹⁵ Therefore, examination of the knowledge contained in the major texts of the period is essential, but not sufficient, for determining how obstetric and gynecologic knowledge was social.

Understanding of the underlying construction of medical concepts is enhanced by attending to debate about those concepts. Such debates are more frequently revealed in journal articles, than in texts. The fact that debates were more explicit in journals, such as the YearBook of Obstetrics and Gynecology, was evident in one assessment of this particular journal. The reviewer stated:

This edition presents, as have all similar editions in the past, the eternal dichotomy between the passing and the permanent. In the articles themselves one does not expect to find the distilled and permanent truths of the specialty...These abstracts serve a more modest (but nevertheless useful) function in reflecting accurately the current gynecologic beliefs and standards as preached by thoughtful practitioners...the editor's comments provide a permanence and stability to these volumes.¹⁶

Debate around obstetric and gynecologic concepts became apparent through the editor's comments upon the views of contributors.

¹⁵ Review of Greenhill, J. P., ed., The Principles and Practice of Obstetrics, 10th edition, Philadelphia and London: W.B. Saunders, 1951, in American Journal of Obstetrics and Gynecology, Vol. 62, #6, Dec., 1951: 1390.

¹⁶ Review of Greenhill, J. P., ed., YearBook of Obstetrics and Gynecology, 1951, in American Journal of Obstetrics and Gynecology, Vol. 63, #3, March, 1952: 701-2.

Focusing on medical debates provides information on which alternative explanations of women's reproductive conditions were put forth or discarded, and thereby enhances our understanding of the process of construction of medical knowledge. Dissenting, alternative views, as sometimes found in the journals, are of crucial importance in unravelling the dynamics of the process of construction of accepted knowledge. Subordinate positions and concepts indicate the points of resistance to mainstream obstetric and gynecologic knowledge about women, and bring out more sharply the assumptions underlying each position.

To compile a list of journals prominent in the 1950s, the publishers of obstetric and gynecologic journals were requested to forward any information available on 1950s circulation figures. Very little was located, for the same reasons discussed regarding the texts. The final list of journals chosen included the main ones used in Canadian medical schools and their libraries during the 1950s. This selection was based on library searches and discussions with obstetricians and gynecologists regarding the significant journals of that period. These two criteria indicated which journals constituted important sources.

The selected obstetric and gynecologic journals were supplemented by the more general Canadian Medical Association Journal, primarily to provide knowledge of the professional context. As the aim was to arrive at a

representative sample of articles from across the decade, each of the following journals were sampled by surveying an early, middle, and late year for each - 1950, 1955, 1959:

- (1) Canadian Medical Association Journal
- (2) American Journal of Obstetrics and Gynecology
- (3) Obstetrics and Gynecology (1953 was used in place of 1950, as 1953 was the first year of publication)
- (4) YearBook of Obstetrics and Gynecology (J. P. Greenhill, editor)

The Canadian Medical Association Journal was the only journal which would provide a broader professional context to the research findings. Greenhill's YearBook of Obstetrics and Gynecology was a particularly useful summary of the major developments in the obstetric and gynecologic field in any given year. Hence, these two journals were closely researched. Additionally, my attention was directed early in the research process, by obstetricians and gynecologists, to Obstetrics and Gynecology and The American Journal of Obstetrics and Gynecology as having been important sources in Canadian obstetrics and gynecology during the 1950s. Each of these latter two journals was also characterized by a particular approach to medicine. The variation provided a contrast between articles from the more biomedically-oriented American Journal of Obstetrics and Gynecology and from Obstetrics and Gynecology, which at that time was more oriented to the notion of psychosomatic aspects involved in health and disease. The alternative,

psychosomatic orientation of Obstetrics and Gynecology may actually have been the rationale for the development of this journal in 1953.

Issues in the middle year of the decade, 1955, were sampled from two additional obstetrics and gynecology journals, to round out the survey of the field in a delimited manner. Those two journals were:

- (5) Obstetrical and Gynecological Survey
- (6) Journal of Obstetrics and Gynecology of the British Empire

A limited sampling of these two journals provided further investigation of the writings of various groups of authors, for while several of the journal articles were written by hospital practitioners, the journal editors were usually academic physicians. In addition, this extended sampling permitted examination of a broader range of obstetric and gynecologic paradigms. This was because the emphasis in the content of each particular journal varied considerably, partly according to who was the editor at the time. For example, Obstetrics and Gynecology, mentioned earlier, the journal of the American Academy of Obstetrics and Gynecology, published a large number of articles on psychosomatic concerns during the 1950s. Yet the Journal of Obstetrics and Gynecology of the British Empire was far more biomedically-oriented, with articles primarily focused on abnormal conditions and complications. Both the American

Journal of Obstetrics and Gynecology (mentioned earlier) and Obstetrical and Gynecological Survey fell between the two extremes but the latter was a useful journal for the purposes of this research, as it consisted of abstracts, followed by editorial comments. The main editors of this journal were Eastman¹⁷, head of obstetrics, and Emil Novak¹⁸, chair of gynecology, both at Johns Hopkins. The associate editors included Beck¹⁹ and Thoms²⁰, the latter of whom promoted natural childbirth training in the United States. Hence, Obstetrical and Gynecological Survey tended to publish a mixture of biomedical articles, with a particular emphasis on endocrinology, and a number of more psychosomatic articles. As suggested earlier, the YearBook of Obstetrics and Gynecology, edited by Greenhill each year, also considered a variety of approaches, and offered summaries of the articles considered most important during that year.²¹

17 Eastman, Nicholson J., Williams Obstetrics, 10th edition, New York: Appleton-Century-Crofts, Inc., 1950.

18 Novak, Emil and Edmund R. Novak, Textbook of Gynecology, 5th edition, Baltimore: The Williams and Wilkins Co., 1956.

19 Beck, Alfred C., Obstetrical Practice, 5th edition, Baltimore: The Williams & Wilkins Co., 1951.

20 Thoms, Herbert and F. W. Goodrich, Training for Childbirth, New York: McGraw-Hill, 1950.

21 Greenhill, J. P., ed., YearBook of Obstetrics and Gynecology; Greenhill, J. P., Principles and Practice of Obstetrics, 10th edition (originally by Joseph B. DeLee), Philadelphia: W. B. Saunders Co., 1951.

Comparative Data

In addition to relying on 1950s texts and journals for data, later editions of three texts and one earlier edition of Grantly Dick Read's Childbirth Without Fear. The Principles and Practice of Obstetrics and Gynecology were used.²² The later editions of texts selected were:

- (1) Myerscough, P. R. Munro Kerr's Operative Obstetrics. 9th edition. London: Bailliere Tindall, 1977.
- (2) Novak, Edmund R., Georgeanna Seegar Jones, and Howard W. Jones. Novak's Textbook of Gynecology. 9th edition. Baltimore: The Williams & Wilkins Co., 1975.
- (3) Pritchard, Jack A., Paul C. MacDonald, and Norman F. Gant. Williams Obstetrics. 17th edition. Norwalk, Connecticut: Appleton-Century-Crofts, 1985.

All four of these texts are earlier or later editions of texts whose 1950s editions were selected for study. These earlier and later editions helped to point out alternative conceptualizations of women's reproductive conditions which were accepted in different periods. This, in turn, highlighted the aspects particular to obstetric and gynecologic knowledge of the 1950s and revealed the changes in content between the two editions of the same text.

²² Read, Grantly Dick, Childbirth Without Fear. The Principles and Practice of Obstetrics and Gynecology, New York: Harper & Brothers Publishers, 1944.

Contextualization of Obstetric and Gynecologic Knowledge

Once the selection of texts and journals was made, two of the texts and three of the journals were briefly surveyed in order to determine initially which, in physicians' own perceptions, were the main obstetric, gynecologic and broader professional concerns of the period. The Canadian Medical Association Journal provided information on the professional issues, while Obstetrics and Gynecology and the American Journal of Obstetrics and Gynecology supplied two differing emphases on the major obstetric and gynecologic issues which were discussed in those journals. Greenhill's Principles and Practice of Obstetrics and Jeffcoate's Principles of Gynecology were the texts which were scanned for the main obstetric and gynecologic concerns of the 1950s.²³ Both had been recommended as important texts of the period in that field and, in addition, Greenhill's provided an American slant and Jeffcoate's a British perspective.

The most frequently recurring obstetric and gynecologic issues in these texts and journals, then, were found to be:

- (1) sex and gender concerns, i.e. pseudohermaphroditism
- (2) gynecological, menstrual conditions, e.g. premenstrual syndrome, dysmenorrhea, menopause

²³ Greenhill, J. P., Principles and Practice of Obstetrics, 10th edition (originally by Joseph B. DeLee), Philadelphia: W.B. Saunders Co., 1951; Jeffcoate, T.N.A., Principles of Gynecology, 1st edition, London: Butterworth & Co., 1957.

- (3) maternal and infant mortality
- (4) pregnancy and prenatal care
- (5) labour and childbirth, e.g. "natural" childbirth
- (6) fertility and sterility

These categories of major obstetric and gynecologic issues were then used to focus the abundance of research material. However, it still meant that approximately 4,000 pages of texts and 277 issues of journals had to be considered. To assess the prevalent conceptualizations of pregnancy, for example, it was necessary to analyze the discourse on that condition in chapters on physiological processes. In addition, sections on the prenatal care of pregnant women -- both "normal" and "abnormal" -- had to be examined.

Which were the professional issues of greatest concern to obstetricians and gynecologists was also a question asked of the sources. Investigation of the medical profession's general concerns was important for suggesting how physicians perceived the social context of the 1950s. That context included not only the political climate and changes in gender relations, but also the professional concerns of physicians, concerns which had a direct impact upon their social positions and status. In the 1950s journals, these professional issues included state attempts to introduce universal health insurance, a perceived decline in the quality of the doctor-patient relationship, and

specialization in medicine, with the resulting fear of a threat to the status of the general practitioner. The concerns regarding specialization and changes in the doctor-patient relationship were closely tied to debates around the trend toward more "scientific" medicine (biomedicine), and a possible consequent decline in the "art" of medicine.

Evidence of coherence between the broad social context and the obstetric and gynecologic knowledge generated in that specific context was sought. Therefore, secondary sources were used for an examination of the socio-political and professional context of the 1950s. Further, the nature of that coherence was examined, to argue the case for a particular version of the social character of obstetric and gynecologic knowledge. In some cases, it was fairly explicit that particular social resources had been employed in the construction of medical concepts of women. For example, norms and expectations about women prevalent in the social context of the period emerged in discussions of how labour and delivery should be managed. In other instances, the use of social resources to make technical distinctions was more implicit and indirect. Anatomical and endocrinological descriptions were often informed by particular expectations of what constituted normality for women, reinforced by a social trend in the direction of rationalization.

To effect this analysis, it was essential to tap the assumptions about women, family, and social problems, which were drawn on as resources for production of the obstetric and gynecologic knowledge. Indirect methods were employed, such as considering what was fundamentally at stake in the alternative positions taken on an issue. Controversy over pain relief in labour, for example, was partially a debate about the priority of the needs of women, as opposed to those of fetuses. There was also a question of whether the goal of alleviating "social problems," such as delinquency, eugenics, divorce, and political instability, could be achieved through the administration of particular types of anesthesia or through mother-infant bonding. Additionally, the language and analogies used to depict physiological processes, which conditions merited the designation of "problems" (e.g. infertility), and how women were recommended to be "managed" were taken into consideration in this textual analysis. In places, a comparative perspective on knowledge about women was accessible through an examination of the language used to describe men and other groups in the population, such as children.

All of these approaches were used to examine the ways in which social resources, such as concepts of femininity in the 1950s, were employed in making technical distinctions. In addition, how those scientific distinctions were used as resources for normalizing and regulating the social realm,

such as population fertility, was an issue in the present study. In particular, the question of which resources were used for which purposes was central in this analysis of obstetric and gynecologic discourse. For example, formulations of sex and gender determination were examined for the links evident between technical and social definitions of sex and gender. "True" sex, as it was termed, was determined chromosomally. This definition then acted as a resource for interventions involving, for example, surgical removal of testes in "female" individuals. The aim of such practice, with the normal/abnormal technical distinction as a means, was to provide therapy which was seen to more rigidly dichotomize the sexes and genders involved. In addition, attention was paid to how the medical profession's social status acted as a resource for it recommending a particular, ostensibly technical and neutral version of biological and behavioural normality.

The present study inquired as to which version of normality was offered for women and it was found that technical definitions involved notions of "reproductive capacity." The only relevant hormones considered in females, for example, were those deemed important for reproductive processes, not, say, for sexual potency. Such technical resources were employed to define the world in a particular way, with a pronatalist definition of women's behaviour as normal.

The identification, definition and treatment of further obstetric and gynecologic "disorders" were also examined with a view to the issue of which resources were employed for the achievement of which ends. The findings which resulted from pursuing these research questions allow feminist appraisals of medicine's knowledge of women to be addressed. Specifically, the findings speak to the issue of how medical knowledge of women can be conceptualized as social.

Chapter 5

"Normalization" in the Social Context

As indicated in the Introduction, this chapter draws on secondary sources to outline aspects of the social context of the 1950s in Canada, Britain, and the United States. Familiarity with the social circumstances is essential for grasping the connection of the context with the obstetric and gynecologic knowledge of that decade. The social character possessed by that knowledge is demonstrated by the parallels found between the textual knowledge and this social context. Similar concerns emerge in both, in the form of particular definitions of the normal and abnormal, accompanied by a process of rationalization. A thrust toward developing standardized categories, clearly delineated in terms of normality and abnormality characterizes both the social context and the texts. The context was not an external, biasing influence on the obstetric and gynecologic knowledge, but rather, was an integral part of the construction of "normal" medical knowledge (medicine as usual) about women in the 1950s.

As noted in the earlier discussion of methodology, the texts and journals selected for examination were those used most widely in Canadian obstetrics and gynecology. Most of

the writings were of British and American origin. Hence, it is important to attend to some general information on the social contexts in Britain and the United States. The latter is particularly relevant because American texts and journals formed the majority of those selected. However, the issue under consideration in the dissertation is that of the social character of obstetric and gynecologic knowledge accepted and used in Canada during the 1950s, rather than where and when that knowledge was originally generated. So the Canadian social context must be carefully considered. What demands explanation is why the Canadian context was conducive to the acceptance of British and American sources of obstetric and gynecologic knowledge. Ideally, a thorough treatment of the relation of the British and American contexts to the medical knowledge which originated in those social contexts would be helpful. Such research was beyond the scope of the project taken up in this dissertation, but future studies on this would be valuable.

Context of the Construction of Categories of Knowledge

The major disruptions of the second world war were followed during the 1950s by attempts at social and political restabilization and "normalization." The attempts to overcome socio-political and economic instability contributed to views of women which would encourage social

stability. Efforts to achieve a particular version of social normality were linked with a standardization of pronatalist notions of womanhood and a traditional gendered division of labour. These constructions of women, which were specific to the social circumstances of the 1950s, emerge again as part of obstetric and gynecologic knowledge of the period. One of the bases of the form and content of that knowledge, then, was the emphasis in the 1950s on achieving social stability and normalization.

Economic boom and relative affluence characterized this period, at least in North America. This situation supported endeavours to attain "the good life," in stark contrast to the deprivations experienced during the war. In Britain, material conditions of continuing austerity were accompanied by efforts to alleviate social and economic deprivation through the development of the welfare state.¹

But while life was more affluent in the 1950s than it had been during the war, especially in Canada and the United States, persistent social and political tensions served to encourage strong attempts to ensure continued stability. The fears and anxieties of this period stemmed largely from the social implications of: (1) the Cold War and its various manifestations (2) changing gender relations and (3) the rationalizing character of the economy and the nature of

¹ Barker, Elisabeth, The British Between the Superpowers, 1945-50, Toronto: University of Toronto Press, 1983: 103.

work. A strong emphasis upon "normalization" and standardization arose out of these tensions, including, ironically, concern about the trend toward rationalization itself. In order to demonstrate the parallel with obstetricians' and gynecologists' constructions of knowledge about women, this section elaborates upon the concerns as they were manifest in the socio-political context of the 1950s.

Political Tensions

Much of the concern about social instability, and consequent efforts to attain a particular form of normalization, were connected to international tensions in the political realm. Obstetric and gynecologic knowledge of the 1950s was accepted and/or generated within this context of general insecurity following the war. As Canada experienced aspects of both British and American fears, the problems felt in Britain and the United States are also discussed here.

The dropping of the atomic bombs over Hiroshima and Nagasaki generated visions of potential dangers never previously confronted.² The end of World War II, then, did

² Granatstein, J. L., Irving M. Abella, David J. Bercuson, R. Craig Brown, H. Blair Neatby, Twentieth Century Canada, 2nd edition, Toronto: McGraw Hill Ryerson Ltd., 1986: 296; Lewis, Peter, The Fifties, London: Heinemann, 1978: 86-7.

not finally destroy the insecurities that accompany times of war, but rather contained the seeds of new ones. The Americans were spurred on to develop the hydrogen bomb, by the knowledge that the Soviets were advancing in the development of nuclear weapons, from 1950 on.³ Britain and Canada were both also involved in the development of nuclear weaponry in the 1940s and 1950s.⁴

What came to be known as the "Cold War," between the United States and the Soviet Union, was fueled by a number of events. Spy cases came to light in Britain and Canada (for example, the Gouzenko case) after the war, which were interpreted as evidence of a Moscow-led "conspiracy."⁵ In addition, American-occupied South Korea was challenged in the early 1950s by North Korean communists.⁶ Britain's interests in the Korean War included support of the Americans against "what they saw as Soviet-instigated aggression" and inhibition of the development of a full-scale, possibly nuclear, war.⁷ The combination of these circumstances, with the emergence of the United States as a

3 Lewis, Peter, op.cit.: 86-7.

4 Calvocoressi, Peter, The British Experience 1945-75, London: The Bodley Heald Ltd., 1978: 206-211; Whitaker, Reg, Double Standard. The Secret History of Canadian Immigration, Toronto: Lester & Orpen Dennys, 1987: 17.

5 Calvocoressi, Peter, op.cit.: 66; Whitaker, Reg, Double Standard. The Secret History of Canadian Immigration, Toronto: Lester & Orpen Dennys Ltd., 1987: 17;

Granatstein, J. L. et al., op.cit.: 296.

6 Lewis, Peter, op.cit.: 68.

7 Barker, Elisabeth, op.cit.: 193.

major world power following World War II, provided the stimuli for the development of the Cold War.

With the Labour Party in power till 1951, Cold War fears and rhetoric developed only gradually in Britain, fostered primarily by the 1948 events in Prague. But it was sufficient to push Britain into an Anglo-American alliance, in which the British came to share, though to a lesser degree, the American view of communism as an international monolith.⁸

This world view was also extant in Canada, though less overtly than in the United States. Canada became increasingly anti-communist and entrenched in the Western military alliance, as it moved towards becoming a "junior partner" to the United States, the new power on the international scene.⁹ State surveillance for the purposes of national security developed in Canada during the Cold War, though the Canadian state was less open about communist purgings than the American. It led to more security in the civil service and to a new basis for immigration screening.¹⁰

Fears of a communist conspiracy reached hysterical heights in the United States, however, with the formation of the House UnAmerican Activities Committee, peaking with the

8 Calvocoressi, Peter, op.cit.: 206-211, 216; Barker, Elisabeth, op.cit.: 103-112, 236.

9 Whitaker, Reg, op.cit.: 16; Granatstein, J. L. et al., op.cit.: 334.

10 Whitaker, Reg, op.cit.: 6, 18, 24.

allegations of "witch-hunter" Senator McCarthy.¹¹ The search for signs of "UnAmerican" activities ensued, the internal expression of the Cold War. One of the accused, Arthur Miller, commented that interpretation of the concept of "UnAmerican" had multiple meanings. It was used to refer to pro-Communist or pro-Russian leanings, but could also mean the taking of an anti-big business or big unions stance, being an atheist or in favour of birth control; in other words, a term for any views that were at all "remarkable."¹²

International tensions were aggravated again when the U.S.S.R. battled the Polish and Hungarian uprisings in 1956.¹³ Then, on October 4, 1957, the Soviets launched Sputnik, the first satellite, and twenty-nine days later sent the second Sputnik into space. This was significant in that it tested the exuberant, international self-confidence of the Americans that had existed since the second world war. It was perceived as a demonstration that Americanism, as a way of life, was not an absolute guarantee of "national superiority."¹⁴

Nasser's nationalization policies, meanwhile, leading to the Suez affair, particularly affected the status of

11 Lewis, Peter, op.cit.: 68, 70-1, 78.

12 Ibid.: 84.

13 Ibid.: 106-7, 109.

14 Jones, Landon Y., Great Expectations. America and the Baby Boom Generation, New York: Coward, McCann, and Geoghegan, 1980: 53.

Britain. The Anglo-French invasion of Egypt ultimately contributed to the final decline of the British Empire. This meant some loss of status on the part of the ruling class establishment within Britain, so that British weakness evident in the Suez canal events had both international and national repercussions.¹⁵ Britain had already emerged from the war in a difficult political and economic position. Food and petrol rationing continued till the mid-1950s and the onerous conditions of the winter of 1947 aggravated the early post-war deprivations in Britain. The country had lost many of its foreign investments, become dependent on American capital through loans, and needed to rebuild its industries. Generally, Britain was losing its position as a world power. Nationalisation of services and industries and the development of a welfare state, including the National Health Service, were part of the effort to stake out a new place for Britain internationally and to rebuild Britain economically and socially.¹⁶

A similar trend toward the development of more social welfare had begun in Canada during the war. The Royal Commission on Dominion-Provincial Relations led to the implementation of unemployment insurance, baby bonuses, and

¹⁵ Ibid.: 143-4, 159.

¹⁶ Barker, Elisabeth, op.cit.: 103, 241-2; Calvocoressi, Peter, op.cit.: 10.

hospital insurance during the 1940s and 1950s.¹⁷ Such developments were encouraged by groups such as the Saskatchewan C.C.F., but were also more readily accepted in the postwar period because the measures would provide some semblance of security.

On the international level, the 1950s were a period of transition from a British to an American empire.¹⁸ Yet not only Britain, but also the States, experienced degrees of postwar insecurity, which fed into the development of particular views of women during the 1950s. However, the factors generating these insecurities differed between Britain and the United States. In Britain, the decline of the colonial empire and the internal devastation left by the war (with the accompanying need to rebuild economically) created a situation in which women and families could be turned to for stability and renewal of the population. In Britain, perceived threats to the "British way of life," such as through Americanisation, expressed fears of social change.¹⁹ On the other hand, the new imperialism and economic strength of the United States meant that Americanism was becoming the universal standard of

17 Granatstein, J. L., op.cit.: 341-4; Bothwell, Robert, Ian Drummond, John English, Canada, 1900-1945, Toronto: University of Toronto, 1987: 389-398; Creighton, Donald, The Forked Road, Canada 1939-1957, Toronto: McClelland and Stewart, 1976: 284.

18 Lewis, Peter, op.cit.: 157; Granatstein, J. L., op.cit.: 334.

19 Pearson, Geoffrey, Hooligan. A History of Respectable Fears, London: Macmillan Press, 1983: 19, 20.

comparison and normality. But to achieve and maintain that political and cultural dominance demanded vigilance against internal and external threats, as communism was considered to be at that time.

There was also a definite move to Americanisation in Canada, both culturally and economically. The influx of American capital contributed to the economic boom of the Canadian postwar years, so there was less protest against Americanization than there was in Britain.²⁰ Attempts to enforce American standards in Canada and Britain, as well as the United States, included definition of communism as abnormal and pathological. Internally, women and motherhood were turned to as one solution to the communist problem and a route to maintaining the normal American, British or Canadian way of life. Definitions of the normal woman in the 1950s, not surprisingly, were consonant with the dominant definitions of American family life and values.²¹ Communism was viewed as a threat to this private family life, so cherished in America.²² Women, especially as

20 Granatstein, J. L., op.cit.: 316-7.

21 The "version of reality" produced by more powerful groups (including nations, as discussed here) tends to become the dominant one because those groups have the "resources to command attention." Epstein, Cynthia Fuchs, Deceptive Distinctions. Sex, Gender, and the Social Order, New Haven: Yale University Press and New York: Russell Sage Foundation, 1988: 8.

22 Rogin, Michael, "Kiss me deadly: Communism, motherhood, and cold war movies," Representations 6, Spring, 1984: 1-36, cited in Wini Breines, "Domineering Mothers in the 1950s: Image and Reality," Women's Studies International Forum, Vol.8, #6, 1985: 606.

mothers, were relied on to protect American freedom and democracy, and general social stability, through the creation of emotionally stable families.

But in the Cold War era, when nationalism and patriotism, not to mention rank suspicion, reached a high pitch, the housewife was seen as important not only because she spent her husband's money, but also because it was she who could shore up the family against liberalism, socialism, and communism. Mrs. Consumer became Mrs. America, and the experts turned their attention on her in earnest as Sputnik, Krushchev, and the Bomb loomed ominously (sic) on the nation's horizon.

It was no accident that the nuclear family became reinforced as the American norm in the 1950s. World War II had torn families asunder and put women to work, men to war, sometimes against their will. ... And by 1950, conditions were ideal for starting and raising a family.²³

Motherhood may have been considered a perfect solution, but all was not well in the families that blossomed during the baby boom years of the late 1940s and 1950s. Particular notions of women and motherhood emerged out of the emphasis on social stabilization and normalization, but there were enormous tensions in the gender relations involved in those notions. That situation created further anxieties in many quarters. Some of the concerns around gender were linked to changes occurring in both men's and women's participation in the wage labour force.

²³ Ogden, Annegret S., The Great American Housewife. From Helpmate to Wage Earner, 1776-1986, Westport, Connecticut: Greenwood Press, 1986: 171.

Rationalization and Feminization of Wage Labour

Alterations in the nature of men's work during the postwar period stimulated two types of fears. The first was that the more social, less individualistic values and behaviour expected from male corporate workers, along with the developing Welfare State (especially in Canada and Britain), meant that communist tendencies were emerging in the West. This contributed to and developed out of the prevailing Cold War atmosphere. Secondly, the less individualistic, more bureaucratic trends in men's work were perceived, to some extent, as emasculation. The workplace expectations were, in one way at least, closer to more social, traditionally defined, feminine modes of behaviour and values. It has been suggested that this in fact may be central to the pervasive 1950s concern with gender relations.²⁴

Following the war, a fairly rigid sexual division of labour reemerged. The most striking development in men's work was the expansion of the new middle class of white-

24 Breines, Wini, op.cit.: 602-3. Breines refers to Ehrenreich's and English's argument, that David Riesman's book is actually about changes in American manhood. They contend that the development of the "other-directed" personality and emphasis on conformity were viewed as attacks on masculinity. Ehrenreich, Barbara and Deirdre English, For Her Own Good. 150 Years of the Experts' Advice to Women, Garden City, New York: Anchor Books, 1979.

collar professional and managerial positions.²⁵ The large corporations, in particular, provided this expanding sector, as power became increasingly concentrated in the larger corporations.²⁶ The tendency in these large corporations was to be hierarchical in nature, with a highly developed, specialized division of labour and an emphasis upon scientific, bureaucratic efficiency.

Concerns were expressed that individualism was threatened and that the conformist organization man was being created. This signified that men were perceived as being more "other-directed" than in the past, in other words, more dependent on the approval of others and in a situation of enforced sociability. On the one hand, the enforced conformity and rigid hierarchy "served as an effective antidote to the disorienting jolts and upsets caused by World War II."²⁷ However, on the other, organization life was being perceived as antithetical to the "American Dream," which was the culmination of the Protestant Ethic.²⁸ This formalization had been present in the United States since the 1930s. But unique to the 1950s, when an increasing number of men became involved in that

25 Riesman, David, Nathan Glazer, and Revel Denney, The Lonely Crowd, New Haven: Yale University Press, 1961: xxviii.

26 Whyte, William H., Jr., The Organization Man, New York: Simon and Schuster, 1956: 4.

27 Horn, Richard, Fifties Style. Then and Now, Harmondsworth, Middlesex: Penguin, 1985: 146.

28 Whyte, William H. Jr., op.cit.: 4.

form of work, was the emergence of discontent with bureaucracy.²⁹

The effects of male involvement in such work organizations, upon family and gender relations, was considered cause for concern. The fact that the organization demanded full commitment and competitive striving on the part of its male workers was viewed by some as working in a "rat race" on behalf of the corporation.³⁰ Family became subordinated to career in more ways than one, partly because of the pressures of increasingly high standards of middle class living. A simultaneous pressure on men to make family commitments a higher priority in their lives led to tensions and conflicts. Job demands, for example, meant that men were physically absent from their families for a considerable amount of time and that the family was even viewed as an extension of the organizational career; the wife was regarded by the company as a potential

29 Berkley, George E., The Administrative Revolution. Notes on the Passing of Organization Man, Englewood Cliffs, New Jersey: Prentice-Hall, 1971: 11.

30 The angry feelings generated by such dependence on the demands of the corporation and their interference with family life were well expressed in the 1950s novel, The Man in the Gray Flannel Suit. Author, Sloan Wilson, recently commented that "The main problem which concerned Tom Rath, the usually forgotten name of the man in gray flannel, was that he felt the world was driving him to become a workaholic in order to succeed at business enough to support his family well, and this dilemma still seems current to many men and women in their twenties in 1983." Sloan Wilson, Introduction to The Man in the Gray Flannel Suit, Markham, Ontario: PaperJacks Ltd., 1985 (originally 1955): 9.

asset.³¹ Corporations recognized that wives could play a supportive, helper role, but were also ambivalent about the wife's place. Potentially, the wife could also prove to be a competitor with the corporation, making demands on the husband's time.³² The informal role of corporate wife was important enough for many corporations to screen wives of employees eligible for promotions, for suitability.³³ Wives were also taken into account as factors when the wives might influence their husbands' decision-making on an issue.³⁴

And, of course, wives were essential elements at social gatherings, sometimes acting as hostesses for people with whom the company wanted a good relationship. Such events occurred outside the business day but hardly outside the business boundaries. In all these ways, wives were part of the organization.

From the wives' perspective, the company was a critical part of their lives, defining how they spent their time and influencing what was possible in their relationships with their husbands....Some wives considered themselves unpaid workers for the corporation, in the sense both of direct services and of opportunity costs for options in their own lives they had forgone. As wives saw it, then, they were very much inside the corporate system.³⁵

31 Seeley, John R., R. Alexander Sim, and E.W. Loosley, Crestwood Heights. A Study of the Culture of Suburban Life, Toronto: University of Toronto Press, 1956: 135-6.

32 Kanter, Rosabeth Moss, Men and Women of the Corporation, New York: Basic Books, Inc., 1977: 125.

33 Ibid.: 116-7.

34 Ibid.: 105.

35 Ibid.: 105-6.

These aspects of the work of the middle class were having an important impact upon the nature of men's and women's relationships. The 1950s middle class suburbia was in fact a "dormitory" for these organization men and divided men's and women's worlds.³⁶ What is most crucial to consider, however, are the anxieties which were wrapped up with the changes in men's work. The concerns included fear of emasculation, as the result of a lessening of gender demarcations, and of increasing rationalization and regulation of life. Wage labour was one of many spheres which was rationalizing. This involved increasing "scientism" or "social engineering," and specialization, for the sake of efficiency.³⁷ And the world of wage labour was gradually taking shape in a way that would no longer pay as strict heed to gender differences.³⁸

World War II had threatened the traditional sexual division of labour by drawing greater numbers of women than ever before into the labour force and, for a number of reasons, not all women returned to the home on a full time basis after the war. The North American economic boom of the 1950s, increasing middle class standards, and some degree of acceptance of married women's wage labour during the second world war were all factors which encouraged some continuation of women's labour force participation, even if

36 Whyte, William H. Jr., op.cit.: 10.

37 Ibid.: 23.

38 Breines, Wini, op.cit.: 602.

on a part-time basis. The rapid expansion of the white-collar sector, which influenced the work of middle class men, also encouraged women to take up the increasing number of low-paid, temporary, and often part-time service sector jobs.³⁹

Table 1⁴⁰

PERCENTAGE DISTRIBUTION OF WORKING WOMEN BY LEADING
OCCUPATIONAL GROUPS, CANADA,¹ 1941-1961⁴

Occupational Group	1941 ⁵	1951	1961
	%	%	%
Clerical	18.3	27.5	28.6
Personal Service	34.2	21.0	22.1
Professional	15.7	14.4	15.5
Commercial and Financial	8.8	10.5	10.2
Manufacturing and Mechanical ²	15.4	14.6	9.9
Other ³	7.7	11.9	13.6
Total ³	100.1	99.9	99.9

1 Includes Newfoundland (1951 on), but not Yukon and Northwest Territories.

2 Includes stationary enginemen and occupations associated with electric power production.

3 Includes armed forces.

4 15 years of age and over, 1941-1961.

5 Not including active service, 1941.

39 Margolis, Maxine L., Mothers and Such. Views of American Women and Why They Changed, Berkeley: University of California Press, 1984: 64.

40 Adapted from Department of Labour, Canada: Women at Work in Canada, 1964: 28, in S. J. Wilson, Women, The Family and The Economy, Toronto: McGraw-Hill Ryerson Ltd., 1982: 78 (Table 5.2).

In the 1950s, it became more acceptable for white, middle class women to participate marginally in the labour force, as opposed to working class women who had been doing wage labour all along.⁴¹ In North America, the majority of young married women with children who moved to the suburbs took up full-time housewifery. Yet a large number also worked outside the home, at least sporadically. The percentage of Canadian women in the wage labour force declined after the war (from a high of 33.5 per cent in 1944 to a low of 23.6 per cent in 1954, and then climbed up again). The percentage of women in the labour force was steadily increasing, though, over the course of the twentieth century.

⁴¹ Berkin, Carol Ruth and Mary Beth Norton, Women of America. A History, Boston: Houghton Mifflin, 1979: 280.

Table 2⁴²FEMALE POPULATION AND LABOUR FORCE, CANADA,¹ 1901-1961

<u>Year</u>	<u>Labour Force²</u>	
	Per cent	Percentage of
	Economically <u>Active</u>	Total <u>Labour Force</u>
	%	%
1901	12.0	13.3
1911	14.3	13.4
1921	17.2	15.5
1931	19.1	17.0
1941	20.2	18.5
1951	23.6	22.0
1961	29.5	27.3

1 Includes Newfoundland (1951 on), but no Yukon and Northwest Territories. Also includes armed services.

2 10 years of age and older in 1901 and 1911.

14 years of age and older in 1921-1951.

15 years of age and older in 1961.

Anxiety about changes in gender relations was generated by these trends. In addition, married women formed an increasing proportion of the work force, a trend not completely reversed in Canada after the war; while 35 per cent of paid working women in 1944 were married, in 1951 there was still a proportion of 30 per cent of women in the

42 Adapted from Department of Labour, Canada: Women at Work in Canada, 1964: 10, in S. J. Wilson., op.cit.: 71 (Table 5.1).

labour force composed of this group.⁴³ While the 1951 figure indicates a decrease from 1944, the relatively small difference demonstrates that the wartime trend of married women participating in the labour force was not fully reversed. The absolute numbers of married women declined, but there remained a substantial proportion of them performing wage labour.⁴⁴ In fact, there was a 4.5 per cent participation rate by married women in the labour force in 1941, which doubled to 11.2 per cent in 1951. During the 1950s it rose, so that by 1961, married women constituted a larger proportion of the female labour force than did single, never-married women (49.8 per cent to 42.3 per cent, though the proportion of single, divorced and widowed women totalled 50.2 per cent).⁴⁵

43 Pierson, Ruth Coach, "They're Still Women After All." The Second World War and Canadian Womanhood, Toronto: McClelland and Stewart, 1986: 215-6. Pierson takes her statistics from Pat Armstrong and Hugh Armstrong, The Double Ghetto: Canadian Women and Their Segregated Work, Toronto: McClelland and Stewart, 1978: 19 and Pat Armstrong and Hugh Armstrong, "The Segregated Participation of Women in the Canadian Labour Force, 1941-1971," Canadian Review of Sociology and Anthropology, 12, 4, Part 1, November, 1975: 370-1; "Wartime History of Employment of Women and Day-Care of Children, Part 1: 75, Canada, Department of Labour, Women at Work in Canada: A Fact Book on the Female Labour Force, Ottawa: The Queen's Printer, 1959: 14-24.

