AN ABSTRACT OF THE THESIS OF

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Abstract approved:

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Sharyn Clough

In the West, the growth of the modern, androcentric medical establishment can be shown to be correlated with the decline in women's authority and status in the healing arts. As the world of science and medicine expanded exponentially, the understanding of the body changed through the studies of anatomy and physiology. The male body became the "normal" example of a healthy body, and functions occurred that in the female body (e.g., child birth and menstruation) were considered diseases. The process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and disorder, is called "medicalization" – a process that has often negatively affected women.

The decline in numbers and influence of women healers is related to the advent of medicalization of women's bodies. As a result, components of political, social, and moral struggles become embodied in women's physiological beings. Scientists create truths about sexuality, and women's bodies incorporate and confirm these truths. These truths, sculpted by the culture in which biologists practice their trade, eventually refashion our cultural environment.

Corresponding e-mail address: longmy@onid.orst.edu

The Impact of Medicalization on the Authority of Women Healers

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Myra Long

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APPROVED:

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Mentor, Sharyn Clough, representing Philosophy

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Mentor's Academic Affiliation

_____

Committee Member, Melissa Cheyney, representing Anthropology

_____

Committee Member, Kristen Barker, representing Sociology

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Dean, Dan Arp, University Honors College

I understand that my project will become part of the permanent collection of Oregon State University, University Honors College. My signature below authorizes release of my project to any reader upon request.

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Myra B. Long, Author

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Chapter 1: Women Healers

1.1: Introduction

As long as there have been healers, there have been women healers. These women were the herbalists and food gatherers for their families. They were the midwives in their local communities and keepers of the wisdom passed from friend to friend and mother to daughter. There was a time when mostly women knew the secrets of life and death and primarily were allowed to practice the healing arts (Ehrenreich & English, 1973). However, in the modern West, as healing became professionalized, women were often not allowed to have books, attend schools, or hold degrees. Eventually, women not only lost their medical authority, but their legal rights to practice were eroded (Achterberg, 1991).

A study conducted by the American Medical Association (AMA) in 2004 revealed that 26.6% of the physicians in the US were women, the highest the AMA has ever reported in its history (http://www.ama-assn.org/). While this is a positive trend, it is worth comparing it to the fact that women make up approximately 70% of the healthcare workers in the US. Clearly only a small fraction of these women are physicians, while the remainder are workers in an industry where the bosses, directors, and CEOs are positions dominated by men. In contrast to ancient times, women in the modern West are often alienated from

the sciences and the healing practices in particular, and instead are assigned to be nurses, technicians, clerks, and maids.

Using anthropological, social, and historical research, I argue that, in the West, the growth of the modern, androcentric medical establishment can be shown to be correlated with the decline in women's authority and status in the healing arts. As the world of science and medicine expanded exponentially, the understanding of the body changed through the studies of anatomy and physiology. The male body became the "normal" example of a healthy body, and functions that occurred in the female body (e.g., child birth and menstruation) were considered diseases (Martin, 1987). The process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and disorder, is called "medicalization" – a process that has often negatively affected women (Conrad, 2007)**.**

I argue that the decline in numbers and influence of women healers is related to the advent of medicalization of women's bodies. As a result, components of political, social, and moral struggles become embodied in women's physiological beings. Scientists create truths about sexuality, and women's bodies incorporate and confirm these truths. These truths, sculpted by the culture in which biologists practice their trade, eventually refashion our cultural environment (Fausto-Sterling, 2000).

1.2: Women Healers in Ancient Cultures

Throughout various ancient cultures, medical practices were limited to prayers and incantations, and a basic use of plant materials. A large number of diverse cultures, such as the Amazon and Ona of South America, the civilizations of ancient Crete and Eastern Europe, and the oldest of cultures from Sumer, have myths or artifacts from a very early time showing that women were the primary keepers of the healing and magical arts (Gimbutas & Campbell, 2001). These cultures have also produced thousands of ample female figurines that date as far back as the Upper Paleolithic age. Carved of stone, ivory, or bone, they are the earliest finding of the expression of women as the embodiment of the beginning of life. These “Venus” figurines were placed on household altars and were a part of the ceremonial life of early humans. Until the Greek mythological era, the image of the female was surrounded by common motifs and symbols that represented the female’s connection to life, regeneration, wisdom, and mysteries that surrounded her inner being (Gimbutas & Campbell, 2001).

Then, rather abruptly, at different times around the world, the male became the sacred object of worship (Achterberg, 1991). Changes in the ecology and economy, as well as invasions from other cultures, played a major role in this shift. Furthermore, women and the products of their labors were placed in a secondary position of importance as humans began to feed themselves in ways that honored male contribution. Patriarchal religions developed myths on the

origin of humanity and promoted a creator in a male image. Male superiority was ordained in all matters of life (Achterberg, 1991).

Massacres that destroyed the age of women's magic are legendary in the Ona tribe of Tierra del Fuego; while in Stone Age cave temples in Europe, the decimated remains of the female figurines suggest a similar violent overthrow. In other instances, more benign cultural transformations occurred (Achterberg, 1991).

These are the stories of an ancient turning point that are reenacted throughout the record of humans. Invariably, the deities of the old ways become demons in the new; what was good becomes evil. For example, in the Hebrew Bible and Old Testament versions of Genesis 3, the female, the chief representation of the old ways, suffers the consequences as the ancient mother goddess figure. Even the discomfort of birth, rather than being viewed as a divine act of producing life, is now viewed as a hardship that women deserve. Women are viewed as ominous threats to the established order, and within the patriarchal framework of the modern West, women cannot perform the sacred arts of healing.

1.3: The Middle Ages

Because of this decline in women's social status, women healers practiced widely, but informally. Little is known or appreciated about the role of

women healers in the Middle Ages, however their role must have been significant, given the backlash that developed during the three centuries preceding the Renaissance (1300-1600). At this time, the role of women as healers was threatened as a result of two roughly parallel developments (Minkowski, 1992). The first was the evolution of European universities and their professional schools that, for the most part, systematically excluded women as students, thereby creating a legal male domination of the practice of medicine. Ineligible as healers, women waged a lengthy battle to maintain their right to care for the sick and injured. The second development was the campaign – promoted by the Church and supported by both clerical and civil authorities – to brand women healers as witches. The Church may have perceived these women, with their special, often esoteric healing skills, as a threat to its supremacy in the lives of its parishioners. The result was the persecution of unknown numbers of mostly peasant women (Minkowski, 1992).

The period between the 14th and 16th centuries witnessed profound social and economic upheaval as Europe evolved into centralized ruling units. With the establishment of universities and professional schools, the character of health services changed too. Early in the 13th century, female health workers, long accustomed to the trust and respect of their patients, began to face opposition. Barred from most European universities because of their gender and denied academic training in medicine, they were considered ineligible as healers, and those who persisted often met with erratic, even harsh punishment. Yet they stood their ground against the hostile decrees of secular and clerical authorities,

and in doing so, they risked large fines, flagellation, excommunication, and exile (Minkowski, 1992).

