Marginalizing Women: Images of Pregnancy in Williams Obstetrics

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Abstract

This research analyzes the historical development of the medical construction of the pregnant body in 17 of 20 editions of *Williams Obstetrics*, an obstetrical textbook published continually from 1904 to 1997. Examination of the visual imagery of these works produced three key findings. First, depictions of the healthy or "normal" pregnant body are virtually absent throughout the series. Second, visual depictions of women's full bodies adhere to a race-based hierarchy of presentation. Finally, the fundamental discourse about pregnant and female bodies communicated to physicians (primarily) by these images is one of pathology and fragmentation. We conclude that the resulting social and medical construction of the pregnant and female body presented in the *Williams* series is one of disembodiment, abjection, and ultimately marginality. These findings support recent feminist research that criticizes both the increasing erasure of the person of the women from the medical interpretation of pregnancy and the concomitant decrease in women's perceived sense of empowerment as pregnant beings.

Journal of Perinatal Education, 9(2), 14–26; pregnancy, feminism.

Introduction

Criticism of the historically male-dominated medical specialty of obstetrics, as well as its highly successful usurpation of pregnancy care in the past century, has grown dramatically in the past three decades. Authors have argued that what we understand about female reproduction has increasingly become dominated by the intersecting ideologies of patriarchy, capitalism, and

technology (Adams, 1994; Ehrenreich & English, 1978; Firestone, 1972; Kaplan, 1992; Oakley, 1984; O'Brien, 1981; Raymond, 1993; Rothman, 1989). In his excellent insider's exegesis on the medical profession, Smith claims that obstetricians and gynecologists "have, for economic reasons, maintained a system in which they are totally in control of obstetrical care, both routine and high-risk" (1992, p. 137). Scully's (1994) work on obstetrical student training asserts how this happens, showing that medical school socialization increasingly puts the economic, career, and personal interests of the physician at the center of the obstetrical practice.

In the past century, physicians and medical staff members have virtually displaced midwives' and women family members' roles in pregnancy, and hospital settings have displaced the home environment as the birth site (Bashford, 1998; Dye, 1986). To the extent the medical profession is predicated on an assumption of illness rather than wellness, it fits that they would follow an increasing emphasis on pregnancy as a *medical* event rather than a biophysical and cultural phenomenon. Oakley (1993) writes that the result has been a shift away from traditional cultural interpretations of pregnancy as a "normal" and healthy experience toward one in which the expectation is that every pregnancy is a potential crisis waiting to happen. Overanticipation of pregnancy illness and crisis, then, justifies and necessitates further medical intervention. The combined result of these changes is a realignment of our cultural interpretation of pregnancy that further displaces the pregnant woman.

This shift in the "cultural control" of the conduct of birth has disconcerting consequences (Eakins, 1986). Technology encourages pregnant women to hand over control of their pregnancies to their care providers. For example, standard prenatal examinations now routinely include bloodwork and urine analysis, fetal heart monitoring, and ultrasound examinations—all methods of "measuring" and "defining" pregnancy and available only to the pregnant woman with the aid of a care provider. Simultaneously, the opinions and observations of pregnant women—their knowledge—about their bodies are less likely to be considered relevant to the "supervision" of their own pregnancies (Martin, 1992). Furthermore, pregnant women may be required now to vie for equal attention as the objects of obstetrical care. Stabile (1992) and Oakley (1987) observe that, as new technologies that foreground the fetus increasingly allow it an

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ever more prominent position as the "second patient" for obstetricians, the threat to the privilege of place historically commanded by pregnant women becomes increasingly unstable. Recent court decisions displacing the desires of pregnant women in favor of fetal interests are testament to this increasing erasure of pregnant women's role in reproduction (Condit, 1995).

