

CONCEPTIONS OF BIRTH:
A THEORETICAL ANALYSIS OF BIRTH PRACTICES IN THE US AND MEXICO

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AND MEXICO

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ABSTRACT

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SUPERVISING PROFESSOR- ANA JUAREZ

This thesis uses ethnographic and historical data to examine how the worldview of a culture directly affects the birth practices utilized by that culture, in this case, the United States and Mexico. Two worldviews are analyzed for their influence on childbirth practices—the Western worldview, and the ecological worldview, which have molded and formed biomedical and midwifery practices, respectively.

Chapter One

Introduction

Context

In Western societies, the female body is often a very controversial topic. Private decisions regarding appearance, sex, lifestyle choices, and reproduction tend to take center stage in national and international cultural and legal debates. The most powerful and contentious of these is anything to do with reproduction. It is in this arena that women have had to fight the hardest for their rights—access to birth control and the right to use it, abortion, and child custody issues. However, a less-discussed but no less crucial side of the reproductive coin is women's rights and personal autonomy during the childbirth process. In the US and most of the westernized world, women today face one of the most powerful threats to their reproductive autonomy and human rights—the biomedical healthcare system. The biomedical healthcare system is the form of medicine practiced in the US and many industrialized societies that focuses on pathology and technological interventions. The philosophical foundations of biomedicine are the philosophical foundations of the Western world. As such, biomedicine is subject to the same biases and prejudices as any other facet of culture, despite its claims of objectivity.

In the United States particularly, birth practices have become increasingly politicized and a source of contention for many. This conflict is mostly between biomedicine, or 'hospitalized birth', and the advocates and practitioners of home birth. Though consumers are only recently waking up to the realities of the situation, this clash has been going on for over a century in America. Beginning in the late 1800s, physicians became integrated into the middle- and upper-classes (Feldhusen 2000:10). Healthcare suddenly became an industry in which it was possible to

make money and physicians began to form associations to protect and promote their professional and economic interests—the largest and most powerful of these was the American Medical

Association, founded in 1847. Almost immediately following its inception the AMA began a campaign to marginalize and remove lay practitioners from the American medical scene. It was quite successful at outlawing and removing bonesetters, herbalists, and many other lay practitioners from the practice of medicine, except for the midwives. Not willing to give up on what could and would be a very lucrative business, around the late nineteenth century the AMA began to wage one of the largest and most expensive PR campaigns in history, aimed at wiping out midwives. The campaign used a combination of stereotypes and prejudices directed against the competency and intelligence of women, blacks, immigrants, and the poor, combined with the promotion of the idea that childbirth was inherently deadly and should only take place in hospitals under the supervision of a doctor. However, despite claims to the contrary, giving birth with a doctor was dangerous and often deadly, so much so that in 1910 and 1912, reports were published stating that America's obstetricians were poorly trained and incompetent. These reports advocated that all poor women should only give birth in charity hospitals, which would then serve as a much-needed training ground for obstetricians so they would better serve the upper classes (Feldhusen 2000:10). In 1915 Dr. Joseph DeLee, author of the most widely used obstetrics textbook of the time, published an article in which he described childbirth as a pathological process that required constant medical interventions to avoid the deaths of the mother and child (Rooks 2006). Due to his theories, the medical model of childbirth in hospitals became an endless progression of interventions based on the fear of something going wrong, rather than the actual health or status of the mother and infant. To this day, most physicians do not believe that having a normal or natural childbirth without surgical or pharmacological interventions is even physically possible, and this lack of belief has influenced and shaped hospital and insurance policies. Because of the money and power behind the AMA it was incredibly successful in lobbying and passing legislation that still has repercussions today—by as early as the 1950s eighty-five percent of all births occurred in hospitals, up from five percent fifty years earlier, and midwifery is now illegal in all but 14 states. By the late 1960s, ninety-seven percent of all US births occurred in hospitals—a statistic that remains accurate to this day. As recently as 1993, the American Academy of Family Physicians released a statement in opposition to midwifery, specifying that all midwives should practice under physicians and that all payments should go through licensed doctors (Feldhusen 2000:12). Despite research and many, many case studies conducted by doctors, midwives, and social scientists showing that

midwives have equal, and many times, better statistics regarding outcomes than hospitals (Jannsen 2009, Rooks 2009, Null, Dean, Feldman & Rasio 2003), the AMA and the majority of American physicians refuse to believe that midwives are qualified, competent professionals. Just this year, the Canadian Medical Association Journal published results of a study into perinatal deaths showing that among equal risk-matched clients, physicians had higher death outcomes than midwives (Jannsen 2009: 6-7). This study echoes the findings of many American researchers, but to date the AMA has never published any articles or issued any statements in favor of midwifery.

Due to globalization and the perceived supremacy of Western biomedicine in developing countries, the US has begun to export its already ailing maternal health care system to other parts of the globe. As second and third world countries adopt Euro-American cultural norms and institutions, they also adopt the ideologies that come with those institutions, as is the case with Mexico, which borders the United States and is heavily influenced by its policies. Unfortunately, recently globalized countries, Mexico included, do not have the infrastructure to fully support a biomedical model.

The Mexican government has whole-heartedly adopted policies supporting and enforcing the supremacy of Western biomedicine. In Mexico, government officials push for the increased medicalization and westernization of the process of birth, but in most parts of the country hospitals are distant and when nearby, often dangerously under-staffed and under-funded (Davis-Floyd 2000:69). The Mexican healthcare system has three tiers—The Mexican Institute for Social Security (IMSS), the Ministry of Health (MH), and the private sector.

Healthcare reforms in the 1990s brought the number of rural poor using the MH up to about 11 million, or fifty percent of the Mexican population. The MH is the largest component of the Mexican healthcare system and is currently undergoing decentralization. Hospitals in the MH system are often the most understaffed and underfunded. Because of budget deficits in the 1980s, many hospitals are using obsolete and worn-down equipment. These deteriorating conditions have immediate effects on patients (Lloyd-Sherlock 2000:130). As one study found, “a baby born in a MH hospital was three times more likely to die in its first seven days of life than a baby of the same weight born in an IMSS hospital” (Lloyd-Sherlock 2000:134).

The second largest component of the Mexican healthcare system is the IMSS, which serves about 40 percent of the Mexican population. The IMSS provides services for workers in the formal private sector, as well as federal civil servants, the armed forces, and some state employees. Unlike the MH, the IMSS also implements internal programs designed to promote greater technical quality, with an emphasis on more thorough regulations and evaluations (Thai 2002:225). The remaining ten percent, generally the wealthiest, of the Mexican population has their medical needs met through the private sector. The private sector operates on a similar level to American healthcare, if not an equal level. This equality in care is matched by equality in cost, something that relatively few Mexicans can afford. Most private hospitals are found only in urban areas, and those who are not well off are denied the best biomedical services in the country by social and economic class and are instead shuffled into second- and third- class hospitals.

Since the American model of birth places all of its trust and faith in the ability of technology to triumph over the fundamentally flawed physiological process of birth, the only way that the American model can be applied faithfully is in places where the equipment and technology is available (Davis-Floyd 2003:71). When the appropriate technology and training isn't even available, the already risky biomedical system becomes dangerous for the safety and well-being of laboring women and infants. Based on ethnographic research I conducted in the summer of 2009 in Quintana Roo, Mexico, it is clear that currently, most hospitals and clinics in Mexico, both rural and urban, are not set up to support the kind of births that most politicians consider to be evidence of progress. The average town clinic (Centro de Salud) has no experienced surgeon capable of performing episiotomies and C-sections, let alone an anesthesiologist on staff. Sterile operating rooms are few and far between and many women express disgust at the conditions in local hospitals. In Mexico, midwives still attend the vast majority of births in areas that are far from hospitals—especially undeveloped indigenous areas. However, this is being challenged by the increasing rise of a middle class and the correlating increasing dominance of a wage labor economy.

Families are leaving the villages where they have traditionally lived in search of paid jobs. When the families leave, they sever close ties to traditional medical practitioners, such as midwives. Once they arrive in the new city or town, it is often very hard to find a new midwife whom they deem trustworthy and can form a close relationship with. In addition, middle and

upper class women in cities and urban areas are urged to be modern and go to hospitals to utilize doctors instead of midwives—a transition that in many ways mirrors the one which took place in America. If an upper-class or middle-class woman lives far away from a hospital, it is usually arranged so that she will travel to a city in order to give birth with a physician and have a C-section. As Judith Rooks has pointed out, “Cesarean section rates...are highest among well-educated, upper class women who receive their care from private physicians. Thus high-tech obstetric care, including cesarean section, acquires the patina of modernity and ‘the best care money can buy’” (Koop 2001:206).

The use of a midwife or *partera* is rapidly becoming associated with poverty, indigenous peoples, and of course, dangerous and superstitious practices (Davis-Floyd 2003:1929). According to Fernanda Alonzo, a midwife in Chiapas and MANA representative for Mexico, Mexico’s Cesarean rates are close to the highest in the world, at over 40 percent and rising. In the cities, where women are much more likely to use private physicians, the statistics are often much closer to 80 percent. Mexico also has the dubious honor of hosting the city with the highest Cesarean section rates in the world—Monterrey, at close to 90 percent.

Positionality and Methodology

The theories I utilized and the conclusions that I drew from my research are of course influenced by my personal history and beliefs. I consider myself to be a feminist and have been for as long as I can remember. I grew up reading about the pioneering efforts of Mary Wollstonecraft and Elizabeth Cady Stanton and I have always been very aware of how misogyny and discrimination still influence our culture today. Through my scholarship, I do not wish to elevate either sex to a position above the other but rather call attention to inequalities and promote changes that will finally enable true equality and human rights for both sexes.

I am a first generation American—my family only recently emigrated from Canada in the late ‘80s. My family is lower class and my father self-employed, so we have never had health insurance or easy access to medical care. However, I consider this to be positive in terms of my research topic because I am more aware of and comfortable with alternative forms of medicine. In addition, my family continues to use old family remedies for less serious illnesses and injuries and this contributed to an early education in herbalism and homeopathy. Though this has aided

in my comfort with the topic, I was not familiar with midwifery at the beginning of my research. I had heard about it before in passing, but I began this project without any particular bias in favor of a certain birth method. Though I now consider myself to be a supporter of midwives and the Midwifery Model of Care, I did not start out that way. Rather, I have arrived at this point as my research and knowledge of birth systems have developed.

My research occurred over a period of approximately twelve months, beginning in central Texas and culminating in Mexico. For the first 6 months, I researched midwifery and the biomedical healthcare system in central Texas, and the next two months were spent in Tulum, Quintana Roo, and San Cristobal de las Casas, Chiapas. In December 2009, I attended an International Midwifery Conference in Tulum, along with approximately 250 *parteras tradicionales* from Mexico and Guatemala, Professional and Nurse Midwives from the US, Brazil, Costa Rica, Colombia, Canada, Spain, Ecuador, and Cuba, physician midwifery advocates from Brazil, Ecuador, Denmark, and Mexico, and public health officials from Brazil and Mexico. Later this same trip I also returned to San Cristobal de las Casas in Chiapas to do some follow-up interviews in the midwifery clinic there.

In Texas, in addition to a historical and literature review, I interviewed midwives, nurses, midwifery clients, hospital clients, other anthropologists, attended childbirth education classes in both the hospital and midwifery setting, and took tours of hospitals and birth centers. In Mexico, I interviewed local, indigenous, and expatriate midwives, indigenous and expatriate midwifery and hospital clients, and an anthropologist. Through my attendance at the conference in December, I met and informally interviewed approximately fifty midwives and doctors, as well as heard ethnographic and personal accounts through my participation in various workshops, panels, and forums. Overall, I formally interviewed twelve midwives—four Certified Nurse Midwives and five Certified Nurse Practitioners, two traditional Mayan *parteras*, one independent midwife in Chiapas, three nurses who work in a hospital maternity ward, one doula, one Lamaze certified childbirth educator, two fathers who participated in the homebirths of their children, two anthropologists specializing in midwifery studies, and multiple midwifery and hospital clients in central Texas, Tulum, Mexico, and San Cristobal de las Casas, Chiapas, Mexico.

