Journal of Prenatal and Perinatal Psychology and Health 23(3), Spring 2009

The Masculinisation of the Birth Environment

Michel Odent, M.D.
Primal Health Research Center, London, England

ABSTRACT: This article offers a historical account of the changes in birth that the author reflects on after decades as a practicing obstetrician. In preliterate and pre-agricultural societies, women used to isolate themselves to give birth. It seems that at that phase of the history of humanity the only person who could be around was the mother of the parturient, an ant, or another experienced mother. Then, for thousands of years, childbirth has been more and more socialized and culturally controlled. During this long period the birth environment remained mostly feminine. It is only after the middle of the twentieth century that several factors made the environment more and more masculine. First, more and more specialised doctors were trained and, in many countries, most of them were men. Then, suddenly, the doctrine of the participation of the father spread out in most industrialized countries. At the same time many sophisticated electronic machines were introduced in the birthing place (technology being a male symbol). The main question being posed: Is this masculinisation of the birth environment the main factor why today, at a planetary level, the number of women who deliver babies and placentas thanks only to the release of natural hormones (i.e. a 'cocktail of love hormones') is approaching zero? Dr. Odent suggests that the answer to this dilemma is to focus on a better understanding of the physiological processes during the perinatal period.

KEY WORDS: masculinisation, birth, physiology, oxytocin, hospital, midwifery, doula

Introduction

The gradual "masculinisation" of the environment is an obvious trend in the history of childbirth during the second half of the twentieth century. I will begin with my own observations as a practitioner, having been indirectly or directly involved in childbirth since 1953.

Editor's note: This study is reprinted with permission of Michel Odent, MD, Director, Primal Health Research Center in London and the newsletter Primal Health Research, published in North and South America by Birth Works, Inc., Medford, NJ.
Contact information: Email for Dr. Odent is: modent@aol.com

© 2009 Association for Pre-and Perinatal Psychology and Health

A Personal Viewpoint

During the winter of 1953-1954, I spent six months as an "extern" (medical student with minor clinical responsibilities) in the maternity unit of a Paris hospital. In the late 1950s, being trained as a surgeon at a time when the lower uterine segmental technique was developing, my involvement in obstetrical practices was indirect, via the caesarean section, which then was usually performed as emergency surgery. Next, I was in charge of both a surgical and a maternity unit in a French state hospital near Paris (Pithiviers), becoming more and more directly involved in childbirth. After my hospital career and until now, I have had experience with home birth in London. I have also practiced occasionally in North Africa (Algeria) and West Africa (Guinea Conakry). Additionally, I have accepted many invitations to speak on the five continents, so I can also look at the masculinisation of the birth environment from an international perspective.

Historical Overview

Before examining birth in the second part of the twentieth century, it is useful to present an overview of its history among humans. We have a sufficient amount of anthropological documents to suggest that in pre-literate and pre-agricultural societies women, like most mammals, used to isolate themselves to give birth—going to the bush, or to a special hut, for example. Usually, when a woman was giving birth her own mother, an aunt, or another experienced mother in the neighbourhood was usually around, protecting the environment against the presence of a wandering animal or a wandering man. This is probably the root of midwifery.

Then, during thousands of years childbirth gradually became socialized. The midwife became more often than not a guide who dared to interfere with language. She became the one controlling the event, and also the agent of the cultural milieu transmitting beliefs and rituals—using a great diversity of procedures, including invasive procedures such as manual dilation of the cervix, compression of the abdomen, or traditional herbs. An important step in the socialization of childbirth occurred when women started to give birth in the place where they were spending their daily life: home birth is comparatively recent in our history.

It is notable that although childbirth had been socialized for thousands of years, women always tended to protect the birthing place against the presence of men, particularly medical men. There were

many strong objections to male attendance; during the sixteenth century in Hamburg, a doctor was condemned and burnt alive after disguising himself as a woman in order to see a birth. At that time, it was said, women were prepared to die rather than admit a man to the lying-in room (Von Siebold, 1839). This is not to suggest that male physicians rarely interested themselves in childbirth, but their influence was discreet and indirect. Their roles concerned two spheres of competence. One was to intervene in desperate situations when the midwives called. Before the invention of forceps, usually all a medical man could do was to remove the infant piece-meal using hooks and perforators, or, if there was still hope of delivering a live child, to perform a caesarean section on the mother after her death (Donnison, 1977). The realm of instruments is eminently male. The other sphere of competence of literate male physicians was writing about childbirth, mainly for the purpose of educating midwives and instructing other physicians on the supervision of birthing women. Hippocrates, Aristotle, Celsus, Galen, Soranus of Ephesus and other writers on medical matters devoted part of their works to this subject. The realm of books is also originally, and eminently, male. Since the medical man was called only for disasters, he had little opportunity to gain a real understanding of the birth process and the basic needs of labouring women. This history helps us interpret the deep-rooted and widespread lack of understanding of birth physiology.

