PART ONE

The Self-Diagnosis of Early Pregnancy: An Investigation of Lay Competence

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1. INTRODUCTION

Like many other physiological phenomena such as eating, sleeping, or dying, any consequential pregnancy (any pregnancy whose course and termination become an object of attention) is seen in contemporary Western societies as an event belonging to the domain of professional medical practice. Accordingly, the diagnosis of pregnancy has generally been considered a task that requires professional knowledge and specialized technology for its proper and efficient execution. Whether this is so, is a question that will be investigated here through a study of the ability of lay women to diagnose their own pregnant state.

There do not appear to be any a priori grounds why women should have an ability of this kind except, possibly, from an evolutionary vantage point. The capacity for early self-diagnosis
of pregnancy might have had adaptive significance in maintenance of population homeostasis in prehistoric and pretechnological societies, many of which are reported to have relied on induced abortion for fertility control (Devereux 1976). Unfortunately, data on the diagnosis of early pregnancy in indigenous societies are sparse. If ethnographers have shown an interest in such matters at all, they have usually confined themselves to reporting the presence (and more rarely the absence) of certain indicators, the so-called "presumptive" criteria of medical pregnancy diagnosis.

Ford (1964) provides a cross-cultural summary of information on presumptive pregnancy indicators. In a sample of 64 preindustrial societies from the Human Relations Area Files he found that 19 recognize cessation of menses as indicative of pregnancy, 7 find breast changes important, for another 7 nausea is significant, and in 6 of the 64 societies loss of appetite and general lethargy are known to accompany pregnancy. There is no systematic information on the time at which these symptoms appear and it is not clear whether we are dealing with general descriptors for a recognized pregnancy or with true diagnostic criteria.

The literature also contains a few accounts of indigenous methods of pregnancy diagnosis that have no equivalent in the Western scientific model. In the West Indies, for example, some Carriacou women "claim to know the moment they conceive and some rely on dream messages" (Smith 1962: 132, quoted by Galanti 1976: 13). However, sporadic reports of this nature notwithstanding, it is probably fair to say that next to nothing is known about methods of early pregnancy diagnosis outside of Western scientific medicine.

In the United States and other technological societies, the medical model of pregnancy diagnosis is the only one that is, and can be, taken seriously at this time. The major objective of this paper is to propose an alternate or, more accurately, a complementary model for pregnancy diagnosis. This model approaches the diagnostic process from the point of view of the primary experiencer of gestation: the pregnant woman.

The following report, then, addresses itself to an examination
of lay competence in self-diagnosis, specifically to women's ability to diagnose their own pregnant state in the absence of expert medical judgment. I will begin by discussing the prevailing Western scientific view of pregnancy diagnosis since it provides the background against which questions for investigation have been formulated. I do so from two points of view: I first examine (1) what might be called the "official" (or practitioner's) version of pregnancy diagnosis: the body of knowledge transmitted to medical students and encoded in medical textbooks; and (2) the "pragmatic" (or patient's) version through the criteria actually encountered by potentially pregnant women seeking a diagnosis in a doctor's office.

The third section of this paper is concerned with the "non-medical" environment in which the data for this study were collected. The ideology of the Feminist Women's Health Center is outlined and the role this ideology plays in creating an atmosphere conducive to the emergence of potential self-diagnostic competence is discussed. After a delineation of the methodology utilized for this investigation, results of the study are presented in section 5. Finally, medical and lay criteria for the diagnosis of pregnancy are contrasted and some possible implications of the findings of this study are discussed.

2. THE MEDICAL MODEL OF PREGNANCY DIAGNOSIS

The medical determination of a pregnancy must be seen as a social event in the sense that it is interactional, involving minimally a medical professional and a patient. For present purposes, two aspects of the diagnostic process are of interest: (1) how that process appears from the point of view of the physician; and (2) how it is encountered by the patient.

The Practitioner's View

Though one might assume that, among physicians' diagnostic tasks, the diagnosis of a pregnancy would be less problematic than most, misdiagnosis appears as an ever-present and recognized possibility. Hellman and Pritchard, in the prestigious
Williams Obstetrics, write:

There is hardly a gynecologist of experience who has not opened the abdomen on one or more occasions with the expectation of removing a tumor of the uterus or its appendages only to find a pregnancy. (1971: 277)

We are further warned that the chance of diagnostic error is greatest during the early months though it is often of considerable importance that a diagnosis be made at that time. What, then, are the criteria by which a medical diagnosis of pregnancy can be made?

Medical textbooks divide diagnostic criteria of pregnancy into three classes: (1) positive; (2) probable; and (3) presumptive indicators. Positive signs are: hearing the fetal heart beat; perception of active fetal movements by the examiner; and demonstration of the fetal skeleton. Recently, ultrasound technology has added a fourth criterion. The earliest positive diagnosis of pregnancy can be made by the sonographic detection of the characteristic “gestational ring” about eight weeks after the woman’s last menstrual period (Pritchard and MacDonald 1976: 207). However, for a variety of reasons, not the least of which is that the procedure is costly and involves equipment not available in the doctor’s office, sonography is not employed routinely in pregnancy diagnosis. X-rays, unless the fetus is dead, are of no practical use during the first few months because of the associated radiation hazard. Auscultation and identification of fetal movements—the methods which can be used without additional expense and technology—do not produce positive results until after the fourth and fifth months (Hellman and Pritchard 1971: 277, 278).

We note the following about positive diagnostic criteria: (1) with the exception of ultrasound, they are not applicable until late in the pregnancy, at a point of fetal development too advanced for a simple termination; (2) they consist of signs accessible to the examiner, in accord with the notion that “there is no subjective evidence of pregnancy [i.e., evidence from the woman’s point of view] which can be accepted as diagnostic” (Benson 1971: 45).
Of the *probable* signs of pregnancy, those that are detectable comparatively early include: softening of the cervix after six to seven weeks LMP (Benson 1971: 39) but sometimes not until much later; generalized enlargement and diffuse softening of the corpus of the uterus, generally present after ten weeks LMP (Benson 1971: 40); abdominal enlargement near the end of the third month LMP (Hellman and Pritchard 1971: 280); and a positive laboratory pregnancy test. The latter, because of the central role it occupies within the diagnostic process, merits further discussion.

Within the last few years, previously used bioassay methods (i.e., methods using test animals such as rabbits or frogs) have been supplanted by immunoassay techniques which can be done cheaply and rapidly in the laboratory. All such pregnancy tests (hormone tests, endocrine tests) are based on determining the presence of HCG (human chorionic gonadotropin) in the patient's urine. The production of HCG begins almost immediately after implantation of the fertilized ovum and, in most cases, reaches a level high enough to be detected by six weeks LMP. Apart from incorrect readings and human error in recording (which should not be underestimated) there are a number of reasons for the possible failure of these tests. A basic problem is that they react not only to HCG but also to LH (luteinizing hormone) which, secreted from the pituitary at the time of ovulation, may be present in the woman's body for some time. Consequently, if the test is so sensitive that it will react to small amounts of HCG, it may also react to the small amounts of LH present. If, however, the sensitivity of the test is reduced, some pregnancies, especially early pregnancies, will not be detected because the level of HCG is still too low. Furthermore, the outcome of the test can be influenced by a variety of substances in the woman's system such as marijuana, large doses of aspirin, and possibly tranquilizers; or HCG may be present for reasons other than pregnancy, for example with a hydatidiform mole, choriocarcinoma, or because the woman has been receiving injections of HCG in the course of obesity therapy.