Not surprisingly, as women become more marginalized, they become increasingly unsure about what is biologically "normal" about their bodies and their pregnant selves. As a result, they frequently express concern about the normality of their bodily changes. Moore's (1978) work, aimed at determining pregnant women's body images in comparison to the American cultural "ideals" of women, found that pregnant women's body image as *attractive* decreased as their pregnancies progressed. Research by Hoffmeyer, Marcos, and Butchart (1990) found that 53% of the 800 pregnant women they studied reported body image/attractiveness dissatisfaction. In yet another study, Martin (1992) cites an interview with a young, pregnant woman, who noted that, when she went to the obstetrician, neither he nor his assistants seemed to *see* her while they were "treating" her pregnancy. They saw her stomach, they saw the fetus, they even saw her urine and blood pressure, but they didn't see *her*. She perceived that they never saw her as a whole woman, as a person.

Authors have expressed a concern for the paradoxes faced by women raised in a culture that transmits mes-

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sages about how “the” female body ought to look, function, and be used, and the material conditions, experiences, and contradictions that attend pregnancy (Fox & Yamaguchi, 1997; Young, 1990). In the preliminary phase of this project, a limited number of unstructured interviews with pregnant women identified physicians as a primary source for knowledge about their bodies, their sense of embodiment, and their identity during pregnancy. Because they are influential, knowing what and how physicians come to think about the pregnant body is key to understanding the development of women’s body images and their sense of pregnant embodiment.

This paper analyzes the visual discourse and medical construction of the pregnant body in 17 of 20 editions of *Williams Obstetrics*, an obstetrical textbook published continually from 1904 to 1997. Our research centered on examining the view of the female body, both pregnant and not, through the photographic and other visual imagery displayed in obstetrical texts like *Williams Obstetrics*. These images may influence the view of health professionals. On the one hand, it can be argued that obstetricians and other health care workers have ample opportunities to look at whole pregnant bodies in person, so they would not necessarily depend on textual images to form a view of pregnancy. On the other hand, how they learn to perceive what they look at when they see a pregnant form may be strongly shaped by what they are trained to see in the pregnant bodies at which they look. Thus, our primary assumption was that the visual imagery of women’s bodies in obstetrical texts creates a view of the female and pregnant body that both reflects and influences how the readers see and care for pregnant women (Barrett & Phillips, 1992). It is a Möbius relationship, to draw on the discourse of Elizabeth Grosz (1994); one in which reality is created through a constant, interchanging relationship. The outside and the inside are mutually permeable. In this case, how physicians and others learn to think about pregnant women, and how pregnant women come to think about themselves and their pregnancies, are mutually porous experiences.

Methodology

To understand the view of the pregnant body created in obstetrical medicine, two primary questions guided our research. The first entailed asking how women’s bodies,

both pregnant and not, are depicted and deployed in obstetrical works. The method we employed entailed examination, categorization, and analysis of the content and themes of the pictures and images of women’s bodies used throughout the series. The second question we sought to answer was the following: Has the obstetrical view about women’s bodies changed through time? That is, given the feminist critiques for the past 30 years, do contemporary editions of obstetrical works reflect a more holistic approach to the depiction of women’s bodies?

Obstetrical texts were specifically chosen as a data source for numerous reasons. Medical students are first introduced to women’s health issues through such textbooks. One useful method for understanding how physicians learn to interpret their experiences of the pregnant body and the experiential contributions of pregnant women may be to examine a key source of knowledge that shapes the thinking of medical practitioners. Additionally, an historical content analysis of one text over time allows a longitudinal comparison of trends and patterns in the depictions of women’s bodies.

Williams Obstetrics was chosen for a variety of reasons. First, in unstructured, informational interviews conducted as a prelude for this project, all five practicing male obstetricians who were interviewed identified this particular series as a basic resource. Each reported that he had been trained using *Williams* and that he also currently uses *Williams* as a reference. Although the age range of these physicians (from early 30s to mid-60s) was unrepresentative of the population, it provided some reassurance that *Williams* has both historic and current salience for practicing obstetricians.