44 Pierson, Ruth Coach, op.cit.: 216.

45 Connelly, Patricia, Last Hired, First Fired. Women and the Canadian Work Force, Toronto: The Women's Press, 1978: 64.

Table 3⁴⁶

WOMEN'S LABOUR FORCE PARTICIPATION BY MARITAL STATUS

1941-1961

Year	Participation Rate of Married Women ¹ (%)	Marital Status of Female Workers		
		% Single	% Married ¹	% Other
1941	4.5	80.0	12.7	7.3
1951	11.2	62.1	30.0	7.9
1961	20.8	42.5	47.3	10.2

1 For 1941 and 1951, separated women are included with married women, while for 1961 they are included in the "Other" category, that is, along with widows and divorced women.

In Britain, the rates for married women in the labour force during the 1950s were even higher. In 1950, 40 per cent of female workers were married and by 1956, this had climbed to 50 per cent.⁴⁷ The number of married women in the British labour force increased "both absolutely and relatively to all women workers" between 1939 and 1957.⁴⁸

Most of these women remained "supermothers" though, in that their primary focus was on the family.⁴⁹ As the largest group of women to enter the labour force in the

46 Adapted for 1941 and 1951 from Canada, Ministère du Travail, division de la main-d'oeuvre féminine, La Femme Canadienne au Travail, (Publication No. 1), Ottawa: Imprimeur de la Reine, 1957: 10, 13; and for 1961, from Canada, Labour Canada, Women's Bureau, Women in the Labour Force 1971: Facts and Figures, Tables 9 and 10, in Armstrong, Pat and Hugh Armstrong, The Double Ghetto, Toronto: McClelland and Stewart, 1978: 152 (Table 20).

47 Riley, Denise, War in the Nursery. Theories of the Child and Mother, London: Virago Press, 1983: 147.

48 Ibid.: 147.

49 Ogden, Annegret S., op.cit.: 168.

United States were those over forty-five years of age, this pattern didn't necessarily conflict with demands of the ideal nuclear family.⁵⁰ A rise in the average age of women in the labour force also characterized the patterns in Britain, both throughout the war and following it. It has been documented that the labour force participation of that group of women aged thirty and over increased considerably from 1946 to 1955.⁵¹ The types of jobs available to these women remained consonant with the view that women's first obligation was to their family. Scientific management experts argued that the low status and low paid jobs available for women during the 1950s were ideal, as they did not conflict with "good mothering."⁵² The rationalization process occurring in the workplace encouraged reformulation of the meaning of womanhood by these experts. Office work, for example, was deemed suitable for the use of women's "natural" traits of docility and aptitude for boring, repetitive work.⁵³

A simultaneous trend occurring in women's work was an emphasis on their responsibility for consumption. The role of consumer permitted the retention of the home as the site

50 Margolis, Maxine L., op.cit.: 78.

51 Riley draws on Richard Titmuss, Essays on 'The Welfare State', London, 1958: 102-3 and Planning (Political and Economic Planning), 'The Employment of Women,' Vol. XV, no. 285, 23 July 1948. Riley, Denise, op.cit.: 147.

52 Margolis, Maxine L., op.cit.: 78.

53 Matthews, Jill Julius, Good and Mad Women. The Historical Construction of Femininity in Twentieth-Century Australia, Sydney: George Allen & Unwin, 1984: 96.

of women's primary status, while participating in the growing North American and British economies.

In fact, society conveyed two powerful but contradictory messages to American women concerning the goals that were considered acceptable for them. One message was, *Be a wife and mother and gain your fulfillment at home.* The other was, bluntly, *Get a job.*⁵⁴

And, as we have seen, many women did take up wage labour, if only temporarily. The great concern during the 1950s about defining women's "place" could have been related to the fact that it was perhaps the first time that women on a widespread scale began to have "real options."⁵⁵ Many married women gained a modicum of greater independence from the home and this development may have been interpreted as the placing of greater demands on men.⁵⁶ These social changes in men's and women's work generated tensions in gender relations during the 1950s, leading to the construction of categorizations of normality and abnormality for women. These categories were imbued with content arising out of this context particular to the 1950s.

Defining the "Normal" Woman

The prosperous North American economy set the conditions for a decline in the marriage age during the

⁵⁴ Ogden, Annegret S., op.cit.: 172-3.

⁵⁵ Breines, Wini, op.cit.: 601.

⁵⁶ Riesman, David et al., op.cit.: 280.

1950s, leading first to a marriage and, then, a fertility boom. The median age for American women at marriage was at a low of 20.1 years in 1956.⁵⁷ In Canada, the marriage rate increased from seventy-five per 1,000 population for women aged 20-24 years in 1937, to 100 in 1,000 by 1954.⁵⁸ More jobs were available, making it possible for young people to support children and, at least in the United States, the government encouraged this trend by providing easy access to credit for education and mortgages.⁵⁹

The birth rate in the United States and Canada had begun to rise during World War II. This fertility boom continued in North America through the 1950s, with the average number of births per woman in Canada being 2.759 in 1940, 3.433 by 1950, and at a peak of 3.947 in 1959.⁶⁰

⁵⁷ Jones, Landon Y., op.cit.: 23-4.

⁵⁸ Pierson, Ruth Coach, op.cit.: 215.

⁵⁹ Jones, Landon Y., op.cit.: 23-4.

⁶⁰ From Statistics Canada, Population Projection for Canada and the Provinces, 1972-2001, Tables 4.2 and 4.3, 1974, as cited in Manpower and Immigration, Immigration and Population Statistics, Table 1.10, Ottawa: Information Canada, 1974: 18-9.

Table 4⁶¹

GENERAL FERTILITY RATES, CANADA, 1871-1965
(ANNUAL NUMBER OF BIRTHS PER 1,000 WOMEN AGED 15-49 YEARS)

YEAR	CANADA
1871	189
1881	160
1891	144
1901	145
1911	144
1921	120
1931	94
1941	87
1951	109
1956	117
1961	112
1965	91

Interestingly, both blacks and whites participated in the North American baby boom, although American blacks did not live in the suburbs or benefit greatly from the economic boom.⁶² After the second world war, rather than moving to the suburbs, blacks migrated to the inner cities. Black women also continued to work in the wage labour force. Overall, amongst both blacks and whites, there was an increase in two to four children families and the rise was an urban, not a rural phenomenon. In a reversal of the most common pattern, the number of children varied directly with

61 Adapted from Jacques Henripin, Trends and Factors of Fertility in Canada, Ottawa: 1972: 21, in Angus McLaren and Arlene Tigar McLaren, The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1980, Toronto: McClelland and Stewart, 1986: 127 (Table 6).

62 Jones, Landon Y., op.cit.: 21.

the level of women's education and the upper classes tended to have the greatest number of children.⁶³

In contrast to the North American pattern, Britain's fertility rate increased during the war and peaked in 1947. The birth rate fell after that year, contributing to concern about the declining British population and, consequently, the establishment of the 1949 Royal Commission on Population.⁶⁴ With this decline in fertility rate occurring, Britain was particularly worried about the emigration of its young, most able population groups.⁶⁵ Replacement by immigration was viewed as potentially problematic. Immigrants were generally considered to have fewer job skills than British-trained emigrants, and there was attention paid to the extent to which immigrants could integrate into the "British way of life."⁶⁶ This concern about the problems associated with immigration became stronger as the 1950s progressed. Immediately after the war, there was a major influx of Russian and Polish immigrants. Then, due to the shortage of labour in the United Kingdom, the proportion of West Indian immigrants increased from 1955 to 1961. Public concern about

63 Jones, Landon Y., op.cit.: 29, 31-3.

64 Marwick, Arthur, British Society Since 1945, Harmondsworth, Middlesex: Penguin, 1984: 35, 36, 64; Calvocoressi, Peter, op.cit.: 153.

65 Halsey, A. H., Trends in British Society Since 1900. A Guide to the Changing Social Structure of Britain, London: Macmillan, 1972 : 488, 490.

66 Ibid.: 488, 490.

immigration policies became strong by 1961, probably because by then there was a great shift from the early 1950s, when most immigrants were white.⁶⁷ This anxiety about population composition and growth was basically a renewal of fears of "racial degeneration" and discussion about the need for preservation of the white race and the "British way of life." As Riley suggests:

Immigration was thus not a desirable means of keeping the population at replacement level as it would in effect 'reduce the proportion of homebred stock in the population'. And, it reported that, even allowing for increases in the number of marriages, 'the fertility rates of the immediate prewar years are too low to sustain a stationary population, and would lead, if maintained, to one that would continuously decline by something like twenty per cent in each successive generation'.⁶⁸ (Economics Committee of the Royal Commission, Report, Papers of the Royal Commission on Population, Vol. 3: 53) ... Population-fall anxiety acted as a backdrop to all proclamations and speculations on women, work, the nation and the family, throughout the war. ... At the end of the war pronatalist feeling became both more diffused and more emphatic.⁶⁹

The perceived need for renewal of the British population, then, contributed to a pronatalist definition of normality for women. The construction of womanhood, whether by the state or the medical profession, was a critical factor in addressing this social problem.

⁶⁷ Ibid.: 454-7, 484.

⁶⁸ Riley, Denise, op.cit.: 158, 156.

This was also a significant part of the North American context. Prior to the war, people from Third World nations were particularly discriminated against as immigrants to the United States.⁶⁹ And parallel to the British situation, there was still concern about preventing destruction of the "American way of life" following the war.⁷⁰ Yet a relatively prosperous economy in America meant that immigrants were becoming less threatening as competition for employment.⁷¹ Circumstances were such that theories about the genetic basis of racial superiority were also declining.⁷² The American alliance with China during the war led to the repeal of the Chinese Exclusion Acts in 1943, in particular, and gradually to more openness to immigrants from the Third World, in general.⁷³ But opening the doors to more varied groups of immigrants entailed debate about the potentially hazardous effects of such a policy, and how to control the immigration flow so that it did not take on threatening proportions.

Immigration into Canada increased enormously during the 1950s, constituting a large proportion of the forty per cent increase in the population which occurred between 1941 and

69 Reimers, David M., Still the Golden Door. The Third World Comes to America, New York: Columbia University Press, 1985: 8-10.

70 Ibid.: 16.

71 Ibid.: xiii.

72 Ibid.: xii-xiii.

73 Ibid.: 11.

1956.⁷⁴ From 1941 till 1951, twenty per cent of the population increase, for example, was the result of immigration.⁷⁵ The extent of the immigration boom during the 1950s can be seen in the following table:

Table 5⁷⁶

COMPONENTS OF POPULATION GROWTH, CANADA, 1921-1971
(Thousands of Persons)

Decade	Natural Increase	Net Migration
1921-31	1,360	229
1931-41	1,222	-92
1941-51	1,972	169
1951-61	3,148	1,081
1961-71	2,703	627

Canada's immigration policies during the 1950s were less overtly racist than in previous decades and immigration itself was more accepted. But the Cold War emphasis on national security controls frequently operated as a cover for continuing racist immigration policies.⁷⁷ The British, for example, continued to be the most favoured group of

74 Cited from Urquhart, M.C. and K.A.H. Buckley, eds., Historical Statistics of Canada, Toronto: 1965: 14, in Creighton, Donald, op.cit.: 243.

75 Cited from Canada, Manpower and Immigration, Immigration and Population Statistics, Ottawa: 1974: 31, 6; Leroy Stone, "Canadian Population Growth - Past and Future," Proceedings of the Conference on Future Immigration Policy, Toronto: 1974: 61, Table 1, in Reg Whitaker, op.cit.: 12.

76 Adapted from Department of Manpower and Immigration, Census of Canada, in Manpower and Immigration, Immigration and Population Statistics, Ottawa: Information Canada, 1974: 8 (Table 1.4).

77 Department of Manpower and Immigration, op.cit.: 9, 24; Granatstein, J. L. et al., op.cit.: 308.

immigrants, while others, such as Chinese and blacks, were considered "unassimilable."⁷⁸ Southern Europeans (e.g. Greeks and Italians) were viewed as not being particularly desirable, although Italians formed the second largest group of postwar immigrants.⁷⁹ Ethnic discrimination was also prevalent in the form of strong anti-semitism during and immediately following the war.⁸⁰

In Canada, the United States and Britain, then, a new leniency toward multicultural immigration was accompanied by fears about loss of a familiar population composition, one considered to be racially superior. This provided a social context in which the construction of the "best" women was particularly pronatalist. It was essentially a form of positive eugenics that could have been envisioned as potentially offsetting the impact of the influx of immigrants in the postwar period. Not surprisingly, the context gave rise to pronatalist definitions of normality for women. With concern expressed about the low birth rate

78 Whitaker, Reg, op.cit.: 58-61, 93; Creighton, Donald, op.cit.: 244.

79 Whitaker, Reg, op.cit.: 61-3, 69-73; Creighton, Donald, op.cit.: 243; Granatstein, J. L. et al., op.cit.: 308.

80 Whitaker cites John Holmes, The Shaping of Peace: Canada and the Search for World Order, 1943-1957, Volume 1, Toronto: 1979: 100; Freda Hawkins, Canada and Immigration: Public Policy and Public Concern, Montreal: 1972: 238-40; Irving Abella and Harold Troper, None Is Too Many: Canada and the Jews of Europe, 1933-1948, Toronto: 1983: 190-285; Leonard Dinnerstein, America and the Survivors of the Holocaust, New York: 1982: 192-6, in Reg Whitaker, op.cit.: 27, 63-9; Granatstein, J. L. et al., op.cit.: 266-9.

in North America during the war, the appropriate solution was considered to be the encouragement of women to reproduce, preferably four children each.⁸¹

Pronatalism involves the social encouragement of reproduction and parenthood, and usually includes the assumption that women's fulfillment requires the experience of maternity.⁸² "At its extreme, such thinking results in a view of woman as essentially a reproducing machine."⁸³ This was a view not new to the 1950s, but strongly reinforced in that period. Such pronatalist views have been criticized for their limiting of individuals' "free" choice in a "prejudiced cultural context," but it is difficult to conceive of the existence of any completely unprejudiced context.⁸⁴

This pronatalist thrust, which surrounded the baby boom of the 1940s and 1950s, also promoted the sentimentalization of children as a category, a development which began long before that period. In other words, the increasing importance of purely emotional ties between parents and children had created a new "normative ideal" of the child as a non-commercial, emotional asset.⁸⁵ This trend substituted

81 Riley, Denise, op.cit.: 151.

82 Peck, Ellen and Judith Senderowitz, Pronatalism. The Myth of Mom and Apple Pie, New York: Thomas Y. Crowell Co., 1974: 1.

83 Ibid.: 2.

84 Ibid.: 2.

85 Zelizer, Viviana A., Pricing the Priceless Child. The Changing Social Value of Children, New York: Basic Books, Inc., 1985: 11, 15.

another reason for promoting reproduction, once the economic usefulness of children had declined. The mother's existence became not only home and consumption-oriented, but child-centred as well.⁸⁶ The supervision and domestication of children, a recent development in the case of working class boys, were tasks which fell primarily to mothers.⁸⁷

One of the outcomes was the isolated "family haven." This seemingly private sphere in fact entailed an ideal of a family-centred father as well. Theoretically, middle class men were now expected to participate, at least to a minor degree, in child care and "companionate" marriage. Advice manuals of the time, for example, noted the importance of fathers to families. However, even in those texts, fathers remained situated in the distant background.⁸⁸ And in practice, gender relations similar to those which existed during the war persisted throughout the late 1940s and 1950s. The difference was that the absent middle class father was now at work in the city, instead of at war.⁸⁹ One study of Canadian suburbia of the 1950s concluded that men and women had wholly separate "cultures" and ideologies, with the men acting as "visitors from the "real world" " of business.⁹⁰ Hence, a quite rigid gendered division of labour persisted, particularly with the pronatalist trend of the

86 Ogden, Annegret S., op.cit.: 167.

87 Zelizer, Viviana A., op.cit.: 52, 54.

88 Margolis, Maxine L., op.cit.: 74-5.

89 Breines, Wini, op.cit.: 604.

90 Seeley, John R. et al., op.cit.: xi, xiii.

1950s. This division of labour and the slight amount of increase in the total number of women in the labour force, from the war till 1957,

demonstrated that Canadians still remained overwhelmingly a patriarchal society, resistant to change in the relations between the sexes.⁹¹

This appears to have been the case in Britain as well. The gendered division of labour had changed little from the prewar period to the 1950s.⁹² Post-World War II, welfare state legislation perpetuated some of the assumptions that had characterized earlier middle class notions of the proper gendered division of labour - "especially the ideal of dependent wife and children and the importance of good mothering."⁹³ Women's sexuality was generally defined and categorized, with heterosexuality classified as normal. Condemnation of homosexuality, as well as of prostitution, was "related to concern for the race, motherhood and population."⁹⁴

It was probably the case that many women who had grown up through a Depression and war looked forward in the 1950s to more stable and prosperous environments.⁹⁵ In all

91 Granatstein, J. L. et al., op.cit.: 315.

92 See Marwick for a discussion of social class differences in the gendered division of labour in postwar Britain. Marwick, Arthur, op.cit.: 67-9.

93 Gittins, Diana, The Family in Question. Changing Households and Familiar Ideologies, Atlantic Highlands, N. J.: Humanities Press International, Inc., 1985: 146-7.

94 Ibid.: 147.

95 Woloch, Nancy, Women and the American Experience, New York: Knopf, 1984: 496.

likelihood, sentiments of pronatalism and domesticity would have been appealing to women following the war. The fact that women held some of these notions does not mean that they were imposed from above or that women experienced a period of self-delusion. Betty Friedan recently described why "the feminine mystique," the notion of fulfillment through motherhood, for example, was widely accepted at the time. In her view, the only other option for most women was a dead-end job or a career where, being a woman, they would not be accepted. So many women adopted pronatalist ideas because child-rearing was the more secure and fulfilling alternative.⁹⁶

The huge increase in middle class suburban growth which accompanied this gendered division of labour may have represented a re-privatization of women.⁹⁷ However, it also symbolized security, through upward mobility and a certain standardization of lifestyle. O'Neill writes that:

We have been caught up in a curious mixture of commercialism and welfarism that has sold us the ideal of nuclear family, in a form suburbanized and standardized to the point of inanity.⁹⁸

Suburbia, as a phenomenon, became part of the North American norm of the middle class, nuclear, monogamous and heterosexual family, with its distinct gendered division of

⁹⁶ Lewis, Peter, op.cit.: 45.

⁹⁷ Riesman, David et al., op.cit.: 280-1.

⁹⁸ O'Neill, John, Five Bodies. The Human Shape of Modern Society, Ithaca: Cornell University Press, 1985: 84.

labour. However, the forty-seven per cent population increase in American suburbs from 1950 to 1960 excluded ethnic minorities and the poor.⁹⁹ The international power of the United States and its internal racial segregation, meant that white, middle class suburbanites, the "prototypical" Americans of the time, were able to ignore social problems.¹⁰⁰ Although the racial and Cold War tensions were ever-present, the group of North Americans designated "normal" were able to avoid dealing with those tensions in everyday life and could concentrate upon their own upward mobility.¹⁰¹ Whyte found that a dual ethic of egalitarianism (amongst suburbanites themselves) and of upward mobility was characteristic of this group. The homogeneity of the setting in fact made people more sensitive to the symbolic meaning of the acquisition of possessions, resulting in a process that Whyte termed "inconspicuous consumption." This was a phenomenon directed, not so much at acquisitiveness for its own sake, but at the attainment of stability, as the definition of "the good life."¹⁰² In Canada and the United States, the rhetoric about stability included fears about the decline of the family, as reflected in the increase in the number of divorces. Looking at the figures, however, we

99 Ogden, Annegret S., op.cit.: 180.

100 Horn, Richard, op.cit.: 28.

101 Lewis describes the central importance of social striving in suburban life, including the effort to move continually to "better" suburbs. Lewis, Peter, op.cit.: 28.

102 Whyte, William H. Jr., op.cit.: 312, 324.

find that the divorce rate increased in Canada during the first two years following the war, but subsequently steadily declined.¹⁰³ By 1956, the rate was 37.4 per 100,000.¹⁰⁴ This was also apparently the pattern in the United States, as indicated in the following table:

Table 6¹⁰⁵U.S. DIVORCE RATES, 1920-1960

<u>Year</u>	<u>Divorce and Annulment Rate per 1000 Population</u>
1920	1.6
1930	1.6
1940	2.0
1946	4.3
1950	2.5
1960	2.2

Discussions about the prevalence of divorce also contained the notion that more juvenile delinquency would result from this threat to family stability. Yet, the crime

103 Urquhart, M.C. and K.A.H. Buckley, 42 in Donald Creighton, op.cit.: 246.

104 Urquhart, M.C. and K.A.H. Buckley, 42 in Donald Creighton, op.cit.: 246.

105 Adapted from Historical Statistics of the United States, Colonial Times to 1957, Series B-29: 22; U.S. Bureau of the Census, Statistical Abstract of the United States, Washington, D.C.: 1972: 63; National Center for Health Statistics, Monthly Vital Statistics Report, March 14, 1980: 2; National Center for Health Statistics, Monthly Vital Statistics Report, October 5, 1983: 9; American Demographics 9, June, 1987: 20, in Gerald R. Leslie and Sheila K. Korman, The Family in Social Context, 7th edition, New York: Oxford University Press, 1989: 502 (Table 18.1).

rate, or at least the arrest rate, does not appear to have altered substantially in Canada, following the war.¹⁰⁶ The number of offences remained constant from 1940 to 1955, and the rate of juvenile delinquency actually dropped from the beginning of the war.¹⁰⁷

There reigned in Britain, by the late 1950s, a perception of increasing affluence and Americanisation of British culture. Economic development, weakening of family ties with the emergence of a welfare state, and the increased numbers of working mothers, were all targetted as causes of increased hooliganism and violence in Britain (e.g. the Teddy Boys). The "British way of life" was a prevalent rhetorical phrase of the time, which was used in a way symbolic of a perceived loss of traditional authority, greater permissiveness, and more delinquency. Contradicting the argument that easy affluence was to blame, working class boys were, in fact, the source of the hooliganism. This violence was perceived as an alien, new development in British society, one repeatedly linked in rhetoric to "racial degeneration" and social instability.¹⁰⁸ The British Medical Association, for example, emphasized postwar

106 Urquhart, M.C. and K.A.H. Buckley, 643, 649, 650, 653, in Donald Creighton, op.cit.: 245.

107 Ibid.: 245.

108 Pearson, Geoffrey, op.cit.: 12, 15-20, 225.

prosperity as contributing to " 'wild behaviour, even crime'"¹⁰⁰ in its assessment of the situation:

'The society in which today's adolescents find themselves is one of bewildering change ... the whole face of society has changed in the last 20 years ... a decrease in moral safeguards, and the advent of the welfare state has provided a national cushion against responsibility and adversity.'¹¹⁰

One solution to these problems of social degeneration was the promotion of pronatalist sentiments, within a traditional gendered division of labour. In other words, women were to reinforce their long-standing social role as moral guardians, a role designated as part of normal womanhood.

Women's reproductive and mothering capacities, then, became emphasized in the social contexts of the 1950s in Britain and North America. The categorization of female reproduction as normality was partially the outcome of efforts to attain wider social stability in the postwar period. This was particularly the case in the 1950s, when there were political upheavals (such as the Cold War), tensions around gender relations, and the desire to manage populations for particular ends. These aspects of the social contexts informed the construction and acceptance of medical knowledge about women. Specifically, the contexts

109 British Medical Association, The Adolescent, 1961: 5-6, in Geoffrey Pearson, op.cit.: 16.

110 British Medical Association, The Adolescent, 1961: 5, cited in Geoffrey Pearson, op.cit.: 15.

provided resources, such as the social definitions of womanhood and the gendered division of labour, which physicians drew on in the production of medical knowledge.

Chapter 6

Turning to the Scientific Experts

A social reliance on expert knowledge reinforced the formulation of categories of normality and abnormality for women, and the standardized content with which they were infused, in 1950s medical knowledge. The broader social context, discussed in the previous chapter, provided resources for the construction of that medical knowledge of women. But, in addition, the professional concerns of physicians formed a context which those physicians drew upon in formulating their ideas and discourse. Hence, this chapter reviews some important aspects of the medical context which were relevant to the production and acceptance of obstetric and gynecologic knowledge specific to that era. It is a discussion of the significance of debates and tensions for the content of this knowledge. These tensions were produced by: state interest in national health insurance, the scientization of medicine that produced a biomedical model, the relation of that process to the medicalization of life and the inclusion of psychosocial approaches in medicine, and increasing specialization, as part of a general rationalization of medicine. The focus is on how these trends formed a medical, professional context

which encouraged the development of categorizations of women as normal and abnormal in obstetrics and gynecology, with content particular to the 1950s.

The suburban mother was the epitome of normal womanhood during the 1950s. But what constituted proper mothering was not decided by mothers alone. Some sociologists of the family argue that there has been a historical trend toward increasing state intervention into the family.¹ This direction was given added impetus with the postwar development of the welfare state. The predominance of expert opinion and its specific content in the 1950s were closely linked to the expansion of the economy and education.² Administration of the welfare state relied on and provided state-sanctioned legitimacy to scientific experts, such as the medical profession. And increasing intervention by scientific experts supported a particular definition of normal families, women, men and children. One of the tasks of these experts was the defining of normality

¹ See, for example, Jacques Donzelot, The Policing of Families, New York: Pantheon Books, 1979; Christopher Lasch, Haven in a Heartless World: The Family Besieged, New York: Basic Books, 1977. For discussions of this view, cf. Denise Riley, War in the Nursery. Theories of the Child and Mother, London: Virago Press, 1983; Diana Gittins, The Family in Question. Changing Households and Familiar Ideologies, Atlantic Highlands, N.J.: Humanities Press International, Inc., 1985.

² Matthews, Jill Julius, Good and Mad Women. The Historical Construction of Femininity in Twentieth-Century Australia, Sydney: George Allen & Unwin, 1984: 103-4.

and the detection of deviations from the set norms - of abnormality.

This included the construction of the maternal body in terms of normal and abnormal processes, and of normal womanhood as motherhood. The process of defining reality was not, however, a medical monopoly or the result of a unilateral imposition by experts or the state.³ In many instances, women accepted an alliance with the experts because it addressed women's own needs. For example, such a coalition between medical experts and women may have benefitted women by contributing to the decline of familial patriarchy.⁴ An alliance between women and the medical profession, though, was composed of unequal power relations, meaning that the decisions women made regarding maternity and child rearing were constrained, within limits framed, among other factors, by the professional, scientific experts.⁵ The medical sciences were major sources of this expertise in normality and abnormality, sources shaped in turn by their social and professional context.

This turning to medical science for expertise has been part of a process of increasing medicalization of life, in

3 cf. Riley on the lack of consistent alliance between psychologists and the state in postwar Britain. Riley, Denise, op.cit. passim.

4 Donzelot, Jacques, op.cit. passim; Riessman, Catherine Kohler, "Women and Medicalization: A New Perspective," Social Policy 14, Summer, 1983: 3-4.

5 Matthews, Jill Julius, op.cit.: 176; Riley, Denise, op.cit.: 109.

particular, of women's biology and reproductive processes. Foucault points out that "political anatomy" is important; the reproductive body is central to the exercise of power and scientific discourse.⁶ The process of medicalization of women's reproduction is part of a larger process of subordination of the body to bureaucratic, professional care. "Private" life, including mothering, was increasingly standardized by the helping professions - with doctors at the top of the professional hierarchy.⁷ After World War II, the legitimate right of experts to establish standards and norms became more widely accepted by the general population.⁸ From the second world war on, medical expertise was equated with "progress," as that was how the most efficient and beneficial decisions were deemed to be made in a standardized and rationalized society.⁹ Behaviour which did not fit the model of normality was perceived as individual illness, and experts held the right to ensure

6 Foucault, Michel, Discipline and Punish: The Birth of the Prison, tr. Alan Sheridan, New York: Vintage, 1979: 28; as cited in John O'Neill, Five Bodies. The Human Shape of Modern Society, Ithaca: Cornell University Press, 1985: 132-4.

7 Matthews, Jill Julius, op.cit.: 100.

8 Ibid.: 102; Susman describes how science and psychiatry were included in the group of counsellors expected, even by the forties, to teach Americans how to participate in the American way of life. Susman, Warren I., Culture as History. The Transformation of American Society in the Twentieth Century, New York: Pantheon Books, 1984: 202-3.

9 Starr, Paul, The Social Transformation of American Medicine, New York: Basic Books, Inc., 1982: 363.

that deviant behaviour was made to conform with the ideal of normality.¹⁰

There was major postwar growth in medical research, the result of the notion that scientific and medical research had been crucial to national security during the war. In the United States, national interest in the research industry was maintained because of the desire to guard the dominant position of the States as an international power, particularly in the face of the Cold War.¹¹ This encouraged a great expansion in medical and scientific knowledge following the second world war.¹² Consequently, there was advancement in that period in medicine's capacity to affect positively the outcome of disease, a significant factor in the legitimization of medical expertise. There were major developments in drug therapy, particularly with the new availability of antibiotics. Diagnostic and surgical skills also increased, contributing to the faith in medical experts to cure disease.¹³

The medicalization of life also meant that these practitioners increasingly took over what were previously moral, value questions - about the definitions of maturity,

10 Matthews, Jill Julius, op.cit.: 103.

11 Starr, Paul, op.cit.: 335.

12 Gill, Derek, "A National Health Service: Principles and Practice," in Peter Conrad and Rochelle Kern, eds., The Sociology of Health and Illness. Critical Perspectives, 2nd edition, New York: St. Martin's Press, 1986: 462.

13 Shorter, Edward, Bedside Manners. The Troubled History of Doctors and Patients, New York: Simon & Schuster, 1985: 21-23.

illness and wellness, rational and real. The portrayal of expertise as emerging out of a neutral science of medicine denies the fact that value judgements are being made regarding what constitutes "the good life" and criteria of normality.¹⁴ For example, breastfeeding was advocated as being "good" (relative to bottle-feeding), meaning not just that it was natural, but that the mental health experts deemed it important for the production of a "good" child.¹⁵

Designations of deviance have increasingly shifted from the moral to the medical sphere. With the apparent success of medicine in controlling communicable diseases, the growth of scientific biomedicine, the political organization and lobbying of the American Medical Association, and the profession's control over medical education and licensing, medicine has become a prestigious profession in the 20th century. The medical profession dominates the organization of health care and has a virtual monopoly over anything that is defined as an illness or a "medical" treatment.¹⁶

With this "defamilization" of the body, life as a whole entered the marketplace.¹⁷ Science took up the task of educating the middle class woman in child care and this contained the expectation that mothers apply efficient

14 Turner, Bryan S., The Body and Society. Explorations in Social Theory, Oxford and New York: Basil Blackwell, 1984: 209, 214.

15 Seeley, John R., R. Alexander Sim, and E.W. Loosley, Crestwood Heights. A Study of the Culture of Suburban Life, Toronto: University of Toronto Press, 1956: 419.

16 Conrad, Peter and Joseph W. Schneider, Deviance and Medicalization. From Badness to Sickness, St. Louis: C. V. Mosby Co., 1980: 36.

17 O'Neill, John, op.cit.: 120, 132-4.

"principles of management," as extracted from the marketplace, to childrearing.¹⁸ The thrust towards medicalization, with the application of medical categories to women's biology and designated social roles, was essentially, then, part of a larger process of the rationalization of life.

While Dr. Spock's¹⁹ permissive practices in child-rearing were well-known, there were also behaviourist notions underpinning the child psychology of the period. The mother's influence on the child was considered very important, as it was thought possible to develop a child's behaviour in a desired direction.²⁰ Spock's advice to mothers diverged from the previously strict behaviouristic principles, but emphasis on the importance of the mother and the environment on the child remained. Particularly with the additional influence of Freudian theories, the early years of a child's life were deemed crucial. In terms of practical expectations, this implied that women should be discouraged from working outside the home if they had children.²¹ Children were seen to require emotional, as well as physical, care from full-time mothers who made the

18 Margolis, Maxine L., Mothers and Such. Views of American Women and Why They Changed, Berkeley: University of California Press, 1984: 61.

19 Spock, Dr. Benjamin, Baby and Child Care, Cardinal Edition, New York: Pocket Books, Inc., 1951.

20 Ogden, Annegret S., The Great American Housewife. From Helpmate to Wage Earner, 1776-1986, Westport, Connecticut: Greenwood Press, 1986: 177.

21 Lewis, Peter, The Fifties, London: Heinemann, 1978: 47.

nation's need for "well-adjusted" citizens their first priority.²²

British psychologist, John Bowlby, was renowned for his emphasis upon the child's need for full-time mothering.²³ The commonplace notion of "maternal deprivation," which emerged out of that thesis, was a castigation of the working mother. Obviously that version of normality referred only to middle class, white women, as all other women were occupied outside the home. The rejecting mother was regarded with disapproval, and the meaning invested in the concept of "rejecting" was broad and included working mothers. The vision of the overprotective mother was also a social concern, as expressed in the phenomenon of "Momism." This was a portrayal of mothers as powerful and threatening to men and their children. Mothers might well have been very involved with their children, since middle class, suburban women had few other interests to pursue, but significantly, the fear was mainly that sons might be overprotected.²⁴ The anxiety around the supposed

22 Margolis, Maxine L., op.cit.: 70-1.

23 cf. Bowlby, John, Maternal Care and Mental Health, a report prepared on behalf of the World Health Organisation, Geneva, 1952; Child Care and the Growth of Love, London: 1953, 1965; "Can I Leave My Baby?" (pamphlet), National Association for Mental Health, London: 1958; "The Nature of the Child's Tie to His Mother," International Journal of Psycho-Analysis, 38-9, 1958: 350-72, etc., cited in the bibliography of Denise Riley, op.cit.: 219.

24 Breines, Wini, "Domineering Mothers in the 1950s: Image and Reality," Women's Studies International Forum, Vol.8, #6, 1985: 603.

emasculatation of men's lives in the work world, as noted earlier, was one of the sources of this notion of mothers' "overinvolvement" with their sons.

Such management of the quality of population and biological processes like reproduction, as attempted by these experts on mothering and children, have socio-political significance. The populations of nations have been increasingly rationalized, with state attention to the regulation of mortality, reproduction, and so on. As Foucault's studies of rationalized institutions makes clear, increased standardization through the use of scientific expertise results in the power of surveillance over populations and reproduction. Less tolerance for any deviance from the normal, as it is defined by medicine, characterizes these societies.²⁵ This rationalization includes, for example, control over the sexuality of populations. The "sciences of the body," such as medicine, participate in producing discourses about sexuality as part of the management of populations, specifically with the "aim to control and normalize sexuality."²⁶ As we have already seen, during the 1950s, this took the form of labelling homosexuality abnormal and frequently pinpointing

25 Turner, Bryan S., Medical Power and Social Knowledge, Beverly Hills: Sage, 1987: 13; cf. Foucault, Michel, The Birth of the Clinic. An Archaeology of Medical Perception, New York: Pantheon Books, 1973.

