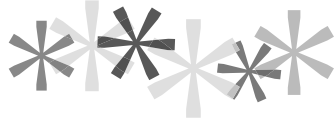


1 * ALONE AMONG STRANGERS

The Medicalization of Childbirth

The vast majority of American women (99 percent) currently deliver their babies in hospitals, accompanied by their physicians, nurses, and midwives and often by their husbands, partners, family, and friends. The hospital routine is fairly standard, although variations exist among hospitals, and medical protocols have been developed for most exigencies. Many women discuss the possible procedures in advance with their physicians and midwives and, within prescribed limits, make birth plans outlining their choices about what might happen to them during labor and delivery. Once labor begins, however, some women find that their desires are ignored, either because a different physician happens to be on call or because the course of their labor necessitates unexpected specific interventions. Because of the need for medical assessment on the spot, often more decisions are left to the hospital and the physician than to the woman or her family.[1]

This kind of "medicalized" childbirth is relatively new, a product of the twentieth century. Even though we have come to accept it as typical, the

historical record is very clear on how recent a phenomenon it is for physicians to be in control of labor and delivery and for women to bow to their expertise. Before settling in with the fathers for the rest of the book, this chapter reviews the broad trends in American childbirth and examines how and why and under what conditions such hospital-based, physician-directed, medicalized childbirth evolved. In the process, it lays out why mid-twentieth-century birthing women came to want their husbands to accompany them through labor and delivery in the hospital.

Traditional Childbirth

For most of human history, childbirth was exclusively a woman's event. When a woman went into labor, she "called her women together" and left her husband and other male family members outside. "I went to bed about 10 o'clock," wrote William Byrd of Virginia in the eighteenth century, "and left the women full of expectation with my wife."[2] Only in cases in which women were not available did men participate in labor and delivery, and only in cases in which labor did not progress normally did physicians intervene and perhaps extricate a dead fetus. A midwife orchestrated the events of labor and delivery, and women neighbors and relatives comforted and shared advice with the parturient.

Ebenezer Parkman wrote in the middle of the eighteenth century of one of the twelve times his wife was "brought to bed": "My wife very full of pain. This Morning I sent Ebenezer for Mrs. Forbush. . . . A number of Women here. Mrs. Hephzibath Maynard and her son's wife, Mrs. How, Mr. David Maynard's wife and his Brother Ebenezer's, Captain Forbush's and Mr. Richard Barns's. My son Ebenezer went out for most of them. At night I resign my Dear Spouse to the infinite Compassions, all sufficiency and sovereign pleasure of God and under God to the good Women that are with her, waiting Humbly the Event."[3]

Mary Louise Fowler wrote to her pregnant sister Nettie in 1863, when Nettie was in Europe with her husband: "I think of you in anticipation of your coming trial. I know you will have all that can be procured under the circumstances, but it would relieve me of great anxiety if you were in our best bed-room where I could nurse you as only a *mother* or a *sister*

can."[4] The ethic of a proper childbirth was, for the overwhelming majority of women in the United States, rich or poor, and over a long period of time, a home birth attended by caring, concerned women relatives and friends. One mid-nineteenth-century woman put it this way: "A woman that was expecting had to take good care that she had plenty fixed to eat for her neighbors when they got there. There was no telling how long they was in for. There wasn't no paying these friends so you had to treat them good."[5]

To this women's world husbands, brothers, or fathers could gain only temporary entrance. In one instance, a new father was invited in to see his wife and new daughter, but then, "Mrs. Warren, who was absolute in this season of female despotism, interposed, and the happy father was compelled, with reluctant steps, to quit the spot."[6]

The women's world around the home birthing bed that is revealed in letters and diaries represents the existence of a specific female group identity among women. Women could write and speak to each other about intimate details of confinement-related care; they could confide their innermost thoughts about their coming motherhood. While nineteenth-century conventions did not permit discourse about such private matters in public, among themselves, in private, women could and did speak more freely. In their private writings and around the confinement bed, women identified with each other's concerns, shared their wisdom, and united, as women, in the knowledge that they were not alone in their problems. The roles women played for one another were not just psychological support but also involved very specific duties to aid labor and delivery along, such as applying olive oil and perineal massage.[7] In the words of one observer, women could be counted on to "know what to do without telling."[8] Another wrote, "Only a woman can know what a woman has suffered or is suffering."[9]

Physician-Attended Home Childbirth

Despite the very female nature of the childbirth experience, women in eighteenth-century American cities who could afford medical aid began inviting male physicians to attend them during labor and delivery. They

did so because they thought doctors could improve on their chances of survival and comfort. They had no intention at that time to give over decision-making authority to the doctors. They wanted medical help and sought it in very specific ways. For a long time historians assumed that, when male doctors began attending normal births, women's birthing networks disappeared.[10] But more recent research has shown that women continued to help each other and to control childbirth events until birth moved to the hospital.[11]

The "medicalization" of childbirth did not occur in the eighteenth century, when physicians first attended obstetrical cases; nor did it develop in the nineteenth century as physicians became established figures in the home birthing rooms of most middle- and upper-class American women. Childbirth was not medicalized, in the sense that we use the term today to mean under physician control, until birth moved to the hospital.

In the home-birth period, physicians entered women's world around the birthing bed, and they learned how to act within a domain that was not their own. Some doctors learned it better than others as they tried to create a place for themselves in women's domestic world. One physician realized that "obstetrical practice is an intimate intrusion into family affairs."[12] Some doctors fit right in. "Dr. Marsh stalked into the room," wrote one birthing woman, "like an easy old friend. In a few minutes he was playing with Louisa [a child] and talking to me about the new baby. . . . He did what was expected of him, ate a bite of breakfast with Kate [her friend in attendance], then made himself so much at home, he put us all at ease. He took Louisa on his lap, and soon had her speaking pieces and singing."[13] Dr. Daniel Cameron, who practiced medicine in Wisconsin in the 1850s, told of one of his obstetric calls: "Wednesday, a week ago, was called on to confine Mrs. Conklin. . . . Sat up all night and talked *scandal* with some Cornish women in attendance."[14] Successful physicians were those who learned to relax and interact with the birthing woman's female attendants.