1.4: The Witch Hunts and the Birth of Modern Medicine

As these campaigns became more organized in the last four centuries of the Middle Ages, female healers became the sustained target of witch hunting. While this period has been well documented by feminists and other historians, its importance to the question of women healers makes the topic of the witch hunts worth revisiting, however briefly. The record of that cruel era, which peaked between the late 15th and the 17th centuries, is based on the testimony of prosecutors, not on that of the accused. Judged as witches, the women often met death on the rack or at the stake.

European female healers of the Middle Ages performed a service virtually indistinguishable from the one cherished and aggressively defended by academically trained male physicians. Yet they received scant attention from early historians, whose reporting concerns may well have been shaped and colored by the more dramatic, male-dominated events of empire-building and developing power structures (Minkowski, 1992).

Women's skill in the healing arts was generally not question. But, since women were not officially allowed to study medicine, the source of their skills was questioned and often believed to be the product of demonic forces. The position

of the Church was “that if a woman dare to cure without having studied, she is a witch and must die” (Achterberg, 1991). The other side of the suppression of witches as healers was the creation of a new male medical profession, under the protection and patronage of the ruling classes. This new European medical profession played an important role in the witch hunts, supporting the witches’ persecutors with “medical” reasoning.

The age of the witch hunts spanned more than four centuries, from Germany to England. It was born during a time of feudalism and lasted well into the “age of reason”. The witch craze took different forms at different times and places, but did not lose its essential character: that of a ruling class campaign directed against the female peasant population. Witches represented a political, religious, and sexual threat to Protestant and Catholic churches, as well as to the state (Ehrenreich & English, 1973).

Some believed the witch hunts were caused by mass hysteria of the peasantry or a mass suicide by hysterical women. Historical evidence indicates that it followed ordered, legalistic processes resulting in well-organized campaigns, initiated, financed, and executed by Church and State. To the witch hunters, the unquestioned authority on how to conduct a witch hunt was the *Malleus Maleficarum,* or *Hammer of Witches,* written in 1484 by the Reverends Kramer and Sprenger, under the leadership of Pope Innocent VIII. For three centuries this book was on the bench of every judge and in the hands of every witch hunter (Ehrenreich & English, 1973).

However, at the height of the witch hunts, some physicians were suggesting that witches were actually ill and should be treated medically and not killed or exorcized. Johann Weyer (1515-1588), a Dutch physician, suggested that witches needed medical treatment (a progressive argument at the time). He wrote the widely influential *De Praestigiis Daemonum et Incantationibus ac Venificiis* (On the Illusions of the Demons and on Spells and Poisons) in 1563 as a rebuttal to the *Malleus Maleficarum.* While he defended the idea that the devil's power was not as strong as claimed by the Catholic Church in *De Praestigiis Daemonum*, he defended also the idea that demons did have power and could appear before people who called upon them, creating illusions; but he commonly referred to magicians and not to witches when speaking about people who could create illusions, saying they were heretics who were using the devil's power to do it, and when speaking on witches, he used the term *mentally ill,* which he is credited for being the first to apply. Although he was among the first to publish against the persecution of witches, the witch hunts were at their height and his arguments were not widely accepted (Martin, 1993).

The alleged crimes of the witches included: sexual crimes against men, being organized in a secret society, and having medical powers affecting health. They were often charged specifically with possessing medical and obstetrical skills. Women healers were often the only general health practitioners for the impoverished and diseased who had no doctors or hospitals. However, the Church was not against medical care for the upper class because kings and nobles had court doctors who were men, sometimes even clergy. Male upper

class healing under Church control was acceptable; female healing of the peasant class was unacceptable (Ehrenreich & English, 1973).

While women healers treated the common people, the ruling classes were developing their own secular healers: the university-trained physicians. In the early 13th century, European medicine became firmly established as a science and a profession. This medical profession was actively engaged in the eradication of women healers. The exclusion of women from universities and professional schools began long before the witch hunts. As the new surge of interest in medicine grew in universities, more and more men sought medical training. The Church imposed strict control over the profession, and allowed it to develop only within the boundaries of Catholic doctrine. This form of medical "science" relied more on superstition than on any rational science. Ironically, this superstition- and incantation-based new medicine replaced women healers who were persecuted for practicing "magic." It was the women healers who developed an extensive understanding of bones, muscles, and herbs, while physicians were basing their predictions on astrology and Church doctrine (Ehrenreich & English, 1973).

During the witch trials, the partnership between Church, State, and the medical profession grew exponentially. The doctor was viewed as the medical expert and lent scientific credibility to the witch hunts, just as the Church legitimized the medical profession, denouncing non-professional healing as equivalent to heresy. The witch hunts also provided a convenient excuse for the

doctor's flaws and mistakes in practice by implying that anything he could not cure was a result of sorcery (Ehrenreich & English, 1973).

Ultimately, the distinction between women healers and male doctors was made final at trial. The trial established the male physician on a moral and intellectual plane far above the women healers he judged. The trial placed him on the side of God and the Law, while it placed her on the side of darkness, evil, and magic. The male physicians owed their new status not to medical and scientific achievements of their own, but to the Church and State he served (Ehrenreich & English, 1973).

1.5: Cultural Implications of the Eradication of Women Healers

The witch-hunts left a lasting and profound effect: an aura of contamination and inferiority around the female healer has remained. This early and devastating exclusion of women from independent healing roles was a violent foreshadowing of what was to become a theme in history (Ehrenreich & English, 1973).

Gradually, women retreated. They backed away from practicing medicine in public, unless they were especially courageous or had the protection of a powerful man. Women scientists, scholars, healers, and physicians were forced to study alone and to hand down their knowledge orally, in secret and in fear

(Achterberg, 1991). Women's knowledge was not often written down and so was not available to men. Women quietly cared for their families in private as they became more and more submissive to the dominant paradigm. As modern medicine grew in parallel with science, women's live became more and more oppressed. Because females had no voice in medical science, her body was not studied as she was now secondary to the "normal" male body. As time evolved, medical science became one of the most powerful sources of sexist ideology in our culture. Justifications for sexual discrimination – in education, in jobs, in public life – ultimately rested on the one thing that differentiated men and women: their bodies. Theories of male superiority ultimately rest on biology (Ehrenreich & English, 1973).

Chapter 2: The History of Medicine

2.1: The History of Women's Bodies

For centuries, the law has mostly defined women's bodies as men's property. In many ancient cultures, women who were not slaves often belonged to their fathers before marriage, and to their husbands after an arranged marriage. These marriages typically were contracted between the future husband and father-in-law, with the woman having little if any role in the arrangement of the marriage (Weitz, 1998).

