Sociology of Health & Illness Vol. 18, No. 1, 1996, ISSN 0141–9889, pp. 17–44

What is gender? Feminist theory and the sociology of human reproduction

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Abstract Feminist theory and research on the sociology of human reproduction have historically been bound together as each has developed. Yet recently sociologists of reproduction and 'women's health' have lost sight of core debates in feminist theory. They still tend to work with the assumption that feminism is an internally coherent body of thought, despite the emergence of significant internal divisions since the mid-1980s. In this paper we evaluate the challenge that feminist post-structuralism poses to prior conceptualisations of gender in the context of reproductive health through a critique of sociological work in this area from the 1970s and 1980s. We conclude with a critical exploration of the new insights that might emerge from a post-structuralist 'deconstruction' of gender in the context of human reproduction.

Introduction

Feminist scholarship has now been active in the field of medical sociology for well over twenty years. During this period it has mounted a significant challenge to the patriarchal visions of both the sociological and health care establishments. Issues of health and illness were virtually synonymous with the emergence of second wave feminism, yet recently the sociology of health and illness has drifted away from core debates in feminist theory. As previously marginalised theoretical positions become established they often undergo a process of *dissipation*; their conceptual foundations lose their currency as they are incorporated into, or co-opted by, the mainstream (Fine 1993). Much research in the sociology of health and illness now uses feminist theory only tacitly. This means that it is often *derivative* of a particular feminist perspective rather than a close application of its guiding ideas. As a consequence, interpretative frameworks are often more implicit than explicit and researchers tend to work from the assumption that feminism is an internally coherent body of thought. In reality, however, it is

increasingly marked by internal divisions. Feminism is widely recognised to have undergone a major transformation during the late 1980s and early 1990s. As Michele Barrett has recently remarked,

> contemporary Western feminism, confident for several years about its 'sex-gender' distinction; analyses of 'patriarchy', or postulation of 'the male gaze' has found all these various categories radically undermined by the new 'deconstructive' emphasis on fluidity and contingency (Barrett 1992:202).

Writers in the area of gender and health such as Lesley Doyal (1994) and Deborah Lupton (1994) have drawn our attention to emerging tensions within feminism, but their implications for the way in which we conceptualise the influence of patriarchy upon women's bodies and their health has not yet been fully appreciated. The recent challenge of feminist post-structuralism, in particular, invites us to re-evaluate the current state of gender-related research on reproductive health.

In this paper we reflect upon the contribution that second wave 'modernist feminism' has made to our understanding of gender and health and the challenge that is posed by post-structuralism. The field of gender and health is wide and, since we cannot do justice to the full range of concerns which might be raised in a short paper, we have chosen to focus upon issues in the sociology of reproduction. Reproduction could be viewed as a paradigmatic case since it may embody the contrasts between modernist and postmodernist perspectives in accentuated form. However, feminist work on reproduction has been at the centre of and informs sociological work on gender and health and has at some point been an overriding concern of most of the eminent writers in the field. Concerns with reproduction centre on birth but also encroach upon conceptualisations of health more broadly. Social, legal and medical discourse puts reproduction in the foreground in discussions of individuals' rights and responsibilities, and sociological conceptualisations of women's and men's health develop out of these debates (for example, in dividing lives into the public and the private, work and home *etc*).

The paper begins with a discussion of the post-structuralist critique of the modernist conceptualisations of gender that are embedded in research on the sociology of human reproduction. Particular attention is given to the negative consequences that can arise from feminist thinking which is premised upon a binary division between women and men, male and female, and sex and gender. These consequences include: the universalising and valorising of gender differences; a preoccupation with the abnormalities of women's reproductive health; and a focus on women to the neglect of gender (and men's health) which, it is argued, inhibits our ability truly to understand women's experience. The paper concludes with an exploratory reconceptualisation of gender and reproductive health through the lens of feminist post-structuralism.

Feminist theories, gender and health

The contemporary acceptance of gender as a legitimate area of study in the sociology of health and illness, belies a hard fought and ongoing battle for recognition. Early challenges to male hegemony emphasised women's invisibility (Clarke 1983). Oakley (1974), for example, wrote of women's concealment in academia and the consequent exclusion of areas of social life, such as the domestic world, from the vision of sociology. A distorted picture was created by malestream social theory as it attempted to fit women into pre-defined male-oriented categories. In retrospect, it is clear (Oakley 1985) that sexism in sociology cannot be overcome just by bringing women into the various subareas of the discipline (such as the sociology of work, deviance, the state, and so on), rather the various domains of sociology need restructuring. As second wave feminist theory gained momentum during the 1970s and 1980s, a range of contested approaches began to emerge.

Basic and common to *all* feminisms is the understanding that patriarchy privileges men by taking the male body as the 'standard' and fashioning upon it a range of valued characteristics (such as good health, mastery, reason and so on) and, through a comparison, viewing the female body as deficient, associated with illness, with lack of control and with intuitive rather than reasoned action. In associating 'deficiencies' of the female body with women's *reproductive* capacity, patriarchy conflates biological sex and social gender. The broad task of feminism has been to question this elision by showing that gender is socially constructed. Through this we can identify the social processes that construct the female body as inferior and that discriminate against women (and favour men). At the most general level, then, feminist theories of health, illness and health care have the same task in common: the attempt to show that women's experience of health is socially constructed rather than built directly upon biology or the materiality of the body.

However, there are significant differences in the particular way in which feminists theorise patriarchy and its relationship to health. Indeed, a broad appeal to the *socially constructed* nature of sex and gender itself conceals a range of different positions. For example, much second wave feminist writing refers to the way in which women's social experience (including her health and health care) is mediated by the institutions of patriarchy, usually in oppressive ways. There is the sense that we can lift the veil of the social and reveal the 'reality' beneath. Foucauldian social constructionism develops a quite different agenda. As Nettleton writes, it is an approach which is very 'different to the sociology of medical or scientific knowledge which aims to expose the social, technological or ideological interests which distort or contribute to the creation of certain types of knowledge' (1992:149). Rather, women's bodies and their

experience are only *knowable* through the discourses that constitute them. In these terms 'the sexed body can no longer be conceived as the unproblematic biological and factual base upon which gender is inscribed, but must itself be recognised as constructed by discourses and practices that take the body as their target and as their vehicle of expression.' (Gatens, 1992:132).