In the eighteenth century, physicians used opium and bleeding to help ease labor's discomforts, and by the end of that century they applied forceps to help along a protracted labor. In the mid-nineteenth century they added anesthetics, primarily ether and chloroform, for effective pain re-

lief. The possibility of a difficult delivery, which women fearfully anticipated, and the knowledge that physicians' remedies could provide relief and successful outcomes encouraged women to seek out practitioners whose obstetric armamentarium included drugs and instruments.[15]

Throughout the nineteenth century, the decision of whether to employ a physician remained where it had been traditionally, with birthing women and their female relatives and friends. Often the women consulted with their husbands, who paid the bill. The birthing woman, her midwife, and her assistants might have decided to call a doctor after labor had begun, and they then gave or withheld permission for each procedure suggested. Home birthing rooms usually contained the traditional female attendants right alongside the newer medical attendant, and these people all discussed and decided what procedures might be employed during the labor and delivery, the doctor adding his voice to the others. William Potts Dewees, for example, wanted in one case to take blood from a laboring woman: "I represented to the friends of the patient, the danger of her case. . . . They agreed to the trial."[16] Although male physicians had broken the gender barrier and birth was no longer exclusively a women's event, women, by making their own choices about attendants and procedures, continued to hold the power to shape events in the birthing room.

As new obstetrical techniques became available—especially forceps and anesthesia—they worked to the advantage of physicians, who held a monopoly over their use.[17] Centuries of female traditions and the domestic environment in which those traditions operated, however, continued to work to the advantage of women. Both women and physicians had an expertise about childbirth, physicians' based on textbooks and theory and women's based on experience. Some physicians welcomed the knowledge of the birthing woman and her attendants. Chicago physician Morris Fishbein admitted that when he was a medical student in the second decade of the twentieth century, he "received better instruction" from a poor Irish woman whose eighth birth he attended than he ever had in any classroom. "She was thoroughly familiar with every step of the process."[18] Others found well-informed women intimidating. One physician recalled, "A young doctor, fresh from medical college, can pass many embarrassing moments in the presence of the neighborhood midwife."[19]

As advisers in women's homes, physicians had to learn that while their words could be added to the other voices in the room, their views might or might not predominate. Sometimes considerable tension resulted from differences of opinion. An Oklahoma physician explained to his fellow doctors, for example, that he would never try to shave a patient's pubic hair (a procedure associated with the understanding of germ transmission at the end of the nineteenth century) even though he thought it would help prevent infection. "In about three seconds after the doctor has made the first rake with his safety [razor], he will find himself on his back out in the yard with the imprint of a woman's bare foot emblazoned on his manly chest, the window sash around his neck and a revolving vision of all the stars in the fermament [*sic*] presented to him. Tell him not to try to shave 'em."[20] Similarly, Dr. J. H. Guinn of Arkansas City, Kansas, wrote of the impossibility of achieving sterile conditions in urban or rural homes "in which there are five or six neighbor women, and, perhaps, the mother of the patient—all mothers of large families of children." The doctor could not, he thought, under such observation, "strip his patient and go at her with soap and scrub-brush, lather and razor."[21] Another practitioner put it bluntly: a doctor, he wrote, "has his living to make and cannot be too insistent with his patient over whom, usually, he has no control."[22] Doctors could offer advice, but they did not have the freedom of action in women's homes that they later achieved in hospitals.

The pressures some physicians felt in home birthing rooms did not abate as long as birth remained a home event. Dr. Samuel X. Radbill, who delivered babies in Philadelphia in the 1930s before limiting his practice to pediatrics, remembered the discomfort of working under the close observation of parturients' female friends and relatives. In one delivery he attended, the birthing woman's mother, who, after two days of labor, was extremely anxious for her daughter's welfare, "came rushing in in a rage, brandishing the [kitchen] knife and yelling, 'Doctor, if my daughter dies, I kill you!'" Radbill reported with great relief that shortly after that "the baby was safely delivered and everybody was as delirious with joy as they had been frantic with terror before."[23]

Under such conditions physicians had to keep a cool head and a steady

hand. Radbill was relieved when a nearby hospital opened a maternity ward, where he could deliver his patients outside their homes and away from the pressures of the woman's family. From such examples, it is clear that physicians did not have the kind of control they came to want in obstetric cases until birth moved to the hospital. Home birth was medicalized only as much as women wanted it to be.

Birth Moves to the Hospital

In the twentieth century, birthing women and the growing number of physicians who specialized in obstetrics increasingly found fault with these home-based childbirth practices. Application of the new knowledge about bacteriology and germ transmission made home deliveries, even under the best of conditions, difficult to manage. Bacteriology was only one of five forces that pushed both birthing women and their physicians to try to modernize birth by moving it to the hospital.

The first factor propelling birth into the hospital was a continuation of fears about the dangers of childbirth; in the words of nineteenth-century women, it was the "shadow of maternity," a burden women carried through their reproductive years. The burden grew from high fertility rates and the ever present possibility of death or debility that concerned women as soon as they found themselves pregnant.[24] Women worried throughout their nine months of pregnancy that they would not survive the ordeal or that they would be maimed in the process. Clara Lenroot confided in her diary when she found herself pregnant in 1891, "It occurs to me that possibly I may not live. . . . I wonder if I should die, and leave a little daughter behind me, they would name her Clara. I should like to have them." Three days later she again worried, "If I shouldn't live I wonder what they will do with the baby! I should want Mamma and Bertha [sister] to have the bringing up of it, but I should want Irvine [husband] to see it every day and love it so much, and I should want it taught to love him better than anyone else in the world."[25] Lillie M. Jackson recalled her 1905 confinement: "While carrying my baby, I was so miserable. . . . I went down to death's door to bring my son into the world, and I've never forgotten."[26]

The shadow of maternity, which repeatedly darkened women's lives, moved women to seek to improve and make safer their maternity experiences. It led women to seek medical expertise in their confinements and helped them to appreciate, especially after germ theory was understood, the promise of the new medicine. They anticipated improving their own conditions by calling in doctors, and this growing faith in medicine ultimately led women to want childbirth to move to the hospital, where seemingly cleaner and safer conditions prevailed.

