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The Medicalisation of Childbearing Norms: Encounters Between Unmarried Pregnant Women and Medical Personnel in an Irish Context

Abbey Hyde

Introduction

This chapter is based on the accounts of a sample of unmarried pregnant women and focuses on medical interest in the social organisation of the woman's reproductive practices. It is argued that medical jurisdiction can stretch beyond physiological aspects of pregnancy to concerns with normative social standards, whereby wider social discourses on the timing and context of childbearing in women's lives are brought to bear during medical encounters. Medicine can lay claim to this 'social' aspect of women's lives through appeals to holism and 'social health'; however, the notion of social health is contentious in that medicine's cues to problematise a pregnancy in a social sense are rooted in wider discourses on normality. Medicine's assessment of a socially 'questionable' pregnancy in turn contributes to the construction of normative boundaries for childbearing.

While medicine's potential to operate as an institution of social control is well established within medical sociology (Zola, 1972; Foucault, 1973; Illich, 1976; Armstrong, 1993, 1995a, 1995b) and public health medicine (Skrabanek, 1994), feminist sociologists in particular have elucidated the medical appropriation of childbirth, which was previously constructed as a natural process (Oakley, 1980; Murphy-Lawless 1988a, 1988b; Lupton, 1994). The medical takeover of physiological aspects of childbirth is one issue; a second — and centrally important for this paper — is at least some medical practitioners' use of moral judgements on the social circumstances of pregnancy, and the impact these have on the nature of medical interactions.

'Unmarried mothers' have long been institutionalised and categorised by the medical profession for transgressions of societal norms. Murphy-Lawless's
historical analysis of male medical midwives (early obstetricians) in the
Rotunda Hospital in the last century elucidates the mediation of moral and
physiological boundaries in relation to non-marital mothers in the contem-
porary period. Post-natal puerperal fever suffered by unmarried women was
causally linked to the distress of "seduction" and their non-marital status
(Murphy-Lawless, 1988c). More recently, Sally Macintyre (1977) in a Scottish
study found that medical practitioners constituted categories of women based
on the latter's sexual histories and behaviour and used these to make 'medical'
decisions (for example, whether or not to sanction an abortion). Macintyre
(1991) also noted how women's marital status influenced the medical inter-
pretation of post-natal depression; for married women, this was normalised,
while for single women it was perceived in terms of ambivalence towards the
infant. Finlay and Shaw (1993) have also identified tension between medical
and scientific issues on the one hand, and moral issues on the other, in the
arguments proposed by the Department of Public Health Medicine in
Northern Ireland for the initiation of a Brook Centre in Belfast to deal with
the 'problem' of teenage pregnancy.

It is argued here that the recent emphasis on 'holistic medicine' (Armstrong,
1995a) serves to legitimate medicine's concern with psycho-social areas of
childbirth, and can operate as a mechanism of social control in distinguishing
problematic from acceptable pregnancies. As well as furnishing further
evidence to support the broad notion that at least some physicians extend their
intervention into delimiting socially approved reproductive arrangements, this
paper explores the place of 'holism' in the care of pregnant women. It is
argued that what a number of participants in this study reported was a kind of
'paternalistic holism' whereby obstetricians assessed women's health status and
acted according to normative dictates, with the impact of problematising
pregnancies without adequately considering participants' versions of their
circumstances.

Firstly, the methodological stance of the study will be outlined. This will
be followed by data that buttress the argument that non-marital motherhood
continues to be problematised by medical personnel.

Methodological Stance

Fifty-one study participants were selected from the Out-Patient Clinic of a
large maternity hospital in Dublin to which access was successfully gained via
the medical and midwifery directors. Inclusion criteria were that potential
participants would not be married to the father of the fetus and be first-time
expectant mothers. The age range of participants was 16 to 36 years with
12 of the women under 20 years at the time of the birth. Informed consent
was obtained and anonymity guaranteed. Those who assented to partake were
informed of their freedom to withdraw from the study at any time. Ninety
women were invited to participate of whom 51 were eventually interviewed.1

In-depth semi-structured interviews were held on two separate occasions:
firstly in the third trimester of pregnancy, and secondly, in almost all cases,
between weeks six and eight after the birth. The interviews were conducted
from mid-1992 to late 1993. Since the present paper is concerned with
medical encounters during the pregnancy, accounts presented here are from
the first interviews.