On average, I met with each midwife multiple times and the interviews ranged anywhere from thirty minutes to two hours. In addition, I had several informal conversations with the fathers of women who have given birth with a midwife. Through my participant observations in the hospital and in midwifery childbirth education classes, I met and informally and quickly interviewed approximately 25 expecting couples. I was unable to directly interview any obstetricians/ gynecologists (OBGYNs) or doctors in the US, but my literature review and discussions with hospital nurses and staff has helped to fill in what gaps I might have otherwise had. Through my participation at the conference in Tulum, I interviewed three OBGYNs and one family practice doctor who are very involved in the obstetrical practices of their countries—Mexico, Ecuador, Brazil, and Denmark. Though they are not from the United States, they are subject to the same practices and worldview that has caused the maternity healthcare crisis in the US and so their opinions and experiences are entirely applicable to the American healthcare system.

In order to protect the identity and safety of my informants, I have used pseudonyms where they are quoted and at times slightly altered their locality in cases where it would be otherwise obvious who they are. Formal interviews generally occurred after a series of informal conversations with the subjects in order to build a relationship and sense of trust. To my surprise, with the exception of biomedical practitioners in the United States, all of my interviewees were thrilled to speak with me once they heard about my research and the themes I was concerned with researching. Midwives and midwifery advocates were delighted to share the details of their cause and insistent that I truly understand the Midwifery Model of Care and its importance to women. The mothers I interviewed about their birth experiences were also adamant that I record and take notes during their stories to preserve the information I was receiving. The hospital clients felt this way because they felt that the discomfort, and oftentimes horror, of their experiences was something that must be taken into account if any positive changes are to be made. The midwifery clients felt this way because they wished to share a story of how beautiful and empowering the birth process can be when undertaken with faith and trust in the female body.

Throughout this process, I have done my best to honor my informants' experiences and use as much ethnography as possible. Scholars often forget about the experience of the

individual, preferring instead statistics and generalized accounts. However, in order to address the global crisis in maternity care, scholars must note the many voices clamoring to be treated as individuals whose experiences matter. Until this happens, women's human rights and autonomy will continue to be trampled and ignored by the demands of development, profit, and "progress".

Theoretical Perspectives

In seeking to explain the recent phenomenon of biomedical supremacy over practices that have existed for all of human memory, I found that historical perspectives, globalization theories, ecological theory, and broader social theories were necessary to see the full picture. As Paul Farmer put it, "Without a historically deep and geographically broad analysis, one that takes into account political economy, we risk seeing only the residue of meaning. We see the puddles, perhaps, but not the rainstorms and certainly not the gathering thunderclouds" (Farmer 2001:309). In my consideration of globalization and biomedicine, Michele Foucault's theories of biopower and Paul Farmer's work on structural violence proved to be indispensable in analyzing the origins of and the reasons behind Western society's treatment of childbirth. In addition, invaluable to my treatment of the Western worldview and its effects on our contemporary society were the ecological theories of Ralph Metzner, Carolyn Merchant, and Debora Hammond. In terms of understanding contemporary midwifery practices and beliefs, the ethnographies and analyses of Robbie Davis-Floyd and Bridget Jordan proved to be indispensable to forming a solid foundation and background in my own understanding and conceptualization of birth practices.

To explore the foundations of the Western biomedical maternity system I turned to an apparently unlikely source—ecological theories and philosophies. Recent works in ecology are very concerned with the roots of Western society and how that society has influenced, and continues to influence the world. A prominent concept in this field is that of the Western worldview and its effects on the past, present, and future. In anthropology, this is known as "Discourse and Ideology", but I chose to call it "worldview" due to the theoretical grounding of my work.

Theories of the Western worldview provide outlines for examining the institutions of Western society within a historical, philosophical, and theoretical context. Ralph Metzner and Debora Hammond, two very eminent ecologists specializing in systems theory, lay out the

general tenets and patterns of the Western worldview, as well as the ecological worldview. I utilized these patterns to analyze biomedical and holistic birth practices within their respective worldviews.

Using these worldviews, specifically the Western worldview, I was able to extrapolate how two other theories of state social structure, biopower and structural violence, can be applied to biomedical maternity care. Both are perfectly in line with the tenets and themes espoused by the Western worldview, and both serve to help explain how such things not only occur but also are sanctioned by most of Western society. Structural violence theory, in general, explains how widespread acts of violence against particular ethnic, social, religious, and gender groups not only occur within Western societies but are often sanctioned by them based on the demographics of the victimized group and the structure and values of the society (Farmer 1999:305-325). However, where Paul Farmer believes that biomedicine is above the biases and prejudices of Western society and seeks only to correct the violence perpetrated against minorities, I disagree. The biomedical system is wholly a product of the Western worldview and as such, is subject to the same pressures and philosophies as any other Western institution. While biomedicine should be championing the rights of marginalized populations, including women, unfortunately it often seems to do the opposite. Though political economy is at least partly to blame, another interpretation can be found in the works of Michel Foucault.

Michel Foucault traces the development of modern Western conceptions of power—what it means, who wields it, and who is excluded from wielding it. Biopower is a technological tool of the state used to control groups. Rather than the historical sovereign holding the power of death over the population, the focus of power in the industrial age has shifted to the power to control and promote life. According to Foucault, this is evident in the view of the body as a machine and in the development of biopolitics—societal methods of controlling the anatomical and biological processes of human life. Biopolitics is especially concerned with issues revolving around reproduction and reproductive rights, because controlling birth is one of the most important methods of controlling life. In addition, Foucault also pointed out that the stakes are very high when the matter at hand is life itself. He goes on to say that this enables the state to justify almost anything in the name of preserving life, even death and violence (Foucault 1998). I found his work on this topic to be highly applicable to the US medical system, particularly the

birth practices espoused by said system. Mandating, either by law or social norm, that all births take place in hospitals gives the state unprecedented control over every newborn and mother and allows it to drastically influence what is a very fundamentally powerful rite of passage for women (Davis-Floyd 2003).

Chapter Two

Conceptualizing Biomedicine

Though scientists today have recently reached groundbreaking conclusions about the nature of the universe and even the concept of time itself that lend themselves to an understanding of our universe as cyclical, interconnected, and unified, those theories, such as the Heisenberg Uncertainty Principle and String Theory, have not yet had the chance to directly influence our society or worldview. They are not yet considered “mainstream science” and the majority of the non-physicist population has never heard of them. There is inevitably a lag between the introduction of new concepts and the application of those concepts in the every day, and when they are actually incorporated into a worldview they may be very different from the original idea. The same can be said of the discoveries of the Scientific Revolution. Beginning with the groundbreaking works of Newton, Galileo, and Descartes, scientists and the societies they came from began to see the world not as a unified, interconnected system, but as a series of “quantitative, mechanical models of physical processes [which] developed in the course of three centuries into a mechanomorphic worldview” (Metzner 2006:91).

Though they may have started as purely scientific concepts, several centuries and various interpretations of these theories combined with the technological advances of the industrial age have created a mechanomorphic, industrial, worldview stressing hierarchy, sexism and racism, capitalism, limitless economic growth, exploitation, and the domination of nature, and has spread to encompass most of American culture and society (Metzner 2006:90-99).

Table 1. Themes of the Western Worldview

Mechanomorphic	Linear Causality	Conquest of Nature
Control, Domination	Exploitation	Patriarchy
Racism, Ethnocentrism	Hierarchies	Profit-Driven Technology
Specialized Disciplines	Competition	Limitless Growth

Table adapted from Transitions to an Ecological Age (Metzner 2006: 89-100)

The industrial worldview also places a great deal of emphasis on the pursuit of profit and power to the extent that in many cases, shortsighted visions of the future are the norm. Though admittedly the scientific revolution is responsible for much advancement in the fields of medicine, politics, and technology, it is also responsible for many negative developments in Western culture.

In this chapter, I will examine how the principles of the Western worldview have shaped biomedical maternity care in the United States and how this system is affecting Mexican biomedical maternity care as well. I will then demonstrate the effects that this system is having on women’s health and experiences during labor in hospitals. Though the Western worldview has done many great things for our society, it has also fostered negative practices, particularly in the field of maternity care.

One of the most powerful and far-reaching principles of the Western worldview has been the conception of the body as a machine. As Debora Hammond said, “while it is important to acknowledge that these insights have led to enormous technological progress, giving humankind an unprecedented mastery of nature, Bertalanffy, like many other before and since, argued that the worldview they reinforced led to an impoverished view of humanity and, ultimately, a diminished quality of life” (Hammond 2005:21). In the words of Bertalanffy himself, “The acceptance of living beings of machines, the domination of the modern world by technology, and the mechanization of mankind are but the extension and practical application of the mechanistic conception” (Bertalanffy 1952:135). This concept of humans as machines is particularly prevalent and dangerous in the Western system of biomedicine, a system that has taken the mechanistic and reductionist tendencies of the Western worldview to a completely new level. Furthermore, the perceived dominance of technology over nature has had a profound effect on

the way American society views the processes and functions of the human body, especially the female body.

Gender Marginalization

Birth is a deeply gendered process. Though in some cultures, including the contemporary United States, men actively participate in the birthing process as aids and helpers to the mother, birth remains a private female process attended only by other women in most non-Westernized areas of the world, including the United States (Jordan 1993:33). As such, in Western history the act of birth has been presented as something mysterious and even dangerous, for that is how it has often appeared to men, standing on the outside looking in while female midwives took care of females in labor. Since until very recently it was men who wrote literature and decided what was history, birth has been passed down in Western culture as something to be feared, even as it is a cause for celebration when everything turns out right. For birth, in all its beauty and necessity, is also a time of extreme liminality. Mother and infant are bridging the gap between life and death as a new person is brought into the world. This proximity to the divide between life and death presents a threat to society. As Foucault has pointed out, "...it is over life, throughout its unfolding, that power establishes its domination; death is power's limit, the moment that escapes it; death becomes the most secret aspect of existence, the most 'private'" (Rabinow 1984). Western society can only control its population during life.

As birth, though an entirely natural and necessary process, is so proximal to death, it also presents the same threat to the supremacy of biopower. In order to attempt to mitigate the consequences of this, Western societies built on the practice of biopower need to control the process of birth as much as possible. In contemporary society, the agent of control is the Western biomedical healthcare system. In fact, numerous studies and books have been written exploring the function of biomedicine in controlling the population and ensuring the transmittal of Western values and norms (Farmer, 1999; Morsy, 1995; Davis-Floyd 2003). As Robbie Davis-Floyd's book *Birth as an American Rite of Passage* points out, nearly every policy and procedure of birth in the hospital contains a ritualistic meaning—from laboring women entering the hospital being forced to sit in a wheelchair to mandatory shaving and enemas (Davis-Floyd 2003). If, as these theories suggest, hospitals and hospital practices are the agents of biopower, then anyone who attempts to escape these agents must be encouraging the threat that uncontrolled birth presents to

Western society. Midwives and advocates of homebirth are often cast in opposition to Western biopower and the practices it mandates during the childbirth process. The conflict first emerged in the late 1800s as biomedicine began to achieve hegemony over lay practitioners and has since crossed many spheres.

