

BIRTHING CENTERS AS RITUAL SPACES: THE EMBODIMENT OF  
COMPLIANCE AND RESISTANCE UNDER ONE ROOF:

A CASE STUDY

by

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A THESIS

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A somewhat unknown option for pregnant women receiving prenatal, birth, and postpartum care is that of a birthing center, where midwifery and medical practices come together in varying forms. After conducting feminist-based, participant-observation research at a particular birthing center in the northwestern United States run by a licensed, certified professional midwife, I use ritual and rites of passage analysis to display both the benefits and downfalls of the mainstreaming of midwifery as found in a birthing center. I discuss how the birthing center is a ritual space. Within this ritual space, elaborated rituals act as both compliance with and resistance to established

medical paradigms of birthing. These rituals serve as active negotiated appropriation and display the ways in which midwives knowledgeably balance trust in natural birth and medical practice, which both play important roles in pregnancy and birth.

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## CHAPTER I INTRODUCTION

But when I became fixated on home birth I also became very enamored with the idea of being involved in birth after this. I just felt like way more attached to it. And I knew it was the beginning of a whole new life, not just a new life that was in my body but my own rebirth as well.  
-Tiffany (Feb 2008)

In the United States, 99% of pregnant women choose to give birth in a hospital (Cheyney 2005: 58). However, midwifery and planned home births, a somewhat unknown and underused option in our society, have increased since the women's health movement of the 1970s (Rooks 1997: 55). While these may seem the only options for pregnant and birthing women, there is another important alternative for women in the United States. That alternative is the use of birthing centers, often thought to be a compromise between hospital and home births. My research is a case study of a particular Northwest Birthing Center (NWBC). I plan to display the benefits and losses of placing midwifery care under a medical facility, that is, the mainstreaming of midwifery. Through participant observation and interviews with women choosing NWBC for care, I plan to show the ways in which the NWBC is a ritual space, or an environment in which multiple enactments of cultural beliefs and values are found, and are emphasized through repetition, patterns, and symbolism (Davis-Floyd 1992: 92).

Within this space, elaborated rituals act as both compliance with and resistance to established medical paradigms of birthing. These rituals serve as active negotiated appropriation, where medical practices are commonly used, albeit in modified forms. This negotiated appropriation displays the ways in which midwives knowledgeably balance trust in natural birth and medical practice; both play important roles in pregnancy and birth. Through this balance, messages are sent to clients of NWBC that will be lived out in their daily lives as mothers and parents.

At NWBC, a spectrum of choices is offered that brings together many aspects of both hospital and home birth paradigms. Because of this, NWBC is particularly useful in providing an alternative for women who are seeking neither solely hospital nor solely home birth environments. NWBC balances human touch with technology, and does so in a way that holds to important traditional values of midwives, while also attending to the cultural values placing technology and science as highly important and safe. Within this space, women negotiate, renegotiate, and even reshape the world around them in order to come to terms with the tensions felt between the United State's highly technological culture, as represented by the medical paradigm of birth, and a strong belief in the importance of nature and natural living, as represented by the midwifery paradigm. An understanding of the "opposing" paradigms and their history is necessary before discussing, in later chapters, NWBC's role in bringing these approaches together.

### **A Brief History/Outline of Hospital and Home Birth**

Despite midwifery's longstanding presence in birthing in the United States, medical practices had gained such widespread popularity by the beginning of the 20th century that

midwifery became nearly extinct (Litoff 1978: 3). Well into the 1970s, hospitals remained the main provider of care for labor and birth, despite their many disadvantages. These disadvantages included separation of families during labor and birth, little privacy, routine use of drugs that had negative effects on mother and baby, frequent use of instruments and procedures such as forceps and episiotomies, as well as poor postpartum care with little encouragement to breastfeed (Rooks 1997: 54).

Today, hospital delivery, with its high level of technological intervention, is still the most common choice for birthing women. It is this technological intervention that provides today's women with a sense of security, as they are increasingly accustomed to using and seeing the use of sophisticated equipment in many aspects of their lives (Rooks 1997: 114). During prenatal visits, medical care focuses upon detecting any abnormalities in the fetus and mother through technologies such as ultrasound, fetal heart monitors, and lab work (Rooks 1997: 126). It is the common belief of many American women and families that hospital births provide the safest route for their child to enter the world, and it has been found that many women believe the technologies available in hospitals to be necessary, as is the relief of pain during childbirth (Rooks 1997: 114).

Hospitals provide a number of technological interventions that women are able to access in order to speed up labor and relieve the pain associated with labor and birth. Similarly, the hospital provides technologies, such as Cesarean sections and oxygen, which are very important to families when faced with emergencies or complications during birth (Rooks 1997: 115). Despite the positive uses for these technologies in birth, the disadvantages previously noted, such as separation of families, routine use of drugs

with negative effects, and poor postpartum care, became highly criticized and emphasized by advocates of the 1960s and 1970s. This criticism encouraged hospitals to incorporate more natural and family-centered care, including the unity of families during labor and birth, acceptance of women asking for natural births, private birthing rooms, and even hot tubs for pain relief. This was not enough for some advocates, who spoke against hospital births and called for alternatives through the creation of publications and organization for the promotion of midwifery and home birth (Rooks 1997: 55). A renaissance in midwifery occurred by aligning itself with other movements, such as the civil rights movement, women's health movement, and the consumer movement (Rooks 1997: 55).

Only about 1% of births in America take place outside of a medicalized, hospital setting (Cheyney 2008: 254), despite the well established benefits of the natural, "hands-off" approaches to birth as found in home births assisted by midwives (Acheson et al. 1990; Boyer 1990; Crotty et al. 1990; Durand 1992; Ford et al. 1991; Fullerton et al. 2007; Hosmer 2001; Olsen 1997; Page et al. 1999; Rooks 1997; Tyson 1991; and Woodcock et al. 1990). In the natural, home birth approach, there are very few interventions, because birth is viewed as a natural process, and the woman and her body as capable of giving birth (Rooks 1997: 128). During prenatal visits, much attention is given to the education of women on their various options during pregnancy, labor, and birth. Midwives focus upon assessing not only physical concerns, but also women's emotional states, nutritional habits and needs. During labor, midwives tend to maintain an approach that is "hands-off," believing that too much intervention disrupts the natural

process of birth (Rooks 1997: 128), and that each woman has a different path by which her labor and birth follow.

Midwives focus on allowing the women to gain power through their births, because of their abilities, intuitions, and strengths. A woman makes her own decisions surrounding birth, which include position changes, food and liquid intake, family and friend involvement, and natural pain relief options, among others. Midwives stress mother-child unity directly after birth as well as breastfeeding and community support through the postnatal period. Most American women have had little exposure to home birth, and as such, it remains a little used option. Similarly, there are many misunderstandings, confusions, and negative stereotypes surrounding the legacy of home births that create barriers to the promotion of this option (Rooks 1997: 464).

### **Types of Midwives**

Furthering the confusion around midwifery is the various types of midwives available in the United States (see Appendix, page 151). There are generally understood to be two different labels for midwives, with a wide variation of practice found even within these categories. The main differences between midwives are the types of education and training they receive, the environment in which they practice, and their state-by-state regulation. The first category of midwives is the Certified Nurse Midwife (CNM). CNMs are medically trained midwives who are required to go to nursing school, and often also have a Master's degree specializing in midwifery. While CNMs can practice legally in all 50 states, their degree of practice and autonomy varies in each state

and facility (Cheyney 2005; 94). CNMs practice almost solely in hospitals and birthing centers, although some are able to attend home births, depending upon the circumstances.

The other category of midwives is that of the Direct-Entry Midwife (DEM). A DEM enters their midwifery education without formal nursing training. Additionally, there are many different routes that can be taken to acquire education and training for a DEM (Cheyney 2008; 256). Generally, a DEM will derive her education through formal schooling, self-study or apprenticeship, and then follow these studies with an apprenticeship in which she is practicing under the eyes and guidance of a trained and experienced midwife. The legal status of DEMs varies widely state by state, and their practice is found in homes and freestanding birth centers.

Two sub-categories are found within the category of the DEM, that of the unlicensed “Traditional” or “Lay” midwives, and that of the Certified Professional Midwives (CPM) or Licensed Midwives (LM). The Lay Midwife completes educational training through a number of routes including formal accredited schools, study groups, and internships or lengthy apprenticeships (Cheyney 2008: 256). The CPM follows the same routes as that of the Lay Midwife. However, she takes further steps, which include passing important courses in midwifery and also a national certification exam, in order to gain the professional title of LM or CPM (Cheyney 2005: 94).

Often, a midwife becomes licensed through meeting criteria set forward by the North American Registry of Midwives (NARM). These criteria include the completion of a portfolio outlining apprenticeships beginning with observing and actively participating in births and followed by attending births as the primary under supervision.

There are many skills that licensed DEMs are required to master, and they must also complete a practical and a written exam. Also, certain classes must be passed, including neonatal resuscitation and Drugs, Legends, and Devices ([narm.org/htb.htm](http://narm.org/htb.htm)). Ongoing education is required to maintain one's license as a midwife. Unlicensed midwives, while legal in very few states, practice without being licensed through NARM or any other state certification program, but usually have a long history of apprenticeship and have assisted many births.

There is much variation and flexibility in the practices of midwives of all kinds. Though they may be lumped into specific categories, those found in the same category may have very different beliefs and practices surrounding prenatal care and birth. Melissa Cheyney points out that midwifery practices of all categories can be placed on a spectrum ranging from the most medicalized CNMs to Traditional Birth Attendants (TBA) who have little access and need for the technologies of birth, and rely heavily on traditional midwifery knowledge and wisdom (2005: 96-97). The DEMs might be found somewhere in the middle, however, there are many DEMs who do not agree with the beliefs and practices of their fellow DEMs. While some may relate more closely to TBAs, others might find more agreement with the practices of CNMs. Even though a midwife is a CPM, she may relate more closely to a TBA than an unlicensed midwife.

A midwife's beliefs around birth and the practice of midwifery are highly dependent upon the individual woman, her training, and many other factors. A simple categorization of midwives cannot immediately outline what a midwife believes and how she practices. It does, however, provide a certain understanding of the training they may

have had and the education they have received to get to their point of practice. It also provides insight into the legal status of their practice, depending upon the state, and the environments within which they are most likely to practice. Overall, it is important to remember that most midwives have the best interest of their individual clients in mind and vary their practice according to client needs and concerns.

### **Birth Centers: An Alternative Paradigm**

Despite the presence of midwives and the move toward natural birth that can still be found today, midwives all over the United States struggle to keep their profession a viable and visible option for women giving birth. They face continual marginalization from the medical field; consequently, birthing women choosing midwife assisted births also face this marginalization. In the face of marginalization, some midwives believe radical measures are necessary to preserve their very core beliefs. However, it is not practical to expect women, with little knowledge of this system of care, and with strongly ingrained beliefs valuing the safety of technology, to suddenly become comfortable with the idea of a home birth, despite statistics showing its benefits (Acheson et al. 1990; Boyer 1990; Crotty et al. 1990; Durand 1992; Ford et al. 1991; Fullerton et al. 2007; Hosmer 2001; Olsen 1997; Page et al. 1999; Rooks 1997; Tyson 1991; and Woodcock et al. 1990). The birthing center can be a place where these ideals are transformed.

According to Raymond DeVries:

Most promising are strategies that strengthen the structural position of midwives and work to create supporting cultural ideas. The 'birth center' idea...is a strategy of this sort. It gives the profession more autonomy while making it attractive to policy-makers and clients. As more clients use these services, cultural

ideas are transformed in a way that favours the profession (1997: 264).

Some hospitals have responded to the demand for environments more conducive to natural birth by creating birthing centers or suites, found within the hospital. Birthing centers are generally broken down into two different categories: a birthing center or birthing suite and a freestanding birthing center. Often, a freestanding birthing center is also referred to as a birthing center. A birthing center or suite, in the categorical sense of the word, is a space found within or attached to a hospital. It is intended to provide more personal, family-centered care for pregnant women and families, with a comfortable, home-like environment conducive to natural birth. Many people feel that these centers are akin to a hospital setting because they are highly interventive, with impersonal care and little control by the families over their birth process. According to Robbie Davis-Floyd, in a study based on only two particular birthing suites, only 30 to 45 percent of women beginning their labor in the birthing suite succeeded in a natural birth (2003; 186). “Even if they are in a space that appears to be designed for natural childbirth, the couple is placed, interactionally and psychologically, under the sway of the technocratic model” (Davis-Floyd 2003; 185). Within these birth suites can be found the practice of obstetricians, CNMs, and nurses.

These birthing suites, however, are not to be confused with freestanding birthing centers. Delivering in freestanding birthing centers, a hybrid approach to birth that tends to bring together hospital and midwifery practices – is relatively new, having flourished during the “midwifery renaissance” of the 1970s. Freestanding birthing centers are not

physically attached to medical facilities and provide centralized care under one roof, which is home-like in design and décor. In freestanding birthing centers, the space is physically separated from the hospital, and may or may not have associations with medical practices. The terms freestanding birthing center and birthing center will be used interchangeably below, and those found within hospitals will be referred to as birthing suites.

A wide range of freestanding birthing centers are found throughout the United States and are run by obstetricians, CNMs, and DEMs. According to a study conducted by Judith Rooks et al., the majority of freestanding birthing centers are run by CNMs who provide 76 percent of the primary care (1992; 225). Though CNMs are the most common providers of care in most freestanding birthing centers, some are run by OBs, while others are run by LMs. Again, the state-by-state status of DEMs highly affects their opportunities to become primary care providers in freestanding birth centers and may be indicative of the small number of freestanding birthing centers run by DEMs. It is to be noted that while a freestanding birthing center may not be physically attached to a hospital, it may have attachments in business and practice. Others, however, not only have no physical attachment, but also have no business and practice attachment.

Because freestanding birthing centers are not physically connected to the hospital, many believe the success of natural birth to be higher. Davis-Floyd states of Rooks' birth center study that "the results showed clearly that the physical lack of connection to a hospital is accompanied by a conceptual lack of connection to the technocratic model. Births in such centers tended to be intervention-free, and the outcomes were

outstanding...” (2003: 186). Most birth centers do not use major technological interventions such as labor induction through medication, surgical procedures, and painkillers and epidurals.

As noted, CNMs are the most common care providers in birthing centers. CNMs’ management of these centers displays one of many ways in which birthing centers bring together paradigms of both hospital and home births. Like home birth care, treatment within birthing centers provides women with the opportunity to control their childbirth experience, through education, decision-making, and empowerment (Rooks 1997: 343). One-on-one support from midwives is provided throughout labor and birth. Many of the comforts provided by the hospital are also available in birthing centers, including access to oxygen and anti-hemorrhaging drugs, as well as technologies for lab work, Pap Smears, and suturing. On the other hand, water birth tubs and herbal remedies are often found in birthing centers, options infrequently available in hospitals. The concentration of care in one building, as well as exam rooms where Pap Smears and blood work are conducted, is reminiscent of hospital care. However, birthing center prenatal exams and births take place in private, cozy bedrooms that are characteristic of home birth settings.

In addition to the quality medical care mothers receive in birth centers, their nutritional and emotional needs are also addressed. At prenatal visits in birthing centers, as well as in hospitals, different practitioners may attend women, as opposed to one consistent care provider, which is found in home birth procedures. However, during birth at most birth centers, as in a home birth, a woman is guaranteed the continuous care of one midwife who has been seeing her throughout her pregnancy. By contrast, in hospital

births, a woman is usually not guaranteed that her obstetrician will be the person aiding her birth, and the birthing woman does not know the nurses.

These examples elucidate the ways in which a birth center provides both midwife and medical care; both midwives and pregnant women are able to negotiate the benefits found in each model of birth. Through birthing centers, women are provided with the many comforts found within both settings, and are educated about these options so that they may individualize their care. In linking the positive aspects of hospital and midwifery delivery, birthing centers provide an important third alternative for care.

However, bringing these paradigms together under one roof does not come without its problems. On the one hand, it is important to mainstream midwifery so that it might become a commonly chosen option for women in the United States. On the other hand, the very act of placing midwifery within a medical facility *changes* the traditional practice. While the degree to which the traditional practice of midwifery changes depends highly upon the state in which the birthing center is placed, its associations and connections to hospital and medical practices, and the practitioners providing primary care, each birthing center is, no doubt, subject to regulations and limitations based on state standards. Davis-Floyd states that, “Because such centers must be formally organized and licensed, they are more subject to regulation and control than home-birthers, and thus are generally less able to hold open the total alternative to the technocratic model than can be held open in home birth” (Davis-Floyd 2003; 300).

The benefits and downfalls of birthing centers are both embodied within the space of the NWBC studied here, a freestanding birthing center in the Northwest, owned and

run by a licensed DEM, and with no physical, business, or practice connections to medical institutions. In this space, rituals both resist and transmit medical paradigms of birth, and consequently, communicate messages that might embody contradicting values. These contradictions and tensions, which will remain in the lives and parenting decisions of the clients of NWBC even after their care is over, are what I focused on in my research at NWBC.

### **Birth Rituals and Birth as a Rite of Passage**

In order to focus on these tensions, I use ritual and rite of passage theory, as discussed by Arnold Van Gennep, Victor Turner, Catherine Bell, and Robbie Davis-Floyd. These theories will be discussed in detail in Chapter IV, “Birth Center Birth as a Rite of Passage,” page 103. Through ritual theory and participant observation at NWBC I have found that the practices of the midwives at NWBC constitute rituals whereby messages of empowerment and trust in oneself are communicated to clients. These messages are communicated through routinized and ritualized midwife practices, as well as active appropriation of medical practices that are modified based on individual client need and informed choice. I refer to the modification of medical practices as active negotiated appropriation. The following chapters outline the ways in which the NWBC setting and space, the practices of the midwives in NWBC, and the client responses display juxtaposition of medical and midwife symbols and rituals.

Much scholarship has compared the benefits and downfalls of both hospital and home births. Examining the rituals found within each practice has proven to be a key to the comparison between hospital to home births (Davis Floyd 2003, Cheyney 2005).

Many theorists have discussed birth, including American medical birth, as a series of rituals that together constitute rites of passage. Rites of passage can serve the purpose of bringing a person, “from one situation to another or from one cosmic or social world to another” (Van Gennep 1961: 10). In this movement from one state to another, the values and beliefs of a community and society are thought to be embedded into the initiate (V. Turner 1969: 103).

With respect to birthing practices, studies have found that “the ways procedures are performed and the messages attached to them (either consciously or unconsciously) influence participants’ perceptions of themselves, their infants, and their bodies” (Cheyney 2005: 126). While it is important to understand the ritual influences birth may have on a family, it cannot be assumed that women receive ritual messages fully and unthinkingly. Some ritual scholars, such as Bell, view those partaking in rites of passages and rituals not simply as rote receivers of communicated messages, but as active participants able to negotiate messages in particular circumstances (1992: 194). It is in this interpretation of ritual and rite of passage that I understand birth centers, NWBC, and the clients choosing their care. Using ritual as a basis for analyzing birth center procedures is key to understanding the messages communicated to women, and the ways in which they negotiate these messages.

In order for ritual analysis of NWBC practices to be most effective and to discover the ways in which it brings together paradigms of home birth midwifery as well as medical practice, one must understand previous analyses of both hospital and homebirth rituals. This will be outlined in Chapter IV, “Birth Center Birth as a Rite of Passage,”

page 103. Davis-Floyd's 1992 study of hospital delivery rituals has become paradigmatic in the study of delivery practices. She argued that hospital delivery was a rite of passage, clearly divided into the classic stages of such rites - separation, liminality, and reintegration (Van Gennep 1961, Turner 1969)- and she ethnographically studied each stage of hospital delivery, with special emphasis on the liminal stage. Cheyney provided a basis for comparison when she applied the same methods to home births (2005). My case study of NWBC will use the same methods as Davis-Floyd and Cheyney in order to look at the rituals and birth rites of passages within the birth center. These methods yield insight into the benefits and losses of placing midwifery under a medical paradigm, as well as how birthing centers provide combined care that communicates multiple messages to contemporary American women. These messages include those of empowerment, trust in oneself, and the ability to question American core values and institutions from within a mainstream system.

### **Folklore**

There are a number of ways in which my research falls under folklore. Martha C. Sims and Martine Stephens provide the following definition of folklore:

Folklore is informally learned, unofficial knowledge about the world, ourselves, our communities, our beliefs, our cultures and our traditions, that is expressed creatively through words, music, customs, actions, behaviors and materials. It is also the interactive, dynamic process of creating, communicating, and performing as we share that knowledge with other people (2005: 12).

Furthermore, Barre Toelken discusses what he terms "dynamism" and "conservatism" as the "twin laws of folklore process" (1996: 39). He theorizes that folklore is necessarily conservative in order for folklore materials, customs, and expressions to be passed

through time and space intact, retaining the beliefs and customs of a culture or folk group. At the same time, folklore must be dynamic so that its usage is relevant to the context in which it occurs, which may call for alterations as it is passed repeatedly through space and time (Toelken 1996: 39-40).

Important to the understanding of folklore are understandings of culture and folk groups. Culture is the “complex of interrelated behaviors that human beings create, learn from, and teach each other and that serve as bases for collective social identification” (Georges et. al 1995: 159). Similarly, folk groups can be defined as “any group of people who share informal vernacular contacts that become the basis for expressive, culture-based communications” (Toelken 1996: 56). Therefore, folklore is important in the creation and passing on of the beliefs and ideas of particular groups of people who share a collective identity, and this is often done through folklore’s ability to be “dynamic” over space and time (Toelken 1996: 56).

The study of midwifery, then, is important to folklore because it researches a folk group that has persisted for thousands of years. Its continuation has depended upon the informal transmission of its values and practices from one woman to the next and the group’s ability to be dynamic in changing environments. The midwives with which I worked at NWBC were informally trained through apprenticeships. Their knowledge of the profession was learned and expressed through orally communicated and modeled forms such as words, actions, and behaviors. Through their informal education they developed an understanding of the community around them, of the midwifery culture and its beliefs and values, and also of the clients whom they served.

However, as pointed out by Robert Georges, the dynamism of a particular cultural form may result not simply because members and contexts within a group demand it, but because of the interaction between groups within a society. A consequence of this contact is that “one group may ‘borrow’ folklore from another, adapting it as necessary to suit its needs, and making the other group’s folklore a part of its own culture” (Georges et. al 1995: 212). In this borrowing is recognition that the other group’s folklore is potentially useful and meaningful. This brings forward an important part of my research. At NWBC, there is a strong foundation of midwifery knowledge and practice. However, NWBC also represents a space where the borrowing and modification of another group’s practices and customs, that of the medical community, has been used in order to gain wider acceptance from mainstream America. Therefore, NWBC pulls from traditional practices of midwifery while also appropriating certain medical practices found to be beneficial for NWBC midwives and clients.

Another aspect of my research which aligns with folkloristics is that of narrative, a genre of folklore often divided into different sub-groups. One of these categories is referred to as the personal experience narrative and is a genre that I collected during interviews with clients of NWBC. According to Elliott Oring, folk narratives are conceptualized as “those narratives which circulate primarily in oral tradition and are communicated face-to-face” (1986: 122-123). Folk narratives consist of three main characteristics including existence in multiple versions, reflection of the past and present, and reflection of the individual and community (Oring 1986: 123). Ideally, narratives are collected in a setting where they are told without the prompting of the researcher. While

I collected the birthing narratives of women in an interview setting, I did so with an approach that did not use question and answer based interviewing. Rather, I approached interviews with an openness to women's words, so that they guided their own stories and emphasized aspects they felt to be important. Through this approach, I was able to understand what practices were most important to the clients of NWBC and how they experienced these practices. Similarly, I could understand their experiences of hospital births, and find connections and disconnections between the practices of medicalized birth and those of NWBC midwives.

One of the defining elements of folklore research is the type of research methods used. While many academics in other fields conduct their research from books, folklorists conduct research not only in books but in "the field". This is often referred to as participant observation, in which a researcher involves herself in a particular group, observing their actions while also interacting with the tradition-bearers and collaborators (Sims et. al 2005: 220). The substance of folklore scholarship comes from fieldworkers coming in direct contact with tradition-bearers or collaborators and "collecting" their expressions, as well as examining folklore within specific contexts so as to understand how folklore operates in specific settings. Once this has been done, the folklore expressions and observations can be archived and further analyzed (Toelken 1996: 347).

There are many different approaches that can be taken to folklore fieldwork and research, also known as ethnography, and many ethical aspects that play into folklore fieldwork. Generally speaking, a researcher will do much background research surrounding her subject of interest. She will then develop rapport with peoples actively

involved in those folklore communities or activities of interest, and eventually, collects folklore through these interactions. Often, a folklorist will follow up fieldwork with interviews, and then analyze observations, interactions, and interviews into a final written product. This is the process by which I have done my own research on midwifery and NWBC, as I will discuss in Chapter II: Meet the People, page 23.