Women's status as property reflected the belief that women's bodies were inherently different from men's in ways that made women both defective and dangerous. These views are evident in the writings of Aristotle, whose ideas were the foundation of the science behind women's bodies from 4 BCE through to the eighteenth century. According to Aristotle's biological theories, only embryos that had enough heat could develop into a fully human [read: male] form – the rest became female. Building on this idea, the influential Greek doctor Galen, declared that women's reproductive organs were virtually identical to men's, but were located internally because female embryos lacked the heat necessarily for those organs to develop externally. This view remained common among doctors into the eighteenth century (Weitz, 1998).

This lack of heat was believed to also produce many other deficiencies in women, including a smaller stature, a weaker constitution, a less developed brain, and emotional and moral weaknesses that could endanger any man that fell under a woman's spell. These ideas would later be reflected in Christian interpretations of Mary and Eve and would play a substantial role in fueling the witch hunts. By the eighteenth century, women's legal and social position in the world had changed very little. Once married, a woman lost any rights as a citizen, including the right to own property, the right to make contracts or to sue over legal issues, the right to have custody over her children, or the right to keep any wages she earned (Weitz, 1998).

The combination of new "scientific" ideas with older definitions of women's bodies as ill or fragile continued to contributed to the view that women (even white middle class women) were unable to sustain the responsibilities of political power or the burdens of education or employment. Ideas about middle-class women's frailty drew heavily on the writings of Charles Darwin. As part of his theory of evolution, Darwin argued that males competed for sexual access to females, with only the fittest succeeding and reproducing. As a result, males continually evolved toward greater "perfection." Females, on the other hand, did not need to compete for males, and therefore were not subject to the same process of natural selection. Darwin also argued that females must expend so much energy on reproduction that they retain little energy for either physical or mental development. As a result, women remained subject to their emotions and

passions: nurturing, altruistic, and child-like, but with little sense of justice or morality (Weitz, 1998).

Nonetheless, with women's increasing entry into education and employment, ideas about the physical and emotional frailty of women were adopted by nineteenth century doctors as justifications for keeping women uneducated and unemployed (Hall, 1905). Belief in the frailty of women's bodies similarly fostered the epidemic rise during the late nineteenth century in gynecological surgery. Many doctors routinely performed surgery to remove healthy ovaries, uteruses, or clitorises, from women who experienced an extremely wide range of physical and mental symptoms – including symptoms such as rebelliousness or malaise, which reflected women's constrained social circumstances more than their physical health. These operations were not only unnecessary but also dangerous, with high mortality rates.

As the history of women's bodies evolved with modern medicine and scientific discoveries, the history of women's medicine also changed with industrial, scientific, social, and political views. Two important areas of women's medicine, midwifery and gynecology, evolved into what is now the modern women's health movement.

2.2: Midwifery

It is unknown exactly when midwifery emerged as a profession but it can be assumed that ever since women have been birthing children, there has been the need for aid during this life-changing event. Evidence of midwifery exists in records from ancient Egypt and the imperial Roman Empire but no written records of midwifery are known to exist from before these times (Towler & Bramall, 1986).

Midwifery came to the United States with the earliest settlers. In this setting, midwives not only provided care for childbearing women, but also were often called upon to provide basic care for others in the community. Over the next few centuries, more and different immigrant groups began to settle in pockets around the country. Each brought with them midwives from their home country. This influx added to the diversity of knowledge and skills of midwives providing care to women in different areas. Midwifery care remained virtually unchanged over the centuries, up to, and including the 19th and early 20th centuries in the United States. At the same time, physicians, and later nurses, began to organize, standardize education, and grow in scientific knowledge. The social status of women in general was at an all time low because after the witch hunts, women lived in fear and therefore were socially more submissive. As a result of the social shift in women's roles, women's opportunities for education were limited (http://www.mnmidwife.org/History.html). Being that midwives were women and did not have access to this growing knowledge, they were largely

excluded from the changing world of health care. Midwives were also being blamed for the high rates of death to mothers and infants during childbirth. Though midwives continued to provide care for the medically and socially needy, by the late 1800's, upper class women began to favor the care of physicians for childbirth. This started in Europe and spread to the U.S. by 1905.

In an effort to control mother and infant death rates, childbirth was increasingly being moved from homes into hospitals. Despite this move, death and illness during childbirth remained high and most evidence shows that it actually increased. However, maternal mortality was remarkably low before the move to hospitals. At the same time, a debate raged about “The Midwife Problem”. While a few supported education and regulations of midwives, the majority wished to abolish the practice all together. By the 1930's the abolition of midwifery nearly succeeded. In 1900, midwives attended almost half of all births; this number dwindled to 12.5% by 1935. From this interest in infant death rates, the Children's Bureau was established in 1912 to study rates and causes of infant death. Their first studies showed that the infant death rate was 124 in 1000 live births. The link between infant health and the health of the mother during pregnancy was also made clear. This began a national push for prenatal health care to reduce the number of deaths to both mothers and infants related to pregnancy (http://www.mnmidwife.org/History.html).

The status of women at the beginning of the 20th century was at one of its lowest levels. Women were regarded as economically exploitable, but at the

same time, socially and politically incompetent in the sense that they were perceived as being unfit to exercise good judgment concerning their own affairs or the affairs of others and were legally prevented from practicing the healing arts. Paternal domination of home and society was prevalent throughout society. It was in this kind of atmosphere that midwives were outlawed and women were blamed for the appalling conditions under which mothers and babies died at that time. In actuality, women were powerless to control social conditions, and coped as midwives as well as they could with circumstances which were largely the product of a man-made industrial and social revolution (Mcgregor, 1998).

2.3: Gynecology

In the 18th century, the physiological changes in a woman's body during gestation were recognized, and together with the creation of forceps, the new practice of obstetrics was created (Moscucci, 1990). Obstetrics included more than what was commonly practiced in midwifery. Besides aiding in childbirth, midwifery included various medical therapies for female ailments and was the domain of women healers for centuries. Medical training moved into the specific areas of birthing. In the 19th century, male medical practitioners made steady progression into this formerly all female profession by supervising births in far greater numbers, establishing obstetrics as a specialty, and creating the practice of gynecology – the study of the female in terms of her functions and diseases.

Medical therapies were at this time focused on the individual and her environment and social situation (Mcgregor, 1998).

