# BOSTON BIRTH WORKERS: ADVOCACY DURING THE MATERNITY CARE CRISIS

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ABSTRACT

This ethnographic study follows Greater Boston birth workers to understand the following questions: 1) What do area birth workers see as the problems within the maternity care system? 2) What role does knowledge, i.e. medical vs. alternative knowledge, play in their work? 3) What is their reason for doing this work? 4) How do they go about their work?

In analyzing my ethnographic data, I used theory on discourse, power and knowledge (Foucault 1973; 1971; 1978; 1980), childbirth and authoritative knowledge (Davis-Floyd & Sargent 1997), the commodification of healthcare (Rylko-Bauer & Farmer 2002), and social movement theory, including work on communities of practice (Wenger 1998), reflexive consumption and citizen publicizers (DuPuis 2000) and consciousness-raising (Hooks 2000).

Through this I find that Greater Boston birth workers find fault with the singularity of medical discourse surrounding birth and with the fact that the commodification of healthcare has resulted in lower quality care for marginalized populations, primarily people of color and low socioeconomic status (SES) individuals. Furthermore, Greater Boston birth workers aim to advocate for their clients through the unique discourse about birth which their community has formed. By employing narratives counter to medicalized birth and sharing alternative, experiential knowledge, birth workers allow women to be conscious of the ways the medical maternity system does them a disservice.

## INTRODUCTION

My journey of understanding childbirth in the United States started my first year of college. My immediate roommate and close friend was working to become a doula. Doulas are non-medical professionals who specialize in interventions which mitigate negative birth

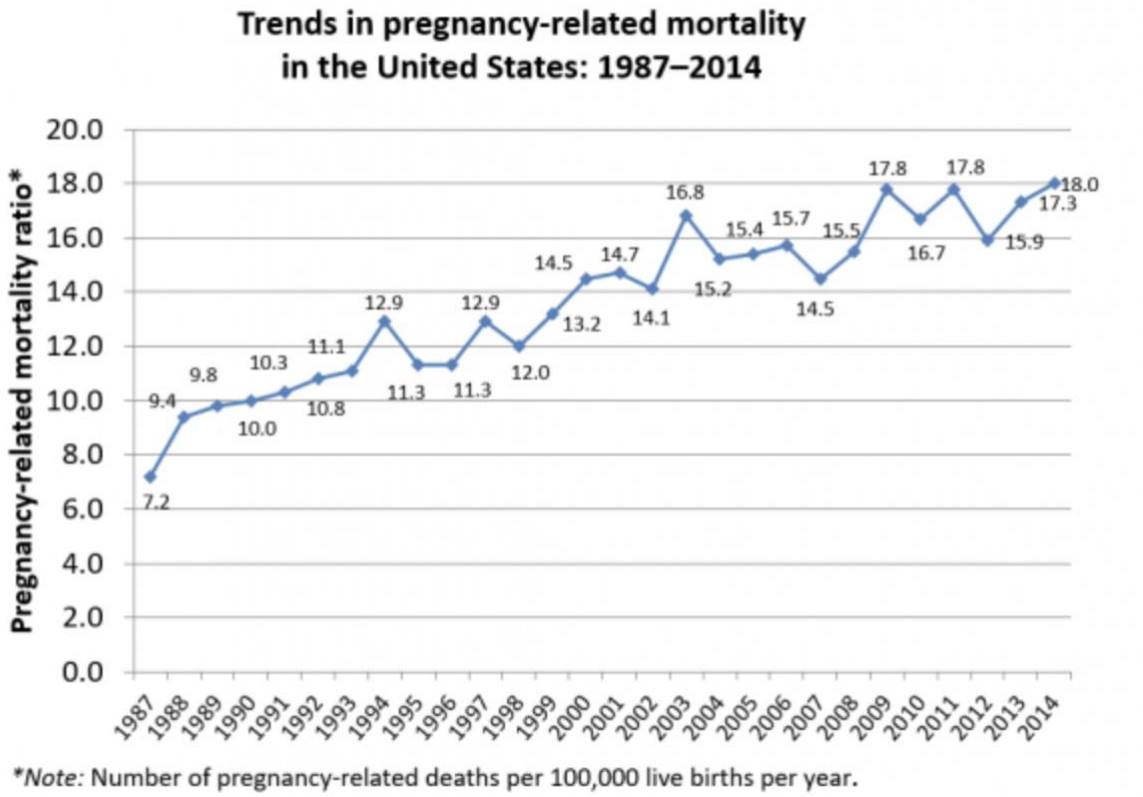
outcomes. They do so by emotionally supporting the well-being of the mother during pregnancy, labor, and the postpartum period (Hunter, Hurst 2016: 10). A doula is a form of woman-to-woman support which gained traction during the 1970's and has since become increasingly popular, spreading throughout the Global North (McLeish, Redshaw 2017: 150). The prevalence, and legitimacy, of birth work was affirmed by the World Health Organization (WHO) in 2016, when they included birth companions as a critical aspect of a safe birth on their "safe childbirth checklist" (World Health Organization: 2015).

As a staunch supporter of women's rights and women's empowerment I loved the idea of woman-to-woman support. However, as an aspiring physician I fully rejected my friend's indictment of hospital births and the medical model of maternity care. She told me that this indictment was the general consensus of the wider community of birth workers, an all-encompassing term used for prenatal doulas, birth doulas, postpartum doulas, childbirth educators, and lactation consultants. My admiration for them was quickly overshadowed by my anger that they didn't have faith in what I understood to be scientific facts and modern medicine.

Over the last four years, including one year of in-depth research on the state of maternity care and Boston-based birth workers, I have come to understand birth workers not as the propagators of lies but as brave women who bear witness to a broken maternity care system.

Around the United States there is increasing awareness about how the medical system is failing pregnant and laboring women. First, there is a clear trend of increasing maternal mortality rate across the U.S. (see Figure 1).

Figure 1:




(Center for Disease Control and Prevention: 2018)

In 2014 the average maternal mortality rate across all women in the U.S. was 17.3/100,000 live births, the worst rate of any developed country (Center for Disease Control and Prevention: 2018). Perhaps even more shocking is the racial disparity of these rates. Between 2011 and 2014 the average maternal mortality rate for white women was 12.4/100,000 live births, while for black women it was 40.0/100,000 live births (Center for Disease Control and Prevention: 2018). This means that black women are three to four times more likely to die from pregnancy than white women. This demonstrates not only that the maternity care system is

failing women, but it is failing some more than others. To put it bluntly, the most odious effects of racism in healthcare are being demonstrated in the maternity wards.

Furthermore, even when laboring mothers live and give birth to a healthy child, they too often suffer from traumatic experiences during labor. These experiences have been coined with the term obstetric violence, and while it hasn't been written into U.S. law, it has been acknowledged as a reality by the American College of Obstetricians and Gynecologists (ACOG) (Tucker 2018). In 2016, the ACOG released a document called the "Refusal of Medically Recommended Treatment During Pregnancy" to serve as a guideline for physicians to navigate when women's opinions about treatment plans differ from theirs (American College of Obstetricians and Gynecologists 2016). The ACOG understands that these cases "raise profoundly important issues of patient rights, respect for autonomy, violations of bodily integrity, power differential and gender inequality" (American College of Obstetricians and Gynecologists 2016: 1). While their acknowledgment is a step in the right direction, it does not mention race or ethnicity. This is evidence of a clear lack of intersectional thinking on the part of the ACOG. Despite the shocking racial disparities, medical institutions, such as the ACOG, and subsequently, providers, do not acknowledge that the marginalization of women of color directly affects their medical care. Furthermore, its language is not deterrent enough for the current state of maternity care. It only "discourages" the "duress, manipulation, coercion, physical force, or threats, including threats to involve the courts or child protective services to motivate women toward a specific clinical decision" (American College of Obstetricians and Gynecologists 2016: 2).

Birth workers bear witness to these occurrences. Part of the gender inequality which the ACOG references, above, also takes place in the context of caregiving during birth. Support

people during childbirth were historically women until the paradigm shift of the 1920's (Hunter, Hurst 2016: 4). With a shift towards hospital births, and the beginning of obstetrics as a profession, women present at birth became increasingly rare. Despite the fact that every obstetric patient is a woman, women providers or support were no longer were welcome in this social space. Over the 20th century it became clear that something critical had been lost from the birthing process, and women started to become involved once more, with support roles during labor.

This project aims to explore the reasons for the necessity of woman-to-woman support, as well as to understand the community of birth workers in the Greater Boston area. Hunter and Hurst explain it best when they say that, at its most basic, woman-to-woman support is standing together in shared experience and endorsing each other's autonomy by encouraging each woman's freedom to choose what she wishes for her body (2016: 115).

Through interviewing birth workers and spending time with their communities in the Greater Boston area my project moved to understand the following questions: 1) What do area birth workers see as the problems within the maternity care system? 2) What role does knowledge, i.e. medical vs. alternative knowledge, play in their work? 3) What is their reason for doing this work? 4) How do they go about their work?

This paper is broken into two main sections. Part One delineates the problems birth workers have witnessed in the Greater Boston maternity care system. Part Two focuses on their work to combat these issues.

## METHODS

In order to answer these questions, I spent seven months involved in the Greater Boston birth worker community. Over the course of these months, I was welcomed into online Facebook groups, invited to various meetings, and conducted eleven semi-structured interviews. During this time, I also studied other works on the topic and stayed up-to-date with current issues of maternity care in the news.

I first made contact with the community through a friend who is a certified doula and college student. She was able to add me to online groups and put me in contact with her colleagues and mentors. I then used snowball sampling to reach out to birth workers to request interviews or visit meetings they were facilitating. These included various "Meet the Doula" gatherings, the Northshore Meet-Up, and Boston area La Leche League meetings

The interviews were held with women aged 24 to 60. All participants were certified doulas. Some were also certified professional midwives, registered nurses, lactation consultants or were in the process of becoming certified nurse midwives. I followed the protocol given to me by the institutional review board (IRB). I obtained informed consent verbally prior to each interview. Each interviewee was given an overview of my project and the opportunity to ask any questions they may have. The interviews were conducted either in person or on the phone and lasted between one and two hours. While I audio recorded one interview, the others were recorded via note-taking. In accordance with IRB protocol, the audio recording was transcribed and then deleted from my computer. All interviewees provided their contact information for follow-up questions and interviews, which I did in several cases.

Each semi-structured interview utilized similar prompts in order to guide the conversation. These prompts included: 1) asking for a short biography; 2) inquiring about how

they got involved in birth work; 3) inquiring as to whether they believe what they have seen of maternity care is problematic and, if yes, in what ways; 4) inquiring about the nature of their typical client services, and its impact on their clients' birth experiences and; 5) inquiring about their beliefs in what the current maternity system needs.

When attending meetings, I observed the meetings and took notes but did not actively participate in the conversation. These meetings were primarily used as a means of making personal connections to members of the community and understanding how engaging in a community of practice affects the individual's work.

## MEET THE DOULAS

In the following section I introduce the birth workers who made this project possible. Their names and details regarding their personal lives have been changed to protect their privacy and maintain their relationships with medical institutions and providers.

Suzanne was my first interview subject. Our interview took place in a coffee shop in Brighton, MA. I had been connected to Suzanne through my college roommate who had met her at a rebozo workshop. Rebozos are a traditional Mexican textile, resembling a large scarf, which started being used by Mexican midwives during labor support and have become widespread among birth workers globally.

Suzanne entered the coffee shop wearing a long tunic and colorful leggings. She was Caucasian, late 30s, with a small frame, curly brown hair, glasses and a warm smile. Her appearance matched my own imaginary criteria for what I expected from a professional doula, but I quickly refocused, trying to rid myself of preconceived notions about what 'type' of people did this work. She quickly proved my foolish presumptions about doulas wrong when she started her introduction explaining how she has a doctorate in chemistry and worked in the world of

academia and scientific research for over 12 years. The aspiring physician within me immediately lit up, curious to find out how she merged her birth work with her professional past. She explained that she realized her career in academia was no longer fulfilling and did not make her happy, which I would come to find as a trend among the community. Her dissatisfaction with her career coincided with a monumental and exciting change in her life, her first child. She birthed her daughter at home and she cited that as the inspiration and final push for her to leave her life as a chemist and join the birth work community. She acknowledged her immense privilege in being able to leave her job to pursue her passion. She used her newfound freedom to take a doula training through a national organization which facilitates local trainings. Furthermore, she explained how the skills she gained through scientific research allowed her to stay up-to-date with the state of the field in the world of labor and delivery, prenatal recommendations, and postpartum strategies.

Three years after her doula certification, Suzanne tells me that birth work is her full-time job; she does four to six births per month. In addition to this she takes on as many volunteer births as she can through a volunteer program catered to adolescent reproductive health at a Boston area hospital.

Jordan is in her late thirties and has been practicing birth work for about ten years. Before finding her calling in birth work Jordan was a pediatric nurse for fourteen years. After moving to Boston in 2009, she decided she would take a break from nursing and figure out what she truly wanted to do. While she "stepped away from healthcare and the medical model very deliberately because [she] was not comfortable working within the system anymore," Jordan still wanted to find a way to stay connected to the medical community. She also knew that she wanted to stay involved with working for others in a way that engaged her passion for "advocating for human

rights, agency and autonomy." Jordan described her discovery of birth work as a moment when "the stars aligned." A close friend told Jordan that she was doing "radical doula work" and encouraged Jordan to look into it. At this point Jordan had no idea what a doula did, nor did she have any intention at this point of getting married or having children of her own. Regardless, Jordan signed up for a training with a local chapter of "To Labor", a national organization that focuses on birth work through a social justice lens. She had a "phenomenal" experience with her training, attended a few births and "was hooked. [She] knew this is where [she] wanted to be."

Jo is a 52-year-old certified professional midwife (CPM) and birth doula. She thinks she might be the oldest practicing doula and midwife in Massachusetts, so it's hard to believe she had an entire career before she started this work. She has both bachelor's and master's degrees in business and worked in human resources for fifteen years. Like many women who find birth work, she turned toward it after the birth of her first child in 1995. Inspired by Ina May Gaskin, she wanted to have her son at home but was told that wouldn't be possible. Her hospital birth took place at thirty-five weeks and a third-degree episiotomy was performed. She now recognizes this event as proof that medical evidence and protocol change; this would not happen now. After the birth of her son she suffered from terrible postpartum depression and although she was able to work full-time she realized that she could not work in human resources forever.

Inspired by the home births her friends had, Jo had her daughter at home with a midwife in 1999. She cites that as the moment she decided definitively that she "couldn't go back to corporate America and would become a home birth midwife." Her first step in this journey was to attend a training through Doulas of North America (DONA) and begin her work towards being a certified professional midwife. She has now been a doula and midwife for over eighteen

years and attended over 800 births. Jo is also the president of the Massachusetts Midwives Association and earned her degree as a Registered Nurse (RN) four years ago.

Sarah, at age twenty-four, is the youngest doula I interviewed. She was mentored by Jo, described above. Originally from Rhode Island, Sarah moved to Massachusetts for college. She attended Clark University in Worcester, MA, where she was a double major in psychology and biology. Birth and maternal care first piqued her interest during her senior year when she was a research assistant for a psychology professor doing a study on postpartum depression in racially and socioeconomically diverse families. Sarah described listening to the interviews as "eye opening," and said that until then she had never heard women talk so openly about their experience with birth. These interviews were also when Sarah heard the word "doula" for the first time, which inspired her to learn more about the work they do. She had worked for a student sexual health group, which had focused on feminist and reproductive justice-based goals, but she described learning about birth work as a "beautiful 'aha!' moment." Sarah realized that birth work was the way in which all of these passions could form a career. She reached out to Jo, a matriarch in the Massachusetts birth community. Jo talked to her about birth work and invited her along to a few prenatal meetings where Sarah "fell in love."

Robin is a middle-aged woman who spent much of her adult life dedicated to being a full-time mother. However, since her children are now grown she has refocused her efforts on helping other mothers. She is a birth doula and a certified lactation consultant. She leads a La Leche league on the North Shore, a free group for new moms to come together and discuss breastfeeding, voice concerns, and be together in a community experiencing new motherhood together.

Alyssa is a fairly new doula who fell into birth work during her personal research about pregnancy. She graduated from college with a degree in interior design and entered the corporate world shortly thereafter. She eventually worked in sales, which "didn't feel good on the soul." As she continued at her company Alyssa realized that they were very unsupportive of families, particularly of female employees of child-bearing age. When Alyssa was passed up for a promotion, and the company chose a man with little experience in her department, she decided to pursue starting a family and changing her career.

These life changes ended up coinciding as Alyssa got pregnant only a few months after taking her doula training through DONA. She herself was pregnant during her first birth, and after only three births she had to stop to focus on her own birth experience and taking care of her newborn. When I spoke with Alyssa her son was eight months old and she was just preparing to start taking births again.

Abigail is a middle-aged mother of four from the suburbs of Boston. She has always been passionate about children and has spent many of her working years as the director of an early child education center for the Army while her husband served. At her most busy stage she oversaw more than twenty staff members and was responsible for almost one hundred and thirty children. After his discharge they moved to Massachusetts and she continued her work in education until she had her third child and decided to dedicate more time to her family. As they got older she recognized her newfound free time and started looking into options to fill it. She knew didn't want to take on the responsibility of early child education and said, "I always thought I'd be a great doula but never really got motivated or had time."

