

Catching Babies: The Politics of Midwifery in
Documentary Birth Narratives

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Abstract

The Politics of Midwifery in Documentary Birth Narratives

Culture is a salient factor in a woman's experience of pregnancy and childbirth. Expectations of a hospital birth, continuous electronic fetal monitoring, epidurals, and ultrasounds (among other "normal" maternity care practices) are deeply tied to the American master narrative of childbirth.

Midwifery practices in different spaces—home, birth center, and hospital—are interrupting the trajectory of medicalized childbirth. Today, the profession of midwifery involves many different groups of practitioners working toward a common goal of providing woman-centered care. Midwives believe in the innate ability of women's bodies to give birth. They see birth as a safe, physiological process. They safely monitor their patients without pathologizing the process.

I have focused on American documentaries about midwives and childbirth, looking specifically at how the history and culture of birth has been represented in different spaces from World War II to the present. How do they construct knowledge and authority within different birth spaces, and how does that affect the social statuses of the midwives, of the mothers? How do race and class and privilege operate in terms of access to care? And how are documentary films shaping the collective imagination of birth and midwifery in the United States?

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Introduction

In the United States there is a typical idea about when, where, and how the contemporary American woman gives birth. Excited and intentionally pregnant, she and her husband visit their obstetrician, anticipating the moment they can see a little heartbeat on an ultrasound. Nine months go by, and mom is suddenly in labor! Her water breaks at the most inconvenient time—perhaps while they're out for dinner—and hubby has to rush her to the hospital! Upon arrival mom is wheeled onto the labor and delivery floor, screaming at the nurses, begging for an epidural. Once admitted, she is hooked up to fluids and an electronic fetal monitor (EFM). She is given an epidural to numb the unbearable pain. If all goes according to plan, the next image we see is of mom lying flat on her back in a hospital bed, screaming, grimacing, holding the hand of her husband while a few nurses hold her legs back and count to ten, encouraging her to push, push, push. The baby is born into the doctor's arms and is whisked away to be cleaned weighed, assessed, tested, and clothed before returning in a neatly swaddled package to an exhausted but happy mom.

This the story we are told about childbirth in the United States, the “master narrative,” that teaches us norms and values, expectations and ideals. It trains us not to question the status quo, and it makes encultured experiences seem natural. If most American women have

never seen a live birth until they experience it themselves, where does this master narrative originate? It is not coming from a single source, but is woven into the social fabric of how we view gender, motherhood, health, and bodies.

This narrative assumes that the birthing mother is heterosexual, educated, and middle class.¹ She is cisgender, white, married, and she is a legal citizen of the United States. All of these privileges grant her access to privatized healthcare. She can reproduce and raise a family, attended by all of the comforts of modern science. These discourses present in the master narrative underlie media representations of childbirth. Hollywood movies such as *Sex and the City: The Movie* (2008) show fantastical shots of Charlotte's water breaking over brunch and her friends rushing her to the hospital, fearing that she'll deliver

¹ I have chosen to use the words "mother," "mom," and "mama" in this project to refer to a spectrum of identities. In the midwifery community, it is often a term used even before the baby is born. While this may not be appropriate in the prenatal period for those not wishing to carry the pregnancy to term or raise the baby in their own families, this is not the case for the parents in the films that are being discussed. I have used the word "mother" in place of "patient" which is often used by technocratic practices, and "client" a term sometimes utilized by homebirth midwives—both terms are attached to capitalist power structures. Throughout the project "patient" and "client" are only used when the films or literature set the precedent. "Mother" can also be alienating to parents who identify as gender queer or trans*. While I am not aiming to marginalize, I have chosen to retain the language as a way to honor the gendered and undervalued work of mothering.

the baby in a taxicab.² Movies like this dramatize birth, but reality television programs show “real” depictions of pregnancy and childbirth. Shows such as *One Born Every Minute* (2011) and *A Birth Story* (2009) allow the audience to watch “average” American women give birth.³ Primarily filmed in hospitals, both of these programs allow for direct viewing and internalization of the master narrative. While these television shows offer entry into birthing spaces that would otherwise be inaccessible to the public, Elizabeth Rink at the University of Michigan found that showing college students an episode of *A Baby Story* reinforced their fears about childbirth.⁴ As easily accessible sources of information about pregnancy and birth, these media representations are central to shaping the master narrative.

Robbie Davis-Floyd is an anthropologist and a prominent voice in midwifery activism, and her 1992 book *Birth as an American Rite of Passage* theorized the systems under which American women are birthing. Her work continues to be foundational to understanding the

² Michael Parker King, *Sex and the City: The Movie*, Videorecording (2008; Los Angeles, CA: New Line Cinema, 2008), Web.

³ *One Born Every Minute*, Lifetime, Videorecording (2011; New York: A&E Network, 2012) Web; *A Baby Story*, The Learning Channel, Videorecording (1998; Santa Monica: Genius Entertainment, 2009), Web.

⁴ Lauren Elizabeth Rink, “Even More Scared’: The Effects of Childbirth Reality Shows on Young Women’s Perceptions of Birth,” Undergraduate Thesis (Ann Arbor: University of Michigan, 2012).

current state of maternity care in the United States. Davis-Floyd asserts that culture is a salient factor in a woman's experience of pregnancy and childbirth, and that the expectations of hospital birth, prenatal vitamins, and ultrasounds (among other "normal" maternity care practices) are deeply tied to the contemporary American lifestyle.⁵ Through exploring the prevalent culture of childbirth in the United States, we can better understand the specificities of childbirth in different spaces. Much of Davis-Floyd's work on American birth experiences has focused on defining two models of health care, and specifically, maternity care. She has termed this master narrative of childbirth "technocratic," revolving around the notion that "If you can do it with technology, you must and will do it with technology."⁶ This mentality has spread into every fiber of American society. We value information above all else, and the use of the external fetal monitor (EFM) in childbirth is testament to that. The EFM is a routine part of many hospital births. It is a monitor placed on the mother's belly when she is admitted, and it tracks the length and strength of her contractions as well as the baby's heart rate. While some newer EFM models are wireless, many still require the mother to stay in bed during labor, inhibiting her ability to cope with contractions through

⁵ Robbie Davis-Floyd, *Birth as an American Rite of Passage* (Berkeley: University of California Press, 1992).

⁶ Robbie Davis-Floyd, "Birth Across Cultures: An Evolutionary Perspective" (presentation, Hampshire College, Amherst, MA, September 23, 2014).

movement and positioning. Now that the baby can be monitored continuously, random decelerations in the fetal heart rate—that may be perfectly normal and would not have been picked up on previously—are cause for emergency Cesarean sections, or surgical deliveries.⁷ This is just one example of technocratic childbirth and the ways in which the value placed on technology and information have had arguably detrimental effects for birthing mothers.

But what about those who reject the technocracy? What is their story in the fabric of American society? Davis-Floyd contrasts this technocratic model of childbirth with a deeply wholistic model that values collaboration of body, mind, and spirit: “Under this wholistic model, the needs of the mother and baby are complementary: there will be no conflict for example between the emotional need of the mother for a self-empowering home birth, and the safety of the child.”⁸ This model is one in which the family is a “significant social unit” and the mother accepts responsibility for her informed choices. The

⁷ Leah L. Albers, “Monitoring the Fetus in Labor: Evidence to Support the Methods,” *Journal of Midwifery and Women’s Health* 46, no. 6 (2001): 366-373; Kate Pateman, Asma Khalil, and Patrick O’Brian, “Electronic Fetal Heart Rate Monitoring: Help or Hindrance?” *British Journal of Midwifery* 16, no. 7 (2008): 454-457.

⁸ Davis-Floyd, *Birth as an American Rite of Passage*, 157; Davis-Floyd makes a conscious decision to spell this model of care “wholistic” instead of the traditional “holistic,” as this is referer to the “whole” person. I have chosen to adopt this same spelling throughout my project.

institution, the care provider, and the space are there to serve mom and baby, to protect the safety of birth.⁹

These two models are at the center of Davis-Floyd's work. Her interviews with first time mothers who gave birth in the hospital explore the ways in which the rituals of hospital birth act as rites of passage, initiating women into a patriarchal and technocratic dependence on hospitals and medicine. Davis-Floyd was surprised at how many women were at peace with their hospital birth experiences. Many of these mothers went in *wanting* highly medicalized births; other women did not, but felt that being in the hospital had saved their or their baby's life. Davis-Floyd explains the discrepancy between those who were satisfied versus unsatisfied with their hospital births by the clashing or meshing of their deeply held personal beliefs with those of the technocratic model. She argues that those women who were satisfied with their experiences were truly comfortable with technology and fully ascribe to a technocratic society. It is those who experience hospital births as disempowering that hold counter culture beliefs—whether or not they acknowledge them. As Davis-Floyd followed up with mothers who chose home birth for their next pregnancies, she found that many used their birth experiences as transitions into a different kind of political life. Making the decision to give birth at home opened up opportunities for other radical political

⁹ Ibid., 156-157.

choices that were better aligned with their deeply-held beliefs about the world.¹⁰

Davis-Floyd identifies a third group of people who chose to have hospital births, but did not internalize the messages that the technocratic rituals generally reinforce. They managed to “maintain conceptual distance between themselves and [the] procedures.”¹¹ It is these women who used the technology to their advantage instead of having their choices limited by strict adherence to the technological paradigm. However, these subversive examples are not possible unless physicians (or midwives practicing in the hospital) are willing to shed the beliefs that were drilled into them in their own rites of passage of medical school and residency in which a central objective is “the practitioner’s systematic objectification and mechanization of, and alienation from, the patient.”¹² It is practitioners who are willing to combine the technocratic and wholistic models of childbirth, letting the technology serve the women—not the other way around—who will

¹⁰ Ibid., 206.

¹¹ Ibid., 208.

¹² Ibid., 253. Although out of the scope of this project, expanding the conversation regarding the importance of rites of passage is key to understanding contemporary midwifery. Mothers are making significant decisions to reject the technocratic rite of passage when they choose midwifery care. And midwives and physicians are making decisions that subvert their own rites of passage when they choose to collaborate with one another and blend their practice models. This should be explored further in a different project. For more on medical education as a rite of passage see Davis-Floyd, *Birth as an American Rite of Passage*, 252-280.

work to change the systems in hospital birth to value the experiences of mothers and families over the importance of technology and information.¹³

Davis-Floyd identifies midwives in the United States as practitioners who can move the norms of birth in this country towards a more wholistic model. However, this can be difficult in a society where most women have not even considered using a midwife. In the United States in 2004, 0.56% of babies were born at home; this number has been increasing steadily since then, and was at 0.89% in 2012.¹⁴ Though still a small number of births, this increase has led to a fair amount of national attention surrounding homebirth through news outlets such as the *New York Times* and less formally on blogs dedicated to pregnancy, childbirth, and motherhood.¹⁵ This certainly creates a counter-narrative to the technocracy, but the image of midwifery and homebirth is often just as unrealistic and stereotypical as the master narrative.

¹³ Ibid., 277.

¹⁴ Marian MacDorman, et al., "Trends in Out-of-Hospital Birth in the United States, 1990-2012," *National Center for Health Statistics Data Brief*, no. 144, PDF file, 2014.

¹⁵ Examples include: Nicholas Bakalar, "Hospitals Safer than Homes for Births," *The New York Times*, April 8, 2014, Web; Randi H. Epstein, "The Lore of Labor," *The New York Times*, February 15, 2014, Web; Danielle Pergament, "The Midwife as Status Symbol," *The New York Times*, June 15, 2012, Web; Amy Tuteur, www.hurtbyhomebirth.blogspot.com (blog), accessed February 13, 2015. Web; and January Harshe, www.birthwithoutfearblog.com (blog), accessed February 13, 2015.

Persistent myths about midwives in the United States are rooted in oral traditions, evoking images of an older, uneducated folksy woman, but the “new midwifery”—as it is being referred to in Canada—is about more than catching babies.¹⁶ It “is about making a unique model of low intervention, woman-centered maternity care work in a practice with other midwives and in a larger network of trained professionals and public health services.”¹⁷ Midwifery draws on modern technologies to support the body’s natural ability to give birth. It doesn’t ignore the use of technology to save lives, but it utilizes it only when necessary. Because of this low-intervention model, midwifery is a more cost-effective form of maternity care. However, midwives are market competition for obstetricians, who hold memberships in large, well-funded interest groups and who also hold many of the leadership positions on hospital boards. Often, obstetricians opposed to midwifery care can make it difficult for midwives to practice if their presence is threatening the obstetric business model.¹⁸ The significance of the midwife is absent in the

¹⁶ Margaret MacDonald, “Tradition as a Political Symbol in the New Midwifery in Canada,” *Reconceiving Midwifery*, ed. Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd (Montreal: McGill-Queen’s University Press, 2004), 59.

¹⁷ *Ibid.*

¹⁸ Here, it is important to note that physicians and midwives are, of course, individuals. The binary between obstetrics and midwifery that is explored in this project and other critiques of the maternal health care system are not a judgment of the quality or character of physicians and midwives; there are technocratic midwives

master narrative as a result of technology and profit-driven processes in and around childbirth; we must delve into the history of childbirth in this country in order to better understand why.¹⁹

Richard and Dorothy Wertz's *Lying-In: A History of Childbirth in America* (1977) discusses the complexity of the transition from colonial midwifery to our modern physician-managed hospital births. During colonial America there was a significant transition from social childbirth—the involvement of female relatives and friends in the labor, delivery, and postpartum period of a community member's birth—to birth as a solitary, nuclear family experience. Social childbirth, along with the use of midwives, was gradually phased out as physician attended births became more common. In the late 1700s, some American physicians were interested in assigning uncomplicated births to licensed midwives while doctors would handle only more complicated cases, as was the model in Europe. New medical schools in the United States offering midwifery classes would allow women to enroll, but unlike in Europe, medical and midwifery education was not subsidized. Women in the 1700s had neither the social nor the

and wholistic obstetricians. This is, instead, an exploration of the differences in the philosophy and training characteristic of the overall professions, and their influences on the maternal healthcare system and mothers seeking care.

