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Risky Business: Framing Childbirth in Hospital Settings

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"Risky Business" considers hospital childbirth and the production of the concept of risk in obstetrics. Risk is a defining concept of medicalized childbirth. Approaching obstetrical risk with a goal of challenging its hold on practices demonstrates how risk itself is produced and maintained in particular institutional contexts. The goal here is to imagine new ways of understanding and assessing obstetrical risk, as part of an overall strategy of challenging technocratic approaches to childbirth and mothering. Surveying feminist approaches to childbirth, the essay discusses how the mother's health profile affects both medical education and the construction of childbirth as "risky business."

KEY WORDS: feminist; childbirth; risk; fetus; technology; mothers.

INTRODUCTION

Feminist approaches to medicalized childbirth practices generally critique the shift toward the "active management" of birth that accelerated through the 20th century, while at the same time acknowledging women's complicity with the changing terms of obstetrical care.[2] If the story is somewhat more complex than the "childbirth was better when women were in control" version that is popular amongst my women's studies undergraduates, many feminist scholars nevertheless convey a wariness of medical management and the technological prowess that has encouraged, in this view, the United States' upward creep in cesarean rates and other interventionary birthing techniques. As an example, Robbie Davis-Floyd argues that the American way of birth (drugged up, on a time-clock, lying down)

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[2]See Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750–1950* (New York: Oxford University Press, 1986).

initiates women into the core technological values of American culture; these practices also encourage the belief that babies are the result of doctors' exertions rather than the product of women's bodies.[3]

One core feminist belief informing this critique is that pregnancy is a normal physiological process, not an illness. Clearly, such a view has significant political ramifications, a primary one being that pregnancy is not a disease and thus pregnant women should not be treated as patients who are sick. It is important for feminist scholars to continue to underline this point, since demonstrating the normality of the everyday female body (which involves its reproductive capacities) remains a political project in a culture that tends toward the pathologization of all sorts of ordinary biosocial practices like eating and sleeping. This is the view that I took into both of my pregnancies, and it is a view that I carry into my courses on feminist theories of the body. Yet it is also a view that has difficulty conceptualizing the pregnancy experience of women who are, indeed, sick, and whose pregnancies are marked by illness, debilitation and the possibility of death for either themselves or the fetuses they carry.

Some feminist scholars have raised this latter issue, especially concerning the role of various reproductive technologies in helping women through difficult pregnancies. Judith Walzer Leavitt argues that American women worked with doctors to secure hospitalization for childbirth as a safe alternative to home confinements but then experienced a diminution of their control over childbirth in the institutionalized setting.[4] Rosalind Petchesky has discussed how ultrasound images can empower women who have experienced previous pregnancy loss or difficulty.[5] Currently, women often embrace the various technologies offered them throughout their pregnancies—most American women seem to seek the very kinds of technological management that many feminist scholars deride as misogynist and medically unnecessary.[6] It is easy to produce an analysis of the "American way of birth" (to use Jessica Mitford's phrase)[7] that demonizes the choices most women make; Helena Michie and Naomi Cahn demonstrate that the rhetoric of the natural childbirth movement involves an equally problematic and constraining representation of "proper" birth that portrays the cesarean section (surgical birth) as always a failed birth experience for any woman.[8]

[3]Robbie Davis-Floyd, "The Role of Obstetrical Rituals in the Resolution of Cultural Anomaly," *Social Science and Medicine* 31 (1990): 175–189, and *Birth as an American Rite of Passage* (Berkeley, CA: University of California Press, 1994).

[4]Leavitt, *Brought to Bed*, 5; see also 171–195.

[5]Rosalind Petchesky, "Fetal Images: The Power of Visual Culture in the Politics of Reproduction," *Feminist Studie*s, 13 (1987): 263–292; reprinted in *The Gender Sexuality Reader*, ed. Roger N. Lancaster and Micaela di Leonardo (New York: Routledge, 1997), 134–150.

[6]Robbie Davis-Floyd, "The Technocratic Body: American Childbirth as Cultural Expression," *Social Science and Medicine* 38 (1994): 1125–1140.

[7]Jessica Mitford, *The American Way of Birth* (New York: Penguin—Dutton, 1992).

[8]Helena Michie and Naomi Cahn, *Confinements: Fertility and Infertility in Contemporary Culture* (New Brunswick, NJ: Rutgers University Press, 1997), 45–67.

As a cultural critic of medical practice, I investigate the expanding domains of medicine's authority to realms of social life and personal practice not always under its purview historically. As a feminist scholar, I'm interested in the social construction of gendered embodiment and the experience of women in the health care system. Having just completed a book about breastfeeding in American culture, I have been thinking through the ways that maternal practices are framed medically and enacted by mothers in social spaces. As a biological and social mother, I am interested in how culture constructs and maintains the experiences of pregnancy, childbirth and lactation as specifically *feminine* experiences that constitute ideal female subjects. Together, these interests—and the scholarship and experiences they imply—dominated my understanding of childbirth and infant care at Hershey during the 2002 Summer Institute. But the experiences at Hershey also deepened my understanding of common contemporary practices of childbirth and maternity in the United States. This paper recounts and analyzes this new understanding in the context of feminist approaches to U.S. birthing practices and considers how "risk" is framed in obstetrical settings.