Like many doulas, much of Abigail's interest in this work started when she had her own children. While she expected to be much more actively involved in decision making during her

own births, once she experienced labor she realized the vulnerability of the process. "Every few minutes, seconds depending on where you are in labor, you experience a contraction and that's all you can focus on." In these moments the process takes over all aspects of existence, she states, asserting that it is hard to feel autonomy over oneself. However, Abigail recognized her immensely privileged experience: she was white, older, and in a loving marriage. Also, unlike some of her fellow Army mothers, she was fortunate enough to have her husband present and supporting at each of her births. Despite all of these factors, she still found labor to be one of the hardest things she has ever done. She also recognized that something was missing from the experience. Abigail attributes much of this feeling to a lack of support from somebody emotionally uninvolved in the birth. While partners are a wonderful source of love and connection during labor, they are "so wrapped up in the mother's emotion and pain, and they too are experiencing so much emotion it is very hard for them to detach themselves and be fully present to make suggestions and give care." She saw this in her own births and realized her husband was having an experience of his own and was under a lot of pressure to talk her through something he had never experienced. This realization inspired her to get involved with other women's births, ranging from women as fortunate as herself to women who have no resources, economically, and emotionally. Abigail committed herself to find a training. She soon had been trained to be a birth doula, a postpartum doula and had taken breastfeeding training.

Hailee is a full-time graduate student studying divinity and social work at a local university. Hailee is queer and non-binary and uses the pronouns they/them. Hailee identifies as "very femme." During college Hailee volunteered with Planned Parenthood "as a cool feminist thing to do." This exploration of the world of reproductive justice led Hailee to meeting a radical doula for the first time at a queer conference.

Hailee entered the world of support work in Washington, DC directly after graduating from college. There Hailee offered support for miscarriages and abortions. Most of Hailee's colleagues were also part of the DC Doula Support Collective, which had birth workers from the District of Columbia, Virginia and Maryland. Through Hailee's work in DC, they became well versed with a model of full spectrum support. This includes prenatal, labor, abortion and miscarriage, and loss. After spending two years working in DC, Hailee moved to Boston to start graduate school and became involved with a Boston-area abortion support collective. Like the DC collective, this group also had many birth workers, and during their time with the group Hailee was introduced to another community of like-minded people, heard about birth worker training and started to seriously consider pursuing it. Hailee completed training and attended four births this past year.

Terri is about thirty years old and a mother of two. She lives in a Boston suburb and recognizes herself as "one of the only black doulas in the area." She has been a doula for about two years and previously was a cosmetologist. She fell into birth work naturally as a self-described "baby lady." She does not attribute her work to personally having a negative birth experience but she "has heard horror stories." She knew that she wanted to help mothers have the best births possible in whatever circumstance they found themselves but was not interested in any medical work.

She "entered the work hopeful and very idealistic, expecting great kumbaya moments and every birth to be this great feel-good moment." However, like most doulas, she was quickly met with disenchantment. As her journey into the world of birth continued, she realized that "infant and maternal mortality rates are abysmal, especially for black women." Terri realized that far too many women were dying and realized that this work was much more serious than she had

originally thought. Since then her work has shifted. She describes herself as a "serial learner" who started attending as many conferences as were available and became obsessed with understanding what is happening in our maternity system.

Nicki is a thirty-six-year-old, white, and a mother of four who has lived on the North Shore of Massachusetts her entire life. She is a self-described "serial volunteer" and tries to stay active in her community. She grew up in the same town she lives in now, and never attended college. When she was twenty-three years old she became involved in birth work, and now has been involved in the birth world for thirteen years. She "felt the call to action" after being present for many of the births of her friends' children.

Finally, Judith is in her mid-thirties and has a five-year-old son. She says that much of her inspiration and passion for birth came from her own birth mentor, her older sister. Judith says that her sister repeatedly told her that "birth is not a medical case to be solved." This resonated with Judith and she decided to give birth at a birth center. She describes her birth as "a powerful and awesome experience" and attributes this to her sister giving her a "great birth culture mindset." She realized her passion about birth was something she wanted to pursue in a professional sense. She trained as a doula with the popular workshop organization To Labor. She has kept her previous career as an education researcher, where she evaluates school programs and curriculum. Additionally, she usually takes on two births per month.

In order to analyze the work that these women take part in, I will use the sociological theory outlined in following section.

# LITERATURE REVIEW

Whether they see it as a crisis in maternity care or a process during which women need more support, these birth workers see their work as a calling to advocate for the needs of women. This advocacy takes different forms, but each center around the distribution of information among women. They do so differently, towards different ends, and motivated by different factors. Ultimately, however, their tool, tactic and weapon are sharing knowledge.

Knowledge, both in its construction and transmission, must be examined within the social context in which it exists. This project looks at birth workers' propagation of different forms of knowledge. This knowledge is mostly an alternative to the mainstream medical narratives about pregnancy and birth. The information ranges from indictments of doctors and the medical model, to personal birth experiences, to strategies to create and adhere to women's birth plans. Birth workers bring their own sets of knowledge to client relationships and to the Greater Boston birth worker community. Their knowledge is influenced in part by aspects of their identity, such as race, gender, religion, and socioeconomic status. Other influencing factors are their community involvement, education level, upbringing, and their personal relationship to medical institutions and hegemonic society at large.

## *Knowledge as a social force*

To understand these individuals' work, it is first necessary to explore knowledge as a social force. The production and spread of knowledge can be understood through Michel Foucault's concept of discourse. He uses this term to refer to language used to produce knowledge about a certain topic (Hall 1997: 29). In his piece "Foucault: Power, Knowledge and Discourse," Hall explains discourse as a "system of representation" which constructs

"meaningful practice" (Hall 1997: 29). Foucault's *The Birth of the Clinic* delineates a "discursive shift change" (Hall 1997: 31) in medical practice which connected directly to his ideas about knowledge being the product of institutional power, particularly over the body (Hall 1997: 38). Perhaps the most important point to understand about Foucault's concept of discourse is that the knowledge it constructs is always directly affected by historical and cultural context. Furthermore, the social hierarchy of a given time or social space affects the application and efficacy of knowledge as well (Hall 1997: 49), regardless of "truth."

Foucault (1980) explains it best, saying:

> truth isn't outside power .... truth is a thing of this world; it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its 'general politics' of truth; that is, the types of discourse which it accepts and makes function as true, the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned ... the status of those who are charged with saying what counts as true. (P. 131)

Foucault's understanding of truth explains that discourse backed by power presents itself to be knowledge of unequivocal fact. Foucault believes this presentation to be false and understands that truth operates this way because of what he sees as "dissymmetry" (Foucault 1971: 18) of discourse. This means that those in power are able to impact discourse in a way that continually benefits themselves, their social group, and the institutions to which they belong.

Foucault describes the space of medicine as one of unspoken discourse and assumptions, rather than just a "confrontation of a gaze...or a glance and a silent body...with the calculated addition of reasoning…the general form of all scientific observation" (Foucault 1973: xv). Medicine is a place where what is visible is often the only representation to the lived experience. When there is no visual, Foucault states the physician is the interpreter of the "whole relationship

of signifier to signified" (Foucault 1973: xv*)*. This means that the physician becomes the sole translator of the reported embodied experience of the patient to scientific truth. That is the power that medical practitioners hold. That is the power they use to create widely accepted knowledge about individuals' bodies. This "knowledge-power [is] an agent of transformation of human life" (143).

Foucault understands modern medicine to be the first time which "biological existence was reflected in political existence" (Foucault 1978: 142). This means that the way your body operates, and is treated, is inextricably linked to your place in political society. This is due to the fact that medicine holds "bio-power" (Foucault 1978: 140), in its "calculated management of life" (Foucault 1978: 140). Medicine as a social institution thus has the "power to foster life or disallow it" (Foucault 1978: 138).

Brigitte Jordan, the late anthropologist whose work focused predominantly on birth, sees this "bio-power" implemented through physician's possessing authoritative knowledge. She describes authoritative knowledge as the phenomenon that "for any particular domain, several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better...or because they are associated with a stronger power base (structural superiority)" (Davis-Floyd & Sargent 1997: 57). She points out that while one system of knowledge is legitimized, another must be deemed less legitimate, and she calls upon Etienne Wenger to explain that "the constitution of authoritative knowledge is an ongoing social process that both builds and reflects power relationships within a community of practice" (Davis-Floyd & Sargent 1997: 57). Jordan sees authoritative knowledge as the direct result of "the devaluation of nonauthoritative knowledge systems" (Davis-Floyd & Sargent 1997: 57), generating "hierarchical knowledge structures" (Davis-Floyd & Sargent 1997: 57). She also

explains that due to Bourdieu's theory of misrecognition, which states that people will misconstrue the socially constructed as naturally occurring and logical, "people actively and unselfconsciously engaged in its [authoritative knowledge] routine production and reproduction" (Davis-Floyd & Sargent 1997: 58). This means that while authoritative knowledge is the product of those in power, many take it to be sensical and innate and therefore gladly propagate it without any analyses of its production. Jordan explains that when "persons in positions of authority are members of a community of practice they will share the local version of authoritative knowledge." (Davis-Floyd & Sargent 1997: 58). She then uses this to explore "why and how it was the case that women's knowledge didn't count while medical knowledge carried the day (Davis-Floyd & Sargent 1997: 59).

Jordan's theory of authoritative knowledge, particularly in the context of women's healthcare, grounds the work that the Greater Boston birth workers community is doing. Their work actively dismantles the authoritative knowledge which is constantly being reified and "interactionally grounded" (Davis-Floyd & Sargent 1997: 58). By refusing to act in adherence to the hegemonic power structure and by spreading their own alternative knowledge. They work to break what Davis-Floyd's and Sargent's collection, *Childbirth and Authoritative Knowledge,* calls "biomedical hegemony."

Nonauthoritative or alternative knowledge is that which falls outside of the accepted production and reproduction of knowledge. In the context of birth, those who possess alternative knowledge are midwives, birth workers, and the women laboring (Davis-Floyd & Sargent 1997: 59-61). Jordan explains that in American hospital births, knowledge such as "woman's prior experience and knowledge she has of the state of her body [is] nonmedical and is devalued by all participants, usually including the woman herself" (Davis-Floyd & Sargent 1997: 61).

*Consciousness-raising*

Another way of understanding alternative knowledge, its transmission, and its outcomes is to explore its cultivation and its relationship to consciousness-raising. Consciousness-raising, an activism tool to make individuals more aware about a social justice issue, was originally utilized during second wave feminism (Norman 2006: 38), a movement that is generally thought of as white-washed. It was also adopted by intersectional feminist thinkers such as Bell Hooks. Hooks, in her book *Feminism is For Everybody,* dedicates a number of pages to the process and efficacy of consciousness-raising. She explains that "consciousness-raising emphasized the importance of learning about the patriarchy as a system of domination how it became institutionalized and how it is perpetuated and maintained." (Hooks 2000: 7). It was the process of women helping to make each other aware of how their oppression operated. It also created a space, usually someone's home, where women could share their experiences, voice their discomforts, and come to the realization that what they were facing was much more far reaching than an individual problem. It was systemic. Hooks reiterates that this was done through simple communication and dialogue among women who did not have a academic or authoritative space for their burgeoning feminist theory (Hooks 2000: 8-9). This is important to note as it ties back to the idea that authoritative knowledge can only be produced by those with in power. These women, therefore, whose understanding of the world was seen as alternative knowledge at best, turned to transmitting knowledge not through academia or other institutionalized forms of discourse but rather in their backyards and living rooms.

Consciousness-raising groups fueled the activism by an inward focus on women supporting each other, regardless of class, race, religion etc., and therefore fostered the group members' confrontation of their own prejudices and internalized sexism (Hooks 2000: 10).

Borne from these groups was a capacity for intersectional thinking, as long as they were made up of women from diverse backgrounds. Hooks notes that with the movement away from radical feminism towards a "lifestyle-based feminism" (Hooks 2000: 11), a term she uses to describe the idea that any woman can be a feminist regardless of her beliefs, there was a loss of the original meaning of a "politicized sisterhood" (Hooks 2000: 11). With this loss came the fragmentation of the movement. Subsequently, consciousness-raising groups moved away from inclusion, radical thought and intersectional thinking, eventually no longer serving their original purpose. Hooks believes that activism will be renewed when "consciousness-raising groups... take place in communities, offering the message of feminist thinking to everyone irrespective of class, race, or gender" (Hooks 2000:11).

It is critical to note that while Hooks believed consciousness-raising, as a tool for activism through the spread of knowledge, is effective for the feminist movement, it is also effective for any movement founded upon the alternative knowledge of a marginalized group.

*Communities of practice*

Another way of understanding groups centered around producing and distributing knowledge is through what Etienne Wenger calls a community practice. He writes, "communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger 1998: 4). Under this definition, consciousness-raising groups and other groups of advocacy or activism would be considered communities of practice. Wenger explains that these groups of people start out as tied together by navigating a certain subject together, and eventually form "common knowledge, practices and approaches" (Wenger 1998: 5)

which they can then transmit to others. Wenger claims that communities of practice were "our first knowledge-based social structure, back when we lived in caves" (5) but have since changed. While knowledge still structures social organization, the society which it shapes is different. Knowledge is therefore known as an asset, "managed" (Wenger 1998: 5) by profit driven entities -- what Wenger calls the "knowledge economy" (1998: 7). This means that rather than knowledge being used as a collaborative force for the good of the many, knowledge is manipulated -- picked and chosen -- for the benefit of the few. Knowledge is not produced by, nor distributed to, those who don't have stake in the market. It is truly an asset of the market holders. This is important because it ties into what knowledge is deemed authoritative and reminds us that we must question who produced this knowledge and what stake they have in its propagation. Furthermore, because knowledge -- deemed authoritative or nonauthoritative -- is the foundation of communities of practice, they too are subjected to this binary.

*Medicine as a commodity*

There are nonetheless examples of social movements started by consumers -- those outside the market -- who do not possess authoritative knowledge as an asset. For example, Melanie DuPuis writes about the 'not in my body' (NIMB) movement, in which "consumers participate in the formation of the industry through a process of 'reflexive consumption'" (DuPuis 2000: 285). Reflexive consumption means that consumers can shape the service or product they receive through their positive or negative responses to the producer.
Using some consciousness-raising strategies, this movement relies for example on spreading a discourse of beliefs about the effect of growth hormones in dairy. DuPuis describes this movement as one of "contested knowledge" (2000: 290), in which the scientific community is

not in agreement that growth hormones introduce risk to the consumer. Rather, it is a risk put forward by "citizen publicizers" (DuPuis 2000: 290). This spread of alternative knowledge, not backed by the scientific community, as the basis for "reflexive consumption" is not limited to controlling growth hormones in food but is an activism technique that can be seen in other markets exerting control over consumers' bodies.

Similar commodification of bodies, and everyday bodily functions such as eating, even more gravely impacts individuals when it is seen in healthcare. In a piece called "Managed Care or Managed Inequalities? Critiques of Market-Based Medicine," anthropologist Barbara Rylko-Bauer and anthropologist, physician, and humanitarian Paul Farmer argue that medical care in the United States is more concerned with profit than "access or quality of care" (2002: 386). Like DuPuis, they also focus on consumers at odds with the scientific community in this market. Medicine is subjected to "market ideology and corporate structure" (Rylko-Bauer & Farmer 2002: 387). Rylko-Bauer and Farmer find that from the 1980s to the early 2000s, discussions about healthcare have centered around economics (2002: 387). They delineate the clear connection between market-based medical practices rooted in capitalist tactics, such as "competitive market principles" (Rylko-Bauer & Farmer 2002: 388) and "commercialization and commodification" (Rylko-Bauer & Farmer 2002: 388), and increased healthcare inequality. They explain that genuine care for patients has been replaced by "selling a 'product' to 'consumers'" (Rylko-Bauer & Farmer 2002: 389). Simply put, commodifying medicine means that, as with any other product, those with the most economic capital can procure the highest quality product. This is evidenced by the fact that the healthcare inequality directly mirrors society's other inequalities, including income, criminal justice and education (Rylko-Bauer & Farmer 2002: 389). This is the reason why "despite the huge amount spent on medical care, the United States

ranks low on many health indicators...when compared to countries which spend much less" (Rylko-Bauer & Farmer 2002: 389). Unfortunately, unlike DuPuis' consumers, the consumers of low-quality market-based healthcare are often marginalized populations, meaning they do not wield the power to practice "reflexive consumption", in this life or death matter. That being said, having a doulas present, with their wealth of knowledge about medicalized birth and medical institutions, the access to the "reflexive consumption" becomes more equal.

These aspects of marginalization factors are referred to as "structural violence" by Rylko-Bauer and Farmer, poverty, racism, sexism, violence, homeless, domestic abuse, etc., as the most salient factors in reforming healthcare inequality (Rylko-Bauer & Farmer 2002: 480). Improving healthcare disparities in the United State is more than needed access to doctors, but rather access to a holistically higher quality of life. In short, Rylko-Bauer and Farmer see healthcare inequality as being fixed only by a larger societal overhaul in which inequality is tackled at its roots.

## PART I: DEFINING THE CRISIS

### *Medicalization of Birth: The Medical Model*

The medical field is a particularly strong manufacturer of authoritative knowledge. Public sentiments towards medical claims are generally that they are undeniably factual. However, many doulas push back against this with their own indictment of the medicalization of birth. Medicalization is a "process whereby more and more of everyday life has come under medical dominion, influence and supervision" (Conrad 1992: 210). Central to medicalization is the idea that medicine is being used to "treat" something that has historically been considered part of a natural part of human life, in this case birth. Until about the 1920s, childbirth in the United States was considered to be a natural process, not a medical procedure (Hunter, Hurst 2016:4).

However, by the 1950s approximately 95 percent of births occurred in the hospital. Dr. Marsden Wagner, the former director of women's and children's health at the WHO, see medicalization as the antithesis of humanization (*The Business of Being Born* 2008). Many birth workers reflect Wagner's view: to be in the medical model is to be outside of humanized interactions.

