The medical construction of midwifery. Representations and practices in Catalonia, Spain

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Abstract

Objective. To describe how discourse has been constructed regarding parturition (delivery) and the need for medical intervention in Spain. **Methodology.** This was a qualitative study. Interviews were conducted with seven midwives who practiced in Cataluña (Spain) during the middle of the last century. Their opinions were compared to medical discourse gathered from research published in the Spanish Journal on Obstetrics and Gynecology *(Revista Española de Obstetricia y Ginecología)* between 1954 and 1960. **Results.** Against the normality of the evolution of most parturitions reported by the stories of the midwives, in medical definitions these appear as problematic or altered in their duration and by the presence of pain, justifying their systematic interventions; although the aforementioned poses a risk for women and their offspring. As a result, the discourse defining most deliveries as pathological is reaffirmed. **Conclusion.** The medical system constructed midwifery as a surgical process. Women are engaged in other more realistic constructions in agreement to their needs. Care at birth is perceived as a cultural construction and, hence, susceptible to change.

Key words: parturition; women; power (psychology).

La construcción médica de la asistencia al parto. Representaciones y prácticas en Cataluña, España

Resumen

Objetivo. Describir cómo se han construido los discursos sobre del parto y la necesidad de intervención médica en España. **Metodología.** Estudio cualitativo. Se realizaron entrevistas a siete matronas que ejercieron en Cataluña (España) a mediados del siglo pasado. Se compararon sus opiniones con los discursos médicos recogidos en las investigaciones publicadas en la Revista Española de Obstetricia y Ginecología entre los años 1954 a 1960. **Resultados.** Frente a la normalidad de la evolución de la

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mayoría de los partos que informan los relatos de las matronas, en las definiciones médicas aparecen como problemáticos o alterados en su duración, además, por la presencia del dolor, justificando sus intervenciones sistemáticas, aunque lo anterior suponga un riesgo para las mujeres y sus criaturas. Como resultado, se reafirma el discurso que define como patológicos la mayoría de los partos. **Conclusión.** El sistema médico aparece construyendo la asistencia al parto como un proceso quirúrgico. Las mujeres están haciendo otras construcciones más realistas y acordes con sus necesidades. La asistencia al nacimiento como una construcción cultural y, por tanto, susceptible de cambios.

Palabras clave: parto; mujeres; género; poder (psicología).

A construção médica da assistência ao parto. Representações e práticas em Cataluña, Espanha

Resumo

Objetivo. Descrever como se construíram os discursos sobre do parto e a necessidade de intervenção médica em Espanha. Metodologia. Estudo qualitativo. Realizaram-se entrevistas a sete matronas que exerceram em Cataluña (Espanha) em meados do século passado. Comparam-se suas opiniões com os discursos médicos recolhidos nas investigações publicadas na Revista Espanhola de Obstetrícia e Ginecologia entre os anos 1954 a 1960. **Resultados**. Frente à normalidade da evolução da maioria dos partos que informam os relatos das matronas, nas definições médicas aparecem como problemáticos ou alterados em sua duração e pela presença da dor, justificando suas intervenções sistemáticas; ainda que o anterior suponha um risco para as mulheres e suas criaturas. Como resultado, reafirma-se o discurso que define como patológicos a maioria dos partos. **Conclusão.** O sistema médico aparece construindo a assistência ao parto como um processo cirúrgico. As mulheres estão fazendo outras construções mais realistas e conformes com suas necessidades. A assistência ao nascimento como uma construção cultural e por tanto, susceptível de mudanças.

Palavras chave: parto; mulheres; poder (psicologia).

Introduction

Our way of interpreting social events, indicate Berger and Luckmann, responds to a given way of understanding reality within a time and context, which "is presented as objectified, *i.e.*, constructed (…) as an organized reality".[1] It is in this sense that we speak of the medical construction of the delivery, that is, how we currently represent it, responds to a given way of interpreting these events within a limited time and context. Since recent years, we have been interested in the evolution that has shaped the reality of current delivery care in Spain.[2,3] The stories of the women, the social and medical representations, the threats surrounding it, or the risks supposedly accompanying it led us to seek in its construction in the discourse and medical research from the middle of the last century, comparing them to the discourse and practices of other professions that participated in this process; these are the midwives. We gathered their practical experience in caring for women in their homes, looking to inquire on the events which have resulted in the current representations of the delivery.

