

## Chapter 6 Gender and reproduction

### CASE STUDIES

#### Case study: advertisements in medical and nursing journals in the USA

Krantzler<sup>29</sup> in the mid-1980s analysed advertisements in medical and nursing journals in the USA. She pointed out how these adverts had shown a gradual reduction of the traditional medical symbols used by doctors (such as the white coat and stethoscope). Instead, this symbolic display of science-in-action was now more frequently seen in nursing journals, and it was nurses who were now more frequently shown using the healing symbols previously associated only with physicians. In many of

the adverts they were still associated with the older key symbols of nursing – the white uniform and cap – but, increasingly, these adverts suggested that nursing symbols and behaviour had come to mimic those of physicians. She speculated that this 'reflects the desire not merely for respectability but for professional status'. In these nursing adverts, male physicians now tend to be peripheral and 'nurses are shown alone, with other nurses or with patients'. She noted that in the USA, this 'direct relationship with a client, unmitigated by a third party, is an important symbol of professionalization'.

#### Case study: psychotropic drug advertisements in the UK

Stimson<sup>36</sup> in the 1970s studied advertisements for psychotropic drugs in British medical journals, and found that images of women in the adverts outnumbered men by 15 to 1. In the adverts, the women's place in society was predominantly shown 'as one which generated stress, anxiety, and emotional problems'. Images of the tired and tearful 'harassed housewife' in a

cluttered kitchen, surrounded by crying children, were common. According to Stimson, these adverts reveal that women's role problems and conflicts are increasingly defined only in medical terms, and the message of the adverts is that 'certain life events put people in a position where the prescription of a drug might be appropriate'. Furthermore, the descriptions of the drug always showed the individual adapting to the situation with the aid of medical help rather than by changing the social situation itself.

#### Case study: medicalization of the menopause in Manitoba, Canada

Kaufert and Gilbert<sup>45</sup> in 1986 studied 2500 women in Manitoba, Canada, aged between 40 and 59 years. Thirty-seven per cent were premenopausal, 14 per cent perimenopausal and 30 per cent postmenopausal; 19 per cent had previously had a hysterectomy. They found that in this sample of women, menopause was much less medicalized than anticipated. Overall, just under half the women said they had never discussed their menopausal status with a physician. Kaufert and Gilbert concluded that, within the sample, the

experience of menopause was not a highly medicalized process, and was one in which some women involved their physicians not at all. This was unlike childbirth, which is highly medicalized in Canada; childbirth is a publicly visible process with little choice over whether to disclose it, unlike menopause. In Canada, the culture of pregnancy usually includes seeing a physician and, like the USA, nearly all births involve some form of medical intervention. However, North American society attaches a relatively light weight to menopause, compared with childbirth, and this may explain why it has only been partly medicalized.

#### Case study: the nana in Jamaica

Kitzinger<sup>56</sup> in 1982 described an example of a traditional birth attendant, the *nana* or folk midwife of Jamaica. She estimated that about 25 per cent of Jamaican babies, especially in rural areas, are delivered by a *nana*. Because these women are not legally recognized by the state, most of these births are

registered as 'born unattended' or 'delivered by mother' (or by a friend or relative). In the villages, the *nana* is a person of high standing and great authority, 'a key figure in the cohesion of women in Jamaican rural communities'. Together with the village schoolteacher and the postmistress, she forms 'the political centre' or core of the social networks that tie the community

together. *Nanas* are familiar figures, deeply rooted in their communities, and are often called upon for help in a variety of family crises. The midwifery skills of the *nana* are handed down within families, from mother to daughter. *Nanas* are always mothers themselves, for 'to be a *nana* is really an extension of the mothering role, so all *nanas* are mothers who are seen to be successful in their role'. They see their role as shepherding the women safely from conception to birth by facilitating their natural processes, and in doing so assisting in the drama of 'the re-birth of a woman as a mother'. Their care usually continues from pregnancy until the ninth day postpartum. The *nanas* supervise all the many rituals and taboos of pregnancy and birth (see Chapter 9) that mark the woman's transition from pregnancy to motherhood, and which help give meaning to her experience, by placing it in the context of the wider cultural values of her religion and community. Kitzinger contrasts this intimate, culturally familiar approach with the Western-style,

technological birth procedures used in many Jamaican hospitals, where nurses and midwives value 'efficiency, speed of delivery of the patient, hospital routines concerning hygiene and order, and the suppression of emotional factors in childbirth so that they can get on with the work in an organized way, and treat the greatest number of patients in the shortest possible time'.

According to Kitzinger, the Jamaican *nanas*, who do things in 'the old time way', tend to be derided both by the medical profession and the educated middle-class as inefficient and harmful to health, and as echoes of a past of slavery and subjugation. However, she points out that the *nanas* are very experienced in the techniques of midwifery, are keen to learn more from modern obstetrics and are quick to call in a trained midwife or send the woman straight to hospital if anything goes wrong with the birth. Many rural women now use *nanas* during pregnancy and the first stage of labour, and then transfer to a qualified midwife for the birth itself.

### Case study: couvade syndrome in Rochester, New York, USA

Lipkin and Lamb<sup>100</sup> carried out a study in 1982 on the couvade syndrome, in Rochester, New York. They defined this syndrome as the occurrence of new physical or psychological symptoms in the mates of pregnant women, for which they sought medical care, and which were not otherwise objectively explained. In their study of 267 mates of postpartum women, 60 (22.5 per cent) of the men were found to have suffered from this

syndrome. This translates to a prevalence rate of 225 of 1000 husbands at risk due to their wife's pregnancy. Many of their symptoms were vague and non-specific, such as 'feeling rundown', 'feeling lowdown' and 'weakness', as well as more 'pregnant' symptoms such as backache, genital burning, water retention (not confirmed on physical examinations), retrosternal burning, groin pain, dizziness and abdominal cramps. One patient complained of a chest pain that felt like 'something was pushing out'.