However, despite thousands of years of culturally-controlled childbirth during which the basic mammalian needs of the labouring women and of the newborn babies were ever-more denied and even ignored, and in spite of the indirect influence of male medical men, women were still giving birth in predominantly female environments—until the middle of the twentieth century. Around 1950, in the case of home birth, childbirth was still "women's business." The doctor—usually a general practitioner—was called at the last minute to use forceps or to witness a disaster. The husband was either in the pub, or the café, or he was given a task such as boiling water for hours. At that time, even for a hospital birth, the environment remained eminently female. The "knitting midwife" was the central person in the maternity unit (Odent, 2004). There was a very small number of specialized doctors who were almost invisible, appearing suddenly if the midwife called them for a forceps delivery, and disappearing as quickly as possible after the birth. In the maternity unit where I was an "extern" the doctor in charge spent only minutes in his office every morning, listening to a fast report of what had happened during the previous twenty-four hours and, occasionally,

talking with the medical students. As a male medical student, I did not dare enter a room where there was a woman in labour. I could only appear during the second stage, because I was supposed to learn the use of forceps. Of course, at that time, nobody could even imagine that the baby's father might be introduced in the maternity unit.

After the Turning Point

It was just after the middle of the twentieth century when the atmosphere started to be "masculinised." The number of doctors specialized in obstetrics increased at lightning speed, and almost all were men. Later on, during the second half of the century, other specialized doctors were introduced into the birth environment, such as neonatologists and anaesthesiologists. Around 1970 an occasional woman made a new demand (as a way to adapt to the 'industrialization of childbirth') for the participation of the baby's father at birth. It became almost overnight a doctrine supported by theories: the participation of the baby's father at birth became within some years an undisputed "rule." At the same time, sophisticated electronic machines invaded the delivery room: high technology is a male symbol. There was such indifference to the gradual masculinisation of the birth environment that there were no serious discussions when midwifery schools started to accept male pupils. Furthermore most schools adopted such selection criteria that in some countries a young man with a good scientific background could more easily be selected than a mother of three. There are countless stories of women who gave birth (or, rather, were delivered) under the control of an electronic machine, in the presence of the baby's father, a male midwife, and a male doctor. The almost total masculinisation of birth had been achieved.

One Simple Question

Is this masculinisation of the birth environment the main factor why today, at a planetary level, the number of women who deliver babies and placentas thanks only to the release of natural hormones is approaching zero?

I am personally convinced that the best possible environment for an easy birth—even for many modern women—is when there is nobody around but an experienced and silent midwife or doula, perceived as a mother figure. I learned this in the time of the 'knitting midwife'—the early 1950s. I became gradually more aware, during my career as a hospital practitioner, of the turning point in the

masculinisation of childbirth. And I am relearning this today when, occasionally, I attend a home birth, making the baby's father busy in the kitchen or elsewhere around the house, leaving the labouring woman with only one person around—experienced, motherly and silent. However, in the present age of evidence-based obstetrical and midwifery practices we cannot rely on clinical observation to provide an answer. At the same time, the "golden method" cannot evaluate the effects of different degrees of masculinisation of the environment on the birth process and on the first contact between mother and newborn babies. That is, randomized controlled trials (RCTs) are not feasible. This is why international comparison is one of the best approaches.

International comparisons are valuable because the alteration of the birth environment in industrialized countries, although a global phenomenon, did not occur simultaneously and at the same speed. Number one among countries where masculinisation started early and developed at a high speed was the USA. Very early during the second half of the century, there was such a surplus of American obstetricians that most of them had the time to be involved in every birth: they became 'primary care-givers' instead of being experts only in unusual and pathological situations. Furthermore, in the USA, the doctrine of the husband/partner participating in the birth was already well established in the early 1970s. A similar surplus of (mostly male) obstetricians had also existed for a long time in most Latin-American cities. In sum, the turning point started earlier and developed more quickly on both American continents than anywhere else.