The possibility of having Access to the stories of these midwives –in general poorly represented in medical texts-, is an ideal opportunity that will allow us to establish comparisons among the different forms of interpreting the reality of birth in the past 60 years. We start from how care at birth is understood is a changing, dynamic process and

in interrelation with the other social processes. For this work, the starting questions are: How and why have ideologies been constructed with respect to current delivery care? Is the delivery really a situation needing medical aid? Is the evolution of the delivery accompanied by its supposed risks? The initial hypothesis is that current representations on the delivery problems are a cultural construction that responds to certain gender relations, where structural differences are maintained of the division of work and; therefore, of power and prestige.

From this, we set out on the objective of knowing how the problem of the delivery process in Spain has been shaped and, as a consequence, the need for experts to control it, the widespread fear among the population, the supposed disability of the female bodies to undertake it, their submission to medical interventions, and their dependence on professionals. We understand that this research theme is of interest for women's health. Our ultimate purpose is to provide a critical analysis, which captures the articulation among the different ideologies and practices that have emerged in the construction of midwifery, supporting the emergence of discourse more in line with the real results of births, from where confidence of women in themselves and in their own biological capacities is promoted.

Methodology

This was a qualitative study frame worked within the methodological perspective of grounded theory. To collect the information, we used two resources; the first aimed at knowing the experiences of midwives and the second centered on the review of research published in the Spaniard Journal of Obstetrics and Gynecology.

For the initial sample, 12 midwives were identified through records from the School of Nursing of Tarragona and followed by the snowball strategy. The inclusion criteria were that they had practiced in Tarragona (Spain), both in rural and urban areas between 1950 and 1960. Excluded were those whose cognitive situation kept them from participating in the study and those who rejected participating. The final sample included seven midwives ranging between 70 and 88 years of age.

The technique used for data collection was in-depth interview, with a script reflecting the different thematic sections that permitted identifying the experiences and views of the midwives from an "emic" perspective, that is, from the vision of the very protagonists. To contact the midwives, in the first place the School of Nursing requested their consent and, in case they accepted, provided their telephone contact to the researchers. Again, participant consent was secured during the first telephone meeting and, in their homes, they were explained the nature of the research requesting their signed written consent, guaranteeing ethical and legal principles like anonymity and confidentiality. Interviews were conducted between 2009 and 2010. All were carried out in the homes of the midwives and digitally recorded; these lasted approximately 90 minutes and were literally transcribed.

For the data analysis, in the first place, each interview was read and then coded, establishing an initial identification of the categories. Second readings consisted of reviewing and clustering the categories to, finally, define subcategories for each block. Along the whole process and, due to the number of midwives interviewed, saturation of the data was not sought, but to know the general trend of that considered "normal" in care of deliveries by these women, so that it could be contrasted with the medical discourse and practices.

The second resource in collecting the information was the review of research published in the bi-monthly journal *Revista Española de Obstetricia y Ginecología*, from 1954 to 1960. We selected this medium because it is the most prestigious obstetrics journal in which renowned Spanish obstetricians participated during the years of study. Additionally, it includes investigations by obstetricians in South America and other European reference. All this brings to knowing the situation of obstetrics at the time. The process initially followed was the selection of the obstetric research publications from each number, included

the issue of "summary and comments from obstetric literature". From these, topics narrowed to those aimed at shortening the time of deliveries and to those centered on the cancelation of pain. The rest of the topics were discarded. In total, 18 articles were reviewed. Our interest focused on discourse, ideologies, power, representations stemming from what being a woman was supposed to mean for the medical institution and the control practices over their bodies.

Adhering to the orientation of grounded theory, to contrast the data, we used other texts from medical authors considered influential during the time in Spain, like the director of the journal mentioned,[4] the text aimed at the formation of midwives,[5] and the work of a matron.[6] The years of study are justified in that said years culminated the practice of medical appropriation of the delivery and reproductive control, becoming the prelude to the disappearance of midwifery in homes. The methodology followed for the analysis was the same used during the interview, establishing comparisons within the common themes between medical practices and those of the midwives.