A second prominent factor leading women to put increasing trust in medical science was bacteriology, the science of the study of microorganisms, many of which cause infectious diseases in humans. The beginnings of bacteriology are usually associated with the work of Hungarian physician Ignaz Semmelweis, who instituted cleansing the hands and instruments used on laboring women during the 1840s, and the French chemist Louis Pasteur and German physician Robert Koch, whose investigations from the 1860s through the end of the century led to the identification of specific microorganisms and an understanding of their role in causing infection and disease. In obstetrics, the practical application of these discoveries took the form of physicians trying to keep a clean birth environment and minimize the transmission of bacteria that could cause postpartum infection, the single most significant killer of birthing women. By the end of the nineteenth century, physicians routinely tried to use sterile techniques when attending childbearing women in their homes; because they could not always achieve the desired cleanliness, physicians increasingly argued that childbirth would be safer in the hospital, where the environment could be better controlled.

Many physicians complained in this transition period that it was hard to persuade birthing women and their attending friends of the necessity for sterile environments. While it is no doubt true that some women did not understand why such extreme precautions for "scrupulous cleanliness" had to be taken, others very quickly took up the language and promise of the new science and worked hard to help physicians and nurses in their efforts. Whatever their feelings about bacteriology and its impact on obstetric practice, women found that the new prescriptions for cleanliness were hard to follow in their own homes. Thus both physi-

cians and birthing women understood that the hospital offered the kind of environmental control that would allow for routine sterile deliveries and lessen—potentially—the danger of infection. One impact of the new medicine was to provide a compelling reason to centralize obstetrics practices within hospitals, where women's voices became weaker.

If promises and hope pulled women toward medical institutions in the early twentieth century, an equally potent force pushed them away from their traditional confinements. A third factor in the move to the hospital was the breakdown of the strong women's network that had existed through much of history. As America industrialized and urbanized, it became harder and harder for women to have at their beck and call a group of women who could offer the kinds of assistance they needed at the time of labor and delivery. The hospital thus beckoned the growing number of women who found their home births logistically hard to manage. Hallie Nelson's experiences in rural Nebraska emphasized some of the reasons women had begun to dread the ordeal of childbirth at home. Recalling when she was pregnant with her fifth child in 1936, Nelson wrote, "We had been at wit's ends to find a woman to take care of me and the baby and to help take care of the children." While she had been relatively successful in finding neighboring friends and relatives to attend her during her first four births, this time Hallie lamented, "The Clines had left the hills. . . . My sister Beulah was not available. . . . The other neighbors had children of their own to care for."[27]

The traditional woman-centered event in the home, called "social childbirth" by historians, had been predicated on women being available when parturients needed them. With the increased mobility of the population and subsequent physical isolation from families and friends, women found it more and more difficult to obtain the help they needed. Helen Whiting of Winchester, Virginia, believed that "if there are other children, the mother cannot have the peace and rest she needs [at home]."[28] Getting out of the home for confinements seemed the only way of coping with the stresses that developed when a woman was ready to deliver her baby.

The fourth factor that encouraged increased medicalization of childbirth at the turn of the century period was the use of new technology.

Throughout American childbirth history, two trends have been evident: one, women's awareness of the dangers of childbirth for their own lives and postpartum health, and two, the attempts to improve the level of safety for both mother and child through the use of new drugs and new instruments and the application of new technology. Bleeding techniques and opium derivatives were used in the colonial period to help women through labor; forceps were welcomed by the end of the eighteenth century; and in the nineteenth century anesthesia use increased to alleviate the pains of labor. Physicians modified and improved forceps innumerable times. Yet not until the twentieth century did the use of such innovations begin to work in the direction of increasing more exclusive medical authority over childbirth.

The relationship between the new technology and growing medical authority can best be seen through an examination of cases of difficult delivery—for example, cephalopelvic disproportion, in which a woman's pelvis is too small or misshapen to allow the passage of the fetal head. In such cases, physicians intervened, using forceps and other implements to attempt a live delivery, but often could not succeed. When forceps did not work—a situation more common in the past because of the prevalence of rickets, a vitamin D deficiency resulting in abnormal or weak bone growth—physicians tried to perform a craniotomy. By puncturing the fetal cranium and removing its contents, physicians reduced head size, facilitating delivery and saving the mother's life. By the end of the nineteenth century, a series of improvements on the cesarean section and new surgical procedures like the symphysiotomy or pubiotomy—procedures in which the pelvic opening was increased through the surgical separation of the pubic bones—offered a real chance for both mother and child to survive problematic deliveries. It was this potential that allowed physicians to transform their participation in such cases into a new, more active and authority-wielding role in the birthing room. Prefacing his argument with the remark "It would seem hardly necessary for me to emphasize the fact that the obstetrician alone must be the judge of what is to be done," Dr. George McKelway explained why such cases demanded medical control:

> The preference of the ignorant or prejudiced parents or of the friends, the disposition on their part to save the life of one being from any added risk at the expense of the other being, or any sentimental considerations on their part of any nature, for or against either life at the expense of the other, should not weigh at all in the obstetrician's mind or decide his course. The responsibility is his for his conduct in the case, and he cannot answer to his own conscience if he does that which he believes to be inadvisable or wrong, simply because someone else prefers that he should.[29]

Obstetricians, for the first time in history, tried to take command on their own terms rather than respond to the problems as others defined them. It was in such high-risk cases requiring surgical interventions that physicians found their first true voice in the birthing room; they later learned to use the new authority in all birthing rooms, especially as childbirth moved out of women's homes and into medical institutions.