Differences in the way in which various feminist theories conceptualise the relationship between sex and gender have a number of implications for the way in which we understand women's health. Undoubtedly, a number of objections can be raised against categorising feminist thought: it can obscure more than it reveals and can lead to the stereotyping of particular views (Stacey 1993). Clearly, there is a danger of artificially constructing a common position out of what is, in effect, a continuum of views. However, it is possible to suggest that there are feminists who hold more in common with each other than with other groups of thinkers, while also appreciating that heuristic groupings (such as liberal, radical, marxist, and post-structuralist feminisms) may conceal differences between individual writers.

Liberal feminists argue that there is no intrinsic relationship between sex/biology and gender. Emphasis is placed on women's access to positively valued 'male roles' and male experiences (see Wolf 1994) which are associated with good health. As a consequence of focusing on rational behaviour, the body is mute and passive (Jaggar 1983, Scott and Morgan 1993). Radical feminism takes a contrasting approach which endorses a strong connection between sex and gender. It attempts to undermine patriarchal privilege by positively valuing what is distinctive about the female, rather than the male body. The body is central to, and for some radical feminists effectively determinate of, women's experience. Control over the body is also central to marxist feminism, although many writers in this tradition are critical of what is seen as radical feminism's essentialism, arguing that while the 'biological base' is important, it is modified in different social contexts according to women's historical relationship to the means of production under patriarchy (Allen 1983, Barrett 1980). There are, then, important differences within second wave 'modernist' feminist thought. However, from the perspective of a post-structuralist critique they have much in common. It is to this perspective that we now turn.

Feminist post-structuralism

Some writers claim a particular affinity between feminism and post-structuralism (see Fraser and Nicholson 1990, Hekman 1990) notably in regard to the work of Foucault (Sawicki 1991, Weedon 1987) even though, as will be discussed later in the paper, this affinity is recognised

not to be without tensions by many (see Diamond and Quinby 1988, McNay 1992). For some, such as Shilling (1993), feminism itself is an enabling condition (far too lightly acknowledged by male writers (Morris 1988)) for the development of post-structuralist discourses generally, and for particular areas such as the sociology of the body.

With its rejection of the 'grand narratives' of modernist thought, which guarantee some forms of knowledge as legitimate and morally 'right', post-structuralism has forced feminism to confront head-on a range of dilemmas that have been under review for some time. In particular, it is critical of Marxist/socialist and radical feminisms which are premised upon an ultimate 'cause of oppression' (be it patriarchy and/or the class structure) for all women, and which believe that the privileged reason carried by particular social groups, such as the proletariat or women (Haraway 1990, Sarup 1993), is the harbinger of liberation. The work of black feminists (which traverses the spectrum of feminist thought) has been particularly important in drawing attention to the oppressions that can result from the notion of 'sisterhood' (hooks 1984) with its implication that gender is the sole determinant of women's fate (Collins 1990).

It is difficult to provide a concise overview of the defining features of post-structuralist feminism, even speaking of *a* post-structuralism can be seen by some to run the risk of 'violating some of its central values – heterogeneity, multiplicity, and difference' (Flax 1990:188). Central, however, is a reconsideration of prior conceptualisations of the 'subject'. In modernist social thought the individual subject is the prime agent of social transformation. In post-structuralism this is inverted and the focus is on how subjectivity is shaped, not on how individuals shape the world (Linstead 1993). The rejection of any sense of an 'essential subject', coupled with a challenge to the search for original causes (Barrett 1992) and the rational pursuit of reason (Flax 1990), culminates in the view that knowledge (held by the individual, which includes the sociologist) is never authentic. Since we can never uncover 'reality' in pure form or find a guiding logic for social change, a social realist epistemology is clearly rejected (Fox 1993). There is no 'objective reality' out there in the social world to be discovered by the sociologist. Rather, the various 'truths' that seem to exist for us – such as, the existence of women and men, old and young people – are discursive categories created through the use of binary logic.

Jane Flax summarises the appeal of post-structuralism to feminism in the following way. Its focus, she writes, is on 'how to understand and (re)constitute the self, gender, knowledge, social relations, and culture without resorting to linear, holistic, or binary ways of thinking and being' (1990:29). The deconstructive method intends to reveal that gender differences are created textually: the privileged term depends on unconscious displacement or suppression of its opposite (Derrida 1982, Grosz 1990). Thus the category 'woman' depends for its existence on the 'opposite'

category 'man'; one cannot be understood without the other. In creating this opposition we artificially, and inappropriately, divide people into two camps. Once we have done this we build a series of other characteristics on top of gender i.e. women are unhealthy, men are healthy; women are irrational, men are rational and so on. It is by this process that man is privileged. The aim in deconstruction is to show that real life experience is not like this; attributes and experiences like acting rationally or being healthy cross-cut gender and are not the province of men or women *as a group*. Central to post-structuralist feminism's political agenda is the aim 'to destabilise – challenge, subvert, reverse, [and] over-turn' (Barrett and Phillips 1992:1) these hierarchical oppositions by recognising commonalities across gender so that men can no longer be easily associated with all that is valued and women with all that is de-valued.

Such an approach is becoming increasingly evident in feminist work in anthropology, psychology and the natural sciences. By the 1980s feminist scientists, in particular biologists, had begun to raise questions not just about androcentricity but also about the dualistic thinking which has led to the construction of the scientific paradigm, which includes biomedicine, as masculine and anything outside it as necessarily feminine and unscientific, constraining our knowledge of the natural world and forcing it into organisations, which might not exist (Bleier 1984).

The biography of Barbara McClintock, a cytogeneticist (Fox Keller 1983), illustrates the way in which the 'masculine paradigm' with its 'male hierarchy' may be called into question. Her challenge to scientific and thus male authority came through a reconceptualisation of the relational order of the behaviour of molecules. Using 'feminine methods': feeling, intuition and ideas of relatedness; in her own terms 'a feeling for the organism', McClintock discovered that the molecules of which the cells are composed, rather than being directed by what Crick and Watson had called a 'master molecule' with its implicit hierarchical order, were controlled through their complex interaction. A similar challenge came from Fox Keller's (1985) account of the 'pacemaker concept' in theories of aggregation in cellular slime mould. Fox Keller was interested in the differentiation of cells from the same initial cell in morphogenic development. Cellular slime mould provided an interesting case since it has the 'property of existing alternatively as single cells or as a multicellular organism' (1985:151). In questioning the triggers for aggregation, Fox Keller found that what were later to be called pacemaker or founder cells, were not needed; aggregation could occur without prior differentiation. In much the same way that a 'master molecule' concept held sway in the McClintock story, Fox Keller reveals here that a monocausal 'governor understanding' cut out more 'global, interactive accounts' (1985:155) of cell diffusion until the 1980s.