¹⁹ The specific details of this history of midwifery practice are incredibly location-specific, differing drastically by state and community. This is a general history intended to lay the foundation for thinking about the significance of these documentary films discussed here.

economic capital to enroll in these classes and so midwifery became just another specialty for a male physician. The schools collected tuition from men who could afford it and graduated physicians who saw midwives as business competition.²⁰ Soon, obstetrics became a vital part of a general practice for an American physician because the doctor who delivered a woman's first child often remained the family physician.²¹

Though early American midwives were not pushing for increased education and licensure for their practices, physicians, nevertheless, saw them as business competition. By 1900 about half of American women were attended by a doctor at birth, and women who could not afford the services of a doctor were taken care of by midwives.²² In *Midwifery and Childbirth in America* (1997) Judith Rooks notes, "It has been argued that the indifference to regulating midwives reflected lack of concern for their clientele: predominantly poor, immigrant, or Negro woman and their families."²³ By the 1940s almost all women in urban areas were giving birth in the hospital, and even rural women had increased access to hospital birth with the

²⁰ Richard Wertz and Dorothy Wertz, *Lying-In: A History of Childbirth in America* (London: Collier Macmillan Publishers, 1977), 1-28.

²¹ Judith Rooks, *Midwifery and Childbirth in America* (Philadelphia: Temple University Press, 1997), 21.

²² *Ibid.*, 22.

²³ *Ibid.*, 21.

popularization of the automobile. Though hospital births were not producing better outcomes for mothers and babies, shifting American values and ideals of modernity, along with increased access to anesthetics, kept birthing women returning.²⁴ Wertz and Wertz contend, "It became unthinkable that a woman could both give birth and attend birth. Giving birth was the quintessential feminine act; attending birth was a fundamental expression of the controlling and performing actions suitable only for men."²⁵ In reality, up until the twentieth century maternal and child health in the United States was suffering. Neither midwives nor doctors had the tools and knowledge that we do today to prevent many deaths of mothers and infants. However, physicians had an air of authority and modernity that midwives did not. Most maternal deaths were related to postpartum infection, and this was more common in hospitals before the spread of germ theory, hand washing, and septic technique because doctors would go from woman to woman, sick patient to healthy laboring mom spreading infection along the way. All the while midwives were generally only taking care of one woman at a time in the comfort of their own homes where the mothers were already familiar and immune to the germs that were present.²⁶

²⁴ Wertz and Wertz, 133-177.

²⁵ *Ibid.*, 59.

²⁶ Rooks, 23.

Though practicing midwives dwindled to some northern rural immigrant midwives and black Granny Midwives in the American South, physicians drew negative attention to midwifery practices in the early twentieth century. Because they were women and members of disempowered social groups, midwives could not yield any power against obstetricians who “felt that their specialty would never gain respect as long as women without scientific training were allowed to deliver babies.”²⁷ This increasing attitude of competition fueled smear campaigns and slander against the remaining practicing midwives:

Private and academic physicians publicly attacked the reputations of midwives as a group, characterizing them as being poor, black, immigrants, dirty, illiterate, untrained, ignorant, immoral, drunken, unprincipled, overconfident, superstitious, callous, rough, “relics of barbarism,” and, in some cases, criminal abortionists.²⁸

Physicians’ efforts were rewarded as “the proportion of U.S. births attended by midwives declined from about 50 percent in 1900 to 12.5 percent in 1935.”²⁹

Another factor that contributed to this decline was the increased use of anesthetics. While fighting for the right to vote, “the burgeoning feminist movement sought to banish the suffering of

²⁷ Ibid., 24.

²⁸ Ibid., 25; The specifics of the history of black midwives in the South will be explored further in Chapter 1 of this project.

²⁹ Ibid., 30.

childbirth once and for all.”³⁰ Attempting to escape the notion of biology as fate as well as their social roles as mothers, upper-class women fought for the drug scopolamine combined with morphine, better known as Twilight Sleep, to be available for all birthing mothers in the hospital. Twilight sleep caused a laboring mother “to fall into a semiconscious state and emerge hours later with a baby in her arms, remembering nothing that happened in between. In truth, she’d feel pain; she just would not remember it.”³¹ Thus, Twilight Sleep was not truly an anesthetic (it did not cause one to lose consciousness) nor an analgesic (it did not take away pain). The drug also caused many women to become “highly excited” and even to hallucinate.³² Women would scream, cry, and thrash about, and the hospitals’ response to this was to gag the mothers, put them in straight jackets, and tie their arms and legs to the bed. However, the women had no remembrance of these adverse side effects. This was a dark period in the history of American childbirth. However, some hospitals maintained regular use of Scopolamine into the 1970s when many women began to reject this forced alienation from the experience of birth, seeking doctors who

³⁰ Tina Cassidy, *Birth: The Surprising History of How We are Born*, (New York: Atlantic Monthly Press, 2006), 91.

³¹ *Ibid.*

³² *Ibid.*, 92.

were uncomfortable with these practices and willing to let the women labor naturally.³³

In the 1960s the political climate provided a perfect set of circumstances for the revitalization of midwifery.³⁴ Social childbirth experiences regained popularity as communities of women began to reclaim authority over their own births, wanting to feel the sensations associated with labor and delivery. Renewed interest in midwifery has steadily increased since the mid twentieth century.³⁵ Experiencing birth as a community (that was larger than a nuclear family) provided early American women an opportunity for solidarity, and it serves a similar social function for those involved today.

The constant transfer and negotiation of authority within birth spaces illustrates the importance of the power that lies in the knowledge of women's bodies and childbirth. It is dangerously threatening to our patriarchal and capitalist society for groups of women to collect, share, and enact such knowledge. In doing so, the social importance of the rational individual consumer is interrupted by a group of women collectively sharing in their own bodily experiences. It is this shift back to the popularization of homebirth and reclamation

³³ Ibid., 91-94.

³⁴ Wertz and Wertz, 195.

³⁵ I will explore the history and significance of this in Chapters 2 and 3.

of social childbirth experiences—this interruption of the master narrative of childbirth—that is of importance to this project.

Today, the profession of midwifery involves many different groups of practitioners working toward a common goal of providing woman-centered care. Midwives believe in the innate ability of women's bodies to give birth. They see birth as a safe, physiological process that almost always results in a healthy mom and baby. They safely monitor their patients without pathologizing the process. This is the work that midwives do in relation to birth, but many midwives' practices also involve well-woman care, birth control consultations, and abortion care. While the camaraderie of a common midwifery profession is present, there are political differences within the community that have led to disagreements about education and licensing for midwives. These disagreements and inconsistencies within the broader profession have resulted in multiple certification options, each with differing legal status across the 50 states. I do believe that all midwives have enough in common to be able to productively talk about midwifery work as a whole. However, when discussing the politics of licensure, scopes of practice, and authoritative influence, the specificities and differences between midwives must be situated.³⁶

³⁶ Though doulas are not a part of this project, it is vital to note the difference between the role of the doula and that of a midwife. Unlike midwives, doulas do not provide any medical care. They are

Many midwives dispute that “profession” is an accurate descriptor for midwifery. Is midwifery a spiritual calling? A life’s work? Every midwife I have spoken to has articulated a deeper connection to the work, as it is a central part of their identity. However, this insistence on simultaneous professionalism and spirituality does not situate midwives comfortably within the American capitalist scheme. Within these constraints, it is difficult to have both recognition of medical legitimacy and acceptance of the intuitive nature of the profession. With these tensions in mind for the remainder of the project, I will explore the ways in which systems of power are operating on and within the midwifery community.

This is only a glimpse at the political history necessary to understand why birth spaces are so important to midwives and mothers. Ideas and beliefs regarding what makes a safe space for birthing women have shifted over time, and we are at a critical

physical and emotional labor support for the mom and family. Doulas are usually compensated privately, though some insurance companies do cover doula services and some doulas work on a volunteer basis. Doulas are also not a regulated profession—though there are a few training organizations, anyone may call herself a doula regardless of certification or experience. Another correlation exists between the professionalization of midwifery and the use of doulas—as midwives have gained legitimization and access to practices outside of the home, the use of doulas has increased. Homebirth midwives with small practices who are on call for all of their clients’ births have the ability to provide time and energy for full labor support. But midwives working in more professionalized settings often share call and have multiple patients in labor at a given time—here, the use of doulas has increased as a way for a mother to have continuous labor support that a midwife may not have the flexibility to provide.

moment in history. Both radical and cultural feminisms have argued that in order for women to take back control of their bodies, freedom in childbirth is a necessary step.³⁷ Women function in mainstream society under patriarchal pressures that greatly influence their decision-making. Choices are important, and the midwifery model of care highlights this by teaching mothers and helping them make informed and empowering decisions for their families. Contradictions between societal pressures and what may be best for a specific woman creates room for feminist dialogue and interruption of the master narrative surrounding childbirth.

This project explores the representation of the uprising and creation of a new midwifery profession in the United States over the past sixty-five years from post World War II to the present day by analyzing five documentary films with the intention of telling a story about the importance of midwives in the United States, the relationships possible between midwives and mothers in different spaces, and the political and social role of midwives. Through close readings of these films and their significance in the political history of American midwifery, I will explore how relationships between midwives and mothers are represented and manipulated. These documentaries are artifacts of the relationships possible between mothers and midwives in different spaces. Births and relationships

³⁷ Judith Lorber, *Gender Inequality* (New York: Oxford University Press, 2012), 139; 175.

between participants are represented differently at home, in hospitals, and in birth centers.³⁸

In discussing these films I will also consider: the intended audience, the producers, and the subject of the film.³⁹ Some of these documentaries choose to expose the camera and tell a story about the filmmaker, creating an authorial point of view that differs from what one may see in a major motion picture. Some films I've considered serve very obvious purposes, but others are more ambiguous. Many of these filmmakers seem to be participating in a feminist project, questioning how spaces of birth have been traditionally represented through the male gaze. In contrast, their films rely on the authority of mothers and midwives to tell their stories. Most of the filmmakers are mothers, many of whom were drawn to produce these documentaries after positive experiences with midwives. Many of the behind-the-

³⁸ Is there a narrative and ritual structure to birth? If there is, perhaps documentaries give back an authoritative voice to women's experiences that are diminished in the master narrative. For more on ritual structure of birth see: Davis-Floyd, *Birth as An American Rite of Passage*.

³⁹ Though not considered in this project, exploring the relationships between time, space, and representation in documentaries about childbirth is critical. The time-space experience of birth is subject to the politics of the space in which it takes place. A two-hour documentary cannot possibly represent the full experience of labor and delivery for mother, midwife, or baby. Documentary filmmakers must cut and edit their footage in order to create an impressionistic experience for the viewer. This can have the effect of making one feel like they were there in the room, but the decisions to keep or to scrap certain shots or sounds inherently create an artificial experience of reality. This should be explored further in a different project.

scenes technicians are also women. For these filmmakers, the project becomes like their baby—as artists, they give birth to their film.

Chapter 1 will include a discussion of George C. Stoney's 1953 film *All My Babies: A Midwife's Own Story*, depicting the work of a black midwife in Georgia named Miss Mary. Intended as a training film for Granny Midwives, this historical document is a snapshot of a version of the profession that is now extinct. As a collaboration between Stoney, the Georgia Department of Health, and the midwives, themselves, this film challenges ideas about authorship and authority, making room for discussions of the politics of race and difference that have greatly shaped who has access to midwifery, to certain birth spaces, and, in particular, to certain forms of maternity healthcare services.⁴⁰

Chapter 2 will focus on the reemergence and regeneration of the midwifery profession starting in the 1960s. *Birth Story: Ina May Gaskin and the Farm Midwives* is a 2012 film depicting the life and work of midwife Ina May Gaskin, who is considered to be the mother of modern American midwifery. Her story of a particular moment in history has greatly shaped access to homebirth for women today, and led the way to a revitalized popularity of midwifery.⁴¹ Through

⁴⁰ George C. Stoney, *All My Babies: A Midwife's Own Story*, Videorecording, 1952 (San Francisco: Kanopy Streaming, 2014), Web.

⁴¹ My use of last names and first names when referring to midwives and scholars in this project is inconsistent. Many

interviews with Ina May and The Farm midwives and archival films of birth the viewer has access to a world in which the voices and experiences of women actually shape the culture of birth.⁴²

One of the most well-known documentaries about childbirth, Ricki Lake's 2007 film *The Business of Being Born* presents information about the workings of the hospital-based maternal healthcare system by illustrating facts and figures and constructing an image of what exactly happens when you have a baby in the hospital. The film also invites its audience into people's lives through the work of a homebirth midwife in New York City. This documentary provides the tools for a contemporary, American viewer to question what she thinks she knows about the business of birth.⁴³

Birth Story and *The Business of Being Born* offer a framework for understanding the trajectory of the midwifery profession in the late

midwives—even those practicing in hospital settings—choose to use their first names when interacting with mothers. Introducing myself as “Mary Alice” creates a vastly different professional dynamic than telling you my name is “Dr. Martin.” Therefore, I have decided to honor this in my writing as a reflection of the collaborative nature of the profession. Midwives, practitioners, interviewees, and filmmakers who choose to use their first names in professional writing and film will be referred to as such throughout the project. All others will be referred to using last names.

⁴² Sara Lamm and Mary Wigmore, *Birth Story: Ina May Gaskin and the Farm Midwives*, Videorecording (2012; New York: On and Beyond, 2012), Web.

⁴³ Abbey Epstein and Ricki Lake, *The Business of Being Born*, Videorecording (2007; Burbank, CA: New Line Home Entertainment, 2008), Web.

twentieth century and challenge us to think about who has access to homebirth, who is creating and perpetuating knowledge about birth, and who holds the authority and expertise about midwifery and childbirth.

Chapter 3 will take us into shared technocratic and wholistic birth spaces that midwives and mothers in the United States are accessing. Brigid Maher's 2015 documentary *The Mama Sherpas* follows three different hospital-based nurse-midwifery practices, challenging assumptions and stereotypes about the kind of work that midwives do. Here we will explore the kinds of practices that are available in different spaces and under the governing bodies of hospitals. Though midwives are trained as "experts in normal," how is their work in hospitals challenging and expanding the scope of their practices?⁴⁴ This film will also offer an opportunity to discuss the creation and history of nurse-midwifery practice in the United States.

Finally, we will look at a 2009 film, *Natural Born Babies: A Modern Birth Story*, produced by a homebirth midwife and birth center owner in Southern California. *Natural Born Babies* also attempts to challenge assumptions and stereotypes about the kind of work that midwives do. With a focus on "modern" natural birth, the film constructs the viewer as a critical and rational consumer of midwifery

⁴⁴ Brigid Maher, *The Mama Sherpas*, Videorecording, Work in progress, Web, 2014.

services.⁴⁵ Together, these two films will open a discussion about the future of midwifery. Where is it going? What choices are becoming available, and to whom?