As gynecology grew as a field, male doctors characterized themselves as the carriers of rational, scientific expertise to an area previously dominated by dangerous practices. They contrasted the ‘incompetent’ midwife with the enlightened medical practitioner of gynecology, claiming that the male “midwives” were the only people who could conduct mother and baby through a safe birth. These men managed to undermine public confidence in the traditional midwife’s abilities. The upper classes were the first to seek his services; by the beginning of the 19th century, basic surgeons were delivering babies as a routine part of their practice, a sign that the midwives’ monopoly of childbirth was being broken lower down the social scale. Male physicians had also extended their sphere of intervention beyond the delivery alone: they were now managing pregnancy and the post-partum period and treating diseases specific to women, such as post-partum depression (Moscucci, 1990).

Midwifery had been incorporated in general practice because male doctors co-opted the knowledge of midwifery. In the early 19th century, it was widely accepted that keeping up a medical practice without any form of midwifery was impossible. General practice was centered around the delivery of the baby, and the resulting care of the mother and baby depended on the success of the first client contact. This is how the concept of the general practitioner as the ‘family doctor’ originated. Male physicians usually used the term ‘family’ to

indicate the mother-child dyad, a social and biological unit where the father was peripheral; popular medical advice books addressed to the family often were mostly about women and children (Moscucci, 1990).

In the 19th century, the core of midwifery and gynecology in general practice held the key to understanding the development of the obstetrical and gynecological profession during this time. Although hospital practice was beginning to set the limits for a class of specialists, there was no sharp distinction between the general practitioner and the obstetrician and gynecologist. It was for this reason that the regulation of midwifery was believed to be an integral part of the organization of medical practice as a whole (Moscucci, 1990).

Throughout the 19th century, debates took place about whether midwives should be admitted to medical schools to study obstetrics so they could continue their tradition of attendance at birth, or whether male physicians should be the birthing attendants. Even after physicians had established themselves in childbirth, it was well into the 20th century before experience and clinical education became a part of obstetrical training for medical students.

2.4: The Political Body

The social construction of women's bodies is the process through which social forces, such as medical and other institutional policies, come to affect, restrict, and create the knowledge that is available about women's bodies. This is

a political process, which reflects, reinforces, or challenges the distribution of power between men and women.

Like all political processes, the social construction of women's bodies develops through battles between groups with competing political interests and with different access to power and resources. For example, medical doctors have presented their ideas about the existence of premenstrual syndrome (PMS) as objective truth claims, that is, claims whose truth is unsullied by anything other than direct medical evidence. Yet those claims reflect a specific economic and social context rather than reflecting any "simple" medical evidence regarding the frailty and dangerousness [read: sexuality] of the female body. Doctors' ability to convince the public to accept these ideas has depended on the economic and social power of medical doctors and, of course on the support they have received from women who believe they have PMS and want validation for and treatment of their symptoms. Women are not passive players in this and other examples of medicalization but their power is in some real sense restricted by the doctor/patient relationship (Weitz, 1998).

The social construction of women's bodies often serves as a powerful tool for controlling women's lives. The existence of PMS as a diagnostic category gives employers an excuse not to hire women – regardless of whether they have PMS – on the grounds that women's menstrual cycles make them physically and emotionally unreliable. Similarly, when a woman acts or speaks in ways that others find threatening, those others may dismiss her actions or remarks as

symptoms of PMS – regardless of whether the woman herself believes she experiences such a syndrome and even regardless of whether she is in fact premenstrual. This social feature of PMS encourages medical practices, including the use of sedatives, hormones, and hysterectomies, that materially change and control women's bodies, while encouraging women to monitor and control their own behaviors more closely during their premenstrual days (Weitz, 1998).

Today, medicine has achieved social control over women's lives through the special sanctity of the private physician/patient relationship. The relationship between a woman and her doctor is often one of profound inequality on every level, an exaggeration of the power imbalances evident in many client-professional relationships in Western society. Often times, in relationships where one of the individuals is less powerful than the other, the individual with less power tends to attribute to themselves any failures or weaknesses of the relationship. In the doctor/patient relationship, if the female patient does not understand something, she may feel inadequate or intimidated and find it hard to admit this and ask for an understandable explanation. Patients, both men and women, often believe that a doctor's superior education, training, and experience automatically produce infallible judgment (The Boston Women's Health Book Collective, 1998).

People typically go along with their society's hegemony for status because the societal norms and expectations get built into their sense of worth and

identity as a certain kind of human through the process of socialization. These beliefs emerge from the way people think, the way people see, hear, and speak, and the way people feel. “The paradox of human nature is that it is always a manifestation of cultural meanings, social relationships, and power politics – not biology, but culture, becomes destiny” (Weitz, 1998).

Chapter 3: Medicalization

3.1: The Emergence of Medicalization

The term “medicalization” entered academic and medical publications in the 1970s. Peter Conrad conducted some of the first studies of the medicalization of social deviance, but the concept was soon applied to several other social phenomena. The concept of medicalization has also gained attention from other social sciences beyond sociology and can now be easily identified on internet search engines such as Google, Google Scholar, Medline, and several social science databases (Conrad, 2007).

Conrad argues that the key to understanding medicalization is in the way it is defined. Medicalization is the process by which a given phenomenon becomes defined in medical terms, described with medical language, and understood through a medical framework. Medicalization is a problem insofar as it inappropriately reinterprets and/or reduces complex social phenomena to simpler biological problems that then fall under the exclusive control of the medical establishment and can become an excuse to not examine the social context of illness and inequality (Conrad, 2007).

The medicalization of deviance includes the redefinition of addiction, eating disorders, sexual dysfunction, gender differences, learning disabilities, and physical abuse from social problems to medical problems. Medicalization has

also created new categories of deviance, such as ADHD (Attention Deficit Hyperactive Disorder), PMS, CFS (Chronic Fatigue Syndrome), and PTSD (Post Traumatic Stress Disorder). Various behaviors, once defined as immoral or anti-social have been given a medical meaning; behaviors that were sinful are now symptoms of illnesses. A number of common life processes have been medicalized as well, including menstruation, birth control, childbirth, infertility, menopause, aging, death, mood, and anxiety (Conrad, 2007).

The expansion of the categories that have been affected by the growth of medicalization is not the only result of medical "imperialism." Social movements, patient organizations, and individual patients have been advocates for medicalization (i.e., Alcoholics Anonymous). In recent years, the pharmaceutical industry viewing potential patients as consumers has begun to play a more significant role in medicalization (Conrad, 2007).

Conrad further suggests that certain social factors predominate the rise of medicalization. First, he suggests that the power and authority of the medical profession and the expansion of medical jurisdiction were the primary reasons for medicalization. Second, medicalization was related to social movements and interest groups where organized efforts were made to create a medical definition of a problem or to promote the importance of medical diagnosis. Third, inter-organization activities publicized medicalization, where professions competed for authority in defining and treating problems, as the case with obstetricians and the near eradication of midwives (Conrad, 2007).

