fish are particularly popular in the north." Certainly some of the terminology of working class hobbies seems to have spilled over into fishkeeping: there is a Guppy *Fanciers'* Association, for example.

Whether there is a class bias in what different people choose to keep (as there s with the growing of, for example, chry- santhemums and dahlias) is doubtful. The progression of choices is a progression of challenge: starting with the easy-to-keep coldwater fish, like fancy varieties of gold- ish, through tropical fish, like angel fish, o the hardest of all to keep—marine fish. Like the "Peace" rose, some species quickly ecome bestsellers. Angel fish and the neon etra, which sells itself entirely on its bril- ant colours, are currently popular.

To find distinct traits of personality, the shkeeper has to choose the larger fish: scars, a tropical fish, for example, will se to the top of the tank to feed from our hand or allow themselves to be roked. These traits may, as they are sup- osed to do in dog owners, fashion those ' the fish's keeper. "I think, to some de- ree owners grow like the fish they own," n James ventures.

If so, the current taste of a fringe of hkeepers for "pugnacious" fish is disturb- g. Last year, the trade noticed that every ranha it put on sale was being snapped . Piranhas are colourless, ugly, and when ngry enough, can tear at an open wound an incautious fishkeeper's fingers. They o need to be fed with live food—prefer- ly goldfish—so that their owners might expected to have a Hobbesian view of, least, aquatic society. Likewise, there is appetite for snakeheads, creatures with- t even the redeeming beauty of scorpion . But for real kudos, the "pugnacious" ıkeeper will go for a stonefish—the only lly lethal pet fish.

The guess of the pet fish trade is that nes Bond films have developed this taste. rtainly, the biggest draw at the London o's aquarium is the piranha tank, fol- red closely by the electric eel tank. Both atures provide the frisson of horror that racts young people, particularly. The raction of a pike, too, lies in its *un*socia- ty, and its ruthless subjugation of other . When someone put two pike in an amental pond at the Barbican develop- nt (which cost the City of London 8,500 the 10,000 goldfish it had put into it), was described as a sophisticated though piece of vandalism.

ut this pugnacity remains only a fringe etite. Most of the 25 million fish kept wo million homes in Britain are either y goldfish or harmless tropicals. And eted in, on average, one tank per home. serve much the same purpose as caged ils, hamsters, guinea pigs and rabbits; xtension to the family (messages over- read out on *Family Favourites* invari- mention pets, down to the family ish.) But a much smaller band of eepers are not content merely to watch fish swimming around on the side- l. They are the dedicated aquarists, readers of the *Aquarist and Pond-keeper*, who breed and show fish. Their interest in fish mirrors the top gardeners' fascination with prize vegetable marrows.

Partly this is to supplement earnings, or recoup the capital laid out on equipment. By breeding, for example, broad-banded angel fish (the common angel fish has narrow bands) or angel fish with blushing cheeks, fishkeepers can introduce a scarcity value in an over-subscribed fish; much as rose growers do. "Fish are fairly easy to control," says Ian James," and a breeder can change their body shape in five years."

Partly it is for the satisfaction of carrying off a trophy and a £50 prize at an open show. To see how he's progressing, a serious fishkeeper can't avoid showing his fish. This is quite an elaborate business, according to Anthony Evans. Fish are judged in a neutral, undecorated fishtank, and the change of environment can change a showy fish into a sulky one. The fish must therefore be allowed to get used to a judging talk before it reaches the show. To keep it alert while being judged, Evans suggests feeding it just before it goes into the judging tank; it will then swim around the top looking for more food. The owner cannot hold its hand during judging; he must keep well away. It is a tense business.

There are more than 500 aquarist societies in the United Kingdom; most hold club shows, compete with other clubs or band together for open shows. The climax of the showing year is the Aquarium Show, the fishkeepers' equivalent of Crufts, where the Supreme Champion is chosen. Aquarists admit that these shows can be pretty dull stuff to the lay public. And one solution has been to dress up the showing tanks by building them into a tableau. Father Christmas and his reindeers, an Apollo spacecraft, even a vacuum cleaner, featured at the British Aquarist Fair in Manchester.