26 Turner, Bryan S., The Body and Society. Explorations in Social Theory, Oxford: Basil Blackwell, 1984: 36, 48.

overbearing mothers as the source of this sexuality as deviance. The extent of this concern about controlling sexuality was particularly evident with the 1952 Canadian Immigration Act. Pressure from American security forces and the R.C.M.P. resulted in the formal barring of the immigration of homosexuals, based on the assumption that they posed a security risk to the Canadian state. While the legislation does not appear to have been translated into policy, the R.C.M.P. sought out and attacked homosexuals in the Canadian public service later in the 1950s.²⁷

Women were central to such efforts to control populations. The regulation of populations and bodies took the form of a racial and class-oriented eugenics, which operated through control of women's reproduction (though the latter term was in disfavour after the Nazi eugenic policies during the war).²⁸ The pronatalism that targeted the "working mother" as responsible for deviance from the definition of normality, represented a rhetoric of the management of population quantity and quality.²⁹

27 Girard, Philip, "From subversion to liberation: homosexuals and the Immigration Act 1952-1977," draft paper in Reg Whitaker, Double Standard. The Secret History of Canadian Immigration, Toronto: Lester & Orpen Dennys Ltd., 1987: 37-8.

28 Haller, Mark H., Eugenics. Hereditarian Attitudes in American Thought, New Brunswick, New Jersey: Rutgers University Press, 1984 (originally 1963): 183.

29 Pearson, Geoffrey, Hooligan. A History of Respectable Fears, London: Macmillan Press Ltd., 1983 : especially Chapter 3 and p. 223.

The central focus of this population ideology was women's bodies; its principal mode of control was women's work within their families; its central icon was the Ideal Mother.³⁰

Reproduction was being rationalized and regulated, encouraging middle class, white reproduction and discouraging that of the working class and immigrants. In particular, those who failed to succeed economically and, therefore, did not achieve the North American middle class norm, were considered suitable candidates for population control. For example, one population controller warned in 1958 that data from the United States, the United Kingdom, and Sweden indicated persistently high fertility amongst those with the least educational and economic resources. He claimed that this was "one of the potent forces in the perpetuation of slums, ill health, inadequate education, and even delinquency."³¹ What was at stake here was largely a question of national and international security and social order.³² This fact became evident when this same author claimed that:

It would be very hard to continue a stable, democratic government in India,

30 Matthews refers to Michel Foucault's Discipline and Punish: The Birth of the Prison, Harmondsworth: Penguin, 1979: 139, in Jill Julius Matthews, op.cit.: 75.

31 Osborn, Frederick, Population: An International Dilemma, New York: The Population Council, 1958: 14.

32 Reed, James, "Doctors, Birth Control, and Social Values," in Morris J. Vogel and Charles E. Rosenberg, eds., The Therapeutic Revolution. Essays in the Social History of American Medicine, Philadelphia: University of Pennsylvania Press, 1979: 128.

or in any other country, if poverty and hunger were on the increase.³³

Overpopulation was considered a problem primarily of the Third World. One reason for the increased emphasis upon population control on an international level after the war was the fact that American capital was now dominant, making it important to ensure international stability, and thereby, economic growth.³⁴ This growth was also dependent on the quality of the country's population.

Family planning and population control became positive eugenicist policies, acceptable alternatives to the previous negative eugenics, perhaps because they were thought to encourage social stability through building stronger nuclear families.³⁵ In the United States, Canada, and Britain, pronatalist sentiment encouraged white, middle class populations to reproduce. Not only the States, but also more class-conscious Britain, was concerned with social order after the war. This emerged as a concern to dampen "sex antagonisms" and to diminish class demarcations.³⁶ In texts about work and maternity, the discussions referred to the existence of "society" and "community," while social class was "rendered invisible."³⁷ This ideology of consensus

33 Osborn, Frederick, op.cit.: 10.

34 Shapiro, Thomas M., Population Control Politics. Women, Sterilization, and Reproductive Choice, Philadelphia: Temple University Press, 1985: 66-67.

35 Ibid.: 9.

36 Heron, Liz, Truth, Dare or Promise. Girls Growing Up in the Fifties, London: Virago Press, 1985: 5.

37 Riley, Denise, op.cit.: 188.

meant that one form of normality could be put forth as representative of all classes of society. So while there was strong pronatalism, a seemingly contradictory acceptance of birth control and genetic screening was also increasing, as a means to quality control of the population.

Eugenics had acquired a more scientific form in this period³⁸ and shifted its emphasis from hereditary factors to the impact of the environment on human development. More concern with the mutating effects of radiation and medical genetics emerged out of fears about nuclear power.³⁹ This led to efforts to manage the quality, not only the quantity, of population at the national level. Gittins notes that state legislation is frequently

concerned with the overall problem of population - the quality and quantity of a nation's populace, an issue directly related to a nation's wealth and resources, but also to its political and social stability.⁴⁰

The concern for both quantity and quality meant that pronatalism and family planning could be accepted simultaneously.⁴¹

The notion of quality population revolved, then, around the norm of the nuclear, middle class, suburban family with the full-time mother. This contained an implicit obverse, that deviation from this version of normal reality was

38 Haller, Mark H., op.cit.: 183.

39 Ibid.: 183-4.

40 Gittins, Diana, op.cit.: 152.

41 Riley, Denise, op.cit.: 159.

pathological and threatening. Such a vision promoted a conformity that would lend itself to a predictable, stable society characterized by manageability.⁴² The helping professions, with the expertise of science and medicine, helped to identify and manage deviations, such as family breakdowns and juvenile delinquency.

For many years, those in the social sciences and counseling professions saw and wrote of a wide gap between the "normal" majority and the problematic minority -- those who could not achieve the domestic American dream.⁴³

As we have already seen, the British medical profession participated in targetting delinquency and hooliganism, activities primarily engaged in by working-class youth.⁴⁴

As noted earlier, these social problems and pathologies were frequently linked to the abnormal mother, the mother who worked in the wage labour force.⁴⁵ Such allegations were prevalent in popular media, as well as the writings of professionals such as psychologists and physicians.⁴⁶ The process of rationalization, scientization, and standardization in all spheres of life contributed to an enormous concern with normality and pathology, in which

42 Peck, Ellen and Judith Senderowitz, Pronatalism. The Myth of Mom and Apple Pie, New York: Thomas Y. Crowell Co., 1974: 6.

43 Ogden, Annegret S., op.cit.: xiii.

44 Pearson, Geoffrey, op.cit.: 15-17.

45 Woloch, N., Women and the American Experience, New York: Knopf, 1984: 506.

46 Pearson, Geoffrey, op.cit.: 17; and, for example, the psychologist John Bowlby's theory of maternal deprivation. Bowlby, John, op.cit. passim.

women were viewed and defined in particular ways. These were class and racially-specific conceptualizations, although the prevalence of the single, standardized version of ideal social reality partially concealed that fact at the time. Notions of womanhood were central to the ideal which was created in the knowledge of scientific and medical experts, owing to the significance of women's reproductive capacities for management of populations.

Reliance on Medical Expertise

The professional context of obstetrics and gynecology during the 1950s felt the impact of the growing rationalization of western capitalist societies. As the medical profession was increasingly consulted for the provision of a rational, scientific basis for social practices and concepts, the profession increased its influence. The task of providing legitimate definitions of social and biological reality granted greater power to the profession.

That these frequently took the form of definitions of normality and abnormality was reinforced by the emphasis on pathology already existent in the biomedical model, so prevalent at the time. The term biomedical refers to the dominant model which emerged out of the scientific advances of the nineteenth century "regular" faction of doctors.

advances such as the germ theory of disease. Disease, according to this model, arises out of biological problems within the body. The biomedical model pays little attention to the external environment.⁴⁷ The consultation of medical experts in delineating concepts of normality and abnormality created further incentives for particular trends to develop within medicine, such as specialization and scientization. But such professional changes created conflict in the profession generally and within individual specialties, like obstetrics and gynecology. Bureaucracy, state intervention, specialization, and the increasing emphasis on scientific medicine itself were all viewed differently by various factions, based on the effects which would impinge on their specialty, the cohort affected, and so on.

The changing position of the medical profession in the wider society, coupled with related internal transformations, formed a professional context in the 1950s, filled with ambivalence about these processes. Knowledge about women's biology and gender emerged with a form consistent with this professional context of the time. Obstetricians and gynecologists drew upon such social, professional resources in their construction of the meanings of biomedical normality and abnormality for women.

⁴⁷ Conrad, Peter and Joseph W. Schneider, Deviance and Medicalization. From Badness to Sickness. St. Louis: The C. V. Mosby Co., 1980: 13-4, 35.

As already noted, the cadre of professional experts, including medical ones, expanded greatly following World War II. With increasing bureaucratization and the development of new, middle class, white-collar occupations, professions like medicine became routes to the maintenance of upward mobility for those in the upper echelons of the middle class.⁴⁸ It has been suggested that in the case of medicine, professionalism may act as a method of class closure for the middle class.⁴⁹ For example, at the beginning of the twentieth century, entrance requirements were introduced by medical schools, which emphasized the need for students to possess particular educational credentials. This effectively excluded American working class applicants, reinforcing the middle and upper class character of the medical profession.⁵⁰ A split developed between academic, university, teaching doctors and community practitioners. Academic medicine was more exclusively restricted to the new middle class, and was a form of medicine in which doctors were more aligned with their career than with their

48 Most doctors were recruited from the upper middle class, as indicated by their father's occupation. Most had fathers holding managerial and professional positions. Blishen, Bernard R., Doctors and Doctrines. The Ideology of Medical Care in Canada, Toronto: University of Toronto Press, 1969: 32-3.

49 Parry, Noel and José Parry, The Rise of the Medical Profession. A Study of Collective Social Mobility. London: Croom Helm, 1976: 52 & 1.

50 Ludmerer, Kenneth M., Learning to Heal. The Development of American Medical Education, New York: Basic Books, Inc., 1985: 118-121.

community.⁵¹ The expansion of both the medical profession and the middle class during the 1950s contributed to an entrenchment of their alignment. These professional experts were from the social class which was experiencing rationalization in all facets of life during the 1950s.

It was also the group being consulted for rational, technical knowledge.⁵² This was knowledge used to define normality, and seen as desirable, owing to the apparent status of that knowledge as value-free. Critical Theory was fundamental to the disclosure of the fallacy of this depoliticisation of science and the biomedical model.⁵³ What is claimed by professions, like medicine, is that the technical status of their knowledge distinguishes it from

51 Ibid.: 215.

52 Freidson notes the close association between rationalization and the development of formal, scientific knowledge. The end of such knowledge is the use of reason to attain functional efficiency. It is a product of accounting and management methods that developed fully with capitalism. The knowledge is also a result of the rise of administrative means for obtaining "predictable social order" - the rise of rational-legal, bureaucratic aspects of the modern state. Freidson, Eliot, Professional Powers. A Study of the Institutionalization of Formal Knowledge, Chicago: University of Chicago Press, 1986: 3-4; cf. also Weber, Max, The Protestant Ethic and the Spirit of Capitalism, New York: Charles Scribner's Sons, 1958 and H. H. Gerth and C. Wright Mills, eds., From Max Weber: Essays in Sociology, New York: Oxford University Press, 1946: especially Chapter VIII on bureaucracy.

53 Comaroff, Jean, "Medicine: Symbol and Ideology," in Peter Wright and Andrew Treacher, eds., The Problem of Medical Knowledge. Examining the Social Construction of Medicine, Edinburgh: Edinburgh University Press, 1982: 59; Marcuse, Herbert, One-Dimensional Man. Studies in the Ideology of Advanced Industrial Society, Boston: Beacon Press, 1964.

the rest of life, where socio-political and value considerations lie.⁵⁴ In other words, as Habermas pointed out, rational knowledge can eradicate the value choices or political alternatives, in its concentration upon means or technical decisions.⁵⁵ Indeed, the replacement of moral by scientific-technical arguments denies responsibility and ends up "denying the validity of debating...beliefs on their own merits."⁵⁶ The significance of this for the professionalization process is great in societies where this claim is accepted at face value. The possession of special knowledge is part of the mainstay of the status and power of professions. It allows a profession to control not only the production of knowledge, but also the definition of what constitutes knowledge at all.

...it is clear that it is a valuable asset for a professional group if the knowledge that they employ acquires the status of technical. Power and knowledge are thus clearly linked. The recent sociology and history of the professions demonstrate countless ways in which possession of power enables a group to redefine what is knowledge and numerous examples of successful claims to the possession of knowledge resulting in increased power.⁵⁷

54 Wright, Peter and Andrew Treacher, eds., op.cit.: 6.

55 Habermas, Jurgen, Toward a Rational Society, Boston: Beacon Press, 1971, in Eliot Freidson, Professional Powers. A Study of the Institutionalization of Formal Knowledge, Chicago: University of Chicago Press, 1986: 7-8.

56 Freidson, Eliot, Professional Dominance: The Social Structure of Medical Care, Chicago: Aldine Publishing Co., 1970: 6.

57 Ibid.: 6.

Hence, the rationalization of society as a whole, including the importance accorded professional expertise, gave rise to a more influential medical profession during the 1950s, and one which could more legitimately define women's biology and femininity. This increase in prestige, however, resulted in tensions within the profession, tensions which were part of the social, professional context of that knowledge of women. The insecurities and particular trends experienced within the profession at that time contributed to the development of categorizations of women's medical conditions that were, partially, expressions of those trends. Other aspects of rationalization intruded upon the professional autonomy cherished by the medical profession, and factions differed in their responses to this new context. One of the issues, which was particularly threatening for the profession during the 1950s, was that of state efforts to develop and implement universal health insurance.

The Threat of Socialized Medicine

Although it did not directly affect the medical construction of knowledge about women, the health insurance issue was important as an instance where views of broader socio-political changes interacted with health care issues impinging on the profession itself. The focus of our study

is the knowledge about women accepted in Canada in the 1950s, so the discussion here concentrates upon the Canadian situation. However, the debates about universal health insurance in the United States and Britain informed the

Canadian discussions of the period, so also need to be noted.⁵⁸

58 The history of struggles over universal health insurance are detailed in many useful sources. On the Canadian situation, cf.: Blishen, Bernard R., *op.cit.*; Bothwell, Robert S. and John R. English, "Pragmatic Physicians: Canadian Medicine and Health Care Insurance, 1910-1945," in S.E.D. Shortt, ed., *Medicine in Canadian Society. Historical Perspectives*, Montreal: McGill-Queen's University Press, 1981; Soderstrom, Lee, *The Canadian Health System*, London: Croom Helm, 1978; Badgley, R. F. and S. Wolfe, *Doctors' Strike. Medical Care and Conflict in Saskatchewan*, Toronto: MacMillan, 1967; Taylor, M. G., *Health Insurance and Canadian Public Policy*, Montreal: McGill-Queen's University Press, 1978; Walters, Vivienne, "State, capital and labour: the introduction of federal-provincial insurance for physician care in Canada," *Canadian Review of Sociology and Anthropology*, 19, 1982: 157-172; Torrance, George M., "Socio-Historical Overview: The Development of the Canadian Health System," in David Coburn et al., *Health and Canadian Society. Sociological Perspectives*, 2nd edition, Markham: Fitzhenry and Whiteside, 1987.

On the British context, refer to: Barker, Elisabeth, *The British Between the Superpowers, 1945-50*, Toronto: University of Toronto Press, 1983: 103; Calvocoressi, Peter, *The British Experience 1945-75*, London: The Bodley Head, 1978: 33-7; Doyal, Lesley, *The Political Economy of Health*, London: Pluto Press, 1979; Gilbert, B. G., *The Evolution of National Insurance in Great Britain*, London: Michael Joseph, 1966; Gill, Derek, *op.cit.*; Marwick, Arthur, *British Society Since 1945*, Harmondsworth: Penguin Books, 1984: 55-8; Oakley, Ann, *The Captured Womb. A History of the Medical Care of Pregnant Women*, Oxford: Basil Blackwell, 1986; Sidel, Victor W. and Ruth Sidel, *A Healthy State. An International Perspective on the Crisis in United States Medical Care*, New York: Pantheon Books, 1977: 140-7; Walters, Vivienne, *Class Inequality and Health Care*, London: Croom Helm, 1980.

The American situation is dealt with in: Ludmerer, Kenneth M., *op.cit.*; Mechanic, David, *The Growth of Bureaucratic Medicine. An Inquiry into the Dynamics of Patient Behavior and the Organization of Medical Care*, New York: John Wiley and Sons, 1976; Shryock, Richard Harrison, *The Development of Modern Medicine. An Interpretation of the Social and Scientific Factors Involved*, Madison, Wisconsin: University of Wisconsin Press, 1974; Starr, Paul, *op.cit.*: 236-280.

Universal health insurance was most strongly opposed in the United States. Those groups in the population who were most influential already had private insurance, so had no reason to support the universalizing of public-subsidized insurance plans during the 1950s.⁵⁹ The Canadian federal government pushed for more public intervention in the form of health insurance with its 1945 Dominion-Provincial Conference on Reconstruction.⁶⁰ But most of the medical profession advocated voluntary physician-controlled plans because it would allow them to provide insurance on their own terms.⁶¹ So any state intervention in the form of a universal insurance plan was still opposed during the 1950s.

The National Health Act could be enacted in 1946 in Britain partially because of the weaker anti-communist sentiment, stronger socialist parties relative to those in the States, and the desire to rebuild a more equitable society under the Labour Party.⁶² The pronatalism of the postwar period in Britain was an additional factor, conducive to the development of the National Health Service:

The purpose of the NHS was to create a better and still healthier world for Britain's babies - and a world in which women would be happy to bear them.⁶³

59 Starr, Paul., op.cit.: 334.

60 Blishen, Bernard R., op.cit.: 112-3.

61 Ibid.: 108.

62 Barker, Elisabeth, op.cit.: 103; Gill, Derek, op.cit.: 455.

63 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 131.

Still, although doctors themselves made some of the recommendations, the British Medical Association, composed mainly of general practitioners, expressed concern about state regulation.⁶⁴ Essentially, there were major splits even within the British medical profession over the development of health insurance and between the British Medical Association and the state.⁶⁵ General practitioners and the higher-status consultants (specialists), for example, maintained different positions, a lack of coordination between the two which originated prior to the introduction of the National Health Service.⁶⁶

There was a great deal of discussion in the medical journals of the period about the, primarily negative, effects of the 1948 introduction of the National Health Service upon doctors in Britain. The belief was that the National Health Service had resulted in overuse of the health care system by patients, long waiting lists, overworked medical practitioners, and escalating health care costs. These fears were not unfounded.⁶⁷ Utilization of services and costs did increase with the introduction of the National Health Service.⁶⁸

64 Calvocoressi, Peter, op.cit.: 34.

65 Ibid.: 35.

66 Mechanic, David, op.cit.: 321; Gill, Derek, op.cit.: 466.

67 Calvocoressi, Peter, op.cit.: 36.

68 Gill, Derek, op.cit.: 457.

The main concern on the part of the medical profession was the potential loss of professional autonomy, especially to state control. Canadian doctors feared that losing professional control over payment for services rendered would lead to third-party control of quality and quantity of services as well.⁶⁹ Such bureaucratization was viewed as a threat to individuality and freedom in two senses.⁷⁰ The first was to the profession's self-determination and power, the second was to the democratic societies of the west. Health insurance was continually referred to by doctors who opposed the introduction of such insurance (and apparently by some groups in the general population as well) as "socialized medicine."⁷¹ Any degree of state intervention was interpreted as socialism or communism during the Cold War of the 1950s. They employed the rhetoric of the times to support their position:

For now compulsory health insurance became entangled in the cold war, and its opponents were able to make "socialized medicine" a symbolic issue in the growing crusade against communist influence in America.⁷²

69 Blishen, Bernard R., op.cit.: 126.

70 cf. Mechanic on the increasing bureaucratization of medicine, with the doctor becoming more an "organization person," than an autonomous professional. Mechanic, David, op.cit.: 1, 49.

71 Marcuse notes the "self-validating hypotheses" which characterize such discourse. Marcuse, Herbert, op.cit.: 14.

72 Starr, Paul, op.cit.: 280.

This political context was a resource for the doctors' positions on health insurance, and the basis for the stances taken was the threat, through state intervention and bureaucratization, which that insurance posed to their autonomy.

Yet pressure from social changes sustained the discussion of medical insurance plans in Canada; urbanization had led to the problem of access to health care in rural areas, an improved economy contributed to increasing demand for high standards in medical care, and costs were higher with greater medical technology and hospital capital expenditures.⁷³ Federal and provincially cost-shared hospital insurance was enacted in 1958 in Canada, even if general health insurance was not, partially due to the financial problems of hospitals.⁷⁴

Similar concerns and fears surrounded the issue of universal health insurance in Britain, the States, and Canada. The group of physicians who opposed the development of national health insurance in Britain were a minority and their fears were voiced in the immediate postwar period, with the enactment of the National Health Service. Hence, this preceded the opposition in Canada and the United States. But the rhetoric used, an expression of professional concern about state intervention, was common to

73 Blishen, Bernard R., op.cit.: 121.

74 Soderstrom, Lee, The Canadian Health System, London: Croom Helm, 1978: 159; Blishen, Bernard R., op.cit.: 69.

all three situations. The discourse of the opposition in the States, though, drew on Cold War sentiments as a resource more strongly than did the profession in Britain or Canada. National health insurance generally created an insecure situation for the medical profession. It posed a continuing threat that demanded a defensive posture by the profession in Canada and the United States and, in Britain, its development was viewed as the first step in a larger trend towards increasing state intervention.

The Scientization of Medicine

The character of the medical model is an aspect of the professional context that strongly influenced the construction of particular obstetric and gynecologic knowledge in the 1950s. The war gave impetus to more than one approach to medicine, aggravating tensions within the profession around new directions in the field. The scientifically-oriented biomedical model was particularly strengthened during the 1950s and this was accompanied by a trend toward increasing specialization.

...a tremendous lurch toward the "basic medical sciences," and in particular toward chemistry, took place in the 1950s...Biochemistry and the other newer basic sciences offered medical students a mainly organic picture of disease: disease arising in disorder among the molecules and correctable with

appropriate drugs. It is a picture of disease that ignores the mind.⁷⁵

Part of the impetus for this post World War II development in medical education and practice came from:

...the faculty in internal medicine, swept away by the new therapeutic possibilities of the drug revolution, maintained that the students get a proper grounding in the chemical sciences so they could "understand" disease.⁷⁶

This was the dominant postwar trend in medicine, but ambivalence was expressed about the direction being taken, particularly in Canada and the United States where the trend was strongest. Internal conflict emerged between the scientifically-oriented internal medicine practitioners and their allies, such as other specialists, and the more traditional group in the medical profession, including general practitioners.⁷⁷ The background to this conflict was the stronger rationalization and scientization of medicine from the early twentieth century on, with the formation of the academic medical center. Clinical research was facilitated by the combination of hospital laboratories with the basic sciences in medical schools.⁷⁸

This scientization of medicine, strengthened in the postwar period, reinforced the dominance of the biomedical model. Consequently, the definition of disease as deviation

75 Shorter, Edward, op.cit.: 185.

76 Ibid.: 185.

77 Ibid.: 185.

78 Ludmerer, Kenneth M., op.cit.: 231.

from a biological norm, and the dual categories of normality and abnormality inherent in that scientized medical model, also became dominant.

The 1910 Flexner Report had encouraged the scientization of medicine and had promoted the rationalization of licensing procedures for medical schools.⁷⁹ Flexner recommended American and Canadian medical schools affiliate with the universities. The report was also instrumental in standardizing medical education and sanctioning the inclusion of the basic sciences. Not just any form of science was accredited, but rather "a positivistic science that included a mechanical construction of the human body."⁸⁰ Flexner, for example, saw medicine as exclusively a biological science, and while he noted the importance of social factors in treatment and prevention of disease, psychosocial factors received relatively little emphasis in his report.⁸¹

The report had less impact on Canadian medical education than it did on American schools, in terms of reducing medical graduates, but nevertheless it did mark the legitimation of a trend toward more rationalized and

79 Flexner, Abraham, Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching, Bulletin #4, New York: 1910, cited in Robert K. Merton et al., op.cit.: 17.

80 Mishler, Elliot G. et al., Social Contexts of Health, Illness, and Patient Care, Cambridge: Cambridge University Press, 1981: 227.

81 Mishler, Elliot G. et al., op.cit.: 227-8; Ludmerer, Kenneth M., op.cit.: 174, 182.

scientific medicine.⁸² It also contributed to the increased power of the academic elite who were given control over medical education, removing it from the medical practitioners.⁸³ This was one of the developments which gave rise to more factional groups within the medical profession, factions which conflicted, in the 1950s, over these directions.

Modern Science as the Root of the Biomedical Model

These developments meant that the whole relation of science to medicine was thrown into question, including the mind/matter duality embodied in the dominant model of biomedicine. This is a model which still expressed, in the 1950s, aspects of its roots in the emergence of modern, mechanistic science of the seventeenth century. Newton's work, a part of the scientific revolution, emphasized science as a description of nature. Mechanism includes a conception of this nature as a machine, "moved by physical necessity, indifferent to the existence of thinking

82 Torrance, George M., "Socio-Historical Overview: The Development Of The Canadian Health System," in David Coburn et al, op.cit.: 15.

83 Ludmerer, Kenneth M., op.cit.: 131.

beings."⁸⁴ Cartesian dualism removed thought and psyche from this material realm of nature.⁸⁵

This scientific revolution also promoted the empiricist epistemology of Bacon and the rationalist one of Descartes as the basis of research. Scientific progress was to develop by means of empirical research and experimentation, as it entailed an assumption that "what we can see...is real."⁸⁶

Medicine relinquished, with modern scientific methods, its earlier basis in ancient authority for observation and experimentation.⁸⁷ Disease is implied, in this view, to be natural pathology which through investigation can be discovered in the world "out there." Ignored are the socio-historical and linguistic processes involved in our constructions of reality, including disease.⁸⁸ The empiricist theory of knowledge gave priority to supposed pure data of the senses in medical education, research, and practice. Medical students, for example, were to begin learning physical diagnosis or studying specimens in pathology, through use of their senses, before knowing what

84 Westfall, Richard S., The Construction of Modern Science. Mechanisms and Mechanics, Cambridge: Cambridge University Press, 1977: 31-3, 159.

85 Ibid.: 31-3, 159.

86 Turner, Bryan S., Medical Power and Social Knowledge, Beverly Hills: Sage, 1987: 10.

87 Graham, Harvey, Eternal Eve, London: William Heinemann Ltd., 1950: 242.

88 Turner, Bryan S., Medical Power and Social Knowledge, Beverly Hills: Sage, 1987: 10.

they were expected to see. But their ability to see was in fact dependent on

"a knowledge of what you're supposed to observe," an ordered method for making these observations, and a great deal of practice in medical ways of perceiving. ("We see only what we look for. We look for only what we know," the famous Goethe axiom goes.)⁸⁹

Mechanistic philosophy of science encouraged the division of phenomena into component parts, in order to locate underlying causative laws. In biomedicine, this led to reliance upon a technical, mechanical approach to the patient, with the patient as object of investigation. It not only involved a changed view of the patient on the part of the doctor, but a new view of disease as well, as the basis of medicine increasingly incorporated science and the biomedical model became dominant.

The Roots of Categorizations of Normality and Abnormality

Biomedicine in the postwar period was subject to increasing scientization, and so absorbed the categorizations characteristic of modern science. The development of the "clinic," as an expression of scientific medicine, had stimulated new forms of conceptualizing

89 Fox, Renee C., "Training for Uncertainty," in Robert K. Merton, George G. Reader, and Patricia L. Kendall, eds., The Student-Physician. Introductory Studies in the Sociology of Medical Education, Cambridge, Massachusetts: Harvard University Press, 1957: 214.

illness and disease, using the language of positive science.⁹⁰ The eighteenth and nineteenth centuries saw the continued growth of positivist medicine, with its oppositions between mind and matter, subject and object, and fact and value.⁹¹ But during the eighteenth century, medicine attended more to health matters, such as the qualities of vigour, rather than to questions of normality.

...it did not begin by analysing a 'regular' functioning of the organism and go on to seek where it had deviated, what it was disturbed by, and how it could be brought back into working order...⁹²

It was particularly during the nineteenth century that medicine became more concerned with normality than with health; theory and practice came to be in relation to "a standard of functioning and organic structure," with physiological knowledge designated as central.⁹³ A differentiation between normality and abnormality found in 1950s obstetric and gynecologic conceptualizations of women, characterizes the biomedical model founded on this mechanistic, empiricist notion of science. Biomedicine came to hold an assumption characteristic of the biological

90 Foucault, Michel, The Birth of the Clinic. An Archaeology of Medical Perception, New York: Pantheon Books, 1973: xviii.

91 Comaroff, Jean, "Medicine: Symbol and Ideology," in Peter Wright and Andrew Treacher, eds., op.cit.: 56.

92 Foucault, Michel, The Birth of the Clinic. An Archaeology of Medical Perception, New York: Pantheon Books, 1973: 35.

93 Ibid.: 35.

sciences, that disease is "deviation from normal biological functioning." in other words, relative to a biological norm.⁹⁴

In the evolving emphasis on objective, physical measurement we can see the concern with defining disease as deviation from the normal or average...⁹⁵

The political and social implications entailed in this definition emerge when one questions the significance of the concept of normal for different population groups and recognizes that it must be in relation to a particular standard. Normality can also mean either an average occurrence or an ideal standard.⁹⁶ These underlying aspects indicate that the biomedical definition of disease is not an objective measurement in the sense of being neutral and value-free, as is assumed in the biomedical model. Social class differences in what are considered pathological and normal female reproductive processes, for example, exemplify the population concerns which highlight the relation of politics with science and medicine, a link which has been an inherent part of the development and spread of modern science.⁹⁷

The scientization of medicine led to a more empiricist methodology in medicine, and a greater tendency to

⁹⁴ Mishler, Elliot G. et al., op.cit.: 3.

⁹⁵ Ibid.: 224.

⁹⁶ Ibid.: 3.

⁹⁷ Webster, Charles, Biology, Medicine and Society, 1840-1940, Cambridge: Cambridge University Press. 1981: 1.

differentiate between the normal and the abnormal. But the social notions of normality entailed in the definition of disease in scientific medicine, the biomedical model, should not be taken to imply that biomedicine is unscientific and, hence, problematic on that basis. Rather, both science and medicine are social entities, entailing concepts like normality and abnormality which are imbued with particular meanings.⁹⁸ Such categories do not exist prior to biomedical discourse; instead, they are created through the discourse which describes them. It is doubtful that an asocial medicine, which would be free of interests and social influence, is possible.⁹⁹

This positivist, mechanical science, then, was one of the sources for the emphasis on normality and abnormality prominent in medical knowledge about women during the 1950s. The exclusive significance attributed to objective observation in this model also contributed to the notion of scientific neutrality which was incorporated into medicine.¹⁰⁰ This was a view consistent with the general reliance in the 1950s on neutral, professional expertise in

98 Armstrong also notes that the concept of abnormality is not the statistical one, as claimed in biomedicine, but rather "the social or ideal." Armstrong, David, "Theoretical Tensions in Biopsychosocial Medicine," Social Science and Medicine, Vol. 25, #11, 1987: 1215.

99 Wright, Peter and Andrew Treacher, eds., op.cit.: 7, 15.

100 See Shryock for a discussion of the relation between empiricist use of measurement and instruments, and observation in modern science. Shryock, Richard Harrison, op.cit.: vii-6, 225.

the 1950s. "The core tenet of biomedicine is the reduction of illness to the 'lesion'."¹⁰¹ And so long as illness is located as a lesion on the interior of the body, only biomedicine and the doctor are able to access this truth.¹⁰²

The degree to which the emphasis upon defining normality and abnormality in medicine has roots in what is also a patriarchal model of positivist, mechanistic science, is a contentious issue. Some researchers claim that the basis of the dualist notions in modern science (and, by extension, in biomedicine) is patriarchal in origin; that it was a means of sanctioning the domination of both women and nature, in the guise of neutral, objective science.¹⁰³ While it is certainly the case that modern science was constructed in a male-dominated culture, and by male individuals, the argument still contains some problematic aspects, such as the universalism of patriarchy as an explanation. How, for example, are we to explain the development of alternative sciences and medical models in other, equally patriarchal societies? The historically dominant masculine world views and experiences probably influenced the forms of science and medicine that developed, but the complex of interactions

¹⁰¹ Armstrong, David, op.cit.: 1214.

¹⁰² Ibid.: 1214.

¹⁰³ See Merchant for one example of this argument. Merchant, Carolyn, The Death of Nature. Women, Ecology and the Scientific Revolution, New York: Harper and Row, 1980; Critical Theorists had earlier emphasized the technological domination of nature inherent in modern science. cf. Marcuse, Herbert, op.cit. passim.

with the rest of the context is unclear. This problem has been the impetus for the studies discussed earlier, on the relation between science and gender.

Tensions in the Scientization of Normality and Abnormality

The dominance of the biomedical model was further entrenched during the 1950s. But the emphasis on scientific medicine and the trend toward increasing rationalization led some groups of doctors to question this direction in medicine. Fears were expressed that with concentration upon the science of medicine, the traditional art of medicine was being lost. The art of medicine was considered a more holistic approach to the patient and family, entailing a closer doctor-patient relationship, and less reliance upon laboratory tests for diagnostic purposes. Prior to massive urbanization, this golden age of medical care may have existed. However, it probably always approximated an ideal, more than it did a reality. This was certainly the case during the 1950s, when calls for attention to the whole patient were voiced by groups like the general practitioners, whose work consisted of more direct patient contact. But such rhetoric was actually a vital indication of the reinforcement of rationalization and specialization within medicine, and the anxiety stirred up in some quarters by such developments. The impetus given to biomedical

research by the second world war meant that during the 1950s it was becoming even more difficult to attain the ideal of the art of medicine.¹⁰⁴ Medical schools and teaching hospitals were taking shape as large industries, with the increase in clinical research. In fact, this research led to findings which were of significance for the natural sciences. For example, the study of endocrinological diseases aided the development of knowledge of the various hormones.¹⁰⁵

In such an environment, it is not surprising that there would be a backlash within medicine, a "renewed emphasis" on viewing the patient as a whole.¹⁰⁶ The war also provided impetus for the development of this subordinate position, as the effects of war (for example, psychiatric conditions) created more attention for the psychosocial aspects of disease. But the fact that the notion of the whole patient was asserted so forcefully following the war, says most about the lack of holism in medicine.