The most important folklore aspect of my research is that surrounding ritual and rites of passage, which I discuss in detail in Chapter IV: Birth Center Birth as a Rite of Passage, page 103. According to Sims et. al, rituals are very complex “ceremonies or performances that enact deeply held beliefs or values” (2005: 94). They often bring together many forms of folklore, including material, verbal, and customary aspects, and signify a change in status or state (Sims et. al 2005: 94-95). In the culture and ritual practices of midwifery is found these multiple forms of folklore. For instance, a common way for midwives to speed a stalled labor is through the use of two herbs called black cohosh and blue cohosh. The need for the administration of these herbs might be expressed from one midwife to another through the simple statement, “black and blue.” In this statement, and the events that follow can be found material culture, that of the herbs, verbal folklore, that of the expression “black and blue,” and finally, customary folklore, that of an understood practice of administration which indicates intimate membership in a folk group. This is only one example of the many forms of folklore found in midwifery practices and rituals.

Pregnancy and childbirth are highly ritualized, complex rites of passage that involve many forms of folklore. It is with an understanding of folklore aspects of midwifery, and

the importance of ritual and rites of passage, that I approach the analysis of care provided at NWBC. This adds much to folklore and anthropological scholarship surrounding pregnancy and childbirth, as well as that of midwifery. Importantly, the study of midwifery customs and rituals can also display the ways in which folklore expresses the need for change. According to Georges et. al, folklore can be “the expressive basis for communal identity and collective action” (1995: 225) and can be used “for social and political critique in attempts to alter institutions, values, and policies dominating their lives” (1995: 177). In my own research at NWBC, I have found the rituals of the midwives to be active critiques of society and medical birth, and as important commentary on the strength of women and their ability to affect social change in American society.

### **A Brief Outline of the Chapters**

In Chapter II: Meet the People, I will begin my discussion of NWBC by describing my own position as a student conducting research at a birthing center and volunteering in exchange for the help afforded me during my research phase. As I have been working at NWBC for close to two years, my path has been long and changing, as have my roles at and feelings about NWBC. My research methods will be intertwined in this chapter. Following the description of my personal connection will be that of my research subjects. There were four women who agreed to allow me to observe their births and then interview them afterwards. I will describe their personal experience narratives surrounding birth, midwifery care, and NWBC. In this chapter, I will also introduce the

individual midwives working at NWBC, their licensure status, education, and time working at the birthing center.

In Chapter III: "Northwest Birthing Center: Mainstream or Alternative?" I give a detailed account of the space of NWBC, describing every room, its environment, purpose, and what happens within each room. Within each room are juxtaposed symbols of midwifery and medical paradigms of practicing birth; these are further discussed at the end of the chapter. In this chapter, I will describe what services are offered at NWBC, what a normal prenatal visit day looks like at the birthing center, as well as how the birth center transforms during a birth. This description will familiarize the reader with the space of the birthing center, as well as how it brings together "opposing" paradigms of birth under one roof.

This will lead to Chapter IV: Birth Center Birth as a Rite of Passage, which outlines ritual and rite of passage theories as related to birth. First I discuss rites of passage, a type of ritual first discussed by Van Gennep (1961), as related to and important to birth. Then, the concept of ritual will be discussed drawing from the works of Turner (1969), Bell (1992), and Davis-Floyd (1992). To further my analysis, I will look at how other theorists, specifically Davis-Floyd and Cheyney (2005), have discussed birth as a rite of passage. Each broke down pregnancy and birth into phases and analyzed specific rituals related to hospitals and midwifery. After briefly reviewing their findings, I will take the same approach with the birth center and discuss the differences and similarities found, and, finally, the ways in which NWBC is a ritual space, within which midwives and clients at once resist and comply with medical paradigms of birth.

In the Conclusion, I discuss the effects of the birthing center as a ritual space, whereby messages of empowerment, trust in oneself, and ability to question mainstream ideals are communicated to women. It is my hopes that my research will contribute to women's knowledge of midwifery practices and the benefits and downfalls that come with choosing a birth center birth. Additionally, I hope to add to feminist and gender studies through the advocacy of women's rights, freedom of choice, and freedom to privacy in their birth settings. I have used the words of the women I interviewed, or collaborators, to guide my research and to be central to my arguments and my findings surrounding the birthing center. I have attempted to reflect the women's perspectives fairly and accurately. Through my two years of intensive fieldwork and also the discussion of birthing rituals, I hope also to add to medical anthropology, folklore, and ritual studies, which have done little in the way of examining birthing rituals within a birth center setting.

## CHAPTER II MEET THE PEOPLE

### **The Researcher and Her Methods**

I am from Missouri, where the practice of lay midwifery, even if one is licensed by NARM, is considered to be practicing medicine without a license, a felony\*. This means that if a woman desires to have her baby outside of a hospital setting, and follows through with this desire, her midwife is performing an illegal service. Ironically, if the same woman chooses to have her baby unassisted, or the baby comes so fast that it is accidentally caught by, say, the milkman, there is nothing illegal involved in this occasion. It is when there is a skilled, experienced midwife present that it becomes an illegal act. To some, this may seem normal and expected. Indeed, to me it certainly seemed normal to have children in the hospital. I never really thought otherwise and, if prompted to explain this belief, might have said that the hospital was the safest place for birth to occur. Why would one choose to give birth at home if there were hospitals?

During my early 20s, I met a woman in Missouri who practiced midwifery for over 20 years. Of course, this meant she was practicing illegally for that entire time, and the stress of the situation had eventually led her to give it up, despite her passion and trust in the birth process. Three of her five children were born at home. The first two births, which occurred during the 1970s, were traumatizing hospital births. During one birth, she

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\* At the time that I began my research this was true of midwifery in Missouri. I am happy to say that midwifery is now a legal practice by Missouri state law.

was strapped down to the hospital bed. She began apprenticing in midwifery while living in the Ozarks, a poverty-stricken, rural area of Missouri known for its folk music and mountains. She had to push her way into acceptance from the midwives with whom she apprenticed, who made her clean up after births and help them with the more menial, but essential, tasks of midwifery. Through this she proved her dedication and desire to learn more of the art of midwifery.

At the time that I met this woman, I knew her as a mother, a musician, and an artist. To hear about this aspect of her life was fascinating, and even more fascinating was the practice of midwifery itself, which I knew very little about. I do not think I even knew of the existence of CNMs in hospitals. I had many questions for this woman about midwifery and also about what it was like to have to practice illegally. She talked of helping her clients to get birth certificates by claiming the baby came so fast they didn't quite make it to the hospital. She also talked about fear, not of birth, but of transporting the babies to hospitals, and of being found out and persecuted. It was a risk for herself and for her family, but one she felt important enough to pursue for 20 years. And why was it so important? It was important for women's choice, the empowerment of women and for the peaceful entrance of children into this world, a peaceful entrance she believed was hard to come across in a hospital setting, especially one in Missouri.

Years passed and I found myself in graduate school at a university in the northwest, in a state where the laws surrounding midwifery are quite different than in Missouri. In this northwest state, a woman can practice midwifery even without a license. As I began thinking about my final program of study in an interdisciplinary

Master of Science program, I came across a multitude of research on birth and midwifery in relationship to folklore and anthropology. Additionally, I realized I was surrounded by a huge community of midwives and also of women who had had home births. Through research, I found that midwifery and home births were safe and quite empowering to most women partaking in this form of prenatal and birth care. I decided this would be my area of study. I was not yet sure in which direction I would take it, but to me it seemed unfortunate that it was not a legal service to women in many other states, and felt it a violation of human rights, women's rights, and rights to privacy. So began my journey as a researcher focused on midwifery.

My first year was spent researching birth and midwifery. I wrote many papers discussing birth as a rite of passage and the spectrum of midwifery that can be found in the United States. I decided that I wanted more direct experience, and so I took a course to become a doula, an assistant who helps women during their pregnancy, birth, and postpartum periods. A doula can work in any setting; home, birth center, or hospital. I finished the course and was even more inspired than before. However, I could see that a doula's role might be more useful in a hospital than at a home birth, because they act as advocates to women in settings not always conducive to birthing women's desires and needs. I looked into other avenues for getting more involved with home birth.

In October of 2006, I began to volunteer at NWBC, a local freestanding birthing center that is run by a licensed, certified professional midwife (LDEM, CPM), Toribia\* . Looking back at my long path at NWBC, which began at that first meeting with Toribia

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\* Names of midwives have been changed to protect their privacy and the privacy of NWBC

and continues to this day, two years later, I see a multitude of experiences. I have truly been from one end to the other. There was a point at which midwifery still remained so romanticized and idealized in my mind that I thought I would never find anything negative or critical to say about NWBC. A year later, after my responsibilities increased and I decided to become a midwife apprentice, while finishing a thesis and working two other jobs, I felt so burnt out and frustrated with NWBC that I could not remember any of those wonderful things that I had to say originally. Thankfully, after time, I was able to find myself somewhere in between, able to see many different aspects of the birthing center.

I started at NWBC helping with simple tasks, such as sorting and compiling files and answering phones. Soon, I was able to sit in on prenatal appointments for observation. I talked extensively with the different midwives at NWBC about their perspectives on midwifery, their histories, and their individual paths that lead to midwifery. I gained enough respect from Toribia that she told me she would like me to come to the next birth, so that I could see what it was like. I later realized this was what she did with any volunteer; the sooner she could get them to a birth, the sooner they would know if it was something they were really passionate about. Passionate I was.

The first birth I was at was powerful and amazing. I got a call in the middle of the night, an experience I would later find to be the norm. I rushed to NWBC, and found it set up for a birth. The birthing center was dim, with soft decorative lights lining the windows, and moaning sounds coming from the back room downstairs. I poked my head into the office where one of the student midwives was setting up some supplies. She

greeted me with a whisper and a smile. I cannot explain what it felt like to be in the place of a birth, but it was like being in a different world. I was directed by Toribia to follow the student midwife and to take notes about the birth. I was given a watch and told to write down every detail possible. Most importantly, I noted heart tones of the baby, and the time of the birth of the head and the birth of the whole body.

The one thing I remember with great clarity is the moment the baby's head emerged from the woman's yoni\*. It was the most surreal thing I had ever seen and the picture of it sticks with me to this day. I think I remember this so clearly because even now, after observing over 20 births, the moment the head emerges continues to be the moment at which I find myself in the most amazement. Here is this child, emerging for the first time into the world, still a creature of the womb, yet transforming into a creature of the outside world, moving from water to land. Sometimes a baby tries to breathe at this moment, and sometimes she waits until she is all the way out. Sometimes a baby will start to cry with only her head out and sometimes she will even open her eyes. Sometimes her body follows seconds behind her head, and sometimes minutes. Most the time, a woman will feel her baby's head after it has come out and it seems like maybe, until this moment, she had forgotten why they were doing the work of labor. This is the second most amazing thing I see in birth, a woman's immediate connection to her child and the way that child will gaze into it's mother's eyes as if the baby had done it a million times before.

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\* Yoni is a Sanskrit word for "divine passage," "place of birth," or "womb" and is commonly used to refer to the vagina.

After the placenta was delivered and the cord cut, the student midwife showed me how to examine the placenta to make sure all the pieces were intact and that the vessels and veins were present in the umbilical cord. We then assisted Toribia in examining the woman for tears on her yoni. There were mild tears requiring suturing. After the suturing was finished, I helped the woman to the bathroom and assisted her in cleaning herself up. Toribia then sent me to bed on the upstairs couch.

I continued my research in books, but found the most important information and education to come directly from my experiences at the birthing center. I soon began to see the birthing center as a place in which the comforts of medical-oriented practices as felt by American women in today's society met with the benefits of midwifery care. With this in mind, I began to design my research methods, which I later presented to Toribia. I went through the process of being approved through my university's Office for Protection of Human Subjects, and ethically designed the recruitment and involvement of participants. I had the head midwife make a list of clients she felt comfortable with me contacting. I also agreed to volunteer at the birth center for a year in exchange for her allowing me to conduct research within this space.

With the list Toribia gave me, I sent out recruitment letters explaining who I was as a researcher and volunteer, the purpose of my research, and what their involvement would be if they chose to become a participant. I mailed these to their homes with a self-addressed envelope and contact information for myself. I received responses almost immediately from some women, and from others after some time. Five women agreed to be involved with my research, which meant that I would observe their prenatal

appointments closely, attend their births, and conduct in-depth interviews with each of them sometime after their births.

The women expressed that they enjoyed having me around and felt that my research was very important. As it goes, two of the original participants did not follow through with interviews due to personal circumstances. I later sent out another batch of recruitment letters in order to find more participants. Only one responded, and it was her story that I found to be the most amazing of all. I will introduce each of my participants in the following pages.

During this time of fieldwork and participant observation with my collaborators, I was relieved to step outside of my office and the library to do research, feeling the need for more practical experiences and hands-on work. In the back of my mind I was thinking I might like to become a midwife at some point. I increased the amount of time I spent at NWBC during the days of prenatal visits, and I worked hard to schedule my collaborators' appointments during the times I could be there, or to work my schedule around theirs. I quit my outside jobs during the periods when I was on call. I soon became an integral part of the birth center, catching on quickly to office work and the structure and setting up of prenatal exams and births. I did a lot of cleaning, because this is what one does as a midwife apprentice. I gradually became confident of my decision to become a midwife.

Soon after, life caught up with me. I could more easily say that death caught up with me. While I will not go extensively into the details of the death of an infant whose birth I was assisting, I do not feel I am able to leave this out, as it largely affected my

personal self, my researcher self, as well as the path and time frame of the writing of this ethnography. Most people in the United States have a hard time talking about death. We have all the technologies to save people who might not have survived in the past, to help people live longer, and to detect and prevent life-threatening illnesses. Many of us are so scared of death and even more scared to admit or realize or think of or talk of the fact that life and death are connected. Death is *never* easy, at least not for me, and probably not for most people. It is not easy if expected, if necessary, if unexpected and certainly not when it could have been prevented.

What is hardest is knowing the best ways in which to provide support for families who have lost a child, while you yourself are in a state of mourning or post-traumatic shock. I was holding so strong for the family that I could never allow myself to cry. Months later, I found myself bawling my eyes out at the most random moments, a waterfall of tears gushing forward, with no end in sight. I felt guilty for not spending enough time with the family or doing enough for them, even when I was giving as much as I possibly could. At the same time, I found myself investing all of my extra time in finding resources for that family. I was on a rollercoaster of emotions and was not taking care of myself; I had no interest in research. Needless to say, the research and work of a thesis seemed completely unimportant and miniscule after witnessing the death of a newborn. It is after this that my work came to a complete stop.

What did not come to a stop, though, was my desire to become a midwife. I have never seen so much support provided by a community of people who was not immediate family or friends and could never imagine this kind of support from the medical

community. I saw the outreach of a myriad of resources gathered by midwives. People came together to cook and clean for the family, supply herbs for healing mentally and physically, take the family to counseling, take the family for walks so they could get out of the house, and many other services. When death is involved, most midwives give themselves so fully to their clients, that they may not take care of themselves. What I witnessed, however, was that the midwives of NWBC, especially Toribia, extended themselves beyond their capacity, but somehow managed to find those moments for themselves that were essential. This is when I began to feel like a midwife. I felt that I had faced the reality of what it's like to be a midwife: the sacrifices it involves, the love it involves, the dedication, the openness and all of the giving it involves.

I wanted nothing more than to be a midwife after this, which was a little over a year ago. Maybe I thought it would help me heal. Maybe I thought I could heal others. Probably both. While the thought of a thesis was in the back of my head, it still seemed like a low priority. I soon got back into the work force, having completed all of my graduate coursework as well as interviews with collaborators. All that was left was my thesis. Then, I found myself with three jobs, one as a nanny, one as a server at a restaurant, and one as an apprentice at NWBC. I became completely focused on midwifery and supporting myself through this. I attended other births which continued to amaze me, and in which my knowledge and experience grew. I started to record my experience for the purpose of licensure and worked at the birth center even more as a volunteer apprentice. I was paid only for a few hours at the births I attended. I was

thankful for even that amount of pay, considering the education I was used to getting was something for which I always paid.

After months of hiding from my thesis and focusing so strongly on midwifery, I again faced the fact that I would need to return to my thesis work, and I was finally ready. I was thankful for the time I had spent away from my writing. I had learned so much by focusing and submerging myself in the world of midwifery. I then began to reread the books I had spent so much time with, revisited the members of my thesis committee, and rethought the ways in which I would frame my thesis. I could see, having been from one end to the other with the birth center, that it was more than a place where women give birth in empowering ways, and that it was even more than just a simple compromise between medical and midwife paradigms. It was a constant negotiation between the many different paradigms of midwifery practice, as well as those of the medical practice. In order to gain the benefits of one paradigm, others might be sacrificed, and this I will detail in Chapter 4, Birth Center Birth as a Rite of Passage, page 103. NWBC represented, to me, the everyday decisions women are faced with in American society, and their ability to negotiate between what they believe, and what is expected from the mainstream. NWBC questions the mainstream, while at the same time, in some ways, maintaining the mainstream.

### **Feminist Approaches to Ethnography**

At the time that I was beginning my fieldwork with midwives and clients of NWBC, I was also reading about and taking classes in feminist research methods. One of the main aspects of feminist methods that resonated with me was that of activism. I feel

that the ambiguous nature of midwives' positions in the United States and the limited resources and options for women who give birth is a violation of human rights, the freedom of choice, and rights to privacy. The midwives with whom I work, as well as the women that I interviewed, also share this perspective. Knowing this, I have approached my research from the position of an activist.

Activism in research is a major aspect of feminist research, so that political sympathies are used in order to attempt to make change in communities and raise awareness of masked issues in these communities (Wolf 1996: 4-5). Feminist researchers must be careful, first, that the changes they advocate are those changes that community members also find important. Secondly, feminist researchers must not portray women they are researching as ignorant of important matters of their own communities. Also important is avoidance of "unilinear accounts of social change that might cast the people they study as unwitting victims of forces beyond their control, seeking instead to identify elements of agency in the thoughts and behavior of actors" (Lewin 2006: 22). This approach has been very important to my research, as studies of birthing rituals often portray women as rote receivers of unconscious messages. What I saw in the women that I interviewed suggested the opposite; they were fully aware of the messages communicated to them in the various birth settings that they discussed. Also, they felt it important to spread the message of the benefits of midwifery and NWBC.

Another aspect of feminism that is important is feminist standpoint theory, which emphasizes the importance of the positionality of the researcher (Wolf 1996: 13).

Positionality refers to the personal identity of the researcher, especially in relationship to

those with whom she is conducting research and the topic of research. Originally, positionality was meant to emphasize the importance of women conducting fieldwork with women and in women's culture. Feminist scholars emphasize that, "one's positionality as a woman is crucial in gaining knowledge and understanding of other women" (Wolf 1996: 13). However, some feminists later realized that this idea was essentialist because it ignored the many differences between women.

This led to perspectives recognizing the multiple identities and positions, or "standpoints" (Wolf 1996: 13) of the women studied and of the researcher, and how these positions shaped experiences, research interactions, and interpretations. These multiple identities include not only gender, but also race, socioeconomic status, nationality, and sexuality. The multiple identities of the researcher and their intersection with one another are seen to affect their approaches to fieldwork and also their interactions and relationships with informants, who also hold multiple positions that come into play with those of the researcher (Wolf 1996: 13). Acknowledgement of these multiple positions and the effects they have on research is the first step in situating the researcher among her informants so that the research can be seen as a partial perspective representing different realities, not as presentation of "truth" and "facts" as Ellen Lewin criticizes (2006: 15). In the writing of ethnographies, recognizing and acknowledging partial perspectives highly affected by multiple positions is necessary before analyzing and presenting research on informants (Wolf 1996: 14). Judith Stacey points out that, "While there cannot be a fully feminist ethnography, there can be (indeed there are) ethnographies that are partially feminist, accounts of culture enhanced by the application of feminist perspectives" (1991: 116).

The idea of multiple positionalities was also important in recognizing the power differentials that often come into play in relationships between researchers and those they research (Wolf 1996: 14, Lewin 2006: 19). In recognizing research as partial, problems of power in research were addressed. The problem of power in fieldwork became important because of the tendency for feminist scholars to work with marginalized populations of women. Feminist scholars considered their identities as women to be equalizers, without recognizing that their own identities were privileged. However, because of multiple positionalities, some identities may come from a privileged perspective, while others may come from a marginalized perspective. For example, I come from the marginalized position of a woman, but the privileged positions of being white, middle class, and educated. The women with whom I conducted research, which includes both the midwives of NWBC and the clients that I interviewed, came from similar backgrounds as me. All of the interviewees were white. However, their levels of education and class were varied, and might be considered more marginalized than my own. The midwives, except for Toribia and Melissa, were all white. Their educational and training levels were highly varied, and their socioeconomic status usually fell into the lower to middle class.

I might say, then, that I felt my fieldwork was approached on somewhat equal ground with the people whom I was researching, especially considering that I began apprenticing as a midwife. Indeed, it appears that my investment in the research and its goals highly aligned with those of the interviewees and midwives of NWBC. Many feminist scholars, such as Judith Stacey, point out that feminist fieldwork often leads researchers to believe they are on equal ground with the women they study. Stacey states,

“Feminist researchers are apt to suffer the delusion of alliance more than the delusion of separateness” (1991: 116). However, the distinction often drawn between the “self” and “other” in feminist research seemed not to be as prominent in my own research as one might find in other feminist research because I conducted my research within my own community, and especially because of my strong beliefs in the benefits of midwifery.

Because of my research on midwifery and birth, as well as my fieldwork with midwives and clients of NWBC, I have approached my research as a woman who, despite not having any children, felt oppressed by the marginalization of midwifery. When I began fieldwork, I was approaching it as a feminist folklorist. These positions are complicated, almost contradictory at times. According to Lila Abu-Lughod, in “Writing Against Culture,” feminist perspectives greatly add to the discourse speaking against the distinction between self and other so commonly found in folkloristic and anthropological research. “The dilemmas faced by feminists defy separate notions of self and other, where a split selfhood is found” (1991: 138-141). On the one hand, my position as a feminist “other” is discovered and constructed in opposition to an oppressive force, in this case the medical field and laws surrounding birthing options for women. On the other hand, my folklore “self” is defined in relationship to a non-oppressive “other,” in this case, the midwives and women choosing care at NWBC. These two identities are thus constructed from two different sides of the power structure, and serve to break down binary distinctions between self and other.

Through this perspective, one cannot ignore multiple positions and complicated relationships with positionality, audience, and power. I am working toward creating more

opportunities for women in their birthing options, speaking against an oppressive force. At the same time, I am “studying down” in terms of speaking from a privileged position in which I have the power to exploit or reveal too much about the birth practices in NWBC and the midwives working there. I also have the ability to represent, in the final writing of the research, my research subjects’ words in whatever way best fits what I am trying to say about birth centers and NWBC. According to Judith Stacey, “Ethnographic method appears to (and often does) place the researcher and her informants in a collaborative, reciprocal quest for understanding; but the research product is ultimately that of the researcher, however modified or influenced by informants” (1991: 114). Therefore, the marginal position of the midwives and the ambiguous position of my research subjects make them vulnerable, despite my efforts to accurately represent their words in my research.

In order to downplay the possibility of exploiting or misrepresenting the words, beliefs, and desires of the women I researched, I chose to volunteer at NWBC. Through this, I felt I was engaging in what feminists refer to as “reciprocity,” where I was not the only person benefiting from my research (Wolf 1996: 24). Volunteering quickly became immersion into the midwife community at NWBC. Diane Wolf admits that “immersion into a culture provides one way to downplay one’s privilege and difference, and it may provide a less intrusive and obtrusive methodology” (1996: 9). Sensitivity to those being researched often comes from immersion into their community, so that a more insider view is attained from within the culture. However, as many feminist scholars point out, inequality between the researcher and researched still remains, especially because the

researcher is only temporarily a part of the community she studies. Not only does her positionality remain while in the field, but she is also able to depart when research has ended, leaving behind those she researched in order to write about their community (Wolf 1996: 10).

Stacey points out that “Fieldwork represents an intrusion and intervention into a system of relationships, a system of relationships that the researcher is far freer than the researched to leave” (1991: 113). While this may be true of most feminist scholars, especially those working outside of their immediate communities, the research I have conducted falls outside of these critiques of immersion and feminist fieldwork. This is because I have never left the field in the writing of this ethnography and will remain in the field long after the research product is complete. Not only will I give birth under the care of NWBC, but I will also continue to work there, in my pursuits of becoming a midwife. Because of my continued work at NWBC, I have developed a sense of shared positionality with the midwives and clients, which has allowed me much insight into their beliefs and desires. However, this does not come without its problems, because “it is also very possible that such a position may make it difficult for the researcher to critically ‘air the dirty laundry’ due to her bonds and allegiances” (Wolf 1996: 18). As I said before, there were times when I thought I could never find anything bad about NWBC. However, I have found myself also feeling very critical of NWBC. This has allowed me, I believe, to be critical of certain NWBC practices that I have discussed in this ethnography. At the same time, I have remained a part of NWBC and in alignment with the beliefs and hopes of the midwives and clients.