Robin, a middle-aged, white woman, spent most of her adult life being a fulltime mother. She first became involved in birth work after a personally negative experience with the medical model of care. During her first pregnancy and experience with prenatal care she quickly felt as though the medical practice was impersonal and frankly uninterested in her pregnancy. Her first scheduled ultrasound visit was cancelled with only an hour's notice because the doctor decided to take an impromptu vacation. This despite Robin having explicitly expressed her anxiety and excitement about this visit. She felt pushed aside and unimportant to her physician and decided that day to go in another direction. Robin had heard of a birth center in rural central Massachusetts and took a leap of faith. She recognizes that she had her own doubts about midwifery, and at that point in her life had never interacted with midwives. She says she expected them to "pop out of the woods like witches." While Robin acknowledges that midwives sometimes do have that quirky side, she also said the midwifery model of care is like "flying first class versus coach. They get to know you, you see them as frequently as you would like and they are there with you from conception well into your fourth trimester. Some can even take you on as a regular patient for well woman checks."

For Robin, and many women, her dislike of the medical model of care comes down to the lack of personal concern for individual bodies. This, in turn, stems from a basic dehumanization she believes takes place in these institutions. Robin says that one critical aspect of this dehumanization is the societal myth that giving birth is inherently a terrifying, painful and

generally horrific experience. This strips away the belief that birthing women can conquer birth and be the masters of their experience with any external help. Robin believes, "This is what our bodies are made to do, it is written into our DNA, our bodies know more about birth than our brain, or anyone's brain." According to Robin, much of the problem lies in the fact that women are never taught this.

This is because of what Bridgitte Jordan calls a "devaluation of non-authoritative knowledge" (Davis-Floyd & Sargent 1997: 57). This means that any narratives about women being able to conquer birth with autonomy are not valued and trusted. Therefore, the birth workers with whom I spoke sat that spoke state their clients often have been aught that labor is going to be such an unmanageable process that they should hand over their control to a physician before it even begins. This handing over of power allows for their own dehumanization. Robin strongly indicts the physicians for possessing a "god complex" and for embracing the fear of laboring women as an opportunity to completely control the labor process. "It creates the opportunity for them to say 'just let us do it' or 'don't worry, honey, we'll take care of it'". In those moments, when mothers are terrified and in pain, they quickly hand over the power to make their own decisions and dictate their births. This is exactly the "bio-power" (Foucault 1978: 140) which Foucault refers to. It is control over human bodies due to a certain social context. Robin notes that much of the language used in these medicalized moments are paternalistic in nature. While she recognizes that obstetrics is one of the medical fields which women are seen more frequently, much of the "arrogance of masculine, medical knowledge" is ingrained in them as well. Robin sees this arrogance as the culprit for the medical model denying the validity expertise of midwives and doulas. Additionally, she believes the medical model strips laboring women of knowledge about their own bodies. Both these results of the medical

model stem from its being a system of knowledge which has everything to do with what is observable, what the obstetrician can tangibly measure -- for example fetal and maternal heart rates, and cervical dilation. When childbirth is only understood through these empirical measures, it is redefined by an external observer. This is what Foucault refers to when he states that medicine is too often the "confrontation of a gaze...and a silent body," (Foucault 1973: xv) rather than an interactional process where the patient has an active role in their treatment. This silencing of the body is due to the medical model's principle that the patients has to report about their body is a moot point compared to physicians' diagnostic gaze.

With this redefinition, the laborer's voice of legitimacy is lost. Because the medical model is dictated by such scientific measurements, intangibles such as the trauma-embodied experience of the woman are deemed neither important to, nor helpful for, the delivery of a healthy baby. This dehumanization of the mother takes place within this model of birth because medical professionals understand the mark of a successful birth to be the production of a healthy baby. Robin states that "once pregnancy starts, and especially once labor starts, healthcare shifts increasingly, and ultimately solely, toward the mother." With the ultimate goal being the healthy birth of a child, the mother's experience, comfort, opinion and bodily knowledge are ignored and she becomes dehumanized -- a mere mechanism of production.

The dehumanization, and subsequent disregard for the mother's lived experience during labor, can have lethal consequences. Nicki, a 30-year-old birth worker from the North Shore, remembers such a time:

> Everyone was paying attention to the baby about to arrive and the monitors. Nobody had looked at my friend in minutes. There were probably twenty different people in and out during this labor, and so much going on, and no one even looked at her. She was really hot, I mean sweating a ton and she kept telling the nurses this over and over. Each time she was ignored, and told it was just because she was working so hard to push out her baby. No one was listening. So, I just

> took the thermometer right off the wall and took her temperature. It was 103.5 degrees and I showed it to the nurses. It turns out that she had a severe infection and my friend nearly lost her life.

In this example, the woman's own understanding and expression of what her body felt like and needed was considered devalued knowledge and thus ignored by the medical providers. The disregard for the women's embodied knowledge can be explained by Jordan's understanding of medical protocol being subject to "hierarchical knowledge structures" (Davis-Floyd & Sargent 1997: 57). In this hierarchical structure, the medical provider's knowledge is paramount and women's experiential knowledge is not considered valid. This is how "bio-power" (Foucault 1978: 140) operates.

Nicki saw this dehumanization of a woman at the hands of the medical community in that labor and delivery room. She realized that women supporting each other during birth could not only could help avoid their dehumanization, but also literally save lives.

For Nicki, the issue was not the medical providers, but the institutionalized medical model of care. Her main concern is that the medical model and the gynecological revolution "took birth from humans and women and made it into something that happens to you, that you have to get over." Nicki believes this disempowers parents at birth, which is the "first step in a million-mile journey". Parents are made to believe they have no active role in the birth and the decisions surrounding the birth; thus, they are not trusted in their first step of parenting. She knows that when her client first signs into the hospital, she loses her autonomy. "She signs a paper that says physicians can do whatever they want, and in a case of emergency do not need to ask." While many doulas focus on this downside to the medical model, because it has the potential to lead to violations of their clients' rights and bodies, Nicki believes it ought not be the focus from a feminist perspective. Rather than focus on the unfair treatment of women, Nicki

takes issue with the how the medical model impacts the family unit. “If the goal is to make strong parents, and we’re taking their choices away before they can even make them, we are not putting much confidence in them about their ability to parent.”

She also asserts that the medical model of care is very reductionist. Nicki understands that medicine is needed in order to “keep everyone alive,” but does not accept that this must come at the expense of happiness. “They can be alive and happy and doulas are the other part to that equation.” This speaks to the maternity cases which have “healthy” outcomes for the mother and child but are subject to negative, or even traumatic experiences. She recognizes the difficulty of not getting jaded in this work because “as with anything [she] sees the ugly” of the medical model first hand. “The medical field is slow to change, because it’s concrete, it’s science,” she concedes. This is because science is taken as the only legitimate discourse surrounding issues of the body. Yet she says she has seen some change during her thirteen years.

Alyssa, a white woman and new mother, echoes Nicki’s sentiment that this is an institutional issue rather than a personal failing on the part of the physicians. Alyssa’s husband is a primary care physician in the Greater Boston area and she recognizes the duality of the medical model. While she truly believes that those working in medicine are there because they love and care about people, she also sees a system that isn’t always set up for them to perform the best care. Her husband, for example, is required to see a certain number of patients per day, which is not uncommon in medical practices. While this seems fairly innocuous, it is evidence of the way in which medical care is a business; often times patients are simply the means for profit. Alyssa’s understanding that physicians are often not put into a place to successfully treat patients with equality is backed by Rylko-Bauer and Farmer. They do not place blame for healthcare inequality, both access and quality of care, on individual physicians but rather on the healthcare

system being swallowed by capitalism. They argue that critiques of medical care almost exclusively center around economics and thus resort to the use of "competitive market principles" (Rylko-Bauer & Farmer 2002: 388) and "commercialization and commodification" (Rylko-Bauer & Farmer 2002:388).

Like Rylko-Bauer and Farmer, Alyssa understands this to lead to lower quality of care. Alyssa explains, for example, that if doctors anticipate they might not meet their quota for the day, they are more likely to rush through consultations and miss a possible diagnosis. Furthermore, in the context of a labor and delivery ward, she also believes that doctors and nurses are often assigned to more patients than they can reasonably care for thoroughly. For example, it is common that "nurses just come in a check periodically," Alyssa explains. She believes that ideally the nurses would be present enough to also provide emotional and physical support to laboring mothers. That is not the reality. Alyssa's inclination about the presence of nurses is backed by research. The bureaucracy of the medicalized world demands the need for support roles in the hospital. Standard hospital protocol is saturated in bureaucracy. While nurses were historically substantive persons of support to patients, nurses today spend 35 percent of their shifts documenting treatments on electronic health records (Hunter and Hurst 2016: 25). It is estimated that only six percent of a labor and delivery nurse's shift is spent in a supporting role, and often nurses and doctors are only present during the final stages of labor, i.e. while the mother-to-be pushes (Hunter and Hurst 2016: 25). Alyssa sees a tension between the nurses' and doctors' care: wanting to care deeply for both the humanity and the physical body of their patients; and the fact they are paid by the hospital and must follow their protocol. Alyssa "thinks a lot of this stems from insurance companies and hospitals and their own concern for making money. Before the medical model of birth there was a lot more one-on-one care, like a midwife

will be by their side the entire time." It is the direct result of commodified a healthcare system which is more concerned with profit than "access or quality of care" (2002: 386).

Alyssa's lack of experience did not keep her from understanding the reality of for-profit medical care. This is intrinsically linked to the increased medicalization of processes previously considered natural; they provide an area for profit which was at one time not within the medical domain. While she does not directly indict this, she does believe that it is crucial that a third party, not being paid by the hospital, is there to make sure the patient is truly being cared for, "mind, body and soul."

This is also seen in literature about medicalization in general. Medicalization has been associated with a process of secularization and a loss of spirituality in the context of healing (Conrad 1991: 213). Evidence for this lies in the fact that birthing practices shifted from a spiritual in-home practice, surrounded by friends and family members, to an impersonal, institutional hospital setting.

Abigail, a white, mother of four from the Boston suburbs, sees this impersonality reflected in the way in which she has seen "medical professionals treat women as if this is just routine, it's just not a big deal, but for the women that experiences this it is a big deal, it's one of the biggest deals of her entire life." She believes her maternal perspective is her best reminder that nothing about birthing a child is commonplace. Furthermore, she says that when she tells someone she is a birth worker, "even if they are ninety-five years old, they will explain, everything about of their children were born." This is what she remembers when she goes to work every day but she thinks that often physicians don't know, or forget, that our birth experience "is part of who we are, so having a good and healthy experience is a critical to a positive start to motherhood."

While she notes it is not accurate to portray all physicians in the same light, it is true that they all work within the protocol of their institutions, which embrace the medical model of care to the highest degree. While Abigail is still partial to the style of a midwife, she has seen obstetricians who approach labor with more of a "trust your body" style, evidence of some change in the field. However, she still believes that the field is still far from seeing birth for what it is: "a natural process, not a medical procedure."

Of all the birth workers I interviewed, Jordan -- in her mid-thirties and mother to a toddler -- is one of the harshest critics of the medical model. While she had discomfort with the medical model in the context of her career as a pediatric nurse, she says she "didn't realize the state of the maternity system." Regardless of the fact that many of her friends had already had babies, she had never heard them discuss their birth. Jordan understood this as evidence that her friends had internalized the message that if they survived and their baby survived, nothing else mattered. Once she became a birth worker she realized that this discourse is frequently employed by medical providers in their attempt to coerce the mother into induction or cesarean section and as a silencing tactic wants the mothers submit to such coercion.

Through years of attending births as a full-time doula, and through her newer career as a certified professional midwife, Jordan asserts that "a lot of routine care is outdated and not evidenced based, recommended or necessary." She believes much of this has to do with the training obstetricians receive. This is because the information shared during training is often considered infallible fact rather than a potential approach. Foucault would say this fact is the result of the intersection of knowledge and power. He explains that there is no such thing as a universal truth but rather a "'general politics' of truth; that is, the types of discourse which it accepts and makes function as true" (Foucault 1980: 131). Therefore, the understanding that

obstetricians are trained with the one and only truth about childbirth, is made valid through the social system, politics and power dynamics of the hospital, and the medical model at large. This point is not to say that obstetricians do not possess an important skill. Jordan recognizes that they provide a "life saving and terrifically important service" but she also knows that they are trained surgeons, not experts in physiological birth. Thus, that their truth is not the only truth. Jordan finds issue with the fact that it "seems like the majority of them do not focus on allowing the birth process to happen without them managing it." She does not place the blame on the obstetricians as much as the system within which they work. Not only does their training champion intervention and quick labors, but insurers also prefer this route. Jordan has even seen obstetricians tell her clients false information. She says her "client was laboring just fine when the obstetrician came in and said, 'If I don't rupture your membrane then this baby will not come out.'" In this moment, Jordan admits that she broke character and told the obstetrician that she and he both knew that was not true. While Jordan does not suggest that this action had any malicious intent, she resents a system in which those in power use falsehoods to further an agenda for their own convenience. She describes this as "heartbreaking because [her clients] put all their faith into their physicians."

In general, Jordan believes that "[obstetricians] don't allow women to just give birth. They are out here doing what they've always done and don't seem interested in changing despite the fact that the United States has the worst maternal and infant mortality rates" in the developed world.

Jordan asserts that the medical model lends itself to obstetric violence. This can range from an obstetrician lying to their patient about needing to induce labor to traumatic birth experiences. She prefaces what she has witnessed by saying that she has certainly attended births

where the laboring mother is treated with the "utmost respect," in which women "within the highly medicalized system have had a phenomenal experience and gotten exactly what they want from it." However, she believes that is the exception, not the rule.

She most commonly witnesses the failure to obtain consent for fairly routine procedures, such as "administering Pitocin, rupturing membranes and performing vaginal checks." Pitocin is an intravenous drug used which mimics the effect of oxytocin, a naturally produced hormone which causes labor to start (Mayo Clinic 2017). Even the medical community is starting to accept that Pitocin is rather risky and "heightens patient harm when used incorrectly" (Wojnar et al. 2014: 975)

While these are not uncommon occurrences during a medicalized birth, each must be done only after communicating with and obtaining consent from the patient. Perhaps a more disturbing trend Jordan has noticed is that, most frequently, consent isn't obtained from women in vulnerable positions such as low SES women, women of color and especially women who are not proficient in English. However, Jordan recently had a client who was middle-upper class and white and had a vaginal exam performed unannounced. The obstetrician "walked in, barely acknowledged her and shoved his fingers in her vagina." Jordan points out that beyond being "illegal and unethical" it is also "strips someone of their experience, their power and their ability to make decisions about their own body."

It is not a coincidence that Jo, who has attended more births than many of the other birth workers combined, along with Jordan (who worked in medicine for over a decade), have the strongest sentiments against the medical model of my interviewees. Jo describes herself as "madly in love with birth work because [she] feels like [she] can truly help." Her work is largely fueled by her convictions about medicalized labor: "I think augmentation and Pitocin and C-

sections kill women. Their receptors are flooded, they clamp up, and their bodies can't labor the way they were made to." Augmentation is the process of medically stimulating the uterus to increase the duration and frequency of the contractions (World Health Organization: 2014). She believes that if this were addressed, many infant and maternal deaths could be avoided.

Jo contends that these deaths are not avoided because of issues with the medical model outlined below. First, she believes that maternity care is one of the "last patriarchal, misogynistic protests in medicine." She sees this through the treatment of the mom, her well-being considered secondary to that of the baby. This is made possible by the "bio-power" (Foucault 1978: 140), which physicians hold. This power, wielded by physicians, a historically male profession, is intrinsically tied to patriarchal structures of power. Jo also sees this in what she calls "terrible ignorance and judgment" in the frequent presumptions physicians make -- that they care more about the baby than the mother does. This mindset illustrates how authoritative knowledge is considered the only knowledge and those who possess it are the only people capable of caring or making the correct decision. Jo describes this as the manifestation of "the patriarchal idea that the system knows better." She describes a condescending air with which providers basically say "don't worry your pretty little head about that." Then there is a loss of the woman as a whole. Jo, like her colleagues, notes dehumanization. She says the mother "becomes an incubator, she gets Pitocin, she produces and baby and is packaged up." She asserts that the medical model strips all individuality from the person, describes how their clothes are taken and their names aren't used. She sees this as another piece of evidence of the flawed medical model, "designed to birth four million babies a year," with no concern for individuals and their unique experiences. Jo explains because the medical model leads to "loss of the mother" as her own entity occurs, providers

often find themselves "acting without consent, cutting episiotomies, and often if someone objects they will use their hands to rip the mother open."

Jo attributes this widespread occurrence to physicians being trained to believe it is acceptable. She believes that their training protocol is portrayed as the only factual and effective approach to birth and thus it is all they know. This type of training has subsisted by generations of doctors that learn that "women's knowledge [doesn't] count while medical knowledge carrie[s] the day (Davis-Floyd & Sargent 1997: 59).

Jo says doctors act as if the central message during their training is that "if the baby comes out alive, then use any means to get there." Not only does this show that women's knowledge about their bodies doesn't count, it shows they don't count, period. Patriarchal discourse has continually reified the idea that women's lives are less than and that women are property which exist only to produce more life. Jo is clear in saying that she does not believe medical providers are trying to hurt anybody, that they truly think they are doing what's best. However, she explains saying "it's like the man that beats a woman saying he's doing it for her own good." These hegemonic beliefs feel nearly impossible to dismantle because it is a way of thinking so deeply ingrained in the field.

Regardless of intent, this mentality has damaging outcomes. Jo says that "any doula will tell you a story about a time they were the first to notice their client was unconscious while medical providers do other things." Recall Nicki's experience, previously described. She believes the reason for this, stems from the power structures existing among medical students, nurses, physicians, and certified nurse midwives. She describes a strict environment: "Nobody says anything against the doctor, if you do, you'll be kicked out."