This project will explore the social statuses of midwives and of mothers. Specifically, using documentary films, I will investigate how status—assigned through race, class, and privilege—has shaped access to maternity care in the United States from post World War II to the present. Documentary films give narrative structure to these components, and can act as counter narratives in shaping the collective imagination of birth and midwifery care in the United States.

⁴⁵ Lori Walker, Devan McLeroy, and Kip Hewitt, *Natural Born Babies: A Modern Birth Story*, Videorecording (2009; Venice, CA: TMW Media Group, 2009), Web.

Chapter 1

All My Babies and Contemporary Discourses of Race in Midwifery.

“Granny Midwives” or “Grannies” are the terms frequently used to describe the Southern, African American midwives of the 20th century. Grannies of the South and immigrant midwives of the North continued to deliver babies in poor and rural communities long after white, affluent, urban women had transitioned to hospitals by the 1940s. There were not enough doctors to reach all of the women in need, so midwives were legally permitted to practice in order to fill the gaps. Despite this recognized need for midwives, they were generally unsupported by the health care system, and seen as a necessary evil until doctors could service all women. Midwives worked in the transitional time between an era of community childbirth and the almost total elimination of traditional midwives in the mid twentieth century. Black midwives in the South were also supported in an effort to keep black women out of the hospitals. By allowing legal practice of black midwives, segregation of hospitals was enforced.⁴⁶

Though conversations of race and inequality are largely absent in the midwifery community, there has been focused attention on the stories of Granny Midwives. In “Downplaying Difference: Historical Accounts of African American Midwives and Contemporary Struggles

36. Wertz and Wertz, 133-177.

for Midwifery” Christa Craven and her former student Mara Glatzel explore the:

tendency among contemporary proponents of midwifery to equate the history of African American midwives—who were largely eliminated by the late-twentieth century through racist healthcare initiatives—with the contemporary struggles of primarily white, middle-class midwives and mothers seeking homebirths.⁴⁷

Midwives and academics interested in the expansion of the midwifery profession in the 1980s and 1990s set out to record the stories of Granny Midwives in an effort to document their work and their unique contribution to the history of midwifery in the United States, as well as to rally support for the current midwifery movement.⁴⁸ Craven and Glatzel criticize the tendency to think of American midwifery as a sisterhood, arguing that doing so erases histories of inequality instead of creating a better understanding of the historical reality of midwifery in the United States.⁴⁹ They contend that “downplaying the racial privilege of white midwives . . . in African American midwives’

⁴⁷ Christa Craven and Mara Glatzel, “Downplaying Difference: Historical Accounts of African American Midwives and Contemporary Struggles for Midwifery,” *Feminist Studies* 36, no. 2 (2010): 330.

⁴⁸ *Ibid.*, 330.

⁴⁹ The idea of sisterhood is complex. Who is using it, and to what purposes? Craven and Glatzel criticize the notion of midwifery as a sisterhood as it homogenizes the experiences of midwives across race, class, and identity lines, privileging some midwives’ stories over those of others. But I do believe there is value in discussing the midwifery profession as a collective of practitioners coming from diverse experiences, and working towards shared goals without dismissing the systems of inequality that have shaped these diverse practices.

narratives has problematic implications for the contemporary midwifery movement that prides itself on inclusivity and benefit to all women."⁵⁰ By lumping together the struggles of midwives in different class and race strata we are homogenizing stories that deserve to be told in all their complexity.

All My Babies: A Midwife's Own Story

George C. Stoney, a white filmmaker from North Carolina, spent his childhood in the 1920s watching the black midwives in his town walk to and from births where they attended to the women in their segregated community. As a young adult he began giving them rides, and as he learned more about their lives and professions he became determined to make a film about them. In 1951 he had finally secured enough funding to begin the filming of *All My Babies*. The documentary film was commissioned and mostly funded by the Georgia Health Department as a training video for black midwives. An all-white production crew filmed the documentary in just under a year, completing production in 1952.⁵¹

All My Babies follows the work of Mary Coley, a respected community midwife. We watch Mary as she attends trainings with other community midwives, conducts prenatal appointments, and is

⁵⁰ Craven and Glatzel, 332.

⁵¹ Lynne Jackson, "The Production of George C. Stoney's Film *All My Babies: A Midwife's Own Story* (1952)," *Film History* 1, no. 4 (1987): 367.

called to care for the women of her community during labor and childbirth. The 54 minute black and white film documents two women's births. This film participates in creating stereotypes for black womanhood. Ida is the ideal mother: clean, responsible, quiet. She and her husband attend all of their prenatal appointments. Ida is a docile, black mother. Maybell is her antithesis. In the racist rhetoric of the film she is constructed as poor, dirty, and negligent. She is new to town, in poor health, and is a wild, undisciplined body.

The scene of Ida's birth begins with a shot of a clock, telling us that it is 3pm. Midwife Mary is getting everything set up for the birth, making sure all of her tools and linens are in order. Though Ida is in labor, the scene is silent, giving the audience reprieve from the white, male narration that is present for much of the film. All ambient noise is absent, and we watch Mary cleanse herself before the birth, communicating to the intended audience of Southern, black midwives messages of cleanliness, passivity, and discipline.

A full minute of the scene alternates between close-up shots of Mary scrubbing her hands, her face intensely focused, and inanimate objects that have been prepared for the birth. All the while the audience begins to hear a loud, presumably artificial, scrubbing noise. If the sound had been recorded along with the images one may have heard Ida laboring in the background. Perhaps Mary would have been talking her through contractions, but instead the editing of the film silences both mother and midwife, emphasizing the utmost

importance of the midwife's sterile preparation. As this film was intended to be a training video, the sterile techniques shown are valued above the midwife's relationship with the mother.

After cleaning herself, Mary moves on to clean Ida. Here we have another succession of alternating shots: a close-up of Mary's hand wiping clean gauze against a bar of soap, Mary from the waist up standing over Ida's legs and belly, and a shot that is right between Ida's legs. In this last shot all we see are Ida's legs spread and Mary's hands doing the cleaning work. These shots are silent. We never see Ida's face, and we certainly do not hear her, though she is still laboring and is approaching the pushing stage. Her character and personhood are disconnected from her body. Was this decision meant to protect her privacy or deprive her of it? Peaslee Bond, the credited cinematographer, and his assistant were in the room during a very intimate moment in this woman's life, and we do not know if proper consent was obtained.⁵² Constructing this woman's experience changed the reality of her birth.

Finally, the baby begins to crown. We see close ups of Ida's face in agony, in pure effort to have a baby. It is here that the silence becomes most noticeable. She is clearly exerting effort, but the noises that are products of this effort are absent. Mary's mouth is moving, coaching Ida, but the audience cannot hear what she says. We are

⁵² Ibid., 382-383.

deprived of the intimate words in this moment, yet Ida's body is completely exposed. If the purpose of this film was to detail the work of a midwife, why deny the audience of the necessary language? Coaching, encouraging, and directing a laboring mother are just as much a part of midwifery as the sterile technique that is given so much emphasis. The film replaces the encouraging voice of the midwife and the moaning noises of Ida in labor with clinical knowledge and sounds. Silently, the baby crowns and we watch as Mary guides the baby out of the birth canal. The first sound that we hear is a loud and vivacious cry.

This scene is also void of the music that plays such an integral role in the moral tale of this film.⁵³ The soundtrack is choral gospel music with reference to Jesus, joy, good news, and babies. This adds a kind of religious and moral tone to a film that is produced by the State, an entity supposedly separate from the church. The music reiterates moral judgments, subconsciously dictating right and wrong as the tones change in response to the midwife's and mother's actions. For example, following the cry of the baby and Mary's preparation of the umbilical cord we hear a joyous tune with refrains of "what a

⁵³ With what little funding he had left following filming, George Stoney hired Louis Applebaum to work on the score. Applebaum felt that a symphonic score would take away from the humanity of the film, and instead hired an all-black gospel choir to record an a cappella score with music and lyrics inspired by Stoney's visit to Mary's church; Jackson, 386-387.

wonderful child” and “glory, glory, glory.”⁵⁴ After the birth Ida does not make contact with her child until Mary has thoroughly cut and cleaned the umbilical cord, wiped off the baby, and wrapped it in a warm blanket.

This film teaches the modern viewer about the racial atmosphere of the time regarding practices of hygiene, pollution, racial impurity, and fear of contamination. The narrator explicitly echoes in Mary’s head that “something wasn’t clean,” reiterating the usual tropes of black poverty and lack of education.⁵⁵ Ida’s birth is juxtaposed with the story of Maybell, a poor, black newcomer to the community. Her house is on the outskirts of town, broken down and dirty. Maybell is portrayed as morally irresponsible—she has had a previous miscarriage and a stillbirth, which are attributed to her lack of prenatal care or access to proper nutrition. Maybell is even described as being a “problem.”⁵⁶ Midwife Mary arrives at Maybell’s house to find her in labor and says “Oh, Maybell, what you doin’ on that floor?”⁵⁷ Viewers can hear Maybell’s cries of pain, in contrast to Ida’s silent labor. Her pain may have been vividly displayed to make her look weak, but in modern documentaries the privileged white women are praised for the way they vocalize and express their pain, a

⁵⁴ *All My Babies*, 00:34:32.

⁵⁵ *Ibid.*, 00:39:00.

⁵⁶ *Ibid.*, 00:13:48.

⁵⁷ *Ibid.*, 00:42:00.

badge of honor symbolizing the hard work they are doing to have a baby.

Maybell's baby is born premature and requires extra care—care that Stoney wanted to show midwives were capable of providing, but what is the message sent to the audience about poor black mothers? That they can't even have healthy babies? The white nurse, Miss Penny, brings a high-tech incubator to help Maybell's premature baby stay warm. The technology travels to their home, it rescues them from a situation that falls out of Midwife Mary's scope of practice. The racial politics of the time demand that it is easier to take the incubator to the home rather than have Maybell come to the hospital. Black mothers were reminded to stay healthy—a health that, when maintained, would keep their racially marked bodies out of the “pristine” hospitals.

For her article “The Production of George Stoney's Film *All My Babies: A Midwife's Own Story*” Lynn Jackson reviewed in-depth interviews with the cast and crew of *All My Babies* and conducted extensive research and interviews with the surviving production crew of the film. Her analysis reveals that many of the actors were hired, and they are not necessarily playing themselves. Ida's birth was filmed live, but a woman named Martha Sapp played the role of Ida. Ida's husband is played by Mary's son, Will Coley, and the children in

the scene are also his. The role of Maybell was completely invented.⁵⁸ And so, the article reveals an alternate motive behind the inclusion of this storyline: Maybell's story of improper behavior shows the midwife's ability to work under less than ideal circumstances.⁵⁹ However, there is an obvious disconnect between the stated purposes of the film and its actual effects of reinforcing racist and demeaning stereotypes.

In the other documentary films I will discuss later in the project, the relationships between the filmmaker and the mothers are more transparent, leading the viewer to believe in a kind of trust and consent in the filming of intimate moments. However, that relationship is not established in *All My Babies*. Jackson addresses concerns of consent and exploitation, giving insight into the politics of race and power playing out between the crew and cast, as filming took place in the 1950s, and the politics of race that were being negotiated created an undeniable power dynamic. While Jackson's article concludes that the motives behind documentation of these midwives' life and work were sincere and the utmost care was taken to respect the midwives and the birth process—the racially charged themes of the film were implicit at the time, and are overt to an audience today.⁶⁰

⁵⁸ Ibid., 375-378.

⁵⁹ Ibid., 376.

⁶⁰ Ibid., 371-375; 378-386.

Though the subtitle of the film is “A Midwife’s Own Story,” is this really Mary’s story? Or is it a precautionary tale from the Georgia Department of Health? Perhaps Mary’s status as a well-respected midwife in the community was exploited as a mouthpiece to tell their own tale of ideal black motherhood. Midwife Mary plays many different roles in this film. She is a go-between for the Georgia Department of Public Health and the black community, almost a mouthpiece of the (forming) technocracy. She is also an active and trusted neighbor. As an older midwife she has a solid reputation. She is a mother figure and source of authority in her community. Her status as a midwife is certainly sanctioned by state officials. Where does knowledge about women’s bodies and the birthing process come from in this film? The birth content would have been familiar to an audience of midwives shown this film during a training session, but they also would have been asked to adopt new sterile practices. Are they supposed to trust that this information is coming from Mary? If it came directly from the state would they reject it?

Functioning as both a respected member of her black community and a docile mouthpiece for white society, Mary’s character is constructed as what Patricia Hill Collins has theorized as the “mammy” role. Though the filmmaker intended to give a voice and vision to black midwives, *All My Babies* creates particular kinds of roles for black motherhood. Collins finds that “controlling images like the mammy aim to influence black maternal behavior.” Mary’s role as

a midwife—a role that already claims authority over maternity and womanhood—only solidifies her mammy status.⁶¹ Mary is round, soft, and kind. She is submissive and loyal. Throughout the film we hear her voiceover narration, internalizing and spreading the messages of white society to her fellow midwives for whom the film was intended. As a mammy she is non-threatening, both to white society and to her own community.

The work of Granny Midwifery in the American South can be contextualized within the larger history of black women's labor. Throughout slavery, midwifery remained a way for older women to command authority within their communities, even on plantations.⁶² Post-slavery Granny Midwives remained respected members of their communities, relying on "common-sense psychology and time-honored tradition."⁶³ Gertrude Fraser's essay "Modern Bodies, Modern Minds: Midwifery and Reproductive Change in an African American Community" accounts her ethnographic encounter with a black community she calls Green River in the American South. Her interviews from the 1980s reveal elderly community members'

⁶¹ Patricia Hill Collins, "Mammies, Matriarchs, and Other Controlling Images," in *Black Feminist Thought* (New York: Routledge, 2000), 69-95.

⁶² Jacqueline Jones, *Labor of Love, Labor of Sorrow: Black Women, Work, and the Family, from Slavery to the Present* (New York: Basic Books, 2010), 36, 161.