Medicalization studies by sociologists and feminist scholars have illustrated how women's issues have been disproportionately or over-medicalized. This is reflected in studies of reproduction, birth control, child birth, infertility, PMS, eating disorders, sexuality, menopause, cosmetic surgery, anxiety, and depression (Conrad, 2007). The medicalization of women's bodies has had far reaching consequences because women have been targets in the expansion of medicine, while at the same time being under-researched. The National Institutes of Health (NIH) did not require that women be included in research studies until the late 1990's.

3.2: Medicalization and Women

Women's experience has been a central focus for medicalization. In addition to the complexities that women bring to particular health issues, physicians focus on women as a primary market for expansion for numerous reasons. First, there is a good match between women's biology and medicine's biomedical orientation. External indications of biological processes exist in women (menstruation, birth, etc.), while they are more hidden in men. Based on modern medicine's biomedical perspective, these external indicators allow for women to be easy targets for medical intrusion (Riessman, 1984).

Second, women's social roles make them more available to medical scrutiny. Women are more prone to come in contact with medical providers because they care for children and the family in general (Riessman, 1984).

Third, women have greater vulnerability to medical labels because of their pattern of coping with their own symptoms, as well as medicine's response to those patterns. When women visit the doctor for any serious illness, they are more likely to be checked for reproductive implications of illness. They are more subject to regular checks of their reproductive systems, in the form of pap tests or gynecological exams. Whenever women visit their physician, there is evidence that they receive more services – in the form of lab tests, procedures, prescriptions, and return appointments – than men do with the same complaints and social demographics (Riessman, 1984).

Finally, women's social subordination to men has made them vulnerable to the expansion of clinical treatment. Generally, male physicians treat female patients. Social relations in the doctor's office often reflect patriarchal relations on a larger social scale, and this occurs under the mask of science. This patriarchal control is even more evident when the physician socializes young women regarding sexual behavior, perhaps by withholding contraceptive advice, or criticizing them based on the dangers of promiscuity. For these reasons, women are more subject to medical definitions of their experience than men. In these ways, patriarchal paradigms are reinforced in medicalization.

As a result, women are prime markets for the expansion of medicine because they are desirable biologically, socially, and psychologically. The message that women are expected to be dependent on male physicians to manage their lives is strengthened by the pharmaceutical industry in drug advertisements and also by the media (Riessman, 1984).

The effect of this culture seems to be quite the opposite of that of enabling people to move forward and quickly put their episode of illness behind them. Rather, through objectifying distressful emotional experiences through illness labels, a process has been released where people become more passive and less able to act in relation to their problems and lives, and instead remain "sick." Current applications of illness labels tend to give permanence to these feelings, which are typically temporary, transitory states that will be replaced by other feelings and emotions as time moves on.

However, medical/scientific male healers were not the only health care providers to support the evolution of medicalization. Women healers also engaged in medicalization projects, including those that medicalized women's bodies. Women physicians helped to educate American women about the benefits of maternal and child health activities, just as women physicians aligned themselves with science to increase jurisdictional claim over maternal health (Barker, 1998).

As medicalization evolves in the 21st century, it is expected to become a more global phenomenon. Whatever the medical and social consequences,

medicalization will remain a dominant approach for an increasing range of human problems. Ultimately, how medicalization will affect the organization of society, and how society will deal with the consequences remains to be seen (*The Medicalization of Society,* p.164).

3.3: Implications for Health and Society

The medicalization of human problems is a contradictory reality for women. It is part of the problem and of the solution. As women have tried to free themselves from the control that biological processes have had over their lives, they have strengthened the control of a biomedical view of their experience (Reissman, 1984). As women visit doctors and get symptom relief, the social causes of their problems are ignored. As doctors acknowledge women's experience and treat their problems medically, problems are stripped of their political content and popular movements are taken over. Because of these contradictions, women in different class positions have sought and resisted medical control (Martin, 1987).

The transformation of particular human experiences such as childbirth, reproduction, premenstrual problems, weight, and psychological stresses into medical events has been the outcome of a reciprocal process involving both physicians and women (Riessman, 1984). Medicine, as it developed as a profession, was repeatedly refined. Physicians created demand in order to

generate new markets for their services. Conrad and Schneider, in *Deviance and Medicalization* note that the potential for medicalization increases as science discovers the subtle physiological correlates of human behavior. A wealth of knowledge is developing about women's physiology and as more becomes known, the issue will be how to acknowledge the complex biochemical components that are related to menstruation, pregnancy, weight, and other areas without allowing these conditions to be distorted by scientific understanding. The issue will be to gain understanding of women's biology, without submitting to the control of the medical expert. The answer is not to turn away from discoveries and treatments that may ease pain and suffering. To de-medicalize is not to deny the biological components of experience but rather to alter the ownership, production, and use of scientific knowledge. People need to reconceptualize their whole way of thinking about biology and explore how natural phenomena are an outgrowth of the social circumstances of women's lives (Riessman, 1984).

Because people will continue to need health care, the challenge will be to alter the terms under which care is provided. People need to work for specific reforms and gain what is possible while, at the same time, acknowledging the limitations of reform. However, in the long run, reform alone is not what is needed. For certain problems in this culture, real demedicalization is necessary; experiences such as routine births, menopause, or excess weight based on social norms should not be defined in medical terms, and medical-technical treatments should not be viewed as appropriate solutions to these problems (Riessman, 1984). For other conditions where medicine may be of assistance,

the challenge will be to differentiate the beneficial treatments from those that are harmful and useless. The real challenge is to use existing medical knowledge selectively and to extend knowledge with new paradigms so as to improve the quality of people's lives (Riessman, 1984).

Chapter 4: Connecting the Dots

4.1: The Decline of Women Healers and the Rise of Modern Medicine

The suppression of women health workers and the rise to dominance of male professionals was not an inevitable or “natural” process, resulting automatically from changes in medical science, nor was it the result of women’s failure to take on healing work. It was an active takeover by male professionals (Ehrenreich & English, 1973).

The suppression of women healers by the medical establishment was a political struggle, in that it was part of the history of the struggle of women in general: the status of women healers has risen and fallen with the status of women. The suppression of women healers was also a political struggle in that it was part of a class struggle. Women healers were doctors to the people, not to the ruling class, and their medicine was part of the subculture of the economically disadvantaged. To this day, women’s medical practice has thrived in the midst of rebellious lower-class movements that have struggled for freedom from established authorities. Male professionals in contrast, have typically, served the ruling class – both medically and politically. The universities, the philanthropic foundations, and the law have advanced the interests of male professionals: the dominance of male physicians is owed to the intervention of the ruling class they served (Ehrenreich & English, 1973).