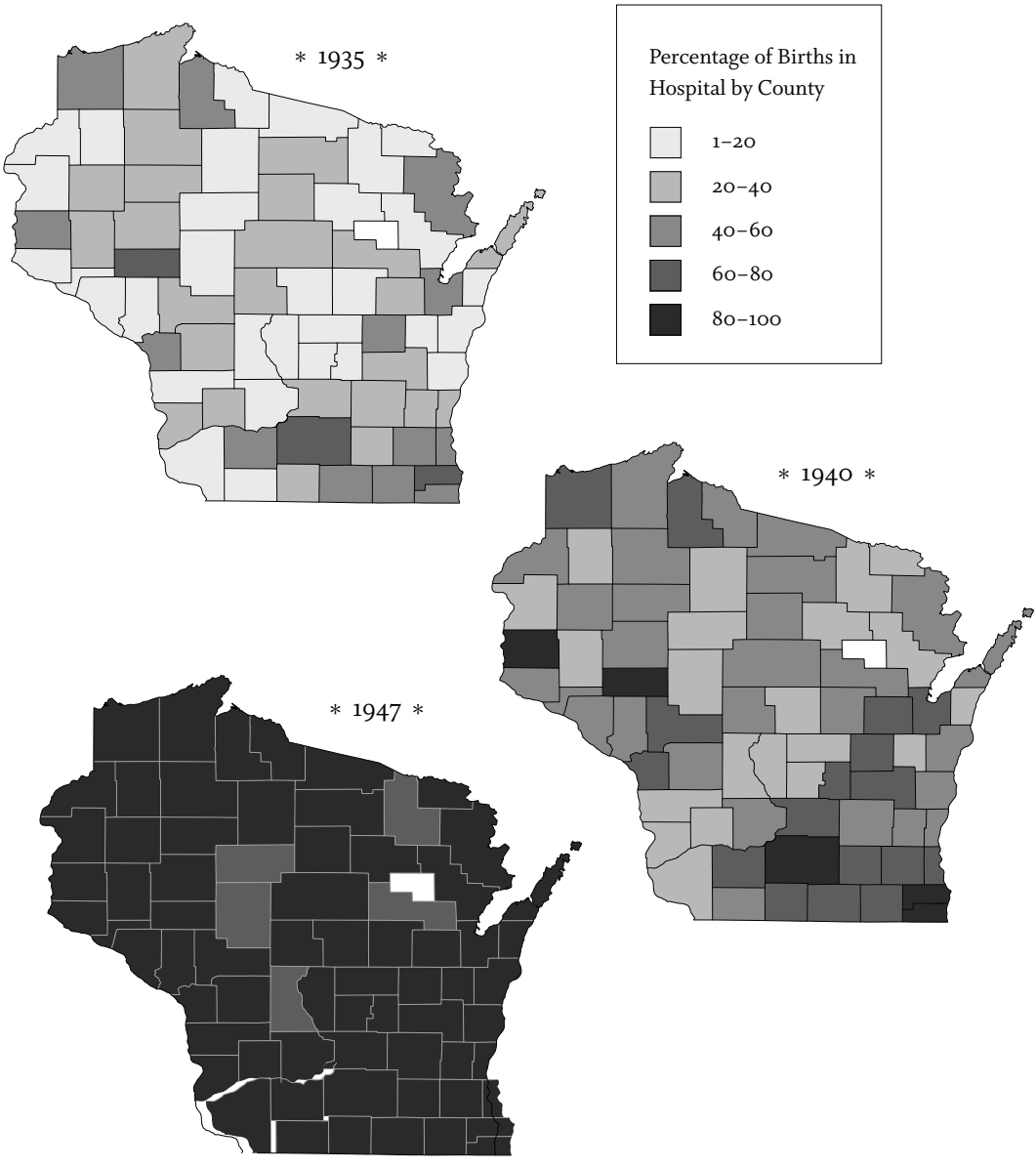
The fifth factor that led to increased medicalization in the early twentieth century was the hospital itself, the institution and what it came to stand for, and the public monies that became available to help some women pay for their hospital stays. The hospital attracted physicians who were trying to maintain a sterile environment, and it attracted those women who supported their efforts. The hospital became more attractive to women as their homes seemed less able to accommodate childbirth disruptions. The "hospital is equipped with every modern device for the safe delivery of babies," wrote one mother; "nursing and medical attention is available at any hour of the day or night. How much simpler—and more restful—to be in the hospital where babies are an accepted business."[30] Another woman found that her stay in the hospital "was like a lovely vacation."[31] Most important, the hospital came to symbolize what the new medicine had to offer. Whether the new medicine yet delivered on its promises (which, in the case of obstetrics, it arguably did not), women traded on the promises and hoped that the miracles of modern medicine would help them through a dangerous time.

Perhaps even more significant was the federal government's new will-

ingness and ability to pay for medically aided maternity care. Arguing that childbirth was women's battleground in the same way as the Great War had been men's, advocates of the proposed Sheppard-Towner Act argued in 1921, "During the nineteen months we were at war, for every soldier who died as a result of wounds, one mother in the United States went down into the valley of the shadow and did not return."[32] The argument was powerful. Under the act, which was in effect from 1921 until 1929, federal funds became available for maternal and child health, and some of these were used to allow women who otherwise could not afford hospital care to go into the institutions for their deliveries. More wide ranging, the 1935 Social Security Act provided federal money for maternal and child health projects, which served to increase the medical attention received by pregnant and childbearing women.

The confluence of these five factors in the early twentieth century propelled childbirth into the hospital. For millennia women had controlled childbirth practices. But in a relatively short time in the twentieth century, women gave up what they had had for something even better: safety and security to survive the dangerous experience of childbirth. Women relinquished their own collective decision making, the traditional ways of helping one another deliver their babies, and participated actively in transferring their own authority to the medical experts, to those they hoped would save them from the dangers that had plagued childbirth throughout history.

Birth moved into the hospital very unevenly in the early twentieth century. Although half of all American women delivered in a hospital by 1938, the numbers varied widely by race and geographic area. In rural areas during the 1930s it was still common practice to deliver babies at home. In the South, especially among black women, hospital childbirth was rare, and almost all deliveries took place under the supervision of African American midwives in women's homes.[33] In the farm families living around Prescott, Wisconsin, the father would arrange for a "medical doctor and a neighborhood lady to be present. . . . Dad's participation was to call the doctor, ensure he arrived, call in a neighborhood lady, and stay out of the way."[34] Hospital births were more common in the cities because of proximity: by 1940, 84 percent of urban births took place in hos-



Maps showing changing percentages of births in the hospital in Wisconsin counties, 1935, 1940, 1947. The transition from home delivery to giving birth in the hospital, first in urban areas and then more generally, occurred relatively quickly over this twelve-year period. (There are no data for one county.) Thanks to Kendra Smith-Howard, who constructed the maps from statistics in the state board of health records in the Wisconsin Historical Society Archives, Madison. Maps are now in the collection of the Department of Medical History and Bioethics, University of Wisconsin, Madison.

pitals; in the same year only 25 percent of rural women had their babies in hospitals. Sixty percent of white mothers delivered in hospitals in the same year, but only 25 percent of black women. For black rural women, the numbers were even smaller: a mere 3 percent of black rural women delivered in a hospital.[35]

This transition occurred in Wisconsin in the twelve years from 1935 to 1947. At the beginning of the period, women living in or near urban Milwaukee and Madison and other population centers used hospitals heavily, but others in the state did not have such access. The changes came quickly. By 1947, the large majority of women in all parts of the state went to the hospital to have their babies.