Twentieth century science increasingly shows a tendency to abandon the certainty of Enlightenment ideas such as Newtonian physics.

Although it would be inappropriate to call McClintock's or Fox Keller's work feminist, a number of feminist writers on science have addressed themes which are consistent with a postmodernist position in their call for a science which is 'de-centred, pluralistic, non-hierarchical and hermeneutic' (Hekman 1990:226). But, in broader terms, feminism has been reluctant to recognise this such that 'no major feminist critic of science has explicitly embraced postmodernism' (Hekman 1990:331). The advocacy of a distinctly feminist standpoint epistomology in particular takes us a long way from such a position. In this regard McClintock's acceptance into the 'male scientific community' justified through her award of a Nobel Prize, raises a number of issues. Does her work involve a reconceptualisation of science in which a new approach is legitimated and a multi-faceted scientific paradigm is the result? Or, might it represent a 'male take over', in which men incorporate 'feminine' methods into scientific practice, turning science once more into a gender-blind activity? Referring to Fox Keller's (1985) description of McClintock's style, Hekman quite appropriately warns that,

> to appeal to intuition as opposed to reason . . . entails not a displacement of [the] gender-based dichotomy, but an attempt to move from one side of the hierarchy to its opposite, to privilege the disprivileged side. The advocacy of intuition involves reifying the distinction between reason and emotion, rationality and irrationality that is central to Enlightenment epistemology. What is needed is not a reliance on intuition to the exclusion of reason but a means of breaking down the distinction between the two modes of thought (1990:132–3).

Though undoubtedly the complex of modern medicine comprises many paradigms, the extent to which dualism is embedded in our thinking may only be fully appreciated when investigating the healing systems of other societies. For example, Ngubane (1976) has illustrated the ways that concepts of health, illness and treatment among the Zulu are related to the whole person within the physical and social environment. Ots (1990) has confronted the problem of dualistic thought in his work in Chinese medicine, showing that whereas in the Western system of medicine, emotions and somatic function are separated, in Chinese thinking they are not. Emotional changes and specific somatic dysfunction are recognised but seen as corresponding and sometimes identical. Duality is collapsed thus making possible, for example, 'the melancholy spleen'. In contradistinction, recent therapies in the USA and Europe use the privileged status of the mind in the treatment of cancer (Delvecchio Good *et al.* 1990, Gordon 1990, Pandolphi 1990).

Hutheesing in 'Becoming a Lisu Woman' explains that, 'I needed the study of a minority group to understand my own Western assumptions of oppression and of the superimposition of male and female' (1993:99). In her explanation of the gender system, 'women were both "superior" and

"inferior" depending on the context of the situation and the frame of reference of the observer.' In a study of motherhood, in many ways similar to that of Oakley (1980), Schrijvers (1993), a feminist anthropologist, has shown how her conceptualisations changed with the experience of resistance in the early 1970s to trying to combine motherhood with work, and the relative freedom she experienced in Sri Lanka where work and motherhood were the norm. Her conceptualisations changed as she 'confronted the different experiences and images of mothering both in herself and those subjects involved' (1993:156). This gave rise, in her own words, to a 'multivocal discourse' dependent upon its historical, local and personal location (1993:156).

In contradistinction to developments in feminist anthropology and feminist science, suggestions of ways to improve women's health and health care from the sociology of health and illness appear to retain the legacy of binary thinking making a basic distinction between men and women, reproduction and production, home and work, emotion and reason and so on. The *privileges* which inhere in the binaristic conceptualisations which gird health care are clearly criticised, but the *oppositions themselves* tend to go unchallenged. In these terms critique centres on the *consequences of dualisms* for women's health while failing to offer a thoroughgoing *criticism of them* in the context of gender. Ironically, this means that feminism can end up colluding with biomedicine as it engages and perpetuates the very modernist (*i.e.* binary) thinking which has historically sustained male hegemony. We turn now to an exploration of how this takes place.

The post-structuralist critique applied to the sociology of reproduction

From the perspective of feminist post-structuralism binaristic thinking has had a number of negative consequences for research on gender and health. These include: the universalising of women's health and health care experience and, in some cases, the valorisation of gender differences; a preoccupation with the abnormal and the pathologisation of women's health; the production of poorly drawn health care 'alternatives' and the homogenisation of the 'mainstream'; and, finally, a focus on women rather than gender (and a consequent lack of attention to men's health).

The universalising of women's experience and the valorisation of gender differences

In summarising the dilemma of 'modernist' feminism, Di Stefano (1990:73) writes that 'the choice seems to be one between a politics and epistemology of identity (sameness) or difference.' This is an ongoing debate among feminists, for example psychologists have struggled with the consequences of the substantiation of these positions through scientific evi-

dence (Kitzinger, 1994). More broadly, in 'equality feminism' identified in early work (Beauvoir, Freidan etc.) and in contemporary liberal feminist work (especially in the USA; see Wolf, 1994) there is an appeal to gender-neutral humanism where a central place is given to the rational subject (Jaggar 1983, Tong 1992). Concern is with the particular roles and statuses that men and women inhabit. Explicitly or implicitly, women's circumstances (which includes her health) are problematic because she is excluded from the valued social positions held by men (for example, the world of paid employment). In the 1970s, political agendas centred quite appropriately upon identifying barriers (particularly legal and educational) to women's access to the public sphere. This body of thought has had a considerable influence upon research on the gendered patterning of illness (see Verbrugge 1985)[1]. Yet here men are still the standard against which women are defined, a position which also holds for radical feminist work, even though the latter operates within an epistemology of difference rather than identity. Referring to the problems of assimilation for women, Di Stefano aptly characterises the counter-appeal of radical feminism; 'the critical activity and insight produced by the voice of the other [*i.e.* women] provides a visceral, tangible sense of alternatives' (1990:71). Yet, as she goes on to note, the 'choice' between improving women's conditions (and, in our terms, their health) by reference to either sameness (liberal feminism) *or* difference (radical feminism) is a pseudo-choice since it is a choice already framed by a 'gendered narrative of *us* and *them*' (1990:73).

Post-structuralist feminism 'stands on the back of' this previous work. Indeed, as Bordo notes, how 'could we now speak of the differences that inflect *gender* if gender had not first been shown to make a difference?' (1990:141). Aware of the need to keep in mind that radical feminism is not a unitary position (Hanmer 1990), we can nonetheless identify as a common theme the designation of patriarchy as the root of oppression militating against any possibility of 'equality on men's terms' (Rowland and Klein 1990). While it is clearly recognised in most of this work that women are located differently by geography, age, class and race, and may experience oppression differently, there is simultaneously the view that women form an inherent class.