...[It] is also said to be a conception more honored in the breach than the observance. Many physicians, it is said, continue to regard the patient as a case of sickness rather than as a person. This suggests that there are forces in the situation which make it difficult for some physicians to live up to this conception.¹⁰⁷

104 Ludmerer, Kenneth M., op.cit.: 262.

105 Ibid.: 262-4.

106 Merton, Robert K., op.cit. et al.: 25.

107 Ibid.: 25.

Each faction in the medical profession utilized the debate of science versus the art of medicine, and the relation of each approach to professional status, to fuel its own claims. The general practitioners argued that the inclusion of social scientific and psychiatric knowledge in medicine could strengthen the profession's grass roots support and social status, by improving doctor-patient relations. However, biomedicine provided the basis for the overall status of academic doctors and specialists, the more powerful groups in the profession, as experts. This was true in Britain, despite the National Health Service providing some support for the continuation of the central importance of general practitioners.¹⁰⁸ But, in the States, where the government did not intervene to rescue general practitioners, the trend toward specialization was more dramatic. In 1949, the proportion of full-time specialists in the United States was thirty-six per cent, but this jumped to sixty-one per cent by 1963. The proportion of general practitioners and part-time specialists declined from sixty-four per cent to thirty-nine per cent in the same period.¹⁰⁹

There were a number of splits in the profession which were reinforced during the 1950s. As mentioned, the more

108 Sidel, Victor W. and Ruth Sidel, op.cit.: 132.

109 Figure 8, "Distribution of Physicians by Specialization Status in the United States, 1949-1972," in Victor W. Sidel and Ruth Sidel, op.cit.: 59.

biomedically-oriented university doctors, specialists and researchers were often in conflict with the clinical practitioners. But the academic doctors were the group who produced the major medical knowledge and incorporated it into texts.¹¹⁰ There were also tensions between the basic science researchers in the medical schools and the clinical researchers in the teaching hospitals.¹¹¹ Competition among specialties over distribution of resources, such as funding, for example, was one area of contention.¹¹² The bureaucratic complexity of such growing departments and institutions was evident during the postwar period.¹¹³

The 1950s saw the relation between obstetrics and gynecology, specifically, in disarray. One 1954 report of American obstetrics and gynecology departments noted the "confusion" and "feuds" of that period:

The ambition of certain professors of obstetrics to obtain control of gynecology without having the faintest conception of major operating techniques was matched by the attempts of general surgery to eliminate gynecology as a specialty...and to relegate the teacher

110 Ludmerer provides more detailed information on the factionalization of the medical profession. Ludmerer, Kenneth M., op.cit.: 269.

111 Blishen, Bernard R., op.cit.: 26-7.

112 Mechanic, David, op.cit.: 323.

113 Ludmerer, Kenneth M., op.cit.: 259.

of obstetrics to his ancient role of midwife.¹¹⁴

These professional splits became embedded in obstetric and gynecologic knowledge of women, as they formed part of the social context of this knowledge.

Overall, however, the most biomedical factions reigned strongly throughout these internal conflicts. The parallel growth of the social sciences and psychiatry provided a minor theme, which supported the practitioners' emphasis upon a need for less specialization and more holism. Much like a biopsychosocial model of medicine which has recently been proposed, the 1950s version employed systems theory.¹¹⁵ Both models prioritize the biological aspects over the psychosocial ones, however, incorporating the latter into the biomedical model. The main significance of the psychosocial supplement was that its "secular, liberal, humanitarian ideology" designated additional areas of human behaviour pathological and hence, treatable.¹¹⁶ Psychiatry, in particular, increased its professional status following the second world war, and was largely responsible for the subsequent trend toward the medicalization of previously

114 Schumann, E.A., "The Combined Departments of Obstetrics and Gynecology in the United States," American Journal of Obstetrics and Gynecology, 68, 1954: 9-11, cited in Harold Speert, Obstetrics and Gynecology in America. A History, Chicago: The American College of Obstetricians and Gynecologists, 1980: 86.

115 Armstrong, David, op.cit.: 1213-4.

116 Freidson, Eliot, Professional Dominance: The Social Structure of Medical Care, Chicago: Aldine Publishing Co., 1970. 5-6; Armstrong, David, op.cit.: 1213-4.

non-medical areas of behaviour.¹¹⁷ Although this expansion of the definition of medical concern had begun by the late nineteenth century, during the 1950s it was given a more scientific basis.¹¹⁸ The experts in psychiatry, the social and psychological sciences, gave scientific legitimacy to the expansion of the realm of medical definition.

Medical expertise in the designation of normality and pathology was extended to additional areas with a new holism in medicine. As the application of medical expertise was expanded, an emphasis on preventive medicine was included: surveillance to detect the potentially abnormal in the normal increased. There was some shift of emphasis in obstetrics, from abnormality to "a better understanding of healthy normality."¹¹⁹ Yet owing to the dominance of biomedicine, these concepts were most frequently interpreted in terms of that medical model and extended the application of its terms. The implications of this were that:

Medicine must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of healthy man, that is, a study of non-sick man and a definition of the model man. In the ordering of human existence it assumes a normative posture, which authorizes it not only to dictate the

117 Starr, Paul, op.cit.: 337.

118 Mitchinson, Wendy, "Causes of Disease in Women: The Case of Late 19th Century English Canada," in Charles G. Roland, ed., op.cit.: 383, 390.

119 Graham recommended a transfer of medical focus from pathology to "positive health" in 1950. Harvey Graham, op.cit.: 659, 661.

standards for physical and moral relations of the individual and of the society in which he [sic] lives.¹²⁰

As we have seen, it meant that during the 1950s there was increased social emphasis upon instilling normality through, for example, the intervention of preventive psychiatry into the area of childrearing.¹²¹ Again, this resulted in the presentation of such views on social life in a depoliticized, neutral, scientific manner.¹²²

The processes of social and medical rationalization and scientization reinforced the emphasis upon defining normality and abnormality, already inherent in the mechanistic model of science, and integrated it into biomedicine. During the 1950s, the social and professional contexts provided resources which were drawn upon to construct those concepts in ways imbued with particular meanings. The interaction of the scientific and medical models with the historically specific context gave shape to the concepts. The content given to normality and abnormality, as it related to women and their reproductive issues, can be extracted through analysis of the 1950s obstetric and gynecologic writings. The feminist argument that normal female reproductive processes have been viewed

120 Foucault, Michel, The Birth of the Clinic. An Archaeology of Medical Perception, New York: Pantheon Books, 1973: 34.

121 Starr, Paul, op.cit.: 337.

122 For a full discussion of the medicalization of deviance, cf. Peter Conrad and Joseph W. Schneider, op.cit. passim.

as illnesses indicates that the contextual resources for concepts of normality may include male-dominated resources.¹²³ The feminist argument is formulated, to some extent though, on the same basis as the medical approach, revolving around the question of what is the correct definition of normality. A full acknowledgment of the constructed and relative nature of the entire concept of normality, on the other hand, would extend the framework of the debate. The discourse attended to in this research on medical concepts of women is primarily that of the powerful, academic members of the obstetric and gynecologic specialty. So it is the notions of female normality held by that particular group that are examined here.

123 Mishler, Elliot G. et al., op.cit.: 210; cf. Turner on patriism as "a defensive regulation of women," through control of women's bodies. Turner, Bryan S., The Body and Society. Explorations in Social Theory, Oxford: Basil Blackwell, 1984: 2-3, 149-150.

Chapter 7

Medical Construction of the Content of Normal and Abnormal Sex and Gender

Following upon the examination of the social context of the 1950s in the previous two chapters, we now turn to an analysis of how that social context was expressed in obstetric and gynecologic knowledge. Chapter Seven entails a consideration of two areas directly linked with the growing interest in endocrinology in postwar obstetrics and gynecology. First, intersexuality is examined; followed by a look at obstetric and gynecologic discourse on female physiology, premenstrual syndrome, dysmenorrhea, and menopause. A strong emphasis on the construction of two polarized sexes and genders, and on reproduction as a central focus for womanhood, were evident in this obstetrical and gynecological knowledge.

The following chapter is an examination of two other areas, also partially based on endocrinological studies. These involve (1) discourse on the management of pregnancy, labour and the post-partum period; and (2) views on fertility, sterility, population control, and sex and marriage education. A great concern for the future population predominates in these obstetric and gynecologic

discussions, in the form, for example, of the surveillance of normal female biological processes necessary to monitor the reproduction of that population. Here, the importance of the mother is viewed primarily in relation to the fetus, the family, and population eugenics.

Some crucial threads run through all four of these concrete areas of obstetrics and gynecology. Those are: the emphasis on population control and management in the broadest sense, a trend toward standardized definitions of normality and abnormality with respect to women's obstetrical and gynecological conditions and physiological processes, and medical surveillance of normal processes which pathologized the abnormal. A strong thrust toward normalization, which produced pronatalism as the definition of the normal, was found not only in the social context of the period, but also in the obstetric and gynecologic discourse on women. One cannot differentiate between the techniques of medicine as a contributing factor to this and the input of the social context of this medicine when considering formation of the character of medical knowledge. The technical is social, as has been illustrated by research in the Sociology of Science and the Sociology of

Technology.¹ For a number of reasons related to this context of the 1950s, a dynamic tension between the dominant biomedical techniques and a newly strengthened psychosomatic emphasis characterized the 1950s. Attempts at standardizing medical approaches in the form of a middle ground were constantly made in order to ease the tension between the two. Biomedicine dominated, however, by expanding to include newly medicalized areas (particularly those indicated by the psychosomatic strand). It made more use of the technical/social split in order to increase its persuasiveness.

An example of the social character of medical technique is the emphasis in 1950s gynecology on locating a way to define an individual's true biological sex. The development of a genetic indicator allowed for standardization of categories of biological sex and normalization of what was considered sex and gender, in directions also found to characterize the social context of the period. The strong distinction between the sexes effected in both that context and the gynecological knowledge contained the same normative assumption that there should be this dichotomous differentiation. The discovery of a genetic indicator

1 cf., for example, Trevor J. Pinch and Wiebe E. Bijker, "The Social Construction of Facts and Artefacts: or How the Sociology of Science and the Sociology of Technology Might Benefit Each Other," Social Studies of Science, Vol.14, #3, August, 1984; Jim Johnson (Bruno Latour), "Mixing Humans and Nonhumans Together: The Sociology of a Door-Closer," Social Problems, Vol.35, #3, June, 1988.

allowed for this distinction to be made on what was thought to be a more definitive basis. But it was not only a medical, technical development, despite medicine's own separation of the technical and the social (as a contrast between the true sex of an individual and their socially-assigned sex). The original selection of intersexuality as a problem for study was, at root, a social choice. The scientization of bio-medicine, which increased following the war, formed part of the social, professional context in which particular definitions of normal and abnormal endocrinology and biological sex emerged. These were definitions which contributed to social stability, partly through pronatalist categorization of the normal woman. Pronatalism and dichotomization of sexes were socially accepted solutions to the perceived problem of social instability. As this social content and the form of normal/abnormal categorization pervade the obstetric/gynecological discourse of the 1950s, it is argued that the knowledge was inherently social in its construction. It was not social in the sense of being in error when distorted in its conceptualizations of women. The actual constructions of knowledge about physiological processes and gynecological conditions were social in character (alternative conceptualizations would be equally social).

This chapter, then, begins with a discussion of the gynecological discourse of the 1950s on biological sex. It is essentially an examination of how women were defined biologically. The discussion then proceeds to how aspects of the reproductive physiology and cycles of those biological women were conceptualized in gynecological knowledge of the period.

Dichotomous Biological Sex as Normal

A number of aspects of the social and professional contexts are evident in the obstetric and gynecologic constructions of sex and gender in the 1950s. The definitions of normal and abnormal biological sex in that period can be interpreted as increasingly scientific and standardized, though equally social, versions or constructions of those realities. Knowledge in the obstetric and gynecologic texts of the 1950s contained not only standardized definitions of sex, but a more profound standardization of particular versions of sex itself. The main view was that there should, ontologically, be only two sexes, male and female. There should not, therefore, be

intersex individuals who do not conform to this normative, dual distinction.²

In fact, the determination of the true sex of all individuals was taken so seriously, that the birth of any person of ambiguous sex was considered a medical emergency.³ The concept of intersex refers to a person in which biological and social components of their sex (as designated by the medical profession) do not coincide with each other. This condition was considered to comprise abnormal biological sex. In normal individuals, sex was said to be able to be deduced from any characteristic usually present in the one sex. But the "normal interrelationship" among those characteristics was not seen in intersex individuals.⁴ The definitions of normal and abnormal altered little by 1975, from those accepted in the 1950s, though they later became even more explicitly categorized in terms of five organic and two psychological criteria essential to one of

2 The project of establishing absolute sex distinctions, and of separating the "natural" from the "unnatural" in dealing with hermaphroditism, has a long history, being part of Renaissance medical thought. Maclean, Ian, The Renaissance Notion of Woman. A Study in the Fortunes of Scholasticism and Medical Science in European Intellectual Life, Cambridge: Cambridge University Press, 1980: 39.

3 Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 49.

4 Carpentier, Peter J. and Edith L. Potter, "Nuclear Sex and Genital Malformation in 48 Cases of Renal Agenesis with Especial Reference to Nonspecific Female Pseudohermaphroditism," American Journal of Obstetrics and Gynecology, Vol. 78, #2, August, 1959: 237.

the two sexes.⁵ The condition in this category that was most commonly discussed in medical writings during the 1950s was that of pseudohermaphroditism, in which a person possesses the gonads of one sex, but the genitals or bodily characteristics of what is commonly considered to be the opposite sex.⁶ It is not focused on here because it was a widespread phenomenon. Rather, it is important to examine because gynecologists paid considerable attention to pseudohermaphroditism, as measured by the number of articles on this topic found during my initial survey of obstetric and gynecology journals of the 1950s.

Research into normal endocrinology contributed to definition and categorization of the pathological, such as intersexuality.⁷ Study of pathological disturbances was also needed, in order to define normal endocrinology and genetic make-up. One of the prime research projects of the period was the study of the normal relation of hormones to the sex

5 Novak, Edmund R., Georgeanna Seegar Jones, and Howard W. Jones, Novak's Textbook of Gynecology, 9th edition, Baltimore: The Williams and Wilkins Co., 1975: 164-5.

6 "True" hermaphroditism is far more rare, and as a term refers to the case where an individual has both ovarian and testicular tissue. Novak, Emil and Edmund R. Novak, Textbook of Gynecology, 5th edition, Baltimore: The Williams and Wilkins Co., 1956: 139.

7 Ibid. passim.

chromatin. It was determined that the latter is uninfluenced by hormones and their fluctuations, meaning that a person's genetic or chromosomal sex could differ from their genital sex. It was also held that the chromosomal pattern and sex chromatin (the latter of which was considered to be present only in females) could be used as an independent measure of a person's sex.⁸ Barr's discovery of a nuclear sex chromatin was considered an indicator of "true genetic sex" and an aid to research on "aberrations in sexual development."⁹ The notion of aberrations implies an assumption that there is a correct mode of sexual development, entailing a norm of two sexes. The sex chromatin was heralded as providing a test for final proof of an individual's biological sex.¹⁰ This test was qualified by some, however, as being an indication of the dominant sex of an individual, rather than any absolute sex. In other words, it was considered possible for modifying factors to alter the dominant sex over a person's lifetime.¹¹

The significance of this discovery of the sex chromatin was that it was usually taken as evidence of a clear

8 Sohval, Arthur R., Joseph A. Gaines and Lester Gabrilone. "Clinical Experiences with the Skin Biopsy Method of Detecting Chromosomal Sex." American Journal of Obstetrics and Gynecology, Vol. 70, #5, Nov., 1955: 1079-1081.

9 Carpentier, Peter J. and Edith L. Potter, op.cit.: 236.

10 Eastman, Nicholson J., Williams Obstetrics, 10th edition, New York: Appleton-Century-Crofts, Inc., 1950: 193.

11 Novak, Emil and Edmund R. Novak, op.cit.: 138.

distinction between male and female. Such a division could not have been made as readily or as absolutely on the basis of the hormonal or gonadal indications on which gynecologists previously relied. As noted, though, hormones that were termed female or male, could be found to some degree in both those sexes. In addition, vestiges of the gonadal organs of one sex were known to be present anatomically in the other. The anatomy chapters of obstetric and gynecologic texts of the 1950s frequently contained descriptions of similarities between male and female gonads and genitalia. At times, this implied that women's anatomical structures were homologous with male anatomy.¹² With the earlier difficulty in making any clear-cut distinction between males and females, then, the discovery of the nuclear sex chromatin was an important step in the direction of creating an exclusive division. Research into normal endocrinology and chromosomal genetics fed into knowledge about pathological conditions, like that of intersexuality. Such research also operated in the other direction; studies of pseudohermaphroditism and Turner's Syndrome (in which an individual has only one sex

12 One example of this is in Baird's well-known text used during the 1950s; he describes the female Bartholin's glands as "the homologue of the cowper glands in the male" and Baird states that the clitoris "corresponds to the penis of the male, and in its general structure resembles a miniature phallus." Baird, Dugald, Combined Textbook of Obstetrics and Gynaecology, 5th edition, Edinburgh: E. & S. Livingstone Ltd., 1950: 10, 12.

chromosome), for example, provided information for the construction of knowledge about what were considered to be the two normal sexes. While it was not explicitly stated in the 1950 edition of William's Obstetrics, the 1985 edition explains the importance of understanding "the mechanisms of normal and abnormal sexual differentiation" as being its contribution to the correct assignment of a sex to an ambiguously sexed newborn. Potential social and psychological problems on the part of the child and her/his family are believed to be avoided by careful designation of the biological sex.¹³

The Social Context as Resource

It is undoubtedly the case that anyone deviating from what was considered normal sexual development would have experienced difficulties in adjustment. However, there was little acknowledgement, in the medical writings, of the origins of those adjustment problems in a social context in which only two opposite sexes are legitimated. In other words, it is a socially constructed, biological problem.

There have long been social definitions of biological sex, but the definitions became more standardized in the 1950s, when a rigid sexual division was accepted. That

¹³ Pritchard, Jack A., Paul C. MacDonald, and Norman F. Gant, Williams Obstetrics, 17th edition, Norwalk, Connecticut: Appleton-Century-Crofts, 1985: 170.

there should be only two distinct sexes is an arbitrary social choice, though it has some basis in the average predominance of sexes. For example, a decision could be made not to classify people according to biological sex, even if such a physiological distinction exists. Although we find that people possess blue eyes, brown eyes, and so on, we have not created a major social distinction on the basis of eye colour. In other words, biological sex simply need not be rendered socially significant. In addition, the components that we consider to comprise biological sex, according to our dichotomous classification, do not always coincide. For example, an individual may possess the genitalia of what we usually consider to be one sex and have the hormonal makeup of the other. Since the components of biological sex do not always match in a given individual, an alternative conceptualization of biological sex could be that of a continuum. Many individuals would possibly fall somewhere along that continuum, between the extremes of femaleness and maleness. However, the dual division of biological sex, not the continuum model, has come to be considered the preferable and perfect mode of standardization.

The particular context of the 1950s gave impetus to this normalization of the categories of biological sex. The changes in the professional context in the postwar period encouraged the continued development of socially-infused,

technological knowledge. It formed the context in which a standardized, more scientized technique for the assignment of indeterminate cases became available. This probably contributed to the ambivalence of obstetricians and gynecologists of the period regarding intersexuality, and to their attempts to decide definitively on the sex of an individual. The author of one obstetric and gynecologic text, Jeffcoate, recognized that no person is absolutely one sex or the other. Yet, he defined intersexuality as "a condition of imperfect sexual differentiation into either male or female."¹⁴ This definition was offered, in spite of this same author's assertion that, "Indeed the borderline between a normal and abnormal degree of intersex is vague and impossible to define."¹⁵ Thus, this is a practical distinction, employed as a resource in a particular, moral universe. It helps to define people, objects, and the relations and expectations between them.¹⁶

The subjective experience of transsexuals tells us a great deal about such a social demand for absolute biological sex. Transsexuals believe they must acquire the designated biological characteristics of the sex which they feel themselves to be (according to their gender identity).

14 Jeffcoate, T.N.A., Principles of Gynecology, London: Butterworth & Co., 1957: 158.

15 Ibid.: 158.

16 Woolgar, Steve, Science: The Very Idea, Chichester, Sussex: Ellis Horwood Ltd. & London: Tavistock Publications, 1988: 83.

to as great a degree as possible.¹⁷ More alternatives might exist for transsexuals in a society which did not have as rigid a dichotomy of sex and gender. More acceptance of what are currently considered feminine traits on the part of a male transsexual would be possible and, hence, there would be no need for a sex change operation. Anthropological studies have also investigated intersexuality in other cultures. These studies suggest that one alternative to medical and broader social constructions of sex as dichotomous is the inclusion of a third sex category.¹⁸ Research on the Potok of East Africa, for example, found that there are individuals in that culture who are not categorized as male or female.¹⁹ There is no confusion about the birth of an intersexed child, an indication that this culture may have a third sex/gender category, rather than a dichotomy.²⁰

The standardization of sexual differentiation as a dichotomy in the 1950s, in the face of acknowledged problems in doing so, may be linked to desire for stability in the

17 cf. MacKie for a discussion of transsexualism. Marlene MacKie, Constructing Women and Men. Gender Socialization. Toronto: Holt, Rinehart and Winston of Canada Ltd., 1987: 12-18.

18 Martin, M.K. and B. Voorhies, Female of the Species. New York: Columbia University Press, 1975, cited in Suzanne J. Kessler and Wendy McKenna, Gender. An Ethnomethodological Approach. Chicago: University of Chicago Press, 1978: 23.

19 Edgerton, R. B., "Pokot intersexuality: An East African example of the resolution of sexual incongruity," American Anthropologist, 66, 1964, cited in Suzanne J. Kessler and Wendy McKenna, op.cit.: 23.

20 Kessler, Suzanne J. and Wendy McKenna, op.cit.: 23, 37.

construction of the sexes and genders. This could be particularly true when, as during the 1950s, many were threatened by changing gender relations and erosion of the traditional divisions.²¹ The construction of distinctive categories of male and female would also have supported arguments for mutually exclusive gender characteristics and behaviours.

As discussed earlier, the context of the 1950s was characterized by a strong focus on the middle class, white, nuclear family as normative - to the exclusion of other living arrangements. Part of that norm was the rigid distinction between the sexes. Medical discourse displayed a diagnosis and categorization of biological sex which also contained that normative assumption. This is not to say that a medical conspiracy existed, aimed at gaining control of such matters and imposing definitions upon the rest of society. Rather, it was an interactive, dynamic process, partially the result of social expectations of such dichotomous categorizations of sex. As we all, including

21 At a British Medical Association/Canadian Medical Association Meeting, disharmony in marriages was linked to "disturbances in role playing by the male and the female in the modern world." In particular, the bonding of a dominant woman with an inferior male, was seen as problematic. Unstable families were deemed the result of changing roles, but it was doubted that the medical profession could do anything to halt, "the present trend among certain sections of our western civilization to a reversal of the traditional roles of male and female...." Editorial, "Crises in the Family," Canadian Medical Association Journal, Vol. 81, September 15, 1959: 494.

doctors, tend to share cultural assumptions that appear common sensical to us, it is not surprising that such norms would be part of the process of construction of medical knowledge. For:

Even scientists must ultimately rely on their own common sense knowledge. In fact, "...any scientific understanding of human action...must begin with and be built upon an understanding of the everyday life of the members performing those actions" (Douglas, 1970, p.11).²²

The gynecological definition of sex which emphasized the sex chromatin and genetics was also a heterosexual vision. If a person felt a same-sex attraction and their chromosomal sex indicated they were living as the wrong sex, that was considered justification for altering their biological sex traits to those of the opposite sex. In other words, that person would then be made heterosexual. This was not a neutral judgement of criteria for sex changes, but rather, it was one which assumed that heterosexuality was the proper form of sexual desire.

The social context was conducive to this situation. Sifting through the therapeutic recommendations allows one to deduce the strength of social, and hence, medical expectations for males' and females' behaviour and traits during the 1950s. This can be seen, for example, in the

²² Douglas, J., "Understanding everyday life," in J. Douglas, ed., Understanding Everyday Life, Chicago: Aldine, 1970, cited in Suzanne J. Kessler and Wendy McKenna, op.cit.: 4.

case of effeminate males who could not easily fit into the gender norms. Analysis of medical writings revealed that it was considered preferable for such men to become social women, than to have to live as effeminate men. Evidently, to be a male with some seemingly feminine characteristics, created a very difficult situation. It was also stated that in American society in the 1950s:

Effeminate pseudohermaphrodites never quite make the grade as adequate males, in spite of androgens and the best that surgery has to offer.²³

If the correct sex of an individual could not be determined with certainty, it was usually recommended that the "neuter person" be given the female sex, as they would "adapt better to the feminine role."²⁴ It seems that to be a male was to have social demands upon one to be or do something over and above what was expected of females. We can see then, that diagnosing, treating, and discovering the etiology of intersexuality normalized a construction of two, heterosexual sexes. Treatment of pseudohermaphroditism was construed as enhancement of "development along more normal lines," with heterosexuality being part of the meaning given to the concept of normal.²⁵

23 Greenblatt, Robert B., "Sex Reversal in Pseudohermaphroditism," American Journal of Obstetrics and Gynecology, Vol. 70, #6, December, 1955: 1179, 1175.

24 Greenhill, J. P., ed., 1959-1960 YearBook of Obstetrics and Gynecology: 538.

25 Greenblatt, Robert B., op.cit.: 1179.

In the major gynecologic and obstetric texts and journals, true sex was discussed as an entity separate from that of social, assigned sex. Both aspects were considered essential from the point of view of therapy with an intersex individual, but the strength of the assigned sex was given particular emphasis. Psychiatrists, in particular, but also other medical practitioners dealing with pseudohermaphrodites, were deemed capable of deciding whether an individual was psychologically and behaviourally male or female. What would usually now be called the gender of an individual (the assigned, social sex) was thought a crucial consideration in deciding on treatment of her/his intersex condition. But the socially constructed, biological and chromosomal determination was the central factor in producing an initial diagnosis. Emphasis was maintained on the scientific aspect of the construction of sex by prioritizing the biomedical definition as a definition of the true sex. In one instance, the importance of early detection of both the true sex and the sex to which the individual can most easily adjust was stressed. Yet it was noted that this true sex (assumed to be purely biological) may not coincide with the sex to which the individual can adjust.²⁶

26 Evans, Tommy N. and Gardner M. Riley, "Pseudohermaphroditism: A Clinical Problem," Obstetrical and Gynecological Survey, Vol. 10, 1955: 624-5.

An elision was made between sex and gender, despite this recognition of a social component to assigned sex. All biological females, on the basis of their anatomical and genetic statuses, were expected to possess the socially-assigned gender traits accompanying that sex. Hence, doctors acknowledged a potential differentiation between sex and gender, while at the same time referring to gender as fundamentally a biological product.

Analysis of the medical conceptualization of a woman who was diagnosed as a male pseudohermaphrodite reveals that the female psyche was believed to consist of "maternal instincts and attraction to the male sex."²⁷ In the case of virilism in a woman (metabolic changes accompanied by excessive hair growth), the authors of one journal article described femininity as a relative term, as a case of varying estrogen/androgen content. The concept of feminine gender included physiological, secondary sex characteristics. The definition was also held to be a question of an average, since:

There is as yet no simple yardstick for the measurement of complete masculinity or femininity. ... This becomes most difficult when we try to define the "normal" female.²⁸

27 Alves de Lima, O., K. M. Rudolph and A. Gastein, "Male Pseudohermaphroditism," Obstetrical and Gynecological Survey, Vol. 10, 1955: 621.

28 Benson, Ralph C., Felix O. Kalb and Herbert F. Traut, "Hirsutism, Defeminization and Virilization. The Endocrine Bases for Diagnosis and Treatment," Obstetrics and Gynecology, Vol.5, #3, March, 1955: 307.

However, according to the author of a major text, virilized females possessed an excessive degree of masculinity. The meaning of the latter concept in females was taken to include asexuality or homosexuality and:

an aggressive manner; ambition; a weak maternal instinct with interests outside the home; a capacity for creative rather than repetitive work; a disregard for appearance and dress and an assumption of male attire and habits.²⁹

The same author describes how parents can be influenced by "unreliable" observations of a child's "behaviour and interests" in assessing their child's sex when it's ambivalent. He points out that much of the behaviour is related to "what is expected of it and whether it is given boyish or girlish toys."³⁰ However, as we have seen, there was less sensitivity to the social roots of sex and gender in the discussion of virilism and masculinity in women.

Where social sex differed from chromosomal sex in any individual, then the final decision on the designated sex included consideration of the socially assigned sex of the person. Other factors were medicine's surgical capacity to effect the necessary changes,³¹ and occasionally, the desire of the parents for a child of a particular sex, if their

29 Jeffcoate, T.N.A., op.cit.: 165-7.

30 Ibid.: 173.

31 Greenhill, J. P., ed., 1959-1960 YearBook of Obstetrics and Gynecology: 49.

wishes coincided with the socially assigned sex of the child.³²

The gynecologic concern for diagnosing the true sex of individuals, though, would have been of some assistance in categorizing newborns of ambivalent sex. Still, the primary factors taken into account were frequently those of directly social factors. Why did this interest in determining a true sex exist and why was the term "true" used to name the concept? First of all, it was felt that with increased understanding of the etiology of intersexuality, more humane treatment could be developed.³³ In addition, the rationalization and standardization of definitions of normal and abnormal biological sex paralleled similar processes which were occurring in the social and professional contexts. While the biomedical model fostered such attempts at categorization, the context in which it was utilized provided further incentives in that direction. A strict definition of true sex would have aided earlier detection of the abnormal in the normal (biological sex), an important task, considering the social tensions in the area of gender relations at that time. Little tolerance was exhibited in the writings of obstetricians and gynecologists for any remnant of the abnormal in an individual who was to become a

32 Goodwin, Willard E., Peter L. Scordino and William Wallace Scott, "A True Hermaphrodite," Obstetrical and Gynecological Survey, Vol. 10, 1955: 629.

33 Novak, Emil and Edmund R. Novak, op.cit.: 137.

member of the category of a normal sex. For example, it was debated whether the testes should be surgically removed from male pseudohermaphrodites possessing female sex characteristics, given that the testes were producing the estrogen for those characteristics. While medical policy prior to the 1950s was to leave them intact, the tendency in the 1950s was to remove them, despite their biological efficiency.

The chief reason for this is the present ready availability of female sex hormone preparations for satisfactory substitutional therapy. It is felt wiser to have such patients get their hormones from a bottle than from what some might still consider a possibly somewhat contaminating male sex gland.³⁴

This physician was referring to what would have been socially contaminating to the "female" patient.

Constructions of biological sex in the 1950s, then, were strongly biomedical concerns. The tendency towards the designation of sex in terms of normal and abnormal categories had some roots in the biomedical model. But this trend also paralleled concerns in the social context of the decade. Those concerns provided particular content for the categories of normal and abnormal in the medical discourse, content which included a strict dichotomization of the sexes. Next, we examine how similar processes occurred in medical conceptualizations of women's physiology, cervical

³⁴ Ibid.: 142.

and uterine cancer, pre-menstrual syndrome, dysmenorrhea, and the menopause.

Standardization of Female Physiology and Gynecological Conditions

Obstetric and gynecologic concepts of that group whose true sex was designated as female are examined in the remainder of this chapter and the following one. The conceptualizations of women's anatomy and physiology can only be understood, however, in terms of an emphasis in the 1950s on standardization of the medical model. Various theories about the precise workings of the physiological processes existed, but the major obstetric and gynecologic issues were generally agreed upon or were in the process of becoming standardized by the 1950s.

Much debate, though, focused upon the degree to which the etiology of gynecological conditions was endocrinological (a biomedical approach) as opposed to psychosocial. The extent to which either realm was influential in altering normal physiological processes was considered in these discussions.

When a person falls ill we can give meaning to the illness in terms of pathology and bacteriology -- that is as some localised disease process in a part of the bodily structure, or we can understand the illness as happening to a certain person, at a particular time in

her life and in certain special circumstances. ... There are, then, two complementary routes to the understanding of all patients no matter from what disease they happen to be suffering. ... emotions are highly complex states in which the autonomic nervous system and all endocrine glands are affected to a greater or less degree.³⁵

Baird emphasized a holistic approach to the gynecological patient, to overcome the Cartesian mind-body split and to consider the woman as an "organic whole."³⁶ Such a stance was taken in an attempt to reconcile the two, sometimes conflicting, tendencies in obstetrics and gynecology, as can be seen in the above passage. One way in which this was effected by supporters of the holistic approach, who were often general practitioners and private practitioners, was to subordinate psychosocial aspects of health and disease to the main academic emphasis upon biomedicine, particularly upon endocrinology in this case.

Baird was representative of the tendency among British gynecologists and obstetricians to emphasize medical approaches needed in clinical medicine, which included attention to psychosocial and environmental aspects of women's conditions. In contrast, while it is not an absolute division, American texts leaned toward scientific biomedicine, with greater exclusion of the context of disease. One doctor wrote in the New England Journal of

35 Baird, Dugald, *op.cit.*: 1286-7.

36 *Ibid.*: 1292.

Medicine that the trend in American medicine generally was toward accumulating knowledge, while the alleviation and prevention of patients' "suffering" was the major concentration in England.³⁷ These emphases express the socio-economic and political differences between the United States and Great Britain in the postwar period. The greater economic affluence which characterized the American context contributed to more state funding of scientific and medical research. In turn, this influenced American medicine to become more scientized than that in Britain. In Great Britain, the existence of stronger leftist political parties, such as the Labour Party, probably contributed to the greater social emphasis in British medicine.

Overarching these differences, though, was an ambivalence about the standardization process occurring in biomedicine. This ambivalence helped support the minor theme of psychosomatic medicine. Ironically, the discourse of this subordinate group that was forced to struggle for acceptance of its discordant views, was essentially another form of standardization, producing its own categorizations of normality and abnormality, for example.

Academic medicine saw scientific obstetrics and gynecology as supplying a solid basis for their specialty's

³⁷ Stokes, J. F., "A British View of an American Hospital," New England Journal of Medicine, 260, 1959: 69, an excerpt cited in the Canadian Medical Association Journal, Vol. 80, June 15, 1959: 967.

claim to expertise, being well aware of the importance of specialists and experts, particularly in America.³⁸ The problems psychiatry and psychosomatic medicine had in being accepted by the medical establishment reveal the form of objective science which was considered acceptable, but which was attained only relatively late by psychiatry. To become more scientific, and hence, accepted, some psychiatrists believed further refinement of tools for measuring ideas and "clinical results," and clarification of concepts in order to "reach general agreement as to nomenclature and description of our major concepts" were needed.³⁹

The standardized, biomedical elements of obstetrics and gynecology were not fundamentally disputed by proponents of psychosomatic models because the lack of those very elements in the psychosomatic approach gave rise to strong criticism of it from mainstream medicine. One reviewer of Kroger and Freed's work on psychosomatic gynecology, for example, referred to it as "unscientific" and "speculative."⁴⁰ They noted that most obstetricians would not agree with Kroger and Freed's "psychodynamic explanations" of women's

38 cf., for example, an editorial in Obstetrics and Gynecology, Vol. 13, #4, April, 1959: 514.

39 Blain, Daniel, "Trends in Modern Psychiatry" (paper given at the C.M.A. Annual Meeting, Halifax, June 21, 1950), Canadian Medical Association Journal, Vol. 64, Jan., 1951: 17.

40 Kroger, William S. and S. Charles Freed, Psychosomatic Gynecology: Including Problems of Obstetrical Care, Philadelphia: W. B. Saunders Co., 1951.

reproductive problems.⁴¹ But the main aim of psychosomatic approaches (and psychiatry) was not actually the undermining of biomedicine, but rather the incorporation of psychosomatics into it, the result being a more scientific, standardized, broader medical model.⁴²

Some saw such a coalescence of approaches as promoting the rationalization of obstetrics and gynecology, by adding to knowledge in the area. Others rejected biomedicine's dominance and hence too great a coalescence. For example, the Dalhousie University obstetrician, Atlee, argued that science and technology themselves were frightening, a claim he linked to the development of the A-bomb and the spread of authoritarianism and Communism.⁴³ Dick-Read, a natural childbirth advocate, saw the solution to the conflict in a holistic medicine which would follow nature, not culture.⁴⁴ Few doctors were as extreme as Dick-Read, as most were amenable to supplementing the biomedical approach in obstetrics and gynecology with the psychosomatic one. Novak and Novak, for example, were American authors who

41 Donnelly, James F., Review of Psychosomatic Gynecology (by William S. Kroger and S. Charles Freed), American Journal of Obstetrics and Gynecology, Vol. 63, #3, March, 1952: 702-3.

42 White, Kerr L., "An Outpatient Department and the Teaching of Preventive Medicine," Canadian Medical Association Journal, Vol. 80, April 1, 1959: 508.