Results

The process and act of giving birth has been traditionally draped within a cloak of mystery. Women and professionals have represented it and accompanied it in different forms and have related it to social circumstances, time, and context in which it is produced.[7] To learn of these events, the results are presented in two sections. The first gathers the representations, relationships, and roles of midwives and doctors and the second centers on the "medical direction of the delivery" with the analysis of the investigations reviewed regarding: shortening the duration and pain reduction during delivery.

Images of the delivery from the midwives. During interviews made of the midwives, generalized discourse emerges that deliveries, for the most part, evolve normally. There is no mystery or wonder in their words, although they did allude to their professional knowledge resulting from their formation. Some explained the few problems they had encountered, after being detected, and made the determination to transfer the women to the maternity ward, notified the physician or rather solved the problem on their own. One of the interviewees expressed: "if deliveries had been as difficult as they are now, all the women would have died on me and I tell you that no one has died" assuring that "we cannot compare the psychosis and fear they feel now to what they had before. They had nothing" (Isabel).

The writing by Vía[6] are in the same regard. Her story captures the generalization of the good results stating that "the highest percentage of good deliveries corresponds to those carried out in homes"[6] coinciding with the results by Bosch Marín.[8] On the contrary, from some medical discourse delivery "is a dirty act" or "a bloody, brutal, and risky function";[4] an opinion that seems shared by other obstetricians, and supposedly by some women as well because "today – generally – all wish, in light of the horror of delivery, to be provided with some remedy to better endure the event".[9] Thus, for obstetricians "no delivery is verified without danger or harm for the mother and child. Who can doubt that all fetuses run risks at birth and always suffer traumatism?".[4] Under these perspectives, obstetricians seem to feel the need to save women from their deliveries that, in our opinion and based on the revision made, the need rather seems to respond to their own interests because "it tests (...) the integrity and compassionate feelings of those witnessing it"[4] and "its fickle termination, may ridicule us when it is precipitous or exhaust our patience and physical energies when it is tediously delayed".[4] Other negative aspects, according to Clavero Núñez are its unexpected and impertinent introduction –most times- "that keeps obstetricians from projecting their rest, their personal lives, as well from planning their activities".[4] With this reputation, it is understood that obstetrics has focused on the objective of its interventions on subjecting and adapting it to its own criterion.

The stories by the midwives also alluded to dedication, but without questioning it, considering

it implicit to the profession: "I went whenever I was called" (Pilar) "I never knew when I would go back to the house" (Ana); these were habitual sentences. The midwives in the city had a space that facilitated the physician's dedication. The midwives were expected to remain by the woman's side, a function requiring patience, dedication, and knowledge for early detection of possible problems. Only when the delivery reached its end with the birth, did the obstetrician or physician, alerted by the matron, show up to receive the child, a moment in which the physician performed certain interventions or "active support",[4] which justified their presence and reinforced their prestige.[10] Vía[6] explained one of these situations and expressed her feelings when comparing how small and simple her instrumentation was "next to all the big instruments used by the physician". And, socially, physicians are expected to perform their role as such, and their professional intervention is legitimized through practices and differentiating techniques.[11] This care procedure is still in effect among some sectors: "We do the work and they take the merit" explained Pilar, and this is also related to significant economic differences. It is noted that "the same tasks may be noble and difficult when performed by men, or insignificant and imperceptible, easy and trivial, when women are in charge of carrying them out".[12]

During their formation, midwives were trained as aides for the physician: "The midwife's collaboration has always been useful (...) when she has been well trained, this saves us a lot of work and avoids useless waste of time"[4] and Orengo reminds them of one of their functions: "she will be well aware, for example, during what moment of the delivery should the physician be called and will make sure the physician does not arrive after the child's birth"[5] advising that if the physician is late "the delivery can be delayed if the woman is placed on her side and is asked to refrain from pushing".[5] Care of deliveries by the physician and the matron was conducted under these premise. We understand this control as responding to the reaffirmation of maintaining medical power against the matron's submission.