As their classification indicates, none of these probable signs of pregnancy are conclusive, though in practice the initial medical diagnosis of pregnancy relies on them to a considerable extent.
Presumptive indications of pregnancy rank lowest among medical diagnostic criteria.

The presumptive evidences of pregnancy largely comprise subjective symptoms and signs appreciated by the patient herself. The signs include cessation of the menses, changes in the breasts, alteration of the color of the mucous membranes, and increased pigmentation. The symptoms include nausea with or without vomiting, disturbances in urination, fatigue, and the sensation of fetal movements. (Hellman and Pritchard 1971: 285)

Medical textbooks are vague about the time at which these indicators appear. Except for the sensation of fetal movements, which occurs after the 16th week, Benson speaks of "the first trimester," "a few weeks after the missed period," or "after the missed period," or "after the first few weeks of pregnancy" (1971: 37-40).

Reviewing the list of medical diagnostic criteria, we note the following:

1. Within the medical model of pregnancy diagnosis, indicators are ranked from presumptive to probable to positive.
2. A low ranking is assigned to evidence accessible to the patient (subjective indicators), a high ranking to that ascertainable by the physician independent of the woman's opinion. [Note that fetal movements perceived by the woman are presumptive evidence, but detection by the physician is a positive sign (Hellman and Pritchard 1971: 278).]
3. Indicators with a low ranking appear earlier in a pregnancy than those with a high ranking.
4. The need for instruments (e.g., the stethoscope) and specialized technology (laboratory facilities, X-ray and sonographic equipment) tends to be associated with higher-ranked indicators.

The Patient's View

It is clear that for a routine diagnosis of pregnancy no physician will evaluate all of the indicators potentially at his disposal. A question to be investigated then is: What does medical pregnancy diagnosis look like in practice? And what are its salient features from the point of view of the potentially pregnant woman? Two
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types of data regarding this question will be presented: the first consists of women's spontaneous tape-recorder comments; the second, the result of a systematic survey of physicians in which the investigator posed as a patient in need of diagnosis.

My interviews on pregnancy self-diagnosis (which will be discussed in detail in sections 4 and 5) happened to contain a number of comments relating to diagnostic interaction in physician's offices. It seems appropriate to inspect these comments for their assessment of the salient features of medical pregnancy diagnosis. No questions eliciting this information were asked. All comments were volunteered, generally in the course of "telling the story of this pregnancy."

"My doctor had me get a pregnancy test. Then he did a pelvic."

"I waited, and then I contacted my doctor, and he set me up for a pregnancy test."

"I called my doctor, and they told me to wait 42 days after the first day of my last period, and then come in for a pregnancy test."

"I figured I was about three weeks along. So I went and had a pregnancy test in the middle of June, and he said I wasn't pregnant. And I was so happy. And two more weeks went by, I went back after two more weeks, and he told me I was about five weeks pregnant."

For these women, the laboratory pregnancy test apparently figured as the most salient feature of the diagnostic transaction.

To further investigate the praxis of medical pregnancy diagnosis, I conducted a telephone survey of obstetricians and gynecologists in a large metropolitan area in Northern California during the summer of 1973. I thought it desirable not to ask physicians what factors they take into consideration when making a diagnosis, but to present them with an apparent case, since my aim was to find out how pregnancy diagnosis is encountered by the patient in need of such a service. I posed as a woman who was convinced she was pregnant, had missed her
period a week ago, and wanted an abortion. These seemed to me to be the most likely conditions under which a physician would be called upon to make an early diagnosis of pregnancy. My intention was to take an exhaustive sample, i.e., to survey all obstetricians and gynecologists listed in the telephone book. I expected a range of responses, i.e., some physicians would suggest a pelvic examination, others might rely on a pregnancy test, others on subjective symptoms, etc., and some, I felt, would utilize a combination of these.

Contrary to expectations, responses were so monotonous that I terminated the survey after 30 calls. The policy of each and every physician was to require a positive pregnancy test before any further action would be considered. Moreover, the test turned out to be a nonnegotiable requirement, even if I insisted that I knew I was pregnant, citing the classic (presumptive) symptoms and pointing to my experience with previous pregnancies.

It is interesting that in the "official" version of the diagnostic process presented in medical teaching and textbooks, diagnosis is formulated as a matter between patient and physician. A significant feature of the praxis of doing diagnosis, however, is that it is mediated by the office staff. (I spoke to only two of the thirty physicians I called, and that only after creating a considerable amount of "trouble.") Typically, the first step in what will come to be seen in the end as a diagnosis of pregnancy consists of obtaining instructions from the office staff who know how to deal routinely with women who think they are pregnant. It is via these instructions ("and no exceptions") from the doctor's office that the required pregnancy test takes on, in the eyes of the patient, its status as the criterion for the medical diagnosis of pregnancy. 4

It may be of interest to note here that doctor's office staff were unprepared to satisfy any questions beyond (1) what to do ("get a pregnancy test"), and (2) how much will the abortion cost (typically three- or four-hundred dollars for the doctor's fee plus hospital charges). It was difficult to find out, for example, what kind of abortion their employer performed (vacuum aspiration or dilatation and curettage, under local or general anes-
Another practical feature of diagnostic transactions is potentially misleading information received from office staff. I was told, for example, on several occasions that I would have to wait until after my second missed period for the pregnancy test to be usable. Given that it takes two or three weeks to get an appointment in most doctors' offices, the pregnancy would have progressed at least ten or eleven weeks LMP. If we add to this delay problems with hospital scheduling, it may well be too late for a suction abortion or curettage.

It is clear that the medical profession's reliance on pregnancy tests can be justified on a variety of grounds: in terms of economics, for example, or of efficient allocation of the physician's time, or even on moral-ethical grounds. As one doctor told me: "I can't do it [an abortion] just because you say so. I'd be doing countless needless abortions. What if I get you on the operating table and you aren't pregnant." Furthermore, a doctor will point out that the positive test is followed by an assessment of other signs and symptoms in his office. My intent here, however, has been neither justification nor criticism. It was, rather, to provide an ethnographic report of the transactions involved in early diagnosis of pregnancy from the point of view of the woman as one party to the business at hand.

Regarding the medical diagnosis of pregnancy we note, then, the following: (1) by methods available in a physician's office, a positive determination of pregnancy is, theoretically, not possible until after the fourth or fifth month; and (2) practically, physicians' diagnoses of pregnancy rely heavily on laboratory pregnancy tests, which may be accurate after the sixth week LMP. Until a positive test has been obtained, a woman finds herself ineligible for either an abortion or prenatal counseling. In other words, she is treated as nonpregnant for all practical purposes, until further developments.