Why risk? Risk as a concept frames medical childbirth protocols, beliefs and actual practices; it also increasingly influences American culture and social behaviors in general.[9] Childbirth has always been a "risky business," and American women prior to declines in infant and maternal mortality rates in the 20th century feared pregnancy for this reason.[10] The medicalization of pregnancy and childbirth has made a medical understanding of the risks of childbirth the standard approach, one shared by women as well as physicians.[11] Elizabeth Cartwright and Jan Thomas point out that the medicalization of childbirth was itself the shift transforming *danger* ("a fatalistic outlook on birth") to *risk* (which "implies an activist stance . . . accompanied by medical technology, monitoring, and oftentimes intervention").[12] Feminist scholars like Judith Walzer Leavitt, Robbie Davis-Floyd, Jessica Mitford, Charlotte Borst and Barbara Katz Rothman, among others, have been trying to understand this transformation and its impact on women's experiences and social power as mothers.[13]

[9]Because of the increasing social influence of risk as a concept, the parameters of any investigation of risk and obstetrical practice are quite large. This essay represents an initial conceptualization of how to think through the construction of risk in obstetrics and does not thoroughly address the social pressures on physicians to overcome all of the potential difficulties of childbirth to produce perfect babies. My starting point is that risk is a concept produced through specific practices; in obstetrics, its meanings are linked to social expectations *and* the technologies that often represent, and incite, those expectations.

[10]See Leavitt, *Brought to Bed*.

[11]Davis-Floyd, *Birth as an American Rite of Passage*, 177–184.

[12]Elizabeth Cartwright and Jan Thomas, "Constructing Risk: Maternity Care, Law, and Malpractice," in *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, ed. Raymond Devries, et al. (New York: Routledge, 2001), 218.

[13]Leavitt, *Brought to Bed*; Robbie Davis-Floyd, "The Role of Obstetrical Rituals in the Resolution of Cultural Anomaly," *Birth as an American Rite of Passage*, and "The Technocratic Body"; Mitford, *American Way*; Charlotte Borst, *Catching Babies: The Professionalization of Childbirth, 1870–1920*

An understanding of how physicians and women conceptualize the risks of childbirth is necessary for challenging the domination of contemporary birthing practices by technological protocols (or what Robbie Davis-Floyd calls a "technocratic mythology").[14] The opposing perceptions of pregnancy as illness or as normal life event have within them differing assessments and understandings of the risks posed by pregnancy—to the pregnant woman, to the social body—but women who are themselves sick, or who carry fetuses who are sick, face a far different calculus of risk than most. The framing of risk in the obstetrical encounter is crucially important to medical and popular understandings of birth itself; in this, the physician's educational context is extremely significant. So too is the context of the feminist critic, whose approach to birth practices and the social perceptions of pregnancy are invested with her own choices and experiences. If I found the notion of "risk" to constrain unduly the choices I could make in a hospital birth (because the notion of risk was used as a threat to compel compliance with medicalized norms), the current management of such risks makes maternity possible for women who might have died trying only one hundred years ago. That this latter claim is offered to many women as an excuse for interventionist care does not render it meaningless in specific instances. Rethinking obstetrical risk in terms of how mothers are themselves differentiated along a spectrum of health and illness can help to clarify how certain kinds of technological practices are dominant in the medical management of childbirth and why feminist critiques of interventionist practice seem to have had so little effect on the "American way of birth."

As this paper approaches risk as the defining concept of medicalized childbirth, it provides a way of framing risk itself in the context of medical education, the teaching hospital, and the use of technologies in managing pregnancy, parturition and maternity. For while risk is the concept understood to define practices, it is, in fact, produced as meaningful by the practices themselves.[15] Thus, approaching obstetrical risk with a goal of challenging its rhetorical and material hold on practices is really about demonstrating how risk itself is produced and maintained within particular institutional contexts. The goal here is to imagine new ways of understanding and assessing obstetrical risk, primarily by highlighting how it is that the concept of risk is created and sustained medically and socially.

(Cambridge, MA: Harvard University Press, 1995); and Barbara Katz Rothman, *In Labor: Women and Power in the Birthplace* (New York: W. W. Norton, 1982) and "Spoiling the Pregnancy: Prenatal Diagnosis in the Netherlands," in *Birth by Design,* 180–198.

[14] Davis-Floyd, "The Technocratic Body," 1125.

[15] See Elizabeth Cartwright, "The Logic of Heartbeats: Electronic Fetal Monitoring and Biomedically Constructed Birth," in *Cyborg Babies: From Techno-sex to Techno-tots*," eds. Robbie Davis-Floyd and Joseph Dumit (New York: Routledge, 1998), 240–54, for an interesting discussion of practice in medicine.

ELECTRONIC FETAL MONITORING AND THE PRODUCTION OF OBSTETRICAL RISK

Perhaps the most thought-provoking of my experiences at the NEH Summer Institute on "Medicine, Literature, and Culture" was a lecture for medical students and residents in obstetrics on the use of electronic fetal monitoring (EFM) in the context of labor and delivery.[16] EFM is a technological strategy to measure the risks of childbirth on the fetus; it is ubiquitous in American hospitals and a publicly expected technology of labor and delivery.