*The medical model and burnout*

Robin brought up multiple times during our conversation that birth work is grueling; while it can be beautiful and fulfilling, the burnout rate is high. In order to work with vulnerable populations, at the highest risk for poor birth experiences, birth workers usually must work for free. While there are some programs that pay a small stipend, those are rare, and they pale in comparison to the compensation sought from paying customers. Furthermore, few insurance plans reimburse for doula work. For those that do, subscribing women can generally afford to pay doula fees in the first place. In short, Robin explains that there is "no money in making sure women feel good about their birth, no money in making sure women breastfeed their babies. Birth workers love it, they're passionate about it but it's really, really hard to make money." This is evidence that authoritative knowledge, in the form of medical care, is thought to have value, but non-authoritative knowledge is once again devalued.

In combination with hospital politics, this leads to very high burnout rate for birth workers. Robin says birth workers often feel helpless in hospital births; they can be disregarded as illegitimate, a result of the power relationships existing in communities of practice (Davis-Floyd & Sargent 1997: 57) However, she says a key to avoiding burnout is to remember that all they can do is "build a relationship, prepare, share their knowledge and offer support, but we can't do it for the mom."

*The medical model and fear, power and control*

As a registered nurse Jo understands that the training necessary to become a medical professional often centers around fear. This training has much to do with avoiding "the worst-

case scenarios." This fear is justified, "because a baby will die and a mom will die and it will rock your world. You will see someone pour blood and you will say 'please God, don't die.'" During her work as a midwife, Jo has experienced this fear first hand and she understands that it contributes to ineffective communication between physicians and birthing mothers. "Under power and control is fear and insecurity," Jo says. She suggests that the physician's efforts to maintain "power and control" result in the use of scare tactics. For example, if a mother hesitates on proceeding with a birth plan she isn't comfortable with, and asks multiple questions, Jo has heard physicians say, "You don't want your baby to die right?" This not only offers another example of the paternalistic communication style to which authoritative knowledge lends itself, but also speaks to the palpable fear that exists in labor and delivery rooms. This is also the kind of "coercion" and "manipulation" which the ACOG has deemed unacceptable but birth workers frequently witness (American College of Obstetricians and Gynecologists 2016: 2). Jo tries to bring an attitude to her births that is not fearful, but hopeful, and instills the sense in her clients that their bodies are made to labor.

Jo believes one way in which the medical model has dealt with this fear and insecurity is through rigid protocol. These protocols aim to reduce blame for harm to either mother or child that could be attributed to the physician. For example, Jo believes that the physicians work under regulations which encourage often unnecessary cesarean sections. She explains, "obstetricians don't get sued if they perform a C-section too soon. They get punished for not producing the perfect baby or the perfect birth. They're given no reward for avoiding a C-Section."

Jo believes that changing the medical model would demand rehumanizing healthcare and making that central to training medical providers. She calls on physicians to be more communicative, to use more kind words, and for those training physicians to emphasize bedside

manner that does not exude judgment and distance. Jo also believes that training physicians to not "show fear" has much to do with her clients' frequent reports of impersonal physicians. Furthermore, she believes physicians see their role in health care as pertaining only to the measurable data presented, such as fetal heart-rate monitors and maternal blood pressure. Recall, Foucault's concept of the "confrontation of a gaze...and a silent body," (Foucault 1973: xv), in which there is no chance for humanized interaction only a gaze which reduces the human experience to the physically observable. These leads to what Jordan' observes as physician's one-dimensional approach to care. She asserts that many physicians do not consider it their role to consider social determinants of their patients' health. Thus, they do not think about their patients holistically or consider factors such as access to high quality nutrition, their domestic environment and other life stressors. Jo sees her role as a birth worker as an opportunity to remind the medical world that they hold responsibility for the whole person. Jo encourages other birth workers, through holding training sessions, to join in her mission to dismantle the medical model.

Sarah, a white woman in her mid-twenties, attended her first birth with Jo, her mentor. It was a home birth, and the mother's fourth child. Her first two births were scheduled cesareans because medical providers stated her babies were too big. For her third birth, she switched providers and hospitals and successfully birthed a nine-and-a-half-pound baby vaginally. Her fourth birth was a home birth attended by Jo, the certified professional midwife, and supported by Sarah, the newly trained doula. She birthed an eleven-and-a-half-pound baby vaginally at home, completely naturally. Sarah says she was "in awe of the process of birth" and saw firsthand that "birth is a natural physiological process, rather than an accident waiting to happen." After seeing how successfully this birth went, Sarah was doubtful that the mother's

previous scheduled C-sections were actually medically necessary. "The mother being lied to about her options set my tone for wanting to help people advocate for themselves and their own experience."

While she values the work that doulas do, Sarah did not envision doing it long-term. It was hard to make a livable wage, and the constant on-call demands were taxing. She decided to continue her work in the maternity care field in a different capacity. She accepted a job at a Massachusetts teaching hospital in their obstetrics and gynecology department. Sarah was responsible for umbilical cord blood donation at the hospital, which would then be used for research at the medical school or donated to a public blood bank. Sarah cites this job as being much more eye opening than doula work in terms of how maternity care operates under the medical model. She describes herself as "horrified" by what she saw over the course of her time there.

Sarah developed the opinion that physicians have a tendency to induce far too many labors. For example, she saw the hospital bring a patient in for an induction and try to induce her for three to four days, when "the baby is clearly not ready to be out." The patients, understandably frustrated, would ask for a cesarean, because they were ready to meet their baby and get home. This is a much more expensive route and makes the hospital much more money. It also allows obstetricians to determine when the baby will be born, and thus when they will be done with their work day. Other inductions happened when the mother-to-be was only a few days past her expected delivery date (EDD) and would complain of mild discomfort; the doctor would happily induce. Sarah calls these scenarios "total bullshit," but does recognize there can be medical reasons for induction. She found that most unnecessary inductions involving mothers who were "young, uneducated and uninformed." She often saw physicians use tactics such as

saying, “Don’t you want to meet your baby?” and catering to their vulnerabilities. These cases normally followed a fairly consistent pattern. Sarah explains she would see a mother agree to the induction, because she did in fact want to meet her baby, but the baby would not be ready. The obstetrician would do a cesarean section and then the mother will likely need cesareans for the rest of her children.

To be clear, Sarah is not against inductions in all cases, but she does believe that there is a “tendency for physicians to say ‘we did all we could but the C-section had to happen’ and pat themselves on the back, but they set themselves up for a C-section because of induction.” This is what birth workers refer to as “the cascade of interventions”, one intervention leading to more and more. Sarah sees inductions as a tactic to “get people in and out because it’s all about time and money,” all about “commercialization and commodification” (Rylko-Bauer & Farmer 388).

Sarah does not see the medical model being able to bear witness to the process of labor and “just let it be.” She attributes much of the interventionist protocol to factors beyond individual physician’s control. For example, even birth centers that are owned and operated by hospitals have strict policies about when mothers require admission to the hospital and treatment by an obstetrician, rather than a midwife. This often leads to cesarean sections.

Sarah also cites many unnecessary cesarean sections as the result of obstetricians untrained in certain types of births. For example, vaginal breech births are “possible and happen all the time.” While in the medical model they are treated as a reason for cesarean section, “the reason breech births aren’t safe is because obstetricians here aren’t trained in it.” Other place in the world are capable of birthing breech babies because it is considered an important skill, but our medical model has devalued this skill. Other issues can be attributed to problematic training as well. For example, the use of forceps and episiotomies are often considered outdated.

However, older physicians at this teaching hospital did their medical school rotations there, did their residency there and now were attendings, training the next generation of doctors. Regardless of the fact that the current medical model is not working for all people, the training discourse remains the same, because it is working for the obstetricians. It's failure to change is due to the fact the discourse is dissymmetrical (Foucault 1971), meaning that those in power control what discourse is valid and what knowledge is authoritative. Furthermore, knowledge, as passed on through training, is interactionally grounded as authoritative (Davis-Floyd & Sargent 1997: 58). In the training there are no differing perspectives or approach, just a single medical narrative, and this interaction reifies that what they are being trained to do is the only legitimate approach.

This can be seen in the fact that Sarah says many of them have literally never seen a breech baby birthed vaginally or an unmedicated, natural birth. They "have only been exposed to intervention-based birth." This is true for the majority of obstetricians with whom birth workers interact. They are also the first to "assume that home birth is really dangerous."

Sarah has also observed obstetricians lack the flexibility to accommodate the modifications that the mother may request, such as squatting instead of lying on her back. While natural physiological birth is not meant to take place with the mother laying down, most obstetricians prefer this position because it allows them to manage the birth as much as, if not more than, the mother.

At the teaching hospital where Sarah worked informal training, which resulted in certain learned behaviors and attitudes, took place as well. For example, Sarah recalls that attitudes about birth workers emanated from the whatever physician was on the floor at the time. "When someone came in with a doula," Sarah said, some obstetricians "would roll their eyes and would

mock a birth plan to nurses or even medical students." Sarah saw such attitudes pass from one staff member to another, which likely interfered with their adherence to the mother's birth preferences. Sarah describes a sense of apathy towards patients who expressed their beith preferences; doctors and nurses justified this by saying "you have a healthy baby, that's all that matters." She explains that she believes this rhetoric is also commonly used to "downplay trauma associated with childbirth. They're basically saying if you have a healthy baby it doesn't matter that you almost died or had your rights or your body violated." These medical professionals use their power and authoritative knowledge not only to "deny people's right to make decisions about their birth experience and their bodies," but also in an attempt to invalidate women's suspicions that something about the process was not right.

Sarah suspects that in addition to medical training and informal learned behaviors, much of the problematic behavior she witnesses is attributable to "a lot of people in those jobs who hadn't thought critically about what birth means to their patients." Her discomfort with the medical model has much more to do with systemic issues than with individual physicians. Sarah acknowledges that the doctors and nurses she worked with care deeply and that "there is a time and place for all interventions." She has seen that such interventions "exist to save people's lives," but cannot overlook that "they are overused entirely."

These "overused" interventions are often the product of physicians displaying power and control as a response to fear about outcomes and about conforming to proper protocol. Similarly, this fear also fuels the how midwifery and obstetrics are largely defined in an oppositional framework, Jordan says, rather than as aiding each other. She understands this relationship as deeply rooted in history: "The eradication of midwifery to make room for obstetrics is a very long-standing tactic, but it's very real and very much alive now. ACOG has made statements that

they do not support births attended by midwives, particularly home births," she says. The fact that much of the same discourse is still used to position midwifery as inferior to obstetrics has to with the desire to maintain power over birth within the realm of medicalization. This allows hospitals, insurance companies and doctors to keep their monopoly over this life process.

Jordan believes that this effort has been fairly effective, as evidenced by the fact that Massachusetts is now trying to pass a bill which requires all midwives to have licensure issued by the state. While this might seem like a good idea, Jordan and members of the midwifery community see this as the latest attack on the legitimacy of their profession. She explains, "all over the country midwifery is being regulated to being obsolete." By regulating midwives, the medical model, which many people blame for poor outcomes and even worse labor experiences, will have control over midwifery. For example, Jordan asserts that regulators will then have the power to make strict criteria for when home birth midwives must hand over their process and bring their client to the hospital. Jordan questions such regulations.

"People think we show up to a birth with a shoestring, a chicken bone and a kettle, but the reality is that if we weren't good you would know about it." She also knows that most places around the world, including those with much better outcomes than the United States, use midwives for all low-risk pregnancies.

Jordan believes time would be much better used "focusing on the shortcomings of our maternity care system and the fact that our C-section rates are three to four times the suggested rates of the WHO" rather than trying to delegitimize midwifery and birth work. Lastly, she calls attention to the fact that "safety is relative."

> I have a homebirth client who is due soon. I know this woman very well; she's near and dear to me. This is her fourth child. During the birth of her first child, she was abused so badly that she birthed at home alone for her second and third

> births. I met her after this and so for this one I will be there. She will have a midwife for her fourth. People are being subjected to astounding trauma and safety is relative. While somebody might feel safe in a hospital being managed from beginning to end, someone else might feel so unsafe, like this woman, that they would rather give birth alone then step foot back in the hospital.

As with so many issues concerning reproductive health, this too comes down to listening to voices calling for change rather than enforcing further mandates which limit choice and subjugate women's bodies.

*Medical model as paternalistic*

Midwifery is often defined oppositionally to obstetrics because of the way obstetrics came to be. Obstetrics as a field has direct ties to paternalistic power structures. This demands clear delineation in order to fully understand birth workers' criticisms. The feminist approach to childbirth and woman-to-woman support is often presented as the counteraction against medicalization movements -- medicine and femininity are not considered to be in the same spheres of knowledge. Indeed, these spheres of knowledge are not taken with equal validity. Rothfield explains that medical knowledge as we understand it today, as well as the scientific process, were developed within the context of men being the sole arbitrators of the field (Rothfield 2002: 320). Rothfield and her contemporaries question whether the dominance of men has flawed the development of medicine in a way which renders objectivity far less objective than we may think (Rothfield 2002: 320). In relation to obstetrics, this may certainly be the case. With the prevalence of men in the field, especially during its creation in the mid-nineteenth century, (Hunter, Hurst 2016:4), birth entered the scientific world as a process external to the mother.

Wendy Moyzakitis explains that feminine understanding has often been undermined epistemologically as knowing by a feeling rather than masculine, factual knowledge (2004: 9). Feminine understanding, especially of female experiences, has rarely been taken to be authoritative knowledge on the topic. This positivistic understanding of childbirth requires that it is a process external to the mother because the epistemologies of scientific knowledge rely only on observational knowledge (Hunter, Hurst 2016: 85). This means the only legitimate information about childbirth is that which can be seen by the scientific authority, in most case the obstetrician, and the experiential knowledge of women is deemed illegitimate. In a culture that seemingly worships technological and scientific progress, it is not surprising that women have come to understand authoritative knowledge as being superior to the knowledge they have of their own bodies. In fact, Hunter and Hurst point out that the delegitimization of "alternative" or embodied knowledge has become so commonplace that women have learned that they must relinquish control of the reproductive process to an expert (2016: 59).

Woman-to-woman support as a feminist movement aims to rupture this hierarchy of knowledge. It moves away from purely medical obstetrics and focuses on "choice, continuity and autonomy" (Campbell and Porter 1997: 349). Rather than conforming to the scientific scripts written and enforced by masculine epistemologies, the reclamation of birth as an embodied process is encouraged. Hunter and Hurst argue that many women want someone present who has given birth, who has the embodied knowledge of the process, whether that be a family member, a doula, or a female obstetrician who has been through the process (2016: 93). By relying on embodied knowledge, and with support in this by those around them, women and their bodies are taking back the birthing process. Instead of relying on external checkpoints, they are embracing the idea that their bodies, and their bodies alone, run the process (*The Business of Being Born*

2008). Women trusting in their own bodies, and seeing the incredible power that they have, is central to the feminist approach and to dismantling the misconception of medical knowledge as superior. Perhaps the most important outcome of this approach is the shift to focus on the holistic well-being of mother and child, not simply preoccupied with the detection of abnormality (Campbell and Porter 1997: 350) or unnecessary intervention. The feminist movement also challenges the medicalized model, emphasizing that social repercussions of medicalization occur whether or not the technological or medical advances are in fact effective (Conrad 1992: 223). In the context of birth this means that the mother's and infant's physical health after labor do not mean the birth was necessarily a success. Physically healthy outcomes do not guarantee the mother had a positive birth experience, in which she felt as though she had fully understood and consented to the medical process. This is a common discourse regarding successful birth which demands a shift in thinking. The growing feminist approach legitimizes experiential knowledge and incorporates subjective reports of the childbirth experience. It moves away from positivistic findings (Moyzakitis 2004: 10) in the still very masculine profession of obstetrics.

Much of this literature reiterates what birth workers vocalize regarding the medical model during their own interviews. It also introduces feminism as critical lens through which to explore birth work.

*Internalized sexism within the medical model*

Robin is one of the most critical birth workers with who I spoke in terms of her disapproval of women who feel they are "too posh to push". This is a style of pregnancy that was coined by celebrities who scheduled their cesarean section and a tummy tuck for the same day. While most doulas, including Robin, will work as a support person for any birth plan, that does

not mean they do not hold reservations about certain birth plans. This is especially clear with her candid disapproval of a societal understanding that it is somehow ungraceful and unladylike to labor hard. “So, few places even allow women to scream, be guttural, be animalistic, a lot of women don’t even feel comfortable making a noise at all.” Robin sees this as another way in which the medical model, and other societal expectations, shape the way births are allowed to go, either by hospital rules or women’s own internalized ideals. She believes that a lot of women feel they will be deemed masculine for seeming aggressive during labor, however she insists that “we need masculine in feminine energies in the world and in every person.”

In this statement Robin fails to align with her more radical colleagues in her inability to dismantle these binary gender roles. While she speaks in admiration of women who birth in an animalistic way, with what she calls “masculine energy”, she strips them of owning power within femininity. Instead, she seems to think this is somehow outsourced in a moment of great need, in which they call upon the strength of the masculine realm. Robin also casts doubts about women’s capabilities in more direct ways when she told me she believes that “there are a small number of women out there who are willing to take charge… for every two women who want autonomy there are eight women who don’t want to know, feel or take responsibility.” The air of judgment with which she said this was palpable, but she quickly expressed that this attitude towards birth would be understandable given a “trauma background, sexual abuse history or no support.”

Given the number of births that fall into one or more of those categories, Robin’s logic about some mother’s desire to disassociate from the process makes some sense. However, she expressed concern that this issue of lack of involvement during childbirth is a symptom of a much larger problem. She believes it is evidence of the way women are disconnected from their

bodies. “It’s really hard to teach a childbirth course and teach them to move a baby through their body when they have no relationship with that body.”