This intrinsic conflict has deeply influenced how the Western world views midwives and has sought their erasure. As Paul Farmer stated, “Erasing history is perhaps the most common explanatory sleight-of-hand relied upon by the architects of structural violence. Erasure of distortion of history is part of the process of desocialization necessary for the emergence of hegemonic accounts of what happened and why” (Farmer 2004:308). The ancient association of midwives with benevolent wise women who maintain the transmittal of culture has been supplanted by contemporary stereotypes of the dangerous midwife, where people still remember that such things as midwives exist. In contemporary Western society she is often presented as an old crone, never married or anchored to a family and therefore not truly a part of the social structure (Ulrich 1990:46). She is a wildcard, and exists outside of the control of the biopolitical sphere. As several of the midwives I spoke to in central Texas told me, in Western countries, particularly America, the popular image of the midwife is linked to the image of the witch, whispering over a cauldron of herbs, possibly using magic to harm. For a patriarchal society, the midwife represents something dangerous—a refusal to accept male domination (and therefore societal domination) over all aspects of life. For, as a midwifery client who recently wrote her Master’s thesis about birth histories informed me, “birth and breast feeding have historically been the only sliver of a woman’s life that she could have any control over”.

This stereotype and fear was something that male-dominated physicians’ associations relied upon to convince families to give birth in a hospital. Midwives were misrepresented as superstitious old women with no medical knowledge whose incompetency and even malevolence killed women and infants. As Allison Dougal, a CNM who has been practicing for nearly forty years in central Texas stated, “Midwifery has been dogged by this negative impression since about the 1800s when there was that transition. And every midwife in history is portrayed as a dirty, slutty, alcoholic who kills people. They are portrayed as ignorant potential baby killers”. Due to the sexist nature of American society, particularly in the early 1900s, these stereotypes served to put most midwives out of business, despite numerous reports and studies proving that

obstetricians actually had far worse infant and maternal mortality rates than lay practitioners (Feldhusen 2000:12). According to Ina Forrest, a CPM in Austin, even in modern times “some of the misconceptions are actually supported by the American College of Obstetricians and Gynecologists—they love to spread it around, and the American Medical Association—they like to maintain the scary stereotypes of the ignorant midwife”. Despite the abundant statistics and studies in favor of natural, humanized birth, physicians’ associations continue to maintain that somehow all of the studies and numbers are incorrect or are the result of deception. At the midwifery conference I attended in Tulum, one of the midwives from Oregon shared this anecdote about conflicts in her own state.

About ten years ago in Oregon, officials started to realize that there had been a huge increase in the past five years in infant and maternal mortality rates. People started to demand answers, and the physicians’ associations immediately blamed the midwives, saying we were incompetent and directly to blame for all the deaths. An outside agency began to investigate, and they found that not only were midwives not to blame for the increase in deaths, but no midwife in the state had lost a mother or a baby in over six years!

Unfortunately, not every accusation against midwives is actually investigated for veracity. Far too often, politicians and the media take the word of physicians without doing research to ascertain the truth of such claims, and midwives’ positions in society become more and more marginalized. The associations that formed years ago to wrest control of healthcare from women, ethnic minorities, and the poor continue to defend the hegemonic interests of biomedicine against the only remaining lay practitioners: the midwives.

The Suppression of Nature and the Need to Fix Women

Once the midwives had mostly been gotten rid of, birth came to be conceptualized biomedically almost universally in the United States. Since biomedicine was influenced greatly by the Western worldview, many of the practices in biomedical maternity care have direct links to principles of the Western worldview. One of these principles is the need to control nature, and as feminists and ecofeminists have argued for decades, the subjugation of nature is intrinsically connected to the subjugation of women (Metzner 2006:89). For most of human memory, cultures

have identified women with nature and the natural world (Merchant 2008: 259-276). To form a system based upon the idea of dominating nature is, whether consciously or not, to form a system based upon the idea of dominating women. Nowhere is this skewed view of the female body as inherent or practicable as in the field of obstetrics. Robbie Davis-Floyd, a prominent anthropologist in the field of reproductive studies, can best summarize an introduction to this concept. She writes,

This metaphor of the body-as-machine could have been inherently egalitarian, but the industrializing nations of the West were male-centered, patriarchal societies. Thus, the male body came to be medically viewed as the prototype of the properly functioning body-machine. The female body, as it deviated from the male standard, was regarded as inherently defective and dangerously under the influence of nature, which due to its unpredictability, was itself regarded as in need of constant manipulation by man (Merchant 1983; Davis-Floyd 1992). As a result, despite the growing acceptance of birth as mechanical like all other bodily processes, it came to be viewed as an inherently imperfect and untrustworthy mechanical process, and the metaphor of the female body as a defective machine eventually formed the philosophical foundation of modern obstetrics (Davis-Floyd 2001: S6).

Once the female body was viewed as inherently broken, the next logical step was to fix it. The biomedical treatment of pregnancy and birth is an excellent example of how the Western worldview has shaped practice. What nature has broken, technology will and must fix, for women's bodies are viewed as being incapable of safely delivering a child without outside intervention. Natural childbirth without interventions is perceived by the biomedical model to be incredibly dangerous and also impossible. In hospitals, according to CPM Ina Forrest,

What they're trained to see is pathology. They never see, most of them never see a completely natural birth. We (midwives) do normal, healthy birth, and we are experts at that. They don't understand that. They see things in terms of pathology. And that's what the textbooks focus on. If you read Williams' Obstetrics and compare it to one of our textbooks, the focus is completely different. If you're always looking for what's wrong, that's all you're going to see: The potential. That's why every woman who walks into the hospital to have her baby is treated like a potential C-section. She's not allowed to eat, not allowed to walk around, she gets an IV or

at least a HEP block, she gets a fetal heart monitor, despite the fact that the evidence shows that it's not necessary (and has been linked to increased complications during labor). And it keeps her immobile; it is nearly impossible to have a natural birth when you're immobile. So when you're always preparing for the inevitable you tend to make that happen.

Midwives and advocates of natural childbirth are fully aware of the threats that the Western worldview poses to women's health and autonomy. In nearly every interview I conducted with midwives and mothers, the concept of a lack of faith in women's bodies was mentioned repeatedly. As an American doula, Elli Thompson, said when discussing the preference of physicians for C-sections and other interventions,

They don't trust your body. And pretty much the whole medical system doesn't trust the body, says the body is a ticking time bomb where things are going terribly, terribly wrong, and obviously that model applied to birth makes for worse experiences and emotional trauma and all that kind of stuff, which is not really healthier. We're creating problems because we're looking for them, and it's just a shame.

Controlling the Birth Process

Even today, when women in the Western world have more power and rights than they have had for centuries, the gender inequalities associated with giving birth in a hospital are substantial. Though more women than ever before are entering into the practices of gynecology and obstetrics, this hasn't caused any great changes in the medical model of childbirth. As Amanda Barnes, a local CNM who has been practicing for over 30 years put it,

I think I have been more disappointed with female obstetricians than any other kind of physician. Back in the '70s, I just knew that female obstetricians were going to take this thing called womanhood and project it on to medicine, and it was going to change medicine. And it didn't happen. American medicine is still very patriarchal. You have to be very male-like to survive. The woman obstetricians, a lot of them, have become more male-like than the men. What is that? Domineering, a certain arrogance there, that they know everything. Being coercive and manipulative [of their patients].

One of the most prominent examples of how the hospital birth model places a greater importance on male dominance than female comfort and control is the position in which women are required to give birth in hospitals. Indeed, because of media enculturation and training, many younger generations born after the 1970s believe that the “natural” birth position is with the woman lying flat on her back, often with her legs tied down and restrained. However, scientifically there is no reason for a woman to give birth while lying on her back (Gupta JK, Hofmeyr GJ, and Smyth R. 2004:16). A woman lying on her back is decreasing the size of the birth canal by over 30 percent, increasing the pressure on her perineum and thus increasing discomfort and pain, and greatly increasing her chances of sustaining injury to herself and her infant, which then necessitates dangerous interventions. In addition, the combination of the lack of gravity and a smaller birth canal means that the woman is far more likely to become exhausted from pushing her child against a partially closed opening, which often tears, causing intense pain and sometimes infection for weeks afterward (Hofmeyr 2007). As Dr. Marcos Leite, an obstetrician from the Brazilian Ministry of Health, stated recently at a conference for humanized childbirth, “The only position worse for giving birth than the lithotomic position would be if the woman was standing on her head.”

Enculturation of hospital practices has been extremely successful, regardless of the actual quality of those practices. As one young father in central Texas told me in the hospital after his exercise class in a conversation about his wife’s third birth, “She’d been in labor for a while in the tub and it took a long time, so she just had to do it the traditional way, lying flat on her back on the bed”. However common this position is to modern Americans, 500 years ago it was completely unheard of and shocking to midwives—the only people who knew anything substantial about the process of childbirth. Susan Ekhert, a CPM in central Texas told me this story about the origins of the lithotomic position. Later, I also found it referred to in a scientific study (Gupta 2004). According to them both, the lithotomic position (woman lying on her back) originated with King Louis IX of France. Oddly enough, this is also one of the first recorded times that a physician attended a childbirth rather than a midwife. Louis had a sexual perversion and wished to see one of his mistresses give birth. The midwives were disgusted by this and refused him entry into the birthing chamber, so he replaced them with one of his own physicians. Frustrated that he could not easily see what was going on around the mistress’s vagina, he ordered that she lie on her back so he could get a better view of the action. Because Louis was

king of a very easily influenced court, it quickly became fashionable for women to give birth while lying on their backs with physicians in attendance (Gupta 2004:15). When one looks at a timeline of birth practices, one can easily see that the rise in the use of the lithotomic positions directly correlates with the advance of obstetrics.

If there is no scientific reason for the lithotomic position, then why is it the preferred position in hospitals? The answer is convenience and control. Certainly not for the woman in labor, but for the doctor it is far more convenient than allowing a woman to be actively in charge of her birth--standing, walking around, and monitoring her own progress. It is much more comfortable for a doctor to sit on a stool at the end of the bed to monitor the progress of the birth and intervene. It is the ideal position for the doctor to remain in control of the birth. Cristina Roco, a mother, midwifery advocate, and anthropologist in Tulum, firmly believes this, and stated during an interview,

... the lithotomic position is the foundation of all these controlling practices and unnecessary interventions. This position, where you must be lying down the whole time--you aren't allowed to be in another position. Why is this? It is because it is the form that is most comfortable for them and it isn't important if you are comfortable. The main thing is that they [the doctors] be comfortable to receive the baby.

Even the biomedical and prominent obstetric textbooks agree, "The lithotomic position is best. Here the patient lies with her legs in stirrups and her buttocks close to the lower edge of the table. The patient is in the ideal position for the attendant to deal with any complications which may arise" (Oxford and Foote 1975:110). Though later editions of this textbook, even those published twenty years later, omit the explanation of why the lithotomic positions is supposedly the best, they still recommend that physicians utilize the lithotomic position (Davis-Floyd 2003:121-122). Even though the more progressive hospitals of today encourage women to walk during labor, for the actual delivery women are generally required to "assume the position" (Davis-Floyd 2003:119-120). This position, particularly when combined with stirrups and other operating room procedures, effectively allows the doctor to be in complete control of the birth process and exercise the full power of his position.

Ironically, it is this birthing position that causes the very problems for which the doctor needs to be prepared to fix! Even in more modern and progressive hospitals that have done away with the custom of strapping women to the bed there are still ways of ensuring that the laboring women be flat on their backs in bed. When I did participant observations in a central Texas hospital during maternity ward tours and childbirth education classes, I had the opportunity to compare hospital policies and stated practices with actual practices. The childbirth education classes as a whole taught the expectant mothers that they would be in control of their birth process and that they could choose which position to labor in. However, during a tour of the maternity ward I spoke with several nurses who unanimously stated that women were not allowed to labor in any position besides the lithotomic position unless their doctor would allow it—an occurrence they said was so rare it was nearly nonexistent. They showed me that the new way to keep women from moving is the increasing use of mandatory electronic fetal monitors and IV drips. Women are told that they must be attached to both the entire time they are in labor for the safety of their baby. However, numerous reports and studies prove that neither of these practices are beneficial to the mother or infant, and in fact increase the likelihood of a C-section or episiotomy (Davis-Floyd 2003:106). Even shifting positions on the bed becomes difficult when the woman is hooked up to multiple machines, and walking requires significant effort and willpower on the part of the woman. Thus, women are unable to dictate the terms of their birth experiences and are instead forced to rely upon alienating technology and doctors to accomplish what would normally be a more spiritual and autonomous act.