Essentially, the EFM records fetal heart rate against the mother's contractions; it is used as a stress test when expectant mothers are past their due dates, largely to detect fetal distress (a concept established in 1893), and during labor and delivery, in most U.S. hospitals, also to detect fetal distress. Operated in most obstetrical settings since the 1970s,[17] but without an established set of norms until 1997, the electronic fetal monitor allows hospitals to get by with less nursing care for birthing mothers, as it can be strapped to mom's belly to create a continuous trace for intermittent reading.[18] This is clearly less labor-intensive than the old-fashioned method of auscultation in which a practitioner listens through a special stethoscope to the fetal heart rate, usually every ten to fifteen minutes during active labor. The lecturer indicated that studies have shown that, in comparison with traditional auscultation, EFM provides no difference in either short-term or long-term outcome for the infant as well as no difference (or a worse probability) in the incidence of cerebral palsy. In other words, there is no established evidence of its ability to improve outcomes for most mothers and babies.[19] In addition, EFM is thought to contribute to the high rates of surgical births in the United States. Surgical births are significantly more risky for mothers than vaginal deliveries; maternal death rates from cesarean sections are higher than those following vaginal deliveries.[20]

[16] All evidence presented here concerning EFM, its efficacy and relation to outcomes, was originally presented in the lecture, unless otherwise noted.

[17] Cartwright, "Logic of Heartbeats," 241.

[18] Electronic fetal monitors are not always strapped in place; they can be held to the mother's abdomen by hand. According to Cartwright, the "logic" of the monitor is to constrain the mother's ability to change position and to free up labor attendants to care for numerous mothers at the same time (Ibid., 246).

[19] See also Michael Benson, *Obstetrical Pearls* (Philadelphia: F. A. Davis, 1994), quoted in Cartwright and Thomas, "Constructing Risk," 223; American College of Obstetrics and Gynecology, "Fetal Heart Rate Patterns: Monitoring, Interpretation, and Management," *Technical Bulletin* 207 (July 1995), cited in Cartwright, "Logic of Heartbeats," 244; and Cartwright, Ibid., 250.

[20] Wendy Savage, "Caesarean Section: Who Chooses—The Woman or Her Doctor?" in *Ethical Issues in Maternal-Fetal Medicine*, ed. Donna L. Dickenson (Cambridge: Cambridge University Press, 2002), 264, 267. Because most c-sections are performed as a result of perceived danger to the infant if born vaginally or if the pregnancy were to continue longer, it is more difficult to assess the relative danger of surgical birth on infants. However, it is well known that infants born surgically often experience respiratory distress, as their lungs have not been massaged by the process of labor.

The lecturer, head of maternal-fetal medicine, concentrated on the typical misuse of electronic fetal monitoring, which usually involves misreading the trace as an indication of fetal distress. He offered tips in how to read an EFM trace accurately, giving the students and residents specific information about what is important in the record and what they can ignore. There was a certain amount of double-speak in his presentation, as he would at times say that such and such a trace represents a "normal physiological response" but then follow that up with the comment that "it can also be a sign of _____, so you don't want to ignore it." This rhetorical strategy emphasized the possibility of missing an important indication of distress, and so it seemed that *not* ignoring it would be the normal thing to do, thus increasing the probability of (mis)reading fetal distress. Yet his overall intention was to encourage more conservative approaches to EFM that would lessen physicians' dependence on it.

What the EFM is good at recording, according to the lecturer, is variability in fetal heart rate. He emphasized that this is its most valuable feature, and one for which practitioners and labor attendants should watch. Lack of variability during labor can indicate problems, since variability "means that everything between the cerebral cortex and the heart is working." But the EFM is not a *diagnostic* test—it cannot offer information for a diagnosis of a specific condition. Rather, it is a *screening* test, an attempt to distinguish between those fetuses that are responding normally and healthily to the stresses of labor and those that are not. But EFM is used to predict outcomes that are extremely infrequent; because of this, it often provides erroneous indications of fetal distress. However, doctors and hospitals continue to use the technology because it exists (almost every American hospital with a maternity service owns these devices), and they have been incorporated into the standard of care; indeed, the lecturer indicated that insurance companies expect their use even though medical studies don't support it.