In the best case, this comes from the disdain women learn to feel towards their bodies from a young age. This disdain has nothing to do with the immense feats their bodies are capable of, but rather a large ribcage, crooked nose, or the fact their inner thighs touch. In the worst case, this has to do with a complete dissociation with their embodied experience due to trauma, frequently sexual. Robin dreams of leading a group discussing “mind-body connection” but has yet to start one.

In terms of the role of the patient during the birth, internalized sexism and thus disempowerment, also plays a factor. One of Abigail’s clients, who was studying nursing and has worked under doctors in the hospital setting, felt as though she could not, under any circumstance, disagree with the doctor. She was not able to directly confront the doctor about her concerns but rather had to have the doctor leave the room so she could voice her concerns to Abigail. This is evidence of her own internalized understanding of medical culture, which fixates on the doctor as infallible. Perhaps it can also be attributed being a black woman operating in a culture, and its institutions, ruled by the white man.

*Obstetricians and Birth Workers*

Just as midwifery and obstetrics are positioned oppositionally, the relationship between obstetricians and birth workers is often a tenuous one. Suzanne explains that her job is first and foremost to work for her clients and be “a bridge between their world and the medical world.” Yet she “always has to be cognizant that [she] represents doulas everywhere. And there’s an administrative aspect to consider because we all fear to some extent that doulas will be banned

from hospitals. Some hospitals in the area have found a way to make working there as a doula somewhat impossible, like they say only one support person, so for the vast majority of people that will be a partner, family member or friends rather than a birth worker." Because of the power the obstetricians, and the hospital institution, have over doulas' presence at births, she explains that she can never be too argumentative. This is evidence of how authoritative knowledge is formed, and reified, interactionally (Davis-Floyd & Sargent: 1997 58). While Suzanne doesn't describe this power-laden relationship to be one of animosity, she does say that "there is often a sort of eye rolling and a 'Oh, here's that quack doula again' when we enter some spaces -- from nurses and physicians alike. I just think that so many of them don't understand really why we want to be there and some of them are wonderful, don't get me wrong, but a lot of them don't bring the same excitement and understanding to each birth, I mean they do this every day."

She sees a positive relationship, based in obstetricians genuinely understanding birth workers' missions, as the avenue to obstetricians understanding birth through a different lens. When asked what exactly she wished they would understand, she answered with no hesitation: "Everyone is coming from a different place in life, with different bodies and different babies and different abuse histories. Every single birth is different. Everyone needs to be empowered and included in their birth process in a way that that makes them feel like they have made informed decisions, they have been guiding their process, and it's not something done to them."

Nicki, as well as most of the birth workers with whom I spoke, shares this sentiment. She is also quick to point out that obstetricians' care varies greatly. She has heard everything from, "This is your body, this is your baby" to "Lay down now," and forcing a certain position on the mother. Obstetricians' reactions to her work vary greatly as well. While she states that "90

percent of interactions have been positive" she has also had very negative experiences. However, for Nicki, most of these negative interactions have been with nurses.

"They roll their eyes, or see you using a rebozo, see you gently shaking and moving your client's hips and they are like 'oh here's that hippy doula again'. One even told me that I was 'trying to kill the mother and the baby.'" She believes that these interactions are most common with nurses for a few reasons. First, obstetricians are not in the room for the vast majority of the labor; second, there is a lot more crossover between the territories of doulas and nurses. She also thinks that some of this conflict stems from the fact that labor and delivery nursing is one of the most sought-after positions in the hospital, meaning the nurses are older and tend to be less inclined to accept change or new techniques. Just as with stagnant discourse used for obstetrician training, the same thing happens with learning to be a nurse. Because doulas are not widely accepted as a legitimate and positive addition to a birthing team, medical professionals do not treat them as such either.

Most of the birth workers acknowledged that their interactions with obstetricians and nurses alike are a delicate balancing act. While they must "stay in scope", a term used among birth workers to reiterate that their role is not to provide medical advice, they also know that true advocacy can mean disagreeing with medical providers. Thus, they too are subject to the power of the medical model, enacted by physicians and institutional policy. This power is shaped by discourse about who is legitimate in hospitals, as a social space and community of practice, and who is not. Jordan describes it best when she states that she understands is very hard to be the change within the hospital. "We're walking into [hospitals] trying to navigate a system in which we really have no control. We will try and empower our clients and tell them they are in control but when they walk through that door ultimately they aren't." The relationship between

obstetricians, nurses and birth workers, especially interactions which are belittling, are symbolic of the hierarchy of knowledge, constantly reified by discursive power, which exists within medical institutions.

*Obstetric Violence*

The medical model's tendency to lead to, what Jo calls, the "loss of the mother," lends itself to patient mistreatment. It is critical to note that every case of mistreatment reported during my interviews was with a birth client who was non-white. Some were non-English speaking as well. The subjugation of women's bodies under the medical model must be examined as an effect of the intersection of identities. Addressing obstetric violence must therefore inherently incorporate considerations of the race, class, and age of the laboring woman.

Clients often do not experience obstetric trauma but still have events during labor from which they feel violated. Abigail had one client who was administered the commonly used induction drug, Pitocin, without her knowledge or consent. Her client only found out after it was injected via her already placed IV. The Pitocin was administered after she delivered her baby, a frequent practice based on evidence that it can decrease the risk of postpartum hemorrhage. While this was not obstetric trauma, her client felt violated and deceived by the failure to provide information about her treatment as well as the opportunity to provide consent to the use of the drug. Her client felt very angry about these circumstances. Their postpartum meetings focused primarily on processing this violation; she felt negatively about her birth as a whole. Abigail understood that the inappropriate action occurred as a result of blindly following protocol. From what she has both heard from colleagues and seen herself, Abigail understood that, "They were gonna do it anyway. She was having a hospital birth and they were doing that. It seems to be just

their procedure." When asked about the possibility of refusing the drug if her client had known about the plan to administer it, Abigail said she wondered the same thing after witnessing this birth. Her community of birth workers shared similar stories and said the most likely way to completely avoid Pitocin would be to deny the IV from the get go. Many had the similar experience of providers injecting Pitocin without warning or consent once the IV was started. Some said that even without a previously inserted IV, providers will often will insist on starting one solely for the administration of Pitocin. Birth workers commonly consider this an unnecessary intervention, a protocol in place to protect the hospital from any potential lawsuit should a postpartum hemorrhage occur.

Suzanne, the first doula I interviewed, has also experienced multiple incidences of obstetric trauma during her career. She notes that obstetric processes -- especially involving women of color, women who do not speak English, and women from impoverished backgrounds -- seemed as though they were being done *to* the women, not *for* women who had provided consent.

Suzanne says that she has also witnessed countless racist incidents while working with an adolescent volunteer program. She notes that even when working with clients who are known by the hospital as program participants, she sees far worse treatment.

"They throw these young, scared, mothers-to-be in small rooms with no air conditioning, clearly the rooms that no affluent woman would accept," she says. She asserts that the knowledge of her volunteer work is one factor the hospital uses, perhaps subconsciously, to determine the status of patients what room they "deserve". Suzanne believes this is almost always treatment associated with women of color. She states that while individual providers

tend to be fairly understanding of personal abuse histories and other circumstances, the treatment of women of color within the system as a whole is decidedly different than that of white women.

Hailee offers an anecdote echoing this sentiment. Hailee is currently a graduate student in Boston and has a long history working within the "reproductive world." Hailee is queer and uses the pronouns they/them. Hailee's second birth was with a black, single mother who already had two children. It was an unplanned home birth. While the mother had always expressed a theoretical interest in a home birth, the birth occurred due to what the client felt was "racial discrimination, condescension, being pushed aside at the hospital." The client went to a Boston hospital with labor contractions five minutes apart. She reported that she was in labor and was anemic. Already a mother of two, she assured those working at the hospital that she knew her body, was familiar with her own labor process, and that she had felt this before. Regardless, the hospital refused to admit her and sent her home. She then clearly stated that if they sent her home, she would not be able to come back. The hospital staff sent her home anyway. When the client returned home she called Hailee and another doula, who immediately came to the house. The client did not have the means or time to find a midwife and decided that she would go ahead with a home birth regardless. Hailee reported that the client sat in the shower for a long time, sang songs by Panic at the Disco, and successfully gave birth fully unmedicated. The client and the other doula caught the baby while Hailee watched in amazement. The next day the new mother called the hospital and requested a home visit from a nurse, something she had done with her last child due to a lack of childcare. The knock she received at the door the next day was not a nurse from the hospital but rather two male police officers. The hospital had filed a report with Department of Children and Families (DCF). Threatening to or involving DCF is one of the actions the ACOG strongly discourages (American College of Obstetricians and Gynecologists

2016: 2), but it continues to happen. Rather than sending a nurse to check on the wellbeing of the child, hospital personnel asserted that Hailee's client was an unfit mother. The mother had gone to the hospital, explained that she knew she was in labor, and requested adequate healthcare for her newborn, yet she was still reported, on the grounds that she may be an unfit mother.

There was no doubt in the minds of Hailee or her client that her race entirely dictated her treatment at the hospital and the subsequent DCF report that was filed.

Another birth Hailee experienced suggests a connection between the lack of continuity of care in the medical model and obstetric violence. Hailee explains that their most recent birth ended in a "pretty traumatic C-section," and described the birth as almost having two identities. The first half was attended by a midwife and the mother's goal of a low-intervention birth was achieved. After four hours of pushing, however, the baby was still not clearing the pubic bone. During the midwife shift change the baby's heart rate started to decelerate. Instead of another midwife taking over, an obstetrician and accompanying team entered the room. This entirely new care team, with a new treatment plan, introduced themselves and announced they would perform a C-section. During her prenatal meetings, the mother didn't feel the need to prepare a plan should an emergency C-section be needed and Hailee did not push her to do so. The whole process in the hospital happened quickly. As soon as the obstetrician announced the plan, hospital personnel came in to do required consent for surgery, and the mother sat there uncontrollably crying. The medical team left during the peak of her emotional moment and did not see her again until they were in the operating room. Both Hailee and their client's husband were present in the operating room.

Hailee was unimpressed with how they were treated during her surgery as well. The client continually asked what was going on and did not receive an answer. One nurse told the

client she would stay there the whole time but did not and wasn't there when the client called out to her. Hailee described the scene, saying "No one would listen to her or her husband. No one paid any attention to the mother, like she wasn't there. They were there, slicing her open and nobody is paying attention to her or what they need." This is evidence of women's experiential knowledge being seen as invalid and thus being subject to the "devaluation of non-authoritative knowledge" (Davis-Floyd & Sargent 1997: 57). Like many patients who experience obstetric violence, this client was a black woman.

Jordan can attest to the racial prejudice she has seen during hospital births. She says she has frequently witnessed teens of color have their pain be ignored, "almost like the nurses didn't take them seriously." One case stands out. Jordan was working as a volunteer doula at the hospital at which she now refuses to work. Her client was a black, adolescent woman who needed an emergency cesarean. Jordan accompanied the teen to the operating room and they began the surgery. The teen repeatedly said that she could feel the lower half of her body and that something wasn't right. The providers in the room ignored her and when she continued to complain they told her she couldn't feel it. This continued until she vomited, blacked out and went into shock. Jordan recalls that only at this point did they believe what she had reported. The client and her baby both survived the surgery, but the mother was "traumatized with the pain" she experienced. She called patient advocacy multiple times but, similar to the providers, they diminished her experience. Jordan states the experience was "traumatic both for the mother and for [Jordan]", they were both "powerless" in that operating room. Jordan acknowledges that this is an extreme example but states that it is evidence of "how racist, classist, and abusive the maternity system is in the greater Boston area."

*Obstetric Violence Toward Marginalized Women*

The abuse suffered during medicalized hospital births does not affect all women equally. This oppression in the medical world, like oppression in society at large, disproportionately affects those with compounded identities of marginalization. Jordan explains this, saying "white or black they don't believe us [women], but women of color decidedly get the short end of the stick." Gender and race both contribute to doctors not taking women's voices in the labor and delivery room seriously. It is as if the combination of gender and race determine the level of incompetence in physician's mind, thus this is an intersectional issue. Jordan sees this as a reflection of a larger cultural ethos about "how we view women's competence and their ability to make decisions about their own bodies." She explains, "There is such a difference between the way women are treated in the system." While, all women suffer from the "underlying control over our bodies," women of color and of low socioeconomic status, in Jordan's experience, suffer the most. "They are just ignored; their care is not seen as a priority." This is an example of what Foucault means when he states that modern medicine is the "power to foster life or disallow it" (Foucault 1978: 138). While some lives are nurtured and protected by the healthcare system, others are decidedly not. This can be understood as the moment in medicine where "bio-power" (Foucault 1978: 140) meets intersectionality. The power over life that physicians hold, which is grounded in white, patriarchal discourse, inherently impacts women of a color in a uniquely damaging way.

Jordan believes this treatment in the medical system for women of color starts long before pregnancy and believes they experience "subpar care" continually in the healthcare system largely because "there are so many implicit biases."

This sets up this most vulnerable population of women to enter pregnancy not only with a potentially worse baseline of health but also ill feelings toward the medical system as a whole. For example, Jordan has had two different young black clients threatened by DCF for defending their birth preferences to the attending obstetrician. The threat of policing women's ability to make decisions for their children is a tactic of power and control, another form of "bio-power" (Foucault 1978: 140), over these women. It also leads to mistrust and dislike for the healthcare system.

Jordan believes this explains why "women of color have abhorrent outcomes." She has seen first-hand that "the care is not individualized and not evidence-based." Even when women of color do have access to care, they rarely have "access to culturally sensitive care," Jordan states. She understands that the inequality goes further than just access to or quality of care. She also understands these women face other structural barriers. For example, they often cannot get adequate prenatal care because they "can't take time off work or can't get to a provider." Jordan also believes that there is "a glaring lack of community-based care, which midwives offer but often not in the communities which need them most." This links back to the flawed medical model of care in that it has "power to foster life or disallow it" (Foucault 1978: 138), and for women of color, it most commonly acts as a disallowing power.

Jo has also seen ways in which "black and brown birth folk are systematically targeted in the health care system." For example, she recently had a client suffering from a cough who was immediately told she must be screened for tuberculosis. While this may seem insignificant, Jo knows that the constant micro and macroaggressions that women of color confront take an emotional and physical toll. She states that "the systemic oppression of women gets held in the psyche of all women but we find that women of color carry that psychological trauma from

generation to generation." Jo explains further that the compound marginalization of women of color means: 1) they not considered an authority on their bodies because they are women; and 2) they are also often thought to not know anything at all because of their race. They are black women existing in a (medical) world created by white men. She recently worked as a birth doula for a black mother delivering her second child.

> The birth took place at a Boston hospital and for the first part of the labor they were so great about everything. My client was unmedicated, sitting on the toilet, while I held a warm washcloth on her privates. She had not been seen by a nurse in a long time and she said she was sure that she was no longer at 5cm. Understanding my role as a doula, and not the practicing RN or CPM at this birth, I called in a nurse to check her again. The nurse entered and without performing an exam basically told my client that she was wrong, and she didn't need to be checked again already. My client asked again saying that something wasn't feeling right and the nurse said she would come back in a bit. At this point, I admit I overstepped my boundaries and I put on my RN/CPM hat and decided I would examine my client. She was at 9 cm. I called the nurse in again to tell her what's going on, once again she said she would come back. I responded, my client was still sitting on the toilet. I said 'I can feel the baby coming.' and now they run in with their hair on fire and tell me to step away. All the sudden they're treating her like a ticking time bomb forcing her onto her back, completely taking control over her and loudly telling her to push.

This story illustrates the way in which the voices of women of color are ignored in medical settings and also how having a knowledgeable support person, focused solely on the mother, can be lifesaving. Jo believes treatment like this has much more to do with high infant and maternal mortality rates than any trauma history women may have. Treatment like this shows how women of color are not taken seriously nor are birth workers. Treatment like this makes birth the most vulnerable time of a woman's life.

Terri, a black woman and Boston native, perhaps has the most valuable insight on the challenges women of color face in their search for maternity care. Terri "doesn't shy away from talking about race, because [she] doesn't have that privilege."

She explains that during her first few years of work she came to two important realizations. First, physicians and nurses hold implicit biases and trauma histories of their own, either "in their personal lives or witnessing a mother or baby die." Second, "the bottom line is that racism is killing black women." While these two aspects of the maternal care system were fairly easy to recognize, addressing them can seem nearly impossible. Terri describes her work as "just mitigating one result of a bigger Goliath to tackle." She is intimately aware of the challenges black women face every day and asserts that their poor births cannot only be attributed to the care they receive in the hospital. Even if doulas and physicians worked together to provide collaborative care, and achieved continuity of care, the issue would not be addressed in full.

> When you unpack racism, you have to say what does this look like day-to-day. And it looks like a black woman going to work every day dealing with microaggressions and macroaggressions. There is the transgenerational trauma, epigenetics. We see the same thing over and over, if you are black it doesn't matter if you're college educated, wealthy, from the suburbs, eat organic, you can do all these things, your birth outcomes will still be the same as white, uneducated teen mom. This is not anecdotal, it's fact. The determining factor is her race.

This takes place all before a black woman even conceives a child. After the news of pregnancy, a new set of systemic barriers is in her way. Terri explains that there is a common misconception that black people do not experience pain in the same way as white people do. This means that when black mothers present for labor, medical professionals often operate "under the assumption that they don't need as much pain management." Terri states that these implicit biases are "far more insidious than just familial beliefs about race." Instead, she asserts that these biases are rooted in the medical system. "When doctors were taught this, they saw it in their textbooks, then they assume it is true." This speaks to the difficulty of eradicating falsehoods borne from a source of authoritative knowledge, in this case the medical field. In her own words,

Terri is describing the fact that our medical system is organized by privileged, white, male hegemonic discourse, that our "biological existence [is] reflected in our political existence" (Foucault 1978: 142).