Feminised difference is a project for the elimination of women's oppression which is, importantly for our concern with health, built around control of the body. Women's embodiment (as differentiated from that of men) is crucially anchored in reproduction and a given affinity with 'nature'. The extent to which this work is imbued with essentialism is a subject of quite heated debate in feminism. Essentialism can be defined as a belief in a true essence 'that is most irreducible, unchanging, and therefore constitutive of a given person or thing' (Fuss 1989:2). Here female/male can be seen as prior to the social experience mapped onto them. Essentialism has been argued to underpin much of radical feminism through the work of such writers as Mary Daly, Andrea Dworkin,

Adrienne Rich and Susan Griffin all of whom have given attention to issues of women's health.

The term radical feminism, of course, covers a wide spectrum of thought. (Ramazanoglu (1989) identifies it as the feminism most difficult to define because of its diversity). In its *strongest* form there is a celebration of women's bodies and the capacity to nurture and create (Gatens 1992), and motherhood is celebrated (Weedon 1987). There is a sense of a pure and original femininity, a female essence outside of the social and untainted by patriarchy (Fuss 1989). The work of Nancy Chodorow (1978) exemplifies this. For Chodorow, a distinct self is formed out of the process of mothering which creates women as different from men through the formation of an essentially *relational* form of interaction with others. In these terms, women must reclaim their bodies from men. The following quote from Lipshitz illustrates this perspective; 'women are witchlike in being able to give birth to live beings and are therefore possessors of an invisible internal substance that provokes fear because it links them to another world than that of male culture' (1978:39). Similarly, Rich summarises her views in the following way,

> I have come to believe . . . that female biology . . . has far more radical implications than we have yet come to appreciate. Patriarchal thought has limited female biology to its own narrow specifications. The feminist vision has recoiled from female biology for these reasons; it will, I believe, come to view our physicality as a resource, rather than a destiny. In order to live a fully human life we require not only control of our bodies . . ., we must touch the unity and resonance of our physicality, our bond with the natural order, the corporeal ground of our intelligence (1992:39).

Rich sees men as jealous and fearful of women's reproductive power. Mary Daly calls for women to discover a new identity founded on 'true' femaleness, based on women's biological nature: 'for we are rooted, as are animals and trees, wind and seas, in the Earth's substance. Our origins are in her elements' (Daly 1984:4). Aspects of femaleness are not open to men and here the '"true" female self is identified with wild, undomesticated nature' (Weedon 1987:134).

In the writing of some radical feminists' experience is valorised in gendered terms through the explicit claim of a superior female morality (Tong 1992, Segal 1987). Griffin exclaims – 'we are mothers . . . the small body lying against our body vulnerable . . . we love this body, because we are part of the body . . . If men bore children, we imagine, they would burst from their heads . . . and be fully grown, and dressed, and god-like, with no need to eat, no substance pouring from their substance' (1980:72–3). Here, then, men are different from women; even if they *could* give birth, that birth and their child would be very different to the child of woman; their experience would be very different, less 'real'.

Of course, not all radical feminists adhere to this 'strong' position. Even those who once appeared to do so have begun to re-think their earlier work. For example, in the 1970s edition of *Of Woman Born* Adrienne Rich wrote: 'the diffuse, intense sensuality radiating out from clitoris, breasts, uterus, vagina; the lunar cycles of menstruation; the gestation and fruition of life which can take place in the female body' (1970:39), has as yet unrealised radical implications. To live a fully human life, Rich wrote, women must realise their 'bond with the natural order.' In the new preface to the 1992 edition of the same book, she writes that she never intended her work to lend itself to sentimentalisation of women's nurturance, and that she would now no longer envisage patriarchy as a pure product (Rich 1992). Andrea Dworkin (1988), whose work is often singled out as essentialist, claims that the whole criticism of essentialism is misplaced. She writes that essentialism is biological determinism, virtually equivalent to Nazism and, as such, has no rightful place in feminism. The debate over feminist essentialism is, then, highly contested and unresolved. With its freight of reductivist determinism, 'essentialism' is likely to be a position that most feminists would want to avoid. Nonetheless, it does seem fair to say that the notion of a 'raw material' that women hold in common, often provides the starting point for the social construction of gender in radical feminism. For example, Rowland and Klein wish to avoid a determinist logic built around the body in favour of a constructivist position, but still remark that 'the fact that women belong to the social group which has the capacity for procreation and mothering, and the fact that men belong to the group that has the capacity to carry out, and does, acts of rape and violence against women, must intrude into the consciousness of being male and female (1990:297–8).

Within contemporary feminism the essentialist position which politicises the body through biological difference inherits some of the problems for which the natural science paradigm has been criticised. Classification, within this paradigm (Barnes 1982) proceeds on the basis of similarities and differences according to the particular properties which objects have. There is in this procedure a clear and precise ordering of data such that a future instance of a particular object has a predetermined classification. In consideration of the biological categorisation of sex, based upon chromosome composition, categoric distinctions may be made between male and female.

Critics have pointed to the tendency of feminist work which centres on difference to collapse a distinction between sex and gender. This occlusion continues in feminist work despite research which shows that markers for sex at birth are drawn from continuous data (Birke 1992, Shilling 1993). Between two and three per cent of individuals are born with intersexual characteristics. But, despite the fact that there is no absolute distinction between the sexes only 'variations on a continuum whose midpoints are less densely populated than its outer edges', 'there is great

cultural pressure to erase these midpoints' (Epstein 1990:124). The experience of living on these boundaries and the pressure to 'chose sides' is poignantly demonstrated in the writings of Herculine Barbin (Foucault 1980). Physicians are under great cultural pressure to mark sex at birth and to use surgical and hormonal interventions to maintain binary gender as an absolute (Epstein 1990).

Hence, we can see biology as 'distorted' by socio-legal classification as gender differences are socially created (Delphy 1993) by the suppression of similarities and the exaggeration of differences (Connell 1987). A classification based on traits, and the search for a 'universally correct' position (Davis 1992) forces us into oversimplification and acceptance of a uni-dimensionality, dichotomies artificially drawn and the possible consequences of an essentialist picture of women which is false. The conventional use of a classification procedure of semantic differences and the structure of language may be seen at one and the same time as both conservative and oppressive. This is not to adopt an anti-essentialist stance, but only to point out that

> a danger underlies the strategy of difference, a danger that deploying commonalities *among* women unavoidably embeds such traits *within* women. Thus, feminist efforts to transform differences between women and men, differences we have assumed are socially constructed and therefore subject to change, may have the unwanted effect of perpetuating gender as an essential, irreducible part of identity (Frug 1992:36).