There are no safe alternatives to EFM except auscultation, which is reliable and time-tested yet labor-intensive and costly; in the long run, nurses are more expensive than these small machines. In addition, Cartwright and Thomas suggest that EFM becomes necessary as practitioners lose skills in alternative forms of monitoring: "U. S. obstetrician Michael Benson . . . points to the need for monitoring *because* of the increased use of labor interventions and the absence of current knowledge about how to monitor the fetus *without* technology."[21] Finally, mothers-to-be are led to understand that the use of EFM constitutes the standard of care, and thus they expect it as part of routine maternity care.[22]

An example from my own experience illustrates some implications of this point. Touring the new "birthing center" at my local hospital before the birth of my second child (my first was born in a different state), my spouse and I were told that the fetal monitors in each LDR (labor, delivery and recovery) room were

[21] Cartwright and Thomas, "Constructing Risk," 224; emphasis in original.
[22] Ibid., 222.

all connected to the central computer at the nurses' station, so that all women in labor at the same time could be monitored centrally. We looked at each other, and I said, "Wow, so the nurses don't even have to come speak to you to ask you how you are doing!" In my own experience, this was a decided negative; I had relied on my caregiver and my spouse to help me throughout my first, unmedicated birth, and I hadn't liked the EFM when I wore it briefly during that experience. The nurses strapped the device on my distended belly as if it might fall off if not pulled tight. It was extraordinarily uncomfortable, especially during strong contractions, and it inhibited my movements because I was connected to the machine at the bedside. Although the use of the external monitor does not prohibit the mother from changing position as does the internal monitor (attached to the infant's scalp), Elizabeth Cartwright comments that "maternal movement is restricted in order to produce the clearest and most interpretable strip. When the woman is attached to the EFM, she is belted into bed, strapped into place."[23] Unlike the straps literally used to tie women down to delivery beds in the 1940s and '50s, the EFM is a technology of voluntary restriction, wherein women take on a constrained posture in compliance with the expectations of the institution.[24]

I asked the residents and students if mothers ever refused the EFM, and how long they were in the hospital being monitored before they gave birth. These incipient and new doctors replied that most of the mothers come to the hospital as soon as they are having contractions, and they stay and are monitored continually; the vast majority of the mothers have epidurals (anesthetic injected into the epidural space around the spine). According to the students and residents, none or very few laboring mothers resist procedures.

The lecturer was clearly against the continuous use of the EFM in most cases (although it was the standard of care at Hershey); indeed, his entire presentation was aimed at encouraging the students and residents to question their routine use of electronic monitoring during labor. However, he acknowledged the factors that worked against changing that standard of care: (1) the expense of having nurses listen every fifteen minutes, (2) mothers' expectations of the standard of care, and (3) the legal ramifications and the objections of the IRB (institutional review board) to changing the hospital guidelines in this regard. Given this scenario, the lecturer advised that residents and interns be more conservative in their use of EFM. This seems all he could offer, since he noted later to two of us from the Institute that when he first came to the medical center, he tried to change the standard of care throughout the entire OB service toward fewer interventions and, especially, cessation of continuous monitoring, but the mothers expected it and resisted its disuse. His current goal, he told me, was to plant in the students' and residents' minds an alternative view that he hoped they would follow once they

[23]Cartwright, "Logic of Heartbeats," 246.
[24]Leavitt, *Brought to Bed*, 189–195; Cartwright, "Logic of Heartbeats," 247; see also Davis-Floyd, "The Technocratic Body," 1137, for women's perspectives.

had their own practices. Yet the "next thing coming down the pike," he told us, is caesarean-on-demand, and his hospital will be able to resist only as long as it doesn't cost them patients.[25]

What astonished me was that the *medical* evidence against continuous electronic fetal monitoring in labor didn't constitute an effective argument against using it for two *nonmedical* reasons—maternal choice and legal risk. I wondered aloud about those mothers who come to the hospital right after contractions begin, as I was always told to wait until the contractions were five minutes apart, but the speaker told me that with high risk mothers, he wants them there from the very beginning. This is the key issue distinguishing a tertiary care institution from a community hospital. The standard of care at Hershey Medical Center is set by the standard care for *sick* mothers.

When I asked the students and residents if the mothers resist interventions or standard procedures, they looked a bit surprised; in this I am reminded of the comment by a founder of La Leche League that her first nonmedicated birth "made the doctor very nervous. He had never worked on a conscious mother before."[26] Obstetrical training not only teaches medical students and residents about the rudiments of pregnancy, labor and delivery, but it also educates them about the norms of practice and what to expect from their patients. Leavitt makes the point that in the 19th century, physicians' lack of experience with actual childbirth during medical training was a serious limitation to their authority as professionals as well as to their abilities in aiding birthing women.[27] We might wonder now about how contemporary obstetrical education constrains practitioner knowledge and thus their practices. What does it mean that medical students and residents in obstetrics train in hospitals that draw a disproportionate population of sick mothers-to-be, that these mothers are precisely those most likely to comply with interventions because they are especially motivated to believe that technological mediations are necessary for reproductive success? The lecturer's lofty goals notwithstanding, it seems improbable that physicians trained in such a way can learn to "question authority" when it comes to the standard of care supported by the legal system, the insurance system and the institutional expectations that result from those systems. To say that low risk mothers often choose to give birth in community hospitals with more women-friendly protocols ignores the extent to which even those contexts often conform to a technocratic and medicalized perspective on childbirth that is not necessary in most instances.

Mothers make birthing choices, but those choices are overdetermined by existing technologies, apparently with little regard for their efficacy (as measured by research evidence). DeVries et al. found in a study of mothers in the United States, the United Kingdom, Norway and the Netherlands that "the desires of women

[25]For a discussion of the ethics of elective cesarean section, see Savage, "Caesarian Section."
[26]Kaye Lowman, *The LLLove Story* (Franklin Park, IL: La Leche League Internation, 1978), 88.
[27]Leavitt, *Brought to Bed*, 42–43.