The study adopted a qualitative approach from a pluralist feminist stand-
point position in order to centralise participants' experiences in medical
encounters. The standpoint position, first proposed within feminist thought by
writers such as Hartsock (1983, 1987), Rose (1983, 1986), and Smith (1979,
1987), contends that the dominance of conceptual schemes rooted in male per-
spectives of the social world has meant partiality and distortion in understanding
events. Such biases may only be ameliorated, it deems, by manifesting an under-
standing of the world from the perspective of women's activities (Harding,
1989). More recently, a "pluralist" standpoint position has been advanced
(Gelsthorpe, 1992) in response to criticisms directed at earlier universal
models of patriarchy that paid insufficient attention to differences in women's
experiences arising from variations in class, race, sexual identity and so forth.
The notion of plurality acknowledges that while women have a particular
perspective as women, their characteristics and situations vary, resulting in a
variety of 'uniquely valid insights' (Gelsthorpe, 1992: 215).

A grounded theory style of analysis (Glaser and Strauss, 1967; Glaser,
1978, 1992; Strauss, 1987; Strauss and Corbin, 1990, 1994) was used to code
data qualitatively, although this strategy was utilised selectively. As data col-
collection progressed, questions about topics became increasingly focused around
theoretical pertinent issues and concepts. A constant comparative method
was employed, whereby like items of data were clustered and later theorised.
In contrast to quantitative research where support for an argument is based
primarily (and sometimes solely) on enumerating the empirical support for a
theoretical position, in qualitative analyses, along with empirical breadth,
the quality of data and its conceptual relevance is considered important
(Dey, 1993).2

Medical Encounters

Three issues reported by participants concerning medical encounters will be
sung out for conceptual purposes, although these overlapped considerably.
The areas are: 1. Medical practitioners introducing the notion of adoption; 2.
Participants being pressurised to see the social worker; 3. The questioning of
participants about social arrangements for childcare or their capacity to parent.
Medical practitioners introducing the notion of adoption

Adoption has long been associated with unwanted pregnancies, and to suggest adoption to a pregnant woman is to raise questions about the acceptability of the pregnancy. A considerable number of women reported that the issue of adoption was raised at the hospital in various interactions with professionals, including medical doctors. Some women were overtly dissatisfied with adoption being raised, especially as in Angela’s case below, where the issue was broached repetitively:

Angela: The first time I went to the hospital I went to the public ward, the time I met you... Every single comment was the fact that I wasn’t married. Every single one of them. It was, ‘Are you keeping the baby?’

Interviewer: Who was it that asked you that?

Angela: The nurse that gave me the blood test and then the doctor said the same thing to me, ‘Are you keeping the baby?’

... The doctor that saw me in the public clinic, I didn’t really like. I mean I’m not like, paranoid, but he did have sort of a patronising attitude, and it did irritate me when he said that, ‘Are you keeping the baby?’ because it was written down. I felt like saying, ‘Can you not read?’ (32-year-old engineer.)

Some women had no doubt that the line of enquiry was directly related to their single status, or, as in Iris’s case, their age, in so far as married women would not experience the same questions:

Iris: They asked me [at the hospital] would I think of adoption.

Interviewer: How did you feel about that kind of questioning?

Iris: Nearly died. I thought it was just because I was young. And you know the way they ask you if you’re single, married or divorced or something. I said I was single, and me, he asked me would I be into adoption, would I think about it, and I knew it was a question he wouldn’t ask a married person or an older person... ... I felt a bit intimidated, like [inaudible]. (21-year-old office clerk.)

A number of women who recalled being asked about the issue of adoption accepted such questioning, suggesting their internalisation of wider social norms around childbearing:

Interviewer: Did he ask you anything about the baby?

Kim: Yeah, he asked me if I was going to keep the baby, and I said ‘yeah’, and that was it.

Interviewer: How did you feel about being asked?

Kim: I didn’t mind. It didn’t bother me. I was expecting to be asked that. (21-year-old cleaner.)