Medical diagnosis includes a principled disregard of the woman's opinion, relying instead on objective signs and procedures that are available to the medical professional. In what follows I will be concerned with an examination of nonprofessional diagnos-
tic competence, specifically with lay women’s ability to diagnose their own pregnant state in the absence of expert medical judgment. The medical model of pregnancy diagnosis has provided the background against which questions for investigation have been formulated. In particular, I will examine the following issues:

(1) Is it the case that women can tell whether they are pregnant without an expert’s judgement? (Recall here the ubiquitous story of the woman who cannot imagine why she keeps gaining weight until, to her complete surprise, she gives birth to a child one day.)

(2) If they can, at what point between conception and birth does it become apparent. (It is possible, for example, that women might first diagnose a pregnancy when they begin to feel fetal movements. Thus DeVidas reports that among the Aranda, Central Australia, “pregnancy is determined by the movements of ‘quickening’ in the fourth month” [1947: 18].)

(3) What do women point to as evidence of their pregnant condition? Do they cite symptoms and if so, what kinds? Are these symptoms similar for most women or do they vary idiosyncratically? If women’s diagnostic criteria can be isolated, would they be useful as a checklist to aid other women in monitoring their own changing body states? Can any physiological basis for such symptoms be identified by correlating them with, for example, endocrine changes?

(4) Furthermore, the question of accuracy will need to be investigated. How many women are likely to be wrong in their self-assessment? A specification of conditions under which competence is to be expected is also desirable.

Given the prevailing view that pregnancy diagnosis is a medical task, an initial problem for the investigation of these questions was to find a “nonmedical” environment with a large concentration of women in the early stages of pregnancy. I found such an environment in the Feminist Women’s Health Center in Santa Ana, California, where I became a member of the all-woman
staff in May 1973. The Center, among its other activities, operates a pregnancy-screening service and an abortion clinic. In order to assess the nature of the data reported in section 5, an explication of the health-related activities of the Center will be helpful.

3. SELF-HELP IDEOLOGY AND ITS IMPLEMENTATION

An ideology is here conceptualized as a guide for behavior: a shared, agreed-upon blueprint that people refer to in order to assess the appropriateness of their actions. This section, first, outlines the Center's stated ideology as conveyed in pamphlets and through verbal communications in "Self-Help" meetings. Secondly, it contains a detailed description of how the abstract ideology is translated into the policies and interactional strategies encountered by the Center's clients. This documentation thus provides the behavioral specification for what is otherwise glossed as "nonmedical environment" in this paper.

The Feminist Women's Health Center (FWHC) was founded early in 1971 by a group of Southern California women with the objective of providing an alternate system of gynecological care for themselves and other women. They proposed and implemented the idea of gynecological Self-Help as an explicit feminist alternative to existing medical services for women.

Self-Help ideology consists of the following tenets: (1) Women have the right to control their own bodies. This right includes specifically the right to self-examination and the right to exercise control over reproductive functions. (2) Within the framework of professional, male-determined and technology-oriented health care, the doctor-patient relationship is typically exploitative and oppressive of women. (3) Every woman can learn enough about female anatomy and physiology to recognize abnormal conditions requiring professional help. (4) Women themselves must develop and operate alternate systems of health care delivery in order to assure improvement in the current practice of obstetrics and gynecology. These ideological statements of what the Self-Help movement is about are important in that
they inform and reflect the conduct of the Center's routine everyday business.

This ideology promises the conditions required for an investigation of lay competence in two respects: (1) It is clear that if there is such a competence, it will remain submerged in medical diagnosis because the medical model has no place for it. An outlook, however, that takes for granted women's right and ability to "control their own bodies" would be favorable to the discovery of such competence. (2) The ideology promises a reduction of the hierarchical characteristics of the conventional patient-doctor relationship in a clinical setting.

For the purposes of this study, two features of the interaction between the staff and the women in need of services are of interest. The first has to do with the ideological tenet that every woman is entitled to have control over her body. As a consequence, women are viewed and treated as competent individuals who might be in need of empathy and support, and almost certainly of information, but who are otherwise perfectly capable of making decisions regarding their bodies. In practice this means that the staff offer to share, on a woman-to-woman basis, the information and experience that they have collectively acquired, leaving actual decisions to the woman having the abortion. (It is, for example, neither clinic policy, counselor's judgment, nor doctor's opinion, but the woman's decision whether a local anesthetic will be administered before the abortion.)

When she enters the clinic, each woman is assigned a counselor who explains to her what data she might want to consider in deciding whether she is pregnant or not, what happens in the course of an abortion (if she should want one), what information is available on the various methods of birth control, and so on. The woman is encouraged to ask questions and to actively participate, rather than to passively receive information. During pregnancy screening, for example, she is invited to look at her cervix with a speculum and mirror, a procedure which gives her the same view that the physician has when examining her. Urine tests for pregnancy are always done in the woman's presence, and with an orientation to demystifying medical procedures. If the woman is interested the counselor will instruct her in how to
do the test herself, explaining possible errors and their causes and showing her how to interpret results.

Every woman is given information about the risks involved in an abortion, about possible complications and their danger signals, about what to expect after the procedure, and about the various kinds of medication she will receive. These explanations are always offered with an orientation to the underlying reasons. For example, all women are given methergine as postabortion medication. But the counselor will explain how it works, that it acts to contract the uterus and thereby tends to decrease bleeding while increasing cramping. She will further point out that this medication is used routinely after childbirth and, though many doctors give methergine to women who have had an abortion, not much is known about specific postabortion effects. With this kind of information the woman is in a position to decide for herself whether she wants to take it or not.

Another example of how the ideological statement of "own-body control" is translated into "nonmedical" practices in the clinic can be found in the treatment of a woman's clinical chart. Garfinkel (1967) has described the role patient records play in warranting clinical activities as a medico-legal enterprise. He points out that:

One of the crucial features of remedial treatment activities is that its recipients are socially defined by themselves and the agencies as incompetent to negotiate for themselves the terms of their treatment. Thus it is the socially acknowledged normal course of affairs that a patient "puts himself in the hands of a doctor" and is expected to suspend the usual competence of his own judgment about his well-being, what he needs, or what is best for him. The same applies to the criminal, mutatis mutandis, who is the sole person barred from contributing his opinion to the formulation of a just sentence. (Garfinkel 1967: 198)

The common understanding by patients and medical staff regarding patient incompetence becomes visible in conventional medical transactions in the fact that patients are neither entitled writers nor competent readers of medical records. By contrast, a woman's chart in the Center's clinic is not only accessible to her at all times, but becomes part of her management of her abor-
tion. She is encouraged to collaborate in its production by writing in it, to examine it for adequate progress of her clinic career, to check it as to accuracy and completeness, and so on. Counselors', lab technicians' and doctors' notations are explained to the woman as a matter of policy. In the clinic, it is specifically not the case that she “puts herself into the hands of a doctor.”

Since staff members see the clinic as operated “by women for women” they treat the physicians as working for the clinic, not the other way around. Standards for physicians' work are set according to what clinic personnel have determined to be the best procedure on the basis of experience with various methods of doing abortions. Interactionally, doctors receive no particular deference. They are addressed by first name like everybody else, and their convenience, like that of the staff, is at all times treated as subordinate to the needs of the women. Since the staff is skilled in recognizing good abortion technique, the physician is under supervision by his or her assistant (a staff member) as well as by the woman's counselor, who is also present during the procedure. They do not permit what they consider insensitive, patronizing or condescending behavior on the doctor's part and they closely monitor technical performance.