⁶³ *Ibid.*, 179.

experiences with Granny Midwives in the mid twentieth century, at the same time that Midwife Mary was practicing in Georgia. The decline of midwifery in Green River coincided with that of subsistence farming, so “rather than being a distinct historical event, midwifery’s disappearance accompanied shifts in the socioeconomic and cultural life of the community.”⁶⁴ Older members of the community even articulated that when midwifery disappeared so did the culture: “Reproduction, midwifery, and home-based healing traditions had been tied to a set of social relations now disrupted permanently, that had been integral to the individual’s and community’s connection to the land and its resources.”⁶⁵ Through her interviews and experiences Fraser reveals the tensions between the deep sense of loss the community feels at the extinction of traditional midwifery, and the simultaneous sense of the appropriateness of medical science to the “modern bodies” of their community.⁶⁶

To make sure the footage was not taken out of context or otherwise abused, Stoney limited distribution access of *All My Babies* “to professional use: doctors, midwives, schools, health departments” in the United States and abroad. He wanted to take precautions

⁶⁴ Gertrude Fraser, “Modern Bodies, Modern Minds: Midwifery and Reproductive Change in an African American Community,” in *Conceiving the New World Order*, eds. Raye Ginsburg and Rayna Rapp (Berkeley: University of California Press, 1995), 46.

⁶⁵ *Ibid.*, 52.

⁶⁶ *Ibid.*, 42.

against the subjects of the film whom he had grown to love being “misunderstood by an insensitive audience.”⁶⁷ When distributing the film abroad, Stoney found that its purpose as a training video for midwives was being misunderstood; instead, it was being screened for doctors and nurses who looked down upon local midwives in their own countries. In an interview with Jackson, Stoney told her that he “didn’t have the heart” to mention that midwives were deeply disempowered here in the United States, as well. Stoney’s relationship to the women in this film is complex—he recognized that he would be doing a disservice to women by allowing open access to the film, as he experienced with a group of crass sailors who laughed at the film. And yet, he could not see that his film participated in the racist rhetoric of the Jim Crow era American South. *All My Babies* is now part of the National Film Registry, and viewing is no longer restricted. Does the worth of this historical film for modern viewers outweigh the narrative harm it might still be doing?

These babies in this film were born in 1951 (only four years before *Brown vs. Board of Education*), coming of age in 1969 in a completely different world from the one they were born into. That this was filmed at such a time of profound political and social activism speaks significantly to the Georgia Department of Health’s effort to

⁶⁷ Jackson, 387.

maintain segregation practices that excluded black women from hospitals.

Contemporary Discourses of Race in Midwifery

Even now—over sixty years after this film was made—discussions of race and difference in contemporary midwifery are severely lacking. The history of Granny Midwives is intertwined in a matrix of race, gender, class, and power relations of the mid-century American South. Though we have some accounts of American midwifery from 1700 to the present, most of them feature the history of white midwives; other than the Grannies, contemporary African American voices are entirely absent.

The scarcity of work written about race within contemporary midwifery communities speaks loudly to the necessity of the exploration of this problem. Conversations of race within communities of midwives are integral to the development of providing better midwifery care and fostering more equitable relationships amongst midwives as peers. Scholarship in the United States tends to focus on the loosely defined idea of “cultural competency” and training midwives to provide culturally competent care. While the American College of Nurse Midwives states that their students should be, “provided with excellence in educational preparation which includes experiences that promote cultural competency and proficiency,” it is unclear what the real effects of an education centered

on cultural competency are.⁶⁸ Though histories and trajectories of the profession of midwifery vary, scholarship originating in Canada, Australia, and the United Kingdom is helpful for comparative purposes when speaking about the United States because all of these countries have long histories of racial inequalities.

Sheryl Nestle is a professor of Sociology and Equity Studies at the Ontario Institute for Studies in Education at the University of Toronto. She has been involved in maternity health care reform in Canada since young adulthood. According to Nestle, Canada operates under “myths of cultural diversity and tolerance.”⁶⁹ Canadian racial tensions differ in their origin, as most of their citizens of color are immigrants as opposed to U.S. multigenerational, American-born people of color. Visible discrimination in Canada also centers on First Nations people in comparison to African Americans in the United States. The Canadian health care system also differs in many important ways from that in the United States, but the work being done in Canada can serve as an example of potential conversations for the American midwifery community. Nestle’s essay “The Boundaries of Professional Belonging: How Race has Shaped the Re-emergence of Midwifery in Ontario” describes her own experience attempting to

⁶⁸ American College of Nurse Midwives, “Position Statement: Ethnic and Cultural Diversity,” PDF file, 1999.

⁶⁹ Sheryl Nestle, “A New Profession to the White Population in Canada,” *Health and Canadian Society* 4, no. 2 (1996): 318.

bring conversations of race into birth work in Ontario.⁷⁰ She recounts workshops that she taught where, in racially mixed classrooms, they “struggled to understand the ways in which gender, race, class, sexuality, ethnicity, ability, and other dimensions of identity position both childbearing women *and* those who are involved in education and health care programs directed at them.”⁷¹ She argues that:

The overwhelming whiteness of the midwifery profession is linked to structural inequities related to race and to the historical conditions that have produced these, as well as to the midwifery profession’s many complex and troubling interactions with groups popularly understood as “racially” different.⁷²

Though Nestle’s work focuses on Canada, it can be used to think about midwifery in the Anglo-American world. Ninety-one point five percent of Certified Nurse-Midwives (CNMs) in the United States identify as Caucasian.⁷³ Why is midwifery such a racially homogenous profession, and how might that homogeneity be detracting from the quality of care?

Nestle notes that her discussions about race were seen as a threat to Canadian midwifery just as it was beginning to gain

⁷⁰ Sheryl Nestle, “The Boundaries of Professional Belonging: How Race has Shaped the Re-emergence of Midwifery in Ontario” in *Reconceiving Midwifery*, ed. Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd (Montreal: McGill-Queen’s University Press, 2004), 287.

⁷¹ Ibid.

⁷² Ibid., 290.

⁷³ American College of Nurse Midwives, “The ACNM Core Data Survey,” PDF file, 2010.

legalization. While some critics saw the validity of Nestle's argument, they believed that surfacing tensions within the profession would weaken its already unsteady hold on cohesion.⁷⁴ I suspect that this same commentary could arise in an American discourse, as the American midwifery community is already divided on so many key issues (such as appropriate education and licensing for midwives). However, having these difficult conversations is necessary for growth. And because midwives are privy to a remarkable event in the shaping of a family, developing a critical understanding of difference that goes beyond cultural sensitivity and competency is vital to the effectiveness of midwifery work.

A weak discussion of racial inequality is attempting to shine through in British midwifery scholarship. In England all midwives are trained as nurses, and most pregnant women access midwifery care unless they have an exceptional case requiring physician management. Protasia Torkington wrote an article for *Midwives Journal* in 1986 titled "I'm not a racist, but . . ." about the persistence of inappropriate racial comments and attitudes within her own midwifery practice. She argues that British midwives believe that they are above racism because "racism is the property of an ignorant minority" and because they are a part of an objectively empowering profession; however, Torkington points out that within every institution there are people in

⁷⁴ Nestle, "The Boundaries of Professional Belonging," 288.

positions of power who “are not consciously racist, but are nevertheless influenced by racial stereotypes,” and midwifery is no exception.⁷⁵

In 2006, *Midwives*, the official journal of the Royal College of Midwives, featured the question “Racism—does it exist in the profession?” in a forum featured in their journal. Participants in the forum are said to be representative of the demographics of the profession in the United Kingdom. There were eleven “yes” answers and five “no” answers. However, the comments displayed a range of understanding of the initial question. Many of the “yes” answers were white midwives commenting on the “racism” apparent when their black peers did not include them in the “sisterhood.” And several of the “no” answers denied obvious racism—such as inappropriate treatment of patients based on their skin color—but spoke freely about other kinds of discrimination.⁷⁶

Midwifery is a well-respected and established profession in the United Kingdom, and one might expect to find more critical reflection within their scholarship if we were operating under the assumption that the lack of critique in the United States is due to the instability of the profession. Themes of implicit racism within midwifery need to be

⁷⁵ Protasia Torkington, “I’m Not a Racist . . . But,” *Midwives Journal* 82, no. 48 (1986): 50-51.

⁷⁶ Royal College of Midwives, “Racism—Does It Exist in the Profession?” *Midwives* 9, no. 4 (2006): 150.

addressed if the profession is to expand to a more universal position within the United States health care system.

Varney's Midwifery is the most famous textbook used for American nurse-midwifery education.⁷⁷ It prioritizes cultural competency for midwives, in the third chapter of the text, which involves a first step of the midwife "get[ting] in touch with [the midwife's] own culture and its influence on clinical practice."⁷⁸ While this is valuable for sparking reflection on a student midwife's personal experiences which will effect her practice, where is the scholarship that is open to critique of the systems of inequality that are affecting the practice of midwifery?

This raises questions about what *would* be successful in giving student midwives a theoretical background for approaching difference and allowing them the time and space for critical self-reflection. I do believe that we would need to begin by disaggregating the history of midwifery, by understanding the specific ways in which some midwives experience and practices have been privileged over others. By participating in this critical reflection as a community we are moving towards providing truly critical, informed, and passionate

⁷⁷ It is not possible to look at how non-nurse midwives are taught to think about race and culture because their education programs are less regulated and often do not use textbooks.

⁷⁸ Jo-Anna Rorie, "Cultural Competence in Midwifery Care," in *Varney's Midwifery*, ed. Helen Varney et al. (Boston, Jones and Bartlett Publishers, 2004), 49.

healthcare. While *All My Babies* may be a relic of the past, of a kind of midwifery practice that is now obsolete, its presence as an easily accessible film shapes access to the history of midwifery. But how did we get from *Midwife Mary* to the present? As we move into the 1960s and 1970s, it is vital to keep in mind the histories of inequality that have shaped the practice of midwifery in the United States.

Chapter 2

Ina May Gaskin, *The Business of Being Born*, and The Politics of Direct-Entry Midwifery

While the suffragettes of the early 1900s campaigned for the legalization of anesthetic use during childbirth, the hippies of the 1970s “wanted more than consciousness, they wanted to ‘feel everything.’”⁷⁹ By the 1970s the traditional, non-nurse immigrant midwives of the Midwest and Granny Midwives of the South were nearly extinct.⁸⁰ Most women were giving birth in the hospital, attended by doctors and nurses, and numbed by an epidural—all while their husbands waited in the other room.⁸¹ The publication and popularization of childbirth books such as Dr. Grantly Dick-Read’s *Childbirth Without Fear* and Marjorie Karmel’s book *Thank You, Dr. Lamaze* (both published in 1959) led to an American resurgence of “natural birth.”⁸² This energy sparked a revitalization of midwifery stemming out of

⁷⁹ Wertz and Wertz, 181; There is an irony to the shifting stance of feminists on anesthetics. Their understandings of what it meant to have a liberated childbirth shifted as our understanding of women’s roles in society changed.

⁸⁰ *Ibid.*, 213-217.

⁸¹ *Ibid.*, 181.

⁸² *Ibid.*, 195; Grantly Dick-Read, *Childbirth Without Fear* (London: Pinter and Martin, 2013); Marjorie Karmel, *Thank You, Dr. Lamaze* (New York: J.P. Lippincott, 1959).

second wave feminism and a reclamation of women's power over their bodies.⁸³

Birth Story: Ina May Gaskin and the Farm Midwives

Ina May Gaskin has been called "the most famous midwife in the world," and she is certainly the most influential from her generation.⁸⁴ Ina May's husband, Stephen Gaskin, was a self-proclaimed hippie living in San Francisco in the 1960s giving Monday night lectures at an experimental college when a group of ministers visiting the city sat in on one of his talks about peace and non-violence. They arranged a speaking tour for Stephen, and his popularity resulted in a caravan of hippies joining him to travel across the country in school busses, bread trucks, and vans. Some of the women in the caravan were pregnant, and when it came time to give birth they did so surrounded by their husbands and friends. Ina May Gaskin had already had a child of her own in the hospital, and seeing birth in a more peaceful and relaxed setting, she knew that birthing would become her life's work. While on the caravan, a frightening situation with a baby who had trouble breathing alerted Ina May to the responsibility she had to maintain the safe birthing conditions for these

⁸³ Wertz and Wertz, 218; A distinctly different practice of nurse-midwifery was emerging in rural Appalachia (miles from the space in Tennessee that is discussed in this chapter). Details of the nurse-midwifery profession will be discussed in the next chapter.

⁸⁴ *Birth Story*, 00:00:49.

women and babies. Thus, she began her self-directed midwifery education.⁸⁵

Following the speaking tour, Ina May and Stephen Gaskin, along with hundreds of community members from the caravan, bought a communal piece of land in Summertown, Tennessee. There, they started The Farm, an intentional community where they would live together in peace growing their own food and birthing their own babies. They lived in commune, sharing everything and accepting anyone who wanted to be a member. Ina May began training with physicians in her area, teaching herself out of medical textbooks, and taking on apprentices from the community. Eventually, these women formed a lay midwifery practice, The Farm Midwives, who delivered babies in their own commune, in the Amish community nearby, and for mothers who traveled from all over the country for their services.

Birth Story: Ina May Gaskin and the Farm Midwives (2012) is a documentary about the history and practice of the Farm midwives and Ina May Gaskin. It is 93-minute color documentary. Filmmakers and directors Mary Wigmore and Sarah Lamm read Gaskin's book *Spiritual Midwifery* in 2006 before having their own children. After meeting Ina May in 2009, the film project emerged. Both with toddlers and babies, Wigmore and Lamm "relied on doulas, husbands, friends, and each

⁸⁵ Ina May Gaskin, *Spiritual Midwifery* (Summertown, TN: Book Publishing Company, 2002); *Spiritual Midwifery* was originally published in 1975 using a printing press on The Farm, and has been through five printings.

other for support, and were grateful to be making a film about midwives. Who better to understand the challenge of juggling cameras and breastfeeding than Ina May Gaskin and her colleagues?"⁸⁶ On June 3, 2012 Wigmore and Lamm launched a crowd-sourced funding project for *Birth Story* on Kickstarter.com. By July 18 they had raised \$84,004 from 1,173 donors, well over their goal of \$50,000, to support the final production and marketing of the film.⁸⁷ This project was truly a labor of love from those who wanted Ina May's story told and preserved. As seen through *All My Babies*, the source of funding for a film greatly shapes its message. While the Georgia Department of Health maintained control over the content of Stoney's film, Lamm and Wigmore were backed by a community motivated to document Ina May's life and work.