[in maternity care] closely track the care they are offered," even though they seem to have some "influence [on] the content and style of care." They choose what's available, what doctors are trained in, what hospitals have purchased.[28] In the U. S. and elsewhere, mothers are also guided by values created in societies that revere (and trust) science, independence defined through separation, and technocratic control of embodied processes.[29] Doctors are also constrained in their choices, as they are guided by (legal) risks to themselves. What happens, however, is that those risks are articulated to mothers as *fetal* risks.

Thus, medical technologies are engaged, by a number of actors, to sustain their own duplicative scenarios. Those who promote their use depend on and maintain discourses of risk to support that use, and they resist, robustly, attempts to forestall or limit this usage.[30]

FEMINIST ACCOUNTS OF CHILDBIRTH

Ann Oakley points out in *The Captured Womb* that birth was once a social experience that became understood as biological and then became medicalized: "To say that pregnancy is a medical activity because it is a biological one is to commit the error of 'writing a history of the past in terms of the present.' What is important is the development of the idea that any phenomenon belongs to this or that expert domain."[31] This view contrasts with Leavitt's perspective, in which the issue is no less to determine how birth moved from the home to the hospital (and the consequences of that move) but in which the status of birth as a medical event is not really questioned.[32] This difference of view permeates the feminist literature on pregnancy and childbirth (and in the interests of outlining it I will likely distort the complexity of analysis in each of these texts).

[28] Raymond DeVries, et al., "What (and Why) Do Women Want? The Desires of Women and the Design of Maternity Care," in *Birth by Design,* 259.

[29] Davis-Floyd, "The Technocratic Body," 1126–1132; see also DeVries, et al., Ibid., for a discussion of how what women want in maternity care is affected by what they are offered by medical professionals.

[30] Elizabeth Cartwright has made a similar point in "The Logic of Heartbeats," 246–247.

[31] Ann Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (Oxford: Basil Blackwell, 1984), 1.

[32] The question for Leavitt concerns who manages the birth situation and thus dominates its meanings for women: "Childbirth is more than a biological event in women's lives. It is a vital component in the social definition of womanhood. Historically, women's physiological ability to bear children and men's inability to do so have contributed to defining the places each held in the social order. The sexual differentiation between women and men fostered a cultural division of labor based on these biological distinctions, a division that allocated the domestic sphere to women and the public sphere to men" (3). Thus, the very beginning of *Brought to Bed* establishes sexual difference as grounded in biology and the cultural meanings of childbirth to be attached to this biological foundation. Leavitt later writes: "My historical interests in the interactions between medicine and society developed into a specific interest in the history of childbirth as a direct result of my personal confinement experiences. During the hours of labor and delivery I understood and accepted a bond with biological womanhood . . . " (5).

The first perspective focuses on the process of medicalization of pregnancy and childbirth, in other words on how these experiences of female embodiment come to be understood in medical terms and as medical phenomena. The second perspective is interested in how phenomena understood as medical have been structured socially and transformed through the development of the medical profession, primarily in the 19th and 20th centuries. The first perspective is most likely to point out the regulatory impetus to changing obstetric practices—"antenatal care is both an exemplar and a facilitator of the wider *social* control of women"[33] —while the latter focuses more on women's agency in instituting changes in practices for and perceptions of pregnancy and childbirth.

Both approaches offer valuable interpretations of the history of childbearing, and together suggest central tensions around how much emphasis to place on the regulation of women versus their involvement in the social experience of their bodies and roles. They also share certain interpretations of the historical record—for example, male practitioners' consolidation of their expertise as obstetricians through their use of specific technologies like forceps and anesthesia (and their refusal to share these technologies with female midwives). Yet in each approach, the risks women take in carrying babies and giving birth to them are assessed and represented differently. Each author's understanding of the risks of pregnancy and childbirth—to women and to babies—is crucial to her presentation of the meanings of the historical changes in childbirth practices in the last two centuries. While the first approach accepts that some risk is involved in childbirth, it views the specific risks women face as constructed historically by both social practices *and* perceptions of birth itself; the second perspective is more likely to accept and promote a basic notion of risk that pervades childbirth. In this view, medicine and medical management do less to shape risk than to respond to and manage it; the risk here is natural, in some sense, and must be approached as any other medically defined risk (with protocols, practices and technologies). The issue for feminists in this understanding has to do with women's choices within medicine's framing of risk for women, while in the former view the issue concerns the more basic question of how risk itself is constructed, perceived and maintained as a basic ideological apparatus sustaining certain forms of obstetrical practice and control of women as mothers.