In general, staff members communicate to the woman that they see the doctor as (1) an experienced technician who is expected to do their abortion in the quickest, most painless, and safest way possible; and (2) a collaborating consultant who will supply needed information for the woman's consideration if some unusual condition requires specialized knowledge. It is the nonhierarchical restructuring of the patient-doctor relationship at the clinic and the principled acknowledgment of women's competence by clinic personnel that recommended this setting to me for investigating possible lay competence in the self-diagnosis of pregnancy.

4. METHODOLOGY

Endogenous Research
Because of the nature of the data to be collected, this study was
conceptualized as endogenous research (Maruyama 1974). That is, data collection was designed and achieved as part of the research setting's (the clinic's) work, not as an extraneous or intrusive activity. Because my interest was in potential lay competence, it was essential not to recreate the interactional structure of medical pregnancy diagnosis, since it was likely that within such a framework, women would merely reveal their ignorance and incompetence. In order to create the conditions which would allow self-diagnostic competence to emerge (if in fact it existed), it was important to keep the interviewing situation free of any notions of professional hierarchy. For the purposes of this study, the very nature of the data to be collected required that the investigator not appear in the role of outside observer, different and detached from the studied, but as part of the scene, as another woman who was interested in, and prepared to take seriously, what women in the clinic had to say about their pregnancy feelings.

Endogenous research has been demanded not only by minority groups and feminists who argue that the usual research for which they find themselves as subjects is all too frequently detrimental to their interest, but also by social scientists who suspect that nonendogenous research is faulty on epistemological grounds. (Fabian 1971; Hymes 1969; Maruyama 1969, 1974.)

Interviewing. Informal, tape-recorded interviews were carried out during the weekly abortion clinic at the Center. Some of the women who come to the clinic already have objective evidence that they are pregnant, usually in the form of a positive pregnancy test. However, many of the women at the clinic do not have “objective” evidence, but have come to the clinic because they believe themselves to be pregnant. A very small minority do not consider themselves to be pregnant but are seeking menstrual aspiration for some other reason. It is the latter two groups, but especially those who think that they are pregnant, that are of greatest interest here.

Interviewing was done as part of the clinic's work. The women whom I interviewed had seen me do the things counselors do: help them fill out papers, run tests, take vital signs, answer
questions, and the like. Given the orientation within the clinic to collaborative information sharing and exchange, a request to the women to verbalize what they know about pregnancy feelings was simply another invitation to participate in the accomplishment of the common business at hand. Before an interview, I would explain that little is known about what women know about their pregnancies, that we wanted to collect this kind of information to share with and benefit other women and, possibly, medical people, and invited them to do an anonymous tape-recorded interview. Thus data collection was achieved as a joint undertaking of women who were, at that particular time, practically engaged in the common task of dealing with pregnancy.

Initially I had no clear-cut notions of what kind of response I would get, and my interviewing activities began as “fishing expeditions.” Early interviews consisted of variations on the questions: “Do you think you are pregnant?” and “How do you know?” As I got some ideas about what variables might be important, I kept to the unstructured format but conducted the interview with a checklist of questions in mind that was designed to give information about those variables. Tape recordings were later partially transcribed and values for relevant categories were entered on a coding sheet.

The Sample. The population from which the sample for this study was drawn consists of a special subset of women: self-selected Southern California women who come to a women’s clinic in order to do something about a possible pregnancy. The clinic population is characteristic of the working-class neighborhood in which the clinic is located. Typically the women are employed as restaurant workers, hospital aides, secretaries, salespersons, and so on. In addition, the clinic serves a few professional women, some students from local high schools and the nearby University, and a number of “society women” from the beach cities. Most of the women who use the clinic are Caucasian, the largest minority subgroup is Spanish-speaking, and there is an occasional Black woman. Ages range from teenage to menopausal, with the largest proportion of women in their twenties.
Given the feminist orientation of the Center, its involvement with the Self-Help movement, and the fact that the Center sponsors instruction in self-examination, I thought it possible that a significant proportion of the women coming to this particular clinic might have been exposed to Self-Help and, therefore, might be more “tuned in” to monitoring their bodily changes than women in the general population. This proved not to be the case. It is rare that a woman coming to this clinic knows how to use a speculum, and none of the women in the sample had any experience with self-examination.

5 THE DATA

Between May 1973 and December 1974, more than one hundred interviews were conducted. However, about half of these belong to the “fishing expedition” stage and do not contain sufficient information on the variables I came to consider relevant. In the sample of 51 women from the second phase of the research, there were 18 who already had objective evidence of their pregnancy at the time of the interview. (These are hereafter referred to as the OBS group.) Thirty-three women (referred to as the SBS group) did not have objective evidence, and it is their responses that are of particular interest.

Before embarking on the analysis of responses by the “SBS” group, I want to offer some general descriptive statistics on the combined group (n = 51). In the following discussion the reported n may be less than 51 because the number of women for whom there is no information on a particular item has been subtracted.

Birth Control at Time of Intercourse
Of 46 women, 1 was pregnant with an IUD in place, 1 had used foam, 4 couples had used condoms, and 1 woman had been told by her partner that he had had a vasectomy. Thirty-nine had not used any form of birth control. The question arises here why the proportion of contraceptive nonusers is so large. With the benefit of hindsight it appears a regrettable omission that I asked no
questions regarding these women’s histories of contraceptive use. Because of the clinic’s orientation to maintaining a non-judgmental atmosphere, I tended to avoid questions with potentially condemnatory implications, such as “Why didn’t you use any birth control?” However, a substantial proportion of women (e.g., 11 of the 33 “SBS”) spontaneously mentioned that they had been on birth control pills and had discontinued their use because of side effects. Experienced counselors noted that that was a typical picture. It appears that women are often not told that disturbances in the menstrual cycle are common after discontinuing the use of birth control pills (see Arrata and Howard 1972, Dodek and Kotz 1967, Halbert and Christian 1969, Horwitz et al. 1968, MacLeod et al. 1970). In particular, the time at which ovulation is reestablished is variable so that a woman may ovulate (and become pregnant) at unpredictable times.

Date of Intercourse Known
Of 35 women, 25 knew the exact date of intercourse involved in the suspected pregnancy. It appears that these women monitor their sex lives carefully, which suggests that the widespread nonuse of contraceptives in this group is not likely to be the result of simple carelessness and irresponsibility, but must be due to other reasons.

Date of Ovulation Known
Of 23 women, 11 claim to know when they ovulate; some of these 11 can specify which side (the right or the left ovary) is involved. Typically, they report the sensation of ovulation as a cramp-like pain (Mittelschmerz), lasting from a few to maybe 20 minutes. Most do not notice it every month, and on those occasions they assume that ovulation occurred during the night. It is possible that women who have access to their ovulation find the disturbance of their internal clock through birth control pills (which inhibit ovulation) particularly objectionable.

Previous Pregnancies
Of 51 women, 34 had been pregnant before, 17 had not. Together the 34 women who had been pregnant before reported 77 previous pregnancies.
Comparison with Previous Pregnancies

Of the 34 women who had previously been pregnant, 22 explicitly compared the present pregnancy with a previous one. Of these, 19 reported that it felt the same, but 3 stated specifically that the present pregnancy was different.