Birth in the Hospital

The bargain that women had counted on when they made the move into the hospital did not occur quite as they had anticipated. The hospitals in the 1930s and 1940s were not as safe as they had been promised to be; maternal mortality did not drop as a result of the move to the hospital. It was not until the development and use of antibiotic drugs following the Second World War that postpartum infection rates fell significantly. In addition, women found that they had given up more than they had expected by moving out of the home for childbirth. "The cruelest part of [hospital] childbirth is being alone among strangers," wrote one woman.[36] Women soon realized that the physical move from their own homes to the physicians' institutions shifted the balance of power. Birth was no longer part of the woman's domain, as it had been throughout history. It became, instead, a medical affair run by medical professionals. Women were no longer the main actors; instead, physicians acted upon women's bodies. Women who entered the birthing rooms of medicine were captured by the routine and by the expertise surrounding them, but they missed the companionship that had been theirs at home, and they often felt alone and alienated by the sterile and impersonal hospital environment. Perhaps they could not have predicted ahead of time that the domestic comforts would not be replicated in the hospital, but they missed them when they were gone. Upon entering the hospital, many women found that hos-

pital routine put them on an assembly line and took away their individuality. The experience helps us to understand why so many women wanted their husbands to stay with them through hospital labor and delivery.

Not all mothers-to-be, however, viewed modern hospital childbirth as an upsetting experience. Many women appreciated the streamlined—medicalized—twentieth-century hospital birth, one that took place under the observation and control of specialist nurses and doctors. Some hospitals were so enticing that author Betty MacDonald, giving birth in the 1920s, recalled, "The prospect of two weeks in that heavenly place tempted me to stay pregnant all the rest of my life."[37] Mothers-to-be learned that, to some extent, they could plan when they would have their babies because doctors could induce labor, and doctors could predict the course of labor because they controlled it with drugs and instruments. "The old way [of having a baby] was no fun," wrote one father about the 1916 birth of his first daughter. Twenty-two years later, in 1938, his second wife gave birth to another daughter, who "was born the new way—the easy, painless, streamlined way." His second wife reflected in the general-interest periodical *Reader's Digest*, "It's a good hour's ride by auto from our house in the country to the hospital in New York and for weeks I had nightmares of a mad dash in the dark over a sleety road, and all the stories I'd ever read of babies being born in taxicabs filled me with terror. So it was with vast relief I heard the doctor say: 'Come in to the hospital next Tuesday night and you'll have your baby Wednesday.' Just like that. It was like ordering something from a store." She and her husband took in a matinee and dinner before she checked into the hospital. The next morning the new medications Pituitrin induced her labor, Nembutal and scopolamine deadened her perceptions and memory of it, and the doctor delivered her baby. "Why, I wouldn't mind having another baby next week," she said, "if that's all there is to it."[38] Maternity wards and maternity hospitals promised women the ultimate in modern and safe hospitalized experiences.[39]

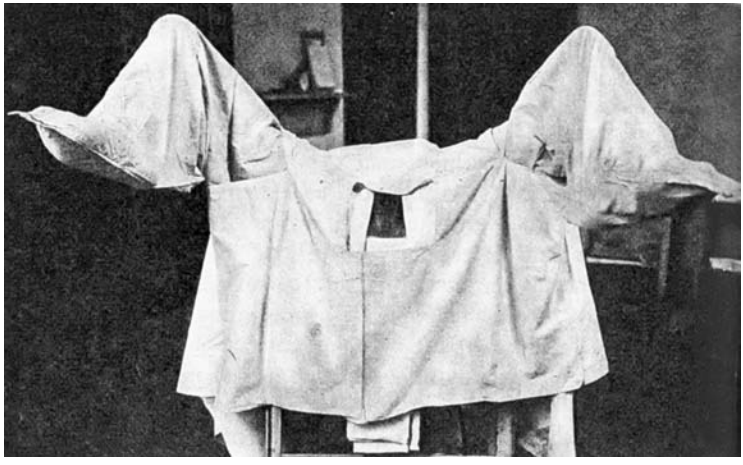
As hospitals attempted to carry out these promises, childbirth in the mid-twentieth-century lost some of the diversity of experience evident in the home deliveries of earlier years; it seemed to become homogenized as hospital policy and medical protocols determined the succession of

events.[40] In typical hospital deliveries in the 1930s and 1940s, women left their family and friends at the door of the labor room and faced their birthings alone, as this account described:

> Arriving [at the hospital], she is immediately given the benefit of one of the modern analgesics or pain-killers. Soon she is in a dreamy, half-conscious state at the height of a pain, sound asleep between spasms. . . . She knows nothing about being taken to a spotlessly clean delivery room, placed on a sterile table, draped with sterile sheets; neither does she see her attendants, the doctor and nurses, garbed for her protection in sterile white gowns and gloves; nor the shiny boiled instruments and antiseptic solutions. She does not hear the cry of her baby when first he feels the chill of this cold world, or see the care with which the doctor repairs such lacerations as may have occurred. She is, as most of us want to be when severe pain has us in its grasp—asleep. Finally she awakes in smiles, a mother with no recollection of having become one.[41]

The use of analgesics and anesthetics to reduce or eliminate a laboring woman's discomfort and the use of forceps to deliver the baby became routine in hospitalized childbirth during the 1930s and 1940s, as did putting women in the lithotomy position—on her back with her legs in stirrups. The drugs and the position reduced women's involvement in and awareness of their births. A nurse who graduated from nursing school in 1946 and worked in obstetrics in Madison, Wisconsin, remembered, "The trend in those days was not for patients to know what was going on and of course, the fathers were . . . no where near. . . . [The women were] real calm. . . . The majority of women had 100 [milligrams] of Demerol and 100 [micrograms] of scope [scopolamine] and then probably a repeat on it. And then, of course, they also had general anesthetic."[42] One historian of the subject concluded: "Indeed, by the end of the 1940s, virtually every physician who wrote on the subject of pain relief in childbirth believed that it was the moral and professional obligation of all physicians to relieve pain."[43] In the 1940s physicians applied forceps in 70 percent of births they attended.[44]

During this period, then, many women labored woozily in a semicon-



Birthing woman in lithotomy position and fully draped for a forceps delivery, 1920s. The woman received general anesthesia. Reprinted with permission of Scribner, an imprint of Simon & Schuster Adult Publishing Group, from *Obstetrical Nursing* by Carolyn Conant Van Blarcom. © 1922 Macmillan Publishing Company, copyright renewed.

scious or unconscious state. Separated from their family supports and familiar surroundings and confined instead to stark private, semiprivate, or ward settings, women in labor were virtually alone, with nurses checking in on them only as frequently as their schedules and other duties allowed. They were willing to give up their traditional decision making and bodily control, however, because they believed that going to the hospital provided protection to them and their babies; the new benefits seemed more important, and they had fewer of the fears of death and debility that had haunted generations of their foremothers.