Women's power rapidly declined in the aftermath of the witch hunts, but the marginalization of women healers continued through to the Industrial Era. The witch hunts did not completely eliminate women healers, but the hunts branded women as superstitious, and dangerous. Women healers were thoroughly discredited to the point that male practitioners were able to take over the last area of female healing – midwifery. As discussed in chapter two, through the use of technological "innovations" such as obstetrical forceps, male doctors took over birthing. Although midwives charged these doctors with commercializing birth and criticized their dangerous use of forceps, it was, in some sense, too late. Male doctors were able to characterize and dismiss the women midwives as ignorant, clinging to the superstitions of the past (Ehrenreich & English, 1973). The last of the women healers were over-shadowed by the increasingly powerful modern medical establishment and the rise of socially organized patriarchy.

4.2: The Rise of Patriarchy and Gender Roles

The labeling of women as witches, ignorant, sexually dangerous to men, and generally incapable of being independent individuals was part of the increasing institutionalized nature of women's oppression. Women were placed in submissive roles where they became the property of their fathers or husbands. Women quietly cared for their families in private as they became more and more

submissive to the dominant paradigm. As modern medicine grew in parallel with science, women became increasingly marginalized.

As Western culture became increasingly androcentric, women were told that their subservience was a natural and inevitable product of biology. Many women began to believe that their status was the fault of their anatomy; they were trapped by the cycles of menstruation and reproduction that prevented them from being free (Ehrenreich & English, 1973). Biological theories explaining women's smaller stature, weaker constitution, under-developed brains, and emotional and moral weaknesses were increasingly popular (Fausto-Sterling, 1992). Women were labeled as frail, inherently sick, weak, and delicate. These labels contrasted with the fact that all women had the role of taking care of family, home, and husband, while women of lower classes, such as Black slaves or immigrant house workers, had additional roles of long hours of work outside their homes, often receiving inadequate rest and nutrition. The social roles of women had always been sensitive to class pressures. During this period, the conflicting labels assigned women were split between affluent women to whom society prescribed lives of leisured frailty, and working class women who performed backbreaking work (Ehrenreich & English, 1973).

Accompanying these class distinctions were two strains of sexist ideology: contempt for (affluent) women as weak and defective, and fear of (working class and poor) women as dangerous and polluting (the "pollution" was often characterized in medical terms, e.g., women were seen to be the primary carriers

of typhoid, cholera, or venereal diseases). Upper- and upper-middle-class women were “sick”; working-class women were “sickening” (Ehrenreich & English, 1973).

4.3: Gender Roles and Women’s Bodies

The roles of women within the patriarchal social paradigm were accompanied by sexist medical and biological accounts of, females as the submissive second sex. As Emily Martin acknowledges that the picture of the passive egg and active sperm drawn in popular as well as scientific accounts of reproductive biology relies on stereotypes central to our cultural definitions of male and female (Martin, 1991). Martin argues further that descriptions of the bodies of women are denied any positive images. Women’s physiological processes, such as menstruation are described as a chaotic disintegration of form and menstruation is described as ‘ceasing’, ‘dying’, ‘losing’, ‘denuding’, ‘expelling’ (Martin, 1991).

By looking at scientific language, such as found in biological descriptions of the egg and sperm, it is interesting how ‘femininely’ the egg behaves and how ‘masculinely’ the sperm behaves. The egg is viewed as large and passive; it does not move but is passively transported, or swept along the fallopian tube. In contrast, sperm are small, streamlined, and very active. The more common picture – egg as damsel in distress; sperm as the heroic warrior to the rescue – is

not dictated by the biological details of these events (Martin, 1991). The degree of metaphorical content in these descriptions, the extent to which differences between egg and sperm are emphasized, the parallels between cultural stereotypes and gender roles of males and females, all point to the conclusion that many of the 'facts' of biology are constructed in terms of and affected by larger cultural processes (Martin, 1991). Based on this skewed perspective of the biology of women's bodies, modern biomedicine evolved into a powerful cultural authority, eventually leading to the rise of medicalization.

4.4: Women's Bodies and Medicalization

As discussed in chapter three, medicalization has affected our sense of both deviant behavior and more "normal" natural life processes (Conrad, 1992). The treatment of women by the medical establishment fits both these categories simultaneously, as women's 'natural life' processes are often perceived as deviant where they differ from men's (Riessman, 1984). Medicalizing attention has tended to focus on events having to do with reproduction – menstruation, pregnancy, childbirth, and menopause. This medicalizing of the natural processes of women's bodies is a result of the lack of equality between men and women, particularly in terms of social roles and the rise of the modern medical establishment.

Just as women's bodies have been stereotyped in Western culture as passive and deviant from male bodies, the rise of modern medicine, and more specifically medicalization, has been a result of the rise of the patriarchal paradigm and the decline in women's power. The forceful eradication of women healers and the take over by the male medical profession propelled medicine in the direction of medicalization. Once women lost control over their bodies, biology took control over their lives. Biological objectivity was skewed by cultural myths and beliefs instilled into society since the time of the witch hunts where women were labeled by the Church and State as witches serving a demonic purpose to endanger the lives of men. Ever since, there has been a negativity attached to women, their biological processes, and social roles.

However, at roughly the same time that medicalization was introduced in the 1970s, there was a response in the form of the modern women's health movement – one of many movements that started as a result of second wave feminism. With books such as *Our Bodies, Ourselves* by The Boston Women's Health Book Collective, women were told to take charge of their own health care and to be informed of health-care options and choices. The rise of feminism has empowered women to be more involved with their health care, but even more so, has opened the doors for a resurgence of a new generation of women healers.

Chapter 5: Modern Women Healers

5.1: Women in Biomedical Health Care

In 2006, the American Medical Association (AMA) stated that women comprised of 27.8% of physicians in the U.S. In 2004-2005, women medical school applicants were at 50.4%, with a matriculation of 49.5%, and graduating at 47.1% (http://www.ama-assn.org/ama/pub/category/12913.html). By the year 2010, women are expected to be about 30% of the physician workforce. However, women doctors are often concentrated in the lower-status, lower-paying specialties and positions (Boston Women's Health Book Collective, 1998).

Many women emerge from the stressful and dehumanizing medical training process expecting the same prestige, money, and position as male physicians receive. Many women are eager to prove that they can be as good as any male physician according to the androcentric criteria of the profession: clinical competence; emotional detachment; dependence on the very latest tests, drugs, technologies, and procedures; and financial success (Boston Women's Health Book Collective, 1998). Often, after training in traditional medical schools, these women are often indistinguishable from their male counterparts, and can be a disappointment for some women patients who expect more warmth and compassion from their women doctors that they do not expect from their men

counterparts. However, there are also women physicians who have survived the traditional training, maintained their warmth and compassion, and remember what it can be like to be a woman patient.

The medical system in the U.S. is like a pyramid, with highly paid male doctors and administrators at the top and underpaid and undervalued women forming the large base. While about 72% of doctors are still men, about 70% of all medical workers are still women: doctors, nurses, physical therapists, medical technicians, secretaries and other clerical workers, maintenance staff, and more (Boston Women's Health Book Collective, 1998). However, it is important to note that many male health-care workers, from physicians to orderlies, also want to transcend the restrictions of the medical establishment. The struggle with the medical system is not a clear black and white issue of men against women.