Structural Violence in Ethnographic Accounts

Since the medical system is intrinsically connected to Western ideologies regarding the inherent flaws and dangers of nature, physicians and hospitals reason that the safest and best course of action is to refuse to give nature any space to malfunction. This line of thought says that the more technological a birth is, the more control the doctors have and the safer it will be. However, reality does not support the theory. Closely linked to themes of the technological domination of nature and women is the reoccurring theme of medical incompetence and unnecessary medical interventions during hospital births. In the US, iatrogenic deaths, deaths due to medical incompetence or mistakes, rank as the third highest cause of death—second only to deaths from heart disease and cancer (Null, Dean, Feldman, and Rasio 2003:2). Though

Americans are used to thinking of doctors as being infallible, unfortunately the statistics prove otherwise and in fact suggest that entering a hospital when not strictly necessary is extremely dangerous. This goes doubly so for hospitals in Mexico, where infectious diseases are even more common than in the US and cleanliness is so rare as to be nonexistent. As a mother in Tulum told me during an interview,

I studied psychology in Switzerland, and I worked in a psychiatric hospital. I know what hygiene is. Here...I've seen things...here it's not only unnecessary medical interventions, but it's unnecessary and it's unclean and unsafe too. It's just irresponsible to go to a hospital. Only if I was dying would I go to a hospital.

Among the women interviewed, many of them expressed distrust in the competency and knowledge of doctors. Even Remy Samson, a woman who had to be rushed to the hospital following a home birth due to her son being born with only one lung stated, “We called the emergency room ahead of time and they still made a lot of crucial mistakes at that point. I'm not convinced that if we'd had it there [in the hospital] it would have been any better”. In fact, she also stated that her midwife was able to diagnose what was wrong with her child and stabilize him before any of the doctors had figured out what was happening.

Among interviewees in Tulum, horror stories about hospital births were rampant and eagerly discussed—common themes were iatrogenic injuries and deaths, fetal and maternal mortality due to abuse and neglect by nurses and doctors, physical and emotional abuse, unsanitary conditions in operating rooms and wards, and acts of racism and sexism. Though the American model of birth generally does not include unsanitary conditions or such extreme and blatant human rights violations, when transplanted to an area without the services and infrastructure to support it the inherent weaknesses in the system open it to horrid abuses. Once such story, related to me by a Swiss midwife who trained with a traditional Mayan *partera*, demonstrates the incredible human rights violations that women in Mexico face in some hospitals:

[One woman] had her baby in [a hospital in] Felipe Carrillo Puerto, and she just sat down with me one day—I think she just had to get it all out, because it was so traumatic. She said that they did an episiotomy, but that it was so deep that it ripped open

her anus and everything around it. Then they sewed her up and she started pooping from her vagina because they sewed her up wrong, so they had to go back again. When she was giving birth the doctor came and gave orders to the nurse, and then the nurse came and said they were giving her an epidural. She said, “No, I don’t think I need one...” And the nurse said, “Shut up!” and gave her an epidural. Then the doctor came and said “What the fuck did you do?! That’s the wrong woman! The woman over there is having a C-section and needed the epidural!” So she had to have her baby with an epidural. And she said that while she was sitting there in labor, they rushed this woman by her, and she was saying, “I have to push!” And they said, “You can’t push now!” And she couldn’t help it and pushed and the baby fell on the floor and died! And they said, “Well, that was her fault.” I think she just had to get it off her chest...I think she was pretty traumatized.

Yet another example from Mexico demonstrates similar themes of medical incompetence, the overriding of the patient’s wishes and rights, and also a refusal of biomedical practitioners to take responsibility for negative outcomes. As Cristina Roco, Mexican anthropology student and mother said,

They injected me. When I arrived, I had asked that they not give me oxytocin [to induce labor], that I didn’t want them to inject me with it, but they began to connect me to an oxytocin drip. Then they [reassured] me, “No, no, no; It is only a serum because you are very weak and we need to put it in you. And I said, “Okay, that’s fine”... They left me there. They injected an epidural, and later they left me with the syringe for anesthesia still in. That is how it was there for another shot of anesthesia when it was going to be necessary. This was the first time I had been given an anesthetic.

Afterwards when I had finished sleeping a little from the anesthesia, and woken up about 2 hours more or less, I was already in a lot of pain again. I asked to nurse to check to see how I was doing, because I could feel the contractions again. She checked me and said, “You can’t be feeling contractions because you haven’t advanced enough. We will wait a little and you will be fine”. Then all the doctors went running to the operating room because there had been an abortion, and I was alone. I had looked at the clock and noted the hour when they gave me the anesthesia, but the nurse didn’t note it in the file. Then I began to feel very bad, I felt as though my legs were shaking and my

body...I was helpless. But the nurse had given me another shot of anesthetic after the one I'd already had. She said, "I'm going to put another in you because the other does not work to relieve pain". After doing this she left.

Then, suddenly a doctor came walking in and I said to him, "Help me, because I'm feeling something very bad!" He scolded me. He said to me, "Oh, Senora, you stop screaming! You do not have to shout so! You will be calm, everything is fine". I told him, "No, everything is not fine, because I feel like my legs are shaking. They left me lying down with the belt to monitor the baby. I wanted to rise to be free of the belt because I no longer wanted to be lying down, but when I rose, I felt like my whole body was asleep below the neck, numb with drugs. I don't think that this is normal, because the injection is not local anymore, and my entire body should not be numb". I said to the doctor, "It is because they gave me an anesthetic."

He looked at the chart as said, "No, they haven't given you anything." And I replied, "Yes, they gave me something, they gave me something at this hour but the nurse had to get to the operating room because she was called for an emergency. He said, "No, you are lying". I told him, "No, they gave me some anesthetic and I feel very bad. I cannot breath, bring me oxygen".

They finally put a little mask on me that I couldn't feel, I only felt that I had air. In a few moments he called the nurse and she said I had been telling the truth...because of the reaction to the anesthesia and the other complications it caused, I ended up having to have an emergency C-section. When I received the documents with the medical history from the birth it didn't say anything about what had happened.

Upon first entering the hospital, Cristina requested that she not be given any major drugs during her labor. Despite her wishes, an epidural was administered, and later another anesthetic. When she began to have a very bad reaction to the drugs, the first thing the doctor did was accuse her of lying and disregard her experiential knowledge of what was happening to her own body. After the confusion had been sorted out, her body and that of her infant had been put under so much stress that the infant's life was at risk and a C-section had to be performed immediately, despite her having a good presentation and being perfectly healthy for the entirety of the

pregnancy previous to entering the hospital. Even after a difficult birth with numerous complications and interventions, the official medical history released by the hospital made no mention of the medical and clerical errors that nearly cost Cristina her own life and the life of her child. In addition, the records also listed her birth as a simple, planned C-section, even though there had been no such plan. The hospital refused to take responsibility for the grievous errors it caused, denying Cristina's rights over her own body throughout the entire birth process.

The Intervention Epidemic

Doctors from the United States were not mentioned kindly in Texas interviews either. Beyond just incompetency, US obstetricians have developed a reputation for far worse things. Internationally, the US ranks lower than nearly all other first-world countries and quite a few third-world countries in terms of maternal and infant deaths (Rooks 1999). This is directly linked to the incredibly high percentages of births that involve dangerous procedures like episiotomies, C-sections, forceps delivery, and vacuum extraction.

Fully one third of American women do not have a vaginal birth, and in cities and urban areas the percentage of C-sections can be as high as eighty percent (Althalbe, 2006; Childbirth Connection 2006). These numbers continue to rise steadily, despite numerous studies and statistics showing that such high C-section rates are dangerous for female populations. As of 2008, 35 percent of all births in the US were accomplished using C-sections (Childbirth Connection 2008). According to the World Health Organization, any numbers above 10 percent have negative consequences for mothers and are a clear sign that something is wrong with the medical model being used (Althabe and Belizan 2006:1472).

However, such findings do not fit Western ideologies and so they are mostly ignored. Interventions are justified as a means of protecting women from the failures of their bodies. As Elli Thompson, a young doula who I interviewed in her home in central Texas stated:

I think doctors really like to control risks as much as they can, obviously. In addition, people like to make decisions where they feel like they're in the most control over us. They [doctors] don't trust your body, and pretty much the whole medical system doesn't trust the body. It says the body is a ticking time bomb where things are going

terribly, terribly wrong, and obviously that model applied to birth makes for worse experiences and emotional trauma, which is really not healthier.

We don't have better outcomes than other countries. We have a terrible C-section rate—a third of the women in this country are giving birth by C-section and there are areas of this country where it's 60 or 70 percent. We have a lot more babies and mothers die [than other countries], and we have no excuse for this. We spend a lot more money on healthcare than other countries do, and we should have the BEST outcomes. We should have a 10 percent cesarean rate. We should have empty Intensive Care Units. We're creating problems because we're looking for them, and it's just a shame.

As interviews and even obstetrics textbooks have shown, the biomedical system views the female body as a dangerous thing that must be controlled at all costs. Interventions that were once used only when the mother or infant was in danger are now commonplace, and even routine, regardless of the actual state of the mother and child. An example of this is the now routine practice of scheduling an induction. As Amanda Barnes, a CNM who has been practicing for over thirty years in central Texas explained:

The medical model of care sees induction as a reasonable option once somebody gets within a few weeks of their due date, even though inductions end up in more C-sections. They don't even acknowledge that inductions are more painful, though they do provide epidurals. But then they also don't acknowledge that epidurals cause serious problems, not just for the labor, but for the blood flow to the baby. They make for a lot more fetal heart rate abnormalities and abnormal patterns in labor, which have to be remedied by emergency things like forceps or vacuums or C-sections.

As Amanda pointed out, every intervention has its drawbacks and its risks. They are dangerous enough that they should only be used when absolutely necessary. However, in a society which views technology and interventions to be universally beneficial, the use of such practices has been abused. Another example of this is the episiotomy, a vertical surgical incision used to widen the vagina if the infant's head is too large to fit, which is now given to over ninety percent of the women who labor in hospitals, both in the US and in Mexico, regardless of whether or not there is a need for it (Davis-Floyd 2003:57). The reasoning goes that if doctors

make the cut it will be straight, clean, and easily controlled, whereas if it tears naturally it will be uneven and ragged, and more difficult for the doctor to suture. Research says that women actually heal faster if they tear naturally, but hospital practices are not based on research. However, not all women tear or need episiotomies. When an unnecessary episiotomy is performed on a woman, it exponentially increases the length of recovery time, the likelihood of infection, and the pain felt by the mother, as does any surgical procedure. Despite all this, and the lack of necessity for episiotomies in most cases, they are still incredibly common and in many cases are forced upon women who don't want them, as was the case when Claudia Barrera, a Mexican woman in Tulum, gave birth to her first son. Claudia did not want an episiotomy at all and didn't feel it would be necessary. However, as things turned out she

...pushed once, and then...I felt it. It was burning already and I could feel him coming. Then they cut me. During all the visits, I begged [the doctor] to allow me [to not be cut]. I know my body. I'm really, really flexible. I knew that if my yoni was as flexible as my body I could handle birth without breaking. I told him that every visit and he would say, "No way!" He told me all this nonsense that if I tore it would be that much harder to sew up, and that I would never be the same and my poor husband would never have pleasure anymore. It was all stories like that. And [when I was giving birth] I heard something, some noise, and then [my sister] told me I'd been cut.