There are theorists, such as Ruth Behar, who believe that researchers who write subjectivity into ethnography make themselves vulnerable, because they have relinquished their authority as a researcher and this places a person at risk academically (1996). Personal accounts in research are not always received well. However, I think, as many feminist researchers do, subjective writing to be necessary to research. It should be clear from my writing that I think my own story as a researcher to be important. This is because I am more than a researcher. I am a woman who is exploring important options in my own and others' reproductive lives. I am an advocate of natural birth but also of a woman's right to choose the way she gives birth, the way her child enters the world, and what is done to her own and her child's body during this process.

I am also a student of midwifery, having chosen to take the route of apprenticeship, and who will also choose the path of licensure. Now, I am a pregnant woman, who, despite her trials and tribulations at NWBC, can think of no other person to be her midwife than Toribia, and no other place to give birth than in her home. Anything else seems outlandish. Ironically, the majority of people in the United States seem to believe the opposite, that to give birth in the comfort of my own home with a midwife attending is outlandish, and selfish, and unsafe.

I have chosen a method of feminist writing that includes the weaving of personal, subjective aspects of myself into my research and writing of ethnography. I have also included short autobiographies of the midwives at NWBC, not based upon interviews with them, but upon observations and conversations during my immersion. My inclusion of the stories of the women who were a part of my research (my collaborators) and their

paths to and within NWBC, are based upon interviews with them, including quotes, and through the summarizing of their words. As much as I would love to place their whole narrative texts here, there is not room for that in this ethnography. I have tried as best I can, to be true to the stories they have told me and to their beliefs surrounding their different types of care. I have weaved their words through the chapters of this ethnography, using their experiences as the main source for supporting theoretical ritual research surrounding birthing ways.

It is my hope that in this writing can be found the argument for the necessity of midwifery practices in their various forms, a hope I share with my collaborators. It is important to note that my positionality may have affected the ways in which my collaborators told their stories to me. I became so enmeshed within NWBC that I would surmise most women believed me to be an inside member, a midwife apprentice, and not simply a researcher. That said, women seemed to be quite comfortable in my presence and in discussing their experiences. It is difficult to say, however, whether or not they would feel comfortable criticizing the practices within NWBC, as it may seem to be a direct critique of me and the birthing center in which I am involved.

I conducted my interviews based on methods suggested by Kristina Minister in “A Feminist Frame for the Oral History Interview.” Minister states that, “Interviewers who validate women by using women’s communication are the midwives for women’s words” (1991: 39). Because the frame for oral history interviews is largely based on male ways of communicating, Minister suggests that women will continue to be silenced from this method of fieldwork. The communication frame must be reworked to instill in

women the belief that they can speak in public settings, without fear of “living up to” the male standard of speaking. Interviewers and interviewees alike, must feel that women’s ways of communicating are valid and meaningful, in order to bring forth women’s words (1991: 31).

According to Minister, much of the way women communicate is based upon collective and collaborative constructions of identity. However, common methods of interviewing are not conducive to women’s style of communication. More often, interview methods are based upon, “topic selection determined by interviewer questions, one person talking at a time, [and] the narrator ‘taking the floor’ with referential language that keeps within the boundaries of selected topics” (Minister 1991: 35). Though women may easily respond to this structured form of interviewing, based upon their knowledge of what an interview is, “taking the floor” can be more difficult. By using these traditional techniques, one will not allow women to speak their own minds and in their own ways. Instead, collaborative, open-ended interviews can be more successful, because what a woman says is highly valued. One of the first things researchers must do under this feminist framework is to “discard their own research oriented time frame in favor of narrators’ temporal expectations” (36). Although I told the women that the interviews would probably last around an hour, I did not time them, look at my watch, or tell the women to start wrapping up their thoughts. Neither did I try to force them to continue talking if they seemed uncomfortable, tired, or appeared to be finished.

Another important aspect of the feminist framework for conducting interviews concerns following a list of topics that are asked sequentially. Commonly, this has been

a tool for interviewers in asking questions and directing the narrator. However, following such a list can be detrimental, because it can cause the interviewer to control the interviewee, by directing her away from her own way of thinking and speaking (Minister 1991: 36). While I did have a set of basic questions written down, in order to guide women through their past birthing experiences, I aimed at informant-driven interviews, in which the women directed the flow of topics, and I based my questions upon what they had brought up. I followed my instincts of communication with women, by using nonverbal and verbal techniques. I reinforced women's thoughts through nodding my head, simple "uh-huhs," and verbal intersupport, where I finished or overlapped their sentences. I also made strong eye contact, sat facing the women with attentive posture, and at times, supported them through bringing up my own personal experiences. I am aware that this approach to interviews essentializes women and the ways in which they communicate. However, it is not the only approach I have used in my work at NWBC or the writing of this ethnography, as I have already discussed.

There are, however, other feminist methods that I wish I had used in the research and writing of this ethnography. One such method is that of reciprocal ethnography, as developed by Elaine Lawless (1992), in response to this dilemma of inequality between the researcher and the researched. In this approach, a dialogue is opened between the researchers and the researched and the researched are allowed the opportunity to interpret the interpretations of the researcher. When the ethnography is written, all of interpretations and re-interpretations are included so that the readers are able to see the shaping of the ethnography. While it is my intention to share the final product of my

research with the midwives of NWBC and the women that I interviewed, because of time constraints, this will be only after the final product has been published at the University of Oregon.

However, it is also my intention to bring my research to other areas beyond academia, areas that I believe may be more affected by my research and the messages that I am trying to convey through this research. Daphne Patai stresses the importance of understanding how our research is returned to the community. She states that feminist research must “ultimately aim at social transformation” (1991: 138). This being my aim, I intend to bring my research back to the community, where they are given the opportunity to read my final product and provide feedback. Using this information, I would like to condense the project, interview the midwives I have worked with at NWBC (something that I have not done in this process and that is a gap in my research), and submit my work to relevant publications such as *Midwifery Today* and other women- and family-centered publications.

### **The Midwives**

The midwives at NWBC have taken many different routes to arrive at this birthing center. They have various training, and the majority of the women at NWBC are student midwives, or apprentices, working their way toward licensure. I chose not to interview the midwives at NWBC. Instead, I focused on the women birthing at NWBC. However, I feel it is important to describe the various midwives at the birthing center, in order to provide the reader with a feeling for the women providing services at NWBC. These brief autobiographies are based on my personal communication with these

midwives and knowledge of their lives that comes from being surrounded by them for nearly 2 years.

Toribia is the only licensed midwife at NWBC, and also the owner who originally opened NWBC. She, therefore, is required to be at every birth that occurs at NWBC or those that NWBC does at the homes of their clients. Not only this, but it is important that she be present for most of the prenatal care provided to women at the birthing center, and that she pays special attention to every detail of the clients' charts. Toribia, a woman in her mid-50s, is a certified, licensed midwife who has been practicing for over 20 years, and has assisted in hundreds of births. She was raised by her grandmother and aunts on a farm in Nayarit, Mexico in the Sierra Madre Mountains. Her great grandmother was a midwife, who would travel by mule to assist women in their births, and was often gone for close to a month while aiding women postnatally. Toribia's childhood was spent working on a farm, where all of their necessities were grown, raised, and bartered. At age seventeen, Toribia left Nayarit to go to Los Angeles, in order to meet her mother for the first time. She soon married and moved to Alaska, where she had twins in a hospital.

At one point Toribia moved to the Northwest. Because of her negative experiences in her previous hospital birth, she chose to give birth with a midwife for her next birth. She never imagined that birth could be so beautiful and empowering, and she felt immediately that midwifery was her calling. She began, in the Portland area, to train with other women interested in midwifery, and was soon attending many midwife meetings, herbal workshops, and other community resources to increase her knowledge in holistic care. She worked several jobs while gaining experience in midwifery,

including cleaning houses, interpreting Spanish for medical patients, phlebotomy, and cooking/catering. She moved back to Mexico several times, only to return to the United States. Her final birth, while she wanted to have it at home, ended in a hospital, where she was treated with little respect and care.

Through both her positive and negative birthing experiences, she developed a system of care seeking to empower women, respect their choices, and offer intimate, personalized assistance throughout pregnancy, birth, and postnatal care. She feels that through her services to women, in which she offers to them much of what was missed in her own births, the pain from her own experiences is healed. She is able to offer herself to women openly and with a strong belief in the ability of women and their bodies to give birth, as well as a belief that each woman deserves the time and love so important throughout childbirth and pregnancy.

Toribia opened NWBC in 2005. She has transferred her philosophy of midwifery care into a home-like, intimate setting, and believes strongly in creating the birthing center as a community space, open to be used for classes, meetings, workshops, family gatherings, and potlucks.

Ali, aged 25, is originally from Arizona, where she is a licensed midwife. Because she is not licensed in the Northwest, she holds the status of a student midwife while at NWBC. In Tucson, Ali was part of a homebirth practice for five years. Midwifery found its way into Ali's heart at the age of three when she witnessed her brother's natural entrance into this world. When she began her college studies, she was planning on becoming a neonatologist. She wanted to gain some experience with

childbirth before committing to medical school so she called up a homebirth midwife who agreed to work with her. Once she became a part of midwifery she found that it was a part of her all along and abandoned her plans to become a part of Westernized medicine. She is passionate about midwifery and its importance in creating and sustaining healthy, loving families. Ali is excited that she is a part of a community where natural childbirth is accepted and celebrated.

Pamela, 38, is a mother, midwife, doula, childbirth educator and Birth Arts Doula Instructor. She has had the opportunity to learn the art of midwifery from several midwives, midwifery study groups, and through self-study since the mid 1990s. She has been submerged in birth in the Northwest since 1997. Pamela has been fascinated for many years by the stories women tell of birth. With experiences ranging from homebirths, birth center, and hospital births she has witnessed hundreds of births and has learned a healthy respect and trust in pregnancy, labor, and the birthing process. She is currently working on finalizing her requirements to become a Certified Practicing Midwife and Licensed Direct-Entry Midwife. After receiving licensure, she will no longer be a student midwife at NWBC, but a practicing midwife.

Becca is a wife, mother of eight, grandmother of seven and midwife, aged 48. She gave birth to her first two children in a hospital and her next six at home with the care of midwives. All of her children are home schooled. Becca was hooked after her first homebirth in 1980. She started reading *everything* she could get her hands on about birth, child care and development, and breastfeeding. She has been practicing midwifery since 1992 in her own small practice in a small northwest town and is currently preparing

to become a Certified Professional Midwife and a Licensed Direct Entry Midwife. Becca recently joined NWBC to help her pursue this licensure and holds the status of a student midwife.

Lauren, a student midwife 30 years of age, has, after carefully deliberating over the myriad paths to midwifery, come to NWBC to learn directly from what she calls the “wise women.” She believes that birth is a natural event that, under most circumstances, need not be tampered with and that women should be the protagonists of their unique journeys. Lauren is dedicated, compassionate and passionate about birth. Her first exposure to midwifery was having the fortune to attend several births with the local midwife in a small Ecuadorian village. She has a degree in Biology and Spanish from the University of Missouri, Columbia, and is currently earning a Masters of International Public Health at the University of Buenos Aires in Argentina.

Melissa, a woman in her 50s, holds a Bachelors of Science degree in nursing from the University of Guayaquil, Ecuador. After graduating, Mirtha began her work as a general nurse in rural-indigenous towns throughout Ecuador. Part of her work in rural communities was to learn the culture specific to the tribe and region where she was to create prenatal and nutritional programs for new mothers and their infants based on the indigenous culture. Melissa also assisted village midwives and learned ancient and traditional birthing methods that she has incorporated into her midwifery philosophy. Later, Melissa returned to Guayaquil where she was named head nurse of Obstetrics at Guayaquil's public hospital. In 1982, Melissa left her native Ecuador for the United States to further her medical education in nutrition at Oregon State University. However, she

realized that her true calling was not nutrition. Rather, her experiences as a nurse, practicing in the traditional medical field, helped her realize that she wanted to pursue work in holistic birthing. Melissa's passionate interest in holistic birthing began as a child. As one of fourteen children, she often observed the village midwives assisting her mother through home birthing using traditional methods. Melissa's birthing philosophy is founded on empowering expectant mothers and their families through an herbal and holistic birthing experience that welcomes joyful celebration of new life. Unfortunately, Melissa left NWBC to keep up with her nursing degree and will not return.

Since I have been at NWBC, there have been several other student midwives that have left, after having been at NWBC for a good length of time. The reasons they left have been various, and include burnout, inability to support themselves and their families while working and volunteering at NWBC, or a desire to work with different midwives. Whether they would have stayed if the pay was higher or the practices at NWBC different cannot be said, but this turnover demonstrates the difficulties of a business run primarily on volunteer work and unpaid apprenticeship, as well as the viability of continuing in a profession that is little used and respected in the United States. Even midwives who are paid are paid minimally, receiving \$150 per birth and sometimes \$11 per hour for prenatal visits, which may add up to 14 hours per week. Where some students have left, others have "replaced" them or filled the positions and needs of NWBC. I am sure this will continue to be an ongoing battle at NWBC, until they are able to hire more licensed midwives and bring in more money that will provide more stable lives for those desiring to become midwives.

### **The Clients and Collaborators**

Tara came to NWBC after hearing about the center through a prenatal yoga course. She had been unhappy with the care she was receiving through an obstetrician, stating that, “she was horrible. She barely even looked at us” (June 2007). Through the prompting of her partner, she began actively seeking midwifery care. Tara claims that she immediately loved NWBC and looked no further after her first time there. The birth of her first son was in a hospital in Alaska seven years before. She did not feel it was a bad experience overall, but she also did not know that she had as many options as were presented to her at NWBC. These options included the timing of cord cutting, suturing decisions, postpartum procedures on the baby, as well as the checking of cervical dilation.

Most importantly, Tara felt she did not receive the same empowerment she so strongly felt during her natural birth at NWBC. In the hospital, she received a full epidural because, “I didn’t know that I could do it on my own. I didn’t know that it wasn’t the most excruciating pain in the world cause it’s not” (June 2007). And despite her family telling her she was crazy for not planning to give birth in the hospital and to receive drugs during labor and birth, she was sure that she would be able to do it. She says she has never felt so powerful than giving birth naturally and wants to shout to the world how wonderful it was. “I just can’t stress how great it was. That’s all I can say. It was amazing. It was awesome. And I’m sad to say this but I didn’t feel this great after my first one. I didn’t feel powerful and so amazed by the whole process” (June 2007).

Tara left NWBC after her child's birth feeling so empowered and in awe of herself. Her partner was also proud that his baby was born with a midwife. Tara reflected on her prenatal and postpartum care as though the visits were with friends at their house. She said she would miss the birth center and values the knowledge and wisdom she found at each visit. She felt there was so much information and many different perspectives to be found at the birth center, and that everyone there really cared about her and her family. She was empowered just by the little things during her prenatal care, such as being able to swab herself for GBS testing, and being allowed to choose, long before the baby was born, those tests and procedures which the baby would undergo after being born, as well as those during pregnancy. She says, "The whole experience was just so awesome. I am so thankful, so grateful for every single part of it" (June 2007).

Leona, a native of the Northwest, had both of her children at NWBC, under the care of Toribia. Her husband is a native Brazilian and a Portuguese speaker. NWBC appealed to her for several reasons; one reason was that Toribia was bilingual and would be able to communicate with her husband as well as herself. Although Toribia spoke Spanish and Leona's husband spoke Portuguese, the similarity in the languages provided a solid basis of communication between the two. To Leona, the birth center was a "good compromise." Because her husband had lived in Brazil all of his life, he was not familiar with midwifery care and had assumed that the birth of his child would take place in a hospital. Leona and her siblings had all been born at home, and her father had been the care provider, as there were no midwives where she had lived. In the birth center, she

found a place in which they could both be comfortable, as it had characteristics of both the kinds of births envisioned by each parent. The birth center was also a nice compromise for Leona because she lived in an apartment, where she didn't feel comfortable giving birth. She worried about the size of her place, the neighbors hearing her during labor, and also about feeling the need to do too much in her own home.

For Leona, both of her births were extremely difficult. During her second birth she even felt she wanted to go to the hospital. However, she knew deep down that it would not change much to go to the hospital, and she absolutely did not want a Cesarean Section. She was further convinced of this when her husband told her that she did not need to go, despite his original preference for a hospital birth. Through the prenatal visits Leona's husband had become very comfortable with Toribia and the other midwives, and he felt it best to stay with them as long as everything was safe. The hardest part of the birth was Leona's exhaustion, which had developed through broken sleep in the previous weeks. This was furthered by her anticipation when she realized she was in early labor.

With help from some rest in the comfortable bed and ease of pain with the water tub, Leona was a little more revived and ready to meet her new daughter. She was ready to push but still had a lip, or a part of the cervix that had not yet gone away, and so she held the lip herself. She felt that this really gave her strength because she was not relying on anyone else but herself and she could feel her daughter's head. It was a relief to her to know that it was almost finished, and this knowledge overpowered the pain. As she pushed her baby out, she was held in a semi-squatting position, by many family members

who had surrounded her during her labor and birth. She saw that she couldn't imagine it any other way.

During labor, Leona said that she felt comfortable in NWBC because of the time spent there during prenatal visits and the time spent getting to know the midwives as well. She could not imagine birthing around people she did not know and in an environment that was unlike NWBC. She says,

It's beautiful and there's no negative energy at all about what's going to happen. And during the birth it's kind of like hanging out. Toribia doesn't bother you, she just checks in and it's so comforting and you know she's there because you're so confident in what she does...It's like a house or a hotel cause it's not your home and your family's there and whoever's there is there and you can walk wherever you want. You can go outside. You go into this nice room with a comfy bed and lay down and I can get up and walk around and have something to eat (July 2007).

Her comfort at NWBC was also a result of the care provided prenatally, which Leona describes as "holistic...They're gonna take care of your whole body, look at the whole picture, and mentally it's much more personal" (July 2007). Her appointments sometimes lasted as long as two hours and seemed like friendly encounters where much more than her physical health was assessed. Similarly, at postpartum visits Leona felt that it always seemed like more of a time for the midwives to play with the baby and that they were "fun cause they're so happy and love what they do" (July 2007). When the baby seemed to have problems eating and was not waking up much, Toribia called in another practitioner, a cranio-sacral therapist, to conduct a home visit, who was very effective. In the end, Leona was extremely grateful for her experiences at NWBC. She stated:

I think that having a baby is one of the greatest things that you can do in that regard and I think it affects other people. We have that attitude that it's all beautiful whether it's hard or easy. I mean, some of the most difficult things are the most beautiful things. I think that birth is the ultimate example (July 2007).

Erica, a fast birther with a tendency to go into labor prematurely, sought the care of NWBC for her fourth child. Most important to Erica was giving birth outside of the hospital, something she had planned for her third birth but was not allowed once labor had begun. For her third child, Erica had planned on a birth center birth with CNMs, however, because she was a little over 4 ½ weeks early, she was required by facility guidelines to birth at the hospital. She felt that even with the CNMs, her knowledge of her own self, body and feelings was not honored throughout her pregnancy and birth. When she called to say she was in labor and was ready to come in, they told her to wait another hour. She did, and once arrived, was already dilated to 9 centimeters. Looking back at her experience with the hospital, Erica realizes that:

Part of the reason it was painful was because the whole situation wasn't conducive to being able to relax. So even if you've learned techniques, you can't use them, because you're traveling in a car, you're getting ready to get in a car...the circumstances make it more tense. I've never met the nurse, you're waiting for your midwife who's not there yet when you're already almost there. It's this big sterile room and bright and all the things that aren't relaxing (July 2007).

With her homebirth through NWBC, Erica found that her birth was quite bearable, and not particularly painful. She attributes this to a number of aspects, including the use of a hot water birthing tub and being at home, where she did not have to move from an atmosphere of comfort to discomfort, such as getting dressed, getting in the car, or going to the hospital. She also talked about reading material that was

recommended by Toribia, namely *Spiritual Midwifery* by Ina May Gaskin. In this book, there are many stories and accounts of women's and families' births, as well as techniques and metaphors women used to get through labor and birth. Through this reading, Erica had come to the realization that birth does not always need to be difficult. She found herself feeling as if she was turning inside out, more than she was feeling pain. This reminded her of a story in the book where the metaphor of a blooming flower was used to describe the feelings of labor. Instead of feeling pain, Erica felt intensity.

Another important aspect to Erica's bearable birth was the care provided by the midwives. She felt that they trusted her knowledge and that they were willing to be flexible with her as an individual. Instead of requiring that Erica deliver at home only when she was past 36 weeks, Toribia allowed for the weight of the baby to determine when it was safe. Toribia told Erica at what point the baby weighed enough to be delivered at home, which was before 36 weeks. Of course, this would not be the ideal time for her to birth, so there was much support from the midwives to provide her with techniques to get her as far as possible. The midwives at NWBC usually only do one home visit prenatally, usually around 38 weeks. However, because of Erica's circumstances, they felt it important to conduct home visits regularly starting at a much earlier time, around 34 weeks. Through this, Toribia stressed the importance of visualizing her birth at a later time, cutting back on her rigorous exercise routine, and talking to her baby to encourage it to wait until everyone else was ready.

Also important to her birth experience were the midwives that were present. It was extremely important for Erica to know exactly who would be at her birth and to

know these women well. She had never really known any of the people who attended her births. At the birth center with her previous birth, Erica had met all the CNMs; however, she did not feel that she knew them well, as their care during her prenatal visits rotated. Also, they all had times that they were on call and so there was no guarantee of who would be at her birth. At NWBC, it can be common to see different midwives throughout one's care, although there is an effort to make these more consistent as a woman is further in her pregnancy. Erica was uncomfortable with this and really wanted more consistent care, so she spoke with Toribia and requested that one of the midwives with whom she was not bonding not be at the birth, so that she was sure to feel comfortable with the women who would be there. After this discussion, her care became more consistent and those that were with her prenatally were also at her birth. She felt this made a significant difference.

Postpartum anxiety had always been a very difficult experience after Erica's previous births, and the NWBC midwives were very aware of this fact. Because of this, recommendations were made to have a doula, especially during the postpartum period. NWBC midwives provide home visit care in the early weeks, until the mother is ready to come to the birth center. However, they can extend this service as long as possible, as was the case with Erica, depending upon the woman's needs. Erica really enjoyed the postpartum visits and felt them essential to her avoidance of postpartum anxiety. Some of the things that helped the most were moxa treatments and herbal sitz baths, which alleviated a lot of Erica's stress. Erica needed more than this, and the NWBC midwives were aware of their limitations. Toribia helped Erica to find an affordable doula who

could give Erica the extra time and attention that she needed. This is also the role of NWBC midwives, who have access to outside resources and services which they draw from when there is an extra need for their clients. Erica was very grateful for the extra support that was provided to her during this time and felt she avoided her postpartum symptoms altogether through the extra support she received during her pregnancy, birth, and postpartum periods.

Tiffany and her partner came to NWBC after having had a bad experience with the birth of their first child, a son. Prior to her first birth, Tiffany had been in a car accident that injured her back. She had multiple herniated discs in her lower back that caused her to be non-ambulatory. She has been in a lot of pain and used a wheelchair ever since. When she realized she was pregnant with her first child, she went to see a midwife in California. The CNM, however, turned her away because her overseeing obstetrician said Tiffany was too high risk. This was not only because of her wheelchair usage, but also because of the large number of medications Tiffany took due to her back injury and seizures. She was referred to an obstetrician who Tiffany felt was very mean and unnecessarily performed vaginal exams at every visit.

During Tiffany's eighth month of pregnancy, her obstetrician told her that her only option for giving birth was by scheduled Cesarean Section. Tiffany did not want this and felt she at least deserved a trial of labor. At this point, Tiffany went back to the CNM she had previously seen and told her about her experiences with the obstetrician. She explained that she was no longer on any of her medications, that all of her ultrasounds showed a healthy baby and begged her to assist her birth and give her a

chance. The CNM again talked with the obstetrician, and they decided they would allow her a trial of labor, as long as Tiffany accepted that a Cesarean was a possibility. The threat of a Cesarean, Tiffany claims, was always hanging over her head and used for increased intervention during her labor and birth. Because it was a trial of labor, she was induced using Cervidil and Cytotec, but this took four days to work.

During these four days, Tiffany was in the hospital from 9 am to 10 pm, with hourly vaginal exams and routine administration of Cervidil into her cervix. Her midwife did not come until the time of birth and she was always surrounded by strangers, being “violated over and over again” (February 2008). She still has nightmares about this experience and feels that when her cervix finally did begin to dilate, she was not in the right frame of mind, as her yoni was sore and she was upset by her treatment. With each intervention, Tiffany grew more frantic, and other measures were required in order to avoid a Cesarean. At the first sight of the baby’s heart fluctuating, her waters were broken and an internal fetal monitor attached to her baby’s head. She was dilated only to 2 and so it took great effort to reach through the cervix and attach the monitor. It was painful and Tiffany could feel her baby squirming at the touch of the metal. She says she grew hysterical from this because it broke her heart to imagine that the first thing her baby felt was a piece of metal attaching to his head. Because she was hysterical, a walking epidural was required, again, to avoid a Cesarean.