Table I presents the preceding information tabulated by group. It is apparent that, by and large, the two groups are quite similar. The only difference is in the number of previous pregnancies: where the 18 "OBS" had an average of 2.33 each, the 33 "SBS" had an average of 1.01 previous pregnancies each. If we eliminate as atypical one woman who had 11 previous pregnancies from the group of "OBS," the average is reduced to 1.8 which is still substantially higher than the "SBS" group's average of 1.0.

An initial hypothesis which motivated collecting data on previous pregnancies had been that women who had been pregnant before would recognize a pregnancy earlier than inexperienced women. There is no support for this hypothesis in the data. At least as far as taking action on a recognized pregnancy is concerned, women who have had children tend to do so later.

Responses of the SBS Group

Let us turn now to an analysis of the responses from women who had no objective indication of their state. Five of the 33 women reported that they were unsure whether or not they were pregnant, while 28 were convinced.

The Convinced Group

A surprising and unanticipated result of this study was the high degree of conviction with which most women expressed their opinion about their state. Typical responses that would lead me to classify a woman as "convinced" were: "I'm positive," "I don't have any doubt," "Don't bother [with the pregnancy test], I know I'm pregnant," and "I've been trying to convince myself [that I am not], but I know I am."

Given the general distrust by medical professionals of the expressed opinions of women and their fear of "doing countless needless abortions," the crucial issue here is not how many
### TABLE I

Some Descriptive Characteristics of Total Sample, by Group

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>&quot;OBS&quot; (n=18)</th>
<th></th>
<th>&quot;SBS&quot; (n=33)</th>
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</thead>
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<td>No</td>
<td>No Information</td>
<td>Yes</td>
</tr>
<tr>
<td>Birth control at intercourse</td>
<td>1</td>
<td>13</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Date of intercourse known</td>
<td>6</td>
<td>2</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Date of ovulation known</td>
<td>3</td>
<td>-</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>At least one previous pregnancy</td>
<td>13d</td>
<td>5</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td>Comparison with previous pregnancy</td>
<td>positive</td>
<td>negative</td>
<td>7</td>
<td>positive</td>
</tr>
</tbody>
</table>

---

*a IUD
*b 4 condoms (1 broke), 1 foam, 1 woman’s partner had told her he had had a vasectomy.
*c Includes one woman who had used “psychic control” successfully for three years. She stated she knew she was unprotected because her “psychic barriers” were down because of an unusually intense emotional involvement.
*d Includes one woman with 11 previous pregnancies.
women thought they knew what state they were in, but how many of them were right. As determined by the abortionist's opinion at the time of procedure (based on microscopic examination of the tissue extracted), 27 of the 28 "convinced" women were right, one was wrong.

The woman who was wrong was wrong for a very interesting reason: she had been receiving injections of human chorionic gonadotropin (HCG) in a medical weight reduction program. HCG is a hormone produced by the placenta very early in pregnancy. A sufficient quantity of the substance in the system will produce a positive pregnancy test even though the woman is not pregnant. Furthermore, there is some evidence from problem cases encountered in the Center's clinic that HCG injections will make a woman feel pregnant. This problem also occurs with the "unsure" group.11

Of the 27 women who were convinced of their state and whose opinion turned out to be correct, two were of the opinion that they were not pregnant. I thought it desirable to include them in the sample since the larger issue here is whether women can recognize their state (pregnant or nonpregnant). The presence of these cases provides some evidence against the contention that women automatically consider themselves pregnant if they have missed a period.

The first woman was interviewed at pregnancy screening. She said she did not think she was pregnant in spite of the missed period. She had just recently stopped taking birth control pills and was concerned that she had not had a period after the initial withdrawal bleeding. An appointment was made for her to come to the clinic for reevaluation which she cancelled because she had begun to menstruate.

The second woman also had stopped taking birth control pills when a relationship of long standing broke up. There was a brief reconciliation, but a final separation was agreed upon. She said she did not feel pregnant, and did not have any of the symptoms, of which she gave a list. Her wish to have an aspiration as "a precautionary measure" appeared in her talk as a kind of cleansing rite, a punctuation mark that would effectively terminate the relationship. The procedure produced no tissue. She was, as she had predicted, not pregnant.
Symptoms
Of the “convinced” group of 28 women, 25 were sure that they were pregnant and were right. The question then arises: what sort of evidence do these women point to when asked: “How do you know that you are pregnant?” A word of caution is appropriate here. The number of women who indicate, for example, breast changes should not be misread as the number who have breast changes. It is sometimes the case that one particular indicator is so strong that others are not mentioned, and indeed are sometimes difficult to elicit even with prodding. For a woman, for example, who never has migraine headaches except when she is pregnant, the appearance of two migraine headaches is absolute and conclusive proof of her pregnancy against which any other symptom pales into insignificance. While I have little confidence, then, in the absolute numbers, the rank-ordering of symptoms produced by these numbers seems reliable and is in accord with the experience of the clinic’s staff.

The single most frequently quoted symptom was “breast changes,” which were typically described as enlargement, soreness, and tenderness of the nipples. Since this is also a premenstrual condition for many women, it is of interest that pregnancy breast changes were described as somewhat like, but recognizably different from, premenstrual changes. Twenty of the 25 women indicated breast changes, 3 said they had none, and 2 did not mention breast changes at all. Of the latter two, one had pervasive nausea (“I feel sick day and night”), and this symptom overrode everything else; the second woman had recently been on birth control pills which often produce breast changes anyway, so it might have been for that reason that she felt no difference.

The second most frequently cited indicator is a missed period. This is particularly significant for women who are very regular either by cycle length, or, if they can tell when they ovulate, by number of days after ovulation. One woman, for example, reported that her period always begins on the 14th day after ovulation—within two hours of the time at which she felt ovulation pains two weeks previously.

Nausea (morning sickness, vomiting, feeling sick) was reported
by 12 women, unusual tiredness by 9, changes in food and fluid intake (weight gain, heavy feeling) by 8 (see Table II). It should be noted that these symptoms were frequently cited as lists, sometimes in conjunction with the "idiosyncratic indicators" discussed below. Of the five most frequent symptoms, only 2 women mentioned none, 4 reported one, 5 cited 2, 8 listed 3, 5 women mentioned 4, and 1 woman described all 5 of them.

### TABLE II

<table>
<thead>
<tr>
<th>Frequency Distribution of 5 Pregnancy Indicators (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast changes (enlarged, sore, nipples tender) 20</td>
</tr>
<tr>
<td>Missed period which is otherwise extremely regular 13</td>
</tr>
<tr>
<td>Nausea, feeling sick, vomiting                      12</td>
</tr>
<tr>
<td>Unusual tiredness                                   9</td>
</tr>
<tr>
<td>Weight gain, heavy feeling, changes in food and fluid intake 8</td>
</tr>
</tbody>
</table>

I have discussed these symptoms as a group, partially because they turned out to be the classical "presumptive" indicators of medical pregnancy diagnosis, but also because, if women cite a list of symptoms, at least some of these five indicators tend to be included. There are, however, a number of "idiosyncratic indicators" which do not appear with any frequency but may carry, for the particular woman, a great deal of weight. These idiosyncratic symptoms include the migraine headaches mentioned above, as well as intolerance to particular foods or smells, frequent urination, particular kinds of low back or abdominal pain, skin change, food cravings, and the like. Such idiosyncratic indicators are most frequently cited by women who have had previous pregnancies. A woman, for example, who experienced a craving for Seven-Up during a previous pregnancy and finds her-
"I felt like that when I took the pill... I mean I feel lousy. I have to be pregnant."