Episiotomies have become so routine for many doctors, regardless of the actual state or need of the laboring woman, that in some cases they have become an integral, ritualistic part of the birth process in hospitals. A prominent midwife in Tulum relayed a story to me about a birth experience one of her friends had in the Tulum Centro de Salud:

The doctor had become so used to doing episiotomies during his births, regardless of whether they were needed or wanted by the mother, that he had started to do them without thinking. When my friend was giving birth, the baby came much sooner and more easily than the doctor had expected. She didn't tear or anything. But the doctor was so used to performing episiotomies that he cut her AFTER the baby was born, and then had to sew her up again.

As the US exports its brand of maternal health care to Mexico, the statistics for interventions and therefore deaths rise there as well. As I learned when I conducted my research in Quintana Roo, Mexico doesn't even have a dialogue on the national stage regarding comparisons of birth methods, other than the push to hospitalize birth. Hospitalized birth in many cases equals birth by Cesarean section in both the US and Mexico, as the majority of women who give birth in hospitals are booked immediately for C-sections, without even an attempt at a natural birth. When called to explain the high numbers of C-sections performed, US physicians often claim that mothers are asking for them and demanding elective surgery. However, surveys asking new mothers why they had C-sections show overwhelmingly that the women felt pressured by their physicians into having C-sections, even if they weren't medically necessary (Declercq et al. 2006a:870).

One reason for the burgeoning rate of C-sections can be traced all the way back to hospitals' policies of lithotomic birth positions. When a woman is on her back giving birth, the process is much more difficult and exhausting and labor can even stop entirely. So, often the woman is pressured into having her labor induced. These drugs cause contractions that should be slowly building in intensity to compress and occur over a much shorter period of time. This drastically increases the amount of pain that the mother feels as she attempts to push her child out. The agony experienced by the woman often causes her to ask (or beg) for an epidural regardless of what the birth plan was in the beginning. But even if she somehow manages not to ask for drugs, nurses and doctors often push them on her, because the sounds of a natural, painful labor often make patients in the surrounding room uncomfortable. By the time the epidural is administered, the woman is often exhausted and weakened, and her body has been through intense stress brought on by not only labor but also the snowballing amounts of drugs and interventions. By now in most labors, the women can no longer push because of the epidural or exhaustion and the interventions have put the life of the mother and child at risk. At this point, and usually at several points beforehand, the woman is generally pressured to have a C-Section by the hospital staff and is told that if she does not agree, her child will die (Business of Being Born 2008). This position and the complications that arise from it also serve to further distance the hospital model from less technological methods, as MacCormack has stated:

Scientific medicine, of course, has its roots in traditional practice but is rather embarrassed by them. Perhaps some of its scientifically questionable procedures might therefore be explained as symbols of opposition, setting scientific medicine clearly apart from traditional practice. For example, throughout the world women traditionally move about during labor, and give birth in a vertical squatting, kneeling, or sitting posture. To insist on an immobile, horizontal position through labor and delivery lengthens the time and increases the pain in birth (Caldeyro-Barcia 1980), but this is being taught as the modern scientific method in medical and nursing schools throughout the world (MacCormack 1982).

Through distancing itself from natural and “traditional” methods of giving birth, the hospital is further reinforcing the misconception that women need technology and doctors in order to give birth (Davis-Floyd 2003:73). This perpetuates a system that becomes a self-fulfilling prophecy—healthy women are told that their bodies cannot handle childbirth and that they must accept preparations for numerous interventions in order to survive with their child, and then the preparations make it necessary to have those interventions. A statement that Amanda Barnes made regarding this serves quite well to illustrate the effects of all these snowballing interventions:

And in a way it's true [that interventions are necessary], because they set this stuff in motion. Something dramatic and lifesaving now has to be done because we've started tipping over all these dominoes. We've taken away your clothes. We've taken away your comfort. We've taken away your confidence. We've put an IV in your arm which limits your mobility. We've tied you on to a fetal monitor which limits your mobility and increases your panic, because there are little variations in your heart rate which are not necessarily significant... You start putting her on pitocin [to induce labor] which gives her these wracking contractions early in labor, and she has to get something for the pain because it's terrible.

Every one of those interventions is a domino and finally, the baby can't take it anymore. It doesn't happen to every baby. The species is pretty strong, most babies getting all that pitocin and epidurals are okay. But a lot of them aren't. Thirty percent of them aren't and they [hospitals and doctors] don't see it because they don't believe this

[slaps her sheet of personal delivery statistics, which are better than the local hospitals’]. They don’t believe this because there’s too much to lose if they do. What do they lose? They lose the whole system of maternity care in the United States.

As though this quote was not powerful enough on its own, another woman whom I interviewed, over 2000 miles away and in a different language, said almost exactly the same thing regarding the snowballing effects of interventions on the childbirth process. As she told me,

You’re there, and they shave you. Everything must be disinfected. Everything. This makes for a very cold, impersonal treatment by this stranger [the doctor]. In addition, there is a lot of distance between you and this doctor because what is driving the whole process is the physical part, the hygiene. The medical practices...for example, oxytocin—it affects a lot of things. It is as if oxytocin is like adrenaline. We all have it inside our bodies. During birth it is as if you are climbing a mountain and your body is secreting a lot of adrenaline and in addition to this adrenaline you inject it with another shot of adrenaline. What do you think is going to happen? It will create a shock inside the body and this is what happens in the hospital with oxytocin. Your body in this moment...your body and that of your infant is producing a large amount of natural oxytocin internally in order for your baby to be born, for your body to open and the baby to be born. And this shot is just more. There are always problems, always, when this second load of oxytocin is given. It is very dangerous at times. But the hospitals don’t know this, don’t know that they do it, because it is a practice they continue doing and I believe they would stop if they knew the consequences.

Even though there are innumerable differences between the United States and Mexico, through globalization the US has managed to export its problematic biomedical maternity care to Mexico, so much so that two women who have almost nothing else in common have had the same experiences and seen the same problem with the biomedical method of care.

Profit and the Political Economy of Birth Practices

The Western worldview has influenced the biomedical healthcare system in many ways. The perceived triumph of technology over natural childbirth, the power of the medical specialist

over the birth, and the large, overarching belief in the mechanization of the birth process are all thoroughly ingrained in hospital birth practices. Also ingrained in birth practices, and indeed any part of the biomedical healthcare system, is the focus on profit. The Western worldview places a very high value on wealth and materialism—this is how corporations and individuals within those corporations have been able to justify countless acts of exploitation and recklessness. It certainly accounts for recent economic collapses. As the biomedical system is unavoidably linked to the Western worldview, it too is subject to the glorification and focus on profits. One very important reason for the biomedical system to continue to use methods that clearly aren't in the best interest of its patients is that it is far more profitable to mandate expensive technological procedures and interventions. In the US, according to my sources, the average hospital birth without any interventions or medication costs about \$5000-\$8000 and can take between 8 hours to several days. While a woman is laboring naturally, she is taking up a hospital bed, nurses' attention, and an on-call doctor that could be used by women who are having interventions and surgical procedures. Surgery takes much less time and allows more women to be moved through the system, resulting in more profits for the hospital. A hospital birth that culminates in a Cesarean section costs upwards of \$15000, and the specialists who deliver babies make quite a large sum per surgical birth. Allison Dougal, a CNM I interviewed in central Texas, explained how this influences hospital practices:

It is multi-factoral why physician's associations work so hard to pass legislation against midwifery, but a big reason is that they feel threatened. Birth is a big business. A big money-making business. Many decisions that are made in the hospital aren't for the health of the baby or mother but are for monetary reasons.

Scientifically it doesn't make sense. The outcomes don't justify the practices, as Ina Forrest, an American CPM I interviewed stated,

There's no reason why a third of the women in this country should be having surgical deliveries. Women know how to birth, our bodies know how to give birth. That's how we all got here. And now we have a third of them women having surgical birth? That's extremely problematic. Not only that, it's a huge drain on the financial system. There is no reason that health care costs have to be as high as they are for healthy pregnancies if midwives can do a better job of prevention and have better outcomes for a

small fraction of the price. It just makes no sense for us to spend the kind of money we do on unnecessary C-sections and extended hospital stay, no reason why mothers should be cut at all and have extended periods of recovery because they had surgical deliveries when they could have had a vaginal birth.

One reason that the practices Ina pointed out are occurring is because fiscal/ capitalistic interests are driving medical practices rather than the specific physiological interests of each patient. As Fernanda Alonzo, a professional midwife in Chiapas explained to me,

Obstetricians are surgeons. They aren't trained to do normal birth, they're trained to do surgery. They don't want to wait around for eight hours with a woman in labor if they don't get to do anything. They want to do surgeries, which take forty-five minutes and they walk away with \$10,000. If they help a woman have a natural childbirth, it can take twelve hours and they only make \$500.

This desire for rapid monetary profit is exactly in line with the Western worldview, which stresses competition and limitless economic growth (Metzner 2006). However, physicians must justify this in a different way to their patients, and often the justification involves the fear of what *might* happen, rather than actual likelihoods based on the patient. This, according to many of my informants, is known as “playing the dead baby card”. As Ina continued in her interview,

There's a lot of propaganda in this country and people relinquish control when they're fearful, so certain people stand to gain when people are afraid and living in fear about their health. And boy, when they start talking about ‘If your baby dies’, and ‘your baby might die’. People get crippled with fear and then they become very pliable patients and they can get you to do whatever they want.

Another major influence of the policies of doctors and hospitals is the ever-increasing phenomenon of the malpractice suit. The American doula I interviewed, Elli Thompson, put it most succinctly when she stated, “In the hospital—liability is the number one thing that affects healthcare in this country, especially maternity healthcare. Liability, liability, liability”. The choice to intervene is often made so that the doctor has an easy defense should a jury ever be called to weigh in. Shannon Ferris, a central Texas midwifery apprentice, expanded on this idea: “I think doctors see what midwives do and MALPRACTICE flashes all over it, for them. I think

they have to make a lot of choices because of the fact that the client might sue them”. Since the medical model already sees every pregnant woman as a sick patient and potential disaster, hospitals and physicians implement protocols and requirements that make it nearly impossible for a woman to have a natural, hands-off childbirth in the attempt to gain control and make themselves seem less culpable should something go wrong. Elli Thompson, the doula who I interviewed, has a lot of experience with hospital interventions and navigating the minefield that is hospital policy:

I’ve worked with an OB where I’ve had a couple of clients who are wonderful, very strong, well-educated and opinionated women, so they challenged him a lot, and he totally doesn’t like it. And one thing that I respect about him is that he’s really upfront that he’s terrified of getting sued, so he’s not just playing the dead baby card, he’s playing the ‘well, if the jury were looking at this they would have wanted me to do this intervention’. And he’s talking to women who are 35 weeks and he’s wanting to plan their induction. It’s like ‘Well, that may be true, but this is still my body and my baby, and you don’t have the right to say, “Well, I might get sued, so we’re going to do this”’. And that’s a very adversarial way of looking at your patients, I think, because you are constantly looking at them as someone who is a threat to you and your livelihood, but I don’t think it’s unusual at all.