Tiffany feels that the pain she experienced during her labor at the hospital was due to her environment. She stated, “The kind of pain that I experienced [at the hospital], I didn’t experience in this labor [at the birth center] at all. So it was all tied to being in

that scenario and where my mind was” (February 2008). Tiffany and her partner were finally left alone during her hospital labor and she felt it was the best moment of the whole labor because she could hold and kiss her partner in privacy. When a nurse came in, Tiffany told her she felt like bearing down, and was advised not to do so. She had been secretly pushing just to see for herself if she was able and by the time her CNM came into the room, the head of Tiffany’s baby was visible. The CNM cleared out the room and dimmed the lights, and Tiffany’s baby came into the world soon after. Tiffany brought her baby to her chest and then her partner held him while the CNM pushed on her abdomen to get out the placenta. This was another traumatizing event for Tiffany because:

I had been guarding my stomach this whole nine months like a pregnant woman would and then to have your midwife come up and just shove your stomach...I found in this birth [at the birth center] this wasn’t really necessary because it all just happened on its own without that kind of manual encouragement. [My son] did it too. He was kicking my abdomen and that brought a lot of it out. They’re designed to help us with those kinds of things. (February 2008)

Tiffany experienced difficulty breastfeeding her son while at the hospital after her first birth. She also blames this difficulty on the hospital environment. She notes that soon after her son was born he was taken away from her to do routine screening and administration of drugs. This made bonding difficult, and she was unable to attempt breastfeeding immediately after birth. When she did have a chance to breastfeed, a nurse came in to demonstrate how to nurse. Though Tiffany and her partner had taken a Lamaze prenatal class, breastfeeding was only briefly mentioned, and everyone else in the course had chosen not to breastfeed. The nurse was demonstrating how to breastfeed

by rolling Tiffany's nipple into her son's mouth. Tiffany would feel him latch and the nurse would pull her nipple back out, for the sake of demonstration. Tiffany feels this angered her son and he rejected her breasts. Lactation consultants were called in with no luck; soon she was being threatened. The nurses said that if she did not pump and get milk in him, they would feed him formula, as it was their obligation during their nursing shift to see that he had been fed.

All Tiffany wanted was to be left alone with him to figure it out, but they would not allow this. He finally was able to nurse a little bit with a nipple shield, as it makes it easier to latch, but he never really got the hang of it. Tiffany was told her nipples were small and inverted and she left feeling that there was something wrong with her and that her baby was strange. Tiffany pumped from the time he was 3 months old until he was 12 months old because she felt it was so important for him to receive her breast milk. "I do whole-heartedly believe that the reason why he never really got breastfeeding was because of the interference in the hospital. Like if we'd had that first hour alone in the dark to just figure it out, encourage him to wander to the breast and smell the areola and colostrums, that it would have been very different" (February 2008).

Her birth at NWBC, however, was quite different, and did a lot to heal the pain and trauma she experienced at her hospital birth. When her second son latched onto her breast soon after birth, Tiffany was overcome with relief. "I kind of blamed myself until [my second son] started nursing and from the moment he latched on in the water I felt this huge relief and all this guilt came off me and I was like, 'Oh, this isn't my fault. There's nothing wrong'" (February 2008). Her first birth reassured Tiffany that she was

capable of giving birth, despite everyone's, including her own, doubts. The CNM from her first birth told her she would be a great candidate for home birth and Tiffany felt that if she ever had another baby, she would not be having it in a hospital, as it was completely unnecessary.

When the time came that she was again pregnant, she was living in the northwest and found NWBC in the phone book. She called expecting to have to convince someone that she was a good candidate for homebirth, and left the conversation feeling overjoyed that she had found a place that would do homebirth, that was covered by her insurance, and that was ready to celebrate her pregnancy with her and her family. The first time Tiffany went to NWBC, she felt like it was the first time she was meeting real midwives. Although she had had a midwife with her previous birth, it was still such a medicalized setting, overseen by obstetricians, that it did not feel to her like genuine midwifery.

Tiffany became more fixated on homebirth, especially with all the trust and confidence that was conveyed by the midwives at NWBC. She drew pages of art that displayed her vision of herself giving birth and had numerous vivid dreams about giving birth in water. She had everything planned out and then, later in her pregnancy, the midwives realized that Tiffany's baby was in a breach position. Toribia said they would have to turn the baby into a better position or Tiffany would have to find a different midwife. Tiffany was given informed consents to read and sign, which explained the risks of an external cephalic version, and when the time came, her baby moved easily into a more optimal position. As easily as he would turn into a head-down position, however, he would also go back into a breach position while not at NWBC. A couple more

attempts were made, in which he willingly moved to the right position, and Tiffany even began to recognize when he was starting to move and would grab him and turn him herself. Though Toribia did not want to deliver Tiffany's baby if in breach position, she never doubted that he would be in optimal positioning for the birth.

Time passed and Tiffany was two weeks past her due date. Though Tiffany had envisioned being at home for the birth, she knew Toribia was hesitant because Tiffany lived an hour outside of town. Also, she was noticing signs from the baby that seemed to tell her he did not want to be born at home. It was hard for her to give up, but Tiffany decided to birth at the birth center instead of home. When she arrived at the birth center to induce her labor, Tiffany felt calm, ready and excited. Toribia made sure that the baby was head down and because he was, they decided to strip her membranes, one of many natural ways to induce labor. Though Tiffany had hoped to get through her labor without being touched or examined, she felt she should do something to help the baby along the way. She said that Toribia was very gentle, and that it was different with her because she was not a stranger. Tiffany felt her contractions pick up and her baby drop lower almost immediately.

Toribia left her alone with her family, instructing her to rest if possible. This time was really special for Tiffany, as she got to lie in the bed with her partner and 2-year-old son. Her partner commented on the fact that, unlike at NWBC, there had been nowhere comfortable and close for the father to sleep in a hospital, and Tiffany treasured these last moments with the baby in her belly. Her other family members fell asleep and Tiffany read an inspiring article in *Midwifery Today*. The contractions were growing more

intense, and Tiffany had a burst of energy in which she was able to lift herself into her wheelchair. Normally, especially at the end of her pregnancy, Tiffany had to get help from her partner to get in her wheelchair, but she found strength in herself to do it. She wheeled to the bathroom and got to the toilet and felt entirely empowered by being alone, moving alone, and working through the contractions alone. She checked her own dilation, finding she was around 3 centimeters and felt total confidence in her ability to give birth.

Toribia came back down to check on Tiffany, and she asked for Toribia to check her dilation. Her waters were bulging and it was becoming difficult for her to assess her own dilation. Toribia said she was around 3 or 4 and she called the other midwives to start setting up for the birth. Sometime after this, Tiffany's son awakened screaming and feeling very upset. Although this initially felt like an inconvenience to her, she later realized it was a great way to pass the time and to work through the contractions. She was able to have her son there and pass by about two hours of intense labor without realizing it. In fact, she felt it was not even pain she was experiencing, but "sensation." When Tiffany finally got into the water birth tub she says that, "as soon as my body touched that water the whole birth experience changed. That was when it became pleasurable. The moment that my body was touching that water it just became a whole new thing. For me, it did become almost like a sexual experience because...there was a whole new connection" (February 2008).

She felt that the water birth tub was a world for her and her partner and baby, and that everyone outside of it was also outside of the experience. She was not worried about

her son and was unaware of the presence of the midwives most of the time. She only remembered a few times when they had to monitor the baby and it was brief and not inconveniencing or uncomfortable. Her cervix was not checked constantly as it had been at the hospital. She was not told what to do as she had been in the hospital. When she did become aware of the presence of the other midwives, she was not at all bothered by them. In fact, she felt as though she were being looked upon in awe and reverence by the midwives. In the hospital, she felt sorry for those having to tend to her. She felt that, “that was just their job, and not something where they were really happy to be there” (February 2008).

At one point, Tiffany felt something strange in her belly and she feared that the baby had turned breach again. She called out to Toribia, explaining her suspicion. Toribia said she doubted that was a possibility and told Tiffany to check herself. Tiffany could feel the bag of waters and then his head and was entirely shocked that there was still so much trust by her midwives and that moment had not been a time for everyone to freak out and pull her out of the water. Soon after this, her son “erupted” from her and she felt that he came of his own will because she did not even push. Her new son breastfed almost immediately and she had no desire to get out of the water. The midwives left her alone with her family for about an hour and checked in periodically to assess the placenta’s progress. Eventually, Tiffany pulled her placenta out herself and was delighted to allow her baby to remain attached until she was ready for it to be cut. At the hospital they had cut it right after her son’s birth and thrown out the placenta. She was really upset by this, as she wanted to honor the cord and placenta. She was sutured

quickly upon assessment and had her baby with her the whole time this was happening. She feels this bonding time made a huge impact on her second son's breastfeeding and was absolutely vital.

Tiffany was so inspired by her natural birth that she wants to become an advocate of natural birth and midwives. She thinks it very important for every woman to feel confident in her ability to birth outside of the hospital because "that environment can cause just as many problems, if not more, than it would resolve" (February 2008). She feels the best way to spread the word is through women's birth stories and wants mainstream media to publish stories of "normal birth and pleasurable birth to portray something that is natural and is happening here all the time" (February 2008).

### CHAPTER III

## NORTHWEST BIRTHING CENTER: MAINSTREAM OR ALTERNATIVE?

I remember with each contraction I would feel this bursting of light and then it'd get sucked back in and then it'd burst back out and reach out and reach even further and then suck back in. And as each contraction got stronger and closer together I was reaching out further. And it's hard to articulate but it's like those tendrils connecting me to all those mothers in my past and all the mothers in my future, and your sister and mother and daughter tell all things in that moment and in between contractions there was like this ecstasy of, "I can breathe and now I'm bursting again and I'm reaching out and then it all gets sucked back into me and then I can breathe." And then there was this ecstasy I did not know at all in my first birth experience because it just wasn't afforded, it wasn't allowed to happen. But because I was allowed to just give birth and be treated as a sacred woman and honored in that respect, I was able to actually make that connection. And for me, that's the most spiritual experience I've ever had in my life.

-Tiffany (February 2008)

Tiffany sits in her wheelchair, nursing her newborn child. We are in an office at NWBC, where she gave birth to her second child. Her first child, recently diagnosed with autism, runs in and out of the room, being chased by his loving and patient father. She pauses to talk to her son, to her partner, and her newborn child, despite her enthusiasm for telling her birthing story to everyone willing to listen. The environment of NWBC is central to the experiences of women choosing their care at NWBC and displays the many ways in which midwifery and medical paradigms come together under one roof.

In this chapter, I will descriptively detail each room of the birth center as well as the procedures found within these rooms. The purpose of this is two-fold. One reason is to create an image of the environment for the readers, so that they may take a glimpse

into the place within which this care is provided. Another reason is to display the many ways in which medical images and symbols exist alongside midwifery images and symbols at NWBC. Through descriptions, one can also see the ways in which medical practices are appropriated by the NWBC midwives, at the same time that they are modified to fit individual needs of clients and midwives. I will then explore the meanings of these combinations of symbols and how they affect women. Bringing together the midwifery and medical paradigms under one roof changes midwifery in many ways and can be referred to as the mainstreaming of midwifery.

In an article titled, “Mainstreaming Alternative Medicine: Doing Midwifery at the Intersection,” Paaige K. Turner conducts a case study of a freestanding birthing center, run by both CNMs and DEMs, in order to show how the intersection of alternative and mainstream birth care practices creates a paradox that, “alternative birth care providers experience as simultaneously marginalizing parts of their occupational identity while allowing them to operate within the dominant sociopolitical system” (2004: 645). Bringing these paradigms together is difficult, because they have emerged from differing schools of thought that enjoy varying degrees of legitimacy and social acceptance in American society. Mainstream medicine is accepted as the social norm, as legitimate science, and therefore as defining reality and knowledge for most Americans. Midwifery, on the other hand, is the marginalized minority and the midwives’ understanding of reality and ways of practicing are not readily accepted as knowledge, because it differs from the mainstream (P. Turner 2004: 646).

When midwives work in an environment such as a birthing center, their practice must in some ways resemble that of the mainstream. This is because the midwives and their birthing centers must remain licensed as businesses and practitioners, and this imposes upon them mainstream ideals of health care. Paaige Turner describes the situation of a birthing center well:

First, to exist, the Birth Center needs to make money. Making money requires that its employees' activities be defined as work and not as a gift. The Center needs to be licensed to receive insurance payments. To be licensed, they must meet quality standards that are defined according to measurable, observable statistics consistent with the beliefs of [mainstream] medicine, not necessarily according to the goals of midwifery, so they strive to demonstrate quality according to [mainstream] definitions while "doing everything else." (2004: 657)

The "doing everything else" is what most midwives really want to do in the first place. However, to remain legitimate, they must first cover the mainstream expectations and requirements.

One commonly finds midwives defining themselves against the medical paradigms of birthing. "What is a midwife is in play with those concepts from which the concept midwife both differs and defers" (P. Turner 2004: 651). At the same time that midwives define themselves against mainstream medicine, they are also defining themselves in relationship to mainstream medicine. It is not only midwives who define their care in this way, but also many of the clients. All of the women who described the care they received at NWBC, did so in relationship to the medical paradigms at some point. Even if they were defining midwifery practices against the medical practices, to show how it was a better option for them, they were still using it as a referent. For

example, Tara discussed the low-intervention midwifery style in comparison to her experiences at the hospital. She said:

That was just amazing, you know, being able to feel him right there before he even came out and them not touching me, not just checking my cervix and stuff like that, it's the greatest thing ever because when I was in the hospital it's like every half an hour somebody or 3, 4, 5 people are all sticking their fingers in you and you're already uncomfortable cause you have to lay in bed. You can't do anything and there's bright lights and everybody's looking at you. But I think that was one of the best things about the whole experience was them letting me do what I came here to do. No poking, prodding, nothing (June 2007).

Tiffany described a similar scenario, comparing her previous experience to her birth center experience.

No one was sticking their hands in the water or telling me how to move or what to do or checking my cervix throughout. Which, when you're in the hospital they are so persistent about, each little centimeter needs to be documented and it's just irritating and violating. And [at the birth center] we were just allowed to give birth (February 2008).

In both cases, these women's understandings of why this low-intervention style of practice was beneficial to them, was based upon their previous experiences in hospital settings.

Even Leona, who had never had a birth at a hospital, only under the care of NWBC, stated, "They're really looking out for you. They're not just gonna give you a prescription. They're gonna take care of your whole body, look at the whole picture, and mentally it's so much more personal. Unfortunately it's not how healthcare is in the mainstream" (July 2007).

Though midwifery is defined as different from the mainstream, many symbols of mainstream medicine are found surrounding midwives' practices, though they are often

hidden. Paaige Turner noted that at the birthing center where she conducted her case study, birthing supplies associated with traditional midwifery were openly displayed, while those associated with the medical end were hidden until needed. This is something I found to be true at NWBC. For example, in the upstairs portion of the birthing center is a prenatal room that transforms into a birthing room when necessary. As a prenatal room, it appears to be a cozy bedroom with a big, soft bed and beautiful wooden cabinets. There is nothing medical about the room, until a prenatal visit begins. Upon beginning the prenatal visit, a midwife opens a medical chart and the bedside table is opened to bring out blood pressure cuffs and stethoscopes.

The medical chart itself is a medical symbol, which can create distance between the midwife and the client. There are many consent forms that must be filled out at proper times and much information that is logged during the prenatal visit. There are checklists of topics to discuss and blanks to fill in for every prenatal visit. Tiffany discussed one of the consent forms that she had to sign for an external version, which is a procedure done to turn a baby from the breach position. Though she understood why she had to sign and read it, it placed a lot of fear in her. She stated, "I remember being freaked out because they had me sign those forms for a manual inversion saying all these things could happen. Nothing bad ever came of it. He was always very willing to turn" (February 2008).

Conducting a prenatal visit is a fine balance between making sure the chart is thoroughly and legally complete, and ensuring the client is attended to in a personal and individualized fashion. Most of the midwives despise all of the charting that comes with

prenatal visits, viewing it as a form of insurance in the event that their charts are audited. Charting is often seen as taking away from time midwives could be spending doing massage or having time to chat intimately with the family. Both intimate care and charting occur within the birth center setting. However, in a homebirth practice, more emphasis is placed on intimate care than on charting, while in a hospital setting, more emphasis is placed upon charting than intimate care. At a birthing center, as Paaige Turner stated, midwives must meet the mainstream while “doing everything else” (2004: 657).

Midwives acknowledge the importance of using certain medical technologies to aid in birth and prenatal care, as well as the importance of informed consent. The acknowledgement of technological necessities is why the midwives of birthing centers have equipment such as blood pressure cuffs, urine strips, and oxygen, and is also why they use them routinely. However, they would rather instill in a woman feelings of trust and belief in their own capabilities and decision-making powers than a fear of the birthing process. It is highly regarded that a woman’s faith and trust in her body and the birthing process is the most important factor in a successful birth. To communicate this message, the symbols of midwifery and comfort, which the clients are familiar with from spending time at the birthing center during their prenatal care, are found alongside the “hidden” medical symbols. Many of the overtly medical aspects of care at NWBC remain hidden until their use is necessary, especially during birth.

Midwifery symbols are most prevalent at NWBC and function to communicate to women messages of comfort, the beauty and naturalness of birth, women’s ability to

birth, and also the celebratory aspects of pregnancy and birth. While medical symbols can be found among the midwifery symbols, they are hidden until their use is necessary and incorporated into the dominant midwifery space. In the upstairs prenatal room is a large sleigh bed made of wood. On it is a golden colored comforter and pillows, including a red pillow. During a birth, this bedding is replaced with white sheets. There are dark red curtains over the two windows in the room, draped with decorative lights that are turned on during a birth. There is a wooden bedside table draped with shimmering gold and green cloth. On top is a small lamp with Kleenex nearby. This table transforms during a birth, by placing a chuck, an absorbent disposable pad, over the top. On top of the chuck is placed a blood pressure cuff, stethoscope, thermometer, pitcher of water, and glass with a straw. Next to the table is a large trashcan. There is a large leather recliner in the room and a long table with the same golden and green cloth over the top. A digital scale lies on top, for weighing the baby.

Along the walls are framed pictures, one an old portrait of a mother and baby. A picture of a woman and a large wall hanging of women bundled up hangs over the table with a digital scale. There is a poem by Suzanne Arms with a picture of a baby in someone's hands and a white baby blanket hanging from one of the windows. There is a picture of a mother and baby lying in a bed together. Also on the walls are a smoke detector, a clock, and posters displaying the fire escape route from that room.

On the opposite side of the room from the bed is a large wooden cabinet with drawers. Inside the cabinet are many medical supplies needed during a birth. These are not visible until pulled out of the cabinet. There is a sharps container on the side of the

cabinet, where used needles and syringes are placed. During a birth, this cabinet is also transformed. A chuck is placed on the cabinet top and medical supplies placed on top. There are usually bowls filled with the medications that might be needed during a birth. These bowls can easily be moved from room to room as the mother moves. Also, infant resuscitation equipment is placed here as well as equipment needed to cut the cord in the event that this is needed in an emergency. All of these supplies are easily covered with a sheet or cloth in order for them to be out of sight of the laboring mother, but easily accessible to the midwife in the event that they are needed. Oxygen tanks are placed outside of the room in the hallway, covered by blankets, where they are also easily grabbed in an emergency. Women may give birth in the birthing room, but they may also give birth in the water birth room or even the bathroom. In the hallway, there is a shelf with many medical supplies on it, and a blanket covers it. The medical supplies on the cabinet in the birth room are also covered up. Toribia does not want anyone to be distracted or scared by the medical equipment that is made accessible “just in case.”

In the water birth room, there are rarely medical supplies visible until the very end when the baby’s head emerges, with the exception of a Doppler, which is a portable fetal heart monitor. Everything is kept right out in the hallway on the shelf. In fact, the water birth room is probably the most welcoming room in the entire birthing center and is full of midwifery symbols. Symbols such as soft lighting and colors, birthing images, and varying textures are important to midwifery because they illuminate the naturalness of the birthing process and the importance of trust. They aid women with relaxation and in turn, with opening to the process of their labor and birth. Through the emphasis on

midwifery symbols that surround women giving birth, medical aspects of birth are downplayed, and thus is the association of labor and birth with fear. The main attraction of the water birth room is, of course, the birthing tub. This tub is designed specifically for birthing. It is large and has nooks and crannies built in that are designed for a woman to place her feet when pushing or to lean on for support. There are metal bars on the side for grabbing, and the water pours out of the tub in a waterfall design. There is a showerhead that can be extended across the tub, and a lever controlling the temperature of the water. There are lights in the tub, which change colors according to preference. The tub is set within a light-colored tiled ledge, which is surrounded by three long, tiled steps up to the tub. A large mirror hangs directly across from the tub. On the wall above the tub is a large window that lets in light. White chiffon curtains cover this window. Above the window is a sign that says, "Imagine."

Along the walls are framed portraits of a past client giving birth in the water. These show a progression, beginning with the woman in the water, which is sprinkled with rose petals. She is in the middle of a contraction. Another shows the mother touching her baby's head just as it is beginning to emerge, and then another when the baby's head has come all the way out. In each picture the mother's face looks very tranquil and peaceful, and no one is depicted intervening in the birth. The next photograph shows the mother holding her baby, still in the water. And finally, there is a picture of the baby floating on the top of the water, being supported by three sets of hands. There is also a framed painting of a woman by Mara Friedman, above the tiled

sink, as well as a clock. There is a painting of a woman in the water, cupping her baby in her hands, and very large hands emerging from the water are cupping the mother.

In the corner is a small, wooden table with a lamp. On it is a tiny, framed photograph of a woman breastfeeding. Next to the table are a small stool and a wastebasket. This table is used for charting during a birth and also has a box of gloves placed on top. Next to the sink is a large white cabinet that opens up to reveal birthing tub supplies such as a hose, nets for scooping out bodily secretions in the water, towels, and blankets. On top are white towels as well as soaps and shampoos, in case the woman takes a bath or shower after she has recovered from her birth. Next to the sink are candles; these often line the edges of the tub during a birth. Above the sink is a sign stating an effective hand-washing technique and on the back of the door is the fire escape route, as well as emergency numbers, including those of hospitals. During the birth, the room is similar, except the towels are usually lying all over the floors, on the stairs and along the ledges of the tub.

Down the hall from the birth room and water birth room is a bathroom. Many women spend a large amount of time in this room for various reasons, some for bowel movements or urinating. Others stay in the bathroom if they are vomiting, and others spend a lot of time on the toilet to help the dilation of the cervix. Toribia believes that the toilet is one of the few places where women are used to really opening up and letting go of their bodies. This can be very useful when it comes to dilation of the cervix, as many midwives believe the mind to be powerfully in control of the body's ability to dilate and

efface. Fear can slow labor and make it more painful. Trust and relaxation can have the opposite effect.

In the bathroom, a large rug covers most of the linoleum floor. There is a sink with a large vanity on which is an old yellow lamp, a soap dispenser, lotion, a basket of shells, and a candle. Right above the sink is a hand washing technique sign and above this a mirrored, wooden medicine cabinet. Next to this is a paper towel dispenser. The room is painted with pink and white terra cotta style designs and on the far wall is a large wall hanging with flowers. Under the sink are cleaning supplies, feminine napkins, chucks, toilet paper and paper towels. Next to the toilet there is a small shelf covered by a large doily. On the shelf are more chucks and a *Mothering* magazine. Below the shelf is a scale. There is also a wastebasket. On the wall hangs a small framed picture of a dove which says, "Let's celebrate your birth...with peace on earth..."

Also upstairs is a large lounge area with a small kitchen inside. There is a big conference table against one wall and opposite to it, a big, cozy couch, a television with a VCR and DVD player and a refrigerator. There are many pillows on the floor. This room serves many different purposes and is supposed to be an area for community access. When there is not a birth taking place, the room is used as a lounge for the midwives during lunch breaks. It is also a place where clients go to watch birthing videos or to read from the extensive library located in Toribia's office. In the evenings and over the weekends, this room is used as a space for classes related to childbirth, such as birthing classes and breastfeeding classes. Also, potlucks are held in this room, which

brings in new and old clients to tell their birth stories, share their experiences, and share food.

When there is a birth taking place, the lounge is an area for both midwives and family members present at the birth. The door can be closed so that the rest of the upstairs area is strictly for the birthing mother and whoever else she might want with her. This allows for privacy during labor, and also for a spot where others can rest and relax while waiting for the birth. There are blankets in a cupboard, as well as food, and paper and crayons, in case children are present. On the wall by the conference table is a large white sheet of paper covering the whole wall. On it are images drawn by women and partners who took birthing classes at the birthing center. There are words of encouragement, pictures of babies, and images that can help each woman with her pregnancy and upcoming birth.

During prenatal care, the most time is spent in the downstairs area of NWBC. Within this downstairs space is found the juxtaposition of many medical and midwifery symbols, which face women throughout their pregnancies. In the room where I interviewed Tiffany is a desk for student midwives, a large table with a teakettle and various teas for clients of the birthing center, such as Mother's Milk, and Woman's Mother to Be. There is a marker board with lists of medical supplies needed at the birthing center. There is a closet with birth center supplies and extra clothes for midwives. Birthing, prenatal, and postpartum supply bags are kept in the closet, ready to take to home births. There is a chalkboard hanging on the wall, with the message, "TRUST LIFE, TRUST BIRTH" written in large, capital letters. On the other side of the

closet is a box with biohazard waste inside, ready to be taken by Stericycle, for safe disposal.