While it is evident that social science work on gender, health and health care may not have explicitly adopted the perspectives that we have outlined, it is in many ways *derivative* of them and, because of this, it inherits their underlying dualistic and, arguably, essentialist thought where,

> what both feminists and phallocentrists see as hegemony based on masculine perceptions of domination, performance, hierarchy, abstraction, and rationality, finds its antipode in a woman's community proclaiming itself as naturally nurturant, receptive, cooperative, intimate, and exulting in the emotions . . . [feminists] assume that such principles exist and that they have been fixed and dichotomous since the dawn of patriarchal history. . . . *Thus it is that the dominant culture and the counterculture engage in a curious collusion in which . . . a rebellious feminism takes up its assigned position at the negative pole.* (Cocks 1984:33, 34 our emphasis).

Central to the post-structuralist line of argument, then, is the point that duality can become more enslaving than liberating. Reproduction is centred in universal discourses in sociological work on health care; in reclaiming birth (from male obstetrics), it can become the province of all women. Eisenstein, referring to women and the law, expresses this well; she writes: 'when the "difference" of childbearing homogenises females as

mothers, mothers are denied their individuality: all women become the same – mothers – which immediately characterises them as "different" from men' (1988:90). Thus in an attempt to create what we can term a 'reverse privilege', reproduction is still *centred* for women and put on the agenda as if it were central to all women's lives. This may serve to lock women *into* reproductive roles which may be politically problematic since the centrality of reproduction, contraception and childbirth to *biomedicine* is transferred to women's experiences. This *may be* the reality of their experience, but equally importantly, it may not. To a certain extent this may be seen as an unavoidable consequence of a critique which appears as if it must engage the dichotomies of biomedicine to develop its own narrative.

Pre-occupation with the abnormal: criticisms of obstetrics and the proposed midwifery alternative

In the area of reproduction, and more broadly, there is a pre-occupation with the *abnormal.* The critique (quite rightly) points to the iatrogenic properties of biomedicine but, unfortunately, this again centres on pathology. Ironically, it is almost as if women cannot be well any more (and, as discussed below, men cannot be ill) – witness the large number of books on women's health *problems* (with the emphasis on problems) within both the academic and more popular press. To a degree this serves to confirm women's disadvantaged cultural position through their (ill) health.

'Alternatives' to male-biomedicine were heavily valorised in research in the 1970s and 1980s. This was particularly evident in suggested alternatives to mainstream gynaecological and obstetric care. Sheila Kitzinger, for example, wrote that

> the new midwifery has a vital part to play in the woman's movement and is at the very centre of the great creative upheaval which is taking place as we reclaim our bodies and come to learn about, understand and glory in them. This new midwifery gives vivid expression to the way in which women are discovering strength and sisterhood as we turn to help and support one another during the intense, exhilarating and powerful experience of childbirth (1988:18).

A clear line of demarcation tends to be drawn in the literature between obstetrics and midwifery: each is portrayed as a unitary and internally coherent body of thought and practice which is at odds with the other (see Oakley 1984, Graham and Oakley 1986, Rothman 1982). The 'alternative' female-midwifery is clearly put forward as the better model. The assumption that we can uncover a contraposition which is unitary has been pervasive in research on the conduct of birth. The fact that the alternative form of maternity care proposed in research in the 1970s and 1980s was not *explicitly stated* as a need *for all groups of women* (ethnic minorities, different social classes, ages etc.) and, instead, that potential

different needs were silenced, only serves to underscore the universalistic assumptions of much of this research. The charge of elitism evidenced in the privileged white middle-class voice of much research, and the silence around differences between women, applies well to Barbara Katz Rothman's influential 1982 work *In Labour, Women and Power in the Birth Place* which ends with an implicit call for a home-based natural birth experience (in contrast to an earlier experience of giving birth in hospital). This is made in joyous terms with little recognition that many women may not be in the position to avail themselves of such an 'alternative' even if they wanted to. If we conceive of power as a fundamentally male preserve we are led to gloss over ways in which women may exert power over others (Flax 1990), including other women (Annandale 1988, hooks, 1984). In these terms, as recent institutional reforms stimulate community midwifery (Winterton Report, 1992 and responses to it) midwives may begin to consider the notion of affinity with women embedded in such concepts as 'continuity of care' (in historical and contemporary contexts) as masking the potential exploitation of midwives by their clients (Hardy 1993).

The demarcation between obstetrics and midwifery begins to explain why we have an extremely poorly drawn picture of 'alternatives' (be it in childbirth or any other area) – they exist in opposition to dominant practice 'A' (obstetrics) but they do not appear as 'B', but as 'not A'. Within this framework the lived experience of midwifery (for example) is revealed only as the largely unresearched antithesis of obstetrics. An alternative is called into existence in powerful and convincing terms, while at the same time its central precepts (such as 'women controlled', 'natural birth') are vaguely drawn and in practical terms carry little meaning. Thus feminist work tends to enter into complicity with male hegemonic culture by attributing to it the power which it gives itself. Cocks writes that the more feminism 'describes itself as all the established society is not, the more it shows itself an unwitting prisoner of the established conceptual schema, which delineates for it definition and counterdefinition, image and counterimage (1984:33). Power and control are conceptualised as oppositional and all encompassing; women become, in Sawicki's words, 'passive objects of medical surveillance and management', 'patriarchal models of thinking and behaving, and the technological instruments of patriarchy, become inherently dominating, controlling and objectifying' (1991:76, 73). Women can become victims.

There is an appeal to a return to what childbirth 'really is', yet as Treichler (1990) maintains, this is untenable since discourse *itself* is the site in which birth becomes knowable. 'Alternatives' (or forms of resistance) are poorly drawn precisely because their meaning is always constructed through a process of deferral (Derrida 1982, Fox 1992). We would argue that 'alternatives' such as 'natural birth' are *relational concepts* constituted *through* dialogue with biomedicine. Obstetrics and mid-

wifery are self-referential: natural birth finds the conditions for its existence in its very critique of biomedicine (as, in much the same terms, obstetrics developed historically).