The adversarial relationship that Thompson describes between doctor and patients is extremely common in maternity care. Because the biomedical system requires that the doctor be in full control of the birth and that technology replace nature, the personal rights and autonomy of the mothers are usually sacrificed to ensure that the hospital has its requirements met. All of the women who were interviewed in Texas and most of the women interviewed in Mexico stated repeatedly that a main reason behind their decision to have a home birth was out of fear that their wishes and choices would be ignored in the hospital setting in lieu of the doctors’ personal preferences and the hospital’s legal policies. In many cases, this fear stemmed either from a previous experience in the hospital or from the experiential knowledge of a family member or close friend. For most of the women, the first choice was the decision to have a natural birth without any drugs or interventions. Upon doing more research and visiting the hospitals and physicians, the women realized that it would be nearly impossible for them to have a natural

childbirth in the hospital, no matter what they told the doctor beforehand. As Elli Thompson, pointed out to me,

Just by stepping into the hospital doors you are lowering the chance of having a natural birth. Just by choosing this OB who thinks that natural birth is ridiculous you're lowering your chances of having this experience. [I often wonder] why someone is seeing this doctor with whom they have no ideological common ground....Why are they having a hospital birth when they don't want any monitoring more than just the Doppler for a moment or two?

During a participant observation I did during a day-long childbirth education class in the hospital I asked the six couples present to write down their ideal birth experience. Five of the couples expressed a desire for a completely natural birth with no drugs or medical interventions. They wanted dim lighting, soft music, and close friends and family nearby. In short, they all wanted the type of birth that is generally only possible with a midwife. When I discussed the results with the childbirth education class instructor, she sighed sadly and told me that “the irony is that just by being in this building none of them will have the birth experience they truly want”.

These experiences echo the findings of a recent study on birthing ethics, which reported that “...the choices expressed in a birth plan are often illusionary and superficial, because the best-laid birth plans are often quickly dismissed when a caregiver decides they are not appropriate” (Torres, De Vries 2009:22). In fact, during my participant observations in the hospital, the nurse teaching the class emphasized to her students repeatedly that the birth plan was more of an intellectual exercise than a contract. She also shared a popular saying from the maternity ward staff, which is that “the longer the birth plan, the less goes the way the woman wants.” In hospitals, it is extremely common for the wishes and desires of the mother to be ignored in favor of a faster or more convenient birth for the physician. Elli again elaborated on this phenomenon:

Doctors and nurses have certain protocols that they want to follow, it doesn't matter what you want. I'm not saying all doctors do this, but the worst ones do—you have doctors performing episiotomies without prior consent or notification. Doctors who will bully women into C-sections that aren't necessary, doctors who will insist on

inducing a woman at 38 weeks because they think it's more convenient....Doctors not discussing options with women.

Structural Violence and Female Autonomy

Though many doctors may see their actions as pragmatism, if not the only way to conduct a birth, they reveal a very troubling pattern of ethical violations, as CNM Amanda Barnes stated during an interview:

As I get older, that part of the Women's Movement is.....it's just basic human rights. Forget the Women's Movement. It is human rights. People have the right to self-determination and to make decisions for themselves. All people. What goes on in hospitals is that there's a lot of manipulation and coercion, and distortion of the facts to the public. Women's rights are trampled left and right in the hospital. Human rights.

This lack of respect for female autonomy is endemic within the biomedical system and causes quite a bit of unhappiness, if not misery for a large portion of the women who give birth in hospitals. As Lauren Brown, mother of three, stated during an interview,

What I noticed [about everyone's birth stories] was that a doctor, or sometimes a nurse marred this wonderful event. They were irritated that he had promised it would go one way, and then would ignore their wishes later. Or, they got into labor and he wasn't listening to what they wanted.

To revisit previous examples from informants, women in both Mexico and the US told stories again and again about their personal experiences in hospitals and the anguish and trauma they felt after having their rights and wishes ignored during what should have been an event entirely under their control. As the quote from Swiss midwife Sally Sanders and the experiences of Cristina Roco demonstrated, not only are women not being consulted before procedures or having their autonomy preserved, but even when they actually try to disagree and alert their discomfort to the physicians they are ignored and silenced. It is not the technology itself that is inherently wrong—at the times when a Cesarean or episiotomy is actually necessary the technology serves its purpose and becomes something lifesaving and wonderful. However, the abuse of technology is a part of the current worldview espoused by American society. Overall,

the birth climate fostered by biomedicine supports incredible acts of human rights violations directed against women. When these factors are analyzed systemically, they reveal patterns of violence perpetuated against the women who live in the United States and, increasingly, Mexico. As anthropologist Paul Farmer has written,

Social inequalities based on race or ethnicity, gender, religious creed, and—above all—social class are the motivating force behind most human rights violations. In other words, violence against individuals is usually embedded in entrenched “structural violence (Farmer 1999).

Because the Western worldview contains a still-present sense of discrimination and prejudice against women, violence against women is, to some extent, a natural extension of the Western worldview. Farmer has demonstrated through his fieldwork and many publications that structural violence is violence typically directed against minorities and the poor and tends to be deeply ingrained within the worldview of a society (Farmer 2001:307). In this case, the violence perpetuated against women by biomedicine is so intrinsically a part of the Western worldview that few consciously realize that it is happening or that there is another way to do things. Society itself is enabling and mandating this violence, so much so that most women are not even aware that what happens to them is a violation of their human rights and have no means to escape it. As Farmer said, “Structural violence is structured and stricturing. It constricts the agency of its victims. It tightens a physical noose around their necks, and this garroting determines the way in which resources—food, medicine, even affection—are allocated and experienced” (Farmer 2001:315). In Mexico, where human rights violations are quite common, especially against women and indigenous peoples, this violence can admittedly be more obvious than in the US. However, as globalization continues to make Western practices and worldviews the norm, it is likely that the violence will lose its novelty and obviousness and it will no longer be strange that women have no control over their own childbirths. When this is accomplished, then gender violence will truly become structural violence: a stainless-steel, sterilized cage made out of scalpels and IV drips.

Chapter 3

Reproductive Ecology

“The significant problems that we face today cannot be solved at the same level of thinking that we were at when we created them.”

--Albert Einstein

Just as biomedical birth practices are deeply influenced by the Western technological worldview, the strengthening “humanized birth movement” in the North American continent is also influenced by a theoretical paradigm. This emerging paradigm, called the “Ecological worldview” by contemporary theorists, is made up of a series of principles and tenets that serve to balance the concepts of the Western worldview.

Table 2. Comparing Worldviews

Western Worldview	Ecological Worldview
Mechanomorphic, technocratic	Organismic, relational
Linear Causality	Non-linear dynamics, cyclical patterns
Narrow and Reductionist	Broad and integrative
Specialized disciplines	Trans-disciplinary
Conquest of nature, nature as enemy	Nature as sacred, necessary
Domination, control	Co-evolution, symbiosis
Sexism, patriarchy	Eco-feminism, partnership, equality
Hierarchies of class and caste	Social justice, social ecology
Racism, ethnocentrism	Multiculturalism, diversity
Profit- driven technologies	Appropriate, necessary technologies
Authoritative	Participatory

Table adapted from *Transitions to an Ecological Age*, by Ralph Metzner (2006)

As this table demonstrates, the ecological worldview encompasses many principles that can be recognized as the foundations of other, separate, movements. The civil rights movement, the women's movement, the green movement—all of these have their roots in the greater paradigm shift contained within the ecological worldview. It should be made clear that the ecological worldview is not necessarily the green movement, but is rather an emerging paradigm shift in Western countries that forms the theoretical grounding for the aforementioned social movements. An evaluation of the humanized birth movement based on these principles demonstrates that the movement is itself an ecological movement, the product of a changing worldview centered not on technology and hierarchies, but upon holism and equal participation. Though in one way or another the midwifery model of care exemplifies all of the ecological concepts listed above, for the purposes of this chapter, I will be analyzing the humanized birth movement in the areas of holistic concepts and integration, the acceptance and embrace of feminine equality and capabilities, the symbiosis of midwife and client and the effects of that relationship on the birth experience, and the effects that these factors have on female autonomy and rights during birth. This analysis, combined with the actual words of women involved in the movement, will demonstrate that the recent reactions to the biomedical treatment of birth are situated within greater patterns transitioning to a new worldview.

Holistic Birth

Holism and integration are central concepts in ecological theory, most notably in the sub-branch of systems theory. Systems theory is a relatively recent arrival in the social and biological sciences, but is becoming more and more mainstream as new advances in physics and biology add further credence to its claims (Hammond 2005:21-22). Envisioned in opposition to the mechanistic worldview as “a new philosophy of nature that is holistic, ecological, and integrative, emphasizing the organized nature of the world”, systems theory “emphasizes relationships between parts, as well as the importance of understanding any system in relation to its environment—or the larger system within which it exists and is itself part of a larger whole” (Hammond 2005: 21). Holism is essential to ecological theory, and in fact is one of the most important principles of the worldview. While biomedicine emphasizes Cartesian dualism and the mind/body split (Hammond 2005:21-25), as well as other methods of isolating parts of a person, midwifery and the humanized birth movement focus on integration and holism. Holistic

medicine maintains that the mind, body, and spirit are one and the same and treatments must acknowledge this in order to be effective (Davis-Floyd 2001:S21). The midwifery model of care used by all midwives in the US and the professional midwives of Mexico is based upon holistic concepts of healing and care and midwives firmly believe in looking after all components of a client's health. Though holism is the foundation of the midwifery movement, many times those unfamiliar with midwifery are unaware just what the theoretical orientation is. As Ina Forrest, a Certified Professional Midwife in central Texas who has been practicing for ten years told me,

The public doesn't know that there is a totally different model of care for the childbearing year, and that midwifery care isn't just care like you would get from a doctor but with a natural birth instead. It's completely different. It's much more holistic, more intimate, involved, and personalized than what they get from doctors. And even if people know, generally, what midwives are, even if they've had a home birth, they may not know the difference between the midwifery model of care and the medical model of care. And the difference is HUGE! People don't understand what midwives are or why a woman would choose a homebirth. They don't see what I see, which is that having midwifery care through your birth and having a natural birth is a good opportunity for personal development for the mother, as well as a gentle and safe way for the baby to come in without intervention.

Another midwife who echoed Ina's sentiments regarding an increasing public awareness of the midwifery model care and the value of holism was Susan Ekhert, a nearby Texas CPM who is very passionate about providing a holistic, personalized experience for her clients. As she explained,

People are starting to realize what a midwife is and does. And then, as they keep learning, they realize that midwifery is actually better care than a doctor. It's not less, it isn't sub-par care. It's so much more and it's very complete and holistic. That's why my business name is Holistic Midwifery, because it's about the whole body and the whole family. It's not just the whole woman; it's the whole family unit. The baby is being born into the whole family. So we don't take the birth away from them and it's not *me* that delivers the baby. The mother, the family all deliver the baby.

The Relational Approach

Holism in midwifery means giving equal importance to the body, mind, and spirit. Midwives know that physical health depends on mental and spiritual well-being and that as a woman's care provider they have a responsibility to look after all aspects of their clients' health. This necessarily results in a very close relationship between midwife and client, much closer than the bond allowed by the medical system between doctor and patient. When Ina Forrest detailed her model of care to me, she emphasized the importance of the whole-life context of pregnancy and childbirth. As she described:

The social context is extremely significant and something I work hard to nurture. The family, the emotional aspect—the mother's body adjusts to whatever emotional state she's in. Spiritually, it depends on the woman and the family and where they are at. Whatever they need in terms of spiritual support is where I'm at with them. I try to just leave all my stuff at the door and be present with the woman and help hold space for that woman and family to do their work.

I also pay close attention to the women's social needs, whether they're getting enough support and other psycho-social needs. I see how the relationship is going if there is one, and monitor the woman's own emotional experience of the pregnancy, as well as the baby's.

The relationship that results from this interaction transcends the unequal hierarchy of expert-patient implemented by biomedicine and instead puts the midwife and the client on a much more equal, personal footing. A young midwifery apprentice who works at a local birth center in Texas elaborated on this concept for me. As she put it,

We have a very different relationship with our clients than doctors do. We really get to know our moms, far more than a doctor does. They sit with us, they cry to us. They cry that they're stressed out, that they have one child and are pregnant and exhausted, their husbands aren't helping out. Every little thing you can talk about. The appointments last a minimum of half an hour and for most of them we just sit and talk, so you develop a really strong relationship.