Outside of the office there is a little play area with toys and books for children. Posted on the wall above is a bulletin board with cards sent to Toribia, as well as to other midwives who have assisted births. Information and resources for safe installment of car seats and the dangers of drunk driving to children are also found on the bulletin board. On the other walls are various framed and un-framed pictures and illustrations of women, storks, and babies. There is a fire extinguisher hanging near the bulletin board.

Near the toy area is the main lobby, which is the first place clients, prospective clients, and family members walk into at NWBC. From the moment clients walk in, symbols of midwifery and medical paradigms are found alongside one another. What first stands out is a wooden table to the left, behind which are windows letting in sunlight. The legs of the tables are carved silhouettes of pregnant women that hold up the tabletop. On top of the table are plants, a small water fountain, candles, and two statues. One is a clay statue of a pregnant woman and the other is a wooden statue of a laboring woman who is being supported by her partner. On the table are also the business cards of many pregnancy-related practitioners. These vary from hypno-therapists for birthing to doulas to lactation consultants. To the right of the door is a stairway leading upstairs. Along the stairway, a large plant has woven itself around the banister and supporting posts. There is a bulletin board with listings for pregnancy classes, birthing classes, and prenatal or postpartum yoga classes. Next to the sliding window and the wooden table is a wooden cabinet with glass display windows. Inside the cabinet are items sold by the birth center.

These include books, teas, sitz baths, supplements, and birthing stickers. Above the cabinet is Toribia's midwifery license from the North American Registry of Midwives.

Along the walls of the lobby are large, professional photographs of pregnant women and newborn babies. There is a healthcare facility license, and a marker board called the "Little Blessings Board." On this board hang the announcements of all the births that have happened at NWBC, with descriptors of the birth, the name of the baby and parents, and the weight of the baby at birth. There are white decorative lights hanging along the walls, and a couch and a chair for waiting. Next to the chair is a wooden magazine rack holding books and magazines including *Midwifery Today*, as well as a water dispenser.

Though much of the center is cloaked in female empowering symbols of midwifery, when clients first enter the center from the outside world, they are greeted by an open, clear, sliding glass window, similar to those found in a doctor's office. On the window is a Mastercard/Visa sticker, as well as a sticker stating "Breastfeeding Welcome Here." Next to the window are various signs stating Oregon Health Plan policies as well as the Privacy Practice Notice. Behind the open window is an office with several desks, a computer, and a receptionist who greets those coming in the door—all well known symbols associated with doctor's offices, clinics, and hospitals.

It is at this window that women or couples first check in when arriving at NWBC. At this time, a receptionist informs them of whether the midwives are ready for them, or if a little more time is needed. The receptionist collects payments at this time and copies insurance cards. A receptionist was hired during the time I have been at NWBC, because

the important task of payment collection tended to be overlooked or forgotten by student midwives in charge of greeting clients. Instead, there was more focus on caring for the women than attending to the mundane, but necessary task of ensuring that payments were made. If the midwife is not yet ready to see her clients, they sit on the couch in the lobby. Most of the time, the receptionist or student midwives ask women if they would like to go to the bathroom to get their appointment started by testing their urine and weighing themselves. They are then directed to the room in which they will have their prenatal appointment, which depends upon the activity at the birth center.

On the way to the bathroom, clients pass the toy area and make their way down a hallway. In this hallway are two large bulletin boards with many pictures. The pictures are those of clients who have given birth at NWBC or at their homes, with the care of NWBC practitioners. There are birthing pictures, newborn baby pictures, family pictures, cord burning pictures, midwives with newborn babies and their mothers, families and midwives at prenatal appointments and postpartum appointments. There are close up pictures of babies emerging from their mothers' yonis or emerging from the water, as well as pictures of the opening of the birthing center. Through these visual images, a sense of community is constituted through the shared experiences of births at NWBC. There is a sign that says, "Diversity is Celebrated. All Families are Welcome Here." At the end of the hallway is another small water fountain placed on a cabinet, with candles, and above, a hanging picture that appears to be Mary and Jesus just after his birth. Symbols of many different faiths are found within the birthing center, emphasizing

spirituality and diversity, without focusing upon one particular faith. One can quite literally find Mary right next to a Buddha.

Before entering the prenatal room, most women stop off at the bathroom, not just because of the increased need to urinate that accompanies pregnancy, but because at every appointment women test their urine. In the bathroom there is much to look at on the walls. There is a painting by local artist Mara Friedman, portraying women in very beautiful and spiritual ways. There is a chart that shows weight gain during pregnancy and on which areas of the body it is gained. This is above the scale on the floor. There are several colorful charts showing what the uterus looks like as it grows throughout pregnancy. There is a framed photograph of two talking women statues, one breastfeeding and the other pregnant. A birth prayer is hung nearby, with a woman inside the shape of a yoni. On the bathroom counter is a framed collage of birthing pictures from Tiffany's birth. There is a candle, soap, lotion, and urinalysis strips alongside cups in which to urinate.

While sitting on the toilet there is more to look at on the walls. Directly in front is a close-up photograph of a baby's head emerging from a yoni. The mother's hand is placed on the head, and on top of her hand, is the grandmother's hand. A midwife's hand is touching the baby from a different angle. Right next to this is a memo from the Department of Human Resource's Newborn Screening Education Coordinator. This discusses the number of infants found, through Newborn Screening, with rare disorders such as congenital hypothyroidism, cystic fibrosis, and biotinidase deficiency. Below this is listed the facilities who submitted 100% perfect specimens, which usually includes

NWBC. This is one of my favorite juxtapositions found in NWBC. Beauty and fear are both wrapped into one sitting on the toilet, and into many prenatal visits. Next to these is a poem by Carl Sandburg titled, "Being Born is Important". Women perform their own urinalysis and relay the results to the midwife or student midwife waiting in the prenatal room right across from the bathroom.

In the bathroom are a number of symbols found on both ends of the spectrum. Those associated with the medical are a scale, urinalysis strips, charts, and diagrams on the walls. While these are associated with the medical, their use is not necessarily practiced as they would be in a mainstream medical facility. The women are taught at their first prenatal visits how to analyze their own urinalysis strips and report the results to the midwife. They also weigh themselves and report the numbers to the midwives. Midwives believe that women can be trusted to read their own information and report it honestly as it is in their best interests and those of their babies'. Though many midwives and clients believe that monitoring is not always necessary, these symbols are still there and still used on a routine basis. Appropriation of the medical practices of routine screening through urinalysis and weight charting are important in the NWBC practice, but they are modified in a way that is different from the practices found with obstetricians. Instead of the midwives monitoring the women, the women monitor themselves. Because the women do it for themselves, messages of ability and control over their own bodies are communicated, as well as trust.

Next to the bathroom is the laundry and sterilization room. While the laundry and sterilization room is used almost daily for laundry, sterilization, and blood spinning, a

practice used for certain blood draws when the lab requires the blood to be separated, it is used the most when there is a birth. On the outside of the door is a sign stating, "Staff Only." This door usually remains open, unless there is laundry running or someone in there sterilizing instruments. What can be seen from outside the door is a counter top on which is an autoclave, used to sterilize instruments used for births and speculums used for Pap Smears. These items are held in the drawers below. There is a centrifuge also on the counter, where blood samples drawn at NWBC can be spun before being sent to the lab. There is a box of Povidone Iodine scrub brushes, used to scrub instruments, boxes of gloves, and a bottle of Germ-X hand sanitizer. On the wall behind the counter is a framed picture of the "Guardian Angel of Children" and a window that is often left open to wash out the smells of sanitizing and bleach products. Next to the counter sits a number of oxygen tanks, marked to show how full they are. These are used at births, either to help the birthing mother or the newborn baby. There are laundry baskets on the floor for soiled laundry and others for clean laundry. There is an adult commode with a bucket, which is often used in helping to deliver the placenta.

Inside the sterilization room is a closet that holds a large shelf and a small refrigerator. On the shelves are various folded linens, such as sheets, blankets, towels, baby blankets, and baby hats. The refrigerator contains medications that are used mostly during birth, such as in the cases of hemorrhaging. These medications include pitocin and methergine. Also in the refrigerator is a sugar filled drink called glucola, which is used in order to test women for gestational diabetes. On top of the refrigerator in a small drawer are other medications that should not be refrigerated. These include injectable

and oral Vitamin K administered to the baby soon after birth to help with blood coagulation. Erythromycin is stored here, which is an ointment placed on babies' eyes in the event that a mother has gonorrhea or Chlamydia. Cytotec is stored here, which is a pill used for very severe hemorrhaging. Injectable lidocaine and topical anesthetics used in the event of suturing after birth are also kept here. These drugs are tracked on sheets taped to the door of the closet, so that expired medications are thrown out and others used on clients are marked off.

Across from the Laundry room is the downstairs prenatal room in which there is a large, comfortable bed with a beautiful quilt and four pillows. Most women sit on the bed during the visit, but some choose the big leather chair, depending on what makes them feel most comfortable. Along the walls are pictures, one of Toribia palpating a woman's pregnant belly, another of a painting by Alex Gray that depicts a pregnant couple with a view of the inside of their bodies and the energies coming from their beings. There is a large Mara Friedman painting, framed, alongside a potluck announcement. There are also a few pictures of clients' newborn babies and a small painting of a laboring woman with assistants around her, as well as a clock. On the bay window sits a scale for weighing babies and fliers advertising various birthing classes. There are two wooden cabinets, both with pretty lamps on them. One is a filing cabinet. Inside the top drawer are a blood pressure cuff and stethoscope, as well as a fetoscope and horn. In the bottom drawer are extra consent forms, information worksheets, and fertility calendars.

In the prenatal room there are two closets, covered by long curtains that are pulled aside when supplies are needed. One of the closets acts as a linen closet with sheets, blankets, shower curtains, baby changing pads, baby hats, pillows, and a birthing ball. In the main closet is a clutter of medical supplies, pamphlets, magazines, and educational materials. Medical supplies include latex gloves, a Doppler, aloe vera gel, flashlights, lancets for pricking babies' heels, alcohol wipes, spoons, and Vitamin K. There are model pelvises with baby dolls, cloth placentas and cloth umbilical cords, which are used to demonstrate the passage of the baby through the pelvis during birth. There are magazines such as *Midwifery Today* and *Mothering* magazine. There are pamphlets about Newborn Screening, photography, and birth control, as well as newborn hearing screening and class information.

It is in this room that clients of NWBC spend most of their time. After making a payment at the front desk and testing their urine in the bathroom, clients settle into the prenatal room. While NWBC attempts to have the client see the same person at each appointment, this does not always happen. As an establishment running mostly on volunteer apprentice work, it can be hard to correlate everyone's schedules. Also, with the high volume of births happening at NWBC, there are often times when other midwives or student midwives fill in for appointments. Toward the end of a woman's pregnancy, though, she usually sees the same people consistently, and these are the people who are supposed to be at the birth.

The care provided at NWBC displays, beyond juxtaposed medical and midwife symbols and images, another way in which these paradigms come together under the roof

of a birthing center, and ways in which the medical is modified. Because there is a high volume of women coming through NWBC, and because Toribia must see every woman at every appointment, she is often spread very thin. Toribia does her best to make it into appointments by the time the mom's belly is palpated and heart tones are found. However, she is not always at the entire appointment every time a woman and family visits.

### **A Typical Prenatal Visit**

A student midwife usually starts an appointment with the more medical aspects of care. She asks the woman how her urinalysis looked and what her weight was. She records this information in the client's chart and then the student midwife takes the client's blood pressure and pulse. She does this not only to assess a woman's baseline, to help monitor during labor and birth, but it is also done to check the woman's health during her pregnancy, to prevent or recognize larger problems such as pre-eclampsia and pregnancy induced hyper-tension. The student records the date, as well as the gestation of the baby, in the chart. To determine the gestation, the student midwife uses a wheel that displays dates based upon either the first day of the last period (FDLP) or the due date. Pharmaceutical companies or labs donate these wheels.

Once a client's vitals have been taken and recorded, the student midwife moves on to discuss other important issues listed in the chart, including discomforts experienced by the woman, such as swelling and vomiting. Emotional issues are also assessed. Sometimes it is clear when a woman has emotional problems or is feeling happy and content, as she will have willingly discussed this already. Sometimes, however,

midwives must directly ask clients how they are feeling. There is always a list of items, specific to her situation, to discuss with each woman, and there is also a master checklist of items to discuss with all women, based upon how far along they are in their pregnancy.

Often, if the student has a good relationship with the woman and has seen her consistently, she will get into more detailed and meaningful discussions with the woman concerning her feelings and emotions surrounding her family, her baby, her birth, and health. However, the person providing care at the beginning of the appointment is not always the same, especially in the early phases of a woman's pregnancy. Erica, one of the women I interviewed, felt uncomfortable with this type of care, as she was not confident in the student's ability to assess the health of her baby and herself.

I was always asking Toribia to be more involved cause she would step out and let the student do the appointment, and I finally had to ask for the student not to be involved. She made me nervous because she didn't seem to have confidence in her own, what she was doing. It was better after that student wasn't involved in it. But in the beginning it didn't matter as much and as we got closer to birth it started to matter more and more (July 2007).

For Erica, consistent and experienced care was extremely important, and it was provided upon her request.

This type of care is similar to that found in medical establishments: a nurse usually does vital signs and takes care of filling in charts and other such tasks, and then the doctor comes in, who may or may not have the assistance of the nurse during the appointment. Often the attending nurse changes from appointment to appointment. However, there is much about this care at NWBC that is still very focused on the midwifery end of care. Assessment of the mother goes further than the simple checking

of vital signs. Emotions are discussed and advice given from different perspectives. The student who begins the appointment remains even after Toribia arrives, and many times both the student and Toribia are in the appointment for the entire time. Nutritional counseling is received no matter the care provider and everything is passed by Toribia at one point or another. While charts may often seem impersonal, they are also an effective way to catch up with what is happening in the woman's life. A detailed summary of each prenatal visit is recorded soon after the appointments. This includes not simply the numbers obtained in prenatal visits such as heart rates, weight, blood pressure, and baby's position. It also includes emotional issues, family life, nutritional advice, and more. Within the charts, a holistic picture of the woman's life is painted, in order to provide intimate, consistent care.

At each appointment, lab work is discussed and, if needed and consented to, conducted. Lab work varies depending upon how far along a woman is in her pregnancy. Toward the beginning of pregnancy, prenatal panels are done, where vials of blood are drawn as well as urine collected to send off to the lab to be assessed for blood type, iron count, and other important information used by the midwife to assess the health of the woman and fetus. Pap smears are done, as well as tests for sexually transmitted infections that can be harmful to the baby, but manageable if known about in advance. Later in the pregnancy, a woman might decide to test for gestational diabetes, get a quad marker screening, and test for Group Beta Streptococcus, a bacterium that lives in many women's bodies and can be harmful to the baby.

For each of these different labs, there is much discussion of benefits, risks and alternatives, and also consent forms associated with the different options. There are many consent forms that must be signed by the client, and these are given to her to read in the birth center or to take home and read and discuss at the next appointment, depending upon the woman's decision. Some women spend a lot of time reading over every consent form, and others sign them without much reading at all. Midwives provide a short synopsis of every consent to the client before they are presented to her.

Lab tests requiring the drawing of blood are done in the lab room, which is located in the hallway between the lobby and the prenatal room and bathroom and is probably the room that looks the most like a medical facility at NWBC. While the medical feel of the room and the procedure conducted within the room create feelings of distance and cold, midwives find the practices within the room to be necessary. However, because the room and symbolic activities are recontextualized within a woman-centered space, the symbols and feelings of distance are mitigated. What first stands out is the classic vaginal exam table with stirrups at the bottom. The base is made of wood, with wooden drawers on the side, and paper covers over the top of the area where one lies down. Next to it are shelves that are full of medical supplies, mostly those associated with drawing blood and collecting specimens for lab tests. On the opposite end of the room are more shelves that hold supplies for births, usually extra supplies used to stock the birth bags. There is a white cabinet that contains more medical supplies. On top are boxes of gloves used when drawing blood or conducting vaginal exams.

The room is decorated with large, purple fabric that is draped below the large, fluorescent lights. This is done in order to make it a more comfortable environment, especially for women who are getting Pap smears. There is a large window with blinds that are usually open to let in natural light; more purple fabric is draped along the edges of the window. There are several chairs in the room, which are moved around depending upon the situation. Often, a prenatal appointment will begin in this room when the other room is being used for a longer appointment or other scheduling conflict. Eventually, though, an appointment started in this room will move to a more comfortable room for palpation and discussion of personal and emotional topics.

At any point during the appointment, Toribia might join, but she is usually there at least before the woman lies down on the bed to have her belly palpated. Palpation is a technique used by most midwives in order to determine the position of the baby, engagement of the head in the pelvis, and the height of the fundus, which is the top of the uterus. It is important to know where the baby is lying and also to measure the fundus to make sure that it matches with the estimated gestation of the baby. Through palpation the midwife determines the amount of amniotic fluid as well as the weight of the baby. While lying down, the midwives also look for the heart tones of the baby, usually using the Doppler. Some women choose only to use a fetoscope, as they feel the effects of the Doppler are unknown and may be unsafe. The fetoscope is more difficult to use, but can show a little more about the position of the baby. The range it covers is more limited than the Doppler, and so when a strong heartbeat is found, it can show more specifically where the baby is lying inside the womb.

If Toribia determines that the baby is posterior, a position where the back is facing toward the mother's spine, she may ask her to do certain exercises that help bring the baby into a more optimal position. If the fetus is in a breach position, Toribia may be able to perform an external cephalic version, where the baby is turned, from the outside, so that it is head down, rather than bottom or feet down. Overall, appointments last about an hour. Sometimes, appointments can last up to two hours, depending upon the needs of the woman. Often, if a woman is single, a teen, has a history of sexual abuse or traumatizing births, or has extra emotional needs, every appointment will last over an hour, sometimes close to two hours. While this can affect the rhythm of the day and other appointments, these are considered important issues that need to be addressed. Also, because there are so many volunteer and staff members, it is possible to be flexible, so that certain people can start appointments while others finish them.

After a woman's appointment is over, she checks out at the sliding glass window, where her next appointment is scheduled. The receptionist and midwives remind her of things to bring to the next appointment, or activities to do in between appointments. If she did not pay at the beginning, or show her insurance card, it is often collected at this time.

### **Water Birth**

I remember Toribia helping me get undressed and getting into the tub and as soon as my body touched the water the whole birth experience changed. That was when it became pleasurable. The moment my body was touching that water it just became a whole new thing. I kind of wish I had been in there the whole time. It makes birth into, for me, it did become almost like a sexual experience. [My partner] talked about how once we got into the water there was a whole new connection, like the water was filling in all the voids in our body and bringing us closer together. He

swears that as contractions happened the water rippled. He was feeling the energy surge out. -Tiffany (February 2008)

A majority of women choose NWBC because they want a water birth. Water birth is a practice that has been around for thousands of years. While the first recorded water birth occurred in France in 1803 by accident, many believe water birth to have been used long before the advent of physicians or hospitals (Harper 1994: 136). After 1803, water birth was being experimented with in Russia and France. Michel Odent, a French physician, began offering water birth as a regular option for women, whom he encouraged to follow their own instincts during labor and birth. Through his work, he demonstrated that water birth was a safe and beneficial option (Harper 1994: 138-139).

With the renaissance of midwifery in the United States during the 1960s and 1970s, came experimentation with new methods in birthing. During the 1980s, water birth became more popular in the United States and its use could be found in many different settings, including hospitals, birthing centers, and homes. The greater the occurrence of successful water births, the more researchers supported the safety and benefits of water birth. Central to this research was Michel Odent's 1984 book, *Birth Reborn*. The Family Birthing Center of Upland, California, which was opened in 1985, and run by Dr. Michael Rosenthal, also popularized this method (Harper 1994: 141-142). The Global Maternal/Child Health Association estimates that between 1970 and 1993, around 10,000 water births occurred worldwide (Harper 1994: 146).

One of the main benefits of water birth is the relaxing effect it has on women during labor. This relaxation helps reduce pain. When in water a woman's body is free

from gravity and so is less likely to secrete stress hormones. A woman's body, being free from these stress hormones, produces endorphins that inhibit pain (Harper 1994: 134).

Not only are there physiological benefits from the use of water in labor, but psychological benefits as well. Midwives have long recognized the connection between body and mind. If a woman is relaxed from the warm water, her anxiety is decreased, and she is often better able to concentrate within herself or to let her body take over the work of labor.

Tara stated, "The heat of the water was the best thing, the best thing. Pouring it on my back kind of distracted me from the actual pain. It wasn't as bad. It was bearable. But the hot water was amazing. I didn't think it would work that well, but it did" (July 2007). Similarly, when describing the many "pieces of the puzzle" that came together to make Erica's labor and birth painless, she stated that one piece was the hot water in the tub. "I remember saying at some point that I wanted the water hotter and that definitely seemed to help" (July 2007). Leona also acknowledged how helpful the hot water was during her difficult labor. Not only is water helpful for laboring and birthing women through pain relief and relaxation, but studies show it also aids in reducing the incidence and severity of perineal tearing through creating perineal support and elasticity (Harper 1994: 135). Of the four water births I observed for this study, only one woman required perineal suturing.

The baby also benefits from water birth in a number of ways. The emotions felt by a mother create hormones that are absorbed by the baby. If a laboring woman is relaxed and tranquil, rather than screaming and tense, these feelings transfer to the baby as

well. Also, it is thought that water birth creates a very peaceful and gentle entrance into the world, as the babies have been living in water their entire lives and then emerge into water, where they are able to stretch out. Their bodies realign, the intensity of lights, voices, and skin is mitigated, and their bodies are able to organize in a non-stressful environment (Harper 1994: 135).

### **Women's Decisions**

Essential to the analysis of the birth center's combined medical and midwife symbols is the reaction of women to the care provided them and the environment within which they spend so much time. All the women I interviewed talked about how much they loved the environment of the birthing center and how it made them feel comfortable and cozy. According to Tiffany:

The first time I came here no one was wearing shoes. It was summer and hot but I just loved the fact that there were all these midwives running around without any shoes on and it just seemed so opposite of what the hospital environment is, which is I'm sure what you guys are going for...a home atmosphere, the beds and everything. It was totally comforting and where I wanted to be (February 2008).

Tara had a similar experience at her first visit at NWBC. "I came here and I just loved it...the atmosphere, the vibe of the place, it smelled nice. It was warm and cozy. The midwife was awesome, meeting with her and she just showed me around. I didn't even go look anywhere else after that. I was like, 'This is where I want to be'" (June 2007).

Not only does the NWBC environment provide feelings of comfort to the clients, but also the kind of care they are receiving during their prenatal, birth, and postpartum experiences is comforting. Leona talked a lot about the appointments with the midwives, stating:

I felt really comfortable there and I loved going to my prenatal. My appointments could be up to 2 hours and I imagine that's not how it is when I go to the doctor's office. You wait for 2 hours. It's so comfortable. You do the testing and you check the baby and stuff but they also talk to you about how you're feeling mentally and physically and just whatever comes up you talk about and you talk about the birth. And we'd end up talking about other stuff too cause they're so friendly. So that's good and then of course you feel totally comfortable with them when the birth comes (July 2007).

Erica shared similar sentiments that the appointments, even when she was worried about her baby, were really quite comforting. "Each of the visits was more relaxed, there was more time spent. It was less serious and more, there was more joking and it was fun. It was always the relaxing and fun and the jokes and silliness that made it pleasant, you know, not so serious" (July 2007). In fact, most women interviewed expressed a sense of loss at their final postpartum visit. Tara, for example, said "I'll miss my prenatal visits. You guys just know so much. I like coming here...it's kinda like coming over to your friend's house and hanging out with people that really care about you" (June 2007).

Another common theme that arose when women discussed why they had chosen the birthing center was that of "compromise". Leona stated that:

The birth center was a good compromise for me and my husband. He wanted to go to the hospital, he didn't know anything else...Me, my brother, and sister were all born at home in San Juan Islands in Washington. And there wasn't really a midwife and so my dad did everything. He's been telling our birth story every birthday for many years. I didn't even think twice about going to a hospital ever. But when I thought about having kids now, I wasn't really in a place to have a home birth because of my apartment. I didn't feel that comfortable with all the neighbors (July 2007).

Leona points out two important aspects to this compromise. Not only is it important for the laboring and birthing woman to be comfortable in her environment, but it is also

important for her partner to feel comfortable as well. For Leona's husband, a birthing center seemed closer to a hospital than a home birth setting, and he was comfortable with this compromise.