Williams Obstetrics offered additional features as a data source. First, it has been continuously revised and published—in approximately 5-year increments—since the first edition in 1904. Second, because the series continues to be published, it has the virtue of providing a current data source. Finally, because the series is one of the premier works among its peers, we were able to locate copies of 17 of the 20 editions (Appendix A).

Coding the images of each edition required a dynamic recoding methodology. The first phase analysis entailed the systematic sorting of each image, including photographs and drawings, into one of three gross categories of pictures. These three categories were (1) those with a whole image of an entire female body, (2) those with only a segment of a female body, and (3) those with no

Appendix A List of *Williams Obstetrics* Editions Examined (Indicated by Year and Editor)

- Williams, J. W. (1904). *Obstetrics: A Textbook for the Use of Students and Practitioners*. 1st edition. New York: D. Appleton and Company.
- Williams, J. W. (1912). *Obstetrics: A Textbook for the Use of Students and Practitioners*. 3rd edition. New York: D. Appleton and Company.
- Williams, J. W. (1917). *Obstetrics: A Textbook for the Use of Students and Practitioners*. 4th edition. New York: D. Appleton and Company.
- Williams, J. W. (1923). *Obstetrics: A Textbook for the Use of Students and Practitioners*. 5th edition. New York: D. Appleton and Company.
- Williams, J. W. (1931). *Obstetrics: A Textbook for the Use of Students and Practitioners*. 6th edition. New York: D. Appleton-Century and Company.
- Stander, H. (1936). *Williams Obstetrics: A Textbook for the Use of Students and Practitioners*. 7th edition. New York: D. Appleton-Century and Company.
- Stander, H. (1941). *Williams Obstetrics: A Textbook for the Use of Students and Practitioners*. 8th edition. New York: D. Appleton-Century and Company.
- Stander, H. (1945). *Williams Obstetrics: A Textbook for the Use of Students and Practitioners*. 9th edition. New York: D. Appleton-Century and Company.
- Eastman, N. (1950). *Williams Obstetrics*. 10th edition. New York: Appleton-Century-Crofts, Inc.
- Eastman, N. (1956). *Williams Obstetrics*. 11th edition. New York: Appleton-Century-Crofts, Inc.
- Eastman, N. (1961). *Williams Obstetrics*. 12th edition. New York: Appleton-Century-Crofts, Inc.
- Eastman, N., & Hellman, L. (1966). *Williams Obstetrics*. 13th edition. New York: Appleton-Century.
- Pritchard, J. (1976). *Williams Obstetrics*. 15th edition. New York: D. Appleton-Century-Crofts.
- Pritchard, J. (1980). *Williams Obstetrics*. 16th edition. New York: D. Appleton-Century-Crofts.
- Pritchard, J. (1985). *Williams Obstetrics*. 17th edition. Norwalk, CT: D. Appleton-Century-Crofts.
- Cunningham, F.G. (1993). *Williams Obstetrics*. 19th edition. Norwalk, CT: D. Appleton & Lange.
- Cunningham, F.G. (1997). *Williams Obstetrics*. 20th edition. Norwalk, CT: D. Appleton & Lange.
- Missing editions: 1909 (2nd edition), 1971 (14th edition), 1989 (18th edition).
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evidence of any part of a female body in the picture. Interpreting these discriminations required careful explanation. First, inclusion in the category *whole female body* required, at minimum, the presence of the head, torso, and upper thighs. This resulted in inclusion of some photographs as “whole bodies” that did not have legs. Because our chief concern was the general impression of women’s bodies conveyed to readers by the texts, we placed primary value on features that would most clearly transmit cues for identity formation and interpretation (e.g., the face and central torso). Furthermore, pictures of women who were obviously pregnant (“showing”) and those of women who were either not pregnant or not evidently pregnant were both included in this category. We reasoned that any differing representations between pregnant and nonpregnant images would ultimately be mutually fluid and influential within the medical construction of the body throughout these texts.