This film was intended for an audience who may already be familiar with the work of midwives and Ina May, specifically. It does not teach the viewer about the basics and benefits of midwifery, but creates a permanent document of Ina May's legacy. The documentary paints a biographical portrait of Ina May's growth from a young hippy woman, to a founder of a community of midwives, and finally to an

⁸⁶ Sara Lamm and Mary Wigmore, "Production Notes," *Birth Story Movie*, accessed March 17, 2015, <http://birthstorymovie.com/production-notes/>.

⁸⁷ "Birth Story Pushes on to the Los Angeles Film Festival!" *Birth Story*, accessed March 17, 2015, <https://www.kickstarter.com/projects/birthstory/birth-story-pushes-on-to-the-los-angeles-film-fest>.

international activist for maternity care. This story is narrated through a series of voiceover interviews accompanied by photos and archival video. Ina May's story is told in conjunction with the foundation and growth of the Farm, including archival video from Stephen's Monday Night Class in San Francisco, the caravan, and early births in the community. This history is supplemented by contemporary footage of the Farm and the work the midwives continue to this day.

A comparison between the birth footage from *All My Babies* and the archival footage of births in *Birth Story* is stark. While there is one modern-day birth shown in the film, this project will focus on the archival movies. Pamela Hunt is one of the Farm midwives still practicing today, and footage from her 1981 homebirth on the Farm is featured in the documentary. Along with the sound from the home movie we hear Pamela's contemporary voiceover narrating her experience in retrospect. The scene opens with a naked Pamela being supported by her bearded husband on her right and a woman friend on her left. Pamela is incredibly tan with a noticeable bikini line, her hair is parted down the middle, and she is breathing rhythmically. Ina May walks into the room and, with a smile on her face, Pamela says to her, "Just blows your mind every time."⁸⁸ The shaky home movie is edited to show close ups of the women's faces in the room. We see calm smiles while Pamela and her husband make out with one another

⁸⁸ *Birth Story*, 00:25:09.

in between contractions. Pamela continues to make eye contact and directly addresses the person behind the camera, suggesting that she consents to this taping of such an intimate moment. We hear Pamela's voiceover, remembering, "This is the worst pain I've ever felt before, and this is the best I've ever felt."⁸⁹ She perfectly describes the complexity of this experience, and we see this illustrated across her face as she fluctuates between grimacing and smiling, panting and kissing, laughing and moaning. During contractions we hear the sounds that Pamela makes during labor—deep groaning as the contraction builds that then eventually transforms into laughter. The sounds of birth are so reminiscent of the sounds of pleasure, and Pamela is encouraged to verbalize and experience this to the fullest. Pamela's birth space differs from Ida's and Maybell's in that she is surrounded by people who are supporting her both physically and emotionally. Pamela's children are in the room, and her husband reminds them, "It's the way you all came out!"⁹⁰ As the midwife, Ina May touches Pamela with her bare hands, she supports her perineum as the baby crowns. The camera begins to pan up and down Pamela's body; we see her face, her belly, her vagina, and the midwife. Pamela is not disembodied or silenced. As the baby is born, attention is given to both mama and newborn. Ina May stimulates the breathing baby as

⁸⁹ Ibid., 00:25:52.

⁹⁰ Ibid., 00:27:35.

the women in the room rush to hug Pamela. Naked baby is put onto Pamela's chest as she repeats "Oh sweet baby, oh sweet baby."⁹¹

Another archival birth scene features a shot of a beautiful laboring woman held by another woman and surrounded by midwives. The phone rings and mama picks it up and responds to the other line, "I'm not by myself at all! I have lots of help. Lots of midwives and friends and everything."⁹² A midwife is rubbing her belly as she speaks into the phone saying, "It's almost here. I'll call you back when it's here, okay?"⁹³ This scene captures the attitude that the Farm Midwives seemed to have had towards birth: this is a special and sacred, but totally ordinary process. This entire film is telling a story about community and support and equality, about what is possible when people work peacefully and lovingly with one another.

This film also paints a portrait of a certain role for midwives: midwife as listener, learner, and teacher of women. These midwives banded together to listen to what women wanted, and to form their own wholistic birth culture. Pamela Hunt describes her own process towards becoming a midwife, "Once I was helping women, I fell in

⁹¹ Ibid., 00:29:03.

⁹² Ibid., 00:40:23.

⁹³ Ibid., 00:40:40.

love with women! . . . You can't help but love someone who's working that hard and putting out great pure effort to have a baby."⁹⁴

The communal process that was birth on the Farm was also the inspiration for the authoring of the book *Spiritual Midwifery*, which was self-published on the commune. One former farm midwife recalls, "All I remember is going out to Ina May's, and sitting on her bed for hours and hours and hours, and telling stories and writing."⁹⁵ *Spiritual Midwifery* as a text is made up of birth tales, stories, advice, and practical midwifery skills. It was in such high demand that the printing press on the Farm property had to be kept running twenty-four hours a day, seven days a week. *Spiritual Midwifery* is now in its fifth edition. Lamm was given a copy during her first pregnancy and told, "This is the ONLY book you need to read."⁹⁶

The communal, collaborative mentality of The Farm commune coincided perfectly with the values of wholistic midwifery. The women all worked together, sharing their knowledge for better births.

⁹⁴ Ibid., 00:17:11.

⁹⁵ Ibid., 00:46:21; Though the book was written in this way and women wrote their own birth stories, themselves, Gaskin is credited as the author. *Spiritual Midwifery* brings up questions of authorship—who truly wrote the book and who is given credit for it? What about birth? Who is the author of birth? Who is congratulated? Who is credited with "delivering" the baby—mom, doctor, midwife? Films, themselves, are collaborative projects. They cannot be authored by a singular person, yet many names are overlooked in the credits while the director is recognized.

⁹⁶ Lamm and Wigmore; This is also the title that was referred to me most often when I told others I was interested in midwifery.

One surprising dichotomy in the film is the separation between women and men's work. Women are participating in a completely different kind of labor, literally. Birth is women's space, women's work. This community was beginning at the same time that second wave feminism was gaining popularity. Cultural feminists, specifically, argued that the female essence was undervalued. They believed that women and men were inherently different, serving different social roles. Cultural feminism coincides with the beliefs of women's space, intuition, and work. Women and men operate in different spheres.⁹⁷ We also do not see or hear about any homosexual members of The Farm, though "free love" is a common refrain of the seventies.

In the documentary the midwives are represented as caretakers, a role that extends beyond the sphere of their community; they have completely embraced these roles in all aspects of their lives. Two different midwives in the contemporary footage break their interviews to offer the camera crew a sandwich or a bowl of blueberries. By including this footage in the final cut of the film the directors are telling a story about the midwives and about the construction of the film. Though we never hear from the directors or see the film crew, by including these direct addresses to workers off screen the viewer is

⁹⁷ Lorber, 168-180.

reminded that this is a constructed reality. Those making the film and featured in the film have real, human needs.

Birth Story and the work of Ina May taps into a realm of midwifery work that is often overlooked. Ina May says, "In all of the medical books and textbooks that get written about birth there's nothing about a special energy that surrounds birth, and yet to me that seemed like the central thing . . . I felt like I was doing something sacred."⁹⁸ This recognition of spirituality and professionalization of midwifery makes the work unique. Audre Lorde's "Uses of the Erotic" (1978) recognizes that "every oppression must corrupt or distort those various sources of power within the culture of the oppressed . . . For women, this had meant a suppression of the erotic as a considered source of power and information within our lives."⁹⁹ Has the technocracy oppressed the erotic power of midwifery that Ina May at the Farm midwives so heavily rely on? Generations of American women have been robbed of the erotic power of midwifery. They have been told that their bodies are defective, their babies are too big, they have "failed to progress." Women are being told that they are failing at giving birth.

⁹⁸ *Birth Story*, 00:08:30.

⁹⁹ Audre Lorde, "Uses of the Erotic," in *Weaving the Visions: New Patterns in Feminist Spirituality*, ed. Judith Plaskow and Carol Christ (San Francisco: Harper, 1989), 208; This is the print citation of a paper that was originally delivered by Lorde at Mount Holyoke College in 1978.

As midwives, once we find “a measure between the beginnings of our sense of self and the chaos of our strongest feelings,” whether through our calling to midwifery or through an experience of connection to the women we work for, we can begin to “require no less of ourselves.”¹⁰⁰ We can require no less of ourselves than to work to help mothers find this same sense of eroticism, of deeply feeling, of truth to oneself in their own lives. This is the meat of midwifery work in which the value of the erotic seems inherent, interchangeable with the profession, itself. Lorde tells us “the erotic . . . is a question of how acutely and fully we can feel in the doing.”¹⁰¹

The Politics of Direct-Entry Midwifery

The political and social movements of the 1970s in the United States created the perfect atmosphere for the reclamation of midwifery that happened independently in communities across the country as white, middle-class feminists became dissatisfied with their childbirth experiences in the hospital. They sought more from the experience, and some women began to educate themselves and attend births—becoming midwives. As these women began to connect with one another and form stronger communities of midwives, discussions and organization around professionalization began to take place. These “lay midwives,” as they were being called, began to organize in the

¹⁰⁰ Ibid., 209.

¹⁰¹ Ibid.

1980s to form what today is known as direct-entry midwifery. The history of the legalization of direct-entry midwifery and modern homebirth is complex, as it is regulated state-by-state. Today, the most popular certification for non-nurse, direct-entry midwives (DEMs) is the Certified Professional Midwife (CPM).¹⁰² The CPM certification was born out of the desire to recognize traditional forms of midwifery apprenticeship education and the desire to reject hierarchical learning institutions.

CPMs can practice legally in twenty-eight states, though their specific scopes of practice vary greatly in each one. CPMs do not practice in hospitals, but may attend homebirths and may work in (or own!) free standing birth centers. Most insurance companies do not cover the costs of maternity services offered by a CPM; however, midwives charge much less per birth than hospitals do and many midwives offer bartering or sliding-scale services. The professionalization of direct-entry midwifery has fundamentally changed the source of authority in the work. For Ina May Gaskin and The Farm midwives, the language they use surrounding birth is woman and family-centered, based not on medical jargon, but on their own dialect. The experiences and voices of the women shape the practice, completely. However, legal recognition also means

¹⁰² Rooks, 225-231.

compliance with standards set by legislative bodies, and that can easily change the dynamics of authority in midwifery practices.

In her book *Pushing for Midwives* (2010), Christa Craven theorizes the relationship between the home birth movement and neoliberalism. Her main argument lies in the appropriation of capitalist language that homebirthers in Virginia (and all over the country) are using to gain respectability in their activism for the legalization of homebirth midwives. Most homebirthers who attend rallies or legislative sessions do not consider themselves as political actors, yet they are clearly participating in political events. They appropriate neoliberal, capitalist language that they believe will gain the kind of respect they are looking for. These women frame themselves as “consumers” of midwifery, surveying their choices, and making economic decisions about purchasing a service. In this way they may be seen as “good American mothers” participating in the capitalist American scheme. Craven argues that these midwifery “clients” would do better to trade the neoliberal framework (that many lower class mothers are uncomfortable using) and “refocus attention on the shared experiences of homebirthers by highlighting the respect, support, and safe care that socioeconomically-diverse women have received from midwives.”¹⁰³

¹⁰³ Christa Craven, *Pushing For Midwives: Homebirth Mothers and the Reproductive Rights Movement* (Philadelphia: Temple University Press, 2010), 137.

Craven's work details ways in which the homebirth movement could become more inclusive, promoting and expanding midwifery care as a healthy alternative for many women. If the midwifery community could become more inclusive to the population at large, it is possible that a shift within the maternal health care system would be driven by demand. To achieve this goal for expansion of the profession, the benefits of midwifery as a space for women's growth and agency must be promoted. And in order for these benefits of midwifery to reach those who need them most, midwives must explore the intersection of their roles as professionals and activists, and consider the kind of responsibility that comes with the unique intimacy of the work.

The Business of Being Born

Documentaries can play an important role in who has access to information and conversations about midwives and alternative birth practices. No film has done more for sparking this conversation in the last ten years than Ricki Lake's *The Business of Being Born* (2007), an 87-minute color documentary. This project follows the work of Cara, a homebirth nurse-midwife in New York City, the celebrity executive producer and midwifery advocate Ricki Lake, and filmmaker Abby Epstein. Woven throughout are interviews, historical footage, and animated statistics with which the viewer is challenged to critique the master narrative about American childbirth practices. In her article

about the reception and cultural effects of *The Business of Being Born*, Kim Hensley Owens has found that documentary films are now becoming a more important source of information for expecting parents who may be questioning current childbirth practices. Films such as *The Business of Being Born* have taken the place of texts like *Our Bodies, Ourselves* (1971) that may previously have functioned as sources of alternative childbirth choices.¹⁰⁴ The celebrity of Ricki Lake, a retired daytime talk show host, increases viewership, but documentaries are generally garnering larger audiences than books presenting the same information because of the time commitment involved in watching a two-hour movie versus reading a book.¹⁰⁵ While reviews of the film critiqued it as “rah-rah midwifery propaganda,” Owens’ analysis of the reviews “demonstrates that dominant discourses and beliefs can be disrupted by such genres as the documentary, effecting possibilities for personal and social change.”¹⁰⁶

The imagined audience of this film is certainly someone who may be making a decision about where and how to give birth. The

¹⁰⁴ Kim Hensley Owens, “Reviews and Reactions: A Rhetorical-Cultural Analysis of *The Business of Being Born*,” in *Rhetoric Review* 30, no. 3 (2011): 294; The Boston Women’s Book Collective, *Our Bodies, Ourselves* (New York: Simon & Schuster, 2005); *Our Bodies, Ourselves* was originally published in 1971.

¹⁰⁵ Owens, 298.