Leona also points out that though a woman may want a home birth, their home environment may not be the most comfortable or suitable situation and the birthing center provides a space where natural birth is promoted. Erica suggested something similar when she described one of her previous pregnancies. She had been in a physically abusive relationship, and as a result of the abuse, she went into labor early. While she had a natural birth with all of her children, she would not have felt safe giving birth at home in this situation because her home environment was not safe. Erica stated, "And I think I felt safe in the hospital where I didn't feel safe at home at that point. So it was good to deliver in the hospital and I don't think I would have considered anything else. In the hospital I was safe. He wasn't going to hurt me there" (July 2007). While she discussed her feelings of safety at the hospital versus home, a birthing center could also be seen as a safe environment for a woman, if in an abusive relationship. During my fieldwork at the birthing center, I saw many women who chose the birthing center birth over a home birth because of similar situations. Some did not feel safe at home, others did not have a home, and still others did not feel comfortable in their home because of size or neighbor proximity. For these women, the availability of a freestanding birthing center and midwifery care was central to their positive natural birthing experiences.

Tara discussed the ways in which the birthing center was a compromise for her and her partner. Her first child was born at a hospital. When she became pregnant with

her second child, she had considered nothing other than a hospital birth. However, her partner had a different perspective.

His mom, they have 3 boys. Their first son was born in a hospital and they just had a horrible experience. It was just awful I guess. And then the next two boys were both born at home on a mattress on the floor and she just said it was awesome. She kept ranting and raving about it and Travis was like, "I would really like you to go to a midwife." I was like, "OK, I'll check it out." At first I was like, "There's no way. Absolutely no way" (June 2007).

However, after coming to NWBC, meeting the midwives, and comparing their practices and attitudes to the obstetrician she had seen during the same pregnancy, she was excited to have midwives and to birth at the birthing center.

Tiffany had planned a home birth with NWBC, but ended up birthing at the birthing center because of the circumstances of her breach baby who kept turning, and the distance that her home was from the hospital. At first, she was very upset with the fact that she could not have the home birth she had been envisioning and dreaming about. However, looking back at the compromise she made, she is grateful and feels that that is where her son wanted to be born.

I just didn't want to leave my house at all and I thought the anxiety of traveling in labor was going to be really bad. I don't know I just had all these fears about giving birth [at the birthing center]. I didn't want to be carried upstairs and I didn't want my son to have to leave his home environment and I just wanted to be at home and I read all these wonderful birth stories about home birth and how amazing it was...Everything that [the baby] was doing was just telling me he didn't want to be born at home. And it was really frustrating, hard for me to let go of cause I had made this sacred space and I had my little altar and I had the tub at my house and had the birth stool and just all the equipment ready to go. But as soon as we got [to NWBC] I felt this calming come over me. I had been totally anxious at home and it was just right. I just felt this rush of endorphins and this energy like the baby telling me, "This is where we're meant to be. I need this and I'm turning not because I'm trying to scare

you but because I need to tell you that you need to give birth in town.” And it turns out that all of my fears [about giving birth at the birth center] were unfounded. I did not drive into town in labor. And then I was worried about the baby and the drive back. I didn’t want to put my newborn in a car seat for weeks but he slept the whole way. He just wanted to be born here because this is a sacred space (February 2008).

The mainstreaming of midwifery is a give and take, a compromise between what is expected from the mainstream standard of healthcare and what is most important under the midwifery model of care. Finding that “perfect” balance between the two is an ongoing battle for the midwives at NWBC. If asked which they value the most, they will state without hesitation that midwifery practices are the most important aspect of their care. They value the time they spend with their clients, so that they can provide important education on nutrition and herbal supplementation. The midwives find it necessary to discuss with women their emotional well being, life at home, fears about pregnancy, birth, and parenting, as well as their excitements surrounding these same issues. NWBC midwives think it absolutely necessary to provide women with all of the options available to them, and through shared communication and knowledge, have her make the right decisions for herself and her baby. Palpating the woman’s belly is often a favorite routine for the midwives because women can be taught how to understand the position their baby is in. The midwives will ask them where they feel kicking and in what position they believe their baby to be. Often, women know exactly where the baby is, and the midwives need only to briefly feel the baby to confirm.

However, in order for the birth center to remain an available option, some of these aspects of care may be changed. A common compromise in the care at NWBC is to

breeze over emotional issues of women, especially if she appears to be happy and content. This is often done because of time constraints, or because inconsistent care does not allow the space for comfortable delving into personal aspects of clients' lives. Also, in an effort to provide informed consent, but also to meet state standards, women are often bombarded with consent forms that midwives find to be daunting and sometimes unnecessarily fear-based. The midwives sometimes find it difficult not to express their personal beliefs surrounding the consent forms and the many medical procedures that are options for pregnant and birthing women.

During birth, NWBC midwives often feel that monitoring of the baby is a nuisance. This is not because they believe it to be unnecessary, but because the time frames required under a birth center setting seem more intrusive than midwives may want them to be. The midwives prefer to follow the rhythms of the mother, monitoring when she is in a good place to do so. For example, monitoring may need to occur between every contraction while a woman is pushing. However, if the contractions are extremely close together, with very little breaks, monitoring can be seen as a distraction to the mother, who is trying to focus on working with her body and not moving to a convenient position so the midwife can monitor effectively.

A common occurrence during the pushing phase is for the heart tones of a child to significantly lower. While this is something that a midwife takes note of in her head and on the chart, she recognizes it to be normal if in short durations. When a woman hears these heart tones or when her partner hears them, though, it can seem very scary, and it is preferable for fear not to be a part of this process. It is aspects such as these that become

compromises for the midwives working at NWBC. In a different setting they might not have to be so strict about focusing on time and charting every detail that occurs in birth. They feel that the charting takes focus away from birthing women and does not allow them to trust their own knowledge and the birth process as much.

On the other end of this, however, is that NWBC was founded and is still running because it allows more women the opportunity to be exposed to the kind of care provided by midwives and to feel they are in a safe environment. Therefore, the compromises that may seem a hindrance become quite important. It is clear from the women I have interviewed that what they are looking for is not just midwifery care, and not just something differing from the hospital. They are looking for something that provides aspects of both, based on their individual needs. NWBC provides an important space where these needs can be met because their practices can vary greatly from individual to individual through negotiation of midwifery and medical paradigms. Mainstream medical care is what frames Americans' understanding of health and what frames the institutional organization of women's care and insurance. Therefore, picking and choosing aspects resembling this kind of care, even if only in appearance, is what helps keep NWBC successful. When a person receives care from a midwife, however, she may finally see that healthcare can be different than what she has before experienced, and this is also important to the success of NWBC.

Looking at the juxtaposition of the medical and midwife symbols found within the birthing center point out to us the things that may be given up in the process of mainstreaming this model of care. Maybe the midwives trust birth less because they

must have medical supplies. Maybe women do not receive all their care in their homes. Maybe midwives spend less time really diving into emotional issues because they have to be sure to get all the “important” information in the charts in the allotted amount of time, to protect the birthing center and midwives. Maybe the higher volume of clients creates barriers to the one-on-one care essential to midwifery. Maybe because of these compromises, the medical paradigm of healthcare, pregnancy and postpartum care continues to remain the norm, and to be the single-most legitimizing force of midwives within birthing centers and home birth practices.

However, a look into how the women respond to their experiences at NWBC supports the opposite. Possibly, because these medical symbols *are* so normalized in our minds, we easily overlook them, or we find comfort in them subconsciously, while allowing the symbols of midwifery to dominate. It is important to mention that none of the women I interviewed discussed in detail the medical aspects of NWBC, possibly because they were hidden well, but more likely because people in our society are so used to these symbols that they go unnoticed. What stands out to clients of NWBC is not the MasterCard/Visa sign, the licenses, blood pressure cuffs and the charts. What are most notable are the multitudes of photographs of naked women giving birth naturally, of their huge bellies and their new babies. Also moving are the close-ups of yonis, and the fact that when you go to NWBC, you feel loved, you know you will not have to wait long to be seen, and you know you will spend much time laughing, talking, and preparing for what every midwife at NWBC believes to be one of the most life-changing, spiritual, and

amazing moments of life. What resonates is the trust placed in pregnant women to know what is best for their babies and selves and families.

One of the couples who came to the birthing center in the past year is illustrative: the mother was a teacher and the father a doctor. Everyone was a bit shocked that they had chosen to receive care at a birthing center, because of the father's medical background. However, he had seen some pretty grueling occurrences during his residency and stated that he knew if they needed to go to the hospital they could always go there. If they were already at the hospital, however, there was no going back. This was interesting, because while the hospital may present itself as having more options than midwifery, what the doctor said was true. Options are always there, waiting at the hospital if needed. But it is difficult to have a natural birth in a hospital.

Perhaps if NWBC did not exist, those people that were not comfortable in their own home, or those who had bad hospital experiences, would have nowhere to turn. Perhaps there are benefits in today's society in keeping those symbols of the medical around but hidden. They seemed to be unnoticed by the women I interviewed, who spoke almost exclusively of the experiences they had with a midwife at the birthing center, and of the empowerment they felt through their births, empowerment they had found in few other places in their lives.

One day, the same doctor I previously mentioned was standing in the lobby and I asked him, "Are you guys having a home or birth center birth?" He looked at me like I was a little crazy and stated very assuredly that they would *not* be having a home birth, but a birth center birth. I know that at NWBC there is little difference between a home

and birth center birth, except of course the place where it takes place. Other than that, we have the same supplies, the same drugs, the option of water birth, the same midwives, and the same practices. However, this made it clear to me that there are people within our society who find comfort in the modern symbols of medicine, even when they are hidden.

## CHAPTER IV

### BIRTH CENTER BIRTH AS A RITE OF PASSAGE

Once I really embraced that this could be my experience, that I could really benefit, that it wasn't just about bringing new life into the world but that it could really transform us all as a family, I just started pushing these ideas out into the universe. And [my partner] has this whole newfound respect and confidence in me because he watched me give birth on my own. I mean the first time around it was like, 'Wow, you can do that. You're a woman. That's amazing.' And this time it was like, "Wow, you're a goddess! No medication, no intervention!"  
 -Tiffany (February 2008)

Many theorists, including Van Gennep, Barbara Katz Rothman, and Davis-Floyd, have posited the idea that birth, including American medical birth, consists of a series of rituals that together can be considered a rite of passage, that serves the purpose of bringing a person "from one situation to another or from one cosmic or social world to another" (Van Gennep 1961: 10). Pregnancy and childbirth is clearly a life-changing event that has the potential to transform, and is thus a rite of passage. The quotation from Tiffany displays a number of ways in which birth *can* transform people. It seems clear that birth brings one from the point of not being a parent to being a parent, or in the case of a second child, from a parent of one to a parent of two. But what other purposes might the rites associated with birth serve in American society?

To fully understand birth as a rite of passage, one must first understand the ways in which rituals function, and further, how they have been applied to various forms of birth. In Davis-Floyd's *Birth as an American Rite of Passage* (2003), she discusses the ways in which the most popular form of birth in America, what she refers to as

technocratic birth, is as much a rite of passage as births found in indigenous cultures or in non-Western countries. She defines ritual as a “patterned, repetitive, and symbolic enactment of a cultural belief or value,” with the primary purpose of transformation (2004: 8). Because the standard procedures of care in hospitals hold these characteristics and can be divided into stages of separation, liminality, and reintegration, she argues the technocratic model of birth to be an American rite of passage.

By calling birth technocratic, Davis-Floyd is outlining a model of birth that has stemmed from the scientific, mechanistic model of practice that supervalues technology, the hierarchical social context within which technology has been created, as well as privileges the people who control the technology. Under this paradigm, Davis-Floyd claims that pregnant and birthing women get caught up in a system that devalues their individual selves and bodies for the benefit of institutions of science, technology, and patriarchy (2003: 47). It is important to note that while Davis-Floyd strongly believes these effects of technocratic birth on women to be true, she also acknowledges that her analysis falls on the extreme end of the spectrum, and that it is the knowledge of how rituals and rites of passage work that allow women more authority over their own birth experiences.

Cheyney, following Davis-Floyd’s analysis of birth as a rite of passage, discussed in her Ph.D. dissertation, *In Transition: A Biocultural Analysis of Homebirth Midwifery in the United States* (2005), the ways in which American homebirths also comprise a series of rituals constituting a rite of passage. Her analysis, however, finds very different messages communicated and enacted in homebirths than those Davis-Floyd found in

hospital settings. In fact, Cheyney theorized that rituals associated with homebirth actively challenge the values of technocratic birth in order to communicate the sufficiency of the female body, the spirituality and transformational potential of birth, and thus the power and empowerment a woman can and should have in her everyday life (2005: 184, 189).

In this chapter, I follow the analysis of birth as a rite of passage, applying it to a setting other than that of the hospital or home birth. I will use my observations at NWBC, as well as the experiences of the women I have interviewed, in order to explore what messages are communicated in the rituals and rites of passage found within NWBC. Undoubtedly, messages communicated will draw from both medical and midwife models, creating a different experience than has so far been analyzed under the birth as a rite of passage paradigm in either hospital or home.

### **Rites of Passage: Pregnancy and Childbirth**

A rite of passage is a series of rituals that is meant to bring a person or group of persons from one state to another, with the intention of transforming those persons. In this transformation, the values, beliefs, and social order of the ritual environment are taught and reinforced in individuals, just as is their role within their new environment. Van Gennep divided a rite of passage into three phases; the first phase is separation, the second phase is transition or liminality, and the third is incorporation or reintegration (1961: 11). In the first phase, a person is detached from a previous social status or from a set of cultural conditions. During the liminal phase, a person is in an ambiguous situation where they are neither where they have been nor are they where they are going. This is

the process of their transformation. During the phase of reincorporation, a person is again in a stable condition as the passage has completed and the person's status has been successfully re-defined (V. Turner 1969: 94-95). "These three subcategories are not developed to the same extent by all peoples or in every ceremonial pattern" (Van Gennep 1961: 11). However, Davis-Floyd notes that the most significant of the three subcategories, no matter its length, is that of the liminal (2003: 18), especially in terms of pregnancy and birth. Davis-Floyd theorizes liminality to be the most important feature of a rite of passage because it is the stage where transformation occurs, and transformation is one of the main purposes of a rite of passage.

In the liminal stage, a person is "neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial" (V. Turner 1969: 95). Turner outlines characteristics enmeshed within the liminal phase of rites of passages. These characteristics can include sexlessness, anonymity, submissiveness, silence, and also the state of being a "*tabula rasa*, a blank slate, on which is inscribed the knowledge and wisdom of the group, in those respects that pertain to the new status" (V. Turner 1969: 103). This state of being a blank slate, according to Davis-Floyd, is the most important trait of a person in a state of liminality, as it is the point at which the values and hierarchies of the society are most easily inscribed onto a person. However, a liminal being does not always come to this situation with a willing "openness" to communicated messages. Often, the initiate must first be broken down.

Because initiates are in an in-between state, it is much easier to break down their systems of beliefs, as they are not grounded in a particular environment or belief system;

they are in a state of chaos and unfamiliarity, where direction and guidance are sought in order to find their way. As Davis-Floyd puts it, there is a “gradual psychological ‘opening’ of the initiates to profound interior change...The breakdown of their belief systems leaves initiates profoundly open to new learning and to the construction of new categories” (2003: 19). In childbirth, this “opening” is quite literal and so remains true for women experiencing pregnancy and childbirth.

The phases surrounding pregnancy and childbirth have commonly been described as comprising a series of rituals that constitute a whole rite of passage and that has a very long phase of transition or liminality (van Gennep 1961: 41, Davis-Floyd 2003: 20). Pregnancy itself is a process of separation, in that a pregnant woman gradually separates herself from her past identity. At the same time, pregnancy is a transition because of the gradual acceptance of one’s upcoming identity as a parent. The point at which one moves from the first to second phase highly depends upon the individual and the society within which they are pregnant. According to Davis-Floyd, the point at which a woman accepts her pregnancy determines the beginning of the liminal stage for this woman. This phase reaches all the way through childbirth and to about three to six weeks after the birth of her child (2003: 23). During different points of this liminal stage, a woman may experience varying degrees of liminality and the “openness” to which Davis-Floyd refers. For example, while giving birth in the stage of “transition,” the intense stage in which the cervix finishes its dilation, one would be at a heightened moment of liminality, as compared to early in pregnancy when a woman begins to pay closer attention to what she should and should not eat.

However, this does not diminish the importance of those less extreme moments of liminality during a woman's pregnancy. Indeed, there are many times and experiences in a woman's pregnancy that will shape her perception of herself, and as a mother or mother-to-be. Davis Floyd discusses, in relationship to women choosing care under the medical model, "domains" of transformation. Each domain correlates to the different social experiences and environments found within a woman's life and pregnancy before birth. These include transformation in the personal, public, medical, formally educative, and peer group domains (2003: 23). Within each domain, different messages are expressed to the women about their pregnancies and roles as mothers, and these messages are often conflicting. For example, within a woman's formally educative domain, she may learn to understand the reality of her pregnancy through childbirth classes that teach empowerment and control over the birth process. Within the medical domain, though, she may learn to understand the reality of her pregnancy as that which she has no control over and about which she knows very little. Davis-Floyd argues that the most powerful of domains influencing and shaping a woman during pregnancy occur in the medical domain, despite the fact that the least amount of time is spent in this domain (2003: 28).

Within the medical domain is found a pregnant woman's "overarching conceptual and structural framework for their experience of pregnancy" (Davis-Floyd 2003: 28). Indeed, a woman relies highly upon the doctor and medical staff to confirm pregnancy, to "show" her the heartbeat, give her her baby's first picture, determine the due date, and to decide the best time for the baby to arrive, as well as the means by which the baby is born and is to become healthy. It is through these medical rituals, and the rituals of the birth

experience, that Davis-Floyd argues that a woman comes to define and frame her birth experience. Through medicalized pregnancy care, a woman comes to terms with the varying and often-conflicting messages from the other domains that are received during her pregnancy (Davis-Floyd 2003: 24, 29).

Because these medical events are framing events, Davis-Floyd points out that “doctors in this society have taken on the role of the ritual elder...with one important difference” (2003: 29). That difference is that ritual elders often impart empowerment and competence in initiates, while doctors seem to do just the opposite. They often express their own competence and empowerment, and thus power over the pregnant women. A distance between the pregnant woman and obstetrician is created through their medical knowledge and procedures, which are withheld and guarded from the patient in order to maintain their authority as specialists.

Some of the women I interviewed discussed their experiences with obstetricians in their previous pregnancies, claiming they felt that they had very little power or say in the way their births went, and that they felt the care to be extremely impersonal. Though Tiffany was in a wheelchair when she was pregnant with her first son, she still wanted the chance to deliver vaginally. Her obstetrician did not intend to allow her this opportunity, and did not tell Tiffany she intended to deliver Tiffany’s baby by Cesarean Section until her 8<sup>th</sup> month of pregnancy. Tiffany states of her obstetrician’s care:

When we’d see her it was like 15 minutes in and out and I had to see her every 2 weeks cause I was high risk in her opinion. She was really mean and did vaginal exams every time I saw her and that was traumatizing for me, using the speculum every time for no reason...When it finally came time to talk about what birth was going to be, she was like, “Oh, you’re going to have a C-Section. What day looks good for you? When do you

want your baby?" I was like, "No I'd really like to have a trial of labor and see what my body can do. There's nothing saying that gateway is blocked off and I can't give birth." And so she pretty much debated it with me, trying to tell me that I would need to prove to her certain physical abilities before she'd let me do that...She never, it was never that birth could be something transforming, or that could be beautiful or could bring a couple together and find a whole new place in love. It was just that her big thing was, "We need to get this baby out. My responsibility is to get your baby out of you by whatever means necessary and this is what's easiest for me and safest for me legally" (February 2008).

Tara expressed similar concerns about medical care. It was because of this obstetrician that Tara decided to check into midwives.

We went to one doctor's appointment together when I first got an OB and she was horrible. She barely looked at us. She was horrible. I'm sure she's a nice person, but as a doctor...cause they see this every single day so it's not, you know, it's a special time for moms which is how [NWBC sees it], as a very special, exciting time. The doctors see it as their job, as a medical condition pretty much, and it's not (June 2007).

Catherine Bell in *Ritual Theory, Ritual Practice*, discusses this concept of the disempowering ritual elder as that of the "ritual specialist." She notes that ritual specialists are most often found in societies with a highly defined social hierarchy and authoritarian structure (1992: 130). Not only this, but ritual specialists tend to oversee rites which are afforded the most power and prestige, often those moderating between humans and nonhuman powers, or over institutions developed by bodies of specialized agents (Bell 1992: 131-135). Bell states that:

The development of a body of specialized agents who possess or control important mechanisms of objectification, such as ritual or educational institutions, is the development of a form of control that can be more total because it is more indirect and invisible. In this development, social control via coercive strategies demanding personal presence and explicit conflict begin to shift to social control via ownership of the means by which 'reality' is articulated for cognitive endorsement by all. (1992: 131)

The codification of ritual procedures into textual formats furthers this control over important rites that define a person and society's reality. With this codification, control and privilege is given to those with access not only to the texts, but also to interpretation of the texts (Bell 1992: 136).

In American society, a highly textual, institutional, and hierarchical society, doctors play the role of ritual specialists, as they are a part of the body of specialized agents residing over medicine and scientific institutions that are so highly regarded in American society. Medical doctors hold the power and prestige afforded the people who come to control rituals and the institutions within which rituals are performed. Davis-Floyd explains that obstetrics gained control over birth and midwives through claiming "exclusive access to esoteric knowledge and instruments such as forceps, presumed by men to be beyond women's intellectual abilities and physical skills" (2003: 30). The marginalization and near elimination of midwifery occurred through the standardization and textual codification of medical procedures surrounding birth (Davis-Floyd 2003: 30).

Bell points to the standardization of ritual as a means by which ritual comes to embody and celebrate not the authority of memory, experience, and practical expertise, but the authority of "ritual as a secondary enactment of prescribed acts, or the performance of a script" (1992: 137). Under this paradigm, anything falling outside the script becomes known as magical or pseudo-science. This is what has occurred with midwifery, in which the knowledge and rituals enacted under the midwifery paradigm are not acknowledged as science, but as pseudo-science, because midwifery does not follow the standard scripts and textual codes of medical procedures. According to Bell's theory,

standards of medical care and the textual codification of their knowledge have become the script by which authority is established and maintained. These standards have also come to define what reality is in American society.

According to Davis-Floyd, the prestige and power of the ritual specialists in obstetrics and birth leads to the belief in their authority and prestige by many of those choosing their care. Indeed, pregnant women are constantly in a knowledge seeking state. However, the inability to access and interpret medical “scripts” about birth leave women at a loss and under the direction of the ritual specialists, the obstetricians. For example, most obstetric care leaves very little time for discussion of important questions that pregnant women may have concerning their pregnancies and births. Because of this, women must find their own answers, at the same time that they must trust the obstetrician to hold all the knowledge necessary for a healthy pregnancy and birth.

Davis-Floyd has found that under the technocratic model, pregnant women are not taught or informed to trust their own personal intuitions and knowledge surrounding their feelings, emotions, and bodies. This is not known by pregnant women as intellectual knowledge, and is therefore disregarded as just that - emotional and unscientific. Their belief is in scientific, medical, authoritative, and powerful information and knowledge to which they do not have access (Davis-Floyd 2003: 31). This belief is created not just through their medical prenatal care, but also through upbringing and life experiences in a technocratic society.

In a technocratic society such as the United States’ and many others found in Western Europe, science is often presented as the underlying means by which everything

is understood. In an effort to move beyond religion during the 17<sup>th</sup> century, science was touted as the way in which to understand the organization of the universe; machines became the metaphor by which organisms were understood (Davis-Floyd 2003: 44-45). Social cohesion, being a necessary part of society, was partly maintained through the scientific understanding of the human body as a machine. Despite the fact that the human body is not a machine, much American discourse still presents it to be such, based upon science as a main underlying metaphor by which many understand reality. Rituals contribute to the creation of reality and social cohesion (or the illusion of social cohesion) and Western medicine's role became central to communicating and embedding in people the beliefs and values of the body as a machine (Davis-Floyd 2003: 46).

America's core values are "founded on principles of patriarchy and the supremacy of the institution over the individual" (Davis-Floyd 2003: 46). Under this paradigm, American people are socialized to believe that science, technology, patriarchy, and institutions should be valued over those of nature, individuals, families, and women. Similarly, technological progress should be valued as a source of political power, and therefore many people see technologies as near the top of the hierarchy (Davis-Floyd 2003: 47). Those controlling access and interpretation of technologies tend to be at the top of the hierarchy, and can be considered ritual specialists. In birth, technical specialists of pregnancy and birth, such as nurses, and especially the obstetricians, play the role of the ritual specialist and the enforcer and communicator of American society's core beliefs.

Under the technocratic paradigm of birth, bodily processes are understood as mechanical and as formulated under the model of the male body. Because of this, many medical texts and therefore medical practitioners, portray and believe the female body to be controlled by nature, defective, and abnormal. One can find this belief underlying medical texts dating from the 1400s to the present. Words describing female bodily processes imply degeneration, disability, failure, and pathology, while those describing male bodily processes imply power, normalcy, and functionality (Davis-Floyd 2003: 52-53). Thus birth is viewed by many to be inherently dangerous, pathological, and uncontrollable because it happens in the female body.