Beyond the hospital, some women had encounters with General Practitioners (GP) during the pregnancy and while most GPs did not discuss pregnancy-outcome options with the women, a small number of participants did recall episodes where the issue of adoption was raised. In Trish’s case, following a discussion on abortion, her GP attempted to propel her towards a decision to place the baby for adoption:

Trish: I was just thinking, ‘What am I going to do?’ and I did think of having an abortion. I was just so messed up, and he [the GP] was talking to me against [pause], but he wasn’t - he was saying like what it could do to you if I did... and he was saying that he wouldn’t pressure me either way - that it was my decision at the end of the day but he just wanted me to know that [pause], he was telling me about different cases that he had experienced and how they were finding it even after years - that you think everything is wonderful but that it can come back and hit you... he then said about adoption. He annoyed me, ‘cause he kept going on about it. He was saying, ‘You don’t realise the responsibilities’, and bla, bla, bla. And I’m going ‘Jesus, like, I have thought’... (22-year-old receptionist.)

A number of women in Macintyre’s (1977) study reported their GPs suggesting pregnancy outcomes other than those they had already intended to pursue, because this had inferences for the kind of definition of the situation that was negotiated in the encounter. A number of participants in the present study similarly took exception to propositions of alternatives from medical professionals. This was because any proposal of alternatives would frame their circumstances as aberrant by undermining the perceived unquestionable assumption that the baby was being raised by its natural parent or parents, as would occur in any ‘normal’ situation, even if the participant was unmarried and/or unpartnered.

Participants being pressurised to see the social worker

It would seem to be a positive and useful practice to offer a social work service to those who might require public assistance during their pregnancies. However, aside from situations where the practice is for all patients to be informed that a social work service is available to them, the offer of a social work service on a selective basis is to construe particular pregnancies as more potentially problematic than others. The practice at the hospital where participants were selected was to identify all unmarried women as candidates for at least one interview with the social worker. Those who circumvented the social worker on their first visit were identified by a sticker placed on their case notes. A number of women slipped through the net, and some who did not voluntarily accept the offer to see the social worker were coerced into doing so by the medical consultant. To be accompanied by a medical escort
(the consultant) to the Social Work Department after a medical check-up was by no means uncommon among those women who managed to elude the social workers on earlier visits:

Janet: So the next time I went to the hospital, then, I got this doctor who was really cranky. He was going on about smoking... Then he examined me. He didn't tell me anything. That was it, like, it was two minutes. So then he says, 'Come with me.' Walked out of the room, marched me down to the social worker.

Interviewer: How did you feel about that?

Janet: I didn't know where I was going or what he was doing, and I was, I was looking at him and he had a hold of the chart. I thought he was just bringing me into reception or something. And we walked by reception, so I just kept on following him. I was a bit taken aback you know kind of and he said to me, 'Sit down there,' he said, 'The social worker will be with you in a minute.' I said, 'Hold on a minute...' and he walked off.

Interviewer: How did you feel about that?

Janet: I was still stunned after what he was after saying to me in the room about the smoking, you know, even though I know he's right about smoking. It was just his attitude, the way he was actually speaking to me, you know... So, the social worker came along and she took me into the room and I said, 'Why do I have to see you? Why do I have to see a social worker?' And she said, 'We just make a point of seeing unmarried mothers, or people who are separated.' I said, 'I'm fine, I don't want to see a social worker,' and she said, 'Well, we'll just check you out anyway.' And I was thinking, like, I could be married and have problems and they wouldn't make a point of seeing me, you know.

(23-year-old waitress.)

Pauline: I never realised you have to see the social worker. The student midwife who came in to me, she said, 'Oh you'll have to see the social worker.' She said, 'You can make an appointment today and come in another day.' But he [doctor] said to me, 'While you're here, I'll bring you to the social worker.' So he just brought me up, and like you were taking out of the room and around by all the different places. I was conscious of that and even [partner] was too cause he followed me, and he goes, 'What's wrong?' And I said 'Nothing'. Like people waiting hadn't got an idea where I was going but I had. But even [partner] didn't know...

...I should have said something, but I didn't. (20-year-old secretary.)

While a number of women, as the examples above suggest, were most unhappy about being ushered to the social worker in such a manner, others, amazingly, accepted this situation without question:

Daria: They asked me if I go to the social worker and I said no, cause I didn't know what I had to see her for. Then on the second visit there was a sticker on me chart, 'Patient must see social worker on next visit.' But the doctor marched me down on me last visit [laughs].

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Interviewer: How did you feel about that?