Yet the routine use of analgesics and anesthetics as well as instruments—especially forceps—and surgical procedures in these years led physicians to a reconsideration of their safety. As early as the 1930s, the New York Academy of Medicine questioned the safety of the new procedures and noted that maternal mortality remained "unnecessarily high" as birth moved into the hospital. The physicians who wrote the 1933 report thought that birth in the hospital contributed to maternal risk with a "high incidence of operative interference during labor . . . undertaken when there was no indication or a plain contra-indication." They con-

cluded, "Clearly a reduction of the mortality rate can be achieved through a reduction in operative interference."[45] In 1926, drawing on his long experience as an obstetrician in Chicago, Joseph B. DeLee attributed the continuing high maternal death rate to infection, which did not decrease as it should have as birth moved into the hospital: "The maternity ward in the general hospital of today is a dangerous place for a woman to have a baby." In 1933 DeLee wrote, "The increasing preference of the hospital as a place of delivery, one of the most marked changes that has taken place during the last few years and is growing, seems not only not to have bettered the results but seems actually to have made them worse[,] . . . increasing maternal mortality and morbidity."[46] Despite these worries, medical interventions continued apace in American hospitals.

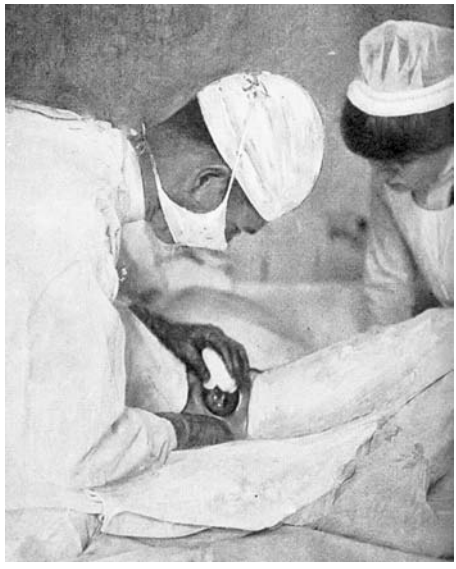
Women knew little about the debates within medicine about hospital safety. But many of the women who went into hospitals did know—even if they did not associate the loss with the traditional domestic supports of home and family—that they did not like their lonely hospital experience. Although, as discussed earlier, some women appreciated the hospital and did not voice any disappointment with it, many others complained about the bustle of starched skirts, the thermometer poked in their mouth at odd hours, and the whispers of strange people speaking among themselves. One woman remembered her 1935 confinement as a "nightmare of impersonality," during which she felt "helpless" and "like a pawn in a strange game." Others remembered being "all alone," "abandoned," and "lonely . . . knowing no one." Hospitals seemed unable to provide a supportive atmosphere for women in labor; perhaps more significant, hospital staffs did not notice that such an environment was needed or desired by their maternity patients. Women felt too intimidated by institutionalized medicine to make their feelings known; doctors and nurses did not show a personal empathy for women's ordeals; and routines and schedules did not encourage providing the comforts of home. One woman found her hospital experience so traumatic that, she wrote, "months later I would scream out loud and wake up remembering that lonely labor room and just feeling no one cared what happened to me, no one kind reassuring word was spoken by nurse or doctor. I was treated as if I was an inanimate object." For many American women in the 1930s and later,

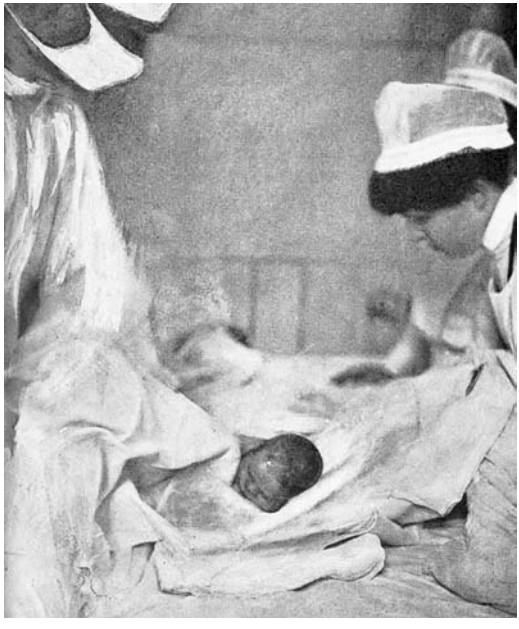
giving birth in the hospital was no blessing at all. It was still dangerous, perhaps more dangerous than being at home because of the potential for cross infection, and it was psychologically alienating.[47]

The women who gave up their home deliveries and went to the hospital to give birth faced the psychological costs of leaving their own domestic world and entering a strange environment controlled by others. When they got to the hospital, said goodbye to their husbands and family, and went to the labor rooms alone, many women did not feel comforted by the efficiency of the hospital. A woman from Elkhart, Indiana, wrote to the *Ladies' Home Journal*, which exposed some of the impersonal conditions in the 1950s in two widely read articles, "So many women, especially first mothers, who are frightened to start out with, receive such brutal inconsiderate treatment that the whole thing is a horrible nightmare. They give you drugs, whether you want them or not, strap you down like an animal." A woman from Columbus, Ohio, concurred that a new mother was "foiled in every attempt to follow her own wishes."[48]

Not only did physicians continue routinely to use analgesics and anesthetics and forceps when they attended women in hospital deliveries, but hospital routines during the 1950s and 1960s often included interventions such as labor induction and augmentation and episiotomy; in the 1970s electronic fetal monitoring joined the list. Robbie Davis-Floyd, a cultural anthropologist who studied hospital birth patterns, describes how women, in assembly-line lockstep, moved through the regimented model of this period: "The vast majority of women giving birth in American hospitals are dressed in a hospital gown, placed in a hospital bed, hooked up to an electronic fetal monitor, and ordered not to eat; they have an intravenous needle inserted into their arm, are anesthetized to some degree, receive the synthetic hormone Pitocin if their labor is not progressing rapidly and regularly, and have an episiotomy."[49] There was little room for individual variation in the regimen.