"I feel different physically, in magnitude it's like the change from normal to the birth control pill state, but different."

"It's just my instinct."

"Bitchy... I just know... I have a feeling... I do a lot of emotional crying."

"My attitude is really changed towards things. I have this thing with me day and night. I can't bear it any longer."

"My mood drops immediately, like one and a half weeks before my period is due. I feel depressed. I can tell the changes taking place, I can just tell. I don't have any doubt."

Having discussed the kinds of body state information women have available for a diagnosis of pregnancy, I now want to consider the question at what time during the pregnancy this information is accessible. At least for the women in this sample, this seems to be unexpectedly early indeed. (See Table III.)

Of the 25 respondents who were convinced that they were pregnant without any objective indication and who were right, 12 stated that they knew or strongly suspected they were pregnant before they missed their period. Of these, 3 said that they knew at the time of intercourse. It is easy to dismiss these statements as fantasies, wishful thinking, stories made up after the fact, and the like. However, Clark and Zarrow (1971) have suggested some time ago that ovulation can be induced by coitus, and all three of these women relate that they experienced an unusually strong sexual response on that particular occasion. Since ovulation is fairly commonly experienced as a physical sensation (Mittelschmerz) it seems possible that some women may, in fact, be aware of a pregnancy's beginning at the time of intercourse.

Of the 12 women who felt pregnant even before they missed their period, another 4 felt changes about a week after inter-
TABLE III

Time at Which 25 Women Who Were Pregnant Reported They Had Become Convinced of Their Pregnant State

<table>
<thead>
<tr>
<th>Time after MiP</th>
<th>Number of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>at time of intercourse</td>
<td>3</td>
</tr>
<tr>
<td>about a week after intercourse</td>
<td>4</td>
</tr>
<tr>
<td>Within a week after MiP</td>
<td>7 (2)</td>
</tr>
<tr>
<td>Within 2 weeks after MiP</td>
<td>4 (3)</td>
</tr>
<tr>
<td>Within 4 weeks after MiP</td>
<td>2 (1)</td>
</tr>
</tbody>
</table>

MiP: Missed period
Numbers in parentheses indicate number of women for whom date of interview was used as time at which they became convinced.

course, generally a slight feeling of nausea that sometimes passed after a few days. It may be possible that this nausea is due to the event of implantation of the ovum in the wall of the uterus. Another 7 women knew within a week after MiP (missed period); 4 within 2 weeks after MiP; and 2 by the time they missed their second period (see Table III). These last three categories are biased towards a later recognition of the pregnant state because they include some women (numbers given in parentheses in Table III) for whom the dates of the interview were used as the time at which they became convinced of their pregnant state, since no information was available on earliest recognition of the pregnancy.

Of the various hypotheses I held and discarded in the course of this investigation, two merit mentioning. There is some evidence that women who have previously been pregnant tend to take action later than those who are pregnant for the first time. I also thought it likely that women who had previously been pregnant might recognize a pregnancy earlier than women with
a first pregnancy. Table IV indicates that there is no difference between previously pregnant and not previously pregnant women in recognizing their pregnant state.

### Table IV

**Distribution of Time at Which Women Recognized They Were Pregnant, by Previous Pregnancy**

<table>
<thead>
<tr>
<th></th>
<th>Previously Pregnant</th>
<th>Not Previously Pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before MiP</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>MiP plus 1 week</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>MiP plus 2 weeks</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>MiP plus 4 weeks</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*MiP: Missed period*

A further hypothesis, which held some promise before data analysis, was that women who had never been pregnant before would see persistence of premenstrual symptoms in combination with a missed period as evidence of pregnancy, while women who had experienced a previous pregnancy might be able to describe the two states as different. Interview data indicate that previously pregnant women tend to point to idiosyncratic specific symptoms more often. Comparison with the premenstrual state, however, seems uninfluenced by the absence or presence of previous pregnancies. Thirteen women spontaneously compared premenstrual with pregnancy symptoms, and the proportions of previously pregnant women found among those who experience the two states as the same and those who describe them as different do not support the original hypothesis.

**The Unsure Group**

It may be recalled that of the initial sample of 33 "SBS" (women who had no objective indication of their state at the time of
interview), 28 had a firm opinion about their state while 5 felt unsure whether they were pregnant or not. The "unsure" group is in most respects not different from the sample as a whole; thus all 5 women knew the date of intercourse, 1 knew when she ovulated, 4 had not used any method of contraception, and 2 had been pregnant before. In spite of the small number of cases, an analysis of the characteristics of this group might give some indication of the conditions under which women's competence to self-diagnose is impaired.

It is of interest that of the 5 women who suspected they might be pregnant but were not sure, all but 1 were in fact pregnant. The woman who was not had had HCG injections in a medical weight-control clinic, had missed her period, and felt vaguely like during a previous pregnancy. Considering that the single woman who was convinced she was pregnant but was wrong was also on weight shots, it becomes clear that HCG injections are a major hazard in the diagnosis of pregnancy. Moreover, they are a problem not only in self-diagnosis but also in the medical diagnosis of pregnancy which tends to rely on laboratory pregnancy tests, since these tests can give false results if enough HCG is present in the body.

In contrast to the rest of the sample (and the general clinic population) several of the "unsure" women were noticeably and unusually distraught. There are many women for whom a possible pregnancy is an upsetting experience but in the supportive, collaborative, nonjudgmental environment of the clinic, practically all of them handle it rather matter-of-factly. However, three of the five "unsure" women were extremely and visibly upset.

One of them, a very young woman, had a Catholic boyfriend and lived at home with her parents. She talked as if she were in her parents' judgmental presence and felt accountable to her boyfriend who had told her that she would be guilty of murder if she had an abortion. She desperately wanted the procedure, talking about it as having her "period reestablished." During the routine pelvic examination, the doctor diagnosed her uterus as enlarged and told her that the procedure would be classified as an abortion. She became extremely agitated, began to cry, and asked him to call it a menstrual aspiration though she had been
counseled before that the distinction was merely a technical one. Realizing her desperate situation, the doctor, after consulting with the counselor, agreed. There was visual evidence of tissue during the procedure and the pathology report states: products of conception.

It is interesting that this woman suspected a pregnancy even before she missed her period. She reported that she had begun to show symptoms about a week after intercourse: nausea, tenderness in breasts, weight gain, and paradoxically, a sense of physical well-being which she described as "an extra good feeling," without, however, drawing the conclusion that offered itself. I think it is quite clear why this woman was unable to face the possibility of a pregnancy. For her to state verbally what she knew bodily, for her to say in so many words: "I think I am pregnant" would have been self-destructive in the face of her judgmental environment.