At the other end of the spectrum, the masculinisation process has been delayed in a certain number of countries. Obstetrics in Ireland is usually associated with the concept of 'active management of labour,' using strict pre-established criteria to control the speed of labour. Yet, the routine presence of the father in Irish births was delayed until the late 1980s. The unique characteristic of the socialized Dutch system of midwifery and obstetrics is that the midwife is officially considered the *primary care giver*. The obstetrician plays the role of the expert adviser on demand. In Holland about 30% of the births still occur at home and childbirth in Holland has not been highly influenced by the theories of most Western natural childbirth movements. The traditional behaviour of the husband going to the pub or being busy in the house persisted longer there than elsewhere. The concept of the *couple* giving birth appeared much later than in other western European countries and likewise the masculinisation of childbirth followed a different and slower route.

Outside Western Europe, Russia is a country where the

masculinisation process has been delayed. During the communist regime most obstetricians were women and there were many midwives. At that time fathers were not permitted to enter the maternity units. In 1992, I saw a mother showing her baby to her husband through the window of a maternity unit in Moscow, while he had to stay outside, in the street. As recently as 2006, when visiting maternity unit no.10 in St Petersburg, all the obstetricians I met looked like nice grandmothers—even the chief neonatologist looked like a grandmother. Midwives were abundant, and fathers were not yet routinely introduced to birth units. Now, suddenly all aspects of the Western lifestyles are becoming widespread in Russia, affecting the birth environment.

Ireland, Holland, and Russia share another common point. The spectacular ascendance of caesarean sections has been delayed as well. The incidence today is similar to elsewhere. We can therefore claim that there is an association between the masculinisation of childbirth environment and high rates of obstetrical interventions, particularly caesarean sections. Of course, in order to interpret this association, we must take into account that in some particular cultural milieus the inhibitory effect of a male environment might be stronger than elsewhere. This might be the case, for example, of Southern Italy, a region influenced by Arabic cultures, where the rates of caesareans are skyrocketing. Anyway the main question remains: can we claim that there is a cause and effect relationship explaining this association? Can we claim that the difficulties in childbirth are related to the degree of masculinisation of the environment? Can we trust the experienced doula saying that oxytocin, the 'shy hormone,' is shyer in a male than in a female environment?

We can also assume—and this is not contradictory—that the masculinisation of the birth environment has been originally a consequence, or a proxy, of a deep-rooted lack of interest in the basic needs of labouring women and newborn babies. If, half a century ago, it had been easy to explain that all situations associated with the release of adrenaline and with the stimulation of the neocortex tend to hinder the birth process, the history of childbirth would have been pushed in another direction. Simply, if it is had been understood that a woman in labour needs to feel secure without feeling observed, the specific role of the midwife as a mother figure would have been more easily interpreted. If the theoreticians of the 1970s had realized how contagious the release of adrenaline is, and if they had anticipated that a man who loves his wife may release stress hormones at the wrong time, they would have been more cautious before affirming the

routine participation of the father at birth. If obstetricians had anticipated that the use of continuous electronic fetal monitoring might be perceived by labouring women as a way to observe their body functions, and therefore to stimulate their neocortices, they could have predicted the results of the many RCTs indicating that the only constant and significant effect of these new inventions was to increase the rates of caesarean sections. Finally, all aspects of the masculinisation of the birth environment appear as direct consequences of deep-rooted ignorance of physiological processes. This can be expected after thousands of years of culturally controlled childbirth (Odent, 2009).

It is notable that in the scientific context of the twenty-first century, preliminary signs of a 'de-masculinisation' of birth environment are already visible. The doula phenomenon has reached global dimensions; it might offer an opportunity to rediscover authentic midwifery. The only fact that today it is becoming politically correct to discuss the doctrine of the father's participation is also highly significant.

Practical Conclusion

The priority is to re-discover the basic needs of women in labour and newborn babies. Since no cultural model exists, we must rely on simple physiological concepts, in particular the concepts of adrenaline—oxytocin antagonism and neocortical inhibitions. The 'de-masculinisation' of childbirth should not be the primary objective, but rather a consequence of a better understanding of the physiological processes during the perinatal period. We must phrase appropriate new questions for absolutely new situations.

References

Donnison, J. (1977). *Midwives and medical men*. London: Heinemann.

Odent, M. (2009). *The functions of the orgasms: the highways to transcendence*. London: Pinter & Martin.

Odent, M. (2004). Knitting midwives for drugless childbirth? *Midwifery Today, 71*, 21-22.

Von Siebold, E. C. J. (1839). *Versuch einer Geschichte der Gerburtshulfe*, Berlin.