Some midwives interviewed, like Maria, opposed this model and opted to work alone. Teresa explained that during her formation, she was not permitted to repair perineal tearing and due to this she also studied a practitioner career, a profession more destined for males who were authorized to perform these functions. Midwives were able to practice with certain autonomy in rural areas and small circles, while obstetricians in general centered their activities on private care, clinics, and maternity wards in big populations, which provided them greater economic benefits.

Medical direction of the delivery. Ruiz[13] indicates that by the end of the 1960s "guided delivery" emerged in the *Maternidad Provincial de Madrid,* which "had the advantage that it was verified at the discretion of the person or team directing it". In articles reviewed, attention is drawn to the repeated publications interested in this direction of the delivery and we found the use of women as laboratory materials for medical experiments or "direction", even if this posed a risk for their lives or that of the fetus.

Control of women's bodies has traditionally been of interest for medicine, which defines them as pathological or classifies them as dysfunctional.[14,15] Now, the body during the process of giving birth does not adapt to a so-called medical order. Additionally, within this ideological structure, women will be introduced as needy, petitioners, and beneficiaries of medical interventions. The following analyzes two different discourses of the medical construction of the guided delivery: the need to reduce its duration and the analgesia or anesthesia.

A short hour. The scheme of the female body, implicit in medical discourse, is characterized by a biologist conception from which it is conceived as prepared for reproduction, to what naturally responds as if it were a machine.[5] But these machine bodies do not work the same way or at the same time. In many, "the delivery motor works to perfection"[9] but in general "it is necessary to pre-heat the motor (in our case the obstetric motor) before making demands on it"[16] and a majority distrusts, because: "even the normal limits are often inaccurate and arbitrary",[17] which opens the door to manipulation based on some subjective criteria like being or not "supportive

of the medical direction of the delivery and of its abbreviation".[18] Having an active attitude – interventionist- is presented as positive against an expecting conduct, which is attributed to ignorance of the physiology of the delivery.[4]

Medical discourse focuses on reducing its duration. It tries to modify the course of the delivery in shortening it by conducting tests with current medication[19], each according to their means and tendencies.[20] Thus, diminishing the time of dilation is in the sights of many,[16-19,21,22] presented as a success that others will seek to overcome as if it were a contest[22,23] to "have rapid and spectacular results".[18] Some authors justified their interventions upon a supposed interest in women because, in the opinion of López Fernando, they increasingly find delivery more difficult and unbearable "even for the attending physician".[9] In general, they are presented as bodies without voice, named as "patients we have subjected to the action of experimented drugs".[22]

We are of the opinion that it is in our medical benefit why the interventions are carried out, as stated by Domínguez Mompell:[22] "As we progress in better knowledge of uterine mechanics during the course of the delivery, and at the same time better knowledge of drugs that modify said delivery, we approach through their use this ideal term that constitutes the perfection of the guided delivery. Probably, not much time will elapse for us to scientifically and rationally guide the delivery in correct manner, shortening it to a minimum amount of time".

Reducing the duration of the delivery is then a medical necessity, first justified in solving some alterations and then generalized within a competitive attempt to dominate the dynamics of all bodies.[24] "We do not cease in testing new drugs that could improve the results obtained until now" indicates López Fernando[9], persistence that Domínguez Mompell defines as "liking" and "addition"[22] and Abad Colomer as "firm supporter",[18] that is, of a trend or personal obsession, not a real social need of the women.

Throughout this experimentation, women are the laboratory material. They are subjected to the action of medications or drugs to which it is not known how they will react and which it is reported that they place the woman and fetus at risk. Repeated examinations to test the evolution of the results of intervention and the imposition of a position that permits access to their bodies when professionals so decide; these are situations that must be endured by women in the process of the medical direction of the delivery. These medical investigations also report how the effect of certain medications must be offset by other medications that, in turn, generate the need for another in a race that ends, with the birth or by ending the experiment because of the risk that has been produced.