Another woman in the "unsure" group was visibly terrified of another pregnancy. She had had two difficult births, both of which resulted in caesarean sections. One baby had been given up for adoption, the other one was retarded. (The woman was Rh negative.) She had recently stopped taking birth control pills, had not had a period after the initial withdrawal bleeding, and both she and her husband were horrified at the prospect of another pregnancy. She reported that she was "more scared than sure of anything." Again, this woman in her extreme agitation presented an easily identifiable atypical case.

The third woman who was noticeably distressed was on HCG injections, which had produced in her a series of physiological, emotional, and interactional troubles, so that the possibility of a pregnancy was only the last in a chain of prior difficulties. She, too, presents an easily recognized special case.

For the remaining two women in the "unsure" group no obvious explanation offers itself as to why they were not able to diagnose their pregnancies. One of them reported that she had had intercourse only once, using a condom, and couldn’t see how she could have gotten pregnant. The other one had stopped birth control pills the previous month and had had intercourse four weeks after the withdrawal bleeding, thinking it was safe.
She thought there was a "fifty-fifty chance" she might be pregnant. Since birth control pills suppress ovulation and seem to mimic pregnancy in a number of ways, it is possible that this woman could not differentiate the two states for that reason. Given that the role of HCG and extreme emotional upset in masking self-diagnostic competence is clear, it is these last two cases that I feel provide the only data in this study that could be considered negative evidence for women's competence in the self-diagnosis of early pregnancy.

6. CONCLUSIONS

The research reported here has established and characterized a phenomenon that had not been investigated previously, namely lay competence in the self-diagnosis of early pregnancy. It was found that this competence was massively present in the women interviewed in the nonmedical environment in which the study was conducted. To what populations of women and under what conditions these results can be generalized remains a question to be answered by further empirical investigation. It is to be noted, however, that there are a number of reasons for believing that the findings reported here would not generalize to conventional medical environments. Since the medical model of pregnancy diagnosis provides no place for lay competence, such competence is not noticeably present in medical diagnostic interaction. The corollary, namely that doctors, by and large, don't know about self-diagnostic competence and that they overwhelmingly dismiss women's testimony if offered, should be seen, however, not as due to individual doctors' ill will, or their misogyny or incompetence, but as the systematic outcome of the organization of medical interaction and of the structure of patient-doctor relationships. The medical view must be taken as literally a bona fide view. When doctors argue what every doctor knows, namely that in their offices and clinics women's opinions about their body states are unreliable and appear as wishful thinking, abstract fantasies, and so on, it must be recognized that they do argue in good faith.
It would be a mistake to construe this study as revealing what women "really" know about their own bodies. The true issue to which this study speaks has to do with the fact that knowledge, at least this kind of knowledge, is not a fixed and intrinsic attribute of persons, but is itself an interactional achievement that is produced under some kinds of conditions and not under others.

Fundamental to the question of why women's self-diagnostic competence does not appear in the clinical experience of physicians is the recognition that the conventional patient-doctor relationship is asymmetrical. That is to say, there is an unspoken and unwritten, but nevertheless interactionally acknowledged agreement between the parties to medical interactions that the physician, and not the patient, is the locus of authoritative knowledge regarding all issues defined as medical. This silent contract becomes visible in the fact that the physician expects to be, and is, treated as the person with the higher status, that both he and the patient consider his time more valuable than the patient's, and in the expectation on both sides that it will be the physician who will make and implement decisions regarding the patient's case. It is essential to recognize that the medical view is not singlehandedly imposed by the physician but is subscribed to by both parties. I have described in some detail the ways in which lay competence is interactionally produced (or, if you prefer, allowed to emerge) within the environment of a feminist clinic.

Medical diagnosis is equally collaboratively produced. Thus a potentially pregnant woman, appearing in a doctor's office, has strong expectations about what are possible answers to possible questions. Within a shared framework that locates authoritative knowledge not in her idiosyncratic and presumptive symptoms but in the physician's positive signs and procedure results, the absence of self-diagnostic competence is to be expected.

We are now in a position to bring into sharper focus the differences between the medical view of early pregnancy and the corresponding lay model, and to discuss the implications of these differences. Medical notions about women's self-knowledge are succinctly summarized in the following paragraph from *Williams Obstetrics*:
Psychologically, the pregnancy at this early stage [the first three months], possessing no objective tangible evidence of reality, is identified in the minds of these women as an abstract concept or fantasy, which, if pleasant, can be accepted, or if unpleasant, rejected and eliminated... (Hellman and Pritchard 1971: 821)

Since we have seen that in a nonmedical environment women’s appreciation of their pregnancy is in no way abstract or fantasy-like but, on the contrary, concretely specifiable in detailed ways, this view is no longer tenable without a specification of the context in which it holds. Furthermore, if we consider the status of this view as a pervasive working assumption in professional pregnancy diagnosis, we find ourselves in a position to see why and how the peculiar vagueness or plain lack of information about such things as kinds of early symptoms, the time of their appearance, their validity and so on, is produced.

The medical view presumes that access to information about physiological functioning is the physician’s privilege, but not the patient’s. Consequently, medical diagnosis is directly tied to the ways in which this access can be gained by a party who is not an immediate experiencer but a processor of information gained via secondary tests and procedures. It is a technical feature of these procedures that they are insensitive to very early state changes. If we consider, then, that the efficiency, accuracy, reliability, and so on of medical pregnancy diagnosis is inevitably limited by the constraints inherent in its method of collecting evidence, we begin to be able to see how medical knowledge about early pregnancy is so peculiarly deficient. Since they are unavailable via the tools of the trade, the changes of early pregnancy are necessarily invisible to physicians so that the textbook view and the physician’s experience are consistent and productive of each other.

If, on the other hand, women’s self-diagnostic competence is to be taken seriously, a number of important implications follow, which range from improvements in family planning programs to determining target areas for research on birth control methods, and from designing alternate (“nonmedical”) systems of health care delivery to providing the motivation for
very early prenatal counseling for women who want to carry a child to term. Clearly, demonstration of widespread self-diagnostic competence would provide the resources for justifying very early abortion on request, without requiring medical proof. Such a policy, at the same time, might prove beneficial for women who do not want to be pregnant, but have seriously ambivalent feelings about abortion.

From a larger perspective and considering the almost worldwide shortage of medical professionals and facilities, it becomes apparent that the reallocation of this specific diagnostic task to lay women in nonmedical environments would allow the use of scarce medical resources in more crucial areas. Moreover, self-diagnostic competence opens up the possibility of self-management of early unwanted pregnancy as a simple and natural extension of the notion of contraceptive responsibility. Technically, self-management may be feasible since early pregnancy does not necessarily require surgical intervention but can be probably dealt with by pharmacological methods. We know that women in many societies have traditionally taken herbal and mineral abortifacients and, though data are lacking, it is likely that the majority of these were employed early in pregnancy in contrast to later mechanical methods (Devereux 1976, Newman 1975, cf. Cosminsky n.d., Shattuck 1933: 64, 65). In this context it is relevant that feminist lay women have reported good results from the ingestion of massive doses of Vitamin C (6 g daily for 5 days) when taken during the two weeks following implantation. This information is anecdotal, with no scientific study of its efficacy or possible dangers. Unfortunately, very little is known about early methods, either anthropologically or medically, and biomedical research efforts in this direction may be appropriate.