43 H. B. Atlee is primarily known for his work, The Gist of Obstetrics, 1st edition, Springfield, Illinois: Charles C Thomas, 1957. Ibid., Vol. 80, Jan. 1, 1959: 38.

44 Dick-Read, Grantly, Childbirth Without Fear. The Principles and Practice of Natural Childbirth, 2nd revised edition, New York: Harper and Row, 1959: 283-4, 339.

recommended that the gynecologist look beyond "the pelvic brim," yet who retained a notion of science as progress.⁴⁵

Much of the discussion was connected to the relative positions of the general practitioner and the specialist. Increasing specialization in obstetrics and gynecology and the whole of medicine,⁴⁶ contributed to what was recognized by some as a traditional backlash. It was a call for a return to the art of medicine, long practised by general practitioners, but long the ideal of good medical care in obstetrics and gynecology as well.⁴⁷ Many obstetricians and gynecologists called for a middle ground to be found and such a balance was not particularly hard to strike, at least regarding general principles.⁴⁸ This concern to retain some of the holistic aspects of traditional medicine provided some support for the psychosomatic strand in obstetrics and gynecology.

Selye's work in the 1950s was an attempt to link the psyche and the soma, through demonstrating more precisely how emotional states could produce endocrinological

45 Novak, Emil and Novak, Edmund R., op.cit.: 40.

46 Johnston, W. V., "The General Practitioner and His Neighbourhood Hospital" and editor's comments, Canadian Medical Association Journal, Vol. 63, Oct., 1950: 377-9.

47 Jeffcoate, T.N.A., op.cit.: 2.

48 cf., for example, an editorial in Obstetrics and Gynecology, Vol.1, #4, April, 1953: 486.

changes.⁴⁹ Some doctors were concerned about the expanding role of medicine which Selye's research implied, as they believed it was making doctors increasingly responsible for "reforming society," i.e. for social control and surveillance of what were seen as essentially social problems.⁵⁰ In other words, they believed that medicalization of life could be avoided, as could a social character to medicine, if medicine was made scientific and technical.

Knowledge of the body increasingly came to depend upon the field of physiology, over the course of the twentieth century. The development of physiological knowledge and the particular form it took was central to the rapprochement of bio- and psychosomatic medicine. In gynecology, it meant that the interaction of psychological and social stress with gynecological conditions could be explained in scientific terms. Menstrual disorders, for example, were connected more concretely with the effects of fatigue and stress on the vascular and autonomic nervous system, including the reproductive processes. Social factors such as "Keeping up with Joneses" or having to respond to a demanding husband were cited as non-organic contributors to gynecological

49 cf. the reference to Hans Selye in Mandy, Arthur J., Theodore E. Mandy, Robert Farkas, Ernest Scher and Irwin Kaiser, "The Emotional Aspects of Obstetric and Gynecologic Disorders," American Journal of Obstetrics and Gynecology, Vol. 60, #3, Sept., 1950: 609.

50 Editorial, "Medicine and Fitness," Canadian Medical Association Journal, Vol. 81, July 15, 1959: 112.

problems, and were connected to physiological functions.⁵¹ But wrapped up in this conceptualization of women's reproductive physiology and anatomy were many assumptions about women's bodies and gender. The historical shift from pathology, to physiology and systems theory, included an increasing emphasis upon understanding the normal, in order to define the limits of both the normal and the abnormal.

Female Reproduction as Normality

The long-hypothesized connection between a woman's uterus and ovaries, and her psyche, was then given scientific ground in normal physiology. The traditional view of the female reproductive system as affecting emotional and mental states was given an added direction, with the recognition that the psyche could influence the reproductive system.⁵²

The female reproductive system and organs were frequently referred to as "mechanisms" and the female body as an "organism."⁵³ This objectifying, scientific language, however, was set in the context of a broadening approach to the body, one which included a systems theory model and, at

51 Johnson, William O., "Fatigue? It's Absurd - I Haven't Done A Thing," Obstetrics and Gynecology, Vol.5, #2, Feb., 1955: 215-221.

52 Baird, Dugald, op.cit.: 1286.

53 Ibid.: 73, 946; Presidential Address in Obstetrics and Gynecology, Vol. 14, #6, Dec., 1959: 811.

times, considered psychosomatic aspects. One major text author commented that gynecology should be interpreted "in the widest sense," and should "recognize that Woman is more than a container for a uterus and ovaries."⁵⁴ Organs were to be seen in relation to other organs, and reproductive systems in terms of other bodily systems. This systems conceptualization of physiological processes developed with the greater influence of internal medicine, psychoneurology, and endocrinology. The impact of these areas on gynecology led to knowledge of:

the hormonal control of the reproductive functions, the delicate inter-relationship of all the hormonal functions of the body (of which the pituitary-ovarian link is but a portion), the influence of mental and emotional states upon hormonal function, and the incalculable and far-reaching ramifications of "sex" amongst these same mental states and emotions.⁵⁵

Earlier in the twentieth century, this hormone theory and studies of the reproductive cycle had become less a clinical and more a laboratory problem.⁵⁶ By the 1950s, the generation of this knowledge had long been the responsibility of academic medical research, rather than a product of practising obstetricians and gynecologists.

⁵⁴ Jeffcoate, T.N.A., op.cit.: 1.

⁵⁵ Baird, Dugald, op.cit.: 946.

⁵⁶ The 1917 discovery by Stockard and Papanicolaou of cyclical changes in the vagina and uterus, and Allen and Doisy's 1923 development of vaginal smears for the study of the chronology of cyclical changes, were steps which first promoted the laboratory nature of the research. Emil Novak and Edmund R. Novak, op.cit.: 57.

The emphasis on endocrinology and the interrelation of hormonal functions among systems, encompassed the notion of psychosocial influences. Hormones were postulated as affecting both the soma and the psyche (still envisioned as a duality, if now an interrelated duality).⁵⁷ At times, this was taken to imply that psychological gender traits were caused by the designated female hormone, estrogen. Feminine characteristics like "sensitivity and shyness," for example, were occasionally linked to hormonal inheritance.⁵⁸ This medical conceptualization considered certain women's mental and emotional characteristics capable of aggravating menstrual problems.

What initially appears to be a purely biomedical, endocrinological model of cyclical and menstrual function, is in fact an integration of biomedical and psychosomatic concepts. Novak and Novak acknowledge that the part played in menstruation by the "higher sex centers," like the hypothalamus, was accepted during the 1950s by most obstetricians and gynecologists.⁵⁹ It was the generally agreed-upon approach, even though it was a hypothetical conjecture at that point, as the Novaks themselves noted :

We know nothing as to the pathways involved, but we must presuppose some such liaison with the higher centers in order to explain the undoubted influence

57 Baird, Dugald, op.cit.: 59.

58 Jeffcoate, T.N.A., op.cit.: 67-8.

59 Novak, Emil and Edmund R., op.cit.: 65.

of environmental and psychic factors on the menstrual function.⁶⁰

So the particular conception of female reproductive processes advocated included the interrelation of soma and psyche in those processes. The language involved in discussions of anatomy and physiology, however, remained biomedical - a crucial indication of the strength of the biomedical model, while it absorbed psychosomatic concepts.

The model of women's reproductive physiology provided knowledge of normal menstrual cycles, and therefore implied a basis for distinguishing the inception of abnormalities.⁶¹ It was a hierarchical model of a system in which there was a chain of connections, headed by the hypothalamus. It was hypothesized that the anterior lobe of the pituitary emitted two main gonadotrophic hormones (LH and FSH), which in turn controlled the ovaries, the ovarian hormones and reproductive processes (follicle ripening, discharge of the ovum and corpus luteum growth). Debated, however, was the question of whether the gonadotrophic hormones acted independently of each other.⁶² The pituitary was usually referred to as the cause of the hormonal processes of this system, including cyclical changes. The Novaks, however, noted that the pituitary domination of the ovaries was reciprocal.⁶³

60 Ibid.: 65.

61 Ibid.: 59.

62 Baird, Dugald, op.cit.: 75.

63 Novak, Emil and Edmund R. Novak, op.cit.: 59 & 70.

It is interesting to compare the textual descriptions of this reproductive system in the female with those of the male. The discourse is in fact very similar and in places, a precise analogy is made from female to male physiology and anatomy.

The testicular function is controlled by the anterior pituitary gland, but the exact mechanism has not yet been explained. It may be that the control is effected by two gonadotrophic hormones, one similar to the follicle stimulating hormone in the female and acting directly on the seminiferous tubules to stimulate spermatogenesis, and the other analogous to the luteinising hormone, acting on the interstitial cells to stimulate production of testosterone.⁶⁴

It is difficult to argue, then, that the general, descriptive use of the biomedical model was a patriarchal conceptualization of female physiology alone. There was one area, however, in which there was a difference between descriptions of the male and of the female. There were more numerous references to testosterone's role in the "development of libido and sexual potency" in males, than to women's libido.⁶⁵ The discussions of women's endocrinology tended to be limited more to their reproductive, rather than to their sexual, capacity.

In fact, evidence that linked women's physiology to sexual functions was overtly minimized in some instances.

64 Baird, Dugald, op.cit.: 84; cf. also Novak, Emil and Edmund R. Novak, op.cit.: 1252.

65 Baird, Dugald, op.cit.: 84.

For example, it was recognized that there is secretion of some androgens and testosterone in women.⁶⁶ The implication, that the distinction between so-called male and female hormones was actually a hazy one, was also acknowledged. The "close chemical relation between the male and female principles" and "experimental evidence that both may be produced by the same gonad" were points offered as indications of the problematic nature of sex hormone differentiation.⁶⁷ Yet the male-female endocrinological overlap was set aside by Jeffcoate when he claimed that "for all practical purposes," there were only two female hormones secreted by the ovary.⁶⁸ The question arises, then, of what the concept of "practical purposes" meant to this gynecologist. The emphasis upon women's reproductive capacities suggests one plausible interpretation, that the acknowledgement of hormones in females was confined to those which participate directly in reproductive processes.

Study of the action of the hormones involved in the reproductive, including the menstrual, cycle revealed a broadening conceptualization of the relevant physiological processes. No longer was the menstrual cycle viewed as confined to primarily a uterine and ovarian, "pelvic phenomenon."⁶⁹ The more encompassing view also provided

66 Ibid.: 79; Novak, Emil and Edmund R. Novak, op.cit.: 63.

67 Novak, Emil and Edmund R. Novak, op.cit.: 63.

68 Jeffcoate, T.N.A., op.cit.: 67.

69 Novak, Emil and Edmund R. Novak, op.cit.: 58.

space for a teleological interpretation of the reproductive cycle in women:

... we now conceive of the reproductive cycle as a constitutional one, involving organs and tissues far removed from the pelvis, such as the pituitary gland at the base of the brain. Menstruation is only one manifestation of this far-flung cycle, the real purpose of which has to do with reproduction, with the egg as the central factor about which the whole process revolves.⁷⁰

There was a standardization and categorization of endometrial and menstrual cycles in all the major texts of the 1950s. The menstrual cycle was divided into three stages (sometimes only two stages): the follicular (oestrus), ovulation, and luteal (progestogens) phases.⁷¹ Analysis of this categorization, reveals that it is based on ovulation as the main criterion for the divisions. This was explicitly stated by Eastman, a major American obstetrician:

The point to be emphasized here is that the phenomenon of ovulation divides the ovarian cycle into two main phases.⁷²

The centrality of ovulation is significant here because of its role as the most fertile point in the cycle. In other words, reproduction per se is the focus. The language used to describe the other phases of the cycle also expressed this concentration. Some of the terms used to refer to the luteal and menstrual phase were "endometrial loss,"

70 Ibid.: 58.

71 Jeffcoate, T.N.A., op.cit.: 62; Baird, Dugald, op.cit.: 59.

72 Eastman, Nicholson J., op.cit.: 66.

"regression in size," "dying," and "failure of the anterior pituitary gland."⁷³ These terms all evoke very negative images. "These are not neutral terms; rather, they convey failure and dissolution."⁷⁴ This discourse portrays the menstrual process in relation to the ultimate, positive function of pregnancy. In other words, pregnancy is considered the norm, to which the other phases are posited as relative. If a lack of endometrium in the menstrual phase, for example, had been the norm, then the discourse would not have contained a view of it as a loss. Rather, the ovulatory phase and pregnancy could have been expressed as possessing excessive endometrial material. The terminology used did not reflect description of an objective reality. This can also be demonstrated through a comparison of words used to depict menstruation with those describing analogous physiological processes, in this case, the shedding of a lining. For example, the mucous cell layers in the stomach lining are continuously shed.⁷⁵ But the terminology used to describe the process is most often not the negative one of decay and degeneration, but rather, the positive one of production of mucus, protection of the

73 Baird, Dugald, op.cit.: 32, 80.

74 Martin, Emily, The Woman in the Body. A Cultural Analysis of Reproduction, Boston: Beacon Press, 1987: 48.

75 Martin discusses how language used in medical texts reflects a view of menopause and menstruation as pathological. She links this language to metaphors of production and conceptualizations of the body as a "hierarchical information-processing system." Ibid.: 42, 48-51.

stomach wall, and "the periodic renewal of the lining of the stomach."⁷⁶ It is evident that the ovarian and endometrial cycles were interpreted in such a way as to embody the notion of fulfilled reproduction as the primary, and perhaps, the sole aim of these physiological processes.

The post-ovulatory phase was viewed teleologically, as was evident in the frequent conceptualization of it as possessing the purposes of preparing the endometrium for the ovum and providing "an ovum for fertilization."⁷⁷

The fundamental cause of menstruation is degeneration of the corpus luteum and this only degenerates if the ovum is not fertilized. Modern knowledge therefore bears out the century old dictum to the effect that "women menstruate because they do not conceive." ... "is sometimes described as "the weeping of a disappointed uterus."⁷⁸

An underlying assumption regarding normality, was also entailed in the conceptualizations of those cycles. The content of that assumption paralleled the pronatalist norms of the social context of the 1950s:

From a strictly biological viewpoint it might be concluded therefore, that menstruation is a sign of frustration on the part of nature in her effort to replenish the species and normally would not take place if pregnancy occurred at the time of puberty and recurred sufficiently frequently thereafter. The author has seen one example of such

76 Ibid.: 50.

77 Eastman, Nicholson J., op.cit.: 60; Beck, Alfred C. Obstetrical Practice, 5th edition, Baltimore: The Williams & Wilkins Co., 1951: 12.

78 Jeffcoate, T.N.A., op.cit.: 78.

"biologic perfection" in the person of a woman who became pregnant at the age of fourteen and gave birth to thirteen children by the time that she was twenty-seven without ever having menstruated.⁷⁹

The assumption made here is that reproduction is the normal state for women. Thus, the ovulatory phase was emphasized to the exclusion of other aspects of female cycles.

In addition, description of the corpus luteum of pregnancy as large implied that pregnancy was the true female condition. The corpus luteum of menstruation, in contrast, was considered small and termed "false."⁸⁰ A terminological debate in obstetrics and gynecology at that time also reflected the teleological positing of reproduction as normality for women. The debate revolved around whether, as the Novaks claimed, menstruation following an anovulatory cycle was real menstruation, or whether it was not real menstruation and so should be called something else, as Baird argued (part of the latter's reasoning was that anovulatory cycles were uncommon, a point with which the Novaks also disagreed). It was suggested by some obstetricians and gynecologists that anovulatory bleeding was "pseudo-menstruation," a pathological condition.⁸¹ Again, the terms of this discussion were based

79 Beck, Alfred C., op.cit.: 20-1.

80 Greenhill, J. P., Principles and Practice of Obstetrics, 10th edition (originally by Joseph B. DeLee), Philadelphia: W. B. Saunders Co., 1951: 7.

81 Novak, Emil and Edmund R. Novak, op.cit.: 75, 78; Baird, Dugald, op.cit.: 82.

on the notion that only pregnancy and processes leading to pregnancy could be considered true norms. A menstruating and potentially fertile woman was considered normal.⁸² Though it was not always deemed necessary that this potential be fulfilled, reproduction was still held as the norm.⁸³ This was considered to be the design of nature.

The general emphasis in the major texts was on increasing the knowledge of the normal in endocrinology. This was reflected in the first three parts of Baird's texts, which, as he said, "deal with the normal."

In the field of gynaecology the major advances in recent years have been in endocrinology; but here also the importance of knowing more about the normal...must be stressed.⁸⁴

The normal was to be studied further and the pronatalist sentiments of the times, linked as they were with desires for socio-political stability, were expressed in obstetric and gynecologic concepts of normality.

Fluidity of the Scientifically Normal and Abnormal

Greater knowledge of the normal provided one route to improved attempts at defining the abnormal. An area which felt the impact of growing studies of the normal in endocrinology was that dealing with hormonal effects on the

82 Jeffcoate, T.N.A., op.cit.: 664.

83 Baird, Dugald, op.cit.: 939.

84 Ibid.: v.

growth of cancer. This research topic only developed during the half-century prior to the 1950s, and was one of the major concerns of gynecologists during the 1950s.⁸⁵

The trend towards increasing preventive medicine, operated through surveillance of the normal to detect the potential presence of the abnormal. This process was particularly strong in relation to the issue of cervical cancer. The main problem debated in the area was that there were no clearcut, objective divisions between the normal and the abnormal in arriving at a diagnosis.⁸⁶ Therefore, somewhat arbitrary decisions had to be made, according to abstract criteria (the degree of lesions, the patient's age and the importance of "preserving the reproductive function").⁸⁷

Decisions about treatment were clinical, practical judgements in borderline cases because it was so difficult to separate benign tissue and cellular changes from malignant cancer. The advent of effective antibiotics, for example, permitted more surgery to be done in cases of

85 Te Linde, Richard W., Operative Gynecology, 2nd edition, Montreal: J.B.Lippincott Co., 1953: vii.

86 Greenhill noted that the literature in 1950 was full of articles on detecting early cervical cancer and that there was much debate about the proper treatment of "true cancer in situ." He mentioned that TeLinde demonstrated it was, in fact, invasive carcinoma in many women. Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 14.

87 Eastman, Nicholson J. and Emil Novak, Editorial Comment on S.B. Gusberg, S.A. Fish and Yin-Ying Wang, "The Growth Pattern of Cervical Cancer," Obstetrical and Gynecological Survey, Vol. 10, 1955: 104.

suspected malignancy. This attempt to detect the abnormal in the normal would enable the concepts themselves, as well as decisions about therapeutic measures, to be placed on what was considered to be a more scientific, objective basis, through the use of laboratory tests. The whole concept of "cancer-in-situ" was hardly a definitive one. So the development of preventive programs for detection of early lesions was dependent upon an initial acceptance of that concept.

One of the rationales for preventive surveillance of this condition was that the cervix, the affected area, could be directly "inspected."⁸⁸ This was one practical factor which influenced medical efforts to distinguish normality from abnormality in this case. Anatomical accessibility as well as flexibility in laboratory interpretations can affect the entire enterprise of defining normality.

Interpretation of tests left a substantial amount of space for judgement, and gynecologists saw rationalization, through the setting of standards, as a way to deal with that ambiguity. Eastman and Novak, editors of the Obstetrical and Gynecological Survey, commented that diagnostic disagreements revolved around whether a section indicated penetration of the "basement membrane" or whether some

88 "Since the cervix is an organ that may be palpated and directly inspected, it lends itself to prophylaxis or exceedingly early detection of malignant disease much better than the internal viscera." Telinde, Richard W., op.cit.: 391.

"buds" of atypical epithelium "represent only gland extension or actual invasion of the stroma."⁸⁹ In discussing these debates, the editors noted that there was no unanimity regarding diagnosis of cancer-in-situ: "Like beauty, microscopic diagnosis is "in the eye of the beholder," and to the eye we may add the mind."⁹⁰ It was considered possible to teach women to recognize "normal as well as abnormal conditions," through self-examination of the cervix, much as seeing anatomy and diagnosis correctly is taught to be seen, as discussed earlier.⁹¹ Control of this constructed knowledge has been retained by the medical profession, however, as part of the realm of their professional expertise. Such knowledge of normal endocrinology was utilized to develop a basis for distinguishing abnormality and for its preventive surveillance, as in the case of cervical carcinoma.

The Social Content of Gynecological Normality And Abnormality

Parallels with the general social context emerge in analysis of the content of the meanings of normality and

89 Eastman, Nicholson J. and Emil Novak, op.cit.: 87.

90 Ibid.: 87.

91 Edwards, Johannes F. Persel, Thomas K. Rathmell and John S. Wise, "Hyperinsulinism and Premenstrual Tension: Report of a Case of Hyperplasia of the Islets of Langerhans," American Journal of Obstetrics and Gynecology, Vol.70, #5, November, 1955: 1128.

abnormality in obstetric and gynecologic discourse during the 1950s. The biomedical, primarily endocrinological, model was applied to conditions such as pre-menstrual syndrome (P.M.S.), dysmenorrhea, and the menopause.

Psychosomatic aspects of these conditions were absorbed by biomedicine, which helped the underlying assumptions of obstetrics and gynecology come to the fore. Again, as with conceptualizations of female physiology, the assumption which emerged was that of reproduction as female normality.

The gynecological states of premenstrual syndrome, dysmenorrhea, and menopause were considered predominantly endocrinological, biological conditions. P.M.S, for instance, was just beginning to be defined as a syndrome at all, though roots of this notion go back to the 1930s. A British doctor, Katharina Dalton, was one of the major figures who pressed for its recognition as a medical problem and an endocrinological one.⁹² Many believed that P.M.S (or P.M.T, pre-menstrual tension as it was often called then) was the result of multiple dysfunctions, including psychogenic ones.⁹³ Endocrine dysfunction was also focused upon as a cause of dysmenorrhea, as the profession acquired greater knowledge of "hormonal control" of uterine changes.⁹⁴ This new knowledge led to the predominant view

92 Editorial Comments, Canadian Medical Association Journal, Vol. 73, July 15, 1955: 138.

93 Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 513.

94 Baird, Dugald, op.cit.: 994.

of dysmenorrhea as being of endocrinal etiology.⁹⁵ But the Novaks attempted to strike a balance between the extreme emphases on psyche or soma:

So important are these possible factors that there are some authorities who assert that the cause of primary dysmenorrhea is invariably psychogenic, a view which we do not share. On the other hand, we are convinced of the prime role of the psychogenic factor in many cases.⁹⁶

Even the academic, more biomedical, gynecologists and obstetricians frequently divided these conditions into relatively normal, slight degrees of symptoms and more abnormal, severe incapacity. So, as is common to use of the biomedical model, the degree of symptoms was one of the criteria for designating abnormality. In addition, the mind-body duality was asserted in this process of definition; biological symptoms were considered endocrinological, while psychological ones were not and were classified as less real. The psychological symptoms were those that were most often used to diagnose the patient as abnormal. Frequently, there would then be a search for a basis formulable in somatic, organic terms.

The search for the etiology of these gynecological conditions in endocrinology was expected to clarify the classification of degrees of incapacity and abnormality. This was a rather vague task, as a minimal degree of

95 Novak, Emil and Edmund R. Novak., op.cit.: 667.

96 Ibid.: 665.

discomfort on the part of women was usually considered the norm. Despite obstetric and gynecologic acceptance of discomfort on the part of women, the terms used to describe even the symptom-free cyclical state denoted a problematic lack or excess. For example, menopause was described as a state of "ovarian deficiency" or "pituitary excess."⁹⁷ P.M.S symptoms were generally held to be the manifestation of "estrogen excess," a dysfunction explained as being "by reason of a deficiency or total absence of the corpus luteum hormone, progestin".⁹⁸

The etiology of abnormal degrees of the conditions, was sought in the study of the normal endocrine system and at times, the normal psyche. There were numerous theories of the causes of P.M.S. But Dalton's main hypothesis was that the normal estrogen/progesterone hormonal balance was upset, there being a relative excess of one over the other. The psychic overlay was asserted by others to be a factor in the etiology of P.M.S. In severe cases, dysmenorrhea, as well, was viewed as an imbalance of the psyche and hormones.

Obstetricians and gynecologists themselves, at times related these conditions directly to psychosocial conditions and attitudes around them. For example, there were references to the threat of communism as causing insecurity, women's envy of men, problems of family breakdown, and

97 Ibid.: 126.

98 Ibid.: 737.

women's devalued social status. Dysmenorrhea was sometimes seen as being aggravated by such social conditions. Doctors discussed the advice to be dispensed so that women would attain normality, rather than experiencing an abnormal degree of symptoms. Over and over, young women were exhorted to take a "healthier attitude" by not letting menstruation interfere with their everyday activities. Recommendations included exercise and "avoidance of the too-strenuous school work which has wrecked the health of many an ambitious girl at this age."⁹⁹ It was widely believed that changing women's views of menstruation as illness, to acceptance of it as a natural phenomenon, would help allay the development of "the psychogenic type of primary dysmenorrhea."¹⁰⁰ Often the doctor's role was conceived as being one of reassuring and educating the young woman; being "something of a psychiatrist."¹⁰¹ The family doctor or gynecologist was expected to tell her

that menstruation should not normally interfere very materially with the usual work or activities of the normal girl.¹⁰²

But when the role of social conditions and attitudes in contributing to abnormality was recognized, it tended to be simultaneously individualized. For example, the notion of environmental influence on dysmenorrhea was interpreted as

99 Ibid.: 123.

100 Ibid.: 123.

101 Ibid.: 665-6.

102 Ibid.: 665-6.

only that individual woman's personal experience, such as her occupation.¹⁰³ So what could potentially have been a social indictment was instead confined within the limits of prescriptions for individual change. Therapeutic measures offered for women with dysmenorrhea included diethylstilbestrol (D.E.S.), exercise, improved nutrition, and the correcting of "any errors in the patient's mode of life."¹⁰⁴ Another recommendation was to "Correct the patient's mental attitude."¹⁰⁵ Obviously this placed the onus on the individual woman to change, but it also implied a goal of normalization of female patients and an assumption of knowledge about the proper or correct content of normality.

Normal and Abnormal Women and their Menstrual Conditions

Gynecologists frequently claimed that the norm regarding menstrual cycles, P.M.S, or dysmenorrhea was a relative one, varying according to the individual woman.¹⁰⁶

It is helpful to ascertain first what was the normal for the individual patient in regard to the menstrual functions, as only when that is known can the degree of any existing abnormalities be judged.¹⁰⁷

103 Baird, Dugald, op.cit.: 193.

104 Jeffcoate, T.N.A., op.cit.: 503.

105 Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 515-6.

106 Jeffcoate, T.N.A., op.cit.: 7.

107 Baird, Dugald, op.cit.: 194.

Hence, knowledge of the individual norm was also one method for detecting abnormality. The determination of whether a woman experienced a sufficient degree of pain to be categorized as having true dysmenorrhea was seen as partly dependent upon the individual's subjective pain threshold.¹⁰⁸ But throughout discussions of these menstrual conditions, assumptions consistently emerged about more generalized concepts of normal and abnormal conditions and the women who experienced them. Analysis of both categories of women reveals a logic wherein the meaning of abnormality is the obverse of normality regarding womanhood.

An abnormal condition was defined by the presence of troublesome symptoms, problems with pain, endocrinologic imbalances, and incapacitation of the patient¹⁰⁹, but also by the woman's difficulties in accepting motherhood, femininity,¹¹⁰ and sexual adjustment.¹¹¹ Abnormal menopausal women, for example, were characterized as "difficult to manage" and trouble for other people.¹¹² Some

108 Golub, Leib J., Hyman Menduke and Warren R. Long, "Semiobjective Criteria of Teen-age Dysmenorrhea," Obstetrics and Gynecology, Vol. 14, #2, Aug., 1959: 179.

109 It is noted that incapacitating dysmenorrhea results in loss of work hours and may damage a woman's general health. Dugald Baird, op.cit.: 989.

110 Rogers, Floyd S., "Emotional Factors in Gynecology," American Journal of Obstetrics and Gynecology, Vol. 59, #2, Feb., 1950: 324.

111 Sexual repression in women was seen as capable of leading to dysmenorrhea. This was expressed as being a function of some degree of sexual repression in most people of that "culture." Baird, Dugald, op.cit.: 1288.

112 Ibid.: 64.

doctors traced such difficulties to the individual woman's problematic attitudes, but also referred to women's social position and wider social views of menopause. Some of the problems encountered were considered avoidable if "normal feminine drives" were fulfilled throughout the woman's life.¹¹³

The major academic gynecologists scorned the widespread administration of estrogen therapy, though, for menopausal symptoms.¹¹⁴ Although they acknowledged the abnormal degree those symptoms could attain, they still referred to it as being a natural condition and not a deficiency in the majority of women.¹¹⁵ Those gynecologists who emphasized the psychosomatic aspects of conditions like P.M.S., dysmenorrhea, and the menopause contradictorily acknowledged both the social devaluation of femininity (part of the social context) and women's rejection of it, as playing roles in the generation of gynecological abnormalities.¹¹⁶ These doctors were certainly insightful in their analysis of the psychosocial context. However, they failed to see the logic in women's rejection of a version of femininity that

113 Donovan, John C., "Psychological Aspects of the Menopause," Obstetrics and Gynecology, Vol. 6, #4, Oct., 1955: 384.

114 TeLinde, Richard W., op.cit.: 852; Novak, Emil and Edmund R. Novak, op.cit.: 616.

115 Novell, Howard A., "Pertinent Comments," American Journal of Obstetrics and Gynecology, Vol. 78, #4, Oct., 1959: 912.

116 Kroger, W. S. and S. C. Freed, "Psychosomatic Factors in Functional Amenorrhea," American Journal of Obstetrics and Gynecology, Vol. 59, #2, Feb., 1950: 324, 332, 335.

was promoted, but not respected, by their society. Rather, the widespread Freudian interpretation emphasized the individualistic focus upon the "faulty attitudes" of the individual woman.¹¹⁷ The women who were considered to have abnormal gynecological conditions were the same ones who were commonly characterized as "neurotic," "unintelligent," "immature" and "emotionally unstable."¹¹⁸

So what was the version of normality which those women were perceived as rejecting? How was a woman expected to achieve normality? How did a woman have to behave in order to be categorized in the positive group, to be seen as "intelligent," "emotionally stable," and "well-adjusted?" To what was she supposed to be well-adjusted?

Physiologically and mentally, normal menstrual and menopausal processes meant relatively painless states:

On the whole, however, the menstrual function should entail no worthwhile discomfort and no interference with the normal activities.¹¹⁹

They were trouble-free, not only for the woman herself, but also for her relations with her family and doctor.

Menopausal women were expected to age gracefully, accepting the aging process and taking on a "matronly" appearance and a "serene" demeanor as they relinquished their central roles

117 Ibid.: 331.

118 See, for example, Dugald Baird, op.cit.: 994, 1294; Jeffcoate, T.N.A., op.cit.: 89, 511; TeLinde, Richard W., op.cit.: 1.

119 Novak, Emil and Edmund R. Novak, op.cit.: 119.

as mothers in the family.¹²⁰ The concepts of mature and stable, as applied to women without any severe gynecologic disturbances, referred partly to the high Protestant value placed upon lack of emotionality, of not being "high-strung."¹²¹ They also reflected the 1950s social emphasis upon rationality and stability, upon security through resistance to change. Most of all, however, the obstetric and gynecologic versions of mature and well-adjusted were explicitly stated to mean a woman's ability to "accept the responsibilities of an adult sex life."¹²² That in turn was defined as acceptance of the socially expected feminine role of marriage and motherhood. Reproduction was central to the gynecological division of normal versus abnormal women and their conditions.

Both psychic and somatic aspects were accepted in the biomedical model applied to gynecological conditions. Yet they were retained in their dual form, and the somatic complaints of women were consistently given greater validity. The more the woman's symptoms fell into the subjective category of the psyche, the more likely she was to be classified as abnormal. Here we again see an instance of only partial acceptance of a more holistic approach, with prioritization of the more prestigious, scientized, biomedical model. It was even suggested by one doctor that

120 Ibid.: 632.

121 Jeffcoate, T.N.A., op.cit.: 89, 512.

122 Baird, Dugald, op.cit.: 1293.

Perhaps increased knowledge of anatomy and biochemistry will result in less emphasis on psychogenic factors. It is certain that excess medication, too early resort to surgery and overemphasis on psychogenic causes are not in the patient's best interest.¹²³

Yet the incorporation of some psychosomatic aspects simultaneously contributed to the medicalization of conditions like P.M.S. It produced an expanded body, one composed of female reproductive processes, and a body more susceptible to medical surveillance and intervention.

The construction of motherhood and reproduction as normality for women was simultaneously a medical and a social process. This particular content was attributed to categories of the normal and the abnormal during the 1950s and it paralleled the socio-political concerns of the time. Those concerns provided the context drawn upon in the construction of normality and abnormality as concepts. Medical discourse, for example, assumed a need existed for preservation of the family as the basic social unit, and mothers were viewed as forming the central core of the family. These assumptions were in turn related to fears about changing gender relations (as implied in the term "rejection of femininity"), and calls for retaining family practitioners, a professional concern. Socio-political fears about international instability also contributed to a

123 Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 521.

situation in which gynecologists emphasized whatever would provide stability and security at that time. In this case, motherhood and the nuclear family were thought to be able to satisfy those needs. Obstetrics and gynecology dealt not only with the abnormal, but also dispensed advice about how women could live a normal life. Part of the reason the gynecologic categories distinguished the abnormal, though, was to prevent its occurrence in the normal woman and hence, promote stability.

This finding contrasts somewhat with the assertion found frequently in the feminist literature on women and medicine, that normal female processes were conceptualized by doctors as pathological (based on maleness being taken as the normative standard).¹²⁴ The normal is discussed as being pathological to doctors, not merely in the sense of medical surveillance and intervention into normal female processes. Feminists contend that women's cycles, labour, and so on were actually conceptualized in medical knowledge as pathological processes. Oakley, for example, states that:

The most characteristic aspect of modern antenatal care is the clinical insistence on the probability of pathology in all childbearing. In

124 For example, Riessman asserts that from about 1910, obstetricians intervened in birth on the basis of a view of it as pathological, and that normal pregnancy was exceptional. Catherine Kohler Riessman, "Women and Medicalization: A New Perspective," Social Policy 14, Summer, 1983: 6.

historical terms, the redefinition of pregnancy to abolish any idea of its essential normality was an obstetrical necessity...¹²⁵

Medicalization of these conditions has certainly led to increased monitoring of normal processes, and while this means that they are then dealt with in the medical realm, it does not necessarily imply that they are viewed as pathological. Conditions that have been medicalized can be seen not only as illnesses or as non-medical, but as deviating from an ideal standard.¹²⁶ Medicalization means, in fact, the expansion of the medical realm to include states of normality under medical control and surveillance. One author discusses how, in the United States, male physicians started to intervene in normal labor in the middle of the eighteenth century. This changed attitudes in the direction of more acceptance of medicalization, that birth could be influenced by those with the expertise to do so. However, she does not state that birth in general was automatically viewed as pathological.¹²⁷ Hence, any separation made, as by Oakley, between pregnancy as "a natural phenomenon" and as "so potentially or actually

125 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 2.

126 Riessman, Catherine Kohler, op.cit.: 9-10.

127 Leavitt, Judith Walzer, Brought to Bed. Childbearing in America 1750 to 1950, Oxford: Oxford University Press, 1986: 3-5.

abnormal that it constitutes a medical condition" is a problematic one.¹²⁸

This research on obstetrics and gynecology of the 1950s points, rather, to a greater emphasis by the medical profession on constructing standardized differences between the normal and the abnormal in women's conditions. Surveillance of the normal was largely to prevent it from moving into the realm of pathology. Hence, there was a conceptual separation of the two made in medical knowledge of the 1950s, but normal processes definitely fell under medical jurisdiction without being considered pathological. Doctors saw a role for themselves in the sphere of the normal, a more preventive one, but they saw it as differentiated from their role in treating pathological conditions.