A mother, nurse, and recently certified CNM who had her first two children with a doctor and her second two with a midwife was also impressed with the relationship she formed with her midwife and the care she received. She told me that

My midwife was just so exponentially better than my doctor. So much more supportive. Our time together was spent really talking about diet, nutrition, and exercise and how that impacts the pregnancy. We talked about emotional things, our family life. It wasn't a five minute appointment, they were hour long appointments. We really got to know the person who was going to be there in that most intimate moment, and that's what I wanted to do.

When asked how this relationship helps during the birth process when she is a midwife, she was quick to add that the trust and the relationship they build smooth the birth process exponentially, and that they have even "had moms say during labor 'I'm soooo happy you're here!'". She also said that,

Women need to be with other women during labor. During a mom's labor we really try and step away....we don't interfere. We're not all around the mom. We do what she wants, and we really try to bring the dad into the labor and the birthing process. But you know, we've had moms where, when we have the dad step in to do things like rub her arm, she'll say 'No, no, bring Sheila or Amber back!' And it's not that the husband's not doing a good job, but there's just that bond between us. It's definitely a woman's profession and women appreciate that. I think midwives provide a lot of labor support and mental coaching, and I think that's why the moms are able to get through their birth and their labor because of the trust that they hold in us.

This trust and the friendship that comes with it form the very basis of all the other aspects of the midwifery model of care. It is what allows the other factors to exist and it is the force behind the movement. As Sally Sanders, a Swiss midwife I met while working among Mayas in Mexico, told me, "a midwife is a woman of trust". The midwife treats her clients with respect and love and this in turn elicits trust from the client that the midwife will support and guide her. Ina agrees with this philosophy and believes that it is integral to the practice of midwifery:

To me, it seems that midwifery is about that relationship, more than anything else. I know it's not true of all midwives, but that's what I've seen, where the relationship is the central component. It has a lot to do with trust and intimacy, and I think that relationship facilitates the journey of the childbearing year. You need to know women close to you and have family and friends and time for listening and reflecting, and the freedom to find your way.

These sentiments were echoed and elaborated upon by Elli Thompson, a doula I met with and interviewed in central Texas. Doulas provide a very important service to women, both in hospitals and at homebirths. At hospitals, Elli explained, doulas are sort of the woman's advocate, armed with knowledge of hospital policies and willing to fight so the mother can have the birth experience she wants. The doula fills a crucial need at homebirths as well:

From the traditional angle, women have always been there to support other women when they have babies. We've always had women filling that role. Calling someone a doula and hiring them and paying them to fill that role is pretty new, but it's something that has traditionally been a really important part of birth. Especially women, who ideally have had babies themselves and have a bit of experience and can encourage the mother.

I'd say there is a broad scale of reasons why we need women supporting each other during childbirth in hospitals and at home too. I don't think that disappears when you're having a home birth, necessarily. But on the low end of the scale, there's just that if you have someone who completely understands and has a sort of rapport with you, it just makes you more comfortable and makes for a better experience, and we should be aiming for women having better experiences.

I think there's something very powerful about having someone there the whole time with you, especially someone who believes that birth is normal and that your body is okay and you can do what you're trying to do. I think that every woman should have the opportunity for that kind of support. Not everyone needs it, but it's definitely very valuable. After all, this is something that will last for the rest of your life. You will never forget what it was like when you had your baby, and those emotions are so powerful.

Though Elli chose to have a doula with her at the birth of her first child, who was born in the hospital, for her second she decided to have a homebirth with just her midwife, who had also become her best friend, and her husband present. Since she had such a close relationship with her midwife, she reasoned that a doula wasn't necessary because she already had a very important bond with the woman who would be guiding her through birth. As she relayed this experience to me, her whole face lit up and she practically beamed as she recalled the night her second son was born. Since one of the major negatives about her first birth was the post-partum experience of the hospital, she described,

[I was] really looking forward to the post-partum experience of the homebirth more than anything else. However, we had this really easy, wonderful labor where I was basically not in pain and it was awesome! I kept being in denial for it too, I couldn't believe I was really having the baby. I would say it got painful for the last 45 minutes. I hit transition and I had to work really hard and pushing was painful, but it was sort of a revelation to me that it could be like that.

I haven't seen *Orgasmic Birth* yet, but it seemed like it could be like that. I'd seen other movies where women were just ecstatic giving birth and having a good experience giving birth. I didn't really know that it could be like that until [my son] John. I gave birth right here in the dining room. We moved the table so we could get the tub in. I just levitated, it was such an amazing experience. It was just such an incredible experience—I didn't realize I was signing up for anything so amazing. I was really just...just the love and care...and I had such an exceptional relationship with my midwife. It was just so loving when he was born. It was quiet. The lights were dimmed. I didn't feel like there was anyone there who didn't 100 percent believe in me, who didn't 100 percent respect what was going on. There was just all this love and all this joy.

Whole Life Context

In addition to a holistic concept of the body and mind and the influence that it has on the client/midwife relationship, the midwifery model of care also utilizes holism in an additional way. The midwifery model of care emphasizes women in the context of their lives rather than as separate, isolated entities. As such, midwives address the needs not only of the women, but also

of their families. In some cases, this support does not end with the actual birth. The emerging generation of professional midwives, more confident in openly practicing their calling, is able to provide a continuity of services for their clients. Ina Forrest, for instance, runs a very successful midwifery clinic in Central Austin that draws an extremely diverse group of clients. This diversity has prompted her to use her past experience as a university professor of psychology and early childhood development to offer post-natal classes and pre-natal classes for her clients. In her own words,

My practice is very holistic in terms of community support—we do stuff together—we go on weekly walks, we do swims, childbirth cooking classes once a season, baby parties. I teach classes for the siblings to help them be accepting of the new baby, pre-natal classes for expecting mothers....I have a very integrative practice.

Ina is not only providing her clients with additional services—she is actively creating a community. In allowing the birth process to remain within the context of women’s lives and then focusing on enriching those lives, Ina is taking what is already a strong holistic model and strengthening it. She has also established herself as an equal member of this new community—a friend, rather than an authority figure. This breakdown of the traditional hierarchical organization of medicine further represents the ecological paradigm shift that is taking place through the midwifery movement.

The concepts of a shared community and the equality of client and birth attendant are important on both the midwifery and the greater theoretical levels. It is extremely important for a holistic healthcare practitioner to be a member of the community they are working with. As Cristina Roco, a Mexican anthropologist who has been studying birth practices in Quintana Roo for several years told me, “The difference with a midwife or *curandera* is that they are people who live normally within a community and are familiar with the people in it. They don’t do consultations without interacting with people in their homes, their lives, their fiestas, their everything”. In short, midwives are generally local practitioners who are viewed as normal people, not experts wielding authority and power.

Though in the US most midwifery clients are not personally familiar with their midwife until they are pregnant, midwives such as Ina who take steps to create a strong birth community

are able to overcome this and maintain the context for the birth, thus extending their commitment to holism far beyond just the actual birth process. In honoring holism thusly, midwives are also honoring another tenet of the ecological worldview, which is that of the essential equality and unity of the midwife and expecting mother.

Equality Instead of Hierarchy

As anthropologist Robbie Davis-Floyd has stated about the nature of the relationship between practitioner and client in a holistic model of care, “the holistic model offers the possibility that they are not separate but are fundamentally one” (2001:14). She goes on to add that sense of equality is demonstrated in how “many holistic practitioners try to drop the word ‘patient’ in favor of ‘client’, as this term implies a mutually cooperative, egalitarian relationship” (Davis-Floyd 2001:13). I have seen many examples of this in my own fieldwork, as well as in my review of the available literature. The midwife respects the client as an equal in the decision-making process, fully capable of being autonomous and self-determining. To visit yet another statement from Robbie Davis-Floyd, “Holistic practitioners in general tend to see themselves as part of a healing team, of which the patient is a full-fledged, indeed, the most significant member” (2001: 15).

This principle of inherent equality and interconnectedness correlates with yet another in the ecological worldview, which is the participatory principle. As Debora Hammond has theorized, “If knowledge is indeed an interactive and collaborative process, as well as an essential part of the decision making process at every level of organization, then systems thinking contains an inherent ethical bias toward democratic and inclusive forms of social organization” (Hammond 2005:24). The midwifery model of care is nothing if not inherently respectful and inclusive of women’s personal decisions and choices. This principle is unavoidable in the midwifery model of care if the other tenets of holism are honored.

By leveling the authority of the birth attendant, clients are able to become more actively engaged in the process of their own health. As Hammond pointed out in her article on systems theory, “If individuals are to become more actively engaged in the decisions that shape their lives, they need to have a sense of ownership in the process, instead of passively deferring to the ‘expertise’ of those in leadership positions” (Hammond 2003:14). Callie Hughes, a CNM and

mother of four, found that one of the main factors in her decision to have her youngest two at home was when her personal autonomy was ignored during a pre-natal visit in a hospital.

When it got to that time in the pregnancy when we would do some further testing, specially a glucose tolerance test, I asked him why, because I hadn't had any glucose problems with my last pregnancies. He said, 'Because I said so'. 'Because I said so' was not the way to take care of me, and not the way to take care of any woman who is laboring or pregnant. I think that for me, having had two children in the hospital and knowing what I know now, I would go back in a heartbeat and do them all at home.

Some of the things that happened at the hospital during my births really made me angry. I have great, wonderful children so I don't have any true horror stories about bad outcomes, but I can tell you that I had two in the hospitals and two at home and I wouldn't trade my two homebirths for anything because it's just so different. You're in an environment that is your own, you're comfortable there. I really felt close to my midwife and I knew I was secure and that she was going to take good care of me. And, AND when I asked a question, I knew the answer wasn't going to be 'Because I said so'. I knew it would be an honest answer and not just something to pacify me, which is what I got when I went to the hospital.

Empowerment through Autonomy

This equal relationship not only defends women's autonomy, but also promotes empowerment and strength, at least according to numerous sources. Because the model of care is participatory in nature, women are encouraged to ask questions, to educate themselves extensively on their bodies, and to form their own ideas about their health. As Ina Forrest told me one day,

[the hospital model is] very different from the partner dance that we do in midwifery. We hold hands, but then we do our best to help the client stand on their own. But we are present with them on their journey. We're not the authority. We hold the knowledge and we have the skills, but we share that with them, we educate the clients, we empower them to make decisions. We are partners in care with them. And I think women want that.

Women want to be autonomous and make decisions based on what their needs are and what their beliefs are and not have it forced upon them. I think it's meeting an important need—this is where the feminism part comes in, you know? It's playing an important role in self-determination versus an external power telling you what to do with your body.

Midwives and mothers acknowledge that it is a big responsibility to allow women the right of self-determination. Though they don't consider it to be 'risky', it does require a lot of trust and mutual communication. As holistic healers, midwives are committed to providing this for their clients. As Robbie Davis-Floyd has noted, "A basic tenet of holistic healing is that ultimately, individuals must take responsibility for their own health and wellbeing. Holistic practitioners in general tend to see themselves as part of a healing team, of which the patient is a full-fledged, indeed the most significant member" (2001: 15). The reason for allowing this autonomy are varied and each important, but there is one reason in particular that has far-reaching effects. In the midwifery model of care, pregnancy and birth aren't just things that a woman must get through in order to have her baby. Rather, they are conceptualized as a very important process and a chance for personal growth and exploration. Claudia Barrera, a Mexican mother and midwifery advocate who I spent a lot of time with in Tulum, graciously shared her birth experience with me to explain what a homebirth helped her to achieve.