I find the emphasis on maternal regulation more convincing as a way to approach the "risky business" of childbirth in America, largely because how the risks of childbirth are understood by women and by medical practitioners have changed historically and also because the concept of risk that is now engaged to promote prenatal care and medicalized childbirth practices is sustained by other articulations of risk that are not, in themselves, primarily medical. For example, the hospital as an institution places requirements on physicians concerning standards of care that are not supported by medical research (as in EFM usage). These

[33] Oakley, *The Captured Womb*, 2; emphasis in original.

requirements have to do with popular conceptions of risk, legal understandings of liability, and institutional expectations concerning patient *perceptions* of care.[34] Thus the correlation of EFM usage with the increasing rate of surgical birth is less significant, conceivably, to a legally conscious hospital administration than the fact that to the public use of EFM is an important *social* indicator of quality obstetrical care. This is partially a result of the fact that surgical birth is perceived to be no less risky, for the fetus, than vaginal birth, even if it is demonstrably more dangerous for the mother. Yet, recent reports about how surgical births prevent possible long-term damage to the perineum contribute to the view that surgical birth is more desirable for women than vaginal birth.[35] Socially, surgical births indicate, in both a semiotic and a legal sense, that the practitioner has done all he or she could to forestall fetal injury or maternal debilitation, whether or not the procedures themselves result in positive outcomes.

In this view, then, women's perceptions of the risks of childbirth—maternal debility or death, infant debility or death—have been manipulated through historical shifts in the management of childbirth from female-dominated contexts to the medically defined hospital obstetric practice to produce new kinds of risks and new ways to approach, address and manage those risks. Indeed, new risks emerge as they can be identified in more precise ways; it is now routine for pregnant women age thirty-five and older in the U.S. to be counseled to undergo amniocentesis in order to detect trisomy 21 in their fetuses, primarily because the risk of the procedure injuring the fetus has approximately the same numerical value as the risk of the chromosomal abnormality.[36] Now that the risk of having a baby with Down syndrome can be measured against the risks of the procedures that detect its presence, Down's has become a congenital anomaly for which women are encouraged to test. Indeed, it has become not simply an unfortunate birth outcome but a condition that is to be avoided; thus, the technology of abortion and its social and medical acceptance in cases of mental disability contribute to the contemporary cultural meanings of the "risk" of Down syndrome.[37]

Clearly, the condition of trisomy 21 has existed historically prior to the ability of medical practitioners to identify it through the karyotyping of fetal tissue in amniotic fluid, but that procedure allows for a specific risk scenario to be defined and presented to pregnant women as well as a particular plan of action if chromosomal anomaly is found.[38] Medicine as an institution has been partner to

[34] Apparently regardless of the effect on actual outcomes; see Davis-Floyd, *Birth as an American Rite of Passage*, 177–184.

[35] See Savage, "Caesarian Section," 266–268, for a discussion of these points.

[36] Michael Bérubé states the risk as 1 in 225 for having a Down syndrome baby and 1 in 200 for having a miscarriage caused by the amniocentesis for a woman aged 36. *Life as We Know It: A Father, A Family, and an Exceptional Child* (New York: Random House—Vintage, 1996), 6–7.

[37] In making this point I am neither arguing against amniocentesis nor against elective abortion in the case of a positive Down's diagnosis (or in any other case).

[38] See Bérubé, *Life*, for an excellent discussion of trisomy 21 (17–24) and for a discussion of the issue of abortion as a response to detection of chromosomal anomalies (40–94). For a good, brief history

the creation of a new public understanding of the risk *and meaning* of these kinds of congenital birth defects, for while the prenatal testing itself does not mandate particular behaviors (such as elective abortion) in response to a positive diagnosis, it nevertheless seems to result in certain kinds of responses. Michael Bérubé notes that "only one couple in ten will choose to have a child with Down's if the amniocentesis is positive."[39] There may be a new social mandate to create perfect babies, but medicine's involvement in the emergence of such a mandate is far from merely responsive; medical practitioners actively work to educate women on the benefits of using new reproductive technologies, creating a culturally sanctioned discourse for their increased demand in practice. After all, women flocked to hospitals to give birth in the first half of the 20th century in part because they were perceived to be safer places to give birth, even though such claims were not well founded.

According to Leavitt, the shift to hospitalized births did not in itself effect decreases in maternal and infant mortality. Indeed, Leavitt argues, "When most middle-class women . . . decided to go to the hospital to deliver their babies in the 1920s and 1930s, there were no statistics proving to them that science applied in the hospital had in fact made birth safer. Maternal mortality remained high during this period." However, healthier lifestyles and the medical reduction of illnesses like rickets (which often led to deformed pelvises in women), along with "increasing hospital regulation of obstetric practices, antibiotics to treat infection, transfusions to replace blood lost by massive hemorrhaging, and prenatal care to identify many potential high-risk cases," contributed to decreases in maternal mortality in the 1940s and 1950s.[40] Eventually, medical science fulfilled its promise to save women from dying in childbirth.

Currently most U.S. women do not fear death when they become pregnant although numbers for maternal and infant mortality and morbidity are stratified according to race.[41] The represented risks of fetal injury or harm, however, continue to drive the medical management of pregnancy and childbirth as well as to insure women's complicity with its norms; the risk of doing damage to their babies (as well as fears of giving birth to babies already "damaged") propels many women to demand highly technological and interventionist management of pregnancy and childbirth. Thus, the notion that childbirth is risky overrides the commonsense idea that it is nevertheless normal and thus not, in most circumstances, deserving of intense medical scrutiny. The idea that women can take advantage of medical advances yet resist the medicalization of childbirth seems culturally anomalous. Indeed, as Robbie Davis-Floyd argues, many women "participat[ing] most fully in

of the development of amniocentesis as a technology, see Rayna Rapp, *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America* (New York: Routledge, 2000), 23–32.