The frameworks of women, their partners and friends, midwives, nurses and obstetricians are unlikely to be opposed in an ontological sense but instead may elide and collide in response to local contexts. Thus the dominant discourse (of obstetrics, for example) *must* itself create the conditions, or discursive space, for a reverse or alternative form. Indeed, the very existence of the dominant form depends on points of resistance to act as a target and support (Burrell 1988). So power is a resource for action and it is possible (or, perhaps, even necessary) to recognise areas such as childbirth as a contested site in both contemporary and historical form. Such an approach moves away from a passive conceptualisation of women controlled by obstetrics (while still recognising the institutional power of dominant discourse), and presumes the co-presence of a contested voice.

Men's health

We turn now to a third consequence of binary thinking in feminist research on gender and health which is that there has been a focus on women rather than gender, and that men's health has been relatively ignored. Much of the feminist discourse on health and social experience centres on women and cuts out men. This can be problematic even in areas which have in recent traditions been reclaimed as female. As Eisenstein notes, this means that 'femininity and biological motherhood are one and the same; masculinity and fatherhood [can] have no similar biological relationship (1988:91). Christine Delphy has recently questioned what she terms 'the maternal demand' in the women's movement which sees the baby as 'automatically affiliated to the woman who brought it into the world' (1992:16). This, she writes, circumscribes women's identity to motherhood, assumes that only a parent can defend a child, and gives exorbitant rights to some groups (women) and not others (men).

Explanation for the invisibility of men in the reproductive process cannot rest with duality alone since cross culturally and historically childbirth has been and still is very largely the province of women, but the entrenchment of women in their reproductive role can leave men without one (Meerabeau 1991, Mason 1993). This lack of involvement, as a consequence, is particularly evident in the investigations and treatments of infertility where researchers (see McNeil *et al.* 1990) have quite rightly pointed to the pathologisation of women's reproductive systems and have significantly questioned the object of technologically assisted reproduction. Yet it is interesting to note that despite this invocation and the questioning of why men have not been the focus of *medicine's* attention, sociologists have gone little way towards an understanding of aspects of

male infertility themselves. Part of the reason for this may be that, once again, at one and the same time as they criticise *biomedicine's* pathologisation of women, sociologists also engage its problematic as they replicate a focus on abnormalities of women's reproduction (although, see Tiefer, 1987). As Pfeffer states, 'implicit in the medical definitions and unchallenged by feminists, is the assumption that the male reproductive system is structurally efficient, and that its functions proceed smoothly' (1985:31). Just as biomedicine fractures social experience, so too can social science research on infertility, where social relations of gender (between men and women and between men and between women) are displaced as women and men are posed as opposites and attention is on individuals rather than the relations between them.

A further consequence of ignoring men and treating women as *a priori distinct* from men is that women's health is constructed as 'poor' against an implicit assumption that male health is 'good'. Ironically, man is privileged as unproblematic or is exempted from determination by gender roles (Flax 1990). In such a view women 'cannot' be well and, importantly at this point in our argument, men cannot be ill; they are 'needed' to be well to construe women as sick. Men's poor health remains invisible. This is a fundamental problem, not just because it is important to look at the social context of men's health, but that the assumption of absolute difference undermines our ability even to understand women's health (as different).

A growing body of both qualitative and quantitative research reveals that women either 'are' or perceive themselves to be more ill than men and make more use of health services (Kandrack, *et al.* 1991, Verbrugge 1985). In some interpretations of quantitative data where men and women are distinguished, male health status is glossed over since it is relevant only to construct women's health as poor in relative terms. While data may indeed portray worse health among women (the factor which tends to be focused on in interpretation), they are also likely to show a residue of ill health among men to be worthy of study (see Blaxter 1990).

This ironic privileging of male bodies as healthy is also becoming apparent in theoretical work. For example, Shilling's (1993) recent study of the body and social theory contains a discussion of 'naturalistic views of the body' which focuses overwhelmingly on women's bodies. Where men are referred to, it is only to provide an unarticulated point of contrast for women. Thus feminist work on body size and shape (i.e. Chernin 1983, Orbach 1988) is discussed as problematic for its reliance on the essentialist premise that women's bodies have natural shapes and sizes which are distorted by society/patriarchy. Whatever the merits of this criticism in and of itself, Shilling's placing of it in the foreground to the neglect of any possible equivalent concerns among men, only serves to promote body shape and size as 'women's difficulty' and to demote any problems experienced by men. And, attendant upon this, body size and

shape as an issue which might cross-cut gender is removed from discussion altogether.

As has been pointed out, the invisibility of the male body as an explicit research focus is 'constructed through and within a wider framework of male dominance' (Hearn and Morgan 1990:7) and this may serve to keep male activities hidden from critical scrutiny. There are, then, from a feminist perspective, a number of 'dangers' in treating the construction of masculinity in men as conceptually equivalent to that of femininity in women. If investigation of the social construction of male-masculinity centres on revealing the 'down side' of masculinity there can be problems if it is suggested that 'female' should be added to 'male' qualities (Ramazanoglu 1992). If this happens, 'the exploration of men's pain is then an area which needs very careful critical attention if men are not to emerge both as the dominant gender and as the "real" victims of masculinity' (Ramazanoglu 1992:346). Yet there is no reason why these concerns cannot be kept to the fore while we also remain cognizant of the possibility that 'patriarchal discourse need not be seen as homogeneous and uniformity oppressive' (Pringle and Watson 1992:130) for women or uniformly liberating and unproblematic for men, and that women do not need to be portrayed as inevitable victims and men as victors. Finally, in the context of health and health care, similarities between women and men and differences between women and between men can be made as pertinent as commonalities built on the elision of sex and gender (Annandale and Hunt, 1990).

Theorising Gender in the context of reproductive health

Taking reproduction as a paradigmatic case, we have tried to illustrate one way in which a conventional understanding of the world and relations of power embedded in engendered difference has been reached. Implicit in the feminist post-structuralist critique has been the position that we might begin to explore gender and health in a different way; that we might dislodge the opposition between men and women and recognise the ground in between (Eisenstein 1988).

However, the movement towards such an approach is highly contested by many feminists. Central to their concern is the possibility that deconstruction will diffuse feminist politics. For example, Barrett and Phillips ask whether 'feminists can or should destabilise the binary opposition between men and women that gives the category woman its meaning' (1992:8) and question whether to do so might pull the rug from under the feminist struggle. Mascia-Lees *et al.* (1989) note the concern that post-structuralist feminism may *itself* be a metaphor for loss of ground felt by men in a period of change in global power relations. In these terms, post-structuralism might, in fact, operate in the service of white male

knowledge/power (Bordo 1990). For some, the implicit androcentricity of the work of Derrida, Lacan, Foucault and others, renders their work an entirely inappropriate base for the development of feminism. Jackson voices her concern that in post-structuralism, '"women" are all being deconstructed out of existence, and "gender" is replacing women as the starting point of feminist analysis' (1992:31). In her view, 'the logical outcome of postmodernism is . . . postfeminism'. For these reasons many feminists are openly sceptical about any alliance with post-structuralism.