To summarize, the study reported here was designed as endogenous research and took as its problem the question of whether women have access to the state of their body in a way that makes them competent to self-diagnose early pregnancy. Data were collected by interviewing women and examining medical charts in a “nonmedical” environment, a feminist-operated health center. It was found that lay competence in the
early diagnosis of pregnancy was massively present. Most importantly, of 28 women who had no objective evidence of pregnancy at the time of the interview, all but one were correct in their assessment of their state. The single exception was a woman who was undergoing hormone treatment for weight control. Almost half of the pregnant women reported that they knew of their pregnancy before they missed a period. An additional 44% knew before the time at which laboratory pregnancy tests begin to show results. It can be concluded that the women in this sample were able to make a diagnosis of pregnancy earlier and with greater accuracy than is possible in a physician's office.

As exploratory studies in a new field tend to do, this investigation has raised more questions than it has answered. Nevertheless, it is hoped that the research reported here will suggest a possible direction for revising current medical professional (and popular) thinking about early pregnancy, about the nature of women's knowledge of early pregnancy, and, in general, about women's awareness of state changes in the course of the female reproductive cycle.

Brigitte Jordan (Ph.D. UC Irvine) is a medical anthropologist in the departments of Anthropology and Community Medicine at Michigan State University. She has done fieldwork with Maya Indian women in Yucatan, Mexico, as well as in clinical settings in the U.S. and Europe. Her current research interests include the crosscultural study of childbirth practices, the use of video-graphic records in the analysis of social structure and social relationships, and the analysis of the "language" of advertising in popular magazines.
NOTES

1. The research on which this paper is based was done while I was a predoctoral fellow at the University of California at Irvine, supported by a Crosscultural Research and Training Fellowship from the U.S. Public Health Service. I am happy to acknowledge here the heavy contributions of criticism, advice, editorial improvements, and moral support of Henry Beck, Michael Burton, Benjamin Colby, Nancy Fuller, John Heiser, Sue-Ellen Jacobs, Jean Lave, Rosemary Mann, Lidia Rubinstein, and David Weinstein. I am grateful to Jane Wood for assistance with some of the interviews. My very special thanks, however, go to the client and staff women at the Feminist Women’s Health Centers in Los Angeles and Orange County, particularly Carol Downer, Lorraine Rothman, and Eleanor Snow, who wholeheartedly supported this study from its beginning.

2. In the interest of consistency, all references to duration of pregnancy in this paper are made in terms of “menstrual age,” i.e., counting from the first day of the woman’s last menstrual period (LMP). This is standard obstetric usage. Embryologists, on the other hand, frequently use “ovulation age” or “conception age.” Women in their talk tend to date a pregnancy from the time of intercourse. Since the most fertile time is at midcycle, a woman’s answer to the question: “How far along are you?” will differ from a physician’s answer to the question: “How far along is she?” by about two weeks. For many women there is something paradoxical about locating the beginning of their pregnancy two weeks before the sexual experience that led to it.

3. Recently, a radioreceptor assay test has been described which would allow very early detection of HCG production, possibly as early as one week after conception (Landesman and Saxena 1976). This test is based on utilizing the antibody to the beta-subunit of HCG which differs from the beta-subunit of LH; it is currently under investigation for potential marketing.

4. Derivatively, the pregnancy test figures also in the decision-making of the woman, as a perceived constraint on her options for action regarding the pregnancy. Cf. the comments of two women from the self-diagnosis study: “Within a week after I missed my period there was absolutely no doubt. But it was too soon for the test. I wanted to verify it, but I knew I was pregnant. You can’t tell people you are pregnant unless you have a test.” And: “I knew both times before I missed my period. The second time I had an IUD, and I thought I was crazy. You want the verification from the test, so you can act upon it. You can’t do anything until you have a positive test to go by.”

5. It may be relevant to the neglected study of the diffusion of innovations within the medical profession (Coleman et al. 1957, 1966) that all of the physicians questioned performed a classical D and C under general
anesthesia in a hospital, though the advantages of suction-abortion under local anesthesia have been demonstrated (e.g., Lewit 1972). In contrast to private physicians' practice, early termination with vacuum aspiration was, however, done at the local "County Hospital."

6. These formulations of the group's ideology are based primarily on promotional literature circulated by the FWHC, and on tape recordings taken during a week of residency in the Los Angeles FWHC in May 1973. During that time, I participated in day- and nighttime activities at the Center, including such events as staff meetings, pregnancy screening, Self-Help groups, and the abortion clinic. Recording was done with the knowledge and informed consent of everybody present.

7. I am avoiding here, self-consciously and somewhat awkwardly, the term "patient" because of its connotations. "Patient" implies, first of all, that the person is a (potential) carrier of disease; and secondly, it calls up its complement, the physician, thus implying a hierarchical patient-doctor relationship. As will become clear below, women coming to the Center are in no way treated as patients in that sense. Unfortunately, the English language has no appropriate alternate term at this time. In this context it may be instructive to note the etymology of "patient." The term is derived from the present participle of the Latin "pati" (to suffer); in other words, a patient is someone who is suffering. The word "passive" has the same root, being derived from the past participle of "pati," so that its meaning is "someone who has suffered."

8. Reciprocal first name use is a powerful equalizer. Interestingly, at least one doctor objected at length to that policy, arguing that if there were an emergency and the woman would have to call his office, his office staff would not know who she was talking about. Presumably, he was not suggesting that his receptionist did not know his first name, but rather was referring to the possibility that his staff might not be able to read as "a medical case" a caller who referred to him by his first name.

9. The physician will be called on using too large an instrument, for example, or for performing the procedure too hurriedly or too slowly. (In general, the less the cervix is dilated and the smaller the cannula—the instrument used for suctioning out the contents of the uterus—the less discomfort the woman will experience. At the same time, greater dilatation and a larger cannula make the doctor's job easier, so that there is a natural tendency towards using larger instruments.) When an expert assistant notices that the doctor is asking for what seems like too large an instrument for the size and condition of the uterus, she will typically say, "Did you really want an eight, Jonathan?" The doctor, knowing that his judgment has been questioned, will reevaluate his decision, sometimes insisting on the original size, but frequently responding with something like: "Well, let's try a seven."

10. One woman claimed to know from which side each of her pregnancies had resulted. Parenthetically, I want to register here, as a self-con-
scious comment on the problems encountered in reporting this kind of data, that there is a constant temptation to leave out responses that are "too far out." Typically, those uncomfortable responses are the ones that do not correspond to medical opinion. One woman reported, for example, that she can always tell when she ovulates because she wakes up with fever blisters in her mouth the next morning. A physician, to whom I mentioned this, thought that "it must be in her mind. She's heard that your temperature goes up when you ovulate." The temptation, then, is to report on the medically recognized Mittelschmerz phenomenon and leave out the embarrassing fever blisters.

11. For a detailed description of the Medical Weight Control Clinic phenomenon and a description of the effects of HCG injections on some of the women who appeared at the clinic, see Jordan, 1975: Part 1. Appendix.
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