Purists argue that fish don't need this sort of top dressing. Certainly the idea that a tankful supplants the colour television supports the argument that the fish themselves are a self-sufficient attraction. In America, psychologists have long realised that the easy motion and attractive colours of fish can soothe savage breasts. In places where there is likely to be panic and stress, like a casualty ward, or a doctor's waiting room, an aquarium is more than interior decoration. It is a sedative. At Moorfields Eye Hospital's waiting room and at a Wimpole Street dentist's aquaria hired out by Herbert Keins's firm, Aqua-Joy, have been installed. At the dentist's, patients told me that the fish *had* distracted them, and taken their minds off what was to come. But at Moorfields, only the children took any notice. Most people were concentrating too hard on the receptionist who was to call their name. And for an *eye* hospital the aquarium is rather too far away from most of the patients.

But the idea of hiring these pacifiers is catching on. No one has yet returned one to him, Keins says. "Waiting rooms are nerve-racking places," he says, "and an aquarium is far better for relaxing people than a heap of old magazines." Hiring isn't cheap: the service costs £9.50 a month. But it is tax-deductible as a legitimate business expense. Keins hadn't expected "residential," non-business customers; but he's got them, mainly the wives of businessmen who have installed an aquarium in their offices.

Hiring implies that the customers aren't very interested in the mechanics of fish-tanks—nor very knowledgeable about the habits of fish. And so the aquaria are sealed off from the public. "Otherwise children would say, 'Oh, look, the fish are hungry,' and drop in a piece of fruitcake," says Keins; "and that would be the end of the fish." "Residential" customers aren't necessarily any better: "People who give regular parties run the risk of guests who get a bit jolly and pour whisky into the tank, and that too, would be the end of the fish." Curiously, biologists have found that fish get drunk at the same rate as human beings, and have therefore used them to find cures for alcoholism and hangovers.

But if people can resist the temptation to drop things into the tank, they can learn something from the sociability of fish in a community fishtank. (Be your own Lorenz or Tinbergen?) "All have different jobs to do," says Reginald Dutta as he walks round the gurgling tanks of his petfish shop. "See, that one is always kissing everything it meets, and see how this one is cleaning the side of the glass. And they all have their levels which they swim at, so they don't crowd each other. They can be a perfect social system." Families, he says, tend to buy fish as families; the child choosing *his* fish, the adult choosing his.

As with most pets, there is some anthropomorphising: it is hard to know whether a fish really appreciates the four choices of "menu" fishfood, or whether humans merely think, from their own experience, that it should. And there was much scepticism when owners claimed to have revived their ailing pets by the "kiss of life." But the real test of man's relationship with his fourth best friend comes when he has to kill it (because of illness). A correspondent in the *Aquarist and Pondkeeper* had described how he had first tried to stun his petfish, then put it into a saucepan of water and heated it. Was there, he wanted to know, a more humane way of killing it? Unwisely, the magazine advised flushing it down the loo. Back came an anguished letter from another reader: "To dispose of a sick fish down the toilet to end its life in unspeakable surroundings is an act of irresponsible cruelty."

The sufferings of pet fish leads into jesuitical quibbling. Was it cruel for a man in a pub to swallow six live goldfish for a bet? Likewise the affection owners feel for their petfish leads to absurdities: like the woman, dressed in mourning black, who placed her goldfish in a miniature coffin and buried it in a Glasgow pets' cemetery. But the attachment fishkeepers have to the fish they keep shows that fish, mute and uncommunicative, communicate something of value.

The trap of medicalised motherhood

Ann Oakley

The 'freedoms' women have gained make the first child even more of a crisis. The identity shock is compounded by the present doctor-dominated style of birth.

Ann Oakley is the author of *Sex, Gender and Society* and of *Occupation Housewife*

Over the last ten years or so, women's inequality in society has become a public issue. It is sometimes argued that sex equality is just around the corner and that we are fast becoming an androgynous society—that women are becoming more like men and men more like women. But how many changes have really occurred, and how much have they affected women? Is the pattern of most women's lives in developed societies today really different from what it was ten or 50 years ago?

Reforms caused by feminist agitation have included some improvements in women's educational and job opportunities. Some of the more oppressive legal definitions of women's role have been removed, and the Equal Pay Act and the Sex Discrimination Bill will end further inequalities. Other social changes reduced the birth rate from 28.7 per 1000 in 1900 to 16.2 in 1970, and have made it more socially acceptable for wives and mothers to work outside the home. The "career woman" has emerged as a respectable deviation from the conventional feminine role, even when combined with marriage and motherhood.