The second category, *female body segment*, encompassed any image that evidenced external female skin, yet did not meet the criteria for *whole female body*. Such images almost exclusively demonstrated diverse birth, pathological, and technological phenomena. These pictures included the following images: a vaginal opening with fetal head crowning; anatomical deviations; localized disease processes and pathologies of the limbs, face, or torso; drawings of the pregnant abdomen framing the fetus’ position or *in utero* fetal manipulation; illustrations of pregnant bodies draped for surgical or other procedures; and demonstrations of technological devices such as scalpels. Interestingly, the primary subject of these images was almost always the particular “pathology” at issue. Only rarely did these pictures focus on the fragment of the female body as the actual subject of the image.

Images identified as *no female body* included pictures of fetuses or infants, demonstrations of technological equipment, magnified physiological drawings, photographs of organs and cells, and a smattering of other related subjects. In a few cases, some photographs that included a minute amount of female skin were included in this category, but this was because of some idiosyncratic feature of the image itself. Such images included drawings demonstrating the use of forceps, for example. In these images, some contours of the female body might have been sketched to provide a spatial reference, but typically only the barest suggestion of a woman’s body was present in such visuals.

The second coding phase required a more nuanced recoding of the images within the category *whole female body*. This phase was designed to permit categorization of the content of the images of women's whole bodies. The first categorical division was between *face discernible* or *face obscured*. Inclusion of an image in either of these categories required agreement about whether or not we would recognize the subject in another context should we see her face elsewhere. Thus, some pictures, in which the facial features were partially obscured or the head was turned too far in profile for recognition, were classified as "face obscured." All others were classified as "face discernible."

The second subdivision of the images was into the categories of *female body normal* or *female body abnormal*. This classification discerned whether or not a picture showed a female body in a nonpathological state, or whether or not it was indeed intended to depict a female body in a pathological or "abnormal" state. Two criteria pertained here. If the picture's caption identified the image as demonstrating a particular pathology, then it was so coded. If, however, the purpose of the image was less clear, as evidenced by a missing or unclear caption, the image was catalogued by how it appeared and by its context. Thus, the bodies of women that seemed outside the bounds of what the medical profession would call "normal" were included as "abnormal." This included pictures of dwarf or heavy women and women with diseases or physical deviations that merited note in the text. In virtually every case, it was obvious that pictures of these women were intended to demonstrate some "abnormality."

The last subcategory of analysis was by race and ethnic appearance. Two gross classifications were used for this discrimination: *white/Western-European appearing* and *non-white and/or ethnically non-Western European appearing*. This coding scheme was chosen when our initial examination suggested that, throughout the series, images of women's bodies were clearly treated differently, based specifically on whether or not the female body depicted had a white or Westernized upper-class or "refined" appearance. While coding images for this last category might have proven to be problematic, coders were remarkably uniform in their classifications of images by race and/or ethnic identity.

Two final coding notes should be made. First, to insure reliability, three trained coders independently examined

each text twice, with the majority coding resulting in the definitive analysis for each image. The rare dispute was settled by the majority categorization of all of the coders. Second, it is possible, with research of this nature, to be tempted to overgeneralize the findings. What we found to be true of the *Williams Obstetrics* series may not be true of other obstetrical series; this examination provides only a snapshot of one series among many. On the other hand, we also randomly examined numerous texts from other series for comparison purposes. Though our method of analysis was much less systematic and rigorous, our first-pass impression of the images of women in these alternative texts was that *Williams* does not differ noticeably from its peer publications. We also conducted a similar, thorough nonsystematic examination of comparable nursing and midwifery texts. Our impression from these works is that there are clearly contrasting, alternative models for depicting women's bodies, pregnancy, labor, and birth (Appendix B).