*Trauma History*

The inherent vulnerability women experience during childbirth is increased in clients who have previous trauma history. Again, birth workers note a direct link between this trauma, as well as obstetric violations, and socioeconomic status and race.

Nicki states that "100 percent of her low-income clients have reported some history of trauma." Like Nicki, Hailee also notices the connection between SES and traumas. Part of the way in which Hailee dismantles systemic social issues, about which they are passionate, is by also specializing in trauma work. Having worked with women and their reproductive justice for years, Hailee knows the vast impact trauma has.

They state: "I assume all my clients are traumatized. I assume that if it's a story that is not shareable, it is something that was never given words when it happened. Trauma shows up in pregnancy and birth so often in a lot of ways that are spoken and unspoken."

Jo says she too "just assumes every woman is traumatized, including providers." These two were not the only birth workers who expressed their assumption that women have experienced trauma. While statistically untrue, this sentiment is a powerful marker of how safe women feel existing in a world in which their power and knowledge is secondary. Women are subject to the "confrontation of a gaze…" (Foucault 1973: xv) and positioned as "a silent body…" (Foucault 1973: xv) in the world as much as they are in the delivery room. That experience with trauma seemingly permeates all female existences within any social space.

Regardless of their immense awareness and aptitude for trauma care, these birth workers do not suggest that the trauma women experience, particularly women of color, explains the United States' maternal mortality rates. Jo asserts that the field has too quickly turned and blamed negative birth outcomes on trauma. In Jo's mind it has become a scapegoat for the immense shortcomings of the medical model.

## PART II
## COMBATTING THE CRISIS: ADVOCACY AND EMPOWERMENT

### *Training and Certification*

The first step to performing birth work is taking a training. All the birth workers I interviewed went through a certification process. This process has become necessary in order to legitimize the support work women have historically always done. Without a certification, doulas are not allowed to work at any Boston-based hospital. This represents a forced assimilation into the rigidity of hospital protocol, where birth workers' knowledge must be validated -- according to the criteria of the system with which they find such fault -- in order to enter the space professionally. This is an example of how knowledge being deemed authoritative, through common discourse, is a dissymmetrical process (Foucault 1971). Specifically, while birth workers are being somewhat accepted into medical space, it is only happening through discourse which the medical community controls. This hegemonic strategy allows birth workers into the space but not necessarily on their own terms and thus not in an effort toward collaboration.

Several of the birth workers with whom I spoke were certified through DONA while others trained with To Labor or other less common training programs. After certification, each

doula must attend three births to achieve official certification. Below I outline how some of the birth workers approached their training.

Nicki was the only birth worker who thought the certification criteria should be more rigid. She is a strong proponent of statewide mandatory training for doulas. This is not because she believes that doulas are not well-trained. Rather, she thinks it will legitimize their careers. She also believes it would help attain insurance coverage for doula support and enhance continuity of care through the prenatal, labor and postpartum periods. These benefits would strengthen Greater Boston doulas' stand against the medical model of care. This makes sense pragmatically and is evidence of birth worker's common goal: to be considered as sources of legitimate information.

For her own training, Nicki took a labor support training course through a world-renowned Boston hospital. She used that training to support five or six pregnant women per year for about a decade. Three years ago, when her children were older and enrolled full-time in school, Nicki chose to enroll in a doula course through DONA, taught by one of the matriarchs of the Boston birth work community.

Hailee (they/them) was very selective in their choice of training. When Hailee heard that Shafia Monroe, a highly regarded West Coast midwife, was offering a training in New England they jumped at the opportunity. Shafia Monroe is a midwife, doula trainer, and cultural competency trainer. She also holds a B.A. in sociology and a Master's of Public Health. Monroe is originally from Boston and in 1978 founded the Traditional Childbearing Group (TCG), whose goal is to reduce high infant mortality rates in black communities. She is regarded as one of the all-time matriarchs of birth work in Boston.

Hailee's experience in, and passion for, the field of reproductive justice started with volunteer work at Planned Parenthood a decade ago. Existing racial disparities particularly drew Hailee to Monroe's work. "[Monroe] is centered around racial disparities and maternal and infant mortality in black communities, which I have seen and heard about as a huge problem both in DC and Boston," Hailee said. Hailee states that this type of training allows them to move closer the goal of liberating women through birth work.

Jordan, who has similar goals, was told by a close friend that she was doing "radical doula work" and encouraged Jordan to look into it. Jordan had no idea what a doula did, nor did she even have any intention of getting married or having children of her own. Regardless, Jordan signed up for a training with a local chapter of To Labor, a national organization that focuses on birth work through a social justice lens. Jordan reports that she had a "phenomenal" experience with her training, attended a few births, and "was hooked. [She] knew this is where [she] wanted to be."

Jordan sees doula training as an essential foundation for lasting change surrounding birth. "Until doula training focuses on basic human rights and reproductive justice we cannot be the source of real change," she says.

At this stage, Jordan fears that some doulas still see their work "making a living wage, accompanying mothers, rubbing their feet and saying 'yes doctor.'" While I didn't encounter this while interviewing a small sample of Boston area doulas, I believe Jordan has the experience in the community to speak to the trend. She indicts this type of birth work, saying, "there is a human rights crisis happening in birth, so if you want to be a doula you have an obligation to do something, to not be complacent."

These doulas took part in different types of training in order to personalize the goals of their birth work. While a mandatory certification may give birth workers some semblance of legitimacy, that legitimacy will come at the hands of an external, authoritative source, which may start to control the counter discourse birth workers have worked so hard to solidify. The current system keeps birth workers as the masters of their own work and allows them to seek out trainings which speak to what inspires their careers.

*Continuity of Care Model*

Every birth worker with whom I spoke centered their work around providing continuous and attentive care from their first intake meeting until the mother is settled with her new child. This is a care model which is not utilized for women who are cared for solely by medical providers, who do not have a birth worker as part of their care team.

While they all believe that this results in a better outcome for the mother's experience, some believe it has an even more meaningful impact.

For example, Robin believes that a well-supported prenatal period, as well as a positive and empowered birth experience, are directly related to successful breastfeeding. She is a strong proponent of breastfeeding both because of the health benefits for the baby and because she sees breastfeeding as an empowering experience in which women connect with their own bodies and babies. Robin also sees it as a first task of mothering that instills a sense of confidence in caretaking going forward. Robin brings her mother-focused approach, which she embraces during birth work, into her breastfeeding work as well. In contrast to many breastfeeding nurses, who focus on the baby, Robin focuses on the mother, particularly on the mother's own feelings toward herself, her birth and her baby. She states that a key to successful breastfeeding often

involves providing the mother the opportunity to unpack how she felt during the birth and how she feels in this transitional stage, especially for first-time mothers. This is an example of how the holistic experience of childbirth critically influences a biological process. Thus, it offers evidence that aspects of birth which are often pushed aside as not a medical issue, such as the mother's feeling during and about birth, does in fact impact the body. Robin's work disrupts the notion that women's lived experience is "nonmedical" (Davis-Floyd & Sargent 1997: 61) and helps shape discourse so it is no longer "devalued by all participants, usually including the woman herself" (Davis-Floyd & Sargent 1997: 61).

Suzanne embraces the continuity of care model and is a firm believer that these prenatal visits and an existing connection is of the utmost importance. This is essential, Suzanne asserts, because one of a doula's primary roles, particularly with marginalized populations, is to be an advocate for the client's consent and all-around comfort -- from the moment she walks through the hospital doors. This is seemingly impossible without having previously discussed the clients' lives, their trauma histories, and a myriad of other details. Furthermore, it is decidedly impossible without clients feeling comfortable enough with their doula to express their confusion, doubt, or discomfort about a medical proceeding.

Nicki approaches continuity of care from a different angle. While she also sees it as the optimal style of care, she doesn't believe the current system is set up to foster it. She is a strong proponent of a statewide mandatory certification. She believes it would help with considerations of legitimizing reputation and career identity, enhanced insurance coverage, and ensuring continuity of care. Nicki believes that with increased accessibility, continuity of care could increase and birth outcomes and experiences would improve. This would legitimize and

strengthen the Greater Boston birth workers' stand against the medical model, which often lacks continuity of care.

Birth workers' dedication to continuity of care is evidence of their ability to see their clients as unique people and approach their care holistically. It is the opposite treatment from the "loss of the mother," which Jo described as a factor in dehumanizing patients within the medical model. The birth workers form an interactional relationship with their clients throughout the process of continuous care and subsequently are able break free from the common physician/patient relationship between "a confrontational gaze…. And a silent body" (Foucault 1973: xv).

*Advocacy: Volunteer and Pro Bono Work*

Every birth worker I interviewed was aware, to varying degrees, of the racial disparity that exists within our country's poor maternal outcome statistics. They also have all participated in volunteer programs or private pro bono work to do their part to improve birth outcomes and close the racial gap. This provides them an opportunity to advocate for the most vulnerable and marginalized birthing women. However, the birth workers with whom I spoke were quick to point out that these volunteer programs illustrate the reality that marginalized women who take advantage of volunteer doulas programs receive a lower quality of care than paying clients. Thus, there is tension between birth workers' desire to serve all women, regardless of race, SES, orientation, or religion, and being a part of a program, run by hospitals, which are not set up to provide the highest level of care. This is similar to the contradiction surrounding doula training. Because medical institutions have the upper hand in the "hierarchical knowledge structure" (Davis-Floyd & Sargent 1997: 57), they control the operation of volunteer programs. Thus,

volunteer programs, created for disadvantaged populations, are subject to the same healthcare disparities which saturate medicalized care.

Every doula with whom I spoke had done private pro bono birth work or had worked with a volunteer doula program. This is often how prospective doulas find clients for the three training births needed to complete their certification. However, this leaves some doubt as to the skill level of the doulas who work with marginalized populations.

Suzanne has concerns about the quality of the volunteer programs based on the lack of continuity of care. Volunteer doula work typically involves one to two prenatal visits. However, these visits often do not come to fruition and the doulas, if even called, are only present at the birth itself. This system does not lend itself to the model of continuity of care.

Three years after her doula certification, Suzanne told me that birth work is her full-time job; she does four to six births per month. She also takes on as many volunteer births as she can through a volunteer program connected to an adolescent reproductive health program at a Boston-area hospital. Suzanne says she regrets she cannot do more, but depends on income from paying clients. She is also unsure if volunteer programs such as the one in which she participates can truly make a difference: the process of providing care differs so widely between paid clients and program clients.

For example, Suzanne's process for a paid client is outlined below:

The full doula package, at a cost of $1,500, provides her clients with two antepartum meetings to discuss client preferences, provide childbirth education, and talk about various comfort measures. Perhaps most importantly, these meetings are used to build a relationship and form a bond of understanding and trust between the birthing person and the doula. Suzanne is present throughout the entirety of the birth, regardless of how long that process takes. She also

provides two postpartum visits, one in which she reviews the birth with the client and the other to answer any questions about swaddling, breastfeeding, or simply to be a safe set of arms while the new parents rest. After that she is available at a rate of $35 per hour to provide additional postpartum services. Suzanne also offers a $900 doula package with only one antepartum and postpartum visit. Both packages also include 24/7 support via phone, text, and email from the time of hire until the final postpartum visit.

In fact, just as our interview was wrapping up, Suzanne took her phone from her pocket and shared that one of her paying clients, who had a scheduled cesarean the next day, had informed her of a loss in the family. I realized then just how intimately involved doulas are in their clients' lives.

The volunteer doula program serving adolescents with which Suzanne is involved has a very different model. After the teens are offered free doula services, usually through the midwives at the practice, they are randomly assigned one of the more than 20 volunteer doulas in the program. Despite the required training, many doulas enrolled in the volunteer programs have not actually attended a birth before. They frequently participate to acquire the three required birth experiences to complete their certification. Therefore, many of the doulas in this program are new and far less experienced than doulas who only work with paid clients. Suzanne is one of the few veteran doulas in the program. She acknowledges that many of her colleagues in the program have little to no experience actually seeing a birth.

Once a doula-client assignment is made, the doula is tasked with contacting the new client and setting up an antepartum visit. This takes place at the community health center where the client's midwife practices. These meetings often do not take place. Suzanne does not offer a single explanation for this, but some of her experiences suggest that her clients are intimidated to

meet with someone, do not want to discuss their trauma (especially if it had to do with how they became pregnant), are anxious about the language barrier, or simply do not totally understand what they have signed up for in accepting a doula's assistance. While this is not always the case, it is a common enough occurrence to note and to explore why this resource is not being utilized. Suzanne says that she tries to set up a second meeting following the first, yet often the first meeting takes so long to coordinate that the client will go into labor before the second meeting actually takes place.

Another frequent occurrence is the client's failure to call the volunteer doula when she actually goes into labor. This could be attributable to factors similar to those explaining clients' failure to attend initial meetings, Suzanne says. It could also be the result of a general lack of connection or trust after meeting with the volunteer birth worker assigned to them.

Suzanne raised all these factors in her recognition that perhaps her volunteer work is not as helpful as many doulas might think. Her main concern is the lack of continuity within the volunteer program versus what she provides paid clients. However, she does point out that there are benefits to this program, and ways in which it arguably offers more continuity than other area programs.

For example, most other volunteer programs in the area schedule using shifts. This shift work model means that regardless of the doula who meets with the client during their antepartum meeting(s), the doula on call at the time of labor will work with the client through her childbirth process. This means the continuity of care is even poorer than that of Suzanne's volunteer program. Even if they had a successful first meeting, in which a trusting relationship was built, it is possible the doula with whom they met will not be the person present during actual labor.

Hailee's attention was focused on this trend throughout working with the collective. Hospital social workers had frequently called stating that clients with pro bono doulas are not supported during their labor. Hailee is particularly concerned because they believe that very important interventions take place at doulas' presence at birth. It permits another person to monitor the mother's well-being and promotes increased advocacy for and adherence to birth preferences.

"A lot of initial studies marking success of doula-attended births come from having a set of eyes to provide accountability for medical staff who otherwise might not pause and consider the necessity of the intervention they may be doing," Hailee says. Hailee also asserts that bearing witness at the birth is critical for postpartum work. Most postpartum discussions revolve around what happened during the birth and the doula is critical in recreating the timeline and reframing the process. Postpartum support also includes evaluating risks for postpartum complications that may have occurred during the birth and went either unnoticed or undisclosed. Postpartum care is not included in any of the volunteer programs' care models and the postpartum period is as important for the mother's well-being as the actual labor.

Hailee believes that controversies about volunteer doula work are rooted in erroneous assumptions about the role of a doulas. For example, pro bono birth workers express that their clients won't call them when they go into labor. Rather than seeing it as giving someone free support and being glad that the mother felt the support was not needed, doulas feel upset that they "didn't get to save the day and be the lovely savior of this poor marginalized person. It's almost like 'God forbid this person had the autonomy on their own or familial support that came through for them.'" Hailee believes that within this "doula savior complex," white savior narratives are inherent.

While Hailee has enjoyed their experience doing pro bono work, they are wary about volunteer doula programs. Specifically, they are concerned about low-income cases in which women receive a pro bono doula through a prominent local program, but only meet with their doula during pregnancy. They don't receive support during labor because their doula is not contractually obligated to attend the birth.

Terri reiterates the tendency for doulas to have a savior complex. As a woman of color, she says she is very familiar with such a complex dictating the relationship between the marginalized and the privileged. She indicts many birth workers for approaching the work from an egotistical perspective. She has noticed that they often think *their* work will solve the crisis our maternal healthcare system is in. Terri considers her work differently. "If I go into a birth and we have a great experience it's not because of me, it's because of the entire team."

On the other hand, Nicki offers an important contrast to this "doula savior complex." While she does exhibit exasperation about pro bono clients not contacting her during labor, Nicki also self-identifies as the mother of a low-income family. She usually can only take on about five clients per year from a Boston-based volunteer program serving adolescents. Nicki would like to spend more time doing this but she relies on the income of her birth work. Nicki reports that her volunteer birth experiences have been generally positive. Most of these clients have been adolescent mothers receiving help for all their pregnancy-related needs through this adolescent reproductive health program.

These clients' medical providers are certified nurse midwives (CNM). They are a strong influencing factor in their patients' choice to use a volunteer doula because "most of them have never heard of a doula before," Nicki explains. She suggests that this is related to her pro bono clients' low-income status. Doula support doesn't really exist in the context of their lives. This

issue of awareness, and subsequent access, is one that the doula community frequently laments, but without a solution. Nicki believes this issue should be addressed by MassHealth covering doula support. By making doulas accessible to all laboring women, the idea and expectation of support during birth would become mainstream.

While birth workers from different walks of life engage in volunteer work, they certainly know it is not the solution to the disparity in maternal health care resources from which marginalized women suffer. Furthermore, volunteer work actually illustrates ways in which the commodification of doula care, like the commodification of medical care (Rylko-Bauer & Farmer 2002), reduces equal accessibility to quality labor support for disadvantaged people. That being said, birth workers do act as a mitigating factor for underserved populations which often need the fiercest advocates at the hands of the medical model.

*Advocacy: Women with Trauma History*

Women with trauma histories are one population which most needs advocates during labor. One of Abigail's births offers a simple example of the importance of this advocacy role.

Abigail describes a time when she was attending a birth at a Boston-based teaching hospital. During a shift change there was the normal medical team, plus five additional medical students. Her client, a young black nursing student, clearly felt uncomfortable: two of the medical students were men and everyone in the room except her client was white. The obstetrician bluntly stated that they were going to check her cervix and a male medical student would perform it. Abigail said her client visibly tensed, looked very uncomfortable, and said something quietly under her breath. At that point Abigail recognized that her role as an advocate in this situation was to amplify her client's voice. She did so by calmly, confidently and loudly

asking, “Are there too many people in the room for you right now?” This easy action gave her client the opportunity to state her needs directly to her doula, without having to engage in a direct confrontation with her medical providers, which can feel impossible in this power-laden dynamic. The client nodded and Abigail turned to the nurse and said, “We probably don’t need all these people in here for a routine check, right?” The nurse responded, “absolutely not” and they were able to clear the room. The client could then tell Abigail the exact number of people with whom she felt comfortable. She also expressed that she did not want any males in the room. They were able to make her room a comfortable and safe space and ensure that the only people who touched and saw her body had explicit approval.