Clearly, these concerns deserve serious consideration. There is an understandable disquiet about relinquishing 'structures' which appear to embody an emancipatory capacity (Lovibond 1993) and which, it is felt, are the only form in which oppression can be signified. But post-structuralism does not inevitably eradicate a politics of gender. It does not deny poverty, racism and sexism, rather it rejects the ability of 'grand theories' to provide answers to these problems (Smart 1990). Recent commentaries have begun to suggest that by counterposing its own distinct epistemology against forms of 'modernist' thought, post-structuralist feminism ends up setting up a dichotomy itself, ironically undermining its own position by buying into the very duality which it seeks to undermine. This has led some (see Spivak 1989) to suggest that feminist politics can best proceed through a 'strategic' use of theory. In these terms the conditions of women's lived experience (including her health) can sometimes be improved by acting 'as if' women are a category (Riley 1988) and sometimes by emphasising the plurality of experience (which may cross-cut gender).

In this last section we tentatively suggest some ways in which a reconceptualisation of gender might be achieved considering as we do the paradoxes and consequences that are integral to it. Pivotal to such a reconceptualisation is the necessary deconstruction of the culture/nature dualism, for although it has not always historically been the case that culture has been privileged over nature (Jordanova 1989), the critique of medical and scientific discourse, and in particular of childbirth in the decade 1970–1980, has illustrated and reaffirmed the association and affinity of women with nature and their cultural domination by men.

As well as disaggregating the elided dualisms of male/female, culture/nature, masculine/feminine, mind/body, and deconstructing each dualism itself, reconceptualisation also of necessity involves the destabilisation of existing theories, or at the very least, a preparedness to come to terms with the dilemmas posed by contradictory ideologies (Davis 1992, Frug 1992, Harding 1991). This process may be fraught with methodological problems as feminists try to avoid oversimplification and wrestle with the complexities of women's lives as they are bound up with social class, ethnicity, education and the social environment. The complexities of specific situations and contingency may be accommodated through the classificatory system which Barnes (1982) calls 'finitism', where concepts are developed through a procedure in which, rather than through their simi-

larities and differences, objects or phenomena are assessed according to their contingent properties at one particular point in time. Such mutability of concepts allows the continuous data of sex, mentioned earlier, and the problem of their undecidibility, to be taken care of. In theory, with situation and contingency accounted for, the possibility is opened up for sex and gender differences to be asserted, only when necessary or desired.

In practice, however, detachment from, or assertion of, a sex and gender identity may be difficult to achieve particularly at the lay-professional interface of the medical encounter, where the elision of dualisms is met head on. Patients see themselves and doctors see their patients in gendered terms. For the patients, the gendered view emerges from a holistic conception (Saltonstall 1993) of the 'lived body', while for doctors this may be overlaid with the dualism of the 'Cartesian model.' Whether perceived in a holistic or dualistic manner, the likely consequences in consultations which involve issues of contraception, fertility, pregnancy, childbirth and other conditions affecting the sex organs, would be affirmation and reinforcement of a sex and gender identity, thus inhibiting gender's strategic use.

However, paradoxically, through the use of high technology medicine (which can be viewed as an integral part of the 'Cartesian model'), medical specialists may assist men and women to overcome a gendered notion of their bodies. Foetal imagery and *in vitro* fertilisation and the accompanying medical language may present them with an ungendered if not dismembered view of themselves. Davis-Floyd's (1994) research in America into women's views about the use of technology in childbirth revealed that for some women 'technocratic control', as it has been characterised, was highly valued and provided an empowering experience for them. A similar conclusion has been reached by Evans' (1985) research in Britain. The discovery that women found the use of technology a liberating experience was a finding contradictory to the feminist researcher's view, yet, as Davis-Floyd (1994) points out, somehow the plurality of women's experiences has to be recognised. Here is an example of women, through their doctors, using technology to meet their own ends, and, by recognising that they did so, of an attempt by the feminist researcher to be reflexive about her advocacy of a particular stance in a particular situation (Davis 1992). What is emerging from this discussion is that whilst the body remains a source of political contention, women's liberation may arise from reconceptualisations of it.

Grosz refers to the use of 'hinge' terms as a means of reconceptualising dichotomies (1990:97). In Derrida's terms new concepts 'function as undecidibility, vacillating between both oppositional terms, occupying the ground of their "excluded' middle"' (Derrida 1982:9). For Grosz (1990) this provides a way for feminism to debate the place of patriarchy while not working within its binary logic. New terms are to serve crucially to disrupt and erode the power of 'normalizing discourses', to open up space for suppressed heterogeneity and differences (Flax 1990).

Applied in the context of gender and health, the body, as a hinge term constituted through social relations, is both culture and nature; 'only human bodies create culture and in the process transform themselves corporeally (as well as conceptually)' (Grosz quoted in Wiltshire 1992:17). In both creating and being transformed by culture, the body as culture and nature is by the same token both sex and gender. In the future, new creations of culture raise the possibility of the body, in concept and configuration, as neither sexed nor gendered. In the continuous data of sex, this process may already be in its early stages of development.

In providing a way through which the reproductive body and its processes may be perceived – for example, the nineteenth century notion of menstruation as 'menstrual economy' (Jalland and Hooper 1986), or the twentieth century medical textbook metaphor of 'signal response', or women's notion of 'hassle' (Martin 1987) – metaphorical language not only demonstrates its relevance to historical and cultural understanding, but also opens up the possibility of reconceptualisations and change. The construction of metaphors engages both empiricism and creativity, so it can be argued they unite reason and imagination (Lakoff and Johnson 1980) thus solving the problem which Hekman (1990) alerted us to in her discussion of the deconstruction of gender in feminist science (referred to on page 23). By requiring us to understand one concept through another, the use of paradoxical terms enables the metaphor to destabilise our conventional understandings (Clark and Williams 1992) and allows the generation of new meanings.