¹⁰⁶ *Ibid.*, 302; 308.

viewer is educated, impressed by statistics and academic prestige, and wants to understand exactly why she should question the master narrative of birth. Why should she go without an epidural? Why should she give birth using a midwife? What's the science, the evidence? *The Business of Being Born* certainly appeals to that. There are different voices of authority presented in the film. We hear the stories of mothers; they speak and command their experiences as valid and relevant. They tell birth narratives of fear and pain in the hospital, and of comfort and autonomy with their midwives. The audience learns to trust them and their experiences, but what about the evidence? High-profile interviews with experts such as Ina May Gaskin; author and activist Robbie Davis Floyd; renowned physician and author of *Childbirth in the Age of Plastics* (2011), Michel Odent; the former director of the Women's and Children's Health division of the World Health Organization, Marsden Wagner; and Tina Cassidy, author of *Birth: The Surprising History of How We Are Born* (2006) are the voices of reason, science, and modernity.¹⁰⁷ *The Business of Being Born* appeals to an audience that views science as the ultimate authority. In contrast, *Birth Story* relies on only the stories of women and midwives. These two films give an account of midwifery as a communal experience versus a commodity, a spiritual work versus a service.

¹⁰⁷ Michel Odent, *Childbirth in the Age of Plastics* (London: Pinter and Martin, 2011). Tina Cassidy, *Birth: The Surprising History of How We Are Born*.

The film opens as we see nurse-midwife Cara meticulously packing up her bags to attend a homebirth. Cara believes that by doing prenatal visits and births at home she is “giving the power back to the woman.”¹⁰⁸ She’s articulating and acknowledging through both her words and her practice that something has been taken from women. By going to them, by meeting them in their homes where they are most comfortable, she is delivering them from the modern maternity care system. Cara also tells us that she believes “women who choose homebirth share something.”¹⁰⁹ They seem to share a deep knowledge that things can be different, a kind of trust in the bodies of women. Homebirth mothers share something amongst themselves, but they also share something with midwives—a belief in the birth process and a mutual agreement to support it.

Ricki Lake is a midwifery convert. She had her first baby in a hospital and felt that she was robbed of an opportunity to fully experience childbirth. In this documentary the viewer is privy to footage from the homebirth of her second baby. After this experience, Ricki wanted other mothers-to-be to have access to information about midwives and alternative birth practices. She approached her friend and filmmaker Abby Epstein with the project of *The Business of Being Born*. Abby became pregnant as she and her boyfriend were making

¹⁰⁸ *The Business of Being Born*, 00:25:00.

¹⁰⁹ *Ibid.*, 00:26:00.

this film, and the narrative of her pregnancy, labor, and delivery are woven throughout the documentary. Abby is everything the imagined viewer of this film should be: white, middle class, liberal, open to hearing the argument, persuaded by the facts, yet still worried about the safety of herself and her baby. After revealing her pregnancy on camera about halfway through the film, Abby meets with Dr. Moritz, an obstetrician who is interviewed throughout the film and who is very supportive of midwives. He sees midwives as the best option for low risk “normal” births and the practitioners who should be taking care of most labor and deliveries. Dr. Mortiz understands obstetricians to be surgeons; they become bored with “normal”—they want “exciting.” He offers to be Abby’s backup doctor, “I can definitely make it God forbid you come into the hospital . . . but if you come in even because you’re tired or you *just want to do it.*”¹¹⁰ What does this mean? Most likely augmenting with Pitocin, hooking her up to an electronic fetal monitor, and giving her an epidural, all with the intention of speeding up the process. The assumption is that giving birth at home is putting yourself through something unnecessarily long and painful and if you come into the hospital you can “just do it.”

From the beginning, Abby wasn’t convinced that having a homebirth was right for her. Maybe she felt pressured to try it because she was making the film, but it’s apparent that she wasn’t 100%

¹¹⁰ Ibid., 00:48:00 (emphasis added).

committed when she spoke with Cara, who she asks to be her midwife, about the hopes of transferring to a birth center if she changed her mind during labor. Cara explained that Abby could choose between different spaces with different resources, but that if she decided to proceed with a home birth she would be transferring to a hospital only if there was a resource there that she needed (such as an epidural or an operative delivery). Unlike in some other countries, midwives in the United States cannot seamlessly travel from homebirths to hospital births, as they often do not have privileges in a hospital where they are not employed. This means that when a mother is committing to a practitioner, she is also committing to a space except in need of transfer to a hospital.

Abby's uncertainty with her choice to hire a homebirth midwife illustrates Ina May Gaskin's idea of the sphincter law—the cervix is shy like a sphincter, and if it is “in the process of opening, it might suddenly close down if that person becomes upset, frightened, or self-conscious.”¹¹¹ Women cannot give birth if they do not feel safe.

Michel Odent reiterates this in his book *Childbirth in the Age of Plastics* (2011):

There is no universal recipe for feeling secure when giving birth. While some women feel more secure in a familiar place close to an experienced midwife perceived as a mother figure,

¹¹¹ Ina May Gaskin, *Ina May Gaskin's Guide to Childbirth* (New York: Bantam Dell, 2003), 170.

others are conditioned in such a way that they need a modern environment with electronic beeps.¹¹²

It is possible that Abby needed to be in a hospital in order to feel safe enough to actually have her baby, and due to an emergency situation she did ultimately transfer care.

Abby goes into labor before her due date, and Cara discovers that the baby is breech; together they decide to go to the hospital, where Abby has a Cesarean section. The baby is born very small. He was incredibly growth restricted in the womb and needed intensive care after birth. Does this negate all of the work that the rest of the film has done? Does it cause a viewer to think, “What if they hadn’t gone to the hospital? That baby would have died. Should they have just started out having the baby in a hospital with a doctor who would be able to handle everything?” Or does this scenario show that the midwife made a judgment call in time to safely get Abby to the hospital and the baby delivered surgically before it was too late? What kind of cultural work is Abby’s birth story doing? Is it sending contradictory messages about midwifery? Or perhaps it’s just complicating the stories, obscuring the binary of hospital and homebirth, revealing the complexity of their interactions.

How does Abby as filmmaker and Cara as subject affect their relationship? Midwife Cara was not phased by this experience. After Abby’s birth, her boyfriend, Ricki, and Cara debrief about the labor

¹¹² Odent, *Childbirth in the Age of Plastics*, 80.

and delivery. Cara had been called to another birth while in the operating room with Abby. She says of the mother whose homebirth she attended following Abby's, "She was so happy. And that's what I want. That's what I get out of it."¹¹³ Though Abby did not deliver at home, and her birth did not go according to plan, birth is Cara's job. In her daily life she will continue to attend to this intimate moment in a family's life.

In addition to her work as a midwife, the viewer also is privy to footage from Cara's own homebirth. She discusses how difficult labor and delivery were for her, joking that she will be writing a book titled *Homebirth Midwife Begged for Cesarean*. She tells us, "I met a place that I think a lot of people meet in labor. The rock and the hard place . . . The rock is, 'I'm not pushing because it hurts too much,' And the hard place is, 'Okay, then, you're staying pregnant forever and it's gonna hurt forever.'"¹¹⁴ This moment of surrender—of confronting one's deepest fears before giving in to the experiences of the pain of labor and allowing room for the baby to move down and be born—is articulated in natural birth narratives everywhere. Elan Vital McAllister, President of the New York City-based non-profit Choices in Childbirth that "advocates to local leaders, policy makers, and healthcare providers to ensure accessible, culturally competent and

¹¹³ *The Business of Being Born*, 1:17:52.

¹¹⁴ *Ibid.*, 00:50:13.

evidence-based maternity care services,” articulates a typical conversation she has with a new mother: “she comes to the end of this journey and she says, ‘You know, I knew I couldn’t do it. I knew I couldn’t do it, and then I did it! I hit a wall that was higher than anything I’ve ever seen in my life and I scaled it.’”¹¹⁵ Communicating the birth experience in this way paints it as an opportunity for spiritual and emotional growth for the mother. There are so few times in one’s life where there is an opportunity to feel this kind of primal power, an opportunity to surrender to the animalistic nature of one’s body, that it must be worth giving up pain medication in order to experience it. If this is the case, what is the role of the midwife? She is the protector, responsible for the mother’s safety. She is both familiar and confident in the process of birth as normal, while sensitive to the fact that these moments are so special, so once-in-a-lifetime to a family. Besides presenting the facts and figures associated with a rational decision to choose the midwifery model of care over the technocracy, this documentary is telling a story about midwives and mothers, and about the genuine relationships possible between them when the medical establishment is not intervening. Midwives are partners, teachers, guardians, friends.

Through *The Business of Being Born* the viewer is invited into the matrices of Ricki, Abby, and Cara’s relationships as women, mothers,

¹¹⁵ “Our Work,” Choices in Childbirth, accessed April 5, 2015, <http://choicesinchildbirth.org/>; *The Business of Being Born*, 00:59:40.

midwives, workers, producers, and people. These three women's individual and collective relationships as well as their experiences of birth offer different models through which the viewer may identify—the expert, the convert, the woman faced with important decisions. *The Business of Being Born* assumes that its viewer has a choice in how and where to receive maternity care. What about women who are not middle class and educated? Where are they in the narratives of *Birth Story* and *The Business of Being Born*? While these films are valuable for thinking about the ways in which the authority of midwifery has grown and changed over the past fifty years, what is the reality of midwifery today? Who is it reaching? Who is it excluding? Which models of care are available to which populations? The next chapter of will address these questions of diversity in terms of both birthing mothers and midwifery models.

Chapter 3

Nurse-Midwifery, *The Mama Sherpas*, and the Future of the Profession

Midwifery and obstetrics are often characterized as contrasting models of care, and while they do differ in critical ways, they also overlap. What is the role of a backup doctor in a midwifery practice or of a midwife in a hospital setting? Eighty percent of Certified Nurse-Midwifery practices are hospital-based.¹¹⁶ These midwives are managing an alternative form of practice within a highly regimented and technocratic setting. Women seeking midwifery within a hospital are receiving care from a blended wholistic and technocratic model of midwifery that combines the compassionate presence of a midwife with the perceived security and safety of a hospital. Additionally, many of the 37% of nurse-midwifery practices that count Medicaid as their primary payer are caring for patients who may be assigned to midwifery care, as opposed to actively choosing it.¹¹⁷

American nurse-midwifery descends from the British system of training midwives to care for low-income or rural populations who were not serviced by physicians. In 1925 famed nurse Mary Breckinridge brought midwives from Britain to the United States to start the Frontier Nursing Service (FNS) in rural Kentucky. She

¹¹⁶ American College of Nurse Midwives, “2012 ACNM Benchmarking Project: SummaryData—FINAL Report,” PDF file, 2012.

¹¹⁷ Ibid.

believed that both nursing and midwifery were needed in order “to deal with the conditions and health problems of poor mothers and their children in rural, medically underserved parts of the United States.”¹¹⁸ FNS was originally created to help support traditional midwives in rural Appalachia, but soon it became the first American nurse-midwifery training program.¹¹⁹ By 1955 the American College of Nurse-Midwifery was established. During the baby boom of the 1940s and 1950s, public hospitals began to take on nurse-midwives as practitioners to deal with the influx of poor women having babies. Nurse-midwives attended to normal births so that doctors could develop more specific skills; this trend continues today as many nurse-midwives practice in hospitals with women supported by Medicaid.¹²⁰

Though nurse-midwives conceive of their profession as separate from nursing, they are nevertheless trained and registered nurses. This training earns respect in our increasingly medicalized society, respect that direct-entry midwives do not always receive. Despite previous efforts, and because of fundamental differences between the professional organizations of nurse-midwives and direct-entry midwives, no consensus of a single legal definition of “midwife” has been made in this country. In her article “From Calling to Career:

¹¹⁸ Rooks, 36.

¹¹⁹ *Ibid.*, 38-39.

¹²⁰ *Ibid.*, 42-45.

Keeping the Social Movement in the Professional Project” Betty-Anne Davis writes about the development of the midwifery and alternative birth movement (ABM) as following less of a path of professionalization, and more so a pattern of institutionalizing a social movement. She argues that becoming a midwife need not be either a career choice or a spiritual calling, but instead a “lifelong engagement in social activism.”¹²¹ While the American College of Nurse-Midwives has followed a path of professionalization, attempting to hold a monopoly over a body of knowledge, both nurse-midwives and direct-entry midwives are working towards a society in which “providing informed choice for women” is the ethical norm.¹²² Davis has settled on New Social Movement theories (NSMs) as the appropriate model for the alternative birth movement:

While NSM theorists understand that the microelements of the organizational, financial, and political process are important, they focus on the larger ethical issues, the importance of looking at the big picture, and the possibilities of all the social movements working together to make large-scale cultural changes.¹²³

¹²¹ Betty-Anne Davis, “From Calling to Career: Keeping the Social Movement in the Professional Project,” in *Mainstreaming Midwives: The Politics of Change*, ed. Robbie Davis-Floyd and Christine Barbara Johnson (New York: Routledge, 2006), 414.

¹²² *Ibid.*, 416.

¹²³ *Ibid.*, 435.

Davis draws attention to the fact that while professionalization and differentiation may be necessary for midwifery organizations, at large, individual midwives are all working toward the same goal.

The Mama Sherpas

There are many documentaries that take homebirth as their subject, but they show little variety in birth spaces. *The Business of Being Born* did feature midwives who worked in birth centers, but they were not the focus of the film. Brigid Maher's 77-minute documentary *The Mama Sherpas* (2015) is currently in production as the first film to focus on midwifery practices within a hospital setting. Maher had her first baby via Cesarean section, and, when she became pregnant three years later, wanted a vaginal birth after Cesarean (VBAC). She sought care from the midwives at George Washington Hospital in Washington D.C. where she had a successful VBAC. As a filmmaker, this experience sparked her interest, and she began the production of the film hoping that it would provide other mothers-to-be with valuable information and resources about the spectrum of nurse-midwifery practice in the United States. Maher and her story are featured in the film, and her intentions are made clear through the questions she poses via voiceover at the beginning of the film: "Is it even possible for women to have a natural childbirth in a hospital?"¹²⁴ *The Mama Sherpas* provides an opportunity to see the work of midwives in a

¹²⁴ Ibid., 00:06:27.

hospital setting, where their practices are undoubtedly shaped by the politics of technocratic spaces.