Tools and technologies are created in order to control the womanly process of birth, and to manipulate, improve upon, and thus regulate the female body (Davis-Floyd 2003: 51). These tools and technologies necessitate ritual specialists with knowledge of these tools, or bodies of specialized agents. The unquestioning use of obstetric, technocratic prenatal care during pregnancy and childbirth allows these ritual specialists to continue to shape, even if unknowingly, society's belief systems and social arrangements. They frame a woman's understanding of herself, her body, her role as a mother and role model, as a partner, and an American citizen.

Melissa Cheyney points out, however, that women choosing to give birth at home, under the care of a midwife, are actively challenging the bodies of specialized agents which come to define and frame women's understandings of themselves (2008). Through recognition of the disjunctions between their personal narratives surrounding childbirth, which focused on the importance of home birth, and the public narratives,

which portrayed home birth as dangerous and selfish, women began, during their pregnancies, a process of unlearning and relearning (Cheyney 2008: 257). In this process they reformulated narratives that “commonly value new sources and definitions of knowledge” (Cheyney 2008: 258). Therefore, we see that a woman is equally impacted by prenatal care with a midwife and in what Davis-Floyd might refer to as the “wholistic” domain (2003: 156). Midwifery prenatal care, as well as childbirth and postpartum care, are also highly ritualized and, therefore, serve to frame a woman’s perception of herself and the world around her.

The worldview communicated to a woman through midwifery prenatal care is much different than that communicated under a technocratic model. While Davis-Floyd and Cheyney do not extensively analyze the rituals of prenatal care as they do those of birth, Cheyney does draw some important comparisons between the two models of prenatal care. There are many aspects that medical and midwife prenatal care have in common, including “fetal heart tone monitoring, maternal blood pressure and weight gain assessment, urinalysis, fundal height measurement, various maternal blood tests and palpation of the baby’s size and position” (Cheyney 2005: 139). The manner in which these prenatal monitoring procedures are implemented vary between each paradigm and also within the paradigms. For instance, whereas obstetricians commonly use ultrasound to determine size, position, and fetal heart tones, midwives routinely palpate women’s bellies to assess these same things. Within midwifery care, one midwife might routinely use a fetal Doppler to assess fetal heart tones, while another will use only a fetal stethoscope, or fetascope.

While there are many procedures common between the two paradigms, most obstetric care ends with prenatal monitoring procedures that are used to assess complications. This is due to the high volume of patients seen by obstetricians in the United States (Cheyney 2005: 142). Most obstetric appointments last from 15-20 minutes, and usually focus primarily on making sure there are no complications (Cheyney 2005: 142), whereas midwifery prenatal appointments tend to last around an hour and can extend as long as two hours, as is evident from my interviews with NWBC clients. This is because midwives feel that their role as a care provider serves a multitude of purposes, including client education, which encompasses counseling in nutrition, exercise and health and stress management.

Midwives believe the health and wellbeing of women and their newborns during pregnancy, birth, and postpartum periods to be directly related to their diets, exercise routines, and lifestyles. Midwives focus not just on the physical wellbeing of their clients, but also on their mental wellbeing. The connection of the mind and the body are emphasized in midwifery care and so midwives engage in what Cheyney calls “mothering the mother,” in which pregnant women are nurtured and guided through their pregnancy experience. This is done in order to empower women to trust their own instincts, the ability of their bodies, and to unlearn “all of the negativity around reproduction and [relearn] more empowering interpretations of their bodies and babies” (Cheyney 2005: 140). A pregnant woman also develops a relationship with her midwives in order to be comfortable with them at the birth, so that they may come to recognize what is “normal” for that particular woman (Cheyney 2005: 140).

Also important is providing the mother with as many outside resources as necessary to maintain her physical and mental wellbeing. These could include referrals to prenatal yoga classes, birthing classes, Women, Infants, and Children (WIC) programs, or doula services. Sometimes an ultrasound is recommended for or requested by the mothers and then referrals to ultrasound practitioners become important. Similarly, some issues a mother has might fall outside of the midwives' scope of practice or need a second opinion. In these situations, referrals to naturopaths or other health practitioners can be helpful for the woman and the midwife. The involvement of the midwife in the birthing community helps her clients to have access to more resources.

Midwives also think it is important to routinely monitor women for such conditions as pre-eclampsia or urinary tract infections and refer clients to medical practitioners when needed. Monitoring is essential to women's care during pregnancy, in the event that they show signs of existing problems affecting theirs or their babies' health. However, midwives tend not to overly emphasize monitoring procedures, opting instead to emphasize more holistic aspects of their clients' care, such as the importance of preventative health. This way, problems are often mitigated before they even arise. Cheyney points out that, "Medicalization of pregnancy creates the illusion that routine tests and procedures will produce improved outcomes. However, these simplistic remedies divert attention from more difficult, complex and time intensive problems correlated with poor outcomes like poverty, smoking and drug abuse" (2005: 145). Midwives reiterate to clients that it is their actions that can solve or prevent problems, not

the monitoring. What is highlighted is the social, psychological, nutritional, and physical wellbeing of the mother during her pregnancy (Cheyney 2005: 141).

In the end, Cheyney theorizes that the rituals of prenatal appointments under midwifery care are conducted by midwives and clients as active resistance against the technocratic model which expresses messages of “danger, fear, incompetence and doctor-as-authority” (2005: 147). Cheyney states, “Women who choose to birth at home with midwives create new realities and explanatory models around childbirth. These new realities are constructed through overt challenges to public and metanarratives, as well as through direct action when women choose to birth at home as an act of resistance and systems-challenging praxis” (2008: 259-260).

Through active resistance, midwives and their clients convey messages valuing transformation, empowerment, strength, and mother-as-authority, which are expressed through education, relationship-building, mothering-the-mother, and flexibility in prenatal care and screening. The rituals elaborated in the “wholistic” midwifery domain during her early transition prepare the pregnant woman for her birth. She is also, as Cheyney points out, empowered to trust her knowledge beyond the time of labor and delivery. “Many of the women who discussed power or empowerment in some form also made an explicit connection to parenting” (Cheyney 2008: 262). Therefore, women choosing midwifery care were also more prepared for their reincorporation into a new role as a mother. These beliefs and values can have a large impact in shaping the woman’s understanding about herself and the structure of her surrounding world. While the prenatal care provided has a large part in this molding, those rituals directly

surrounding birth can have the biggest impact on her worldview. This is especially true because of her heightened liminal state during this stage of birth. A deeper look into ritual provides insight into how this worldview is created.

### **Ritual**

According to Davis-Floyd, “ritual is a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is transformation” (2003: 8). Bell states that three key characteristics have often been cited as essential to ritual and ritualization—formality, fixity and repetition (1992: 91-92). One way ritual works, then, is by setting itself apart from other everyday acts and in a sense, creating itself as more important and powerful than everyday activities. This makes sense when considering that people most often engage in ritualization in order to aid themselves through a particular circumstance or situation not found in everyday life. Prenatal appointments and births with midwives, as discussed starting on page 126, are prime examples of rituals that are designed to aid women through life-changing events not found in everyday life. They are set apart from everyday activities and serve to instill women with values and beliefs reiterating trust in their own bodies and abilities to successfully transform into mothers.

Prenatal appointments at NWBC are highly ritualized because they are fixed, patterned, and routinized. The comforts provided by this routine allow a space where social relations modeled in prenatal appointments are defined and normalized into the everyday lives of midwife clients. In the heightened situation of a ritual, transformation can occur through ritual’s ability to “control by defining, modeling, and communicating

social relations” (Bell 1992: 89). Thus, women become empowered to trust in their own abilities to make important decisions for their families, trust their bodies, and gain insight through knowledge sharing. This way, women believe they hold as much authority, if not more, over their pregnancy and birth as do their midwives. These beliefs follow clients into the birth setting, so that they trust their bodies to birth their babies normally and naturally. Again, the messages communicated in the heightened state of birth, a major time of transition and ritualization, are those of empowerment, trust, and ability. These ritualized messages and models of social relations follow women into their everyday lives as mothers, long after midwifery care has finished.

Social relations are communicated in a very different way than through direct, person-to-person verbalization and communication. With verbal communication, the left hemisphere of the brain receives the information and is able to decode and analyze messages. Through this, a person is able to accept or reject the communicated messages. However, through ritual symbolic communication, messages are received by the right hemisphere of the brain and are felt through the body and the emotions. It is thought that in many ritual situations, there is little room to decipher and reject messages communicated through ritual (Davis-Floyd 2003: 9). The body is the median for communication and its interactions and dynamics are “defined within a symbolically structured environment” (Bell 1992: 93). Messages are therefore received subconsciously, and ritualization, “is designed to do what it does without bringing what it is doing across the threshold of discourse or systematic thinking” (Bell 1992: 95).

This subconscious receipt of ritual messages by participants serves to embed within them the belief systems of the groups conducting rituals, as well as their concept of social order. Bell states that, "In ritualization, power is not external to its workings; it exists only insofar as it is constituted with and through the lived body, which is both the body of society and the social body" (1992: 204). Participants enacting rituals are often in states of transition or chaos, and so ritual, with its ability to mediate between cognition and chaos through its restoration of conceptual order and structure, serves to anchor participants through experiences set apart from daily life. According to Davis-Floyd, "to perform a series of rituals is to feel oneself locking onto a set of cosmic gears which will safely and inevitably crank the individual right on through the perceived danger to safety on the other side" (2003: 14).

Once an individual has reached the other side, they are what Bell refers to as a "ritualized body" (1992: 98). The interaction of the body with a structured and structuring environment, also known as ritual space, creates this ritualized body that is invested with a "sense" of ritual (Bell 1992: 98). With this "sense" of ritual, an individual's ritualized body displays an interesting circular relationship with her environment: "generating it, it is molded by it in turn" (Bell 1992: 99). Not only is one able to generate the same environment within which they were produced, shaped, and socialized, but this very environment also, again, molds them. In turn, this environment, and the messages communicated through this environment, become reality for individual bodies. Reality is created through the very enactment of rituals, which does not simply

express belief, but produces beliefs within the individual, who then becomes a “ritualized agent” (Bell 1992: 100).

Not only does ritual serve to *communicate* messages and belief systems to participants, it serves to *transform and mold* the individuals’ personal belief systems to align with those producing and participating in the rituals. Inherent in the “ritualized agent” is an instinctive understanding of power relations and social organization within their environment, (Bell 1992: 197), which they may not have before understood. Not only do they understand the social organization expressed through ritual, but also their place within this power structure. “When a ritual succeeds at triggering this type of profound cognitive transformation, the individual’s entire cognitive structure will eventually reorganize itself around the newly internalized symbolic complex” (Davis-Floyd 2003: 16).

The individual’s reorganization of cognitive structure displays their “ritual mastery,” or their “ability to deploy in the wider social context the schemes internalized in the ritualized environment” (Bell 1992: 107). Again, this mastery is a circular force, as those who become ritualized deploy similar rituals in non-ritualized contexts in order to control and make sense of them in a way that aligns with and validates their embedded values. While they may understand *why* they conduct a ritual, the goal of the ritual, or the basic transformation that should occur, it is not always true that ritual masters are able to know *how* the enactment of the ritual performs as it does. They cannot see the mechanisms by which transformation occurs. Or as Bell puts it, “Ritualization sees the goal of a new person. It does not see how it produces that person—how it projects an

environment that, reembodied, produces a renewed person freshly armed with schemes of strategic reclassification” (1992: 110).

This theory of ritualization suggests that because one cannot know *how* what one is doing is causing a transformation in ritual participants, the social organizations, power structures, values and beliefs that are communicated and ingrained in ritual masters cannot change with the passing on of ritual tradition. However, the very nature of ritual and tradition is its need not only for continuity, but also for change. Continuity is necessary in rituals as there must be a sense of structure, routine and fixity. “In the fixity of ritual’s structure lies the prestige of tradition and in this prestige lies power” (Bell 1992: 120).

However, power also lies in peoples’ ability to creatively reinterpret and adapt ritual tradition to more current situations and environments, in order to continue domination. With changing times and environments, structure, details, and interpretations of rituals also change, often without ritual enactors’ awareness (Bell 1992: 119). “Ritual *can* be a strategic way...to construct a type of tradition, but in doing so it can also challenge and renegotiate the very basis of tradition to the point of upending much of what had been seen as fixed previously or by other groups” (Bell 1992: 124). Davis-Floyd points out that, “ritual, with all of its insistence on continuity and order, can be an important factor not only in individual transformation but also in social change” (2003: 17).

How does ritual allow room for resistance and change, if it transforms people and their understanding of the cosmos and their place in society through subconscious

delivery and receipt of messages? And how does it allow room for empowerment of ritualized participants, if they are re-enacting beliefs in other contexts, understanding them as “deriving from power or realities beyond the community and its activities” (Bell 1992: 206)? According to Bell, ritualization cannot simply control participants because they are, in turn, the bodies that control the ritualization. “A person’s involvement in ritual activities...is never an indiscriminate openness to what is going on” (Bell 1992: 208). Each ritualized body brings to an environment a personal history that is a negotiation of resistance and compliance of the ritual.

Through this negotiation, those enacting rituals are afforded a degree of resistance, consent, and negotiated appropriation (Bell 1992: 209). Bell points out that ritualization’s unified body of people and their re-enactment of rituals implies that there is more consensus than actually exists. The implied consensus is where ritual loses its power of control over those involved, because there is a need for every person to at least *appear* to comply. In their compliance is found the flexibility to appropriate and resist in varying forms (Bell 1992: 211). Herein lies the power and empowerment of ritual masters, or ritual participants.

Ritual masters are thus engaged in “a set of tensions that involve both domination and resistance” (Bell 1992: 217). They are able to be flexible and to resist only under the guise of compliance with the ritualized systems set forward within their environments. Ritualization cannot create total social control and yet, at the same time, it controls the belief systems of its participants. To resist something is still to understand that there is an overarching system that controls and dominates. Resistance takes carefully negotiated

appropriation of a system that is seen as reality by peoples within a particular environment. “Ritualized practices, of necessity, require the external consent of participants while simultaneously tolerating a fair degree of internal resistance” (Bell 1992: 221). It is in this ability to negotiate that ritual masters can resist hegemonic orders and ultimately, make changes seen as important to individuals within changing environments.

### **Compliance and Resistance in Rituals of Birth: Analysis of NWBC Rituals**

Bell’s theory of ritual masters’ engagement in domination and resistance, and flexibility to negotiate messages communicated through ritual has helped me understand the rituals found in NWBC. While the setting and the procedures of the birthing center have medical symbols, the care is based more fully on midwifery. Through the appropriation of particular medical symbols and rituals, midwives, pregnant and birthing women, and families, as ritual participants and thus masters, are also able to resist, question, and negotiate the benefits of both systems. In the end, the same values and beliefs that Cheyney found to be communicated through homebirth midwifery practices are instilled within clients of NWBC, despite the more medical setting.

The options presented to women and the choices that they make exemplify ways in which NWBC is at once in compliance with while resisting medical paradigms of birth through their rituals. A look at the rituals within the four different stages (which can all be said to be a part of the liminal phase of a rite of passage) composing the prenatal period, the laboring and time of birth period, immediate postpartum, and postpartum, will provide insight into the messages communicated through birthing at NWBC. Comparing

the communicated messages to those found by Cheyney in her study of homebirth midwifery, and the findings of Davis-Floyd's analysis of the rituals of hospital births, provides further insight into the ways in which the NWBC rituals, while appropriating medical practices at the same time that they modify them, still fall closer to the midwifery paradigm of birth.

### *The Prenatal Period*

During the prenatal period, the beginning of the liminal stage of a rite of passage, Cheyney found that women provided with homebirth midwifery prenatal care had very positive experiences. Overall, women felt midwives to be approachable and willing to share information and knowledge in a caring way. Women felt confident after leaving prenatal appointments and the close friendships built with their midwives aided in their positive experiences (Cheyney 2005: 145-146). Midwives in her study focused on the use of shared knowledge and reassurance in order to empower women and affirm them as the ultimate authority over their lives. This was done through prenatal visits, where women routinely experienced information exchange and answering of questions meant to affirm women as authorities over their own lives. Prenatal screening tests were also a routine during prenatal appointments and were used "primarily as opportunities for reassurance" (Cheyney 2005: 147). Through the routines of knowledge sharing and reassurance, midwives knowingly rejected the ideas of fear so highly felt under the medical model, and honored women during their life-changing experiences (Cheyney 2005: 147-148). Women, in turn, felt empowered to make their own choices during pregnancy, labor and birth and this would carry over to their lives as parents.

The women at NWBC shared experiences similar to those found in Cheyney's study. The procedures found at NWBC are highly ritualized. Every woman is presented with the same options for prenatal, birth and postpartum care. However, each family makes their own decision concerning which options they will choose; their care therefore becomes individualized, yet quite routine for the family. For example, one woman may choose to decline weighing herself at each appointment, feeling it an unnecessary part of care. She may also choose to use the fetal Doppler, rather than the fetascope, so that she and her family can hear the baby's heartbeat more clearly at each appointment. For this woman, her prenatal appointments become fairly routine. She walks into the birthing center, she pays at the window, goes to the bathroom and tests her urine. She goes through the regular routine of the prenatal with vitals being taken, and then the midwives listen to the baby using a Doppler.

Another woman, however, may choose different options. For instance, she may weigh herself and test her urine, but decline to use the Doppler because she is not sure of its safety. Instead, she requests the fetascope. Her appointment still becomes very routine for her personally. This also applies to testing, which is offered at different periods throughout the pregnancy period. The options of testing are always presented to women at appropriate times. However, it is up to them to decide if the testing is necessary for them. On the first visit, a complete prenatal panel is offered, where blood and urine are tested for blood type, Rh factor, iron, sexually transmitted infections, and more. While this is highly recommended by midwives, they are flexible with the timing of the panel, so that it may work better with a client's income or insurance eligibility. At

16 weeks, the Quad Marker screening is offered. Later, gestational diabetes testing is offered, as is screening for sexually transmitted infections, as well as testing for Group Beta Streptococcus. Each step of the way, a woman makes her own decision about what is best for her.

Women at NWBC are also, like the women in Cheyney's study, provided with prenatal care based around "mothering the mother," nutritional counseling, education, and relationship building. For example, during each prenatal appointment, time is set aside to discuss a woman's emotional state of mind, home life, and excitements and concerns surrounding pregnancy, birth, and parenting. This is a process of nurturing the mother through her intense time of transformation and serves to mitigate fears surrounding the process. It also serves to affirm a woman's feelings, whether they are negative or positive, and help her to work through them so that she is assured of her ability to grow, birth, and parent a healthy baby.

Nutritional counseling is also an important ritual of prenatal care at NWBC that is discussed at each appointment. Women are required to fill out a diet diary at the beginning and end of their pregnancy. Using this, and discussions with the clients, the midwives develop a system of nutrition, in conjunction with their clients, that fits their specific needs. There is no set standard of nutrition because every woman is seen as having different needs. So, while there may be an understood amount of calories, iron, and calcium that pregnant women need to consume, these are modified based on the individual.

For instance, a woman who is constipated may be encouraged to increase her intake of roughage and calcium, but to decrease her iron supplements. Another woman who may show signs of anemia might be encouraged to increase her iron intake, through supplements and food, as well as Vitamin C. The kinds of foods she eats depend highly upon the diet that she personally chooses. A vegetarian would get very different recommendations than a woman who eats meat. Each visit, nutrition is discussed and recommendations made by the midwives are followed up, and modified based on changing circumstances in the woman's life.

Another important aspect of midwifery care routinely used at the NWBC prenatal appointments is the palpation of the woman's belly. Sometimes the palpation consists simply of the midwife feeling the belly, stating the position, the estimated weight, and finding the heartbeat and fundal height. However, the midwives often follow these procedures while also explaining to the women what it is that they are doing. The midwives will ask the woman where she feels kicking and where she thinks the baby is located. Earlier in the pregnancy, the midwives will place the mother's hands on her own belly and show her how to feel the bottom, the head, the back, and the feet. She discusses with her how to understand the position based on where the woman feels kicking, and also where the heartbeat can be found. Partners are often included in the palpation of the belly and in the education that goes along with it. Soon, it is the woman who first tells the midwife where the baby is located, and through this the midwives intend for women to become more empowered, to trust themselves, and also to connect with their child.

Prenatal visits at NWBC were routinely focused upon allowing a space where women could be the authority over their own pregnancies and births, with guidance from midwives. Women at NWBC expressed that they loved their prenatal appointments and noted that they often felt like they were hanging out with friends. The appointments lasted at least an hour, and were times in which they received a multitude of knowledge about their bodies and upcoming births. This was very helpful when it came time to give birth, as they felt confident in their own selves, as well as familiar with the care providers surrounding them.

All the women I interviewed expressed feelings of loss after their time at NWBC had ended; they left NWBC feeling overjoyed and empowered by their experiences. Women's responses to prenatal care at NWBC align much more with the experiences of women who used homebirth midwifery described by Cheyney than with those who experienced hospital births described by Davis-Floyd. They felt like humans rather than numbers and believed their care providers were their friends. Through NWBC prenatal care, messages of empowerment, beauty, and trust are communicated to women, rather than messages communicated through medical practices such as danger, fear, and doctor-as-authority (Cheyney 2005: 147).

Aspects of their prenatal care that were more medicalized seemed to go unnoticed by the women I interviewed, except for the occasional unrest with inconsistent care. For example, much charting occurs during the prenatal appointments, and the routines of prenatal visits follow a system based around the format of the charts. At the same time, the charts have been designed to fit the needs of the NWBC midwives in order to provide

a guide to presenting options to their clients. Charting, as I have discussed before, is seen by most midwives to be very impersonal and as distracting from important aspects of midwifery care that they are unable to provide women because of time constraints and high volumes. Interestingly, none of the women I interviewed made any negative comments concerning the charting process, beyond stating that some of the consent forms within the chart were scary.

Even procedures such as routine testing of urine and testing for Group Beta Streptococcus, are done differently than in medical settings, where the practitioner must conduct and observe results of the tests. At NWBC, women test their own urine, relaying the results to the midwives. They do their own vaginal and anal cultures in the privacy of the bathroom. This communicates to women that they are capable, able, and can trust themselves to make important decisions and take correct actions in their lives.

When it is determined that a woman needs more time to discuss her feelings than the scheduled hour, the time is made for her. The large number of student midwives allows for some flexibility in this area. Therefore, while apprenticeship and volunteer-based training, as well as the high volumes at NWBC, may lead to inconsistent care, at the same time it allows for more flexibility. Though the system of charting seems very medical, it is used not simply as a way for the NWBC midwives to cover all of their bases in the event that the government audits their files. Charting provides women with the ability to be individuals and to make personal decisions, even in a setting where it would be much easier to standardize care for all women. It is a checks and balances system for the midwives so that the midwives can read the detailed descriptions of

previous appointments to better understand the woman. And more importantly, when the woman goes into labor, the chart can be used as a way to make sure that all of the woman's requests for her birth are known and available.

By using a system of care based on the medical paradigm, the midwives at the NWBC actively appropriate this system. However, they are at the same time negotiating and modifying the benefits that can be found in medical procedures such as charting, prenatal screening tests, and time constraints. This way, midwives can focus upon what they see as most important for each appointment and client, and can develop a relationship that encourages informed choices. Through negotiated appropriation of medical procedures, and a focus on remaining true to midwifery practices in prenatal appointments, women are provided with reassurance about their pregnancies and options and choices for their and their child's care. This affirms the women as authorities in their own lives as birthers and as parents.

### *Labor and Birth*

In labor and birth, Cheyney noted that most homebirth midwives routinely used active support rituals such as massage, warm water immersion, counter-pressure, position changing, and birth mantras, which are "repetitive, formulaic sayings, spoken quietly to soothe women through contractions" (2005: 149). Other common practices in homebirth midwifery are the use of candles and aromatherapy, engaging partners and "support guests" in aiding through labor, and monitoring fetal and maternal vital signs for the purposes of both charting and reassurance (Cheyney 2005: 149-150). Though each birth is different as well as each midwife, the procedures midwives use become quite routine,

as they find comfort in certain practices they have found to be effective over and over again. Monitoring of fetal and maternal vital signs is always used in labor and birth. Also, the various rituals midwives use are seen as possible options for each woman. It is important to homebirth midwives to protect the space and privacy of the birthing woman and to allow her choices in her birth. These choices include how often, if at all, she receives a vaginal exam to check for cervical dilation, position changes, eating and drinking, and the use of herbs to aid in speeding labor.

According to Cheyney, the rituals of homebirth midwives serve several purposes that highly affect women because of the intense liminal state they are in and the “opening” to messages that goes along with this heightened period. These purposes include modeling care giving and supportive behaviors that women will use during motherhood. Not only does this communicate to the mother that support systems are necessary and important in childrearing, but it also communicates to the woman her abilities and strengths (Cheyney 2005: 161).