In relation to human reproduction, metaphors for the womb have fixed women historically and culturally, reflecting and constituting their notions of themselves and their connection to the foetus. As in Grosz's (1990) use of hinge terms mentioned above, the metaphors which women use also resolve the nature/culture dichotomy, through expressions which relate to the work that they do. Cooking metaphors, for example, date back to medieval Europe, where the foetus was dough baked in the oven (Gelis 1991) and are paralleled in the twentieth century by the notion of an empty womb as a plundered kitchen (Feldman-Savelsberg 1994), or the agrarian metaphor of a barren field, denoting infertility (Jeffrey *et al.* 1989). Clearly, while such metaphors help to break down the nature/culture dichotomy, this is achieved by 'fixing' gender in a binary way revealing that metaphorical thinking can be as oppressive as it is liberating. In the examples that have been given, female reproduction is fixed through domestic imagery, other metaphors annex male reproduction with instrumentality – firing blanks in the context of infertility, for example. However, the construction of *new* metaphors can serve a different purpose, helping us to dislodge gendered thinking in the context of fertility-infertility. For example, if we envisage the body as a 'network' we are pushed in the direction of seeing reproduction as an integrated system and fertility-infertility as the product of the *inter*-relation of bodies. The

system metaphor traverses the feminised (domesticity) and masculinised (instrumentality) dichotomy refiguring the reproductive body in a new way.

In such terms sociologists of reproduction would be led away from focusing on 'women's problems' and the pathologisation of women's bodies that was discussed earlier in the paper. Interestingly, this would have an affinity with postmodern visions of the body which some have argued are becoming apparent in medicine. For example, Levin and Solomon (1990) suggest that the new scientific approach of the late twentieth century leads us to see the body in a qualitatively different way from the past. The old biomedical model, it is argued, has been replaced by a postmodern alternative which asks medical science to 'abandon its model of simple causes and work out a new model of multifactoral influence: a model for which the network, rather than the straight arrow, might be an appropriate heuristic symbol' (Levin and Solomon 1990:520). Levin and Solomon claim that this new postmodern vision of the workings of the body which attends to the complex bidirectional interactions between the central nervous system, the immune system and experience, increasingly dissolves 'the three long-standing dualisms of mind and body, body and environment, individual and population' (Levin and Solomon 1990:533).

Exegeses on the postmodern condition, taken alongside a concern with the metaphorical body, turn our attention to the possibility that attempts to create the space for new relations of gender (in the manner discussed above) may be stimulated by broader social changes. In the work of Lyotard (1986), Jameson (1984) and others, new forms of technology and information are seen as central to a shift from a social order built upon production to one centred on reproduction/consumption. Haraway refers to the move from an organic, industrial society to a 'polymorphous, information system' (1990:203). In such a context, the body comes to be seen as a project ripe for construction and reconstruction (Bordo 1993) as previously conceived boundaries (for example, between mind and body) blur. Shilling portrays the irony of this,

> while rationalization may have provided us with the potential to control our bodies more than ever before, and have them controlled by others, its double-edged nature has also reduced our certainty over what constitutes a body, and where one body finishes and another starts (1993:38).

Combining a focus on gender relations in postmodernity with a concern for overturning traditional gender dichotomies, Haraway refers to the 'informatics of domination' (1990:203). The new informatics refigure women in new ways,

> the actual situation of women is their integration/exploitation into a world system of production/reproduction and communication called the

> informatics of domination. The home, work place, market, public arena, the body itself – all can be dispersed and interfaced in nearly infinite, polymorphous ways, with large consequences for women and others – consequences which are very different for different people and which make potent oppositional international movements difficult to image and essential for survival (Haraway 1990:205).

In such a context, Haraway argues, it is no longer possible to conceive of lives in terms of public/private, personal/political, market/home and so on. Machines, she claims, have made ambiguous the difference of natural and artificial, mind and body. To be sure, there are 'dangers' for women, but these cannot be seen as a product of masculinism-capitalism. Haraway employs a 'network image' in place of these dichotomies 'suggesting the profusion of spaces and identities and the permeability of boundaries in the personal body and in the body politic' (1990:212). In the school, work place, hospital, 'if we learn how to read . . . webs of power and social life, we might learn new couplings' (1990:212). She discusses new high-technology work in Silicon Valley, California recognising the problems that accrue from the restructuring of work (for example, the feminisation of poverty, high levels of male unemployment), but argues that high-technology (in the world of work and more broadly) challenges dualism since it is no longer 'clear who makes and who is made in the relation between human and machine. It is not clear what is mind and what is body in machines that resolve into coding practices' (1990:219). Haraway uses the image of the cyborg (a hybrid machine-organism), stating that 'insofar as we know ourselves in both formal discourse (*e.g.* biology) and in daily practice (*e.g.* the homework economy . . .), we find ourselves to be cyborgs, hybrids, mosaics, chimeras' (1990:219–20). Cyborg imagery is, then, another way in which to deconstruct duality and challenge the theoretical positions which construct science/technology (including that around birth) as 'simply' male demonology.

Concluding comment

Feminist theory is in the midst of significant change. The recent emergence of feminist post-structuralism has thrown long-standing debates over the notion of a 'sisterhood' among women, and the issue of essentialism into particular relief, generating heated debates that look set to run for some time to come.

Post-structuralism contests the binary conceptualisations of gender that have traditionally girded the sociology of human reproduction. It suggests that feminist thinking which is premised upon a binary division between women and men, male and female, and sex and gender reinforces women's oppression rather than emancipates them. Universalising dis-

courses draw attention towards commonalities within women (and within men) and draw attention away from differences within men and women, and from commonalities that cross-cut gender. The method of deconstruction that is integral to feminist post-structuralism has a clear political agenda: it seeks to destabilise gender as a hierarchical binary opposition and find the ground in between (Eisenstein 1988) so that men can no longer be easily associated with all that is valued and women with all that is de-valued in society. In the context of the sociology of human reproduction this provides an added impetus to the reconceptualisation of fertility-infertility in inter-relational terms (rather than as 'women's difficulty'), and attempts to decouple the historical association of women with reproduction which has long sustained male hegemony.

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Acknowledgments

We wish to thank two anonymous referees of the journal for their very helpful comments on an earlier version of this paper.

Note

1 Research on social roles and health tends to conceptualise women's and men's health in these terms, linking health to specific roles (such as paid worker, marital status and so on, Nathanson 1980). Here the adherence to normative dualism resonates of liberal feminist assumptions which underpin much of the research in this area. In survey research the differences that are assumed are often not even explored since until quite recently samples were often sex-specific and different questions about roles were asked of men and women.

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