In order to explore the possibilities of midwifery being fully integrated into the modern American healthcare system, Maher travels to four different nurse-midwifery practices across the country. At each practice the viewer is privy to a variety of appointments, births, and consultations. Through interviews and footage of births with these midwives, the viewer may find examples of how midwives are protecting birth spaces within technocratic hospitals. They are interrupting the master narrative of childbirth right in the middle of the system from which it flows. The title “Sherpas,” which Maher assigns to these midwives, evokes images of wise and experienced guides helping laboring mothers through their journey.¹²⁵

In the film, the midwives at George Washington Hospital are painted as the protectors of vaginal birth even for women who have previously had Cesarean sections. Births following previous C-sections can present unique complications. Most physicians recommend a repeat Cesarean. However, risks and morbidities associated with C-sections tend to increase with each subsequent surgery. These risks include: placenta accreta (too-deep attachment of

¹²⁵ Traditionally, “Sherpa” refers to a Nepali nomadic group of people who live in the Himalayas. It is a racialized term as they are non-western people known to help white adventures scale mountains. However, Maher seems to be invoking the positive connotations of this word, as Sherpas are also a highly specialized sub-sect of society with a very specific set of skills.

the placenta into the uterus, which can result in a severe hemorrhage, hysterectomy, or maternal death in severe cases); cystotomy (surgical incision to the bladder); bowel injury; ureteral injury; the need for postoperative ventilation; intensive care unit admission; hysterectomy; and blood transfusion. The length of a woman's hospital stay also increases with an increasing number of Cesarean sections.¹²⁶ Uterine rupture is the most notorious risk of VBAC. This risk varies based on some associated factors: induction or augmentation of labor, use of prostaglandin to prepare the cervix for induction, initial reason for the first Cesarean, and the type of uterine scar. If a woman desires a VBAC she is said to undergo a "trial of labor." If she successfully VBACs, her uterus is said to be "proven." This language is incredibly disempowering and passive, highlighting that a woman and her uterus must be put to the test.

In many hospitals it can be difficult to find a provider who supports trials of labor; women wishing to VBAC have been driven to look for care outside of the hospital. In one of the various interviews throughout the film, Whitney Pinger, CNM speaks of how she started the GW midwifery practice in 2007 with an intention to "rely on the wisdom of women and midwives and . . . balance that with the use of evidence-based science to promote the best outcomes and to not be

¹²⁶ R. Silver et al., "Maternal Morbidity Associated with Multiple Repeat Cesarean Deliveries," *Obstetrics & Gynecology* 107, no. 6 (2006): 1226-1232.

intimidated by established policies and practices in a hospital setting.”¹²⁷ This construction of authority within their practice is in stark contrast to the language of a “proven uterus.” And though their practice is operating within the parameters of hospital rules and regulations, these midwives are actively choosing to place the authority of childbirth elsewhere.

For women who go into pregnancy seeking midwifery care or vaginal births, it can be upsetting to discover that they are too high risk for the type of birth they imagined. It is vital to think about risk in relation to midwifery care. The reason that midwives are able to practice with the kind of education that they have is because they only handle what are deemed low risk and “normal” pregnancy and birth. However, if we consider midwifery as a kind of model or attitude of care, then doesn’t every woman deserve to have a midwife, regardless of how high risk her pregnancy is? This is the work that midwives in hospital settings are beginning to do.

The Mama Sherpas also features Sutter-Davis Hospital in Davis, California, where midwives and obstetricians are working together to provide compassionate, midwifery-type healthcare for mothers who may be pregnant with twins or breech babies. In this practice, the midwives provide all of the prenatal and postpartum care even in high-risk situations. The viewer is privy to a birth scene in which a

¹²⁷ *The Mama Sherpas*, 00:07:13.

woman is having a breech delivery. Her midwife, who has provided prenatal care throughout pregnancy, is seen talking to her, stroking her hair, and providing emotional support throughout her labor. The obstetrician, Annette Fineberg, actually delivers the baby. Dr.

Fineberg acknowledges:

Collaboration can be difficult. If you have midwives and doctors working together and they're just all doing the doctor's model then you're not really going to get different outcomes than if you had only doctors. The midwives push us to be better and to be more patient and to really think about when we say we're going to do an intervention, to really think about it—that's how collaboration works.¹²⁸

For low risk mothers, midwives at Sutter-Davis also provide access to water birth. This is considered an alternative delivery option, and women seeking birthing tubs have often had to look outside of the hospital at homebirth or freestanding birth center spaces. As an available choice, is this cooperation between the midwifery model and the hospital? Or is it co-option of an alternative practice by the institution? If water birth and other such practices become available in a hospital setting, how will these spaces continue to distinguish themselves from one another? There are benefits and consequences to merging practices. Hospital-based midwives are providing options for patients inside of a space where they would not otherwise be available. But entering into hospital spaces also comes with increased

¹²⁸ Ibid., 00:21:24.

surveillance and regulation by physicians. The uniqueness of midwifery gets muddled when the technocracy is introduced.

In the film, both Sutter-Davis and Baystate Midwifery in Springfield, Massachusetts, provide midwifery care to low-income women, immigrants, and refugees. Their practice models are similar in that they are both providing group prenatal care in which women and families with similar due dates come together for prenatal appointments in addition to their one-on-one time with the midwives. Through this model families have more time with the midwife to ask questions and they can voice their concerns and offer support with other parents. This is one way that midwifery practices within the hospital can circumvent hospital or insurance-based regulations such as 15-minute prenatal appointments. Group prenatal care is becoming increasingly popular, the most well-known model being CenteringPregnancy, a program through which about twelve women with similar gestational age come together beginning in their second trimester to create a:

dynamic atmosphere for learning and sharing that is impossible to create in a one-to-one encounter. Hearing other women share concerns which mirror their own helps the woman to normalize the whole experience of pregnancy. Groups also are empowering as they provide support to the members and also increase individual motivation to learn and change.¹²⁹

¹²⁹ "Centering Pregnancy Overview," *Centering Health Care*, accessed March 16 2015, <http://centeringhealthcare.org/pages/centering-model/pregnancy-overview.php>.

Baystate Midwifery is based out of a large, public teaching hospital.¹³⁰ Many women on state or federal health insurance plans get funneled into midwifery care because midwives accept reimbursement rates that are lower than physicians for the same services. In *The Mama Sherpas* the Baystate midwives are portrayed as protecting birth spaces for women who might not otherwise be seeking out midwifery care or have the cultural capital to advocate for their own health needs. In the documentary we witness Tonja Santos, CNM managing the birth of a deaf woman in which the baby's heart rate begins to drop; Tara Starling, CNM holding group care for Somali women with post traumatic stress disorder; and Theresa Couley-Koudaio, CNM midwifing one Somali refugee through her Cesarean section. Through these various situations the viewer sees how hospital-based midwives might be practicing outside the scope of "normal," providing kind and compassionate care for women who might otherwise "risk out" of midwifery practices.¹³¹

Through *The Mama Sherpas* the viewer is exposed to a kind of hospital-based midwifery care at Sutter-Davis and Baystate that is not

¹³⁰ I have a personal connection to Baystate midwifery, as I shadowed their practice from September 2013-April 2014.

¹³¹ Some of these practices veer out of the realm of providing healthcare and into the scope of offering emotional or therapeutic support. The dual roles played by midwives will be touched on later in the conclusion of this project, but it is important to note that the support that these midwives are providing is a necessary part of their role as health care practitioners.

prevalent in either the master narrative of the technocracy nor the wholistic midwifery narrative in this country. The option of midwifery care for low-income women who are on government insurance is complex. In her 2011 book *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* Khiara Bridges conducted fieldwork on women receiving maternity care at a public hospital in New York City. She finds that poor women are thrust into a certain kind of medicalized pregnancy, given that patients with Medicaid have state-specific restrictions about the sites and practitioners from which they access care. Bridges utilizes Foucault's narrative of discipline and governmentality—poor women are taught that their bodies are unruly and therefore require discipline. Bridges argues that privately insured patients have *chosen* a medically managed pregnancy, whereas it is not a choice for many under the restrictions of Medicaid. At community hospitals, patients deemed “low-risk” are often assigned to midwives who will cost the government less money to reimburse. However, Bridges reminds her readers that this midwifery care is still hospital-based and highly medicalized. While the medicalization of the midwifery model is a common critique of hospital-based midwifery practices, Bridges reports that the Medicaid patients did appreciate the extra time the midwives committed to their appointments. Though many of these women were receiving well-intentioned midwifery care in the hospital,

they were still subject to tests and close surveillance—they were not able to escape a medicalized pregnancy.¹³²

The issues that women on Medicaid face vary greatly from those of women seeking VBACs or vaginal breech deliveries. Barriers to midwifery care for low-income women especially differ from the concerns of middle class women weighing the perceived safety of the technocracy versus the desire for autonomy over their bodily decisions. The practice of Physicians and Midwives in Alexandria, Virginia is featured in *The Mama Sherpas* as the response to Brigid Maher’s question, “What can midwifery look like within a doctor-based practice?”¹³³ This model of collaboration does not reproduce the binary that she calls into question, instead creating something entirely new. The patients of this private practice are seen by both midwives and physicians throughout their pregnancy instead of being separated into one model of care based on risk level. The CEO of the practice, David Giammittorio, MD, asserts, “We think vaginal delivery is preferable. We think that a labor where the patient is kept mobile, hydrated, and unmedicated . . . is preferable because it leads to a safer delivery.”¹³⁴ While these goals are certainly in line with the midwifery

¹³² Khiara Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (Berkeley: University of California Press, 2011).

¹³³ *The Mama Sherpas*, 00:26:35.

¹³⁴ *Ibid.*, 00:36:00.

model, how does the atmosphere of the practice or the births change under dual management? The language “the patient is kept” used by Giammittorio suggests that the birthing woman is passive, kept one way or another by whoever is taking care of her. Would this passivity shift depending on what kind of practitioner is attending the birth?

Is a melding of obstetrics and midwifery the future of birth in the United States? Trained in the 1950s—a period in maternity care when women were often being drugged and their ability to make decisions about health care was ignored—Michele Odent’s work discusses the importance of the natural progression of hormone responses by women in labor; he quickly fell into favor with the worldwide natural childbirth movement of the 1970s. Odent’s two most recent books, *Childbirth in the Age of Plastics* (2011) and *Childbirth and the Future of Homo Sapiens* (2013), work together to explore the trajectory of childbirth for the future.¹³⁵ Odent historicizes the increased use of medical interventions with the invention and mass production of plastics. He begins with the physiology of birth—oxytocin is the hormone necessary for the strengthening of contractions that open up the cervix and allow the baby to move down and be born. It is also the “love hormone,” produced during orgasm,

¹³⁵ Odent, *Childbirth in the Age of Plastics*; Michel Odent, *Childbirth and the Future of Homo Sapiens* (London: Pinter and Martin, 2013).

breastfeeding, and immediately after birth.¹³⁶ Odent discusses the shy nature of this hormone: women can only produce sufficient amounts of oxytocin when they feel comfortable and safe. This feeling of comfort and safety has been taken away from women as the “masculinisation of childbirth” has taken place.¹³⁷

Odent theorizes that as male physicians and fathers have been allowed into birthing spaces they have disrupted the natural progression of labor. Along with the masculinisation of birth has come medicalization. Synthetic oxytocin, or Pitocin, is used primarily to strengthen contractions during hospital births. It is distributed from a plastic bag through a plastic catheter, and Odent is concerned with our increasing reliance on plastics to do something as natural as birth. If synthetic Pitocin gradually replaces the body’s production of oxytocin, will the modern woman forget how to give birth? Odent critiques the master narrative discussed in this project by creating an idealized scenario of “authentic midwifery” in which the birthing mother is only in the presence of women, attended by an older and wiser practitioner who has also had a positive birth experience.¹³⁸ These essentializing discourses juxtapose the “masculinisation of birth” with “authentic midwifery.”

¹³⁶ Odent, *Childbirth in the Age of Plastics*, 25.

¹³⁷ *Ibid.*, 53.

¹³⁸ *Ibid.*, 66.

Odent develops his argument to focus on the implications of our reliance on plastics and the masculinisation of birth for the future of humanity. He is fascinated with the “universal lack of interest in the long-term consequences of how babies are born.”¹³⁹ Citing studies of other primates, Odent predicts that the increasing Cesarean rates and use of Pitocin will change the biology of humans in millennia to come. If our bodies are not utilizing the production of oxytocin through orgasm, the natural progression of childbirth, and breastfeeding then the ability to produce the hormone will diminish in humans over time. According to Odent’s logic, if we cannot produce oxytocin, we cannot learn to love.¹⁴⁰

Odent’s compelling concern for humanity is undermined by the way in which he draws cause and effect conclusions. He appears as an expert in numerous documentaries, including *The Business of Being Born* (2008).¹⁴¹ As an older, educated, white man he carries a certain kind of authority. However, he continues to embody the stereotype of the natural childbirth “nut” who uses rare or specific examples to make generalized claims. Odent essentializes ideas about gender in

¹³⁹ Odent, *Childbirth and the Future of Homo Sapiens*, 131.

¹⁴⁰ *Ibid.*, 51-55.

¹⁴¹ Other documentaries include: Gavin Banks and Kate Gorman, *The Face of Birth*, Videorecording (2012; Australia: Baby Banksia; 2012), DVD; Betsy Chasse et al., *Pregnant in America*, Videorecording (2008; New York: Intention Media INC, 2008), DVD; Toni Harman and Alex Wakeford, *Freedom for Birth*, Videorecording (2012; Denmark: Alto Film Production, 2012), DVD.

order to support his prescriptions that men should be no where near birth, and that laboring women should only be attended by a quiet, calming, and experienced midwife. Odent provides this anecdote in *Childbirth in the Age of Plastics*: “A man I had known personally paid an extreme price for the strong emotional reactions he experienced during a ‘wonderful’ out-of-hospital birth . . . This man died from a heart attack when the baby was just a few days old.”¹⁴² This suggests that this man died because his male body was not prepared for the extreme emotion of childbirth, and that men should not be present for the birth of their children if they want to avoid similar fates. Such essentialist argumentation discredits the validity of his scholarly claims. In an increasingly technological world that places high value on data and science, this kind of writing detracts from a movement that is actually fueled by evidence-based care.

Though problematic, Odent’s work does prompt conversation about the trajectory of maternity care. Will the Cesarean rate continue to increase, leading to a world in which mothers no longer know how to give birth? The continuation and revitalization of the midwifery movement are interrupting these trends, providing opportunities for oxytocin production in an atmosphere where women can “feel secure without feeling observed.”¹⁴³

¹⁴² Odent, *Childbirth in the Age of Plastics*, 70.