Martin refers to current critiques made of the medical view of menopause as pathological.¹²⁹ But she also notes that this way of seeing menopause only emerged dramatically after the 1940s and 1950s. In that period, one text described menopause as:

128 This separation is made by Oakley. Ann Oakley, op.cit.: 12.

129 Reference to Frances B. McCrea, "The Politics of Menopause: The 'Discovery' of a Deficiency Disease," Social Problems, 31(1), 1983: 111-23, in Emily Martin, op.cit.: 42.

usually not entailing "any very profound alteration in the woman's life current."¹³⁰

In the 1965 edition of the same text, however, menopause was viewed as a more pathological process:

"In the past few years there has been a radical change in viewpoint and some would regard the menopause as a possible pathological state rather than a physiological one and discuss therapeutic prevention rather than the amelioration of symptoms."¹³¹

This notion of stages in views of women's conditions is supported by Oakley's formulation of two stages in the medicalization process. She argues that pregnancy was viewed as "natural" in seventeenth and eighteenth century medical discourse. But this view gradually shifted to one of pregnancy as pathological, as "a medical phenomenon akin to illness," and "this process has really only become marked in the period since 1950."¹³² This change in definition may be part of the reason that few definitions of women's reproductive processes as pathological were found in obstetrical and gynecological knowledge of the 1950s. In fact, the pronatalist emphasis on reproduction as the

130 From Novak, Emil, Textbook of Gynecology, 2nd edition, Baltimore, MD: Williams and Wilkins Co., 1944: 536; Novak, Emil and Edmund Novak, Textbook of Gynecology, Baltimore, MD: Williams and Wilkins Co., 1952: 600, in Emily Martin, op.cit.: 51.

131 Novak, Edmund, Georgeanna Seegar Jones, and Howard W. Jones, Novak's Textbook of Gynecology, 7th edition, Baltimore, MD: Williams and Wilkins Co., 1965: 642, in Emily Martin, op.cit.: 51.

132 Oakley, Ann, op.cit.: 12.

essence of normality, meant that it was not pregnancy which was pathologized by medicine, but rather its opposite, the lack of pregnancy. This was consistently the social content of obstetric and gynecologic knowledge which took the form of scientifically referenced categories of normal and abnormal female reproductive processes.

Chapter 8

The Rationalization of Reproduction and Population

The social trends towards standardization and rationalization of concepts of normality and abnormality, as characterized knowledge of women's physiology, were also manifested in the two issues discussed in this chapter. The first is that of obstetric and gynecologic approaches to the management of pregnancy and labour; then we turn to medical views on fertility, sterility and general population concerns. Both these issues were influenced by developments in the basic sciences, particularly the endocrinological knowledge predominant in the biomedical model. The categories of knowledge that emerged were given content by the professional and social context of the period, including that of changing gender relations. As demonstrated in the chapters describing the context of the 1950s in Canada, Great Britain and the United States, there was variability in the degree and timing of professional and other social changes. However, these specific differences produced remarkably little variation in the social character of obstetric and gynecologic knowledge of the period. Those differences came into play, at least with the questions

asked in this study of obstetric and gynecologic writings, primarily with regard to differences of emphasis or timing.

One theme that consistently emerged throughout examination of these concerns, was the focus of obstetric and gynecologic discourse upon the normal, with a corresponding lesser degree of attention to the pathological. This emphasis lent itself to medical participation in a form of positive eugenics, i.e. a surveillance of normal populations for detection of the abnormal, and management of reproduction in terms of particular social goals. Obstetric and gynecologic focus on the normal was a distinctively different form of knowledge than examination of only the pathological. The normal was considered potentially pathological, and hence, supplied a motivation for medical intervention. But obstetricians and gynecologists were well aware of this distinction between pathology and surveillance of the normal, for they were explicitly being taught to distinguish between the two. The development of the surveillance aspect increased medicalization of women's conditions, but did not mean, at least during the 1950s, that those conditions were consistently perceived as pathological or abnormal.

Rationalization of the biomedical model meant that knowledge of pregnancy, labour and population control was scientized. In other words, this knowledge was embedded in a discourse of scientific language, one which assumed

objectivity and neutrality. Yet this was a socially-constructed discourse, a characteristic more readily apparent when the content of concepts about normal pregnancy, abnormal problems of women in labour, etc. are analyzed. Women were in some ways caught in the middle of these processes, participating in them and directly influenced by them through obstetric and gynecologic knowledge. The pro-reproduction and motherhood stance which was evident in the issues examined in the previous chapter, are displayed here once more. More specifically, the social norm of nuclear family, middle-class, white reproduction and motherhood was favoured. Through analysis of the medical discourse, it becomes clear that this norm was viewed as a reasonable solution to perceived social problems; mothers could provide social stability and security, both during the 1950s and in the future.

Biomedical Conceptualizations of Pregnancy and Labour

The biomedical discourse, as we saw earlier, cast a particular hue upon conceptualizations of women's reproductive physiology and anatomy. The biomedical approach and its implications were also extended to concepts of pregnancy and labour. A systems model, similar to that applied to women's physiology, characterized the predominant view of pregnancy as a hormonal state, with the hormones

creating effects in the whole body.¹ The question of the etiology of labour's initiation was largely unresolved in the 1950s. But the integration of some aspects of psychosomatics into the medical model produced a predominantly endocrinological theory of the initiation of labour. The complexity of the hormonal processes involved was recognized.²

The description of the functions of hormones and organs in the pregnant woman was again a teleological one. Hormonal processes were frequently characterized in terms of their functional aims; for example, the preparation of the endometrium for embedding and maintenance of the ovum, or the altering of pituitary, adrenal and endocrine gland functions in order to adapt metabolism to "the special needs of pregnancy." Changes in the uterine wall during pregnancy were not only referred to descriptively, but were also discussed in terms of the purpose of the changes, in this case, to increase the space inside the uterus. The structure of the uterine musculature, based on a "spiral course" of muscle fibers, was stated to be following "one distinct plan."³

1 Baird, Dugald, Combined Textbook of Obstetrics and Gynaecology, 5th edition, Edinburgh: E. & S. Livingstone Ltd., 1950: 105.

2 Ibid.: 236, 237; Novak, Emil and Edmund R. Novak, Textbook of Gynecology, 5th edition, Baltimore: The Williams and Wilkins Co., 1956: 67.

3 Jeffcoate, T.N.A., Principles of Gynecology, London: Butterworth & Co., 1957: 108.

The function of the uterus, particularly during pregnancy and labor, is based on this peculiar anatomic arrangement.⁴

The language used in this socially-constructed model of scientific medicine was also mechanistic and objectifying. Particular organs, such as women's uteri, were discussed as though they had a life of their own, separate from the bodies of women; they were basically reified.⁵ Women themselves were repeatedly referred to in an objectifying fashion, as "the maternal organism."⁶ Interestingly, though, this does not seem to have applied only to women. Fetuses and children were also referred to in this manner, as in references to the child's "organism."⁷ The overall conception of labour itself was that of a "mechanism."⁸ Terms like "the passages" (the woman's birth canal), "the passenger" (the fetus), and the "forces" of labour (woman's "expelling powers" or uterine contractions) constituted the neutralizing language of biomedicine in discussions of the "mechanism of labour."⁹

It was also a form of knowledge in which the emphasis was on standardization and measurement. For this reason

4 Greenhill, J. P., Principles and Practice of Obstetrics, 10th edition (originally by Joseph B. DeLee), Philadelphia: W. B. Saunders Co., 1951: 54.

5 Greenhill, for example, refers to the uterus as "the main power" in the mechanism of labor. Ibid.: 157.

6 Beck, Alfred C., Obstetrical Practice, 5th edition, Baltimore: The Williams & Wilkins Co., 1951: vi; and Greenhill, J. P., op.cit.: 212.

7 Greenhill, J. P., op.cit.: 216.

8 Beck, Alfred C., op.cit.: 298.

9 Ibid.: 255.

obstetricians were exhorted to check first for problems with "the passage" or "the passenger," if encountering an abnormal labour. The problem with focusing on the third factor in labour processes, "the forces," was that,

there is no uniform method for the estimation of the forces, neither is there any standard by which they can be compared.¹⁰

This emphasis on standardization was seen in its application to the formulation of concepts of normal and abnormal.

The dual division into normal and abnormal emerged here once more, in the socially-constructed medical conceptualizations of pregnancy and labour. As shown in more detail later in this chapter, pregnancy and labour were viewed as having the potential to follow either a normal or an abnormal path.¹¹ Essentially, labour was divided into the normal group (eutocia) and the abnormal category (dystocia).¹²

An additional indication of the fully social character of this medical knowledge was how the social importance of a particular body part, such as its role in reproduction, influenced the construction of certain concepts. For example, the terminology of "false" and "true" pelves

¹⁰ Moir, J. Chassar, Munro Kerr's Operative Obstetrics, 6th edition, London: Balliere, Tindall and Cox, 1956: 85.

¹¹ For example, cf. the concepts in Eastman's and Novak's editorial comments in Obstetrical and Gynecological Survey, Vol. 10, 1955: 178.

¹² Greenhill, J. P., op.cit.: 143-4.

indicated the clinical and social importance of the "true" pelvis over that of the "false."

The false or upper pelvis is shaped like a flat funnel and forms a support for the uterus and child during pregnancy, directing the latter into the true pelvis at the proper time. The shape and size of the false pelvis give the obstetrician some conception of the shape and size of the true pelvis. The true, lower, or small pelvis is of immense obstetric importance, since it supports the muscles of the pelvic floor and gives shape and direction to the parturient canal, itself being a part of it.¹³

Hence, the process of birthing itself was given priority in the construction of this terminology. It is necessary to examine more closely how the condition of pregnancy was conceptualized, in order to understand how these socially-constructed biomedical concepts were integrated into approaches to pregnancy and labour.

Borderline Pregnancy

Obstetric and gynecologic discourse during the 1950s conveyed an ambivalent view of pregnancy. Pregnancy was considered a medical condition, but this did not necessarily

¹³ Ibid.: 162.

imply a diseased condition.¹⁴ States like pregnancy could be considered within the domain and control of doctors without being pathological, as normal physiological processes came into the realm of the medical profession and pathology was not the only focus.

Pregnancy was definitely part of the medical realm, however, as the medical approach to the diagnosis of pregnancy indicated. The diagnostic process was often said to be based on two separate categories of objective signs and subjective symptoms. Eastman's categorization was only a slight variation, consisting of positive signs, probable signs, and presumptive evidence (the last being the subjective symptoms noted by the patient).¹⁵ Not surprisingly, most of the objective bases were those exclusively delineated with the assistance of medical expertise (e.g. laboratory tests). Female patients presented less reliable, subjective symptoms. Control over the final decision about the diagnosis of pregnancy was definitely held to be in the hands of the doctors, not the pregnant women themselves.

14 This is somewhat different from Riessman's view of the obstetric approach in the early twentieth century. As noted in the previous chapter, she states that obstetricians saw pregnancy and labour as pathological. Catherine Kohler Riessman, "Women and Medicalization: A New Perspective," *Social Policy*, 14, Summer, 1983: 6.

15 Eastman, Nicholson J., Williams Obstetrics, 10th edition, New York: Appleton-Century-Crofts, Inc., 1950: 237.

Occasionally, there were textual references to a view that pregnancy was not an absolutely normal condition.¹⁶ But the concept of the normal pregnancy was an accepted one, in the vast majority of cases.¹⁷ Knowledge of this condition and of how to maintain the normalcy of pregnancies drew on endocrinological research.¹⁸ Its definition was in these socially-constructed biomedical terms:

In normal pregnancy there is a physiologic balance of the endocrine glands of the body.¹⁹

What the term "normal pregnancy" implied, however, is that there was a normal and an abnormal pregnancy. And this is precisely how it was conceptualized. Normality was equated with health and abnormality with disease or pathology, so that a healthy pregnancy was also a normal pregnancy. But the borderline between health and disease was considered to be less distinct than usual in the state of pregnancy. The ambivalence of the medical views comes through in the claim that pregnancy existed on that indistinct border separating health and disease.

From a biological point of view, pregnancy and labour represent the highest function of the female reproductive system, and a priori should be considered as a normal process. But

16 Baird, for example, talks about ensuring mothers' post-pregnancy "return to normal life in good health with their fertility unimpaired." Baird, Dugald, *op.cit.*: 241.

17 *Ibid.*: 135.

18 Greenhill, J. P., ed., "Editor's comments," 1959-60 *YearBook of Obstetrics and Gynecology*: 530.

19 Greenhill, J. P., *op.cit.*: 89.

when we recall the manifold changes which occur in the maternal organism, it is apparent that the borderline between health and disease is less distinctly marked during gestation than at other times, and derangements, so slight as to be of but little consequence under ordinary circumstances, may readily be the precursors of pathological conditions which may seriously threaten the life of the mother or the child, or both.

It accordingly becomes necessary to keep pregnant patients under strict supervision, and to be constantly on the alert for the appearance of untoward symptoms.²⁰

Some critique of medicalization and rationalization can be detected in this quote, a critique which becomes, in the 1980 edition of Williams Obstetrics, an even stronger indictment of the view of pregnancy as disease.²¹

Although viewed as essentially a healthy condition, pregnancy was seen to carry within it the potential for pathology. This conceptualization of pregnancy as dangerously close to shifting from the category of the normal to that of the abnormal had major implications for obstetrical knowledge, such as an expanded definition of medicine's role with regard to pregnant women. It appeared sensible that all pregnancies be surveyed, to screen them for abnormal ones, since pregnancy per se could not be trusted to remain normal.²²

20 Eastman, Nicholson J., op.cit.: 311.

21 Pritchard, Jack A., Paul C. MacDonald, and Norman F. Gant, Williams Obstetrics, 17th edition, Norwalk, Connecticut: Appleton-Century-Crofts, 1985: 245.

22 Eastman, Nicholson J., op.cit.: 10.

By the 1950s, infections were no longer the main sources of maternal mortality. So obstetric focus turned to the toxemias, which had become the predominant causes of maternal mortality in that period.²³ Toxemias were unable to be treated adequately after their appearance as abnormalities, so preventive surveillance was one of the few reasonable alternatives. Prenatal care even in normal pregnancies was presented as a solution, to prevent the development of abnormal pregnancies and hence, lower the maternal and fetal mortality rates. All pregnant women were considered at risk of developing toxemias:

...by assuming that all of them are candidates for it and by treating them accordingly the number of eclamptics has been greatly reduced. ... We still await a specific and universally applicable therapy based upon a definite aetiology.²⁴

The type of contributors to maternal mortality common during the 1950s, along with the available, socially-based conceptualization of pregnancy aided the development of an emphasis on prenatal care. A reduction in the maternal mortality rates was viewed by some as a preventive measure in combatting family dislocation, juvenile delinquency, and

23 Moir, J. Chassar, op.cit.: 984.

24 Watson, B. P., "Factors Responsible for the Lowering of Maternal Mortality in the Last Fifty Years," Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #6, December, 1955: 850-1.

other social problems.²⁵ But the humanitarian and social concerns about maternal mortality decreased, naturally, as the rates plummeted. An example of this decline can be seen in the American figures:

TABLE 1.²⁶ MATERNAL MORTALITY IN THE UNITED STATES

1935-1965

<u>Year</u>	<u>Rate Per 100,000 Live Births</u>
1935	582.1
1940	376.0
1945	107.2
1950	83.3
1955	47.0
1960	37.1
<u>1965</u>	<u>31.6</u>

Responsibility for this decline was attributed by the medical profession to better education of doctors, expansion of medical facilities like hospitals and prenatal care, and the formation of maternal welfare committees which investigated each maternal death.²⁷ This decrease in maternal mortality, was read by many doctors as a demonstration that obstetrics was becoming more

25 Moe, Russel J., "The Value of Maternal Mortality Surveys," American Journal of Obstetrics and Gynecology, Vol. 63, #5, May, 1952: 952-3.

26 Adapted from Table 1-1 in Jack A. Pritchard et al., op.cit.: 3.

27 Eastman, Nicholson J., op.cit.: 9.

scientific.²⁸ And if such scientific medicine could be applied to maternal mortality, then it was reasonable that the still high rates of fetal mortality could be tackled in a similar fashion.

The Focus on Fetal Mortality

The major focus of obstetric and gynecologic attention turned to the problem of fetal mortality, as the level of maternal mortality had declined drastically by then. While fetal and infant (neonatal) mortality had declined as well, the improvement was not as drastic as with rates of maternal mortality.²⁹ This can be seen in the rates for perinatal mortality in the United States, for example:

28 VanWyck, H. B., "Recent Advances in Obstetrics of Interest to the General Practitioner," Canadian Medical Association Journal, Vol. 62, #2, Feb., 1950: 109.

29 Eastman, Nicholson J., op.cit.: 13.

TABLE 2.³⁰ PERINATAL MORTALITY IN THE UNITED STATES1950-1965

	Perinatal	Fetal	Neonatal
<u>Year</u>	<u>Ratio¹</u>	<u>Ratio</u>	<u>Ratio²</u>
1950	39.7	19.2	20.5
1955	36.2	17.1	19.1
1960	34.8	16.1	18.7
1965	33.9	16.2	17.7

1 Deaths per 1000 births.

2 Deaths per 1000 live births; neonatal deaths up to 28 days.

But with maternal mortality no longer considered a major obstetrical concern, attention became focused on new patients - the fetus and the infant.³¹ In a 1955 address to the Fourteenth British Congress of Obstetrics and Gynecology, the situation was assessed as follows:

...as long as there was a maternal mortality around 25 percent to cope with, comparatively scant attention could be spared to the interests of the foetus. ... Nowadays eclampsia is so comparatively infrequent and its maternal mortality is so much under control that the salvage of foetal life has come to occupy more and more of the obstetrician's attention.³²

Because the fall in fetal mortality rates had not kept pace with the decline in maternal mortality over the twenty years

³⁰ Adapted from Table 1-3, in Jack A. Pritchard et al., op.cit.: 4.

³¹ Interview with Nicholson J. Eastman, in Obstetrics and Gynecology, Vol.14, #5, Nov., 1959: 699.

³² Johnstone, R. W., "Intermezzo," Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #5, Oct., 1955: 678.

prior to 1955, the Ontario provincial government supported a research project on fetal mortality by University of Toronto doctors (from obstetrics and gynecology, paediatrics, and pathology).³³ This project was aimed at revealing the extent of and reasons for "fetal wastage" or mortality.³⁴

Discussions about fetal mortality included the use of categories like stillbirth, neonatal deaths, abortion, and premature labour. Although they were most often taken as factual concepts, they were constructed notions divided by fine lines, and were not clearly-defined states.³⁵ But creating such distinctions among standardized categories was part of the scientific medical approach to planning how to rectify the problem of fetal mortality. In the case of habitual abortion (repeated miscarriages), for example, attempts were made by obstetricians to assess the input of the factor of cervical incompetency. The comment was made, however, that interpreting tests for that condition was difficult, as distinguishing between cervical competency and incompetency was problematic.³⁶ Such efforts at rationalization represented increasing interventionism, primarily in the interests of the fetus. There was

33 Connell, D. E. and L. E. Horne, "Fetal Loss in Toronto for One Year," American Journal of Obstetrics and Gynecology, Vol. 69, #2, Feb., 1955: 289.

34 Ibid.: 289.

35 Jeffcoate, T.N.A., op.cit.: 177.

36 Mann, Edward C., "Habitual Abortion," American Journal of Obstetrics and Gynecology, Vol. 77, #4, April, 1959: 713, 717.

intervention into the diagnosis of etiology, as well as therapeutics and the preventive surveillance of abnormal conditions.

One of the social patterns which fed into these biomedical trends, was that of smaller families. With fewer children per family, the social and emotional value of each individual child increased substantially. Obstetricians indicated that they sometimes felt pressured to perform more caesarian-sections or other interventionist measures even when it was in the interests of only the child.³⁷ So the medical concern for fetal mortality rates was obviously a socially-informed concern. The net result was a suggestion for more "methodical vigilance" (in the form of fetal recording during labour) and in the timing of active intervention into labor.³⁸

The timing of intervention in labour was an issue, and a controversial one at that. It was felt, mainly by British obstetricians, that postmaturity could increase fetal distress and perinatal mortality, along with difficult labour and operative deliveries. Obstetricians like Baird believed that intervention in the form of induction of labour was essential for the fetus' well-being. Most American obstetricians (such as Greenhill) disputed the

37 Watson, B. P., op.cit.: 850.

38 Fitzgerald, T. B. and C. N. McFarlane, "Foetal Distress and Intrapartum Foetal Death," Obstetrical and Gynecological Survey, Vol.10, 1955: 855-6.

British position, that postmaturity was a problem for the fetus.³⁹ Both sides of the debate were concerned with fetal viability, but what was at stake was the question of operative intervention.

To determine when such intervention was required, it was necessary to ascertain when a condition was abnormal. All of the major obstetricians of the period railed against medical intervention into the normal and natural, so obstetrics needed to distinguish between that and the abnormal. The social concern with norms reappears here, with greater attention being paid to fetal deaths associated with

...forms of "physiological failure" rather than with definite pathological processes. Thus the goal is no longer the prevention of death but the attainment of efficient physiological reproduction. The doctor must understand the factors which cause departures from the normal.⁴⁰

The focus was on the fetus and normal physiological processes, rather than on pathology. In that way, deviations from the normal could be ascertained and the need for intervention assessed.

The thrust towards resolving high fetal mortality rates also had overtones of the promotion of positive eugenics. The stated goal of "a normally developed, emotionally well-

39 Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 194-5.

40 Baird, Dugald, op.cit.: v.

adjusted child for each conception" was one which contained numerous assumptions.⁴¹ What is significant here, is that the aim of obstetrics was not only a physically live and healthy child, but also optimum efficiency in a psychological sense (as a result of the influence of psychiatric theories on biomedicine). Such concerns affected what obstetricians believed was required in order to produce the desired result.

The interest in fetal mortality and infant quality also synchronized with women's own concerns.

The increased attention devoted to the child nowadays, resulting to some extent from the decrease in the size of the family, has brought about definite changes in obstetric practice. Not unnaturally women are less prepared to accept pain during labour or a still-birth as inevitable.⁴²

The social context, then, also acted through the pregnant and birthing women, to contribute to the obstetric and gynecologic attack on fetal mortality rates. The trend toward surveillance of the normal for deviations on the part of either the mother or the fetus encouraged more emphasis upon prenatal care to attain reduced rates and quality, healthy children.

41 Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 293.

42 Baird, Dugald, op.cit.: 191.

Prenatal Standardization and Prediction

The notion that "aberrations of maternal environment" or "faulty interrelations of fetus and mother" could contribute to fetal death was an important influence on the widening of the obstetric sphere to include preventive medicine.⁴³ Thus, both the pre-conception and the prenatal periods of a woman's life became of increasing concern to obstetrics for the production of healthy children. To this end, attempts to define ideal standards were employed. For example, eclampsia was believed by some to be linked to excessive weight gain during pregnancy, but studies produced no agreement on "what the normal or ideal should be."⁴⁴ The root of this difficulty was seen to lie in insufficient medical knowledge of physiology, with the implied solution being the acquisition of more scientific knowledge of pregnancy.⁴⁵

The medical profession, however, was initially reluctant to accept the notion of prenatal care and preventive medicine. Antenatal (prenatal) care improved in Britain, with no corresponding reductions in maternal mortality or stillbirth rates. Since there was little

43 Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 287.

44 Senior Registrar, Aberdeen Maternity Hospital, Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #1, Feb., 1955: 54-5.

45 Ibid.: 54-5.

overall evidence of the benefits of prenatal care, neither doctors nor the state pushed for its expansion, until other factors combined with prenatal care to reduce the rates after 1935.⁴⁶ But a number of social forces combined to provide incentive for this eventual development. As noted earlier, the higher sentimental and social value of children, and the efficacy of prenatal care in the prevention of eclampsia in high-risk pregnant women, contributed to acceptance of the concept of prenatal care.⁴⁷

While by no means the sole contributor to reduced maternal and infant mortality rates during the first half of the twentieth century, prenatal care came to be lauded for its effects on those rates. In fact, the reduced rates were even referred to as evidence for the efficacy of such prenatal care and a measurement of the progress of obstetrical science. The obstetric conceptualization of the state of pregnancy (as disruptive of the body's endocrine balance and potentially abnormal), contributed to and was drawn on in arguments for the value of prenatal care.

The profound changes which take place in the maternal organism during pregnancy call for early, constant and careful supervision during the antenatal period. The life-saving effect of such care is

46 Baird, Dugald, op.cit.: 250-1.

47 "As the Papanicolaou smear allows the term "preventable cancer," antepartum care permits prevention of eclampsia." Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 124; cf. also Greenhill, J. P., op.cit.: 98.

shown by all maternal and infant mortality statistics.⁴⁸

What was most important in this development was the increasing focus on fetal mortality. The term "prenatal" care essentially refers to surveillance of the fetus, and can be distinguished from "antepartum" care, or the preventive care of the mother.⁴⁹ While both terms were used in the 1950s texts, "prenatal" care was more frequent and has generally eclipsed the latter term. This could signify the growing concentration on the fetus, with the simultaneous lessening of attention to the pregnant woman in herself; she was becoming viewed primarily as the carrier of the fetus.⁵⁰

While there were claims on both sides of the Atlantic as to the initial responsibility for prenatal care⁵¹, it was stated that,

One of the benefits which was expected to arise from antenatal care was a reduction in the stillbirth and neonatal death rate arising from disproportion.⁵²

48 Beck, Alfred C., op.cit.: 197.

49 Greenhill, J. P., op.cit.: 98.

50 Oakley, Ann, The Captured Womb. A History of the Medical Care of Pregnant Women, Oxford: Basil Blackwell, 1986: 253.

51 Eastman contended that prenatal care was begun by Boston nurses in 1901; the British, that antenatal care began with the efforts of Haig Ferguson and J.W. Ballantyne. Eastman, Nicholson J., op.cit.: 10; cf. Pimblett, G. W. and T. G. E. White, "An Assessment of the Value of Antenatal Radiological Pelvimetry Based on 500 Successive Pelvimetric Examinations," The Journal of Obstetrics and Gynaecology of the British Empire, Vol. LXII, #1, Feb., 1955: 17.

52 Ibid.: 17.

It was considered possible to predict the most appropriate method of intervention, if problems like pelvic disproportion could be ascertained before labour began. Prediction meant that rationalized control of labour could be attained with the aim of reproductive efficiency. Efforts to improve the maternal environment during the war in Britain were said to have demonstrated that this reproductive efficiency could be controlled and improved.⁵³

One way to take into account the interests of the fetus was to examine "the requirements of the pelvis for efficient parturition."⁵⁴ For this purpose, the major obstetricians accepted the standard classification of four female pelvis types, as devised by Caldwell and Moloy (or Thoms' variation of it). Their schema included, as the most important types, the "gynoeceoid" pelvis which was round and classified as the "normal female pelvis" (incidence of 41.4 per cent) and the "android," which was said to resemble the male pelvis (incidence of 32.5 per cent cited).⁵⁵ Interestingly, this delineation of normal pelvis shapes was not uncritically accepted by all obstetricians and it was noted that the classification was only of "hypothetical," "pure types."⁵⁶ The racial and class basis of Molloy and Caldwell's schema was emphasized by Atlee. He claimed that Thoms had already

53 Baird, Dugald, op.cit.: 243.

54 Ibid.: 531.

55 Ibid.: 533; Eastman, Nicholson J., op.cit.: 255.

56 Eastman, Nicholson J., op.cit.: 289; Baird also offers a critical perspective. Baird, Dugald, op.cit.: 536.

put forward the critique, and pointed out that what was considered the normal female type was not necessarily the most efficient in terms of reproduction.⁵⁷ Yet the classification's widespread citation was an indication of the perceived need for standardization of procedures and definition of normality, as opposed to the abnormal which required intervention. Even though Baird recognized the hypothetical qualities of so-called normal pelvic measurements, he supplied a table outlining those measurements.⁵⁸

Pelvic radiography specified more minor variations in women's pelvic shapes and sizes than had previously been available, and apparently helped obstetricians to predict their effects on the progress of labour.⁵⁹ Most of the major academic obstetricians were turning to roentgenography as a tool and recommended it for use in prenatal care, though it had not been generally adopted as yet.⁶⁰ Many pointed out that its interpretation was not absolute, however, and therefore that it should not be used as the decisive method in determining the type of delivery in an individual case.⁶¹ In addition, the research into a new technology, that of

57 Atlee, H. B., The Gist of Obstetrics, 1st edition, Springfield, Illinois: Charles C. Thomas, 1957: 105.

58 Baird, Dugald, op.cit.: 569.

59 Baird, Dugald, op.cit.: 531; Moir, J. Chassar, op.cit.: 283.

60 Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 7; Beck, Alfred C., op.cit.: 222.

61 Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 136-7.

ultrasound scanners, took place in the 1940s and 1950s.⁶² Although it was not used in the surveillance of pregnant women and their fetuses as yet, it was during that period that the social decision was made that this was potentially a valuable development.⁶³ The Glasgow obstetrician, Ian Donald, was central to the advancement of ultrasound, a development that occurred in a highly scientized, medical context.⁶⁴ Consensus among obstetricians about the reliability of the images produced had to be achieved, an indication of the social character of this technological development.⁶⁵ For ultrasound images are constructions, not an objective reflection of a complete reality: "Nature is rendered in ways that accentuate certain features of interest."⁶⁶ Hence, interpretation was a necessary part of observation of a mother and fetus and of the images that this technology produced.

With the knowledge added at least by roentgenography, attention to even minor pelvic variations and consequent attempts to categorize women according to their pelvic

62 Yoxen, Edward, "Seeing with Sound: A Study of the Development of Medical Images," in Wiebe E. Bijker, Thomas P. Hughes, and Trevor J. Pinch, eds., The Social Construction of Technological Systems. New Directions in the Sociology and History of Technology, Cambridge, Massachusetts: MIT Press, 1989: 282; also cf. the discussion on the history of ultrasound technology in Ann Oakley, The Captured Womb. A History of the Medical Care of Pregnant Women, New York: Basil Blackwell, 1986: 156-165.

63 Yoxen, Edward, *op.cit.*: 282, 299.

64 *Ibid.*: 297-8, 301.

65 *Ibid.*: 282.

66 *Ibid.*: 282.

shapes, created a recognizable danger of unnecessary obstetric intervention in labour. This could also result from difficulties in interpreting radiographs, a learned ability. It was suggested by major obstetricians that "fallacies in the interpretation" could occur, with a consequent over-emphasis on minor abnormalities and radical interventionist measures like cesarean-sections or labour induction.⁶⁷ The hope of those like Dick-Read that prenatal care would allay the need for doctors to intervene⁶⁸, was difficult to fulfill when that care (an alternative form of intervention itself) gave increased attention to potential abnormalities. This was particularly true with the emphasis placed on monitoring the fetus through prenatal care.

The Creation of Normal Women in Prenatal Care

Knowledge of the process of labour was to be imparted to the woman through prenatal care, in order to achieve reproductive efficiency in labour and thereby produce a maximally healthy, normal child.

The knowledge of the stages of labour
and a full understanding of the part she
has to play will not only ensure better

⁶⁷ Baird, Dugald, op.cit.: 206; Moir, J. Chassar, op.cit.: 20.

⁶⁸ Dick-Read, Grantly, Childbirth Without Fear. The Principles and Practice of Natural Childbirth, 2nd revised edition, New York: Harper and Row, 1959: 219-220.

co-operation but will give the patient confidence.⁹⁹

Thus, it was only indirectly that prenatal care was designated as being in the woman's interest. With the fetus as the main focus, the woman was expected to cooperate with the doctor in attaining the proper aims. One safeguard for the health of the fetus during labour was minimal administration of anesthesia to the mother. Prenatal preparation of the woman was envisioned as one way to obtain the goal of greater tolerance of pain and less pain relief and, hence, to lower fetal mortality rates.

It was argued that one of the professional functions of the obstetrician/gynecologist was that of giving advice. At the same time, the female patient's role was implicitly assumed in textual discussions of the content of prenatal care. The assumption was that the woman was passively there, to be examined and monitored, and to be filled with the doctor's advice. The nature of the advice to be given was influenced by the views of women held in academic obstetrics and gynecology and those prevalent in the broader social context, which were drawn upon by the doctors. What were perceived to be social needs and problems of the time certainly played a part and allowed, for example, the biomedical model to admit socially-acceptable conceptualizations.

69 Baird, Dugald, op.cit.: 246.

For example, the focus on preserving normal functioning through preventive care went hand in hand with greater attention to patients' attitudes and psyche. The eugenicist concern for quality of reproduction and monitoring of population quantity, relied fairly heavily upon psychosomatic theories, which as we have seen, were absorbed into the dominant medical model. In one instance, there was a call for prenatal care in order to produce a strong "race" of healthy, happy "citizens" who would be sane and "not become Communists, Fascists, or Nazis."⁷⁰ Besides the obvious political anxieties, there was an underlying assumption that mental health and social problems were tied to pregnancy and labour.

This secondary incorporation of psychosomatics into the biomedical model was, ironically, utilized to impress upon women the naturalness of pregnancy and labour. Pregnancy was considered so natural and such a normal part of life that one group researching emotional factors in toxemia took some time to realize that the reason many of the women studied were unhappy was the pregnancy itself. Though they noted many pregnancies in this group of women were "out of wedlock" and that motherhood was not as highly valued in western society as in some others, the researchers still

⁷⁰ Blass, James R., "Presidential Address: The Ideals, Responsibilities and Reward of the Obstetrician," American Journal of Obstetrics and Gynecology, Vol. 59, #6, June, 1950: 1187.

concluded that toxemia was more common in "neurotic" women.⁷¹ One of the purposes of prenatal care was deemed to be the induction of women into normal, healthy attitudes. The rising prestige of psychiatric claims to scientific truth worked its way into a biomedical model which already implicitly defined normal and abnormal women and pregnancies. By the 1950s, the physical health of babies was no longer the only priority. Their psychological health was also important. One of the initial ways to ensure the development of desirable psychological traits was taken to be through preventive care of the mother.

Obstetricians and gynecologists recommended to each other that correct attitudes to pregnancy be instilled in women during prenatal care, in order to avoid or rectify abnormal conditions. "Correct" generally meant that the woman should view pregnancy as natural and possess the desire to continue to bear more children. If the pregnant woman resented the "minor discomforts" of pregnancy, disliked having her social activities restricted and was "uncooperative," the doctor was to change her attitude during the prenatal time to one of cheerfulness. Then childbirth would transform her into a "devoted mother" who

71 Soichet, Samuel, "Emotional Factors in Toxemia of Pregnancy," American Journal of Obstetrics and Gynecology, Vol.77, #5, May, 1959: 1065-9.

would enthusiastically wish to become pregnant again in the future.⁷²

Hyperemesis gravidarum was one condition which was considered abnormal in pregnant women. Some degree of nausea and morning sickness was accepted as normal in the first few months of pregnancy, when the woman might not even realize she was pregnant, but continued or extreme problems of this type were viewed as abnormal.⁷³ Theories about the condition's etiology abounded, many stressing the physiological and endocrinological mechanisms involved. But equally emphasized in the more extreme cases, were the psychological and social bases for hyperemesis gravidarum.⁷⁴ Some obstetricians and gynecologists believed it occurred more frequently in "emotionally unstable," "high-strung" women. These women were thought to be from the upper-classes and were considered to have "faulty attitudes" to pregnancy.⁷⁵ Women were once again divided into normal and abnormal groups, with many of the same characteristics

72 Weaver, Richard T. and Fred L. Johnson, "A Comparison of Elderly and Young Primiparas," Canadian Medical Association Journal, Vol. 80, Feb. 1, 1959: 164; Dick-Read, Grantly, op.cit.: 281.