Yet such women still represent a tiny minority of all women. A similarly small minority have benefited from improved access to education and professional employment. The argument that these alterations in women's roles are creating a more androgynous society is true in terms of the kinds of illness that are characteristic of each sex. A report in the *British Medical Journal* showed that ischaemic heart disease (a typically masculine condition which has previously been very rare in young women) has increased in women under 45 by about 50 per cent over the last twelve years. The increase is particuarly associated with more cigarette smoking among women. Another "masculine" illness—alcoholism—has also sharply increased.

Such masculine expressions of stress are paralleled by an increase in female crime. For example, between 1970 and 1971 crimes of violence among males increased by 11.8 per cent and those among females by 16.6 per cent.

Some women may be responding to stress of various kinds in a more masculine way. But evidence that in sickness and health women have become mere imitators of men is tangential to their continuing social and economic differences from men.

Compare a woman born in 1950 with her grandmother, born in 1900. For both education is a prelude to restricted feminine job options—sales or factory work, clerical or secretarial work, nursing or teaching. (In 1971, a higher proportion of women worked in these areas than in 1959.) For both, a job has the function of a pause between leaving school and a life in which marriage and motherhood take precedence over other interests and activities. (In 1971, 60 per cent of the women who stopped work did so because of pregnancy or the domestic responsibilities of their marriage.)

There *are* differences between the pattern of the lives of the 25 year old woman and her grandmother. But they do not stem from the move towards educational, job, economic or legal equality. They come from changes in matters of reproduction, and from general ideological developments. As the 1974 white paper, *Equality for Women*, put it: "Paradoxically the very improvements in the position of women have, in some ways, made their lives harder than before." In contrast to the more straightforward definitions of women as housewives, wives and mothers, which the women born in 1900 probably encountered, a woman born in 1950 must define herself as a worker (outside the home) and as an individual.

The usual reason women give up outside work today is motherhood, whereas in the 1930s and 1940s it was marriage. One specific event causes a direct confrontation with the problems of multiple identity: pregnancy and the birth of a first child. Although average family size has gone down, mar-

Obstetrician's progress: below is a 16th century handywoman. The first male obstetricians operated below a sheet to preserve decorum (page 640). Today, delivery by men is commonplace (page 641).

Mary Evans

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Illich, *Medical ıesis* (Calder & ars, 1975)

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ı Oakley, "Wise- ıan and medicine ı: changes in the ıagement of dbirth" in Juliet chell and Ann kley (eds) *Essays Women* (Penguin ıress)

ıcy Stoller Shaw, *rced Labour: ternity care in the ited States* rgamon Press, ı4)

ı Oakley's research the transition to therhood is suppor- by an SSRC grant

riage rates have gone up. When pregnancies in single women are included, the experience of childbirth—at least once in a lifetime—is more common for women today than it was two generations ago. For these reasons, *the crisis of first childbirth is central to women's situation today*. Not only does it provoke a head-on collision with the ideological dilemmas of femininity, but the role of mother is still an impressive obstacle to women fully participating in life outside the home.

A big difference between those two generations of women therefore relates their reproductive role. There have been fundamental changes in the definition and medical management of reproduction, so that pregnancy, childbirth and childcare have a very different meaning today from that of two generations ago. This, combined with the crucial importance of first childbirth in shaping the female life style, has made the birth of a first child an unequalled crisis for women.

Pregnancy, childbirth and childcare in modern society are "medicalised" processes. "Medicalisation," a clumsy but necessary word, refers to people's dependence on medicine and to the control of health and sickness (and thus of people) by the medical profession; Ivan Illich has written about it extensively in his book, *Medical Nemesis*. The medicalisation of pregnancy and childbirth is mainly evident in the trend towards hospital delivery (from 15 per cent of all births in Britain in 1927 to 91 per cent in 1972—with emphasis on regular antenatal checkups, some twelve to 14 being required during an average pregnancy); and the stress on the medical dangers of pregnancy rather than on the psychological or social ones. Having a baby is a medical, rather than a natural process. It has lost its character as a taken-for-granted aspect of adult life.

The medicalisation of motherhood can be seen in a research project I am currently carrying out on the transition to motherhood. A sample of expectant mothers is being interviewed several times during pregnancy and the first month of motherhood. In addition, encounters between women and medical staff in hospital and clinic situations are being observed. Some first impressions are as follows.

Pregnancy demands medical diagnosis and treatment. Women mainly regard the medical profession with deference and trust, mixed with a residual suspicion that the doctor might not always know best: "My period was two weeks late. I'd never been late before. I went to the doctor and they couldn't tell me straight away—he gave me some tablets for sickness and told me to come back in two months' time. I was a bit—not upset—but dubious. I wasn't examined or anything. It didn't ease my mind. I wanted to know, myself. I wanted to tell my husband."