Findings

Depictions of the Whole Female Body

The first, and most striking, finding of our research is that depictions of the whole female body, whether pregnant or not and whether healthy or not, are virtually absent from the obstetrical texts we examined. There were only 124 (1%) images depicting the full female body, in any state of pregnancy or health, in the 11,486 illustrations and plates of the cumulative editions of *Williams Obstetrics* examined. Because there are effectively no pictures of whole women's bodies in the *Williams* obstetrical texts, both the normal, healthy pregnant body and the unhealthy pregnant body, along with their non-pregnant counterparts, do not have visual representation in the *Williams* series. Thus, when readers consult *Williams* as an authority on pregnant women, the message conveyed is one of silence about the bodies of women.

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Appendix B Obstetrical Texts Not Included in the *Williams Obstetrics* Series but Examined for Comparison Purposes

- Bennett, V. R., & Brown, L. K. (1989). *Myles Textbook for Midwives*. New York: Churchill Livingstone.
- Caplan, R. (1982). *Principles of Obstetrics*. Baltimore: Williams & Wilkins.
- Fitzpatrick, E., & Eastman, N. (1960). *Zabriskie's Obstetrics for Nurses*. Philadelphia: J. B. Lippincott Co.
- Gabbe, S. (1991). *Obstetrics: Normal and Problem Pregnancies* (2nd edition). New York: Churchill Livingstone.
- Nichols, F., & Zwelling, E. (1997). *Maternal-Newborn Nursing*. Philadelphia: W. B. Saunders Company.
- Myles, M. (1971). *A Textbook for Midwives*. London: Churchill Livingstone.
- Speert, H. (1980). *Obstetrics and Gynecology in America: A History*. Chicago: The American College of Obstetricians.
- Tindall, B. (1988). *Mayes Midwifery: A Textbook for Midwives*. London: Bailliere.
- Tweedy, E. (1912). *Practical Obstetrics*. London: Oxford University Press.
- Webster, J. C. (1903). *A Textbook of Obstetrics*. Philadelphia: W. B. Saunders Company.
- Wright, A. (1905). *A Textbook of Obstetrics*. New York: D. Appleton and Company.

Whole Bodies Across Time

Despite the scarcity of whole, female body images within *Williams Obstetrics*, some trends in the few pictures and images found in the series were evident. Most notable was that the types and numbers of depictions of whole female bodies changed across time. The most marked shift was a stark decrease in the total number of whole women's body pictures per edition, from the first edition to the most recent. See Figure 1. It is evident that, from 1904-1936 (the first period), there were relatively more pictures of whole female bodies in any state of being (with an average of 14.3 pictures per edition and 2% of all visual imagery). The second period is demarcated by a distinct downward shift in the number of images per volume and occurs with the eighth volume, published in 1941, through the 13th edition, published in 1966. During this period, there is an average of 4.6 pictures or drawings of whole female bodies, or less than 1% of all visual imagery per edition. The last period begins in

Figure 1 Whole Women's Body Images in *Williams Obstetrics* by Edition Year

1976 with the 15th edition and continues through the 1997 20th edition. During this period, an average of 1.8 pictures of women's whole bodies, or 0.2% of all visual imagery, appears in each edition. It is clear that the overall trend in the series, from publication of the first edition to the most recent, is from few to fewer to essentially none.

The content of these few images of whole women's bodies also changes across the same time periods. Pictures specifically illustrating "normal," healthy, pregnant bodies appear throughout the editions of the first period (editions one through seven). The remaining images of whole women's bodies in those texts demonstrate either various physiological "abnormalities" in both pregnant and nonpregnant women or conditions completely unrelated to pregnancy. Representations of healthy, "normal," pregnant bodies continue to appear—though in decreased numbers—through the 1945 edition but disappear entirely thereafter. Thus, by 1952, images of "healthy" pregnant women are no longer included in this major series on obstetrics.