The rituals used by the midwives at NWBC during labor and birth align very closely with those of homebirth midwives described by Cheyney. For example, position changes are encouraged for every woman birthing under the care of NWBC. Within the birthing center are a number of options that provide women with this opportunity. Women can move freely about the birthing center, choosing whatever position feels most comfortable. Sometimes the midwives will make position suggestions, but they also believe that a woman will instinctively know the best position for herself and her baby. For instance, a woman whose baby is posterior might feel the urge to crawl on her hands

and knees and this is because that position aids in turning the baby's back toward the front, a more optimal position for birth. At NWBC there is a birth stool, birth ball, stairs, and waterbirth tub. Each of these options provides a range of positions that may help a woman through her labor. Sometimes a sheet will be hung from the top of a door so that a woman can hang. Also, midwives at NWBC often take women for walks along the bike path that is nearby.

At NWBC, warm water immersion is a common way to aid women in their labor. In fact, water birth is one of the main reasons women choose NWBC. Sometimes a baby will be born into the water, while other times the water is used simply as a tool for relieving pain or for helping a mother to relax through her contractions. It is very common for the midwives of NWBC to light candles and use aromatherapy in the waterbirth room and around the birthing center. Cheyney points out that this is used in order to help women relax and cope with pain, as well as to define the "labor space as sacred, special or out of the ordinary" (2005: 150).

Another practice found at NWBC that aligns with those of homebirth midwives in Cheyney's study is the routine use of massage and counter-pressure during labor. Midwives often massage women to help them relax and also apply pressure to areas in the hips that provide relief to the women. This practice is also commonly used to help partners and labor supporters to become involved with the woman during her labor. The midwives can guide them on where to massage or place pressure, and a woman is usually fairly expressive about the degree of pressure that she needs and in what moments. These practices communicate messages similar to those of homebirth midwives, where the

importance of support systems is modeled, as well as the reiteration of women's abilities and strengths.

While some of the procedures used by NWBC midwives align with hospital rituals as outlined by Davis-Floyd, they are used selectively and in modified ways. For example, NWBC midwives sometimes administer enemas, but this is very rare and usually only upon request by the laboring woman, who may feel embarrassed or inhibited to urinate or defecate in front of other people. In this case, it can be very useful to provide an enema, so that the woman can relax and focus upon more important matters in her birthing process. Davis-Floyd found that the routine use of the enema, without the request of the laboring woman, communicated that a woman's genitalia were dirty and could only be cleaned by the institution (2003: 86).

Monitoring is another ritual shared by NWBC midwives and hospital practitioners. The manner in which women are monitored, however, is quite different. In the hospital, the external electronic fetal monitor is most commonly used, which is a belt that wraps around the mother's stomach and produces numbers evaluating maternal and fetal vitals on another separate screen or printer. Through this, the authority of the machines is valued over that of the laboring woman and less personal interaction occurs between patients and practitioners (Davis-Floyd 2003: 108). Homebirth midwives and NWBC midwives, however, most commonly use the Doppler or fetoscope. While the women in hospital births experienced their monitoring as something that brought the attention away from their bodies and personal self, those at NWBC felt the monitoring to be unobtrusive.

According to Tara, during her birth at NWBC, “They put the baby monitor on me twice and that was it. Which was not uncomfortable at all” (June 2007). Tiffany stated:

I remember one time she checked the baby’s heart rate. No, twice actually. We were in here once and a midwife came in and did it when I was laying down with [my son] trying to get him to chill out. And when we were in the tub close to the birth I remember her coming up. And the only reason I remember was cause she was like, “Where did we find the heartbeat before?” I was like, “Way down here. He’s coming.” And I don’t even...it was so brief. She just touched me under the water with the thing and then she went away. And that was the most that she intervened or anyone did for that matter (February 2008).

It is important to note that with both women, monitoring did occur more often than they remember; however, it was experienced in such an unobtrusive way that it did not register to them as important. With Tiffany, she was directly asked where to find the heartbeat; this communicates to her her own knowledge of her body, her baby, and her abilities.

The clients of NWBC experienced the unobtrusive and low-intervention labor and birth rituals of the midwives at NWBC in highly positive ways. In fact, most of the “interventions” that were necessary were performed by the women themselves. For example, Tara discussed the checking of her cervix at NWBC, right before she pushed.

They didn’t check me at all. They actually told me to check myself. They’re like, “OK, put your hand down there and see if you can feel the baby.” I was like, “I think so.” They’re like, “Do you feel something hard?” I was like, “Yeah.” “That’s the baby’s head.” And that was just amazing, you know, being able to feel him right there before he even came out. I mean, them not touching me, not just checking my cervix and stuff like that, it’s the greatest thing ever (June 2007).

Though Leona's cervix was checked by the midwives at one point, it was upon her request and she also experienced feeling her baby's head right before she began to push.

She stated:

And then I felt her head myself and pushed and there was still a lip and so I was trying to pull it back and that helped a lot. That gave me a lot of strength, feeling her because she was there and it was me doing it. I'm not relying on anyone else cause I was pulling the lip (July 2007).

Tiffany could not believe that she was left alone throughout her labor, without someone having to constantly follow her. Many times throughout her labor and birth she felt that everything was left to her and she gained much strength through working through her labor alone. She stated:

The contractions started to get more intense to the point that I couldn't sit still anymore. I just had this burst of strength. I actually lifted myself in labor, my partner and son were asleep, and normally I'd have to get my partner up to help to help me, especially at the end of my pregnancy, but for whatever reason I was able to lift myself and I remember being really amazed by that cause I was in pain and didn't even know what was going on. And I went in the bathroom and I dealt with some of the contractions on the toilet and I was just amazed at being left alone. That Toribia was upstairs, no one was there and I was like dealing with it on my own. I was super proud of myself and then checked my cervix and felt the bulging waters and I knew I was at least 3 centimeters which was awesome (February 2008).

And there was something about being on the toilet through some of those contractions alone, that just brought me into this state of total confidence in my ability to give birth. Like, "If I need you I'll ask for you but I got this under control," kind of thing (February 2008).

Each woman expressed that the low- or non-intervention rituals experienced during their births brought them feelings of empowerment. No one had to do anything to or for them, and therefore, the rituals of labor and birth communicated to these women their own personal strength and abilities.

The messages of ability communicated to women during labor and birth while under midwifery are empowering. Interestingly, most of the women I interviewed also expressed the feelings that in a hospital setting, it is not the woman who has to do the work. For example, when Leona was having a difficult time in labor and was considering transferring to the hospital, she said she was thinking, “Well at the hospital they do it for you. I don’t have to do it myself” (July 2007). Tara stated that during her hospital experience she did not feel she was doing the work. “When you’re in the hospital, though, you kind of feel like other people are doing it for you. You know what I mean? Because you have the drugs to help with pain and you’ve got people checking you telling you how much longer” (June 2007). Tiffany eloquently discussed the effects these experiences had on her own perception of herself. “This is really what I came away from the hospital experience with, like they kept telling me I wasn’t qualified. Like, ‘Lay back and let us do this. You’re not qualified to birth your baby’” (February 2008).

In these quotes we see clearly messages of disempowerment and inability of the woman and conversely of the power and authority of the medical practitioner, technology, and the institution. Overall, women’s experiences and the messages of empowerment that were communicated during their births with NWBC, were the opposite of hospital messages. Yet, we see how rituals of midwives at NWBC, while falling under certain medical paradigms, are used in moderation and in ways similar to homebirth midwives. These rituals, thus, serve to challenge the medical model from within.

### Immediate Postpartum Period

In the hour following birth, Cheyney notes that homebirth midwifery care focuses upon assessing the health of the baby, maternal blood loss, and delivery of the placenta (2005: 173). With this paradigm comes the priority of keeping the mother and baby as a unit, so that they may bond, so the baby's temperature is regulated, and breastfeeding can be initiated. The cord is almost always kept intact until it has stopped pulsing, and if there is a need for the baby to be resuscitated, this is done in the arms of the mother, or very near her. According to Cheyney, the rituals of homebirth midwives are elaborated to challenge the medicalized monitoring of the baby, so that the celebratory aspects dominate. Allowing the cord to remain attached to the placenta, promoting breastfeeding, and keeping the mother and baby closely together emphasizes the mother's importance as a parent and her ability to provide everything that is needed for the baby (Cheyney 2005: 182).

At the hospital births, however, less emphasis is often placed on keeping the baby close to the mother, especially if it is in need of resuscitation. Davis-Floyd notes that during the immediate postpartum period at the hospital, messages of a woman's inability to provide, and conversely societal institutions' ability to "save," are communicated (2003: 149). This is done through separation of mother and baby for standardized and routine procedures, cutting the cord quickly, washing the baby, placing it in a bassinet, and resuscitation that occurs far from the mother's side. Those procedures also options for every woman at NWBC, such as Vitamin K injection, erythromycin administration, and Newborn Screening, are standardized hospital procedures performed on every baby,

often with no attention paid to individual needs or requests from parents. These standardized procedures communicate the faultiness of nature and the need for medical technologies (Davis-Floyd 2003: 139).

Tara extensively discussed her experience in the hospital compared to that at NWBC, placing much emphasis on the many choices that she had at NWBC:

[At the hospital] they cut the cord right away. They just kind of cut it, take him away, they wash your baby like a sack of potatoes, they scrub them down and pop a pacifier in their mouth as soon as they start crying when they're away from mom. [At NWBC] I loved being attached to him for half an hour before they even cut the cord. I layed down and [the midwives] just left me alone and I just thought it was neat, you know, that they didn't have to cut him off and you know, wash him up. They didn't even bathe him (June 2007).

I didn't even know you could keep your placenta. I don't even know if they let you do it in the hospital. My placenta is still in my freezer. We actually found a little chestnut tree. A squirrel had buried a chestnut in one of our outdoor potted plants, and it's growing a little tree so we're gonna plant it with the placenta (June 2007).

You know, I remember all the details of his [hospital] birth. But I wasn't as present mentally and emotionally and physically. And I don't want to say I regret it, but I wish I just had all those options (June 2007).

Tiffany expressed similar sentiments, stating that:

As soon as he was born [at the hospital] they gave him a shot, they put crap in his eyes, they weighed him and did all this stuff and I was like, "Give me my baby!" but we were in the hospital and they have to do their little routine (February 2008).

[At NWBC] we had the first hour alone with [our newborn] and we were left alone in the tub for like an hour and everybody just kind of gave us our space and one midwife came in a couple times to try and help me with the placenta cause they were concerned about that happening. I actually ended up reaching in and pulling the placenta out myself which was another of my doing things on my own. It was important to me to leave the cord and placenta intact because I felt like kind of violated with it being cut before the placenta was born, when [we were at the hospital].

And then when they threw away the placenta that was heartbreaking, too (February 2008).

In both cases, the women had the ability to decline particular procedures. They were able to control the situation based upon their own, knowledgeable and thought-out choices and beliefs. The power to decide was given during the prenatal period and was implemented during the immediate postpartum period, extending empowerment during the liminal stage of pregnancy and birth.

Midwives at NWBC know the state a woman is in while laboring and birthing and know it to be an inappropriate time to ask women what they want for their newborns, or to try to describe the different options. Instead, available procedures are discussed well in advance, with much time for clients to do research. The choices women make concerning immediate postpartum procedures vary widely, but following are the options made available: Vitamin K administration either orally or by injection, erythromycin ointment to be placed on a baby's eyes, and Newborn Screening to detect rare disorders such as congenital hypothyroidism, cystic fibrosis, and biotinidase deficiency. Other options and decisions include how soon after birth and by whom the cord is cut, who will catch the baby, if breastfeeding should be initiated quickly, where and how the placenta should be delivered, and what the family wants to do with the placenta.

While the midwives at NWBC have their personal rituals for each procedure, the particular birth and the choices made by women in advance dictate the ways in which the postpartum procedures are performed. Of course, some women change their minds during birth, and sometimes the birth itself dictates changes in what happens in the immediate postpartum period. For example, if a baby has a cord wrapped around his

neck preventing him from being pushed out all the way, his cord may have to be cut more quickly than planned by the family. However, this choice would be for the safety of the baby. It is important for the midwives at NWBC to provide women with options from which they can choose. Through these options and decisions, women feel empowered to make decisions regarding their babies. Similarly, it is communicated to women that they are capable of providing everything necessary for their baby's survival and well-being.

*Postpartum Period: The Reintegration Phase*

Neither Davis-Floyd nor Cheyney extensively discussed the rituals of postpartum visits. However, I find them to be an important part of midwifery care. During the postpartum period, many women in America experience postpartum depression (PPD), due to a number of reasons. Davis-Floyd notes that some researchers have found a correlation between highly technological births and postpartum depression (2003: 42). Also factoring into PPD is the view of mothering in American society as a "role" rather than a "job". It is seen as a woman's responsibility and not as work, and therefore little respect or help is given. There is very little assistance to mothers, financially, and because America's family structure is largely based upon the nuclear family, a dependence upon partners and medical "experts" is often necessary to do the work of a mother. Accompanying this is often emotional isolation, and thus PPD (Davis-Floyd 2003: 42).

At NWBC, the postpartum period is regarded as an important time in which a new mother needs support, not just from the midwives, but also from a surrounding community. The midwives help each woman put together a list of people who can bring

her food in weeks following their births, and the midwives help call to make a schedule for these people. NWBC midwives also provide women and families with outside resources to fit their postpartum needs. During the first week, a midwife or student midwife visits the women in their homes. The women are not expected to come to the birth center for appointments. These visits are conducted in order to check on the mother and baby, but also as a way to help them celebrate their new roles and to aid them through this phase of transition and reintegration.

During home visits, women are provided with moxa treatments, which are heat treatments given with Chinese herbs. These aid a woman's organs to move back into place and to regulate her hormones. Support is given with breastfeeding. Herbal sitz baths are provided as well, especially if a woman has a severe tear. Often, the midwives will cook and clean for the women during home visits. Shared knowledge continues to be a part of the visits, though the focus has moved toward newborn care. However, shared knowledge concerning the mother's body, which continues to change, is also a part of postpartum visits. The education provided for women concerning newborn care is based upon the decisions parents have made surrounding their childrearing ideals. For instance, if parents have chosen to circumcise their child, education is given concerning the care of the baby's penis. If women choose to co-sleep with their child, information is provided about safe practices.

When a woman first returns to the NWBC, she looks forward to reading a passage of celebration that has been written on a marker board in the waiting room of the birth center. This passage might say, "Alisha May: 8 lbs. 2 oz. Born to Lila and Jeff, June 5<sup>th</sup>

4:25 am. A powerful and quiet mother takes her time pushing a chubby-cheeked baby girl into the tranquil waters and hands of daddy.” For some women, they are visiting the space where their baby was born, and for others who had home births, they are visiting a very familiar and friendly space.

Clients of NWBC enjoy the visits very much and some even acknowledge the care as helping them to prevent PPD, which they had experienced with other births. Erica stated, “I really needed help finding support and I needed to know that postpartum they would come to my home. And I feel like the support that I got [from the NWBC midwives], helped me a lot in preventing postpartum symptoms” (July 2007). Tara loved the postpartum visits. “The postnatal visits were great. You guys did my dishes. That was awesome. And the heat treatments were so cool. I want one every week” (June 2007). Leona described the postpartum visits as a celebration of the baby.

Whenever they come visit it’s like friends visiting and they also play with the baby. It’s not like a doctor’s visit at all. They were just playing with her and checking stuff and everything’s good and we talked and, well, I guess they do play with the baby cause they love babies and that’s so nice. It’s not a hassle at all, doing it. The appointments are fun cause they’re happy and love what they do, and it should be that. Everything you do with your baby should be a celebration (July 2007).

Once again, we can see the ways in which the rituals of NWBC midwives align with those of homebirth midwives; the messages communicated to women do not convey risk or necessity for technologies and monitoring, but those celebrating their new life with their baby, their ability as parents, and the provision of community support.

Cheyney found that rituals occurring during the births conducted by homebirth midwives expressed not only empowerment and abilities of the birthing women, but the

importance of community support and networks (2005: 161). While the midwives at NWBC provide women with education for newborn care, it is based upon the individual decisions of the woman. The importance of community support is communicated to women through modeling this support during the postpartum period. Again, midwives cook and clean, bathe, and massage the woman as she is reincorporating herself into the world, and finding her place within her new identity as a mother and parent. Through this, women see the importance of community.

### **Discussion**

While there may be concerns that the placement of midwifery into a more medical paradigm or into a medicalized space such as a birthing center may co-opt the important messages communicated to women through homebirth midwifery practices, the rituals found within NWBC show this to be untrue. Indeed, the rituals that may seem more medicalized were not only used in limitation and on an individual basis at the discretion of the pregnant and laboring woman, but homebirth midwives also used them. Overall, rituals at NWBC aligned much more closely with homebirth midwifery practices as discussed by Cheyney, than those found in the hospital. Because of this, women left their care at NWBC with feelings of power, awe at their own personal abilities, knowledge to last a lifetime, and trust in their bodies and their decision-making capabilities. Women were highly empowered by their births through NWBC and found the care to be invaluable in their experiences.

## CHAPTER V CONCLUSION

I just want to shout to the world about the whole experience because it was so great, just feeling that powerful, in my own little self, and then just in doing your basic day to day things, you know you have the ability to just go through all of those (June 2007).

-Tara

This quote expresses the myriad benefits that can be found under the paradigm of midwifery. Not only do women come away from their care feeling powerful, capable, and trusting of their own abilities to birth their babies and make the appropriate decisions for their families, but also women confirm their abilities to be powerful and capable in making decisions that they face in their daily lives. They learn to question institutionalized, authoritarian systems of our society, so that the best decisions can be made for their and their families' individual needs (Cheyney 2008: 265, Cheyney 2005: 162).

Women's empowerment is, of course, felt most strongly in their parenting abilities and decisions that extend long after the postpartum period. For example, Cheyney discussed that rather than accepting social standards such as scheduled bottle-feeding and crib sleeping, women may choose to breastfeed on demand, use slings, and co-sleep (2005: 185). Other decisions that they will approach with empowerment may include the type of schooling that will be chosen for their children, the schedule of their children's immunizations, the ways in which they approach their healthcare, and the manner in which they define nutrition. Under the midwifery model of care, messages are communicated to parents that they must actively question standard practices in American

society to fit their own needs, and trust in their ability to make the right decision. Under the medical model of care, however, they are encouraged to unquestioningly accept American standards of society, to surrender their authority and power to those of the institution and technical specialists, and to value machines over nature (Davis-Floyd 2003).

The combination of medical and midwife paradigms under one roof, and with this, the mainstreaming of midwifery, undoubtedly comes with its benefits and downfalls. However, after careful analysis of this combination at NWBC, I have concluded that the particular care provided at this freestanding birthing center provides women with the same empowerment found under homebirth midwifery paradigms. Not only are women empowered through their midwifery care at NWBC, but they learn that one can be a part of an institution or system that may appear mainstream, but still have the ability to challenge core American values that do not align with their personal beliefs and experiences. They can at once challenge a system while working within it. NWBC provides a place of “compromise” for many people, who may not be ready for or trusting of the experience of home birth. It centralizes care under one roof, in a structure familiar to most American women, so that they may receive the benefits of homebirth midwifery practices at the same time that they receive the comforts of medical practice.

Women’s experiences of pregnancy and birth at NWBC were highly positive, empowering, and celebratory. The women were bursting with pride and with such gratitude to have the opportunity to birth on their own terms, and with community support. They expressed no overarching themes of fear or risk, which are often found in

the birthing stories of women using medical and hospital care. Rather, they expressed feelings of trust, contentment, joy, awe, and empowerment. Tiffany talked often of the trust she experienced during pregnancy, labor, and birth and the effect of this:

And it was just very important to me more so than I ever thought it could be, to give birth in the way that I wanted to and to have complete control over it. I don't know I just kind of took complete advantage of the fact that I was being trusted so fully with my birth cause it just felt great. When I saw Toribia, she never had any real doubts in me. It was always just, "If you're confident and you believe then I believe," which is something that someone in my position doesn't really hear very much when it comes to such a physical task as giving birth to your child. So her confidence and trust was really important (February 2008).

Tara stated of her experience, "I felt amazing after giving birth. I was just like, 'Wow! I've never felt so powerful.' I can't really explain it...being able to do that pretty much on my own was amazing" (June 2007). As Tara noted, women at NWBC found their births to be amazing and life-changing experiences.

In fact, they even found them to be pain-free and enjoyable. Erica discussed her preparation for birth as well as her experiences during birth:

There was this idea that birth could potentially be ecstatic. It could potentially be orgasmic and I found this very inspiring and very hopeful.

But I can remember getting to 10 centimeters dilated and just being like, "I can't believe I'm 10 centimeters dilated. This hasn't been difficult yet. It still hasn't been difficult." I was just in a state of disbelief, or not complete disbelief but like, awe. The only part that I'm thinking ever really probably hurt were the 2 pushes when I finally pushed her out. And I don't remember the pain. The body takes care of that. I remember feeling sort of like I was turning inside out and I remember one of the metaphors that was talked about in the book was how a flower opens. It almost gets inside out and that was kind of how I felt but I don't remember it being painful, just feeling like, "Oh God" (July 2007).

Through this Erica realized that the pain she experienced in birthing at the hospital was connected to all the stresses that come with transporting, not knowing the people assisting, and not feeling well-prepared by her prenatal care.

Tiffany also found the pain she experienced at the hospital, despite receiving a full epidural, to be much more difficult than that at her birth center birth. She said, “But that pain that I experienced [at the hospital], I didn’t experience in this labor at all.” She experienced pain, not as pain, but as sensation. “When I had [my first son] I was in excruciating pain. With this birth, I wouldn’t say that at any point I experienced pain. It wasn’t really pain; it was something else. I wouldn’t really say it was pleasurable at all. It was still a very intense experience but it was just different.” Tiffany expressed that the differing environments were what created feelings of pain, as compared to sensation and intensity, and even at one point, as sexual and ecstatic.

The environment of birth and the care of midwives is helpful in shaping a woman’s birth experience, as are her expectations. Because the midwives at NWBC conveyed messages of empowerment and of the amazing potential of birth, it was easier for women to find the positive in their experiences. According to Leona:

I think women don’t even know what their missing out on in terms of their experience. It’s just so in our culture to just go the hospital and not want to feel what’s going on. It’s a way of escaping it. And I think we create our own pain sometimes because it’s so expected. Just the concept of modern midwifery is getting in touch with what we’re made to do and what we can do and believing in that again cause I just think, not just personally, but globally, if more people did midwifery, people’s attitude would change and less people would have such a hard time with having babies (July 2007).

Providing women with this potential and with the empowerment and trust that comes with midwifery practice, are essential to providing women with options, choices, and rights in their reproductive lives. Midwifery, as Leona noted, has the potential to change global perspectives on birth, and with that, perspectives on American ways of living and being. If a freestanding birthing center is a way to reach women that may have never before considered midwifery care, then it is essential that more are created. Despite its seeming contradictions, care such as that provided by NWBC is essential for women, so that they may become empowered and so that they learn to negotiate challenges they are faced with on a daily basis.

I think it is appropriate to close with two quotes from Tiffany that express the ways in which NWBC provides a birthing space that ritually embodies the living out of our everyday lives and relationships with other people.

And my birth is all a representation of our relationship and it kind of was a peak of, like you feel the sensation of every road I've ever traveled in my life has led me to this moment and this place and every decision, every turn that my baby made during pregnancy, it all led me to here (February 2008).

I think birth centers are very important for the community and I hope that this one is around for a very long time and inspires a lot of women to take back their births...If you believe you're going to be in such extraordinary pain that you need an epidural, then you probably are going to be there. But if you believe that you are going to be healed through your birth and that it's going to be pleasurable and you're going to love every contraction then maybe you will and maybe it'll be something that makes you grow. And then you love your baby that much more because not only are they your wonderful baby but they healed you (February 2008).

## APPENDIX GLOSSARY OF ACRONYMS

**CNM: Certified Nurse Midwife:** A medically trained midwife who is required to go to nursing school, and often also has a Master's degree specializing in midwifery. CNMs can practice legally in all 50 states, but their degree of practice and autonomy varies in each state and facility.

**CPM: Certified Professional Midwife:** A midwife who completes educational training and lengthy apprenticeships followed by a national certification exam, in order to gain the professional title of LM or CPM.

**DEM: Direct-Entry Midwife:** A midwife who enters midwifery education without formal nursing training. Generally, a DEM will derive their education through formal schooling, self-study or apprenticeship, and then follow these studies with an apprenticeship where they are practicing under the eyes and guidance of a trained and experienced midwife. The legal status of DEMs varies widely state by state.

**LDEM: Licensed Direct-Entry Midwife:** A midwife who completes educational training and lengthy apprenticeships followed by a national certification exam, in order to gain the professional title of LM or CPM, or in this case, LDEM.

**LM: Licensed Midwife:** A midwife who completes educational training and lengthy apprenticeships followed by a national certification exam, in order to gain the professional title of LM or CPM.

**NARM: North American Registry of Midwives:** An international certification agency whose mission is to establish and administer certification for the credential "Certified Professional Midwife" (CPM). CPM certification validates entry-level knowledge, skills, and experience vital to responsible midwifery practice.

**OB: Obstetrician:** A physician who has successfully completed specialized education and training in the management of pregnancy, labor, and postpartum periods.

**TBA: Traditional Birth Attendant:** A midwife who has little access and need for the technologies of birth, and relies heavily upon traditional midwifery knowledge and wisdom for their practice.

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