73 Atlee, H. B., op.cit.: 25; Jeffcoate, T.N.A., op.cit.: 112.

74 Baird, Dugald, op.cit.: 436; Beck no longer considered hyperemesis gravidarum part of the toxemias, as he had in the past. Now, in the light of "present knowledge of their true natures," he combined the physiological and psychosomatic views of the condition; viewing it as "a metabolic disturbance in emotionally unstable women." Beck, Alfred C., op.cit.: viii.

75 Beck, Alfred C., op.cit.: 582; Greenhill, J. P., op.cit.: 119, 335.

attributed to each of those categories as were common in psychosomatic views of women's gynecologic conditions.

The primary focus was on the emotional and attitudinal traits of women; of secondary concern were their intellectual characteristics and relationships. This focus mimicked the social stereotype of the traits most central to womanhood, as well as the emphasis in psychiatry and psychology in general. Comments about female intelligence levels frequently reflected "classist" stereotypes, in which mainly working class women were referred to as lacking intelligence (though they were often viewed as possessing more emotional stability and common sense).⁷⁶ Such assumptions were not consistent, however, as it was also claimed that women of higher intelligence levels complained less than did "unintelligent" women.⁷⁷ One must deduce, then, that problems of abnormality in pregnancy, accompanied women characterized as neurotic, upper class, relatively unintelligent, or some combination of these characteristics. Much of the prenatal advice given to women reflected middle class ideology of the gendered division of labour, for to follow it required that the woman be a full-time homemaker and married. For example, it was suggested that the

76 The comments were those of the (female) medical officer for maternal and child welfare of Scotland's Dept. of Health. Douglas, Charlotte A., "Trends in the Risks of Childbearing and in the Mortalities of Infants During the Last 30 Years," Journal of Obstetrics and Gynecology of the British Empire, Vol.LXII, #2, April, 1955: 227, 230.

77 Greenhill, J. P., op.cit.: 331.

pregnant woman rest for an hour or two following lunch and that she do no vigorous exercise or work, though mild exercise and light housekeeping was permitted.⁷⁸ The advice and terminology used in the obstetric writings was also indicative of a preference for class homogenization. In the 1944 edition of his book, Dick-Read referred to the "working classes," while in the 1959 edition, he employed the term "lower-income" to discuss the issue of women working during pregnancy.⁷⁹

What needs to be asked is what meanings were embodied in concepts like "faulty attitude" and "emotionally unstable." What was indicative of a normal, healthy, correct attitude and emotional stability? "Faulty" attitudes, first of all, apparently referred to fear or, even more so, rejection of pregnancy. Just as rejection of femininity (and therefore motherhood) was considered part of the etiology of gynecological problems, rejection of pregnancy and hence, motherhood, was again viewed as a problem. Such attitudes were thought to be amenable to correction through good prenatal care, so that the woman would give birth to and raise the child with the correct, normal attitudes and emotional stability. The mature woman

78 Beck, Alfred C., op.cit.: 207; Atlee even went to the extreme of advising the pregnant woman to lead a "vegetative existence." Atlee, H. B., op.cit.: 63.

79 Dick-Read, Grantly, op.cit.: 107 (and p.60 in the 1944 edition).

with a proper attitude was one who happily accepted motherhood as her main fulfillment and purpose in life.⁸⁰

However, that this should be a woman's ideal attitude was recognized:

Generally speaking, motherhood is the chief goal and the most fulfilling creative experience for a normal woman who has reached true maturity ... But in our time this "normal" mature woman is almost an illusion. Cultural developments have led women more and more away from mother-instinct, and "maternal love" is nothing more than a remote inner transformation of instincts into emotions.⁸¹

It was a "natural" ideal which many believed had been thwarted by social change and culture. Gender relations and women's role in society were cited as areas in which change was occurring during the 1950s, and which contributed to obstetric abnormalities. Women were said to have found new freedom in a "man's world" and fear of pregnancy was often linked to "hostility" toward or envy of men (and male social participation).⁸² Fear of motherhood was connected in the texts to the ignoring of nature's laws, laws which became problematized by civilization. This was a version of civilization in which gender roles were losing their distinctiveness, a trend sometimes assessed as problematic.

80 Jeffcoate, T.N.A., op.cit.: 114.

81 Deutsch, Helene, The Psychology of Women: A Psychoanalytic Interpretation, New York: Grune and Stratton, Inc., 1944, in J.P. Greenhill, op.cit.: 316.

82 Parks, John, "Emotional Reactions to Pregnancy," American Journal of Obstetrics and Gynecology, Vol. 62, #2, Aug., 1951: 340.

"Pregnancy should be as normal for a woman as wage earning is for a man."⁸³

It was in this social context and the obstetricians' and gynecologists' evaluation of it, that notions of pregnancy and prenatal care were constructed. Those conditions which rendered the obstetric and gynecologic assumptions about women and family problematic were labelled abnormal. This is not to say that medical knowledge and practice were incorrect or untrue; it is to say that they were not exempt from social construction, and that the location of obstetricians in particular professional and broader social contexts (the details of which were outlined in earlier chapters on those contexts) was imprinted upon their knowledge and concepts. They recognized, for example, that women were increasingly looking to the wage labour force for employment and less to motherhood as their sole purpose in life.⁸⁴ It was feared that some women were inclined to reject their pregnancy and motherhood because of the greater options for women. The increased number of

83 Dick-Read, Grantly, *op.cit.*: 130.

84 There was concern about the effects of women's work in the wage labour force upon family life and women themselves, in terms of women avoiding pregnancy and missing "a great experience and honor." Yet it was also recognized that women were in the labour force in large numbers and that pregnant women should receive protection. The trend towards greater numbers of women in the labour force and the "upheavals in home life" were seen as caused by "insecurities and apprehensions" from World War II, the Korean War, and the Cold War. H. Close Hesselstine, "Obstetric and Gynecologic Problems of Employed Women," *Obstetrics and Gynecology*. Vol. 5, #4, April, 1955: 435-7.

women in the labour force was a social, not a psychological trend. However, the obstetricians and gynecologists who recognized the social roots of women's obstetric conditions still individualized the results, and were themselves threatened by the changing trends. One response was a conceptualization of prenatal care in which the promotion of a view of "pregnancy as a vocation" and as "one of the most important and serious jobs in the world" was advocated.⁸⁵

Standardization of Labour

The social trend toward rationalization and standardization was expressed in obstetrical notions of labour. In the same spirit as was evident in the widespread fear that human, cultural interference had produced unstable socio-political conditions, obstetricians claimed that a minimal degree of interference with nature, the natural process of labour, was preferable. Ironically, however, the parallel trend of attempting to lower fetal mortality rates provided incentive for more extensive interventions than had existed in the past. Other than cesarean sections, most of the obstetric interventions on behalf of the fetus took the form of preventive surveillance. Again, the surveillance which prevailed in prenatal care and during labour

⁸⁵ Atlee, H. B., op.cit.: 18.

(monitoring of the fetal heart, for instance) was oriented toward distinguishing normal from abnormal processes in order to predict and control any abnormal developments. Statements complaining that much of obstetrics "is not yet objectively controllable" reveal that the scientific, neutral notion of control was a prevalent goal.⁸⁶ It was thought that undesirable intrusions into the normal, natural labour process would potentially threaten the safety of the fetus and the ultimate, social goal of lowered rates of fetal mortality.

One way to standardize and control the labour process was through prenatal surveillance, but another was through having both normal and abnormal births take place in the hospital. In Britain, by 1959, sixty-four per cent of babies were born in institutions.⁸⁷ By 1985, ninety-nine per cent of white births in the United States took place in hospital, a development which evolved over a period which included the 1950s.⁸⁸ Abnormal labours could receive appropriate intervention, while normal labours could be monitored for potential abnormalities and made even more

86 McKelvey, J. L., "The Role of the Midwife, The Family Practitioner and the Specialist in Normal Labour," Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #5, Oct., 1955: 779.

87 Oakley, Ann, op.cit.: 132.

88 It was stated that the most significant advance in obstetrical safety in the fifty years previous to 1985 was the enormous increase in hospital births. Pritchard, Jack A., Paul C. MacDonald, and Norman F. Gant, Williams Obstetrics, 17th edition, Norwalk, Connecticut: Appleton-Century-Crofts, 1985: 3.

normal in the environment of the expert. The concept of "more normal" meant that abnormalities should be prevented, and labour made "easier and happier."⁸⁹ As we have already seen, pregnancy was conceptualized as normal, but potentially problematic. Hospitalization was envisaged as necessary for safety purposes, in the light of reproduction being conceptualized as "bordering on the pathological."⁹⁰ The view of normality and abnormality as not easily separable in pregnancy and labour was congenial to medical professionals, the primary group of experts controlling the field:

Some of those labelled normal will turn out to be abnormal, while some of those stamped abnormal will deliver their babies themselves. There is an overwhelming case for arranging that all potentially abnormal cases should be delivered in hospital ... A great deal can be said in favour of delivering the so-called "normals" in hospital too, so that they may obtain prompt and skilled attention when they become abnormal.⁹¹

Labour was divided into normal and abnormal states, but even normal labour was envisioned as a violent ordeal, one that was dangerous to the child.⁹² Labour was described by one obstetrician as a "cataclysmic process" in which

89 Nixon, Professor W.C.W., Discussion of article by J. L. McKelvey, op.cit., in Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #5, Oct., 1955: 788.

90 VanWyck, H. B., op.cit.: 109.

91 Claye, Professor A.M., Discussion of article by J. L. McKelvey, op.cit., in Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #5, Oct., 1955: 784.

92 Greenhill, J. P., op.cit.: 244.

"approximately one-tenth of a woman is literally torn from her."⁹³ In discussing the contractile uterine power developed during pregnancy and labour, Greenhill conceptualized it with equally violent imagery:

In this we witness the instructive spectacle of a gathering force intended to overcome, at a definite future time, a definite resistance against which its strength is not tested until the actual moment of conflict arrives.⁹⁴

The emphasis on standardizing labour practices in an institutional, medical setting and on defining normal and abnormal processes, meant that nature was given some free reign - until something went awry, that is. Management of the first stage of labour was to be comprised of "*intelligent expectancy*" if it was proceeding normally:

His [*sic*] duty is to observe the efforts of nature, not to aid, until she has indicated or proved herself unequal to the task. Meddlesome midwifery has cost thousands of lives.⁹⁵

It is not surprising that obstetricians would be wary of that power turning destructive, considering the powerful forces ascribed to labour. Obstetrics was more interventionist in a broad sense (with hospitalization, prenatal care, anesthesia and episiotomies) than was acknowledged at that time, though part of the exhortation to leave nature to take its own course was probably a response

93 Atlee, H. B., *op.cit.*: 18.

94 Greenhill, J. P., *op.cit.*: 9.

95 Greenhill, J. P., *op.cit.*: 243.

to the increase in these interventionist practices. Normal labour and nature were not fully trusted, however, as it was "known" that, particularly with the mutations caused by civilized culture, deviations from the normal could easily occur; hence the motivation for constant monitoring. To the obstetricians, such monitoring was preventing later obstetric interventions, and in one sense this was true. But it was a double-edged sword, as it also provided a means for determining when intervention would be necessary. As was seen in the case of radiographic pelvimetry, the scientific-technological knowledge that had evolved could lead to unnecessary intervention as well. Interpretation of fetal distress, through the monitoring of the fetal heart, was another instance of an inexact science being used to determine the necessity of intervention, en route to ensuring normal labours and fetal safety.⁹⁶

Birthing women had an interest in the safe delivery of their child, but this was not the only reason they accepted standardized, hospital labours. The hospital setting also provided women with some pain relief, which they would have had difficulty obtaining elsewhere. With the increasing trust in experts to handle life events, women probably also believed that placing their labour and delivery in the hands

96 "The only means of discovering the peril to the baby is auscultation of its heart sounds." Greenhill, J. P., *op.cit.*: 244.

of medical experts would ensure a positive outcome for themselves, as well as the baby.⁹⁷

Determination of the normal length of labour was a major concern in obstetrics where the need for intervention in the interests of the fetus had to be assessed. The desired standardization of the length of time was a complicated process, however. First of all, "normal" could mean the average length of labour. Alternatively, it could refer to the ideal length of time that would achieve a favourable outcome. Eutocia (normal progression of labour) could not be clearly separated from dystocia (prolonged or difficult labour) partly because, in the obstetric view, there were the three elements of labour to be considered: the passage, the passenger, and the forces of labour. There was sufficient difficulty in standardizing the first two, as we have seen, but there were still some standard measurements to be relied upon in those cases. However, the forces of labour were believed to play a crucial, and notoriously unreliable, role. Obstetricians were to check the forces of labour last, in the event of dystocia, because they could not be so readily standardized. Hence, they were considered difficult for the obstetrician to control.

Dystocia was usually defined according to an arbitrarily-

⁹⁷ Riessman, Catherine Kohler, "Women and Medicalization: A New Perspective," Social Policy 14, Summer, 1983: 7; Leavitt, Judith Walzer, Brought to Bed. Childbearing in America, 1750-1950, Oxford: Oxford University Press, 1986: passim.

chosen number of hours, though it was connected to some extent to the average length of labours experienced by women."⁹⁸

On the one hand, obstetricians were advised not to intervene unnecessarily and to appreciate "the natural variations of parturition":

The borderline between these two types of labour is not always clearly defined."⁹⁹

But, on the other hand, the physician was to learn how to differentiate "when Nature is at fault":

He [*sic*] must never presume that a parturition is normal. *He must not be content until he has satisfied himself that it is not abnormal.*¹⁰⁰

One can appreciate how delicate this juggling act must have been. The timing was to be such that unnecessary interference did not occur, yet could not be so late as to induce further complications; some rational standardization would obviously be helpful in decision-making. But these standardizations were not value-free medical decisions; policies were constructed within a social context which prioritized the safety and quality of the fetus and promoted rationalization.

98 Ostry, E. L., "The Effect of Delay in the First Stage of Labour on the Forceps Rate and on the Stillbirth and Neonatal Mortality Rates," Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #1, Feb., 1955: 115.

99 Moir, J. Chassar, op.cit.: 3.

100 Ibid.: 3.

Surgical intervention by cesarian section became more available as a way to reduce the fetal mortality rate in cases of dystocia, once its safety improved through the introduction of effective antibiotics in the postwar period.¹⁰¹

We must realize to-day that Caesarean section performed under favourable conditions by expert obstetric surgeons has been rendered so safe for the mothers that it may be employed solely in the interests of the child.¹⁰²

The obstetricians were conscious that this operation could be overused and frequently expressed concern about that possibility. One of the reasons that the potential for overuse existed was that maternal and fetal interests were seen as being in opposition, so that decisions about intervention required the weighing of both.¹⁰³

The obstetrician may thus have a difficult task to "manage" the labour to the best interests of both mother and foetus.¹⁰⁴

Thus, it was feared that the greater obstetrical focus on the fetus was not always in the best interests of the mother.

Obstetric writings on the fetus also referred to normal and abnormal presentations. Evidently, a standard of presentation was accepted. The normal presentation was not

101 Ibid.: 541.

102 Ibid.: 542.

103 Ibid.: 4, 5.

104 Ibid.: 172.

only the presentation most frequently encountered in deliveries, but also the desired ideal.¹⁰⁵ The ideal presentation was one which would ensure easier and possibly safer deliveries. It is interesting, though, that any deviation from that standard was termed an abnormality, rather than the theoretically alternative conceptualization of other presentations as mere "variations."¹⁰⁶ The latter possibility was not coherent with rationalized standards. In numerous texts it was noted that four of the major authors of obstetrics texts of the period, including Eastman and Greenhill met,

for the purpose of attaining uniformity in definitions, terms, classifications and procedures about which there has been considerable disagreement.¹⁰⁷

They developed classifications of the types of breech presentations and their appropriate methods of delivery, of a definition of "engagement," and of the various types of forceps operations.¹⁰⁸ The social and professional context of the period, in which there was a strong push for

105 This was one factor, however. Beck presents a long chart of the different presentations possible and then lists the frequency of presentations: "Vertex, 96 per cent Breech, 3 per cent Face, 0.5 per cent Transverse, 0.5 per cent." Beck, Alfred C., *op.cit.*: 244-5.

106 When variations were held to occur, the context of the term suggested they were still considered abnormal. Baird, for example, stated that "many variations" could result from "any departure from the normal in pelvic formation." Baird, Dugald, *op.cit.*: 174.

107 *Ibid.*: iii.

108 *Ibid.*: iii.

standardization did not lend itself to obstetric acceptance of the notion of multiple variations.

Fetal Safety Through Natural Childbirth

The use of anesthesia and analgesics in labour was an issue which stimulated much debate in obstetrics during the 1950s. With the great increase of hospitalized births, full pain relief could be provided for labouring women, albeit with the risks to women attendant on any anesthesia.¹⁰⁹

However, the effects of various anesthetics on the fetus became a greater concern than in the past. In fact, for the major academic obstetricians, safety of the fetus was their number one priority. Reduced rates of administration of anesthesia to labouring mothers was suggested as one route to achieving more efficient reproduction (defined as avoidance of dystocia, which could be induced by anesthesia). Research was being conducted to develop new drugs which would not hinder fetal respiration, as the ones available at the time presented some danger to

109 The fact that by 1948, 85.6 per cent of live births in the United States were in hospitals gave impetus to the use of anesthetics. It was stated that anesthetics were used in both normal and pathologic labors. The choice and dosage of the particular anesthetic to be used was considered to be "an obstetric problem of the first magnitude." Greenhill, J. P., op.cit.: 254.

the mother "and particularly to the fetus."¹¹⁰ Hence, the general attitude conveyed in the main obstetric writings was that some pain relief could be provided, but only within the limits of safety, particularly for the fetus.

It should be explained that it is not advisable to aim at a completely painless labour. ... The patient will realise that the doctor wishes to make labour as painless as is compatible with safety and with as little interference with the normal process as possible.¹¹¹

It was obviously the physicians who had the power to make the decision about what pain relief was within the limits of safety.¹¹² Only obstetricians, gynecologists, and anesthetists were seen as capable of defining the "limits of safety," with the expert monopoly of knowledge.

Evidently, obstetricians and gynecologists felt that the views of the "lay public" were at odds with those of the medical profession on this issue. Obstetric writings frequently referred to the public's demand for pain relief, a demand that had grown historically.¹¹³ But while

110 McNab, J. A., "Obstetrical Analgesia and Anaesthesia," Canadian Medical Association Journal, Vol.72, May 1, 1955: 681.

111 Baird, Dugald, op.cit.: 248.

112 Beck, Alfred C., op.cit.: 986-7.

113 Lewis connects such demand for pain relief among the British aristocracy (1760 to 1860) to the stronger emotional ties of women with their husbands and children. These ties accompanied privatization of the family and the rise of domesticity for women. Parallel emphases during the 1950s may have contributed to expectations of pain relief in this period as well. Judith Schneid Lewis, In the Family Way. Childbearing in the British Aristocracy, 1760-1860. New Brunswick, New Jersey: Rutgers University Press, 1986: 218-231.

obstetricians in the 1950s were still willing to provide a modicum of pain relief to the labouring woman, they were tempering the use of anesthetics with their concern for the fetus.

At first the effect upon the parturient woman was the sole consideration, and the success achieved in relieving pain was the overriding criterion; but equal importance is now being attached to the effect upon the infant, whose life might be prejudiced by the sedative action of the drug employed. The clamour of the public for relief of pain has attained a high pitch, but as the lay mind does not appreciate the risks entailed, the burden of responsibility on the shoulders of the obstetrician is heavier than hitherto.¹¹⁴

These concerns encouraged obstetric acceptance of the concepts of prenatal care and childbirth preparation, along with the additional aim of encouraging mothers to lessen their demands for anesthesia in labour. Lamaze and Dick-Read were the main proponents of the latter project. They offered their systems of "natural childbirth" in opposition to the mechanization of labour.¹¹⁵ The largely psychological theories of Dick-Read came to be accepted in a somewhat less exaggerated form than that of his original spiritual discourse. Dick-Read's natural childbirth methods, generated in England and imported into North America, had considerable impact on more conventional

114 Baird, Dugald, *op.cit.*: 271; cf. also Eastman, Nicholson J., *op.cit.*: 441.

115 Editorial, "Natural Childbirth," *Canadian Medical Association Journal*, Vol. 73, Oct.1, 1955: 564.

obstetrics in spite of being quite controversial.¹¹⁶ In fact, his system appears to have been more prominent than that of Lamaze during the 1950s, as there was more discussion in the texts and journals about Dick-Read's ideas. Why Lamaze is currently more popular is an open question, but I suspect part of the reason for the switch in systems since the 1950s is that the Lamaze system was eventually more compatible with an increasingly rationalized medicine and broader society. In spite of aspects of biomedicine in Dick-Read's writings, the spiritual overtones and traditional views of the gendered division of labour in his system contrasted with scientized medicine and a rationalized society. This probably contributed to a restriction of its viability to this earlier period.

Childbirth is one of the main areas in which the biomedical model expanded to absorb a subsidiary one, the psychosomatic notions about pregnancy and labour. There was a reconciling of the two approaches within a primary trend toward the rationalization of biomedicine's management of labour and standardization of procedures. Appropriate aspects of Dick-Read's psychosomatic theories were integrated into obstetrics. The main questions, though,

116 One assessment of Dick-Read stated: "Although some of his beliefs were never wholeheartedly accepted by his colleagues, there is little doubt that he had a profound influence on the attitude to labour as a physiological act, an influence which extended to such countries as the Soviet Union, France and the United States." Obituaries, Canadian Medical Association Journal, Vol.81, July 15, 1959: 132.

must be why they were accepted and why at that time. Most of the leading obstetricians disagreed with Dick-Read's contention that labour pain arose mainly out of culturally-induced fear of childbirth, but Dick-Read offered a method for preparing women to deal with that pain, without receiving excessive amounts of anesthesia.¹¹⁷ Its acceptance was encouraged by the obstetric interest in reducing the maternal and fetal risks and mortality rates.

So through referring to psychology as a science, the broadening of "obstetrical science" to accommodate natural childbirth became more acceptable.¹¹⁸ Dick-Read himself aided the reconciliation of his approach with that of mainstream obstetrics. He was seen by some as placing psychology on a physiological basis¹¹⁹, a scientization process which, as we saw earlier, was characteristic of the absorption of psychosomatics into the biomedical model. Dick-Read accommodated biomedicine to a greater extent in later editions of his book, than he had in previous ones, in response to criticisms of his program. For example, by 1959, he no longer claimed that anesthesia was totally incompatible with his system. This caveat probably was addressed to obstetricians' critique that when women needed

117 Dick-Read, Grantly, op.cit.: 23.

118 Thoms, Herbert, "The Preparation for Childbirth Program. A Commentary," Obstetrical and Gynecological Survey, Vol.10, 1955: 6.

119 Editorial, Canadian Medical Association Journal, Vol. 73, Oct.1, 1955: 564.

anesthesia, they felt tremendous guilt at "failing."¹²⁰
 Guilt and feelings of inferiority were held to be engendered
 in women who didn't "measure up to the psychiatrists' code
 for normal behavior."¹²¹ For that reason, the definitions
 of normal and abnormal labour entailed in natural childbirth
 systems did not escape the scrutiny of obstetricians.
 Overemphasis on the psychological benefits of natural
 childbirth, defined as a normal labour, was seen to make a
 woman who accepted anesthesia believe

her mental well-being and her
 relationships to her baby were shattered
 because she did not consciously
 participate in the act of expulsion.¹²²

At the same time, it was advocated that some of the
 principles of natural childbirth systems be integrated into
 hospital antenatal classes (to show that "humanity can
 coexist with the science of modern obstetrics"). The lack
 of full consideration of the needs of the mother in labour
 was castigated. However, it was acknowledged that if
 natural childbirth was fully accepted and anesthesia viewed
 as unnecessary, then obstetricians might also be considered
 dispensable. The stance Dick-Read took in 1959, that
 anesthesia could be used if essential, ameliorated this fear

120 Dick-Read, Grantly, op.cit.: 116, 126.

121 Mack, Harold C., "Back to Sacajawea," Presidential
 Address to the Central Association of Obstetricians and
 Gynecologists (U.S.), American Journal of Obstetrics and
Gynecology, Vol. 69, #5, May, 1955: 947.

122 Ibid.: 937.

by stressing that the doctor was still important in the processes of labour and childbirth.¹²³

But overall, the aspects of natural childbirth and prenatal preparation accepted into biomedical obstetrics were those consistent with the original conventions in obstetrics. The ideal of attendance to the whole woman, including her emotional state, was always considered to be part of the art of medicine. Its loss, which accompanied the mechanization of labour, was lamented by the "thinking gynaecologist" and obstetrician.¹²⁴

Extreme claims of the psychological advantages of natural childbirth were often dismissed, however, whereas its safety benefits (with lowered use of anesthesia) were accepted as scientific and proven.¹²⁵ Even the meaning of natural childbirth, as it was interpreted in the United States, for example, altered the original system to a more scientized version. Thoms, who was one of the main supporters of natural childbirth in the United States, took up Dick-Read's general emphasis on the importance of the woman's attitude towards her labour.¹²⁶ But Thoms worked in the American context, with its greater institutionalization and more frequent sedation during labour and delivery. This

123 Dick-Read, Grantly, *op.cit.*: 126.

124 Review of Niles Newton, "Maternal Emotions," *Journal of Obstetrics and Gynecology of the British Empire*, Vol. LXII, #6, Dec., 1955: 967.

125 Eastman, as the editor, makes such an assessment. *Obstetrical and Gynecological Survey*, Vol.10, 1955: 506-7.

126 Thoms, Herbert, *op.cit. passim*.

context was embedded in the meaning which he gave to the natural childbirth system; that it not only entailed prenatal education, relaxation and breathing exercises, but also attendance by an expert who could provide "reassurance," "properly co-ordinated muscular effort" during delivery, and the patient's confidence in the doctor.¹²⁷ Most importantly, he claimed that natural childbirth proponents never asserted that labour could be painless, nor that anesthesia should not be utilized.¹²⁸ This latter interpretation is in particular contrast to Dick-Read's original ideas.

Even a concept like natural childbirth, then, was considerably influenced by the environment or context in which it was advocated and employed. The meaning of the concept was stretched in different directions, depending upon the appropriateness of a particular interpretation for the professional and social context. Notions of "normal" or "natural" for women were also correspondingly altered. At times, for example, it was believed that in the natural state, women should not experience labour pain, while labour was viewed as normally a pain-laden experience at other times.

127 Ibid.: 3; Eastman, Nicholson J., op.cit.: 384.

128 Thoms, Herbert, op.cit.: 3; Eastman, Nicholson J., op.cit.: 384.

Normal Childbirth Constructed on Normal Womanhood

Social notions of female biology and femininity were embedded in the medical construction of normal and abnormal labour and delivery. We have seen how the concept of normal labour consisted of unproblematic progression with no need for medical, cultural intervention (though it did require medical supervision). Conceptions of women as normal and abnormal paralleled the obstetric categories of labour. The dual categorization was not used only with reference to women, though obviously when dealing with obstetrics and gynecology, that is the group which was discussed in such terms.¹²⁹ How women were viewed tells us much about why particular constructions of labour and delivery came about, including why Dick-Read's natural childbirth system contained aspects that were so appealing.

Normal labour was linked by obstetricians to one group of women - those who were intelligent, well-adjusted, emotionally stable, "devoted," and self-confident.¹³⁰ The

129 From a practitioner at the University of Minnesota Medical School came the following comment: "The people are to a large extent of Scandinavian origin and are stable and intelligent. This is important since the effectiveness of any medical effort is strictly limited by the nutrition and intelligence of the population." The nordic origins of this population probably had a great deal to do with their being placed in the stable and intelligent category, as this categorization had strong racial overtones. McKelvey, J. L., op.cit.: 775.

130 Editorial, "Natural Childbirth," Canadian Medical Association Journal, Vol. 73, Oct.1, 1955: 565.

psychological personality characteristics paralleled the stable, problem-free progression that was to take place in the normal labours these women were expected to experience. It meant that they would be active in their labours, participating, yet ironically, not being overly assertive. They were viewed as being fully co-operative with their medical attendant. These were the women considered to be best suited for natural childbirth, as it was believed that they could tolerate more pain without anesthesia, in a self-disciplined and controlled manner. Yet it seems that a large proportion of women were excluded from this category:

A calm, easy-going woman with a high pain threshold might be a good candidate for this practice, but not the average woman.¹³¹

In fact, some feared that obstetrics' encouragement of women's active participation in labour might lead to physicians' withholding of valuable pain relief, and to "empty" or "masochistic," i.e. abnormal, women demanding natural childbirth.¹³²

The other group of women constructed were believed to experience abnormal, difficult labours or at the minimum, dealt poorly and passively with normal labour. They were often referred to as: "immature," overly sensitive, highly

131 McNab, J. A., op.cit.: 682.

132 Greenhill, J. P., op.cit.: 325.

strung, nervous, and emotionally unstable.¹³³ Some obstetricians seriously questioned the femininity of these women. One Canadian hospital obstetrician, for example, argued that women who had menstrual pain and emotional disturbances had a poor prognosis for labour:

They very often have male characteristics, not only of the distribution of hair but of their bony pelvis and of their mental attitude towards reproduction, associated with fear of labour.¹³⁴

This practitioner continued by asserting that even if such a woman had experienced normal labours previously, this did not guarantee that the present pregnancy would also be normal. He argued that on that basis, she should be monitored carefully.

Clearly, the notion of what constituted normal and abnormal labours was influenced to some degree by views of women and social expectations of them. This was not confined to the lesser-known obstetricians, as Greenhill, for example, made similar statements. One review of the eleventh edition of his text, Obstetrics (1955), criticized Greenhill for using insufficient scientific evidence to support his claim that

133 Green, Martin W., Editorial, Obstetrics and Gynecology, Vol. 6, #4, Oct., 1955: 465; Baird, Dugald, op.cit.: 162; Atlee, H. B., op.cit.: 118-9.

134 White, George M., "Diagnostic Aids in Obstetrics and Gynaecology," Canadian Medical Association Journal, Vol. 81, Oct. 15, 1959: 673.

labour in women athletes is often prolonged and difficult because most of them show characteristics of insufficient feminine differentiation.¹³⁵

Such a judgment was not widely accepted by all obstetricians and gynecologists, but the fact that it could be plausibly suggested and debated at all, indicates that the social context facilitated such categorizations.

Some of the abnormal labour experienced by "disturbed" women was related in the writings to social circumstances and the conflict engendered in women by changing gender relations. Deutsch was drawn on in discussions of this situation. She argued that women were attaining greater opportunities for fulfillment outside their traditional reproductive role, at the same time as they were being offered a glorification of "active motherhood." Only if this conflict was resolved in the individual woman would her pregnancy and labour be normal, according to Deutsch.¹³⁶ The holistic integration of emotional and psychological aspects into obstetrical management of labour, the concept of natural childbirth methods, and those of normal and abnormal labour, were connected with beliefs and anxieties about social change. Entrenching what was considered women's normal femininity and physiology through improved

135 Review of Greenhill, J. P., op.cit., in Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #6, Dec., 1955: 969.

136 Deutsch, Helene, op.cit., in J.P. Greenhill, op.cit.: 327.

obstetrical practices was one way of ensuring the goal of lessening fetal mortality and of dealing with changes in the larger social context.

If modern obstetrics, a masterpiece of masculine efficiency, should come to deprive woman completely of her active participation in childbirth, it will also deprive her of her monopoly in this field and of her one completely feminine experience of creative power. Men may then be unwittingly driving women into activities which they once claimed as exclusively their own and contributing to the progressive wiping out of sex differences.¹³⁷

The rationalized mechanization of labour (which Dick-Read's natural childbirth method was designed to offset), and even its masculine connotations, were recognized. It was feared by some that this trend in obstetrics and scientific medicine generally would accelerate the undesirable changes away from traditional gender relations. But these same views of the social context contributed to the social construction of the debate and to concepts of management of labour.

Positive Eugenics through Natural Childbirth

Another reason for the construction and acceptance of parts of the natural childbirth program during the 1950s, was that it was congenial to a social context in which

¹³⁷ Ibid.: 327.

eugenics concerns were prevalent. These were not the negative eugenics programs of the pre-Nazi era, but rather took the form of population control and positive eugenics. Not only gender relations created anxieties in the postwar period, but the quality of the population (meaning its "correct" racial composition and sound mental health) and the strength of family unity did as well.

The quality of reproduction of some racial groups was of more concern than that of others, so it was argued, for example, that little sedation was required by women of Northern European races. Since, as was outlined in the previous section, sedation was equated with undesirable risks to the fetus, the preservation of quality in the races mentioned was positively associated with little sedation. One obstetrician called for a reduction in the use of medication for pain relief in labour, to produce high quality offspring and, hence, to improve the composition of the human race:

From a racial standpoint you will do better by giving as little analgesia as you can get away with, rather than as much as the patient may clamor for. In order to accomplish this humanely I suggest that you give some thought to what is commonly called Natural Childbirth. You will then have the woman herself on your side.¹³⁹

138 Chassar, Moir J., op.cit.: 38.

139 Atlee, H.B., op.cit.: 152.

The supposed benefits of relying on the natural childbirth program were likely exaggerated by its proponents. But the terms in which that discourse was framed resonated with the social and professional context of the obstetricians. Pregnancy and labour were envisioned in the 1950s in a manner which would address many of these social "problems" which were essentially issues about the stability of the social structure. Dick-Read himself criticized nuclear weaponry, materialism, atheism, communism, and the "subjective materialism" of science, advocating "childbirth and mother love" as the solution to these socio-political threats. Childbirth, he said, is an "emotional experience" which "smooths our social structure."¹⁴⁰

Some of the components of natural childbirth were a turning back to nature as a mode of combatting detrimental cultural developments, including the rationalization of obstetrics itself. The humanization of labour was conceptualized as achieving the long-term aim of a population that was mentally healthy, emotionally well-adjusted, and stable.¹⁴¹ It was hoped that mother-infant bonding (which was said to result from natural childbirth

140 Dick-Read, Grantly, *op.cit.*: xvii, 7, 26.

141 T. Benedek was one of the experts obstetricians drew upon, who argued that the separation of mother and baby at birth could result in the later development of psychosomatic disorders in the child. Abstracts, Canadian Medical Association Journal, Vol. 63, Sept., 1950: 311.

methods), the rooming-in of the newborn, and breastfeeding would ensure the continuance of the nuclear family and social stability. The supporters of natural childbirth drew on psychological theories to argue that completely painless labours and deliveries would jeopardize the normal and ideal relationship between mother and child. The quality of the mother-child relation was considered of great importance, as it was believed to be the basis of the family unit.¹⁴²

According to Dick-Read, the health and contentment of child-bearing women were important for the "progress of human society."¹⁴³ It was considered insufficient for women to reproduce, though that was highly commendable, for reproduction had to be of high quality (especially with the added interest in the fetus and the child). Though fathers were still in the background, their new position as supporters of the labouring mother and their participation in childbirth preparation and rooming-in following the birth¹⁴⁴ were cited as developments which would strengthen the companionate marriage and family unit.¹⁴⁵

While these aspects of natural childbirth were not widespread in obstetric practice during the 1950s, what is important is that they were discussed by obstetricians and

142 Eastman, Nicholson J., op.cit.: 16; and Editorial Comments, Canadian Medical Association Journal, Vol. 63, Aug., 1950: 179.

143 Dick-Read, Grantly, op.cit.: 335, 333.

144 Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 49-50.

