Abigail Carr, *'Technology run riot': The Impact of Birth Interventions on Women's Birth Experiences in 1970s Britain*

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The medicalisation of childbirth fundamentally changed women's experience of pregnancy and labour. Post-war Britain saw increased medical intervention to artificially induce or accelerate birth through surgery or the use of drugs, practices which coincided with the advent of new technologies, the establishment of the NHS, and most crucially with the Peel Report (1970), which advised that all births should take place in hospital.[1] Such interventions were perceived by some feminist writers and natural birth advocates to have removed control from the pregnant woman and thus reduced her own involvement in, and satisfaction with, her birth experience.[2] Conversely, obstetricians maintained that women appreciated intervention as it made childbirth easier.[3] In exploring the veracity of these competing perspectives, this article will determine how pregnant women themselves felt about birth intervention, and how it impacted their experiences. The initial focus will be on induction, a procedure undertaken to initiate birth by rupturing the amniotic sac and artificially stimulating contractions through medication. This practice accounted for 41% of NHS hospital deliveries in England by 1974 and therefore represents one of the more significant changes that came

[1] Davis 2012: 85; Tew 1990: 155.

[2] Kitzinger 2004: 18.

[3] Tacchi 1971: 1135-6; *A Time to Be Born* [film] 1975. The term obstetrics refers to a branch of medicine focusing on the care of pregnant women and childbirth.

with medicalisation.[4] Other birth interventions associated with induction will then be explored, primarily in reference to the 1970s but with some exploration into the 1980s.

The medicalisation of labour began in the 1930s which saw a mechanical approach to childbirth involving the increased use of forceps and uncomfortable birth positions, practices which were perceived by later critics to have reduced the pregnant woman to a simple vessel of reproduction.[5] By the 1960s and 1970s new technological procedures such as induction replaced old mechanical ones, and thus the obstetrician still retained control over the birthing process. Indeed, the scale of this influence also increased as hospital deliveries represented 96% of births by 1974.[6] Doctors favoured medicalisation as it allowed them to manage the labour as they saw fit and cope with complications during childbirth.[7] However, many interventionist procedures were introduced without any real consideration of their efficacy or safety. Author Marjorie Tew suggested that consultant-led hospitals had higher stillborn and perinatal death rates than home births based on data from 1970, and feminist writer Ann Oakley showed that there were no comprehensive studies conducted to prove the superiority of any interventionist obstetric practice before these were implemented on a national scale.[8] Oakley further suggested that doctors only promoted medicalised births to retain their dominance over the field; by the 1970s the (often male) obstetricians had reached a greater status of expertise on birth than their

[4] Cartwright 1977: 745-6.

[5] Tacchi 1971: 1134; Kitzinger 2004: 2; Tew 1990: 140-1.

[6] Cartwright 1979: 1.

[7] Tew 1979: 1388.

[8] Tew 1979: 1390; Tew 1990: 26; Oakley 1993: 20.

female patients, and therefore felt they had earned the medical right to take control of her birth experience through intervention.[9] This illustrates why medicalisation came to be so heavily criticised in the 1970s and 1980s: the obstetrician's appropriation of birth was seen by feminists and natural birth advocates as both an affront to women's individual autonomy and a potential threat to their health.

Nonetheless, intervention persisted and continued to affect birth experiences. Studies conducted in the last thirty years have shown that the amount of control a woman retains in childbirth is central to this experience, in terms of the health and happiness of both mother and baby.[10] For the purposes of this article, then, this notion of control will be the main indicator of how intervention impacted women's birth experiences, and can be understood in two ways: the first being physical control (meaning the extent to which a woman was conscious of what her body was doing, and whether she could influence this), and the second being emotional control (meaning the extent to which she *felt* that she was leading her own birth experience). Due to the lack of comprehensive data gathered on women's experiences from this period, most information used in this essay is sourced from qualitative studies, feminist literature, and documentaries from the 1970s and 1980s. These sources contain both statistical evidence and first-hand accounts of birth experiences, which taken together provide a substantial overview of the experience of medicalised pregnancy in this period from the patient perspective, rather than the medical which has traditionally dominated. They

[9] Oakley 1993: 23.With this came perceiving the pregnant woman as a patient in that she was unwell and in need of treatment (or at least monitoring), which only the obstetrician could provide. See Young 1984: 56.