When people seek care they typically first encounter women staff, particularly at hospitals or a health maintenance organization (HMO). Like many physicians, some of these workers over-medicalize people's health problems, focus too much on technology, and are too busy to offer empathic care. Many women health care workers want to offer supportive care, but like most other women workers, they work within a structure over which they have little or no control (Boston Women's Health Book Collective, 1998).

In 1908, the AMA formally recognized the nurse as a member of a learned profession. By 1914, forty states had adopted "Nurse Practice Acts," with licensing boards or qualification statements in place. The status of the profession

was greatly enhanced during wartime, and since World War I, there has been great demand for nurses in medical care (Achterberg, 1991).

Today, out of approximately one million nurses – registered nurses (RNs) and licensed practical nurses (LPNs) – about 95% are women (Boston Women's Health Book Collective, 1998). Historically, nursing has been a relatively low-status occupation, like other women's jobs. However, graduate nurses and advance practice nurses, such as nurse anesthetists, nurse practitioners, and nurse midwives, command decent salaries because their skills have become more marketable by helping to save physicians and HMOs time and money (Boston Women's Health Book Collective, 1998). However, despite the fact that nurses are the principle players in *caring for* and monitoring of patients, they are not the principle players in the more prestigious role of "curing" patients.

Nonetheless, nurses still come from the middle or working class and the history of nursing has reflected a struggle in which the weight of past tradition, the subordination of nurses, the sex segregation, and the apprenticeship model in nursing education have left a mark on the attitude of present-day nurses (Achterberg, 1991).

The chief issues for those nurses who envision themselves as "nurse healers" are: how to straddle the worlds of art and science, of caring and curing, and how to develop and implement new techniques that better fit their own notion of the role they serve. Currently important tools and strategies include therapeutic touch, biofeedback and other self-regulation techniques, modes of

relaxation and meditation, and health education in its most comprehensive form (Achterberg, 1991). These nurses see sound nursing education and clinic experience not as incompatible with the new techniques, but as the foundation upon which the expanded functions of biomedicine can build.

However, the most significant challenge to the field of nursing is yet to come. As the modern health care model continues to rapidly change, due to corporate reorganization, nurses, once the chief coordinators, administrators, and monitors of patients' experience, are instead being hired to represent corporate interests in reduced-skilled care and in limiting benefits and services. Nurses who are managers of care increasingly oversee not nurses but people who have been hired as aides, yet these managers have little or no experience in care giving: security guards, housekeepers, transport workers, and janitors. As a result, the quality of care for hospital patients is in decline, but the RNs who must manage an unqualified staff are put in the position of being held legally responsible if anything goes wrong (Clarke & Olesen, 1999).

Today, nurses are frustrated with the nursing role, partly because the women's movement has affirmed women's capabilities and worth and has inspired women to express their entitlement to better working conditions (Boston Women's Health Book Collective, 1998).

5.2: The Modern Midwife

Over the past ninety years. midwives have been banned, prosecuted, ignored, or regulated depending upon the mood of state medical societies. As a medical alternative, midwifery is in a very interesting position right now. Like nursing, the field is in transition, with the outcome uncertain.

A direct-entry midwife is educated in the discipline of midwifery in a program or path that does not also require her to become a registered nurse. Direct-entry midwives learn midwifery through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing. A direct-entry midwife is trained to provide what is called the *Midwives Model of Care* to healthy women and newborns throughout the childbearing cycle exclusively in out-of-hospital settings (http://www.mana.org/definitions.html). The *Midwives Model of Care* is based on the fact that pregnancy and birth are normal life processes.

The Midwives Model of Care includes:

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions

- Identifying and referring women who require obstetrical attention

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section (Fullerton et al., 2007).

Under the umbrella of "direct-entry midwife" are several types of midwives:

A Certified Professional Midwife (CPM) is a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the midwives model of care. The CPM is the only US credential that requires knowledge about and experience in out-of-hospital settings. At present, there are approximately 1000 CPMs practicing in the US (http://en.wikipedia.org/wiki/Midwifery). A Licensed Midwife is a midwife who is licensed to practice in a particular state. Currently, licensure for direct-entry midwives is available in 24 states (http://www.mana.org/definitions.html).

The term "Lay Midwife" has been used to designate an uncertified or unlicensed midwife who was educated through informal routes such as self-study or apprenticeship rather than through a formal program. This term does not necessarily mean a low level of education, just that the midwife either chose not to become certified or licensed, or there was no certification available for her type of education (as was the fact before the Certified Professional Midwife credential was available) (http://en.wikipedia.org/wiki/Midwifery). Other similar terms to describe uncertified or unlicensed midwives are “traditional midwife,” “traditional

birth attendant," "granny midwife" and "independent midwife" (http://www.mana.org/definitions.html).

The North American Registry of Midwives (NARM) is a certification agency whose mission is to establish and administer certification for the credential "Certified Professional Midwife" (CPM). CPM certification validates entry-level knowledge, skills, and experience vital to responsible midwifery practice. This certification process encompasses multiple educational routes of entry including apprenticeship, self-study, private midwifery schools, college- and university-based midwifery programs, and nurse-midwifery (Cheyney, 2008). Created in 1987 by the Midwives' Alliance of North America (MANA), NARM is committed to identifying standards and practices that reflect the excellence and diversity of the independent midwifery community in order to set the standard for North American midwifery (http://www.mana.org/definitions.html).

5.3: Women and Complementary and Alternative Medicine (CAM)

Today, there is an increasing availability of a broad range of holistic health care methods that complement and challenge conventional biomedicine and expand current health care options. Some holistic methods, such as massage, herbal medicine, and spiritual healing, have been used by women for centuries to sooth and care for family and community members, to assist during labor and birth, and to attend people through long illnesses. Other non-biomedical healing

methods such as acupuncture and tai chi, yoga and Ayurvedic medicine, which originated thousands of years ago in China and India, respectively, involved more formal training of practitioners. These traditional Eastern methods of healing are practiced in many parts of the world (Boston Women's Health Book Collective, 1998).

In the U.S., these health-care practices are often called "complementary" or "alternative." In much of the world, however, they are the most commonly used methods of healing. The rapid spread of CAM in the U.S. is evident everywhere and is attributable to the costs, inadequacies, and limitations of biomedicine. Over the last two decades, there has been a tremendous increase in the availability of books, articles, and research that address CAM; in the number of health food stores and pharmacies that carry herbs, homeopathic remedies, and nutritional supplements; and in the number of practitioners offering CAM health care (Boston Women's Health Book Collective, 1998).