¹⁴³ Odent, *Childbirth and the Future of Homo Sapiens*, 80.

Natural Born Babies: A Modern Birth Story

Natural Born Babies: A Modern Birth Story (2009) is a 23-minute documentary film produced by Lorri Walker, CNM and filmmakers Kip Hewett and Devan McLeroy, who are former clients of Lorri's. The film consists of a collection of interviews from former clients and midwives about their experience with South Coast Midwifery in Orange County, California. Some of the interviewees hired these midwives for home births and others gave birth at the South Coast Midwifery birth center. The fact that all of the interviewees, midwives, and filmmakers are associated with the same practice does make it appear as a promotional video; however, it is sold online as a documentary, presented as being valuable for anyone interested in exploring natural birth.¹⁴⁴

The promotional website for *Natural Born Babies* works to reimagine the modernity of American midwifery:

Gone are the days when midwifery was primitive and outdated. The modern midwife is presented in this film as she puts women and children first. . . This film attempts to separate midwifery from a tarnished reputation from years of misinformation and negative publicity that has been propagated by the medical community.¹⁴⁵

This claim of midwifery as “modern” and in contrast to the midwives of the past erases the complex history of the profession, in which the

¹⁴⁴ “The Film,” *Natural Born Babies*, accessed March 16, 2015, <http://naturalbornbabies.com/main/about-the-film/>.

¹⁴⁵ Ibid.

experiences of midwives and mothers were shaped by status. In choosing to present the midwife as a symbol of modernity, a certain aesthetic is created. All of the interviews were shot against a blank white background as the subjects spoke directly to the camera. Lorri Walker and Angela Watson, the nurse-midwives interviewed for the film, are both blonde, middle-aged white women. During their interviews both midwives wear white coats, a uniform typically associated with physicians. White coats erect a professional boundary that is not often present in the midwifery model; they create a dichotomy of provider and patient. The entire design and aesthetic of their interviews paint this midwifery practice as the picture of sterility, education, and social capital.

The film appeals to an educated viewer considering where and how to give birth. Much like *The Business of Being Born*, this argument is addressed to someone ingrained in the technocracy, influenced by science, and wanting the statistics to back up their decisions. However, this authority is built solely from the parents' and midwives' experiences—there are no experts or academics interviewed. Instead, the parents preface their decisions with phrases such as, “When you look at the statistics . . .” and “If you read the data . . . If you read the literature . . .” indicating that they have an appropriate amount of access to medical literature, an understanding of the scientific process, and enough health literacy to decode language used by the hospital

and medical establishment.¹⁴⁶ The nine sets of parents interviewed present a variety of life experiences to which a viewer may relate. At the end of the film the professions of the parents are revealed: a minister, acupuncturist, founder of a popular cosmetic brand, yoga instructor, two chiropractors, and three doctors, among others. This range of professions gives a sample of who deems midwifery care an appropriate choice for their family. These parents are racially and ethnically diverse, and because the viewers of the film are posited as consumers this diversity provides a range of experiences with which one may identify.

The doctors' testimonies, in particular, carry an authoritative weight. They are actively rejecting the technocracy in which they were trained in favor of a more wholistic birth experience. Two of the doctors are married to one another, and the other, Ariel Hurtado, is an anesthesiologist married to a nurse practitioner. Throughout the Hurtados' interview it becomes apparent that Ariel is obsessed with safety and control. Before the birth of his baby he made a list of all of the emergency equipment *he* would need in order to resuscitate the baby, assuming incorrectly that he might be the one providing that care in case of emergency. By ultimately choosing to participate in a homebirth, he gives the midwives a kind of credibility because if he was able to trust the midwives with his wife and baby, then any

¹⁴⁶ Ibid., 00:04:09; 00:04:15.

layman could. Ariel voices how difficult it was for him to give up control over the process. His interview addresses a discourse heard in many midwifery anecdotes about the need for mothers and midwives to convince fathers and grandmothers of the safety of midwifery. In this documentary film we do hear more from the fathers that we do in any of the other films explored in this project. The inclusion of their voices and experiences constructs the authority of birth as a family event instead of something only important to the mother.

At the end of the film we see the parents holding their babies above a caption that indicates the baby's name and "natural born" followed by their birth date. What does it mean for a child to be "natural born?" These mothers delivered out of the hospital, so perhaps it means an unmedicated birth, acknowledging what a midwife in *Natural Born Babies* says: "there's no epidural that can replace human touch."¹⁴⁷ If this is a "modern birth story," what is the role of midwives in the future? Will they become hybrid practitioners—"med"wives? Will continued suspicion and uncertainty on the part of powerful medical or insurance groups affect future laws to restrict the scope of midwifery care? Or will documentaries such as these continue to raise awareness of the heterogeneity of midwives and their practices?

¹⁴⁷ Ibid., 00:12:00.

Conclusion

The fourth season finale of *GIRLS*, an HBO series written and produced by Lena Dunham, is an episode entitled “Home Birth.”¹⁴⁸ Upon arriving home Hannah (played by Lena Dunham) discovers her ex-boyfriend’s counter-culture sister Caroline in premature labor. Naked in the bathtub, Caroline and her partner Laird are planning an unassisted homebirth. Horrified, Hannah begins to call for help while urging Caroline to get to a hospital. Minutes later, Caroline’s brother Adam arrives, yelling and screaming that they need “modern fucking medicine.”¹⁴⁹ This, of course, angers Caroline who, responds aggressively:

I am not going to distance myself from the beautiful process that is birth by tubes and drugs and fucking white lab coats. I am going to inhabit my body and bring this baby into a world of aware, peaceful individuals and not fucking drug addicted robots!”¹⁵⁰

Overwhelmed and anxious, Hannah breaks the tension: “You know, I watched the Ricki Lake-produced documentary *The Business of Being Born*, and it let me know that there’s a lot of different angles on this.”¹⁵¹ *The Business of Being Born* saved the day. The episode was spiraling

¹⁴⁸ Lena Dunham, “Home Birth,” *GIRLS*, directed by Lena Dunham (2015; New York: Home Box Office Inc.), Web.

¹⁴⁹ *Ibid.*, 00:13:53.

¹⁵⁰ *Ibid.*, 00:14:00.

¹⁵¹ *Ibid.*, 00:14:19.

into telling the same tales about the perils of homebirth, the nuts who reject the technocracy, and the ultimate safety of the hospital. But Hannah honed in on the importance of these documentaries as having extensive amounts of recognition and influence on modern conceptions of childbirth. Dunham, for her own part, has made a conscious decision to communicate to her viewers a more complex account of birth. The explicit reference of *The Business of Being Born*, in a way that almost mocks it, functions like a footnote both to direct an uninformed viewer to a film that will give more information, and to acknowledge that the documentary and *GIRLS* share an audience.

Ultimately, it is the irreverent, but firm and compassionate friend, Jessa, who communicates to Laird and Caroline the severity of the situation. Jessa realizes that the baby is breech and that the couple is going to have to overcome their hatred of the “birth industrial complex” and get Caroline to a hospital.¹⁵² Jessa tells Laird, “You need to get your wife out of the tub. . . I know you’re scared right now, but if there was ever a time to not be pathetic, it’s now.”¹⁵³ Adam faints, Hannah attends to him, and Jessa and Laird get Caroline out of the tub. Next we see the four of them holding Caroline in their arms, running down the streets of New York city while she screams and

¹⁵² Ibid., 00:18:56.

¹⁵³ Ibid., 00:19:39.

thrashes before ultimately making it to the hospital and delivering the baby with the help of the highly trained, drug-reliant “robots.”

Though untrained, Jessa holds the position of a midwife in this episode, protecting the safety of mom and baby while providing the physical and emotional support necessary for safe and healthy decisions to be made. As a character, Jessa is often lost; she is free-spirited, but searching for some kind of fulfillment in her life. Though unsanctioned, stepping into the role of midwife gave her clarity and sense of worth. At the end of the episode Jessa makes a decision about her future, illustrating her newfound self-assurance about her place in the world.

Did Caroline still have her baby in a hospital? Yes. Was she still painted as an extremist for rejecting the technocracy? Absolutely. But even the mention of *The Business of Being Born* brought in the gray area necessary to question these normative childbirth narratives. Through the characters in the room, the viewer had access to five different perspectives with vastly different experiences and opinions.

When *GIRLS* premiered in 2012 it was hyped as being being the next big feminist television series as *Sex and the City* had been for HBO in decades past—portraying girls living it up in New York City, broke and jobless with all the glamour of sex and drugs.¹⁵⁴ While it has been

¹⁵⁴ Philip Galanes, “Sex? Yes. The City? Yes. But things have changed,” *The New York Times*, January 17, 2014, Web; Alessandra

met with many valid critiques (including for its racial heterogeneity and content accessible primarily to educated, progressive millennials), *GIRLS* can be categorized as a work of third-wave feminism.¹⁵⁵ *GIRLS* highlights the importance of choice, while critiquing the society in which these choices are being made. Throughout the show, Dunham has consistently embraced the third-wave “philosophy of nonjudgement.”¹⁵⁶ In this final episode her inclusion of multiple perspectives extends nonjudgment into the realm of choices in childbirth. Dunham’s mention of *The Business of Being Born* speaks to the importance of these documentaries in shaping the public perception of midwifery and childbirth.

What is the value in thinking through these documentaries as texts, as artifacts of births that actually took place, as relics of relationships between midwives and birthing mothers? I have asked myself this question throughout the process of writing this thesis. I have worked to articulate the significance of these films as shaping an imagined history of midwifery in America. Collectively, the way we give birth tells a story about our society, about how we value women’s

Stanley, “There’s Sex, There’s City, but No Manolos,” *The New York Times*, April 12, 2012, Web.

¹⁵⁵ Judy Berman, “‘I’m a White Girl’: Why ‘Girls’ Won’t Ever Overcome Its Racial Problem,” *The Atlantic*, January 22, 2014, Web; This is just one example of an article that came out critiquing Dunham’s lack of characters of color on *GIRLS*.

¹⁵⁶ R. Claire Snyder, “What is Third-Wave Feminism?” in *Gender Inequality*, ed. Judith Lorber (New York: Oxford University Press, 2012), 310.

bodies, experiences, and wisdom. Documentaries are significant in that they offer a glimpse into a space that the viewer would not normally have access to—she can see a homebirth, perhaps out of the realm of everyday experience. Documentaries appeal to the senses and the imagination in a way that books cannot; they are incredibly persuasive. As a member of the midwifery community I am invested in how these powerful texts are shaping viewers' imaginations of midwives and their practices.

Through George C. Stoney's *All My Babies* we have explored the ways in which difference has molded the midwifery profession. *Granny Midwives in the South* were used and manipulated as tools to keep black mothers out of segregated hospitals. This film lays the groundwork for understanding histories of oppression and privilege in American midwifery; it opens up a conversation about how contemporary midwives are approaching racial and cultural difference. This film makes visible the varied history of midwifery, and it prompts inquiry into inequalities that are still present today.

The 1960s and 1970s provided the perfect political climate for the resurgence of midwifery. Ina May Gaskin's legacy is archived through *Birth Story*, and the audience not only has access to the story of one of the most influential midwives in American history, but also to a society and birth culture in which the voices of women hold the ultimate authority. Evidence of what was healthy, safe, and supportive came from the stories and experiences of women in the

community. Though the Farm midwives are the most well-known, self-taught direct-entry midwives all over the country made way for legitimization and professionalization of midwifery that continues today.

Surviving as an influential text in this neoliberal society, *The Business of Being Born* remains as a document of the science and expertise behind why an educated, rational consumer might choose midwifery care over the medical model. Unlike Ina May and the Farm midwives, those featured in *The Business of Being Born* are participating fully in the American, capitalist scheme. The film presents parents and practitioners with whom the viewer can easily identify, and by appealing to their intellect, their autonomy to make informed decisions about where and how to give birth, this documentary has captured the attention of mainstream audiences of all ages.

Brigid Maher's film *The Mama Sherpas* gives an unprecedented look into the world of hospital-based midwifery. These collaborative models of practice ask us to think about what it means to blend the midwifery model with the technocracy. There are aspects of midwifery care lost in the process, but moving into medical spaces also means increased access to midwifery for many patients who might regularly "risk out." Will midwifery and obstetrics continue to be separated into different spheres and philosophies of practice, or is this collaborative model the future of the profession?

Natural Born Babies blends the traditional and the modern, combating the hippy stereotype of midwifery with a contemporary construction of authority surrounding childbirth. Wielding the testimonies of well-educated parents, this documentary illustrates an alternative future of “natural” childbirth. It relies neither solely on the experiences of women and families nor on arguments of safety and economics. These films of diverse structure, authority, and reception question how conversations about the definition and role of the midwife will continue.

In doing research for this project I came across many films not discussed here.¹⁵⁷ Most of them centered on stories of homebirth midwives and mothers, and it is clear that these are becoming important texts for shaping the future of the midwifery profession. As our practices adapt and grow—change to incorporate new legislation, current evidence-based practices, and cultural preferences—so too will the stories that are being told through film. These documents are creating a space for the public to take part in the work of countering the master narrative of birth. They are providing access to important

¹⁵⁷ Some of these films include: Vicki Elson, *Laboring Under an Illusion: Mass Media Childbirth Versus the Real Thing*, Videorecording (2009; birth-media.com, 2009), Web; Marcia Jarmel and Ken Schneider, *Born in the U.S.A.: A Documentary about Childbirth in America*, Videorecording (2007; San Francisco: Kanopy Streaming, 2014), Web; Allison Kunzia and Melanie Moore. *Midwife: A Look into the World of Homebirth Midwifery*, Videorecording (2014), Web; Irene Lusztig, *The Motherhood Archives*, Videorecording (2013; New York: Women Make Movies, 2013), Web.

conversations that extend beyond the realm of childbirth to concepts of bodily autonomy, choice, and the intersection of those issues with history, culture, and class.

As the discussion in this project has emphasized, the way in which society constructs the experiences of both the mothers and those catching the babies reflects how they are situated in their communities. There is a popular epigram in midwifery circles: "Peace on earth begins with birth." I do believe that this is true, that if we can pay attention to the way in which people are birthing and bringing new life into this world, we will be better in touch with the reality and scope of human experiences. Exploration of these films is just one avenue to accomplish this, and there is an abundance of work available for those who wish to carry on the task.

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