[10] Clesse et al. 2018: 164; Williams 1997: 243; Arney and Neill 1982: 11.

are perhaps limited in how much they represent the national experience of birth intervention, but nonetheless present a more reliable picture of the woman's perspective than socio-medical surveys, for example, which tended not to take this into consideration as thoroughly.[11]

The foremost birth intervention which came with the shift towards medicalisation in the 1970s was induction, which in some hospitals counted for over half of labours. Obstetricians most frequently employed induction when babies were overdue (as there were serious risks associated with this), however it was increasingly utilised in the 1970s for other reasons also: many obstetricians felt that it led to shorter labours (which they perceived as the aim of modern obstetrics, and as something which women wanted) and allowed the hospital to cope the best it could since births were timetabled.[12]

While some women did appreciate induction because it allowed them to emotionally prepare for the birth, knowing when it would be,[13] a significant proportion of women did not always agree with these medical perceptions. This is evident in a study conducted by statistician Ann Cartwright in 1977, which showed that only 16% of women surveyed actually *wanted* an induction.[14] Some women felt that it was 'unnatural' and 'rushed' the baby before it was ready,[15] suggesting that they perceived induction as an affront

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[11] Oakley 1993: 21.

[12] *A Time to Be Born*; Cartwright 1977: 747; Tacchi 1971: 1135.

[13] *A Time to Be Born.*

[14] Cartwright 1977: 747. Cartwright interviewed a random sample of 2,182 women who had live births in 1975, from twenty-four study areas across England and Wales. 24% of the women in this total were induced, though this proportion ranged from 6% to 39% within the study areas. These women gave birth in medically controlled locations, including GP maternity hospitals, teaching hospitals, and private hospitals. They were interviewed when their babies were three to four months old, and therefore the memories of their birth experience were relatively clear.

[15] Cartwright 1979: 106; Cartwright, 1977: 748.

to them being able to manage their pregnancy themselves. Moreover, a further 66% of women said they did not feel they had a choice in whether or not they were induced,[16] which indicates that many women felt pressured into it. Indeed, Jan Williams gives an account of one woman who, at a doctor's appointment, was coerced into having an induction, despite protesting and saying she wanted to discuss it with her husband first.[17] In this case, not only was the woman's physical control over her labour taken away from her before it even began, but her emotional control was also removed in that the doctor 'magnified the doubts of her ability to manage the birth herself.'[18] This type of coercion, Williams argues, was rooted in the obstetrician's claim that induction was safest for the baby, which was why many women accepted the procedure.[19] However, acceptance cannot be equated with satisfaction in terms of birth experience, and this is further evident in that 78% of women surveyed by Cartwright stated that they would prefer not to be induced again.[20]

Furthermore, women's acceptance of induction in this period did not necessarily mean that they felt informed enough to retain any control during induced labour. A significant theme throughout several surveys of birth experiences is that many women felt underprepared,[21] which could both reduce their control and worsen their anxiety surrounding childbirth. Cartwright's study showed that two-fifths of women wanted more

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[16] Cartwright 1977: 748.

[17] Williams 1997: 238.

[18] Ibid.,238.

[19] Ibid.,238.

[20] Cartwright 1977: 748

[21] Davis 2012: 107; Oakley 1984: 245; Cartwright 1977: 248.

information about induction before they had it, and a further 43% of mothers who were induced said that they had not discussed induction with any health professional during their pregnancy.[22] That some women felt unprepared because of this highlights the importance of control in the birth experience, and the difference that knowledge could make to this. For example, Cartwright offers an account of a woman who, upon arrival at the hospital, was induced with little discussion, leaving her 'scared stiff having things done and not knowing what it was.'[23] This woman further described feeling as though she was 'just a thing – not a person with a mind,'[24] suggesting that some women could feel entirely powerless at the hands of birth intervention, having been reduced to less than a person and thus lost the ability to lead their own birth experience (in other words, having lost emotional control). This is supported by Oakley's research which confirmed that women who had induction were more likely than those whose labour was spontaneous to suffer from post-partum depression,[25] indicating how an emotionally stressful birth experience could have serious and damaging consequences for new mothers.

Moreover, women lost physical control over their birth experience through induction itself, specifically through the way it forced contractions. What obstetricians saw as shorter labours were not necessarily seen by women as *better* labours, for the artificial stimulation of 'uterine activity' via an oxytocin drip could cause contractions to come faster and stronger than the woman could naturally cope with.[26] This could lead to a particularly painful

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[22] Cartwright 1977: 745, 748.

[23] Cartwright 1979: 94-5.

[24] Ibid.,94-5.

[25] Oakley 2016b: 693; Cahill 2008: 339.