The National Center for Complementary and Alternative Medicine (NCCAM), part of the National Institutes of Health (NIH) in the United States, surveyed the American public on complementary and alternative medicine use in 2002. According to the survey:

- 50 percent of U.S. adults age 18 years and over used some form of complementary and/or alternative medicine (CAM).

- When prayer specifically for health reasons is included in the definition of CAM, the number of adults using some form of CAM in 2002 rose to 62 percent.
- The majority of individuals (54.9%) used CAM in conjunction with conventional medicine. This is called “medical pluralism” which is the norm across the world.
- Most people use CAM to treat and/or prevent musculoskeletal conditions or other conditions associated with chronic or recurring pain.
- "The fact that only 14.8% of adults sought care from a licensed or certified CAM practitioner suggests that most individuals who use CAM prefer to treat themselves."
- "Women were more likely than men to use CAM. The largest sex differential is seen in the use of mind-body therapies including prayer specifically for health reasons".
- "Except for the groups of therapies that included prayer specifically for health reasons, use of CAM increased as education levels increased".
- The most common CAM therapies used in the USA in 2002 were prayer (45.2%), herbalism (18.9%), breathing meditation (11.6%), meditation (7.6%), chiropractic medicine (7.5%), yoga (5.1%), body work (5.0%), diet-based therapy (3.5%), progressive relaxation (3.0%), mega-vitamin therapy (2.8%) and Visualization (2.1%) (http://nccam.nih.gov/news/camsurvey_fs1.htm)

Many women do not want to give up Western biomedical care completely, but find it does not meet their needs for preventative “well-woman” care. As a result, many women seek out holistic approaches that they can combine with conventional ones. Holistic care methods include practices that people can learn about and use on their own, such as herbal medicine, meditation, yoga, tai chi, some forms of massage, and practices such as acupuncture and naturopathy, which require obtaining care from a trained practitioner (Boston Women’s Health Book Collective, 1998).

Though many holistic care methods are marketed to those who can afford them, there is also a revival of indigenous healing knowledge. Many groups of Black/African Americans still maintain early forms of folk medicine, and Native Americans have held firmly to their traditions. As the population of the U.S. changes, emigrants from Africa, Asia, and Latin America bring with them their own family wisdom as well (Boston Women’s Health Book Collective, 1998). These various forms of folk medicine add to the growing base of what is CAM and holistic healing.

It is important to note that just as women consume more health care in general, they tend to consume more CAM therapies as well, but not at a rate any different than their uses of allopathic medicine.

Chapter 6: What Does It All Mean?

6.1: The Resurgence of Women Healers

Although women are still far from attaining full gender equality, thanks to progressive social movements and feminism, women are experiencing more freedoms and independence than ever documented in history. Women are increasingly empowered to take control of their lives, including their health-care options. Although women still struggle under the patriarchal paradigm, a paradigm shift is occurring as women are entering fields that were once male-only institutions and they are changing the faces of these institutions.

These changes in social roles, the complexity of the social shifts, and the recognition of women's abilities show that Western culture is closer to gender equality, although there are still inequalities that need to be addressed. These changes in social roles, the changes in perceptions of what is a "woman's place," and demographic changes as women continue to join the workforce, have for the most part, had a positive impact on the status of women in the current health-care system in the U.S. Women have been fixtures in health care as nurses and non-medical staff, but women are also becoming physicians.

As society and culture rapidly change and as the current health-care system continues to be in crisis, there is a realistic possibility that women healers can reclaim, in a modern context, their ancient status as healers. While folk

medicine and indigenous healing will probably always be prominent in various subcultures, the new women healers are entering the mainstream as biomedical physicians and also as CAM practitioners. Since the witch hunts, women have struggled under a powerful patriarchal paradigm. The paradigm is shifting, and women are recognized as being competent health-care providers along side male counterparts.

If this trend towards gender equality continues in society generally, the resurgence of women healers will likewise continue. There are still traditions, social perceptions, and legislation that currently deter women from reaching full equality, but if the last forty years is a reflection of what the future holds, there are profound social changes on the horizon. How exactly these changes will occur or when the changes will take effect are not certain, but through education and reform, there is great potential for greater gender equity.

6.2: How Will Biomedicine Change?

It is hard to predict how biomedicine will change as society changes. Medicalization will likely still be a prominent aspect of medicine, just as the pharmaceutical industry will very likely continue to be a rapidly growing aspect of corporate, for-profit medicine. Although people are having doubts and issues with the biomedical industry, it continues to develop in terms of technology and research. While a resurgence of women healers has and will continue to affect

how medicine is practiced, it is unclear how these women will affect the production of biomedical knowledge.

The hope is that midwifery and CAM will be more integrated into mainstream medicine, offering people options in health care treatment. Unfortunately, there is still tremendous skepticism of CAM health care and midwifery as a result of historical myths and perceptions (even though there is an enormous body of literature that supports them), and the validity these forms of health care have in terms of scientific research. How medicalization will change with the increased influence of women healers is unclear, though the recent demedicalization of homosexuality (however not fully demedicalized) gives some indication of the increased stability of marginalized groups to overcome inappropriate medical interventions in their lives.

6.3: Concluding Remarks

I have argued that, in the West, the growth of the modern, androcentric medical establishment is correlated with the decline in women's authority and status. However, as is now clear, the relationship is far from straightforward. After the decimation of women healers in the witch hunts, women healers did not disappear, rather they went underground. Their work as midwives helped them temporarily to regain their status in the period from approximately 1700-1850. Male doctors appropriated midwifery and women's lives became increasingly

biologized and medicalized. However, with the second wave of feminism, the women's health movement encouraged a resurgence of women healers. As women become more empowered and gain more independence generally, there is hope that the health-care system will continue to reflect these changes, and become more inclusive of various types of treatment, less corporate- and pharmaceutically- driven, less profit-driven, and more focused on creating relationships between practitioners and patients.

Of course, there is still the problem of patients getting lost in the system and being over-medicalized, i.e., seen not as people but as illnesses. Women need to be practitioners just as they are patients, and people generally need to be properly and consistently informed of their health-care options. The costs of health care need to be more realistic for the general population, just as insurance coverage needs to be more encompassing of everyone and not just for those who can afford it – in 2005, 16% of the U.S. population did not have health insurance – that is approximately 46.6 million people (http://www.censusbureau.biz/hhes/www/hlthins/hlthin05/hlth05asc.html). All the health care systems around the world that have outcomes better than in the U.S. have two things in common: 1) universal health care and 2) midwives as primary care providers. Although U.S. politicians and legislators are introducing the idea of universal health care, it remains to be seen whether and how these options are realized. However, as social, class, and gender inequality are increasingly recognized and addressed, it is reasonable to expect that positive changes to the modern system of medicine will follow.

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