Susan Howard (a pseudonym) "knows" she is pregnant, but at the same time she doesn't know: she has to be told by a doctor. As textbooks teach, cessation of menstruation in a healthy young woman who has previously menstruated regularly amounts to evidence of pregnancy. Although women "know" this, doctors have to be told it, and it is then part of their professional role to return this knowledge to women. As Susan Howard's comment suggests, a doctor's confirmation of pregnancy is seen by the woman as necessary not only for her own peace of mind, but also for the important ritual of "telling people." Moreover, the onset of pregnancy has to be confirmed by a doctor in a face-to-face encounter; pregnancy tests carried out by chemists, or hospital referral letters handed over by doctors' receptionists, are not adequate substitutes.

The necessity of these medical encounters, and the form they take, remove the "naturalness" of pregnancy and childbirth. Margaret Harrison, a teacher, describes it in the following way: "It's such a natural thing, having a baby. It's something women have been brought up to do, and yet when you go to the hospital and they start sticking needles in you and taking blood and sticking their fingers up you, you tend to forget that it's a natural thing. I've never been scared of having a baby at all, but quite honestly, every book I read now, and every visit I have to a doctor or a hospital, just makes me more scared. I saw a film at the hospital the other day of a woman having a baby, and she really looked ill. I don't want to be like that. Before I went to the hospital, pregnancy was a normal nice condition. I'm not sure it isn't an illness now. It's this concern with medicine that seems to override everything else."

This raises the issue of the medical profession's own contribution to the medicalisation of motherhood. Unlike other patients, most pregnant women are not ill people and they do not require medical treatment. Yet to maintain the definition of pregnancy and childbirth as medical phenomena, the doctor must treat the patient *as if she were ill*.

But the kind of medical treatment a woman receives in pregnancy and childbirth is bound up with the values of modern obstetrics, as well as with those of modern professional medicine. In the early years of the 20th century, doctors supervised only a minority of upper class childbirths, and most pregnancies and births were under the control of untrained female midwives, otherwise known as "handywomen." (As late as 1937, a

government report expressed concern at the number of women who still chose to use the "handywoman" system in preference not only to doctor—or hospital—medicine, but also to the state-certified midwife.) These women took over from the female healers who before industrialisation, were the chief sources of health care for the whole community.[•] Professionalised medicine had gradually assumed control over health care by the 18th century, though not over obstetrics until the 20th century.

Historically the medical management of childbirth is associated with a transfer of control from women to men. Today in Britain, 17 per cent of all doctors and 15 per cent of those in hospital service are women, but women do not have a proportionate share of top medical posts. As Beulah and Thomas Bewley pointed out in the *Lancet* recently, there is a predominance of men in the policy and decision making bodies within the profession. This change of control over reproductive care from women to men and the associated medicalisation of motherhood, has caused women to be massively alienated from the reproductive function.