Inducing or accelerating labor with Pitocin, the synthetic version of oxytocin, a natural hormone released during labor that helps the cervix to dilate, expanded significantly in this midcentury period. With this drug, physicians could schedule deliveries by inducing labor, and, if labor had already begun, they could increase the intensity of contractions that were





Three images of delivery: the head crowning, the physician holding back the head to prevent tearing, and the birth of the head and external rotation. Reprinted with permission of Scribner, an imprint of Simon & Schuster Adult Publishing Group, from *Obstetrical Nursing* 2/e by Carolyn Conant Van Blarcom. © 1928 Macmillan Publishing Company, copyright renewed.

not productive. Even though Pitocin-induced contractions are usually more painful than natural ones, women often requested the medication. Induction rates were much higher for private patients, from 10 to 20 percent; ward services reported much lower rates during the midcentury period.[50] The process took away some of the anxiety of awaiting labor and allowed women and physicians to plan ahead.

Many times physicians planned inductions, urging the women to agree. One physician described his methods: "I never insist on induction, but explain the procedure and if there are any objections the matter is dropped. However, acceptance of and belief in induction is growing, and mothers plan on that method of delivery."[51] During these midcentury years, women mostly did not question medical advice. "I think most of us never thought to question the doctor," one woman wrote. "We just did what the doctors and nurses told us to." She wrote about her 1954 delivery, which was induced: the physician "told her to come to hospital next morning and he would induce her." He gave no reason, and she asked for none.[52] As a woman said about her second and third labors, which were induced, "I really trusted my doctor. I didn't really give it [induction] any thought. I figured he knew what he was doing and I figured he wouldn't do it if it wasn't safe."[53]

Carolyn Splett, an obstetrical nurse who began her career in the 1960s in Daniel Freeman Hospital in Los Angeles, told how some of the physicians there decided on inductions: "The way they were done, was usually it made it possible for the OB-GYN to have an 8:00 to 5:00 practice, and a lot of those doctors had a reputation as this was the kind of practice they wanted to have and they scheduled their inductions for Thursday or Friday mornings, so they weren't going to be bothered on the weekend. . . . So it wasn't unusual at all to have a whole slew of inductions on Thursdays and Fridays."[54]

Once labor was progressing, physicians could monitor the fetal heart rate and health with the use of the electronic fetal monitor, which was either attached to the fetal scalp or fastened with a belt around the mother's abdomen. Rates of use soared. From 2 percent of births at Columbia University's Sloane Hospital in 1970, continuous fetal monitoring rose to 85 percent in just five years.[55] By 1980, according to historian

Margarete Sandelowski, 70 percent of all American hospital births included the use of fetal monitors. Birth attendants, physicians and nurses, found the monitor a more reassuring instrument than the stethoscope because it was more precise and continuous.[56] But birthing women found their movements restricted once the monitor was applied, and they could no longer get out of bed to walk around or use the bathroom.[57]

Despite the relatively rapid adoption of electronic monitors, Sandelowski found that some hospitals responded to the new technology slowly and initially used them only on women having difficult labors. Sandelowski demonstrated a wide variation in use: in some rural hospitals, there were no monitors at all during the 1970s, and some physicians wouldn't tolerate their use. Yet during that decade, nurses came to prefer the instruments because they made it easier to trace the progress of labor and to know when to call the physician. The machines, in fact, helped to put the nurses at the center of diagnosing, since they were the ones to monitor the monitors.[58] Some men who were with their wives during labor came to like the machine, too, seeing it as providing an "objective window" into the labor process that allowed them to experience it "without mediation by mothers or manuals."[59] Physicians came to appreciate the monitors for their help in possible lawsuits, since the tracings throughout labor could be used in court to justify their interventions.[60]

Episiotomy, the precise surgical cutting of perineal tissue to allow the baby's head to emerge without ragged tearing, was developed early in the twentieth century and became a common routine procedure in the 1950s.[61] According to Barbara Bridgman Perkins, some individual hospitals reported episiotomy rates as high as 85 percent at midcentury, and in the following decades national rates generally exceeded 70 percent.[62] Physicians became convinced that the surgery would prevent excess stretching and was beneficial despite many women's protestations that the incision, made with scissors and extending deep into the musculature, was painful and interfered with postchildbirth sexual activity.[63]

Some women felt physicians did not sufficiently consider their wishes when deciding on an episiotomy. Jayne F. related that her doctor told her, "So just plan on having one. And that was the end of the subject. I mean, he is the one who has delivered babies for 20 years. Who am I to say, 'No,

you cannot give me an episiotomy.' All he'll have to do is march out all his evidence and horror stories of women who tore horribly. . . . Well, you have to have some faith in this man. . . . If I would have argued with him up and down, he probably still would have done it the way he did." She described the scene in the delivery room:

> The thing that struck me, even in my disorientation and pain, that it was a room full of people. There were people everywhere. I don't know if they belonged there or were just passing through. But they were all in green scrubs, and were all wearing masks and hood. So I could sort of make out who was male and female, but other than that it was a room full of strangers. There were probably 5 or 6 people there including the doctor. They put me on the table. . . . He did a huge episiotomy. . . . While he was sewing it up, he said to C. [husband] kind of jokingly, he said, "Well I put an extra stitch in for you." Meaning that he sewed me up tighter than I probably was before. And so it was [for] C's benefit.[64]

Such stories fueled women's resistance to the routine adoption of episiotomies.