[39] Bérubé, *Life,* 76.

[40] Leavitt, *Brought to Bed*, 174, 194; see also pp. 170–195 for a general discussion of the impact on women of moving birth from home to hospital.

[41] Bernice L. Hausman, *Mother's Milk: Breastfeeding Controversies in American Culture* (New York: Routledge, 2003), 222.

a society's hegemonic core value system . . . are most likely to feel empowered by and to succeed within that system."[42] That is, many, if not most, women are likely to feel that births complying with the technological model of childbirth are appropriate and warranted and that such births reflect well on their decision-making as (American) mothers.

FRAMING RISK, FRAMING WOMEN

Some women are ill while pregnant; some fetuses will die without the same, intense medical scrutiny that seems unnecessary for most pregnant and birthing women. The experience at Hershey has made me wonder about how to best characterize the problems with the "American way of birth." Is the problem that all pregnant women are treated as if they are ill? Is the problem that they are confronted with "choices" they must make in which what they choose is overdetermined by a risk scenario calculated to offer only one reasonable path, compliance? Is the problem that technologies are held out as the answer to the problems of childbearing risk, while in fact technologies lead to new risks, indeed define new risks? How do we understand mother's rights and responsibilities in pregnancy and childbirth? These questions opened out into others: Why is the medical institution's representation of pregnancy and childbirth risk acceptable to most American mothers? Why are feminist views seemingly so out of touch with ordinary American mothers' experiences of childbirth?[43]

In one perspective, as long as physicians are trained to see childbirth as a medical management issue as well as a set of risks that must be managed by technological progress and manipulation, mothers will always be seen as sick patients whose choices must be carefully circumscribed by the framing of childbirth risk within medical language and understanding. This makes it difficult to see birth as a normal physiological process. The critique of this view makes it difficult for feminists to distinguish mothers who need to be seen as sick and whose choices *are* constrained by medical issues. For many women, having children means accepting medical management and practices defined by a calculus of palpable risk due to their own medical status or that of the fetuses they carry. Yet even the distinction between expectant mothers as "low" and "high" risk involves the understanding that no pregnant woman exists without some risk calculation, and while high risk women are unlikely to move down, low risk women can always increase their risk

[42]Davis-Floyd, "The Technocratic Body," 1137.

[43]The simple answer to this last question may be that ordinary American mothers got their wishes answered when their husbands were allowed access to the delivery room and hospitals responded to the threat of the home birth movement by providing childbirth education, birthing centers, and other more homey birth options. For example, see Diane Eyer, *Mother-Infant Bonding: A Scientific Fiction* (New Haven: Yale University Press, 1992); see also Kerreen M. Reiger, *Our Bodies, Our Babies: The Forgotten Women's Movement* (Melbourne, Australia: University of Melbourne Press, 2001), esp. 62–83 and 212–237, for a discussion of the childbirth education movement in Australia.

factors. To be designated "low risk" is to be identified along a continuum in which there is only one way to move, from some risk to more.

My own experience suggests that the historical risks of childbirth are still present and as incalculable as always. Reading through my personal journal of the NEH institute, I found an account of my son Sam's first illness, which occurred when he was five days old. I wrote, "It is still frightening to me, remembering this experience; sick babies in hospitals always bring me back to Sam and my first encounter with the fear that my baby might die." At three days old, Sam started sleeping full-time; at five days, he developed a significant fever. His blood and urine were collected at the hospital that fifth day but they never cultured, and the physician attending him couldn't get any spinal fluid, so although his temperature diminished with intravenous antibiotics, we'll never actually know what caused the fever. His sister might have had the coxsackie virus a few days before his birth; Sam might have been infected by Group B Streptococcus (GBS) during birth; he might have caught some kind of bacterial infection from the hospital itself; he might have been infected in our house in the days after his birth. The fact that he was a big baby, over nine pounds, probably helped him to survive. He was born vaginally after a labor of about twenty-four hours, approximately twenty minutes after I arrived at the hospital; there were no significant medical interventions during labor or at delivery. How the risks stack up, and how they eventuated in his illness, will be forever unknown to us; for me, it's a story about how uncertain the origins of illness can be.

Others have listened to my story and heard the risk of negligence: how dare I not get to the hospital in time for the prophylactic antibiotics indicated by my positive strep B diagnosis? The implication of this criticism is clear: Sam got sick because I didn't adequately assess the risk of a known condition of my body. Yet for me, the risk of surgical birth or other obstetrical intervention was far more significant in determining my labor practices and goals for Sam's birth. I had a long labor with my first child; I wanted no one to set a clock on my second. I remember the two and a half hours I spent in the hospital before the birth of my daughter (again after long hours of at-home labor) as the most difficult aspects of that experience, as I fought with the nurses to drink water, to jettison the electronic fetal monitor, to sit rather than lie down.