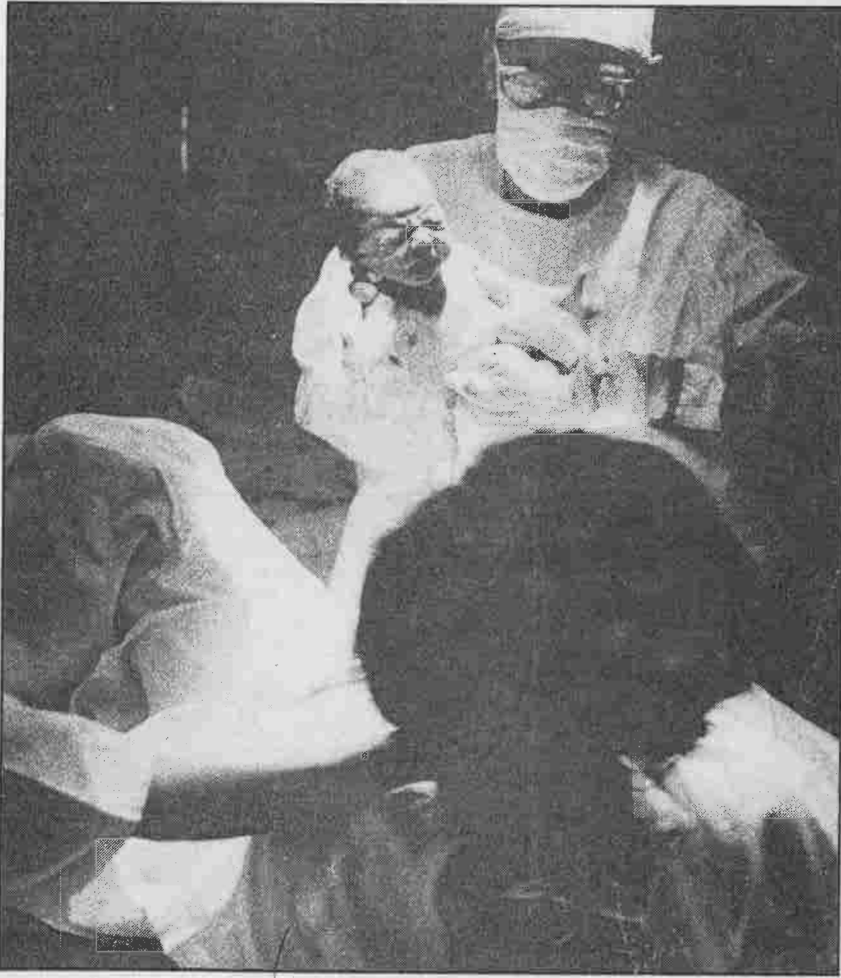
Along with the transfer of control from women to men has gone an increasing emphasis on techniques of *intervention* in the natural processes of pregnancy and delivery and in the postnatal relationship of mother and baby. The earliest inroads on female midwifery were made in the 17th century by "men-midwives" who specialised in surgical techniques; the first recorded episiotomy (a cut to ease birth) was carried out by a man-midwife in 1780; and forceps were introduced by another. A more recent technique of intervention is the induction of labour by clinical means. In Britain the induction rate rose from 13.7 per cent of all hospital deliveries in 1963 to 31.5 per cent in 1972 and has probably increased substantially since that time.

Intervention techniques are not necessarily bad: it is a matter of seeing how they fit into the total picture. (The use of induction, for instance, has saved many lives that would otherwise be lost.) Medical control, has, on the whole, made childbirth safer, but there are signs that it may produce a sense of anxiety and helplessness. In part, this is because the medicalisation of childbirth has taken place at a time when knowledge about motherhood among women has declined. A woman who becomes a mother for the first time in the 1970s is likely to know a great deal less about bringing up children than her grandmother did. The decline in family size has meant less care of children by older brothers and sisters and less contact with children generally. The new sources of information are women's magazines, books, television programmes and the literature handed out by the antenatal clinic and the health visitor. Motherhood is a "scientific" enterprise in which success is only possible by consultng experts. The new style of obstetrics can therefore be seen as a small part of a new definition of reproduction and childrearing in which the woman's own role as expert has been gradually but dramatically eroded.

Maria Graham, a 24 year old shop assistant married to a painter and decorator, talks about the anxiety many women feel at the prospect of first-time motherhood, when they face not only the unknown "scientific" motherhood, but an uncomfortable and unwelcomed switch of identity: "I cannot picture myself being a mother, dear, I just can't. That's what I'm scared of. I can picture myself going out to work but I can't picture myself looking after a baby. I've never missed a day's work in my life since I started work. It's going to be very strange staying at home. A lot of women choose to be single and not to have children: why do they do that? I said that to my sister and she said, well, then, why did you get pregnant? Well, I'd like the experience of having a baby and then I'd like to give it to someone else to look after and go out to work. I love going out to work because if I go to work I can earn good money. I like to meet friends at work. It's very boring at home, that's why I think it'll be very boring just here on my own, and I won't be able to talk to anyone. My sister says looking after a baby comes naturally—does it? I don't think it will with me, that's why I'm scared of everything."

We do not really know what impact this style of reproduction has on the women who become mothers. Does any relationship, for example, exist between the medicalisation process and mental and emotional problems following childbirth? Post-partum depression probably hits about one in ten mothers, and the less specific category of "nervous symptoms" was found by Lennart Kaij and Ake Nilsson to affect one in four mothers during the year following delivery.

It works the other way round as well: the experience of pregnancy and childbirth is important because of the information it provides on the creation of femininity today. Perhaps an androgynous society is not possible until, or if, the era of test-tube babies is reached and maternity hospitals become defunct. Certainly, evidence of a narrowing gap between the social behaviour of the sexes is countered by the continuing importance of the domestic and maternal theme—now played in a different manner but still in a dominant key.



Eve Arnold