While handling her client’s discomfort was fairly simple in this situation, Abigail and her client were both certain that the client would not have been able to say anything if Abigail were not there. Abigail’s amplification of her client’s voice is a form of “consciousness raising” (Hooks 2000: 7) in that it allowed her client to see that the non-consensual tone of her physician should not be normalized and does not have to be accepted blindly. In this example, Abigail illustrates that birth workers, simply by asking their clients a simple question, can simultaneously rupture the unspoken assertion of power between doctor and patient and send a clear message to the patient about how they should expect and demand to be treated.

In addition to the reminder of the importance of her advocacy role, this birth reminded Abigail of the importance of continuity of care, particularly for clients with trauma histories. She realized that multiple, thorough, and candid prenatal meetings are vital. She was unable to obtain a trauma history from this client. Such information likely would have helped her foresee the client’s discomfort with men. This would have allowed her to prepare specific coping strategies for possible triggers. Abigail knows from her own lived experience as a woman that “most

women have some kind of trauma history," but she also recognizes that having an explicit conversation with her client prior to labor would have fostered a relationship of deeper understanding and made her a more effective advocate. Note that with volunteer programs, in which doulas work with marginalized women, the reality of having a chance to do this thorough prenatal work would be low. Therefore, this presents another way in which even birth workers can fall short of providing equal care.

Nicki, along with increasing numbers of birth workers and medical providers, has been trained in trauma-informed care. Her first step in delivering this care is to ask all clients in their initial forms if: 1) they have experienced some sort of trauma; and 2) if they want to talk about it. Most frequently they answer yes, they have had trauma, but no, they would not like to talk about it. For Nicki, the "what and why doesn't matter," but simply sharing the information heightens the closeness and the trust level in their relationship. She states that she is extra attentive to and protective of clients who do have a trauma history. Through this work, she says she hopes birth can be healing, transformative, and create a positive lasting memory.

Fortunately, Nicki states this is increasingly coming to fruition. Trauma-informed medical providers are a fairly new phenomenon, she says. She reports that she has seen much more emphasis on physicians providing more information, seeking consent, and giving opportunities for questions. She sees their work making a lasting impact. "Every woman is asking more questions," she says, which is the first step in regaining control.

Hailee's approach to consciousness-raising (Hooks 2000: 7) in the context of trauma-informed care focuses on clients' connections to their bodies. Hailee starts by asking questions like "What part of you is tensing? What parts of you can't fully be here right now?" Hailee believes that women are socialized to be very disconnected from their bodies and are also fairly

likely to suffer from trauma, further severing them from their bodies. With this disconnection comes a complete loss of both self-worth and belief in the body's capabilities. For this reason, when clients are tense or feeling triggered Hailee does not tell them the they need to relax. These women are "already hearing negative messages about themselves and constantly combatting that. If they can't relax they don't need to beat themselves up on top of that." This consciousness-raising (Hooks 2000: 7) technique can help women start to believe that being triggered is due to the toxicity of patriarchal culture and not their own weakness or shortcoming.

Hailee's goal is to provide a judgment-free space in which their clients feel safe and hopefully have a moment where they feel connected with their bodies. While Hailee doesn't assume that there will be a magical moment during which the clients will "snap into their body," they have seen births be a great reclaiming experience. One example Hailee recalls was during a postpartum visit rather than during the actual birth. Upon arrival at the client's house, Hailee noticed the client was visibly upset. The client then said that she hadn't been cared for in weeks and everything was just about caring for the baby. The client wanted a massage, so Hailee happily massaged her. The client then told Hailee that in that moment she felt her body and knew her body belonged to her and not solely for the child's survival. Hailee says "some of these women actually cry with the idea that I don't think there's anything wrong with their body, there's nothing shameful there. I think that they are incredible, a deeply human person in a body and that is amazing. People have never heard this before." Thus Hailee, through consciousness raising (Hooks 2000: 7), can bring attention to the ways that her clients have consistently been fed cultural discourse that villainizes their bodies. By bringing attention to that discourse, Hailee can help dispel clients' long-standing belief that their bodies are perpetually failing them, and instead insert the possibility of a counternarrative.

Jo also focuses on dismantling the idea that something is wrong with her clients with trauma history if they have trouble relaxing their bodies. Jo believes that many doulas, whose pro bono work engages them more frequently with vulnerable populations, and subsequent high trauma rates, often blame the woman "if they don't open up [their vaginas] enough." She is conscious of this tendency during her own work. She does not want to "blame the victim," making her feel like somehow it is her failure. Her message is clear and concise: "You have done nothing wrong; you can't do labor wrong." Again, this reframing employs a technique of consciousness raising in which women understand they can take personal blame off themselves and instead understand how their bodies have been abused by a society steeped in sexism and rape culture.

Jo approaches her work with the understanding that "everybody is the walking wounded." Recall that this assumption is fairly common, as described in the section entitled "Trauma history". It is an attitude in which Jo and other birth workers approach everyone with compassion, whether Jo knows their specific histories or not. She notes the difference between acting as a doula versus a midwife. When she was only doing doula work she wasn't aware of how much important client history she was missing. As she started midwifery she realized that she was learning critical knowledge about her clients. This includes anxiety, depression, bipolar disorder, maternal or paternal issues, and trauma history. Jo has incorporated this into her birth work because she has realized that being able "identify what's going on and talk openly with the client" is critical to caring for a client holistically. It offers a true contrast to the medical model.

*Advocacy through Counternarratives: Encouraging the Use of Midwives*

While birth workers approach their process from a non-judgmental perspective, many propose that their clients have a midwife-attended birth. Much of this is attributed to what they have witnessed in hospital settings and the faults they find with the medical model as laid out in Part One.

Sarah, for example, is working to get birth back into the hands of midwives by attending a certified nurse midwife program at Yale University. Because her bachelor's degree was not in nursing, she will spend her first year at Yale becoming an RN. During the second and third years of the program she will work towards her master's in nursing, with a specialty in women's health and midwifery. Sarah cites her experience working in a hospital OB-GYN department as a main reason for her interest in nurse midwifery, rather than becoming a labor and delivery nurse or pursuing obstetrics. Her experience at the hospital, and what she has learned on her own time and through the birth work community, has made her partial to midwifery-attended births. She states that time and again studies show that "people who see midwives have lower incidences of complications in labor and use anesthesia less often." She also believes that, unlike obstetricians, midwives are trained to "trust the process." They understand that "a birth is not going to be great because they got up in there and managed every second." Sarah sees this oppositional training as the result of obstetrics being positioned historically, and within modern discourse, as the opposite of midwifery.

Nurse midwifery "is appealing because it is the intersection of medicine and social justice," Sarah adds. She notes the difference between the medical students she worked closely with in the hospital and her peers at the Yale CNM program: she says her peers "give a shit in every way, they truly care about people, and justice and equality." Most importantly, Sarah says

she wants to work with people who "care about the mother's emotional well-being as much as they care about the physical health of the baby and the mother." She understands that birth is a highly emotional, vulnerable, and ubiquitous female experience, and believes that those considerations must be at the forefront of maternity care.

"Midwifery is very spiritual. It is a very different thing than being a doctor. It is sacred profession." In this statement Sarah illustrates the general sentiment of birth workers, who embrace their approach to labor as essentially different than the medical approach but equally, if not more, valuable. It their effort validate "nonauthoritative knowledge systems" (Davis-Floyd & Sargent 1997: 57) and their benefits to maternity care.

Jo, Sarah's mentor, is also a CPM and she sees her work as an avenue toward empowering women to feel confident that they do not need the medical model to have a successful birth. Jo and Jordan, both CPM's, see community-based midwifery as a viable alternative to the broken medical model of maternity care. However, this demands the condition that midwifery no longer be defined as oppositional to medicine but rather as legitimate medical care, relying on obstetrics if surgical intervention is needed. It is critical that the midwife is someone familiar with their client's social context and thus can truly care for the laboring women, mind and body.

Fostering women's wellness as a community-based effort echoes Hooks' view that effective "consciousness-raising groups... take place in communities, offering the message...to everyone irrespective of class, race, or gender" (Hooks 2000: 11).

*Advocacy through Counternarratives: Woman are Made for Birth*

One important aspect of birth work is spreading alternative knowledge to challenge commonly accepted, but sometimes problematic, medical discourse. This section illustrates how various doulas do so as a tool to empower women about their own capabilities.

Sarah's passion for challenging medical authoritative knowledge started with the first birth she ever attended. Detailed above, in the section "*The Medical Model and Fear, Power and Control*," this was the mother's fourth child and she had repeatedly been told by physicians her babies were too large to birth vaginally. However, with Jo as the attending CPM she birthed an eleven-and-a-half-pound baby vaginally at home, completely naturally. Sarah saw first-hand that "birth is a natural physiological process, rather than an accident waiting to happen," as the medical model sees it. Sarah was doubtful that the mother's previous scheduled C-sections were actually necessary as the physician had said. "The mother being lied to about her options set my tone for wanting to help people advocate for themselves and their own experience," Sarah said. She realized that she wanted to support women who knew what their bodies were capable of and empower other women to come to know their own power for birth. Thus, Sarah participates in "consciousness- raising" (Hooks 2000: 7), where she illustrates to her clients that their doubt in their bodies' capability is fueled by hegemonic medical discourse not by experiential knowledge of other birthing women.

Nicki engages in consciousness raising in a similar way, what she calls "reducing classical conditioning" of what childbirth is like. She believes that what most women have been taught about childbirth is wrong. "You are taught your whole life that this is going to be a horrible thing that happens to you," but Nicki reframes this to say to women: "This is your power, and you can own it." Reducing fear is central to successfully reframing the process and

empowering clients through changing their understanding of labor. Nicki does this with a five-step process. First, she educates, providing information about the process and answering any and all questions. She then discusses the mind-body connection, sharing techniques to allow their brain to help, not hinder, the bodily process. Nicki also discusses accessing the mammalian self, reminding her clients that their bodies are made to do this. After this, she teaches them methods toward achieving unconditional acceptance of the process, which their body will dictate. Last, she teaches them the best strategies for avoiding unwanted interventions. These five steps aim to address any fears and anxieties her clients may hold and provide them with the knowledge and the skillset to address potential complications. Through this, Nicki believes she prepares her clients for a birth which will be "a long-lasting positive memory." She hopes this will change the narrative around birth generationally, so women are not taught it is a process they cannot handle but rather are sure it is something that they are made to conquer. This will hopefully empower future women to be the force behind a "discursive shift change" (Hall 1997: 31), in which their embodied experiences dictate narratives about birth.

Nicki specializes in home-hospital birth. This style of birth describes the laboring mother who wants to be in a hospital setting but wants little to no medical interventions. Nicki enjoys these births because she recognizes "the value of medical care, especially in Boston, which has the leading minds in the medical field." Nicki is quick to acknowledge that the prowess of physicians is important and sometimes their medical skills are "absolutely needed." The idea that sometimes medical attention is necessary is the consensus among all the birth workers with whom I spoke. They critique the singular narrative that complete medical control of the process is the only safe birth plan.

For example, Judith advocates against the concept that pregnancy is a medical case, rather advocating for its status as a natural process. She heard this narrative during her own pregnancy and came to believe it was true through her own experiential knowledge. In her prenatal meetings she shares this ideology in an attempt to empower her clients and dissuade them of any fears they may have. She encourages them to pursue a natural physiological birth and prepares them for different scenarios that may arise in this pursuit.

*Advocacy through Counternarratives: Bearing Witness to Birth*

There is a misconception that birth workers must have given birth themselves in order to be effective support during labor. While this is very much contested within the birth work community, and most do not find personal childbirth experience necessary, many birth workers lean on their personal knowledge when talking about their work. All birth workers, however, share the common approach of calling on what they have witnessed behind the closed doors of the delivery room in order to educate others about the process. Their experiential knowledge of this private space is outside the mainstream discourse surrounding birth but is a powerful tool in their community of practice (Wenger 1998) to empower their clients.

Recall Robin, who was introduced to the birth community over twenty-five years ago with the birth of her first child. Her negative experience with obstetricians during her prenatal period led her to giving birth at a birth center. She now uses her unpleasant experience to encourage clients to consider giving birth outside of a hospital setting. She tells her clients that having a midwife is "flying first class versus coach. They get to know you, you see them as frequently as you would like and they are there with you from conception well into your fourth trimester. Some can even take you on as a regular patient for well woman checks." Robin's

personal experience allows her to share an important perspective to her clients, in this case advocating for the use of midwives and warning against some of the pitfalls of the medical model. This too is a form of "consciousness-raising" (Hooks 2000:7), in that it brings awareness to women that the "patriarchy [is] a system of domination" (Hooks 2000:7) which the medical model employs.

Like Robin, Abigail's interest in this work also started when she had her own children. While she expected to be much more actively involved in decision-making during her own births, once she experienced labor she realized the vulnerability of the process. "Every few minutes, seconds depending on where you are in labor, you experience a contraction and that's all you can focus on." She expresses that in these moments the process takes over all aspects of a woman's existence and it is hard to feel autonomy over yourself in those moments. She notes the vulnerability of this time, but it is also happening within a disparate field of power. This places laboring mothers, particularly marginalized women without advocacy, at the mercy of "bio-power" (Foucault 1978: 140), meaning subject to little control over their bodies within this space.

Abigail recalls the vulnerability she felt, even in a self-identified "immensely privileged experience," due to the fact that she was white, older and in a supportive marriage. In addition, unlike some of her fellow Army mothers, she was fortunate to have her husband present at each of her births. Despite all of these factors, she still found labor to be one of the hardest things she has ever done and recognized that something was missing from the experience, someone solely there for the mother's emotional wellbeing.

Abigail gained an understanding of vulnerability during birthing process, which enhanced her sensitivity to making sure her clients are still able to express their needs during labor. Recall

her client mentioned in the "Obstetric Violence" section who was uncomfortable with male providers but couldn't bring herself to say anything. Abigail was sensitive to her client's vulnerability, and subsequent discomfort, and was then able to advocate effectively for her.

Suzanne birthed her daughter at home and she cites that as the inspiration and final push for her to leave her life as a chemist and join the birth work community. She acknowledged her immense privilege in being able to leave her job to pursue her passion. She used her newfound freedom to take a doula training through a national organization which facilitates local trainings.

Jo also turned toward birth work after the birth of her first child in 1995. Inspired by Ina May Gaskin, one of the United States' most well-known midwives, she wanted to have her son at home but was told that wouldn't be possible. Her hospital birth took place at thirty-five weeks and a third-degree episiotomy was performed, which she now recognizes as proof that medical evidence and protocol changes. Her childbirth would have proceeded very differently today. After the birth of her son she suffered from terrible postpartum depression, and although she was able to work full-time, she realized that she could not work in human resources forever.

Several years later Jo decided to have her daughter at home with a midwife in 1999. She cites that as the moment she decided definitively that she "couldn't go back to corporate America and would become a home birth midwife."

Jo and Suzanne both experienced home birth as a process which liberated them from careers which were not fulfilling. Conquering birth outside the hands of the medical model empowered them to take control of their bodies and their lives. Perhaps more importantly, it inspired them to share this same empowerment with other women. Their form of advocacy, as constructed from personal experience, focuses solely on the empowerment of the mother, however she defines it. Furthermore, Jo is able to use her difficult episiotomy experience as

anecdotal evidence for the hazard of blindly accepting a given medical procedure of the time. She explains that medical protocols change through individuals who know their bodies and can say, "Hey, this is not right!"

Another form of advocacy through bearing witness is birth workers acting as a community helping women engage in reflexive consumption (DuPuis) of medical care by engaging in open conversations about the reputations about Greater Boston hospitals and obstetricians. Perhaps the only positive aspect of the commodification of medicine in the U.S, is the fact that patients can sometimes wield a type of consumer power. Birth workers help them do this by sharing information about hospital protocol, racist, classist, and ageist incidents they have seen at certain hospitals, and obstetricians' reputations for violence or unnecessary intervention. Some birth workers like Terri remind their clients of their power as the consumer by "Go[ing] over all their rights, rights of a childbearing women. Most people don't know that they can fire their doctor. Doctors are *employed* by them." This is also a way in which birth workers can help their clients disrupt the "hierarchical knowledge structures" (Davis-Floyd & Sargent 1997: 57) within medical care which contribute to poor outcomes.

Birth workers often post on their private Facebook groups inquiries about the reputation of a hospital or an obstetrician. This is not only an act of reflexive consumption, as they help their client shape her own consumer experience, but it is also an example of how knowledge is the foundation for their community of practice. Their community is shaped and bound together by sharing knowledge outside of authoritative knowledge structures and is thus bound together by navigating birth with "common knowledge, practices and approaches" (Wenger 1998: 5).

*Advocacy: Birth Work During the "Fourth Trimester"*

Birth workers often refer to the first three months postpartum as the fourth trimester. This is evidence that their work is often not complete once the baby has entered the world. The mother still is going through immense change, both physically and emotionally, during this period and frequently needs support. The consideration of the fourth trimester also speaks to the continuity of care model under which birth workers operate. Birth workers have their own unique ways of helping their clients through this transition.

Robin frames this new phase of womanhood in a positive light, using the archetypes of "maiden, mother and crone" to address the transition. She calls upon her own experience of moving through the world as a woman and a mother to help clients embrace each phase of life. Furthermore, she believes their coming to terms with each new phase can also help ease the physical tasks of motherhood. For example, Robin, an experienced lactation consultant, has seen a trend that the more a mother is able to psychologically accept her role as a mother, the more easily she is able to breastfeed her baby.