The 1997 edition had only two images classified as *whole female bodies* among the 712 illustrations in the 1,448 pages of the text. The first was a picture of a woman with a pregnancy condition known as *polyhydramnios* (excessive water retention) that was first inserted in the 1956 edition. See Figure 2. The second was a picture of four grown sisters from a multiple birth with a companion picture of them as newborns. The

Figure 2 Advanced Degree of Polyhydramnios (1956-1993) *Williams Obstetrics* (1993) 19th edition; F. Gary Cunningham; Figure 34-1; “Advanced degree of hydramnios—5500 ml. of amniotic fluid measure at delivery.” Reprinted with permission.

point of these pictures was to demonstrate the successful outcome of a multiple birth, not to examine the pregnant body from which those multiples were born. In summary: By 1950, we found that there were no images of whole, healthy, pregnant bodies left in *Williams Obstetrics*. By 1997, all but two images of women’s whole bodies—healthy or otherwise—were omitted.

Subcategories of Whole Female Body Images

The results of our second phase analysis, in which we recoded the *whole female body* images by subcategories, were equally revealing and particularly troubling. We analyzed each picture three times, coding it by (1) the discernability of the subject’s face, (2) the subject’s rela-

No images of nonwhite women were ever used to demonstrate the “normal” female body, either pregnant or not.

tive state of health, and (3) the subject’s observable race and ethnicity. We found that 35.8% of the *whole, female body* pictures revealed the subjects’ faces and, similarly, 44% of the images depicted healthy pregnant women. Seventy-one percent of the pictures were of white women, with the remaining 29% depicting women of color or women of non-Western European appearance. No images of nonwhite women were ever used to demonstrate the “normal” female body, either pregnant or not. Their only use was to communicate abnormality. Thus, the images of the bodies of white women spoke a discourse of a kind of universality of identity that was denied nonwhite women. See Table 1.

Categorization of images by the relative obscurity of a subject’s facial features follows a similar pattern—particularly when examined in light of race. In some cases, a subject’s face was intentionally obscured from the camera’s gaze in order to hide her identity, particularly in cases where the woman’s body was photographed or drawn in the nude. Various means for obscuring the face were used. See Figure 3.

Just as there were no photographs of nonwhite women as normal, there were also no photographs of nonwhite women in which their faces were obscured. Thus, only

Table 1 Whole Women’s Body Images in *Williams Obstetrics* by Race, Normalcy, and Face Obscured

	White	Nonwhite	Row Total	% of Row Total
Face Discernable (Normal)	6	0	6	4.8
Without Face (Abnormal)	13	25	38	30.6
Face Obscured (Normal)	48	0	48	38.7
Column Total	88	36	124	
% of Column Total	71	29

Figure 3 Obscured Face—"Same Full-Term I-Para in Verticle and Horizontal Positions." *Williams Obstetrics* (1920) 4th edition; Figures 180–181; page 178. Reprinted with permission.

white women were given the "courtesy" of hiding their faces when their whole, nude pregnant bodies were exposed. A total of 69% of the pictures of nonwhite women were nude, while only 38% of the images of white women were nude.

Female Body Segment

The marginalization of pregnant women in *Williams Obstetrics*' imagery occurs not only through the absence of the whole female body but also through the fragmentation that occurs when only body parts are represented. Of the 11,486 pictures, illustrations, plates, and images included in the 17 editions, nearly 12% (1,370) depicted a segment of a female body that (a) demonstrated pathology, (b) portrayed birth, (c) framed the fetus, or (d) served as an object for demonstrating the use of a tech-

nology or an invasive medical procedure such as a cesarean section.

The types of pathologies demonstrated included conditions endemic to pregnancy such as polyhydramnios, skeletal abnormalities, genital warts, and prolapsed uterus (Figures 2, 4, and 5). Fragments of the pregnant body framed fetal images showing positioning, distress, and delivery. Such pictures include X-rays, forceps and vacuum extraction, ultrasound, and Leopold's maneuvers, which determine fetal presentation. The only depiction of physical contact with the pregnant woman, outside of delivery, occurred in depictions of the Leopold's maneuvers (Figure 6).