I had made a lot of love work at home. I cleaned my house three or four times every day. I had candles and incense. My house was so ready for that moment. I had pictured it happening at night. I knew what kind of music I wanted. My best scenario was to have her come out before her brother woke up, and it happened just like that. The house was full of candles, the music that I wanted was playing. It was a full moon so I went between the shower and the garden many times, and through the window I could see my husband and my son sleeping. This is what I really wanted. I was in my own space.

When I knew I was close I called Sally and she came fifteen minutes later. When I saw her face I just completely relaxed. I couldn't take my eyes off of hers. I needed her wisdom and her peace to get me through it. She held my hand, she gave me a beautiful massage, and the time flew by. It was maybe forty-five minutes, and when I started pushing it was still night. When I held her, my daughter, it was day. She was born exactly

as the sun came up. I lived the most amazing experience of my life that night. I was there with all my five senses, six senses, completely open. It's by far the most amazing memory of my life. Having a natural birth, accepting the sensations... it changes your life. It really shows you that you can do anything after giving birth. You really feel as strong as a lioness, ready to protect your baby lions from anything.

Claudia and others not only see the midwifery movement as empowering for individual women, but also as having the potential to influence society on all different levels. She continued,

As I go deeper into this, I'm really convinced that it must be done. I'm convinced that it can make the difference in a woman's life, for the better. I'm sure many people have arrived at this idea, but violence could be reduced in the world, if babies are not treated like they're treated in hospitals. Motherhood can be improved, if ladies didn't have these shocking and horrible experiences in the hospitals. Humanized birth is the ultimate environmental movement as well. If people entered the world in a loving, respectful way, they would grow up to be more centered, compassionate people. If we start to take care of ourselves and enter the world in a more natural way, then taking care of the environment and caring for the rest of the world will come more easily.

This idea that what happens during childbirth can influence and change the world was also brought up during another interview I had with Amanda Barnes, a CNM who has been practicing for over thirty years in Texas, both in hospitals and in her own practice. She explained that,

I've long known that the reason to have normal, natural, spontaneous childbirth, if possible, is for the health benefits for the mother and the infant. Normal childbirth is better for the baby. They don't get drugs, they don't get separated from their mother. They're able to be awake and alert, and go right to the breast where their mother can be with them and comfort them. They don't get jaundice, they don't get as many infections.

But as I get older, the other side benefit which isn't talked about very much has to do with the autonomy of women. When women do something and it's of their own choosing. When a woman who wants an epidural is forced by her husband to have a natural childbirth, she's traumatized by that pain. That's not a good thing. She needs to

make those decisions for herself. But if she does make those decisions for herself, whatever it is, and she goes through childbirth...it's hard, it's exhausting, it hurts. Some people compare it to marathons. I compare it to war. You've got to do some really hard stuff and you're got to be brave and you have to keep going to get finished. When women are able to do that and they've chosen that decision and they come out on the other side—it's not just that they have the joy of this new baby, they also have something else. They have found their courage.

When women find their power they're not just more powerful women. They're more powerful for their families. They can do the right thing, they can leave an abusive husband. They can make the right decisions for their families, and it makes them as wise as grandmothers. Pillars of society. Eleanor Roosevelts—we could have them by the legion. We could. We can. It's women finding their voice and the power to speak up for themselves. And when you say, 'This is what I want for my life', and then you push through, that's what happens.

This focus on female empowerment and strength combined with the movement's principles of holism and nature place the natural birth movement squarely in the camp of ecofeminism, though it may not always be called that. Ecofeminism stems from the theory that the subjugation and exploitation of women and nature are intrinsically connected. Only by fighting both will either battle be won (Ruether 1993:13). Because the other crucial principles of the midwifery model of care are essentially the principles of the ecological worldview, it makes sense that feminism would be a further link between the two. Ecofeminism's concept of the connection between nature and women is hardly unique—it is also an intrinsic part of the midwifery model of care. Even the widely used term “natural childbirth” is an example of how linked the two concepts are in the minds of midwives.

“Natural Birth”

Based upon interviews and conversations I have had over the past year with midwives and mothers in the United States and Mexico, I think it is safe to say that there is no uniform definition of what “natural birth” is. Sally, the Mayan-trained Swiss *partera tradicional*, maintains that a truly natural childbirth is one in which the midwife does nothing directly besides

encourage the mother and then cut the cord with a razor and thread once the child is born. Callie Hughes, a Certified Nurse Midwife who spent years working alongside doctors in the ICU, believes it is possible to have a natural childbirth with the aid of some pharmaceuticals and even an episiotomy. Each midwife has her own definition, which generally correlates with her practices. However, some points were agreed upon, of which the most important is the embrace of nature/female as inherently sacred and whole, and the rejection of biomedical values which view the female body as inherently broken and in need of being fixed.

In contrast to the Western worldview, which demands that nature be dominated and controlled, the ecological worldview embraces nature and natural processes. As Ralph Metzner has noted about the ecological worldview, “The principles of the deep ecology movement teach biocentric or ecocentric values, in which humans are seen as part of nature, not over or against it” (2006:93). This correlates well to the practices and knowledge of the midwives, who accept women’s connection to nature as a positive thing, rather than a threat. Pregnancy and birth not only are not pathological, but are perfectly normal states. As a midwifery client and mother of three stated passionately to me,

Pregnancy isn’t a medical condition. You aren’t diseased and you don’t need to be in a hospital to give birth. And you can pull up stories supporting either side, but the fact remains that hospitals are for sick people—they’re full of germs and contagious things that you aren’t likely to get in your own home.

Many other midwives and mothers I interviewed echoed this—the staunch belief that normal, healthy birth is not a disease or illness that requires interventions and doctors. While none of them would argue against the necessity of a woman who truly needs a C-section or other interventions going to the hospital, they believe that the place for a normal pregnancy is in the home, attended by midwives and family. Again, as Ina told me,

We do normal, healthy births, and we are experts at that. The doctors don’t understand that. Most of them never see a completely healthy birth. Most of them don’t know about the focus on nutrition, exercise, and education that the midwifery model of care involves. And therefore they don’t see the prevention aspect of midwifery. We don’t

do high-risk pregnancies. Women know how to birth, our bodies know how to give birth. That's how we all got here.

This correlates exactly with the ecological focus on viewing the world as organismic rather than technocratic. Nature—birth—can take care of itself in most cases. Technological interventions are not necessary for most babies to be born. As Ina pointed out, if women couldn't give birth without technology then the human race wouldn't be around right now. Certainly overpopulation wouldn't be as urgent of a concern.

Integrative Practices

Closely related to holism and nature in the ecological worldview is the concept of integration and the adoption of trans-disciplinary practices. Midwifery as an emerging movement typically encompasses a diverse and varied tool kit of healing modalities. While mainstream biomedicine promotes and accepts as valid only biomedicine, midwives often learn as many different medical systems as possible. Midwives that I personally met and interviewed all believed in and supported basic biomedical concepts as were deemed necessary. However, nearly every midwife also had received extensive training in one or two other specialties. Several women in both central Texas and Mexico had trained in homeopathy in addition to medical training, three women were certified massage therapists, one practiced Chinese herbal medicine and acupuncture, one used traditional Mexican folk medicine, many were trained in Mayan abdominal massage, and the remaining women used selected practices from nearly all of these healing systems. All of the women were well trained in herbalism and nutrition, and used herbs and natural substances as a gentler and more effective alternative to pharmaceuticals.

This embrace of multiple healing modalities and the transcendence of various disciplines is further evidence of the impact of the ecological worldview on midwifery, and potentially the future of healthcare. As Robbie Davis-Floyd has theorized, “The ultimate holistic vision entails a profound revolution in health care. Were this paradigm to gain cultural ascendance, the dominance of the technomedical model would be replaced with the cultural valuation of a multiplicity of approaches” (Davis-Floyd 2001:16). This differs markedly from biomedicine, which often insists that it is the only real method of healing and refuses to acknowledge the validity of other beliefs. In fact, one of the reasons many midwives do additional training is to

take up the slack, so to speak, and be able to provide their clients with the best healthcare available from around the world. As Susan Ekher, a midwife in central Texas who has been very proactive in integrating various disciplines and skills into her practice told me,

There's a lot of self-study and extra classes involved in your training. You study because doctors don't do a single hour of study in nutrition the entire time they're in medical school. Not one minute of study. And it's one of the most important things for your health! So, on the other hand, midwives do a lot of training in nutrition, herbs, supplements, homeopathy, massage techniques, Mayan abdominal massage, all that kind of stuff. Most midwives are always learning.

This willingness and even eagerness to embrace new healing modalities and diversify their practices and knowledge is an integral part of the multidisciplinary approach espoused by the ecological worldview, as is the holistic paradigm practiced by midwives in the US and Mexico. Together, these principles help make possible the foundation of the ecological worldview within midwifery: the acceptance of birth as a process that can be achieved without technological interventions.

The natural birth movement in the US and Mexico is intrinsically connected to other movements dedicated to human rights, nature's rights, and women's rights. All of these in turn can be conceptualized as parts making up the holistic system of the ecological worldview. Particularly in midwifery's case, this worldview forms the foundation of all the major principles of the movement and is a response to the current maternity system that is rooted in the Western worldview. The midwifery model of care emphasizes holism, nature, feminism and autonomy, and trust in the female body—all principles that are main components of the ecological worldview. Because of its commitment and dedication to these tenets, the midwifery movement is in fact an ecological movement, part of a greater paradigm shift that is beginning to take place in the West.

Chapter Four

Concluding Remarks

Though the Western worldview maintains a strong grip on maternity care in the United States, the tide is slowly turning. As more and more studies are published reporting the benefits of childbirth without drugs and interventions, and the current worldview gradually shifts to an ecological one, women are beginning to seek out a gentler, more spiritual birthing experience. In response to these demands, some hospitals have begun to hire doulas and midwives and install birthing suites. Though it certainly isn't enough, nor will it be enough, it marks a start to the changes that must take place.

Midwives are also noting a change in their clientele, and an increase in their numbers. Whereas twenty years ago the average midwifery client was usually either extremely religious or connected to some sort of alternative movement, nowadays midwifery clients run the entire gambit of society. From the super wealthy to the extremely poor, midwives provide their services for a very diverse array of people. As midwifery becomes even more common, midwives and their clients hope that one day soon they will be fully integrated alongside doctors into a new American maternity healthcare system that uses technology and resources responsibly and in a manner that respects the autonomy of women and beauty of birth. As Susan Ekhert told me,

I think our society is changing. I think that people are starting to realize that modern day midwifery is different and can be a bridge between nature and the appropriate use of technology. I have no problem taking a woman to the hospital for a C-section if that's what she needs. I have no problem giving a sonogram if that's what someone needs, but it shouldn't be a routine. Not everyone needs five sonograms.

This was echoed and expanded upon by Callie Hughes, an Austin-based CNM:

Unless we want to continue on this huge C-section climb and unless we want to get to a place where vaginal birth is obsolete, then we need to have midwives. I think that obstetricians are absolutely vital to our medical system. They are practice surgeons and they are very good at what they do for women who have problems. But they don't belong taking care of women with normal, healthy pregnancies. For normal, healthy pregnancies to take place without interventions in the home, birth center, or even in the hospital, you're going to need midwives because physicians don't want to practice that way.

This was the general consensus among nearly everyone I interviewed, midwife, doctor, and mother alike. The changes that must take place are monumental—and it is the principles and concepts of biomedicine that must be changed first, not just the practices. It is likely, as Callie argued, that biomedical practitioners will not be able to undergo the necessary paradigm shift in order to embrace birth without unnecessary outside interventions. If this is the case, then midwives will indeed need to become an accepted part of maternity care, similar to how things are set up in England and many of the Scandinavian countries. If this could happen in the United States, then the ecological worldview held by the midwives could likely slowly take root in the maternity care system, and humanized childbirth for all women could become a realized dream.

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