Daria: It didn't bother me...

(21-year-old, unemployed.)

Kim: ... I was walked down to the social worker by the doctor.

Interviewer: Were you?

Kim: That didn't really bother me. There was a note on me chart, 'Go see social worker.' I meant to go the first time but didn't... The thoughts of it!

(21-year-old cleaner.)

**The Questioning of Participants’ Arrangements for Childcare or Capacity to Parent**

Some participants were questioned by medical practitioners about their plans for childcare, insinuating that their social circumstances for childbearing were deemed by medical professionals to be possibly sub-standard, or at least questionable:

Penny: The first visit I went to [the hospital] I thought the doctor was very rude because I wasn't married, and he was asking me was I keeping the baby, and I was going back to work, and I said, 'Yeah,' and he asked me who I was going to get to mind the baby, which put me off. It was none of his business anyway. I felt it was nothing to do with him whether I'd go back to work or who'd mind the baby.

(24-year-old receptionist.)

Interviewer: How was the visit to the doctor?

Pauline: ... and the first thing he said to me was... he looked at mechart and he said, 'Miss [her name]', and I said, 'Yes', and he said, 'Do you plan on keeping this child?' in a real stern voice. And I said, 'Oh my God, what other way is he going to scrutinise me, you know.' And I said, 'Yes,' and he said, 'Well how do you plan on keeping this child? 'Oh my God!' I said. And I said, 'With the help of me mam and me mam's friend.' (20-year-old secretary.)

- AN additional participant’s capacity to meet the demands of motherhood was questioned by her GP:

Trish: And I just couldn’t understand why he kept going on at me like [not consider adoption], when I was saying I don’t want it. And he’s going, 'You don’t realise the responsibilities.' And then my mother was down for something else and she said to her to talk to me 'cause 'I don’t think she [participant] realises what’s involved.'

(22-year-old receptionist.)

In the absence of a group of married women with which to compare the medical encounters of unmarried women, one can only speculate as to the interactions married women might experience; however, it would seem most unlikely that married women would be subjected to the kind of questioning explored above.

It was notable that those women who were most dissatisfied about an issue being made about their single status tended to be among the better educated of those attending the public clinic. Women from the highest socio-economic
groups attended the semi-private clinic, and these reportedly did not experience a sense of problematisation of the pregnancy by the medical profession to the same extent.

Discussion

The notion that medical involvement in non-marital pregnancies frequently surpassed a focus on the physio-medical component was supported by data in relation to the three areas presented above: physicians interposing the issue of adoption during the medical encounter; participants' being pressurised (and in some cases compelled) to visit the social worker; and medical practitioners enquiring about participants' childcare plans or potential to parent adequately. Medicine's extension beyond physio-medical aspects of childbirth will be explored here in relation to the concept of holism, and the difficulties associated with 'social health' when this blurs with the notion of social control.

Although it is not known whether the physicians referred to above identified with a holistic agenda in extending beyond strictly 'medical' concerns (in its narrow sense), medicine might legitimately argue that any accusations of surveillance or social control place it in a difficult position. Holistic care implies an appreciation of the multiple aspects of the human person, including physical, social, psychological and spiritual. In showing no interest in social aspects of the pregnancy, physicians might be accused of reverting to 'reductionist' medicine (Armstrong, 1995a: 45) with concern only for the individual (physical) parts of the person. In practising some notion of holistic medicine by encompassing 'social health' they might be censured for social surveillance.

The style of holistic care adopted in medical encounters presented in this paper could be coined 'paternalistic holism' in so far as, in the unequal relations between practitioners and participants, women were seen to be unable to decide what was in their own interest (for example, to visit the social worker), so physicians imposed this practice on women for their own good. This could then be justified on the grounds of care and concern with social health, for example - a need to ensure that unmarried women were aware of their social and welfare rights. However noble the intentions of medical practitioners were in this respect, the difficulties with this practice are obvious. It reinforces women's passivity, and takes the issue of choice and agency out of their hands. Furthermore, dominance is displayed by medical professionals in defining appropriate circumstances for childbearing, that is, medical professionals have a standard for how social reproduction should be organised (a family unit with two married parents).