In addition to reducing the dilation time, intervention will be made with the same objective on the fetus' exit and detachment of the placenta. Some go further stating that: "the obstetrician should not be content at the end of the delivery with touching the 'safety balloon' but rather with a complete uterine exploration to explain the anomalies of evolution, in case these exist".[25] Interventions are done, nothing more, than by the desire of each physician or team. While midwives, within the environment of the maternity wards and clinics, played the role of medical collaborators in the shadows "a matron helps us in conducting the delivery and executes our orders".[9] Few physicians name them in their research and their presence is deduced by the practices. Orengo[19] mentions them positively, justified in that the need for medical presence is one of the biggest inconveniences of the method he investigates and the matron is assumed to provide technical support; and negatively when the author blames them because fetuses are lost during their night breaks, or to remind them of their professional boundaries.[26] Among the midwives from Public Home Care *(Asistencia Pública Domiciliaria)*, as we were informed, deliveries have continued being carried out under their care and the general trend was of normality. The possible presence of alterations during exceptional cases[27] is accepted, which for Orengo[28] is of 4% and which Vía,[6] along the same lines, advocates for non-interference during the course of the delivery; thus, assuring that 95% of them evolve well.

Pain of delivery. Although it may be true that the interest of medicine to relieve the pain of women during child deliveries, we doubt this is its sole objective, given that the medical system "may be considered as one of the main systems for the generation and maintenance of inequalities and discrimination for women in our society".[29] During the 1950s in Spain, religion and dictatorship walked hand-in-hand, and the medical institution has always been part of the dominant classes with which it has shared the characteristics of being a "hierarchical, asymmetrical, classist, and racist" model[30] and which De Miguel, considering his research results, rates as sexist.[31]

We have noted how in the texts reviewed women only appear as nurses and docile, subjected to mostly arbitrary interventions within a discourse that, keeping with tendency of the times, praised the maternal role and defined the delivery as a respectable and divine function[4] they could not escape. We understand, as indicated by, that the passage to maternity –the delivery- fulfilled the functions of redemption of sin –sexuality-; hence, "its resolution should be accompanied by a high dosage of sacrifice and pain",[32] as had been announced: "I will greatly multiply thy sorrow and thy conception; in sorrow thou shalt bring forth children…" (Genesis 3:16). These representations should be modified upon the need for obstetrics to intervene in the bodies, but without abandoning the essence of maternity, as stated by Domínguez Mompell[22] "The new methods, along with correct prophylaxis, positive and scientific education of the future mother will make the delivery an event surrounded by complete physical and spiritual happiness rather than a distressing and sad moment, which requires the woman's overcoming function upon becoming a mother". Norms and social and ideological control of women have been among the characteristic functions of the medical model that, based on supposed scientificity, legitimizes its discourse.

Attempts of medicine to cancel pain during deliveries date to the mid 19th century, but the imperfection and risks of the techniques[33] gave way to different types of psychological induction interventions that, in Europe, assumed the name of obstetrical psychoprophylaxis or "painless childbirth".[34] It was necessary to request approval of the Church (Pope Pius XII) to systematize its use.[35]

The method spread throughout Spain and was well accepted among physicians and midwives. Some of them and two of our participants traveled to Paris to learn its technique. Hernández Jiménez[36] was one of its supporters, but ended up accepting as *"failure"* when the woman did not accomplish the painless childbirth. Sardiñas showed interest in the method and talked of "collective suggestion" to explain the pain "that transmitted from generation to generation has etched the concept of the association between delivery and pain".[16] Said author explains that he tends to women prepared with the method, but upon using drugs that shorten the delivery, intervention is needed with medications. Abad[18] used it for the same purpose and training "the woman during pregnancy through the psychoprophylactic method (…) and the constant presence of a specialized instructor"[17] will facilitate carrying out the interventions he proposed for the medical direction of the delivery. For these authors, psychoprophylaxis was considered inasmuch as it could respond to their need to research on women.

Midwives also joined in the practice of this new method, although pain was not the theme highlighted in their stories. In the psychoprophylaxis they found a setting of professional autonomy in the promotion of normal deliveries. Alba stated that "women did not know how to give birth" and taught them with this method. Vía explained that somehow it is what midwives had been doing and who had preceded it; "offer information to pregnant women so they can achieve painless childbirth or at least with less painful contractions";[6] she reported that she practiced something similar without knowing that it was a method.