[26] *A Time to Be Born.*

labour in which the woman was unable to follow the pace of her own body; indeed, Cartwright's study found that induced women who received more painkillers experienced the same levels of pain as women with less painkillers in spontaneous labour.[27] Additionally, imperfect technology meant that oxytocin levels could become too high, at which point the uterus muscles could go into spasm, leading to surgical intervention.[28] One woman interviewed for the 1975 documentary *A Time to Be Born* stated that her oxytocin drip was increased so much that she had very strong and 'bad' contractions, which ultimately led to a drop in the foetal heart rate that saw her 'shoved' into theatre for an emergency c-section.[29] This demonstrates that not only could induction lead to a more difficult and complicated childbirth, but also that women were consistently unable to manage either their pain or their bodies in induced labour, whether this was due to the physical process of induction itself or the lack of autonomy it permitted.

Beyond induction, other birth interventions to which women were subjected (and may not have initially wanted) could also significantly affect their birth experience,[30] the most common of these being the use of anaesthesia or painkillers. Due to the intensity of induced contractions, women undergoing induction were significantly more likely to be administered anaesthesia than those in spontaneous labour: 89% of induced women (compared to 79% of non-induced women) surveyed by Cartwright

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[27] Cartwright 1977: 745, 747.

[28] *A Time to Be Born*.

[29] Ibid.

[30] These procedures could be employed independently of induction, but all were used more frequently in induced labours in this period.

received pain relief during labour.[31] Women who were induced (and therefore already at some risk during childbirth) were more likely to receive pethidine especially, which is striking considering that its dangers were well-known to obstetricians by the early 1970s.[32] Indeed, pethidine was known to cause women to become drowsy and sickly during labour, and could also affect the baby for up to several days after birth.[33] Several women in Kitzinger's documentary described not wanting anaesthesia during labour for this reason: one mother stated that it would make you 'drugged out of your mind,' with another saying that she refused to have an epidural because 'I wanted the messages coming from the baby to tell me directly what I had to do.'[34] This suggests that women viewed anaesthesia as something which would remove them from their connection to their body and their baby, and thus they considered being 'alert and awake' (and therefore in control) as important to their birth experience.[35]

To some extent, epidurals were viewed as preferable to pethidine (though were not used as often), as they numbed sensation from the waist-down but did not make the woman drowsy and thus did not entirely remove her from the experience.[36] Many women therefore spoke more favourably of epidurals than any other part of their labour, with 63% of mothers interviewed by Cartwright stating that they would have an epidural again.[37] Some greatly appreciated that it allowed them to be fully, mentally present in the labour

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[31] Cartwright 1977: 747.

[32] Cartwright 1977: 747; Kitzinger 2004: 167.

[33] Kitzinger 2004: 167; King's Fund Centre 1978: 18.

[34] *Birth: A Film About Feelings and Experiences* [film] 1986.

[35] Ibid.

[36] *A Time to Be Born*.

[37] Cartwright 1977: 747, 748.

without the distraction or fear of pain,[38] in which case epidurals allowed them to have emotional control over their birth experience. In some ways it allowed them to have physical control also, not in the sense that they could control their body but in that their body was no longer being controlled *by* their pain, which Kitzinger suggests was a huge advantage for women who had suffered previous sexual abuse especially.[39] However, for some women epidurals led to health complications which required even further intervention and made for a difficult childbirth. Epidurals could cause changes in blood pressure that put the baby at risk, and more frequently the lack of sensation meant that women did not always know when to push with their contractions.[40] This increased the likelihood of forceps delivery or emergency c-section; for example, both of the women filmed for *A Time to Be Born* were induced, received epidurals, and had to have their baby delivered by forceps.[41] Another woman, the same who was 'shoved' into theatre for an emergency c-section, had received an epidural after her induction, despite insisting this was 'the last thing I wanted.'[42] This suggests that poor experiences with epidurals were not uncommon among induced women, and highlights that within medicalised childbirth, women could be subjected to increasingly interventionist procedures that they explicitly did not want, and which significantly reduced their control.

Further interventions which impacted birth experience were those which can be understood as surgical: namely, episiotomies and c-sections.

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[38] Kitzinger 2004: 166; Michaels 2018: 56-7.

[39] Kitzinger 2004: 150.

[40] Ibid., 164.