Much of the habitual use of these interventions can be traced to ideas about normal childbirth introduced by obstetrician Emanuel Friedman in the 1950s.[65] Friedman mapped out average times for the various stages of labor, identified "ideal" labor, and defined as normal those labors that fell within the averaged limits on each curve. Depending on how a particular woman's labor developed, physicians could intervene to control its course and put it more in line with expectations. Determining interventions based on such averages added to the idea that a woman's body was a machine that could be regulated. Davis-Floyd found that many American women wanted just this kind of birth (which she calls technocratic birth), one they would not suffer through or perhaps not even remember and one that used medical techniques to help them take home a healthy baby.[66]

Hospital architecture and geography accommodated the increasingly technological births. The standardized stages of birth needed specific spaces. Thus, when a woman first entered the hospital, she went to a

"prep" room, where nurses provided enemas and shaved the perineal area. Then she would go to a labor room, where her contractions started, accelerated, and got stronger. Delivery, as the baby pushed its way into the world, needed to take place in a different room in which the most technologically sophisticated equipment could be called upon to help. Postpartum recovery necessitated yet another room. Hospitals were advised to help the new obstetrics by providing "proper sequential arrangement" of maternity units. The American Hospital Association called for a "maternity center designed for 'assembly-line' efficiency" and sought the "continuous operational flow" of patients.[67] Architectural historian Roslyn Lindheim concluded that postwar hospitals tried to rationalize obstetrical suites in much the same way that wartime munitions factories had done: "Approached like any other industrial process, hospital maternity procedures were designed to keep the flow of patients moving—to avoid crowding and possible back-up." Lindheim quoted a 1964 hospital design text that advised the "conveyor belt concept . . . [that] emphasizes the repeated transference of a mother (as in motor-car assembly) from place and to place," rendering birth, in Lindheim's words, "increasingly mechanized and dehumanizing."[68]

Some women had complained individually and privately about their hospital deliveries during the 1930s and 1940s, but there was a much greater public outpouring of such unhappy sentiments in the 1950s as these interventions and practices became more commonplace. The medical institutionalization of birth took away parts of the birth experience that had previously been under women's control, and it left women vulnerable and alone. The move to the hospital, which turned birth into a physician-directed medical and surgical event, although appreciated by some women, encouraged many others to search for ways to improve the situation.

Birthing women frequently blamed obstetric nurses for their dissatisfaction with hospitalized labor and delivery. The *Ladies' Home Journal* revealed some of the fault lines in its 1958 exposé. One woman wrote about her experiences in a suburban hospital outside Chicago: "I wonder if the people who ran that place were actually human. My lips parched and cracked, but the nurses refused to even moisten them with a damp

cloth. I was left alone all night in a labor room. I felt exactly like a trapped animal. . . . Never have I needed someone, anyone, as desperately as I did that night." Another woman wrote, "I remember screaming, 'help me, help me!' to a nurse who was sitting at a nearby desk. She ignored me." Another woman noted, "I have listened to nurses laughing at other new mothers who were crying out in pain, I have heard other mothers being slapped and threatened with dead babies and misfits. I heard these things while I waited for the births of my second and third babies. What happens to the women who are threatened this way and then do deliver a misfit or a stillborn? Do they spend the rest of their lives blaming themselves? Do the words of these sadistic nurses . . . forever ring in their ears?"[69]

Some registered nurses added their voices to the chorus of complaint in the popular women's magazine. One related, "I have seen nurses . . . become impatient (or worse) with a patient and express their feelings, often within her hearing. 'She got herself in this fix and now is a poor time to change her mind.'" Another nurse admitted, "I have seen careless and callous treatment of obstetrical patients, along with indifference and discourtesy. . . . I have seen nurses be careless in screening patients from public view during procedures requiring their bodies to be exposed, to the outrage of the patients' feelings of modesty. I have heard such unthinking remarks as 'You had your fun, now you can suffer' made by a nurse to a mother in great distress."

Certainly not all nurses were to blame for women's loneliness in hospital labor rooms, and certainly not all women felt this alienated from their hospital births. Many were happy to give up the bother of needing to make arrangements and decisions that home birth represented and instead surrender to the new, more passive hospital routines. They wanted to go home with healthy babies without having the stress of concerning themselves with how the event itself took place. As one woman declared, "Actually I didn't even want my husband around. . . . It was just something that I wanted to do, get it over with, and that's fine."[70]

But most of the women who articulated their feelings in this mid-twentieth-century period instead voiced frustration, loneliness, and helplessness, and they wished things could change. Many of the women who left their husbands to wait in the maternity ward waiting rooms and went

by themselves up to the labor rooms described their experiences in ways that made it clear how alone they felt. Katherine Egan, who delivered at Boston Lying-In Hospital, related that decisions "were pretty much taken out of my hands": "The birth of a baby should be a happy experience, not a nightmare of impersonality. . . . I was given an enema (very unpleasant), shaved with a dull, rusty razor blade (very unpleasant), and put to bed in a darkened labor room with six or eight moaning, groaning screaming women (very unpleasant). . . . Nurses were only in the room part of the time. We were not allowed to walk around or even get out of bed."[71] Another woman described how she felt when her husband was directed to the fathers' room to wait out her labor and delivery in 1951: "'We'll keep you posted on her progress,' the nurse promised him and she pointed out the 'Father's Room.' But that was no comfort to me. I wanted Jim! I wanted to cry on his shoulder, to squeeze his hand, just to feel him near; but hospital routine and rules must come first so Jim went."[72] Another woman described her fifteen-hour 1952 labor at Manhattan General Hospital in New York City: "I had no preparation, was irrational, screamed and felt very lonely. My husband could not see me in labor."[73]

To ease their concerns, the women begged: "Let us have our husbands with us."[74] One woman, who understood from her own experience how husbands could help, wrote, "Only from personal experience can you comprehend the loneliness of lying 17 hours alone."[75] In this controlled hospital environment in which many birthing women felt alienated from the childbirth experience and miserably alone during labor and delivery, the women's husbands, people they knew and trusted, had a potentially important role to play. But in this period the men sat, also alone, a few rooms away, in maternity waiting rooms.

Women had not always wanted their male partners to be with them during labor and delivery. Traditionally, in home births, they had chosen other women—family members and friends who had been through the birth experience themselves and knew what to expect—to be with them during labor and delivery. Now, though, in the lonely and strange mid-twentieth-century hospital, birthing women called out for their husbands rather than their women friends. This change is in part a reflection of the trend toward emotionally closer marriages in which men and women

shared intimacies that they had not earlier shared. Although historians writing about men and fatherhood during the middle of the twentieth century emphasize the men's preoccupation with their work, especially following the Great Depression, and their concerns about the Cold War and the hydrogen bomb, they also recognize men's growing interest in family life.[76] Men's preoccupations with their families went well beyond worrying about financial security; married men's growing desire to become involved in their wives' pregnancy, labor, and delivery demonstrates the widening scope of their domestic interests. Not all men wanted to be included in events such as birth, but increasing numbers found their physical separation from their wives during labor and delivery in the hospital frustrating and unsatisfactory.