A solution often referred to in the 'caring' literature is to use a non-judgmental approach when assessing a person's health status. One possibility is that during the midwives' assessment, all pregnant women irrespective of marital status could be asked the same questions about their perceptions of the pregnancy, and those who view their own pregnancy ambiguously would then be offered social work services. However, this generalised approach might contravene to some extent the notion of individualised care often associated with holistic practice (Department of Health and Social Welfare, 1984). Aside from this, the reality of using an entirely 'non-judgmental' approach in assessing social health is questionable given that some judgement has been made even to raise issues that might suggest that the status of a pregnancy was equivocal. The yardstick for such judgement is most likely to be relativism, with what is considered to be 'normal' social health getting its cues from wider society, and in turn contributing to them. 'Social health' is poorly defined in the literature, opening up the possibility that, in practice, anti-social behaviour or actions that are at variance with established rules of conduct will be treated as pathological.

The extent of medicine's power in creating the boundaries of 'normality' in the social organisation of reproduction or in simply reinforcing normative discourses emanating elsewhere is open to question. An analysis of a variety of Irish newspapers' would seem to suggest that dominant discourses expressing disquiet about non-marital motherhood are rooted in economics (welfare dependence) rather than in medical concerns, or religion as was previously the case; however medical concerns cannot be dismissed easily as these feature in apprehensions expressed about the psychological impact of absent fathers and concomitant anti-social behaviour of children from fatherless families. Whether medicine, economics, religion, some other realm, or a variety of these, is the driving force in the construction of discourses on the social regulation of reproduction, it is clear from data presented here that, whether intended or not, medicine at least plays a part in the maintenance of social order around social arrangements for childbearing.

Practices which maintain social order were evident in each category of data presented. Promoting adoption supports the two-heterosexual-parent family and reduces the possibility of deviant family formations. Insisting on social work contact exposes the client to social work advice, which tends to promote dual parenting, contact with the putative father where the relationship had ended, or adoption (Flyde, 1996). It also implicitly reminds the client that non-marital childbearing is not fully acceptable, and this may act as a deterrent (along with other messages they receive) to future non-marital pregnancies. Questioning women on their childcare plans and/or competence at mothering suggests that fathers are necessary to adequate childcare; ironically, while it must be acknowledged that some fathers take equal responsibility for childcare, most empirical studies suggest that fathers do not engage in day-to-day childcare to anything like the same extent as mothers.
Notes

1 Since data collection in this study was confined to interviews with pregnant women, the analysis is not concerned with presenting any kind of 'objective reality' of medical encounters (even if this could ever be achieved). Rather, it endeavours to understand women's subjective experiences of such encounters. The interpretation of data is based on comprehending participants' constructions of such interactions, and locating these within wider social processes.

2 Dey (1993: 225) notes how qualitative data is characteristically uneven in quality, with some data being 'useful and interesting in the empirical context' and others being 'less useful'. Nonetheless, the weight of evidence is in support of a theoretical position that is important, and an assessment of this in proportion to its empirical scope. Nonetheless, the weight of evidence is in support of a theoretical position that is important, and an assessment of this is in proportion to its empirical scope. Nonetheless, the weight of evidence is in support of a theoretical position that is important, and an assessment of this is in proportion to its empirical scope. Nonetheless, the weight of evidence is in support of a theoretical position that is important, and an assessment of this is in proportion to its empirical scope.

3 Although the analysis of Irish newspapers was rather crude, articles or letters from a wide variety of newspapers were included. These newspapers were:

Irish Independent, 26/03/87; 23/05/87; 23/08/87; 10/09/87; 10/02/88; 30/11/88; 13/03/89; 02/05/89; 25/05/89; 14/06/89; 10/11/89; 01/10/90; 13/11/91; 01/10/92; 6/05/92; 13/06/92; 03/09/93; 09/09/93.

Irish Press, 23/05/87; 10/09/88; 25/01/92.

The Irish Times, 16/02/72; 17/02/72; 18/02/72; 09/05/87; 10/09/87; 05/11/87; 28/12/87; 26/07/88; 28/01/89; 25/05/89; 26/07/90; 25/02/92; 24/04/93; 13/10/93; 19/10/93; 04/03/94; 07/03/94; 27/05/94; 09/11/94; 13/12/94.

Sunday Independent, 20/07/87.

Sunday Tribune, 16/04/89; 31/10/93.

The Star, 13/04/89; 23/09/92; 28/09/93.

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