[41] Tew 1990: 132-3; *A Time to Be Born.*

[42] *A Time to Be Born.*

Episiotomies were common among induced women in this period, with over half of those in Cartwright's study having one during labour.[43] However, this was likely part of a general trend: the *Perinatal Mortality Survey* (1963) showed that 41% of women having hospital births were subject to routine episiotomies whether they were induced or not.[44] They perhaps became more common with inductions because they were required when the uterus pushed the baby down the birth canal too fast, which was more likely to occur when contractions were artificially stimulated.[45] Episiotomies in particular were heavily criticised by natural birth proponents and feminist writers from the 1970s, with Kitzinger describing it as a form of female genital mutilation and Oakley stating that they represented the 'more troublesome' aspect of labour in women's memories.[46] Indeed, first-hand accounts from women who had episiotomies supports this; one woman interviewed for Kitzinger's documentary described becoming overwhelmed by the hospital staff who 'crowded' around her telling her to push when she did not yet need to, resulting in an episiotomy that she was 'extremely angry' about when she 'felt the pain of the cut' a few days after labour.[47] She described the most frustrating part of the experience as being that 'none of that was necessary' – she felt that if she had been left with her husband and midwife she could have 'eased' her baby out, without having an episiotomy, 'which is what I wanted to do and which I felt I could do.'[48] Here it is clear that this woman associated this interventionist procedure not only with unnecessary pain but with

[43] Cartwright 1977: 748.

[44] McIntosh 2012: 107, 108.

[45] Kitzinger 2004: 198.

[46] Kitzinger 2004:198; Oakley 2016a: 542.

[47] *Birth*: *A Film.*

[48] Ibid.

removing her emotional and physical control over her birth experience, leaving her frustrated and 'in a panic' rather than calm and able to give birth at her own pace.[49]

Caesarean sections similarly and substantially could affect women's birth experiences. This procedure was marginally more likely to occur as an emergency surgery if induced labour failed, but if a serious risk was identified antenatally it could be planned.[50] While it was somewhat rare, accounting for only 5.3% of births in 1972 and 10.5% in 1985,[51] it represents the most interventionist procedure possible. Whether regional or general anaesthesia was used, the woman loses all physical control over her labour and is left entirely in the hands of the obstetrician. One woman who had both an elective and emergency c-section in the 1980s described the planned surgery as 'far worse' because she was 'wide awake' during it;[52] this illustrates that even if women were familiar with (or informed about) certain interventionist procedures, they could still have a negative experience with them. It also suggests that the element of emotional control is important, as being conscious of what was happening to her body and how little control she had over it was evidently more traumatising for this woman than being removed from the experience completely. Furthermore, much like with induction, one of the common themes among women who found c-sections distressing was that they were not provided enough information about it, even when it was elective. Historian Angela Davis gives the example of one woman who had attended antenatal classes which proved useless because her c-section was not

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[49] Ibid.

[50] Cartwright 1977: 748; Tew 1979; 24, 128.

[51] Tew 1990: 127.

[52] Davis 2012: 73.

a 'normal delivery,' and thus she found the experience 'extremely traumatic.'[53] In this respect, it is clear that the lack of information left her feeling scared and powerless when things went 'wrong.'[54] Davis describes another expectant mother who had an elective caesarean in 1978, but upon arrival at the hospital was alarmed to discover that the procedure involved surgery; this was likewise described as traumatic for the woman,[55] further illustrating that knowledge and confidence were significant to satisfaction with, and control over, the birth experience.

To conclude, birth interventions significantly impacted women's birth experiences. Pregnant women agreed to intervention when it was best for their baby,[56] and in this way they accepted it. However, this does not mean that these women actually *wanted* intervention, or that acceptance immediately translated to a good childbirth experience. While they were understood as necessary, many birth interventions were retrospectively viewed as generally negative experiences. Furthermore, the elements of intervention which caused the most distress in pregnant women were arguably those which reduced her control the most, illustrating that this was an extremely important element of the birth experience. That the lack of sufficient explanation of these procedures was common to all of them (including anaesthesia) [57] suggests further that the extent to which women were able to make an informed choice regarding birth intervention was significantly limited.

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[53] Ibid.,72.

[54] Ibid.,72.

[55] Ibid.,72-3.

[56] Ibid.,98

[57] Cartwright shows that 'many mothers' did not know what drug they received during labour, presumably because they were not told; see Cartwright 1977: 747.

Indeed, general dissatisfaction with intervention led to what Oakley has called a 'consumer revolt' against medicalisation in the 1970s,[58] and the impact such intervention had on women's birth experiences was undoubtedly crucial to this.

[58] Oakley 1984: 236.

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