Ultimately, we will never know why Sam got sick, and perhaps that is what allows me to be so self-satisfied; no one can prove I was really negligent by attempting to retain control over the conditions of my labor and his birth. There is a standard medical approach to treating birthing mothers who test positive for GBS (prophylactic antibiotics during labor) and there are resisters to that protocol who argue that too many mothers and babies are being exposed to antibiotics in this way.[44] The conflict reveals how mothers make decisions, by weighing risks

[44] According to the Centers for Disease Control, "One in every four or five pregnant women carries GBS [Group B Streptococcus] in the rectum or vagina. A fetus may come in contact with GBS before or during birth." Because GBS "is the most common cause of sepsis . . . and

presented to them and analyzed in the context of popular and personal knowledge and information. That I am skeptical of obstetrical interventions is an effect, at least in part, of my training as a feminist scholar in the field of reproductive medicine; that I am convinced of the possibility of unmedicated and generally noninterventionist birthing is a result of my own experiences of childbirth. I can look at information about GBS and its risks to newborns and decide that prophylactic antibiotics are less important than staying at home during labor, or, rather, that staying at home for as long as possible is the most important goal for my labor. Others read this material and feel that they must go to the hospital as soon as they can be admitted. I'm willing to take responsibility for the consequences of my decision, in retrospect, but then again, my baby lived and had no discernable damage. I can only imagine that the medical students and residents at Hershey, in their clinical experiences, become convinced of the necessity of close monitoring and decisive interventions as a result of their interactions with the particular population of women who use their services and the general expectations upheld at the hospital about proper obstetrical practice.

Managing the risky business of childbirth is thus not only about defining pregnancy and parturition as illnesses; such management also concerns the identification and representation of "risk" as a medical concept with a particular relation to obstetrics as a specialization. Feminist rethinking of the risks of pregnancy and childbirth must attend to the various personal frames of reference that women bring to their own pregnancies as well as the public discourses of medicine that frame particular understandings of obstetrical risk for women.[45] Because so many women currently understand their own pregnancies and childbirth options in relation to a medicalized risk scenario, any proposal to reorganize contemporary obstetrical experience and care must imagine alternative ways to conceptualize obstetrical risk itself. Not only should the idea of fetal risk not be used to bully women into compliance or to justify technological interventions with no established medical value, but questions must be raised about what obstetrical risk is, how women understand its significance, and why they might wish to value its capacity (as a concept) to direct childbirth practice.[46] Mothers' behaviors as obstetrical subjects are produced through a variety of (gendered) experiences and their understanding

meningitis . . . in newborns," the CDC recommends that women who test positive for GBS late in pregnancy be offered prophylactic antibiotics "at the time of labor or membrane rupture." Centers for Disease Control, "Group B Streptococcal Disease (GBS). Division of Bacterial and Mycotic Diseases," http://www.cdc.gov/ncidod/dbmd/diseaseinfo/groupbstrep_g.htm. (Accessed 24 December 2002.) However, there are risks involved in using prophylactic antibiotics in the large population of women who test positive for GBS but are not symptomatic at the time of delivery; such women "have a relatively low risk of delivering an infant with GBS disease." Midwife Archives, Gentlebirth.org, "Group B Strep (GBS)," http://www.gentlebirth.org/archives/gbs.html. (Accessed 31 August 2003.) For a discussion of the widespread use of antibiotics and risk of fungal infection in nursing infants, see Kathleen L. Hoover, "Yeast Infections of the Nipples and Breasts," http://www.medela.com/NewFiles/thrush.html. (Accessed 1 September 2003.)

[45] Davis-Floyd's "The Technocratic Body" provides an especially provocative analysis along these lines.

[46] DeVries et al., "What (and Why)," demonstrate how difficult raising these questions can be, let alone finding answers to them.

of themselves as patients; compliance is only one way of assessing mothers' actions as birthing subjects.

The issue here is less to define what the "real risks" are and more to establish how defining and evaluating the risky business of childbirth might become the joint enterprise of the involved participants. In this manner, the *conscious* social construction of risk—promoting a thoughtful consideration of how the confluence of people and technologies function as co-constructing systems of materiality and meaning—might be a realizable goal rather than just a way to explain how risk operates in obstetrical domains. In this scenario, instead of a lecture detailing the problems with electronic fetal monitoring to students already schooled and practiced in its routine usage (in the context of a hospital unlikely to allow physicians to stop using the technology), we might imagine a lecture that positions the physician in the middle of a political debate about how the risks of childbirth are framed by legal, social and biological interpretations of maternal experience and fetal existence.[47] Such a lecture would admit to medicine's enmeshment in cultural contexts and meanings, both drawing boundaries around the kinds of knowledge produced in particular domains *and* making those boundaries permeable through a recognition of their co-construction with other forms of knowledge. Those empowered socially to manage the risky business of childbirth deserve no less complicated a form of professional education.

[47] See, for example, Thomas H. Strong, Jr., M.D., *Expecting Trouble: The Myth of Prenatal Care in America* (New York: New York University Press, 2000), 1–32, for an example of a physician-authored monograph that attempts this kind of multi-layered analysis.