For Abigail, part of making sure this happens obviously takes place in prenatal meetings while setting up birth preferences, at the hospital while acting as an advocate, and after the birth. Abigail's postpartum work is centered around care for the mother, continuing education, and debriefing the birth. This work takes place over the course of the fourth trimester, the first few months of the baby's life.

Abigail is quick to state that her postpartum work is certainly not playing "the nanny role." While she is happy to take care of the newborn occasionally so the mother can rest or have a moment to herself, her work's mission is to be a care person for the mother. This can even

include “light housework or cooking” as long as her work achieves the end goal of “helping the parents be better parents.” She believes that there is a shift from being cared for during pregnancy, to receiving little care as the new mother, who is bearing the additional responsibility of a newborn.

> I think that we forget that women after they have a baby are recovering, physically recovering, plus they have all the hormonal changes from their bodies, their brains are different; we know their brains are different. Um, and they’re also nervous and they have these new babies to care for and they’re sleep deprived and there’s just so much going on. So, I think having a doula there to help take care of you, first of all it’s not your mother-in-law, so you don’t have to worry about making them feel bad or making them a cup of tea. You know that’s the first thing I say when I get there, they always say can I get you something, and I say “no. we need to establish this right away. I’m not here for you to entertain me. I’m here, I’m not a guest, I’m here to take care of you, I’m here to see what you need.

Abigail also recognizes the heightened need for postpartum care in a country that has neither mandatory paid maternity leaves nor the cultural expectation of mothers receiving a “lay-in period.” This is a time during which the mother has no responsibilities other than learning to care for her baby and, perhaps more importantly, a time when others understand that mothers do in fact need time to recover. The lack of acknowledgement of mothering as a form of labor, during which women deserve to be paid and their sole focus should be recovery, offers a contradiction to the way childbirth itself has been commodified. While the medical world uses “competitive market principles” (Rylko-Bauer & Farmer 2002: 388) to make money off of natural life processes, such as birth, the same commodification of life processes is not accessible to individual mothers. This is evidence of an underlying economic system which will commodify human experience when valuable for institutions but not for the benefit of individuals.

Abigail’s insistence on postpartum care goes beyond the monetary realities for new mothers. It is also due the fact she believes mothers often lack access to what Wenger calls

"knowledge economy" (1998: 7). She believes that postpartum care is more necessary now simply because most women no longer live down the street from their mothers and grandmothers. "We don't raise our babies the way we used to," with influence of older generations, Abigail states. This means that women do not have access to information and advice that would have passed down generationally quite naturally. Specifically, she sees this in her breastfeeding work. "Many women whose mothers didn't breastfeed, grandmothers didn't breastfeed, and have never seen someone breastfeed, they just don't have anyone to help them figure it out." She has seen women who have no idea how to position their baby for being breastfed or hold their babies as if they were going to be bottle fed, because "that's all they've ever seen." It does make one wonder how much of this has to do with our society's frequent rejection of breastfeeding in public. As Abigail puts it, an act "only practiced in private cannot easily be passed from person to person."

Abigail reminds her clients that it is okay not to know these things and explains that it is okay to have questions. She provides a judgment-free space for them to ask any questions they may have about swaddling, breastfeeding, diaper rash, and even maintaining romantic and sexual relationships with a new baby in the house. Abigail believes that "as a society we seem to put more value on being strong and independent than anything else. Women struggle their whole lives to be seen as just as strong and independent and then they have a baby and it is hard for them to admit they need more help." Thus, her mission is to remind them that needing assistance is not the antithesis of strength. She teaches mothers that not immediately feeling maternal instincts, not knowing how to swaddle their newborns, or not knowing why their newborn has low weight gain does not mean that that they are less of a woman or failing as a mother. Her approach dismantles the idea that in order to be adequate mothers, women must have a

superhuman power to never need assistance in their mothering, even within the days after labor. Abigail's work effectively rewrites these problematic narratives, which are often at the center of nuclear family structure.

This work starts with debriefing the birth afterwards, which in most cases is just as important to the mother's emotional experience as what happens prior to and during the birth. For example, if Abigail has a client who expresses that she wants a complete natural birth, then during labor changes her mind and decides she wants an epidural, Abigail will process that decision with her. Abigail explains that often times in such cases, "they feel a little bit like they have failed in some way, you know they haven't quite met their mission." She sees it as her job to help reframe what happened. For example, she will restate the events from her perspective. She explains, "they made the best decision based on what was happening at the time, which is not the same attitude as 'oh none of that matters because you have a baby.' It's helping to talk through it, and saying 'this is what was happening when you made that decisions and after the epidural you slept for three hours and then you really had the energy to push that baby out.'" Just as prenatal work focuses on encouraging clients that they are made for this amazing feat, postpartum work is assuring them that no matter how it happened, they are incredible, and they did not fail. This is a way in which women are teaching other women to reframe and to realize that despite the societal trope, women's bodies are not always failing them.

Examples such as these demonstrate why postpartum doula work is so necessary. Just as prenatal work focuses on encouraging clients that they are made for this feat, postpartum work is assuring them that no matter how it happened, they are incredible, and they did not fail.

Abigail is careful to point out that sometimes it is not a matter of reframing but more a process of understanding and coming to terms with obstetric violence or clients' trauma histories

which still haunt them. Abigail understands that "sometimes, some of the things they went through are really awful and hard and they really need to talk about it until they feel okay, regardless of how long that takes." However, the postpartum process is about validation and reframing, more than mitigating future problems that may arise from obstetric trauma.

Jo describes her work as "amazing and beautiful and gorgeous and exhausting and hard." She is a "tour guide through a crazy process." That process does not stop directly after the baby exits the birth canal, or even the hospital. During the fourth trimester she focuses on reframing the birth so her client feels encouraged and powerful, not "defeated and man-handled." Jo says her job is to share information, positivity and empowerment not only with laboring women but also with her colleagues. She believes that by doing so, each woman can then become "citizen publicizers" (DuPuis 2000: 290) themselves and contribute their embodied knowledge to narratives about birth.

*Advocacy: Empowering Clients through Birth Philosophies and Preparation*

Hailee has worked both as a volunteer doula and with paying clients. They approach all clients with the same philosophy.

> When you're pregnant, literally everyone has an opinion about everything you do from sushi to seatbelts and my goal is to not be one of those people. For them to have someone, literally anyone, to be that person. It says something about our society that they need to pay someone to be that person, who is not going to judge them. Messages about female communities center around cattiness, pettiness, and the expectation that women are just gonna judge each other. They worry that it's just going to be some bitchy situation but in my birth room we have a different way of relating. I am there to affirm who they are and what their body can do. It blows a lot of people's minds. I tell them I'm not here to judge you. We talk a lot about the physiology of birth, that contractions are putting multiple pound per square inch of force. It is such a strong muscle. I try to keep them sipping water, bringing awareness to their whole body, that it's doing something amazing.

These philosophies act as a means to reframe the way women think about their own birth process and their own ability to make decisions about themselves and their bodies. By allowing clients to make their own decisions, Hailee continually reinforces that they are capable of listening to their own bodies and making their own decisions. Hailee hopes that the repetition of this philosophy will result in client's heightened sense of autonomy and empowerment when it is time for labor.

Jo sees her philosophy as intrinsically connected to the birth worker community of practice (Wenger 1998). She states that just as she learns from and is empowered by her colleagues, she tries to send that gift forward to her clients. She is sustained by the "group of women who are the experts. Women are compassionate, women are amazing and powerful when we support each other."

Judith's goal is to "provide informational, emotional and physical support to women and their families. I do it in a way that supports your vision for your birth, with no judgment. What I hope to provide is a sense of confidence in yourself, in your parenting, your new life, the new extension of your life. I want to provide. I am calm and joyful and I want to instill confidence in the decisions of the parents." She believes the key to instilling this confidence is using the stories of women who have conquered this process and who can provide experiential knowledge to counteract medical authoritative knowledge.

Terri focuses on preparing her clients before birth to allow for a smooth process. Rather than having to say something in front of the physician or nurses in the moment, she provides her advice and cautionary tales before. She outlines her process below.

> I start with prenatal visits, two prenatal visits. The first visit is going over childbirth as true physiological birth, not a medical event. I explain you are not sick, you're just having a baby. Once people see that they know how it will go naturally they feel better. I never want to scare you but I do want to prepare you. I

> would rather have you know all the information before you are vulnerable. I go over everything, all of the interventions and the implications of those short-term and long-term. Then I go over all their rights, the rights of childbearing women. Most people don't know that you can fire your doctor. They are employed by you. I recognize that you might have a fear of doctors or feel like you have to listen to them, but they work for you. Your nurse is a patient advocate and should be advocating for you not for the attending doctor. If you're not feeling a doctor or nurse, you can ask for the charge nurse, you can just say you aren't feeling this nurse right now. If staffing allows for it they will change the nurse. This is a life-changing moment for you, you will remember this for the rest of your life. This doctor and nurse it's a shift for them, it is fleeting. Their shift will end and that's it. So, speak up for what you want, this will affect the rest of your life.

Terri tries to continually remind her clients that their births are not about anyone except themselves. She even tells them to "kick [her] right out" if there is a time when she is causing any agitation. She has noticed that as long as she does a thorough job of making her clients feel in control before they go into labor, and knowing their rights, that they will, for the most part, speak up for themselves. In her effort to maintain positive relationships between herself and the medical professionals, she "can't advocate for them in the room, but they can always ask for five minutes alone with [her] during which all the medical staff will leave and [she] will give them the language to advocate for themselves." During this time, she gives the energy and empowerment but stays invisible and does not involve herself with the medical team.

*Feminist Birth Work*

Sarah, Alyssa, Hailee and Jordan all propose ideals of feminism, liberation and radical birth work as the focal points of their careers. It is critical to note that this feminist birth work is not exclusive to cisgender women, but rather is a movement that supports any *body* which gives birth, regardless how they may self-identify.

Sarah describes her work as being "feminist, holistic and human rights-based." She had worked for a student sexual health group which had focused on feminist and reproductive justice-based goals, but she described learning about birth work as being a "beautiful 'aha!' moment." She realized that birth work was the way in which all of these passions could form a career. Then she started researching different training programs and decided to take a training through To Labor, because it "aligned with [her] ideals of approaching birth as a social justice issue." Sarah believes that she was preparing most of her life for her work because so much of it was built through her feminist upbringing and existed before she knew what birth work was. She also attributes her liberal arts education to learning about economic, racial and healthcare disparities. This allows her to take her work past the surface level of merely helping women but fosters an intersectional understanding of social determinants of health necessary to truly engage in social justice.

Alyssa also describes her doula style as being based in her feminist ideals. While she has always thought of herself as a feminist, she is not as familiar with being an activist. Her work is her entrance into the world of activism and advocacy. She recognizes that she still has much to learn about the "whole spectrum of ways you can be a feminist," but, for now, supporting mothers is her outlet. She believes that birth work goes beyond supporting mothers and is actually more of an act of "protection." She says she has always "taken on that protector role. Even since [she] was young and someone was getting picked on." While she recognizes the vast difference between schoolyard bullies and unethical medical practice, she also sees how they are one and the same. "It's really all about power," she explains, "and if I can step in and balance that playing field out, give someone a voice then I will." This "bio-power" (Foucault 1978: 140) is steeped in patriarchal power and thus must be addressed not only from a feminist lens, but

from an intersectional feminist lens. What Alyssa calls “unethical medical practices” are intrinsically tied to gender, race and class and thus must be addressed as so.

While Hailee started reproductive health work to actualize their feminist beliefs, they now see the work more closely aligned with liberation ideology. Hailee’s feminism is more implicitly involved in their work than it was during college. Hailee says they used to talk about feminism all the time, particularly related to policy and politics. However, over the years Hailee has realized many white feminist narratives rely on politics as a fix, one which is both ineffective and exclusionary to marginalized communities. Hailee decided to then turn their work to community-based action -- to help people survive and thrive in “a world that is trying to kill us.” Rather than identifying as a feminist -- while they do align with some feminist values -- Hailee doesn't feel the feminist mission is radical enough or inclusive enough. So, their focus is therefore on an ethic of care which liberates. Hailee instills a sense of agency in hospitals, a space which requires people to defer to a hierarchy.

Hailee’s movement away from white feminism was also inspired by their own queer identity. While white feminism often centers around autonomy, it does not address how other identities deal with autonomy in the context of racialized policing, immigration, and LGBTQ discrimination. Hailee realizes that their queer identity puts their “body under the policing gaze that pregnant people are under,” and felt solidarity with pregnant women. This policing gaze is what Foucault refers to in the clinic as the patient being subject to the “confrontation of a gaze…” (1973: xv), only instead of legal power, physicians wield, the perhaps more influential, “bio-power” (Foucault 1978: 140). Hailee sees an intimate connection between how the queer community cares for each other “in very moralized spaces, where people’s personal lives are policed because of their identities.” Regardless of how Hailee’s clients define their own

identities, liberation work means that Hailee "sits and holds their humanity as sacred, no matter what."

Now that Hailee is a certified doula, attending births is their most recent contribution to liberation movement and reproductive justice. Hailee has attended four births since her certification and each has varied greatly.

Jordan classifies her birth work as "radical" and believes that "radical doula work is necessary; [they] need to be willing to take that risk." She has a clear definition of what being a radical doula means to her.

> Being a radical doula is being willing to step outside of the confines of what a doula is 'supposed' to be. I am willing to cross those lines when it comes to advocacy and serve individuals who don't fit into boxes. I make a deliberate point to be inclusive and to stand up and fight for what's right, champion for reproductive justice whatever that looks like. Radical work has to be full spectrum work, through loss, abortion, miscarriage. It has to be loud. We are entitled to reproductive health care whatever it looks like and whatever we need. It is all about taking radical political action to take back control over our bodies within a society that tells us we aren't capable of deciding anything for ourselves. My mission in the work that I do is to make sure that my clients understand that they always have choices and my goal is to make a change in this system!"

This philosophy was shaped from Jordan's years of work. She described the prejudice she has witnessed to be a contributing factor. Additionally, after seeing "moms give birth in the safety and comfort of their own homes, I see how birth can go and then I walk through the doors of a hospital and I see how 99 percent of people in Massachusetts give birth." Jordan describes this as "women being robbed of an experience they didn't even know they were allowed to have." Her philosophy centers around helping women know what they are missing out on.

> We are told time and time again that our babies are not gonna come out on their own. Sometimes babies won't come out, and we do need help. That's the nature of childbirth, nothing on this earth is perfect or without risk. But at the same time, our bodies are made to do this, biologically we are made for it. Within the

> medical system we are told time and again that we can't do this, but with some time, patience, movement and trust, the babies come out just fine, without yanking and managing mother's bodies. It is frustrating.

Jordan copes with this frustration by relying on the community of birth workers in the Greater Boston area. She says that birth work is the "most emotionally taxing thing [she] has ever done." She describes the community as the thing that "keeps [her] afloat." This bears a striking resemblance to what Hooks call a "politicized sisterhood" (Hooks 2000: 11), referring to the women who engaged in the original effort of "consciousness-raising" (Hooks 2000: 7). Together they bear witness to trauma, and many unfortunate or even tragic things, but the community of doulas reminds Jordan that she is never alone in carrying this burden. Her colleagues are her "life support" and she is eternally grateful for them serving as a constant reminder of "the incredible things that can happen when women come together and decide to demand better."

## CONCLUSION

My ethnographic study of Greater Boston birth workers resulted in several findings. First, these women reject singular medical discourse regarding birth and challenge the idea that medicalized birth is infallible. Such authoritative medical knowledge acts as a binary where experiential knowledge of women is meaningless in comparison. Second, these birth workers make direct indictments, asserting that the medical model is paternalistic and overly controlling in nature, which often leads to unnecessary interventions and obstetric violence. Several of them find fault with the way obstetricians are trained within the medical model and the commodification of healthcare leading to inequality of both access and quality of care. Third, these birth workers see a clear disparity in the way their clients are treated based on race and

SES, and this can be understood as a way through which physicians assert "bio-power" (Foucault 1978: 140) over patients. In this way, biological existence relies on the patient's political existence (Foucault 1978: 142), which is particularly salient for marginalized women. Thus, "bio-power" (Foucault 1978: 140) must be addressed with intersectional thinking at the foreground. Fourth, birth workers push back on what they believe to be a broken maternity care system by forming counternarratives, their own discourse, about birth. They spread this alternative and often experiential knowledge about birth by acting as "citizen publicizers" (DuPuis 2000: 290) on this topic of contested knowledge. Fifth, they engage in "reflexive consumption" (DuPuis 2000: 285) of commodified medical care by speaking both in person and online about the reputations of both physicians and hospitals. They therefore empower their clients, as the consumers of medical services, to interact with market-based medicine as empowered consumers. This is, of course, complicated by issues of class and race, and do not present equally viable options to people who do not have the luxury to shop around for doctors. Lastly, by presenting women with empowering narratives about birth and a deeper understanding of the shortcomings of the medical model, birth workers employ "consciousness raising" (Hooks 2000: 7) as a tool to illustrate to their clients that this form of maternity care is not necessarily made to benefit their well-being.

My sample was fairly small and these results cannot be generalized to all birth workers. Nor can indictments of obstetrics be applied to all practitioners. However, my findings presented common themes as seen through interviews and my observations on online forums. It is critical to note that birth workers do not suggest that obstetricians are irrelevant or unnecessary but rather that their training, protocol, and the commodified system of care in which they exist must be questioned.

Ultimately, birth workers, midwives and physicians alike need to search for collaborative coexistence, where race, SES, religion or any other social factors do not impact birth outcomes, and where the mothers' health and experiences are all considered equally important to the baby's healthy entrance into the world.

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