The last category of *female body segment* images depicted birth imagery, which included head-crowning and other stages of delivery. One particular type of fragmenting image worth noting in this group included pictures

Figure 4 Ethnicity—Front and Back View of a Woman with Spondylolisthesis *Williams Obstetrics* (1917) 4th edition; Figure 638, page 845. Reprinted with permission.

of women surgically draped for examination or delivery. Though the practice has its origins (and justification) in medical concerns about sanitation and sterilization, the extent and visual effect communicate equally important social messages about women's bodies. In its most extreme manifestation, all that is allowed exposure to both the delivering physician and the camera is the vaginal opening (Figure 7). The woman of the exposed vagina is rendered invisible by the shroud. Her vagina becomes a synecdoche (or the substitution of a part for a whole) for her personhood.

No Female Body

The remainder of the pictures and illustrations in the *Williams Obstetrics* series, totaling 9,992 (or 87%) included no elements of the female or pregnant body. The general categories into which these pictures were separated included fetal imagery, pictures of infants, demonstrations of technological equipment, physiological drawings, photographs of organs and cells, and other

Figure 5 Body Segment—Prolapsed Uterus with Fetal Foot Exposed *Williams Obstetrics* (1917) 4th edition; Figure 479; page 609. Reprinted with permission.

subjects that exclude the pregnant woman's identity. This category is large in relation to the other categories, where at least some element of the pregnant woman's body is evident. Thus, overall, little visual space is devoted to the bodies and beings of pregnant women in a text that is about pregnancy.

Discussion

Does not the lack of pictures of whole women render the subjectivity of whole women, whether pregnant or otherwise, as transparent? Women, qua subjects, become foreign, peculiar, and perhaps even unnatural in the medical construction of pregnancy. Given that most pregnancies are "normal," does not this near total erasure of full women's bodies (in general) and healthy, full pregnant

Figure 6 Leopold's Maneuvers *Williams Obstetrics* (1993) 19th edition; Figure 10-10; "Longitudinal lie. Palpation in the left occiput anterior. Position maneuvers of Leopold"; page 279. Reprinted with permission.

. . . if care providers have no authoritative frame of reference for interpreting a nonpathological pregnant body, might not all pregnancies come to look problematic?

bodies (in particular) devalue the "normal" pregnancy and inevitably marginalize the pregnancy experiences of most women? When the normal model is not presented, does this contribute to many modern physicians perceiving the normal pregnancy as "boring" (Smith, 1992, p. 137)? Furthermore, if care providers have no authoritative frame of reference for interpreting a nonpathological

Figure 7 Sterile Draping for Delivery or Operation *Williams Obstetrics* (1917) 4th edition; Figure 342; "Showing patient covered with sterile dressings preparatory to operation"; page 398. Reprinted with permission.

pregnant body, might not all pregnancies come to look problematic? How do care providers, then, communicate acceptance or even celebration of a normal pregnant body to a woman unsure about her own state of being?

Such images portray pregnant and female bodies as just so many parts—dismembered and disembodied. What is the result when the person to whom the dangling legs (Figure 8) or prolapsed uterus is attached becomes irrelevant in the face of the "thing" on display? Seeing the whole person in such fragmentation is impossible. Moreover, given that such fragmentary depictions are the chief ways in which women's bodies appear in *Williams Obstetrics* (1,370 of 1,494, or 92%), it creates the impression that women's bodies are overwhelmingly diseased, fractured, abject. The overly emphasized expectation of the body as ill rather than well and whole becomes the overriding discourse about the pregnant

Figure 8 Walcher Position *Williams Obstetrics* (1931) 6th edition; Figure 660; “Walcher’s Hanging Position”; page 931. Reprinted with permission.

body, despite the fact that illness is an unusual condition of pregnancy.