Detractors emerged for the initial medical enthusiasm, who decided "to put an end to this flood of disclosing literature".[37] The psychoprophylaxis needed the women's participation, and this responded, as noted from the authors, to their intervention perspectives, given that it did not

annul pain during the whole delivery. It was not a good allied for experimentation because – additionally – women remained conscious. Only occasionally, will the method be referred to again along the study years, but always as a wildcard for anesthetics.

Medical interventions sought to find the pharmacological preparation that best responded to the cancellation of pain with the least adverse effects on the woman and the fetus, although it is indicated that "currently, no truly efficient anesthetic exists to suppress pain without it not being harmless for some reason or paralyze the delivery",[9] and this conclusion needed fetal deaths to be demonstrated.[23,28] Dexeus and Varela[38] focused on the analgesic volume, warning of "the possibility of serious accidents for mothers" and then "experiment" taking back their own words, in the association of different drugs according to availability at the time.[22] Regional anesthesia has some supporters[39] and others prefer inhaled analgesics[9,15,22] or intravenous analgesics.[40] All refer to caution when employing these means that will be discarded because of their secondary effects or risks, and which will be substituted by other methods.

Experimentation of the different anesthetic methods in the authors reviewed is always accompanied by interventions aimed at reducing times of deliveries and – consequently – Orengo[41] exposes that "women are subjected to excessive discomfort and because of this analgesics will be frequently used", a recognition we consider exceptional, given that the traditional general thought in the medical system does not admit that its actions can cause pain.[7] Thus, there is pain as a consequence of the delivery's physiological evolution, but which is increased as a result of medical interventions.

Finally, to the risk of experimenting because of the lack of awareness of the la action of drugs on the maternal or fetal bodies, we add the risk related to the expertise of the researcher or team. The authors warn that interventions must be carried out by expert hands and Dexeus and Varela wonder "How to manage a procedure that requires vast experience?"[38], accepting that, even with experience it is possible to fail. It is deducted, as indicated by Foucault, that medical progress brings "medical risk" or "a hard to break link between the positive and negative effects" of medical action, stating that "there is no great medical progress that has not paid the price of diverse negative consequences directly related to said progress".[42] Thus, the women who attended the maternity wards for their parturitions during the 1950s were part implied in the progress of obstetrics.

Discussion

By the mid 20th century, the medical system was already socially recognized as having the power for the theoretical definition of the, although more than 50% of the practice still remained in the hands of midwives.[8] The instauration of maternity wards and welfare centers, along with the implantation of social security systems progressively displaced home delivery care toward these settings. This provided to the progress of obstetrics the opportunity to experiment on women's bodies, resulting in the imposition of standardized medical criteria of how parturition should be, its duration periods, or the pain considered acceptable.

These definitions have reached our days. We no longer speak of the physiology of birth; rather, today we socially accept that the delivery is a medical act with a high percentage of possibilities of surgical finalization, a situation that continues placing women's health at risk.

At the same time, these medical definitions contrast with the practices of the midwives, who reiterated on the normality of the births under their care. It is understood that under the inequality of positions, the discourse wielding the greatest symbolic power prevailed; in this case, the discourse of the medical system, independent of its veracity. Additionally, the logic of order in the prevalence of the definition, responds to power relations according to social systems of gender. One of the difficulties of the study was that of contrasting the stories on the midwives'

practices and points of view to the practices of the investigations and medical opinions. Although both professional groups shared the same field of care, their positioning by mid century was distant, occupying spaces –in general- of dominance by some and subordination of others, with limits imposed by the first. Also, midwives were not prepared for research and we only have one text written by one of them.

Finally, although currently in Spain other more realistic constructions are emerging and closer to the needs of women, it is necessary to go to the sources of the construction of the social reality –in this study, the delivery – as an exercise that will allow us to unveil the positions from which stem their interests, ideologies, and bases that support them, placing care at birth as a cultural construction and, hence, susceptible to change. This will provide us with elements to analyze and eliminate healthcare situations with unnecessary levels of intervention, where inequality and physical and ideological submission of women is still maintained. Nursing professionals are in a privileged environment for this.

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