145 Dick-Read, Grantly, op.cit.: 334.

added to the transformation of biomedical concepts.¹⁴⁶ Many physicians criticized the unscientific and speculative nature of claims that labour could potentially be painless, or that certain practices should be followed to ensure no psychological harm was done to the child. The answer for these critics was in instituting "properly controlled studies" through scientific research.¹⁴⁷ So the psychosomatic aspects of labour were well-known and debated, though far from wholeheartedly embraced.

The discourse of the new childbirth systems arose out of the socio-political fears mentioned and the coincident dissatisfaction with the mainstream, scientific biomedical strand of obstetrics. In turn, the academic, biomedical obstetricians had to confront this challenge. The natural childbirth models emerged out of a context which biomedical obstetrics shared, but each offered an alternative way of addressing concerns related to that context. Hence, the incentive was there for acceptance of aspects of the psychosomatic model into biomedicine, albeit in a subordinated form, and to construct particular notions of normal and abnormal labour, according to the social and professional context in which the knowledge was developed.

146 Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 13.

147 Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 51.

Quantity and Quality Control

The general social concerns and events of the post-World War II period included population reproduction issues and related concerns about women's role in those issues. Conceptualizations of reproductive problems like infertility, sterilization and birth control were very much social concepts. The rationalization of approaches to them and the content given to these issues by biomedical obstetrics and gynecology were closely integrated with their social and professional context.

Control of the quantity of reproduction and the quality of future populations informed some of the biomedical content. Sterility and infertility had only relatively recently become concerns of gynecology in the 1950s, a fact related to medical views of broader demographic trends. There was an apparent inconsistency in medical positions on population quantity, as the discourse of some physicians, such as that of Kroger and Freed, expressed concern about the declining birth rate and the over-abundance of sterility problems. These physicians related such trends to the poor psychological health of the population and the "process of social disintegration."¹⁴⁸ Baird agreed that in certain countries only a "voluntary increase in the average size of

148 Kroger, W. S. and S. C. Freed, "Psychosomatic Aspects of Sterility," American Journal of Obstetrics and Gynecology, Vol. 59, #4, April, 1950: 867.

the family" would remedy the lack of replacement of the population.¹⁴⁹ Others offered an opposing view, that overpopulation was becoming a problem. That fact can be explained by explicit references in the texts to national differences. Greenhill made clear this differentiation of the problem into two separate reproductive issues; he noted the baby boom that was still ongoing in the United States during the late 1950s, but expressed concern with the same population boom which had been occurring in Third World countries since World War II. That the mortality rates dropped without any corresponding decline in birth rates in underdeveloped nations was an issue for him; fertility reduction was advised if standards of living were to be raised.¹⁵⁰ Conceptualizations of the overpopulation-underpopulation issue, then, were heavily informed by concerns about political stability on an international scale as well as by racial priorities.

Birth control was advocated on a world-wide basis by most obstetricians and gynecologists, however, and was retained within the control of the medical profession, defined as a "medical" problem.¹⁵¹ What was considered to be an "unnatural" approach to population control was supported for various reasons. First, it was argued that medicine

149 Baird, Dugald, op.cit.: 189-190.

150 Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 294-5.

151 Novak, Emil and Edmund R. Novak, op.cit.: 605-6.

artificially reduced fetal and maternal mortality, so must counterbalance that by further intervention in the form of contraception. Birth control was envisioned as being used to space pregnancies, not to avoid them altogether, and it was thought that this would result in better physical and mental health, and superior living conditions for the whole society.¹⁵² Frequently, the improvement of marital and family stability was cited as a positive effect of contraceptive use.¹⁵³

It was believed, then, that westerners should be encouraged to reproduce in greater numbers, but that denial of contraceptives was not the correct answer.¹⁵⁴ Positive, not negative eugenics and population control was the answer:

The disturbance caused by the World War makes it impossible to predict what will happen in the future. Attention will soon have to be given to the quality of the future generations as well as to actual numbers.

Eugenics is being studied much more, and it may be possible to initiate soon a positive eugenics policy for human reproduction. This may be forced upon us to some extent by the present differential fertility which, according to Burt, is leading to a steady increase in the incidence of mental deficiency. It is well known that at the moment families are larger amongst couples of low intelligence and small amongst those of high intelligence.¹⁵⁵

152 Jeffcoate, T.N.A., op.cit.: 578-9.

153 Baird, Dugald, op.cit.: 1282.

154 Ibid.: 1282.

155 Ibid.: 192.

There are not only racial, but also class implications involved, since those considered to be of higher intelligence were usually from the middle and upper classes. That "the more intelligent and civilized" were the ones using contraception did not conflict, however, with the interest in improving "the stock." For it was hoped that as overpopulation increased, reproduction could be limited to those with "the best physical and mental attributes," through the use of birth control.¹⁵⁶

There was an increasing amount of research being conducted in the field of genetics at that time, some of which was directed toward determining the hereditary causes of abnormalities. The number of chromosomal pairs in an individual was revised from forty-four to forty-six, an important change since researchers were examining the significance of abnormal numbers of chromosomes in the etiology of congenital problems. One of the main aims of studies in this area was to locate "the causes of mental deficiency," a goal coincident with the more general social concern with mental health and intelligence levels of the population.¹⁵⁷

How to address these concerns was somewhat problematic, considering the mood against negative eugenics left over from the war when sterilization was imposed on racial and

¹⁵⁶ Jeffcoate, T.N.A., op.cit.: 579.

¹⁵⁷ Editorial, "The Chromosomes of Man," Canadian Medical Association Journal, Vol. 81, Aug. 1, 1959: 193.

political grounds by the Nazis. Compulsory sterilization was illegal in Britain, although it was permitted in some states in America.¹⁵⁸ The extent to which there were hereditary and environmental components of mental illness, deficiency, and criminality was debated however. It was suggested, on the one hand, that eugenics in the form of sterilization might be preferable to later incarceration for criminal acts. Crime is "one of the conditions which ardent eugenists expect to be reduced by sterilization...."¹⁵⁹ It was also noted, though, that knowledge of how much input heredity provided to the development of these conditions was lacking. It was acknowledged that since even some of those at the top of the "social ladder" couldn't "conform to society," environmental factors must also play a part in generating criminality. This point was qualified by the prevalent opinion that homes without "advantages," those with mentally defective parents, poverty, and a generally inadequate environment, produce more criminals than do other homes.¹⁶⁰

The problem of alleviating infertility was also a major concern in gynecologic knowledge during the 1950s, a focus probably encouraged by the broader concern to increase the fertility rate in the general population. Infertility was

158 Jeffcoate, T.N.A., op.cit.: 592.

159 TeLinde, Richard Wesley, Operative Gynecology, 2nd edition, Montreal: J. B. Lippincott, 1953: 629, 627.

160 Ibid.: 629-630.

frequently addressed by the application of radiation therapy to the ovaries. However, the increased interest in genetics, the experience of the bomb during the second World War, anxieties about inherited human deficiencies (and the consequent concern with heredity) led many radiologists to warn obstetricians and gynecologists about the negative consequences of radiation for the quality of civilization.

Women, Family and Social Stability

It was women who were considered to be "entrusted" with "the hereditarian line", so it was they who were of central concern to the medical profession when dealing with population and eugenics issues.¹⁶¹ Women were assumed to be in a position to ensure humanity's "racial progress," improve international relations, and confirm the survival of the species. It was seen as possible to "improve the human stock by caring for the mothers."¹⁶² Such discourse was certainly more explicitly phrased by extremists like Dick-Read, but modified versions of his statements ran throughout the texts and journals of the period.

Despite the temporary baby boom in the west following the war, the concern about the overall declining population

161 Rugh, Robert, "Genetic Hazards in Ovarian Radiation," Journal of Obstetrics and Gynecology of the British Empire, Vol. LXII, #3, June, 1955: 463.

162 Dick-Read, Grantly, op.cit.: 346, 350.

emphasized the social changes which created the threatening population trends. A connection with changing gender relations was frequently noted:

although economic factors are certainly important, the changing status of women in our modern civilization is also of considerable importance.¹⁶³

The "status of women" was becoming one where women increasingly moved in spheres outside the home and found fulfillment in more than childbearing and rearing (as was indicated in earlier discussions of women's labour force participation rates). The population and reproductive concerns dealt with in obstetric and gynecologic writings were quite consistent, then, with medical interpretations of the social changes. Women were perceived as abandoning motherhood and femininity for competing pursuits. Much as these changes in women's social behaviours were viewed as creating women's menstrual problems, so they were seen as engendering infertility. Fear and defensiveness against motherhood, related to women's increasing participation in the wage labour force, were considered some of the factors at the root of infertility and larger population problems.¹⁶⁴ The concern about the quantity and quality of reproduction of the population focused attention on women and their normal attributes, as aids in addressing those

163 Baird, Dugald, op.cit.: 1250.

164 Marbach, A. Herbert and Louis H. Schinfeld, "Psychosomatic Aspects of Infertility," Obstetrics and Gynecology, Vol. 2, #5, Nov., 1953: 435-6.

questions. But to do so required attention to what were defined as reproductive abnormalities in women.

Premarital counselling, as a form of preventive medicine, was considered one way to allay the further development of sexual problems, infertility, and declining population. Such counselling was seen as helpful to "overcome a serious defect in our present-day social structure" and as a route to addressing the social problems of the period.¹⁶⁵ The problems discussed by obstetricians and gynecologists in this context included those of preventing divorces and stimulating broader social stability and reproduction.

Any kind of educational program which can help alleviate some of the pitfalls of marriage adjustment and which can make the marriage bond a stronger and more permanent link will be of tremendous help and value to the family, the society, and to the nation.¹⁶⁶

The designated, proper form of reproduction was to be ensured, and the medical categorizations of normal women were perceived as fitting into that scenario. "The psychogram of normality," as one study of fertile and infertile (abnormal) women called it, revealed that the woman who accepted an unplanned pregnancy and saw motherhood

165 McCready, Robert B., "Premarital Counseling: a Multidimensional Approach," Obstetrics and Gynecology, Vol. 13, #4, April, 1959: 420.

166 Ibid.: 421; cf. Greenhill regarding the marital advantages and fewer divorces that would accrue from counselling. Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 20-1.

as "a completion of her life role, a fulfillment of her womanhood" was the ideal.¹⁶⁷ In contrast, the functionally infertile woman was (in psychiatric terms) rejecting and in a state of conflict about femininity and motherhood; she imitated the male role, and her neurotic tendencies produced endocrine abnormalities. This was the extreme version of the psychosomatic approach, and journal editors, Eastman and Novak, commented that some gynecologists would have difficulty with psychiatric terms like "imitation of the male role."¹⁶⁸ The majority of the gynecologic and obstetric writings did not psychologize the concepts to as great an extent. Nevertheless, discussions of sterility and infertility largely entailed similar concepts of women. Reproduction was consistently taken to be women's prime destiny:

The desire for children by the normal woman is stronger than self interest in beauty and figure, stronger than the claims of a career: in the man it is less intense.¹⁶⁹

But the strong emphasis on reproduction and family stabilization demonstrated that the thrust was not directed primarily at women for their own sakes. Rather, concepts of womanhood were tightly intertwined with other social

167 Ford, E.S.C., I Forman, J. Robert Wilson, W. Chan, W.T. Mixson and Carol Scholz, "A Psychodynamic Approach to the Study of Infertility," Obstetrical and Gynecological Survey, Vol. 10, 1955: 777-8.

168 Ibid.: 777-8.

169 Jeffcoate, T.N.A., op.cit.: 553.

concerns, ones that were even more basic. The fear of increasing marital breakdowns and instability in the social structure contributed to the belief that marital problems were caused by childlessness: "The wife insisting on working outside the home," "Financial independence of wife. Failure of husband to support wife and children."¹⁷⁰ Traditional gender relations, with patriarchal authority "exercised for the good of the family," were sometimes considered important for keeping families and the society (at least the status quo) together.¹⁷¹ The normative ideal envisioned was the monogamous, heterosexual, middle class marriage based on reproduction (with "high aims for the children"), not only companionship.¹⁷²

Definitions of the normal and the abnormal woman reflected a duality of neurotic, emotionally unstable and normal, stable women throughout areas of obstetric and gynecologic knowledge. There were also references, however, to other groups as possessing the same types of attributes, at least potentially. This indicates that the total population was conceptualized in such terms, and not only women were targetted.¹⁷³ In fact, I would suggest that as

¹⁷⁰ Ibid.: 551.

¹⁷¹ McCready, Robert B., op.cit.: 424.

¹⁷² Baird, Dugald, op.cit.: 1288; Jeffcoate, T.N.A., op.cit.: 548, 534; Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 31.

¹⁷³ Couples considered for artificial insemination procedures, for example, were assessed for their "emotional stability." Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 373.

husbands and fathers became more important in maintenance of family unity and bonding (e.g. with prenatal care and labour participation). their emotional and psychological attributes were monitored as well. There was an attempt afoot to draw men further into the nuclear family for the sake of stability:

Ever since the beginning of the industrial revolution the man and father has tended to be separated from family life. This is one of the most disruptive forces in the development of the family.¹⁷⁴

It was necessary for medicine to evaluate males, as well, for any abnormalities if they were to participate more profoundly in the structure of family relations. Whether psychogenic theories produced actual evidence of conflicts around femininity and masculinity resulting in sterility was debated.¹⁷⁵ But the male psyche came under scrutiny in predominantly endocrinological explanations for male sterility as well. The male as a factor in sterile marriages had only recently begun to be considered. Husbands, and not only wives, were seen as abnormally psychoneurotic or as manifesting "immaturity" in cases of

174 Here Baird is quoting from the Swedish Commission on Population, arguing that boys should receive equal preparation for parenthood as do girls, in order to strengthen boys' bond to the notion of the family. Baird, Dugald, *op.cit.*: 192.

175 Hanson, Frederick M. and John Rock, "The Effect of Adoption on Fertility and Other Reproductive Functions," *American Journal of Obstetrics and Gynecology*, Vol. 59, #2, Feb., 1950: 312-3.

contraceptive failure¹⁷⁶; and reproductive and sexual problems were noted to be "more common in nervous, overworked, intellectual males."¹⁷⁷ So concepts in the professional (biomedicine and psychosomatics) and more broadly social (family stability and population) contexts provided a setting for the development of particular constructions of both men and women. Women were considered more central than men to the reproductive process, particularly in the 1950s when men were just beginning to lose their peripheral role in the eyes of the medical profession and the wider society. So women were more frequently the indirect solution to many of the social, obstetric and gynecologic concerns.

Meanwhile, the medical profession acknowledged that a trend towards marriage preparation and the monitoring of fertility was taking place during the 1950s. Therefore, for professional reasons, it was to their advantage to gain control of this area as a "medical" one. The implicit eugenics concerns could be drawn upon to improve the status of obstetricians, for instance. Dick-Read claimed that obstetricians could achieve "the highest place among the builders of our future race" by paying attention to the quality of marriage preparation, prenatal care and

176 Lehfeldt, Hans, "Willful Exposure to Unwanted Pregnancy (WEUP), American Journal of Obstetrics and Gynecology, Vol. 78, #3, Sept., 1959: 662.

177 Baird, Dugald, op.cit.: 1252-3.

management of labour (unlike the general practitioners who were concerned with making money).¹⁷⁸ Obstetricians and gynecologists were not unaware that,

In medicine, as in all phases of human endeavor, as frontiers are conquered and retired, new frontiers continually appear to challenge man [sic].¹⁷⁹

Premarital counselling was one of those frontiers which the medical profession strove to obtain for their practice. The fear was that if obstetricians and gynecologists, for example, did not deal with human problems in that area, then the profession would lose another sphere of influence and control.

To default in this area is to relegate irrevocably our responsibilities to fringe practitioners.¹⁸⁰

There was, therefore, some added professional motivation for attention to family and gender relations, and concern for reproduction of the population.

Standardization of Approaches to Fertility

The professional context, and the sort of concepts and tests applied to the problems of infertility and sterility, contained social notions about eugenics, population, and

178 Dick-Read, Grantly, op.cit.: 351.

179 Offen, J. Allan, "The Role of the Gynecologist in Family and Marriage Counseling," Obstetrics and Gynecology, Vol. 13, #3, March, 1959: 302.

180 Ibid.: 302.

women. The social trend towards rationalization was also embedded in the medical approach to the area. More precise definitions of terminology were developed, separating infertility (as conception, but miscarriages) from sterility (meaning no conception taking place).¹⁸¹ But definitions of terms and concepts also entailed a relative sense of each condition. There was no absolute standard for deciding whether or not it was taking too long for a pregnancy to occur. Rather, it was a notion relative to the known norms for length of time taken to conceive by the general population.¹⁸² Even in the case of male infertility, the major approach taken was standardization of the quantity of active spermatozoa cells believed crucial to ensure conception.¹⁸³

However, the quality of the cells was considered more problematic to assess, as rationalization of that evaluation was not as readily achieved as it was for quantification.

One of the great difficulties is the lack of a common standard for estimation of quality of motility. ... the estimate of speed of progression of spermatozoa is a more subjective process and, as

181 Novak, Emil and Edmund R. Novak, op.cit.: 692.

182 Schoeneck, F. J., "Conception-Effort Time in Relationship to Fetal Wastage," American Journal of Obstetrics and Gynecology, Vol. 69, #3, March, 1955: 660.

183 The male factor in infertility was believed to be related to the quantitative "fact that azoospermatic persons produce a much lower ejaculate volume than normals...." Greenhill, J. P., ed., 1950 YearBook of Obstetrics and Gynecology: 345.

such, liable to varied interpretation.¹⁸⁴

Though most physicians agreed that the presence of twenty percent or more of abnormal forms of sperm meant impaired fertility, there was much less agreement on what constituted "an "abnormal" form."¹⁸⁵ The variability of interpretation was problematic, as no rational standards of normal and abnormal could be set. Yet, there were attempts to move in the direction of standardization of tests, as advances in diagnosing and treating infertility were seen to follow. The rationalization of science was seen as the way to proceed towards achieving resolution of perceived social-medical problems.

Part of the route was through the integration and scientization of psychogenic theories of sterility, by placing them on physiological, endocrinological grounds. Towards the end of the decade of the 1950s, some discussions centred around the hypothetical existence of a "reflex arc" linking the hypothalamic-pituitary center to the reproductive functions. The hormones of the anterior pituitary were still considered to play a crucial part in the system, but the anterior pituitary wasn't always seen as "the conductor of the endocrine orchestra" any longer; now, the hypothalamic control was conceptualized as running the

184 MacLeod, John, "The Present Status of Human Male Infertility," *American Journal of Obstetrics and Gynecology*, Vol. 69, #6, June, 1955: 1257.

185 *Ibid.*: 1260; cf. also Baird, Dugald, *op.cit.*: 1266.

show.¹⁸⁶ This was basically the manner in which the biomedical model was standardizing theories about how emotions and reproductive functioning, the psyche and the soma, were interconnected.¹⁸⁷ Disturbances of this finely tuned system were believed capable of producing infertility and sterility.

The obstetric and gynecologic discourse on social problems during the 1950s in North America and Britain contributed to the constructions of pregnancy, labour, and fertility of that period. Standardized and scientized approaches in biomedicine were constructed in a manner which could address these problems. The way in which obstetric problems were conceptualized coincided with more general concepts of women's place in the family and society; concepts of normal and abnormal women. Standards and norms set for women and for the reproduction of populations, pervaded biomedical obstetrics and gynecology.

Even more importantly, obstetric and gynecologic concepts included an implicit surveillance of family and socio-political stability and of the broader reproduction of populations. In other words, there was a surveillance of normal conditions of reproduction (e.g. management of labour) to detect and prevent the appearance of the

186 Israel, S. Leon, "Discussion," American Journal of Obstetrics and Gynecology, Vol. 78, #5, Nov., 1959: 987.

187 Greenhill, J. P., ed., 1959-60 YearBook of Obstetrics and Gynecology: 341-2.

abnormal. And, as was the case in gynecologic knowledge, obstetric concepts of the normal contained assumptions favouring the middle class, white, nuclear family with a traditional gendered division of labour. Maintenance of this norm was probably viewed as contributing to social stability. As social instability was perceived as a major problem, content for the obstetric and gynecologic categories was selected according to socially-accepted solutions to that problem. The knowledge that was constructed consistently possessed this distinctive social character; not only those concepts which would now be assessed as having been in error contained social assumptions about normality and abnormality for women.

Conclusion

This project was an examination of the way in which obstetric and gynecologic knowledge was constructed during the 1950s, and in particular, in what ways that knowledge was social. One of the main aims was to determine the manner in which medical ideas about women were informed by their social context. The research focused on conceptualizations of female biology and gender in obstetric and gynecologic discourse, as well as the social and professional context, and attention paid to their interrelatedness. The social context of the 1950s was found to include concerns over political instability, fertility rates, threatening changes in the gendered division of labour, the social position of men, and scientization and threats to the autonomy of the medical profession. The obstetric and gynecologic writings were examined for indications of which social resources were drawn upon, for which ends.

Analysis of obstetric and gynecologic writings indicated that such social concepts as domesticity were used to make technical distinctions in medical knowledge of the period. Those distinctions, in turn, were used as resources for normalizing and regulating populations in general, and women in particular. This finding was also characteristic

of a general social thrust towards rationalization and normalization in the postwar period, with particular notions of what constituted normality. It was found that medical, technical definitions of womanhood and particularly what was considered normal for the "female" drew on social concepts of femininity that particularly emphasized women's reproductive capacities. For example, technical, gynecologic formulations of female endometrial cycles were constructed around the ovulatory phase as a focal point, rather than, say, the menstrual phase. In other words, reproductive capacity served as a social resource central in the construction of technical knowledge. This technical resource was in turn employed to define the world in a way which included particular concepts of females and normal women.

Obstetric and gynecologic knowledge was scanned for evidence of links between the technical and the social resources. This approach revealed, for example, a definition of normal labour as that which progressed smoothly, with few delays, and with a minimum of complaints from the emotionally stable woman. This technical categorization drew on the social emphasis on pronatalism and then provided a resource in obstetrics for defining a point of intervention into what were identified as disorders and what was defined as abnormal labour. These distinctions

were further drawn upon as a resource in the regulation and normalization of women's reproduction.

This ability of medicine to define its distinctions as technical and objective, gave obstetrics and gynecology a resource for the implementation of surveillance of normal pregnancies and labours in regulating women's reproductive processes. The findings here add a slightly different slant to the argument of some feminists, that medical experts saw women's reproductive functions as inherently pathological.¹ Rather, this research indicates that women's reproductive functions were not always considered pathological or abnormal, though they were frequently viewed as located on a tenuous borderline between normality and abnormality. This was because women's physiological processes were generally considered to be in the sphere of the normal; the obstetricians' and gynecologists' project was precisely that of determining when women's functions were abnormal and, hence, necessitated medical intervention.

This capacity of the medical profession to define, regulate, and control was socially legitimated, based on the use made by the medical profession of the technical/social distinction as resource. The definitions constructed of such behaviours as those of normal labour or normal menopause, appropriate in the 1950s, relied upon the medical

¹ See discussion of this point in previous chapters, especially Chapters One and Eight.

profession's ability to define its knowledge as technical; as scientific and value-free knowledge. The social availability of divergent categories of technical and social was a resource for obstetrics' and gynecology's claim to expertise. Yet analysis of this technical, medical knowledge showed that its content was in fact dependent on social context. This drawing upon social resources for the construction of technical knowledge of women, then, was not objective and value-free, as was claimed. Debates around concepts of female biology demonstrated that observation was far from a neutral, objective process. The number of views which could be offered of one reproductive function indicated that medical observation was in fact interpretive and theory-laden. Underlying many of the debates about the observation of reproductive functions and pathologies was the interpretation of what was being observed and further, what counted as legitimate, scientific medical knowledge about women. Thus, it was not a question of false concepts being constructed, as opposed to the objective reality of scientific facts about women. The social character of the definitions and categories produced in medicine do not permit it to be the disinterested, technical knowledge as claimed.

The primary tendency of that period was in this direction of the rationalization of scientific medicine and the standardization of concepts as technical categories.

This trend was supported by the social context in which scientific, technical discourse was very powerful. But along the way, many issues regarding that process were debated in obstetrics and gynecology and the generation of unified, standardized meanings of concepts entailed negotiated agreements. Disagreements were evident regarding the content of obstetric and gynecologic concepts, and even about the desirability of the rationalization of medicine itself. What this means is that we had various resources employed by different factions within obstetrics and gynecology, for the particular ends of each. For example, a number of the major obstetricians met to explicitly negotiate standardized definitions of a variety of physiological processes.² Also, while natural childbirth systems and mainstream obstetrics shared pronatalist, reproduction-centred concepts of womanhood, each offered alternative degrees of the scientization and rationalization of obstetrics.³

The psychosomatic strand in obstetrics and gynecology was basically absorbed into the more dominant, biomedical one in the 1950s. This meant that the subordinate approach essentially contributed to a broadening of the borders of this scientific medicine. The consideration of social and psychological factors in health and illness, in fact led to

² Refer to the mention of this in Chapter Seven.

³ This example is discussed in Chapter Eight.

medicalization of such areas as prenatal care, premarital and sex counselling, and so on. With psychosomatics a part of the scientific, biomedical model, there were more areas to be monitored, and less leniency for variations in those additional areas. The result was greater surveillance of the normal and perhaps less tolerance, thereby, of what was defined as the abnormal. For example, as psychological bases for stable family life and a secure social structure became delineated, the psychological makeup of mothers was considered an important medical area to be monitored for normalcy and prevention of pathology. The acknowledgement of women's importance potentially empowered women, but this increased surveillance and social control also eroded some of women's power and autonomy.

The body of knowledge examined was not a case of erroneous scientific medicine. Rather, the knowledge was consistently social. The social context provided particular resources for the construction of technical distinctions in obstetric and gynecologic knowledge, distinctions then employed to regulate the social. In other words, it was not just some scientific, medical beliefs and ideas which were socially-constructed, as Interest Theory, some feminist schools of thought and Marxist concepts of ideology would suggest. The social context provided accessible resources for the entire body of obstetrical and gynecological

knowledge, including the biomedical knowledge designated wholly technical.

The findings of our research into the identification and definition of women's physiological processes and obstetric and gynecologic "disorders," and the social resources employed in the process, have important implications for feminist scholarship on science and medicine. The building of a feminist science has been stipulated as a desirable goal by some feminists researching the gendered construction of science. It would be a science less biased and socially influenced, less ideological than masculinist science.⁴ The findings from analysis of 1950s obstetric and gynecologic knowledge suggest that the project of more objective or "more scientific" science is problematic, whether it be the aim of feminist empiricists or of those employing a standpoint epistemology.⁵ Feminist empiricists claim to better approximate the ideal of scientific process than biased, sexist, erroneous science and thereby acquire more accurate, more true evidence about empirical reality. Hence, they create a division in which

4 Sandra Harding's work is an example, and she discusses others. Harding, Sandra, The Science Question in Feminism. Ithaca: Cornell University Press, 1986; cf. also Harding, Sandra, ed., Feminism and Methodology. Social Science Issues. Bloomington and Indianapolis: Indiana University Press and Milton Keynes: Open University Press, 1987; Also, refer to the discussion of critiques of erroneous or "bad" science in Chapter Three of this dissertation.

5 For elaboration of these epistemological positions, refer to the discussion in Chapter Three.

their own "facts" are used to oppose the rhetoric of others, essentially a struggle over who is more objective and scientific. Their project then becomes, for example, one of locating "correct" definitions of biological and social normality for women, i.e. the way women truly are, empirically. This call to examine an empirical reality for access to the truth about women fails to examine, however, the assumptions underlying the feminist empiricist preference for alternative views of women and alternative versions of womanhood. It may be more profitable to analyze medicine and "science as usual" than to continue such efforts to unveil the biases of erroneous science. Instead of arguing that feminist or women's observations are more scientific and less biased, scholars can recognize the moral, value-laden, social basis to all scientific and medical knowledge, including their own. Reference to some empirical reality about which we can have untainted, objective knowledge is unnecessary.

Besides those who wish to develop a more objective science, others hope simply that an alternative ideology, one that better expresses women's interests, can emerge out of women's position as a subordinate social group. Some advocates of a standpoint epistemology take this position,

for example.⁶ Few actually make that claim, though, without implying that their own ideology is superior to that of mainstream science or medicine, in the sense of being "better," more representative knowledge of women.⁷ A large part of the reason for this is feminism's ambivalence towards relativism. Generally, feminist scholars consider mainstream medical and scientific knowledge to be relative, acknowledging it as socially informed, historically specific knowledge. But then problems emerge, as they stake their own claim to either more objective or ideologically superior knowledge, as non-relative. While they do not make the same claim to objective truth as is found in mainstream science and medicine, they often rely upon a claim to greater truth-value for their partial perspective.

This epistemological stance is also built upon the shaky ground of the standpoint of a category labelled "women." Here feminists are relying on the same social resources as those whom they aim to critique, the

6 Dorothy Smith's approach could be considered to be in this category, for while she advocates knowledge begin from women's lived experience, she does not claim that this would result in a special expertise or privileged form of knowledge. Roundtable Session: "Approaches to Sociological Texts," Quebec City: Canadian Sociology and Anthropology Association Meetings, June 3, 1989.

7 Examples include the work of Emily Martin, The Woman in the Body. A Cultural Analysis of Reproduction, Boston, Mass.: Beacon Press, 1987: 22-3, 197-200; cf. also Harding's discussion of Jane Flax's position in Flax's article, "Gender as a Social Problem: In and For Feminist Theory," American Studies/ Amerika Studien, 1986, in Sandra Harding, op.cit.: 26-7.

traditional dualist concepts of gender. The creation of this alternative ideology, with the same assumption of "women" as reality, results in little analysis of the concepts underlying existing medical and scientific knowledge. Analyses of the rhetoric about women in medicine and science and the social concepts on which they are based would lead to more penetrating critiques, not only debunking of other ideologies. For example, one could inquire into exactly what is being debated in medical and scientific discourse on women. Analysis can reveal what is considered to be fundamental to women's physiology in the knowledge, what is assumed about women and gender in general, and what is advocated as treatment or intervention. One could then disclose why those particular medical constructions could be accepted in that form, at that time. Examination of the social conditions which provide a context for scientific, medical concepts of women could reveal what allows them to be accepted as objective truth.

We could, following Dorothy Smith, develop an alternative knowledge, though not necessarily a feminist science, by allowing women to become subjects who speak of their lived experience.⁸ Women's experience has been silenced and regulated by their exclusion from objective,

⁸ Smith, Dorothy E., "Textually mediated social organization," International Social Science Journal, Vol.36, #1, #99, 1984; Smith, Dorothy E., The Everyday World as Problematic. A Feminist Sociology, Toronto: University of Toronto Press, 1987.

technical discourse like that of medicine.⁹ Scientific knowledge currently constructs women as objects of textual discourse and presents this as neutral, technical knowledge.¹⁰ However, knowledge could be informed by women's experience if women became self-defining.¹¹ To a great extent, this is a question of which "community" provides a context for the construction of knowledge, be it the medical profession or an alternative group. But whichever community we decide should articulate knowledge of women, this must be based not on references to an empirical, objective reality as justification, but rather on advocacy of a particular preference in knowledge, with grounds for that preference which differ from those of other communities.

Or, more radically, one could deconstruct the category of "women" altogether. Scientific, medical knowledge about women is more deeply social than is generally acknowledged, for prevailing feminist positions implicitly accept the traditional scientific and medical schema of a duality of sexes and genders as "reality." This is one example of an

9 Smith, Dorothy E., Chapter 1, "A Peculiar Eclipsing: Women's exclusion from Man's Culture," in D. E. Smith, The Everyday World as Problematic. A Feminist Sociology, Toronto: University of Toronto Press, 1987; Epstein, Cynthia Fuchs, Deceptive Distinctions. Sex, Gender, and the Social Order, New Haven: Yale University Press and New York: Russell Sage Foundation: 1988: 1.

10 Smith, Dorothy E., The Everyday World as Problematic. A Feminist Sociology, Toronto: University of Toronto Press, 1987, passim.

11 Ibid. passim.

assumption that is even carried over into attempts to create an alternative feminist science or ideology, due to insufficient analysis of existing scientific discourse. Riley acknowledges the problem this lack of full analysis creates for feminist research, for:

Feminism's impulse is often, not surprisingly, to make a celebratory identification with a rush of Women onto the historical stage. But such 'emergences' have particular passages into life; they are the tips of an iceberg. The more engaging questions for feminism is then what lies beneath.¹²

Not just the historically-variable content of that categorization should be attended to, while assuming its reality. Recognition of the social character of obstetric and gynecologic knowledge points to the need for critique of the construction of "women" as a category and the ends for which such a category is engaged.¹³ Riley argues that we should look at:

the crystallisations of 'women' as a category. To put it schematically: 'women' is historically, discursively constructed, and always relatively to other categories which themselves change

12 Riley, Denise, "Am I That Name?" Feminism and the Category of 'Women' in History, Minneapolis, MN: University of Minnesota Press and Toronto: Fitzhenry & Whiteside Ltd., 1988: 8.

13 This approach, as represented by Riley, and upon which this research builds, contains elements of postmodernist epistemology. This was defined in Chapter Three and is discussed by Harding. Harding notes that much of the writing on standpoint epistemology is informed by some postmodernism, such as the work of Jane Flax, op.cit., in Sandra Harding, op.cit.: 27-8.

... That air of a wearingly continuous opposition of 'men' and 'women', each always identically understood, is in part an effect of other petrifications. ... the arrangement of people under the banners of 'men' or 'women' are enmeshed with the histories of other concepts too, including those of 'the social' and 'the body'.¹⁴

This would produce a more penetrating critique of the way in which knowledge of women is social. The problematic nature of this assumption of dual genders as an objective reality was demonstrated, for example, in discussion of the data on obstetric and gynecologic notions of intersexuality and sexual divisions in the 1950s. Acceptance of a distinctive category of female or femininity as a basis for producing alternative sciences and medicines evades recognition that this categorization is a social construction as well. It is a construction which was particularly crucial to scientific medicine during the 1950s, as was demonstrated. Feminist scholars first need to take into consideration the ways all aspects of scientific and medical knowledge are social, in order to develop feasible alternative constructions. For the women who produce medical and scientific knowledge, this implies the need for caution and reflexivity regarding their own social assumptions about women and gender, so as to avoid perpetuating such assumptions as that "women" is necessarily a valid social category.

¹⁴ Riley, Denise, op.cit.: 1-2, 7.

If the categorization of two dichotomous sexes and genders is to some extent a social construction, as indicated here, the notion of a feminist science based on standpoint epistemology, on women's viewpoint, becomes problematic, except insofar as women are socially assumed to form one objective category. This project of a feminist science perpetuates some of the same assumptions about gender categorization, then, as does mainstream science. However, if "women" as a category was deconstructed, then the world could be divided up in alternative ways and on different bases. The social assumption that the medical and scientific communities should make social policy could be challenged.¹⁵ In other words, we would simply have other social distinctions and could consider what our grounds were for preferring particular social categories. We could develop, for example, knowledge based on women's experiences in reproduction or with childrearing, knowledge that may be classified on another basis than those of normality/abnormality distinctions or males/females.¹⁶ The information produced could even lead to the abolition of

15 Russett, Cynthia Eagle, Sexual Science. The Victorian Construction of Womanhood, Cambridge, Massachusetts: Harvard University Press, 1989: 15.

16 In contrast, Keller still advocates the maintenance of objectivity as a project for science. But her suggestion that the inclusion of women's experience in science could lead to a gender-free science and "a transformation of the very categories of male and female" comes close to this one regarding the field of medicine. Evelyn Fox Keller, Reflections on Gender and Science, New Haven: Yale University Press, 1985: 9, 12, 178.

"women" as a category, if the category of "women" did not emerge out of women's experience.

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