SEX-ROLE INFLUENCE ON BIRTH EXPERIENCE

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INTRODUCTION

Does sex-role ideology affect the experience of childbirth? We contend that there is a basic difference between childbirth attended by a midwife in the home setting and that attended by a medical doctor in the hospital setting, and we also contend that sex-role ideology is the main influence in that difference. These two types of social organizations associated with childbearing have reached a state of competition and complementarity in terms of role expectations of birth attendants, the ranking of people at a birth, and individual and group goals associated with the birth experience. The two groups need to communicate.

BIRTH ATTENDANT'S DIFFERING ROLES

In a modern obstetric delivery in the United States, the expectation of the doctor is that of an interventionist. Usually a male, he uses his skills, training, and expertise to extract the baby (Davidson & Gordon 1979; Shaw 1974). The few women doctors who operate in this role tend to follow the male goal of intervention, as they are culturally conditioned to do (Arms 1975). Intervention is consistent with male socialization to be dominant and to control (Robertson 1980; Brannon 1976; Farrell 1974). The midwife, usually a woman, is satisfied with being an assistor. Feeling less compelled to intervene, she is more prone to let nature take its course (Brannan & Heilman 1976). This is more consistent with the female socialization process, where women are raised to be more nurturant, more passive, and more emotionally expressive (Allen & Harcoun 1976).

The interventionist role of the male doctor includes the use of drugs, instruments, and mechanical equipment, and of processing patients effectively in the hospital setting. Midwives are less apt to use technology or drugs, or to be in such a hurry. As stated by a medical sociologist, "Because of their basically different orientations and roles in childbirth, nurse-midwives and residents emphasized different skills .. Nurse-midwives .. were taught to care for their clients, and human relations were stressed." (Scully 1980 127). The male doctor's role expectations of intervenist, technologist, and scheduler are consistent with the male upbringing to control the situation. The midwife's expectation of assistor and supporter are consistent with female rearing for nurturance, cooperation, and passivity.

ATTENDANTS' RANKING

There is a role hierarcy in the hospital setting, with doctors at the top, nurses in the middle, and patients at the bottom. Women in labor are often treated as naive and ignorant objects to be fitted into the system. So passive is the woman in this situation that one psychoanalyst claims that professionals try, as far as possible, to have the baby by proxy (Lomas 1978). The hierarchical relation is said to continue between doctor and the woman well beyond birth, through unnecessary surgery up to control of menopause (Corea 1977; Gelein & Heiple 1981).

In contrast, the relation between mother and midwife is that of equality. In the home setting, there are usually no formal procedures of submission, admission, or address which the woman experiences with hospital staff members, from orderlies, nurses, and doctors. And in the postpartum situation, the midwife follows the mother's progress and that of the baby as a concerned friend.

INDIVIDUAL GOALS

Though doctors and midwives share the objective of a healthy mother and baby, there are different goals associated with the way the birth is handled. The doctor is under pressure to apply the technical and medical skills learned in medical school. Natural childbirth gives no opportunity to apply these skills. The midwife, however, uses little or no specialized techniques in a normal delivery, and does not feel that her role is diminished.

A contrast can also be seen in the unpredictable pace of labor and delivery. Faced with the demands of keeping patients moving through the hospital facilities and wanting to finish the delivery, doctors often use mechanical and pharmacological means to speed labor and delivery (Anderson 1979). Midwives are more committed to the individual client. In the home environment, they feel no urgency to accelerate the birth

process or to treat it in conveyor-belt fashion. Midwives are apt to have borne children themselves, and sociologist Oakley sees this as an experience which alters attitudes, and as important in making women more empathetic as midwives (Oakley 1979).

GROUP GOALS

The primary group is the family of the woman into which a baby is being born. Restrictions from physicians and hospital administrators may range from not allowing any family members to inclusion of some members in a "birthing room" environment. A more common practice is to restrict children from all participation, and to allow husbands limited participation. If family members are present, they must conform to policies and procedures outlined by hospital physicians and administrators.

When a midwife attends the birth, as she does in over 80 percent of the world's deliveries, it is a family-centered event. Husbands are invited to participate actively, and children are welcomed as well. Friends or relatives may also have roles if they are able and willing (Samuels & Samuels 1981).

Birth attendants make up another important group. Apprentice midwives and invited friends form an assistance and support element for the midwife and mother. As a group, all women who are present lend encouragement in a type of mutual support called social birth (Wertz & Wertz 1977). The *we* feeling parallels the sociological concepts of mechanical solidarity and *gemeinschaft.*

The medical group at the hospital has specialized skills and roles which separate them from the patient, and from each other. In using interventionist skills to remove the baby from the woman, they exhibit the more formal characteristics of a *gesellschaft* in the organic form of solidarity. Childbirth preparation classes can generate the *we* feeling among expectant couples, if interaction is encouraged. However, home-birth preparation classes probably generate more *we* feeling.

CONCLUSION

There are two types of birth in which there is little communication betwen practitioners. Home birth through midwifery is increasing (Baldwim 1979; Petty 1979; Ward 1977). Women's rights advocates are increasingly unhappy with the way male doctors control their bodies (Eichholz 1980 250). Doctors see midwives and the home-birth movement as unsafe for both mothers and babies. Yet some studies comparing home birth and hospital birth indicate that home birth may be safer for low-risk women (Stewart & Stewart 1977). Pregnant women giving birth are caught in the middle. They may choose the male-dominated birth in a hospital, or they may find access to medical services limited if they choose a home birth with a midwife. A few doctors support home birth, such as those in American College of Home Obstetrics, but many doctors label home birth as dangerous, and even criminal (Randal 1980). This attitude goes back historically to male midwifery when doctors claimed their own techniques and hospitals were safer. Some of the doctor's remarks at that time were clearly sexist (Wertz & Wertz 1977). Today, the United States remains 15th among the nations in infant mortality. In many of the nations with lower infant mortality, most of the babies are delivered by midwives. Since the modern midwife uses hygienic techniques and basic equipment--such as a fetoscope and a blood-pressure cuff--to insure that labor is normal, home birth is at least as safe as hospital birth for normal women. Then why are so many doctors opposed to home birth? There may be three reasons: 1) raising the risk and cost of malpractice suits; 2) continued sexism; 3) future competition with obstetricians in the United States (Kraus 1981).

Medical doctors review both sides of the home-birth controversy and state: ".. We must develop a more effective relationship with home-birth advocates .. We believe a more humane and respectful approach .. is possible and necessary." (Adamson & Garem 1979 1736). We hope that midwives and medical professionals will communicate and cooperate. Backup service in case of complications is essential for safe home birth. The certified nurse-midwife is increasingly accepted as a birth attendant, and she may become the link between midwife and obstetrician (Hurzeler 1981). Women should overcome their traditional sex-role learning which encourages passivity and dependence on men, and take responsibility for their own health care. Satisfaction, joy, and safety should be possible for the majority of women giving birth in

woman-controlled childbirth.

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