Our findings suggest that women are beyond the margins in the view of pregnancy in a major medical textbook. The recent feminist message to recenter women in obstetrics has not been successfully received in this medium. Representations of whole, healthy, pregnant women in the *Williams Obstetrics* series were virtually absent. When present, the chief purpose for using images of pregnant women’s bodies was to demonstrate abnormality, disease, and fragmentation of the body. Even more disturbing is the fact that the bodies and identities of nonwhite women, which have been used historically for distinct purposes in American history, also served a distinctly different role in these texts from the bodies of white women (Figure 9). Do not these findings suggest

Figure 9 Pendulous Abdomen in a Primipara *Williams Obstetrics* (1931) 6th edition; Figure 646; “Pendulous Abdomen in a Primipara with a Generally Contracted Rachitic Pelvis”; page 913. Reprinted with permission.

that physicians have been trained to have different expectations about women’s bodies based on their racial identity? It would seem that this might inevitably translate into how women of color are treated by those physicians. Is this, then, related to research findings indicating that women of color often have less access to health care and to quality health care, as well (Cunningham, McDonald, Oeveno, Gant, & Gilstrap, 1993)?

The absence of images of whole women’s bodies, generally, and of whole and healthy pregnant bodies, in particular, pushes the personhood of the pregnant woman to the margins of her treatment. To the extent physicians don’t see the total woman, are not their approaches toward pregnancy more likely to focus on the

swell of the belly, the vaginal passage through which the fetus travels during birth, and the fetus growing inside? The opening sentence of the first edition of *Williams Obstetrics*, a statement included in each edition since, frames the obstetrical vision of pregnancy in just this way. Says Williams (1904):

As the mechanism of labour [sic] is essentially a process of accommodation between the foetus [sic] and the passage through which it must pass, it is apparent that obstetrics lacked a scientific foundation until the anatomy of the bony pelvis and of the soft parts connected with it was clearly understood. (p. 1).

Present in this delivery narrative are the fetus and the vaginal canal—both enveloped by the scientific gaze of obstetrics. Absent, however, is the profound being of the pregnant woman. At best, her personhood is primarily represented through her vagina; at worst, she has been erased. The impact of this on her care provider is unclear, thus far. But, given that stress is a predictor of pregnancy outcome, would it not be useful to represent pregnant women as whole, healthy, and normal? Should there not also be included images of pregnant women involved in exercise, being counseled by their care providers, being supported by their families, and attending childbirth classes?

Some would argue perhaps that it is unfair to ask that physicians be taught to work from such a woman-centered view of care. Some would say that the physician's role is to diagnose and treat disease rather than to step back from a biochemistry and microbiology and to adopt the view of care based on knowledge of the biopscho-social-cultural human being. Perhaps the latter is the purview of the nurse, the midwife, and the childbirth educator. Curiously, however, our further analysis of the discourse of obstetrics in the language of *Williams Obstetrics* (forthcoming in a subsequent article) clearly demonstrates that physicians have actively sought to discourage such a dispersal of the power and control of pregnancy care. Rather, they have made clear efforts to garner control of both the lives of pregnant women and the spheres of care that surround them. Physicians cannot have it both ways. They cannot expect to control the medicine of pregnancy but leave the daily work of care giving to others who, along with pregnant women, are relegated beyond the margins of obstetrical consciousness.

Women seeking health care from a holistic perspective for pregnancy are thus advised to be assertive and inquisitive when choosing a health care provider.

Women seeking health care from a holistic perspective for pregnancy are thus advised to be assertive and inquisitive when choosing a health care provider. This means finding care providers who accept the pregnant body as *prima facie* normal and well, and who can assist pregnant women with their care as pregnant beings, using a model that brings women from the margins to the center of their bodily experiences.

Acknowledgments

The authors express grateful acknowledgement to Wayne C. Hall Research Award Phi Kappa Phi, which funded this project, and to the following students: Riiste Challis, Nhuly Trahn, Amanda Johns, and Loree Erickson.

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