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# Birth matters: discourses of childbirth in contemporary American culture

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BIRTH MATTERS:  
DISCOURSES OF CHILDBIRTH IN CONTEMPORARY AMERICAN CULTURE

A Dissertation

Submitted to the Graduate Faculty of the  
Louisiana State University and  
Agricultural and Mechanical College  
In partial fulfillment of the  
Requirements for the degree of  
Doctor of Philosophy

in

The Department of English

by  
Jennifer Ellis West  
B.A., Mississippi College, 2000  
M.A., Mississippi College, 2005  
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## **Dedication**

For David, who has believed I could do this—and everything else—from the beginning.

For Josie, whose entrance into the world inspired this project, and for Olive, whose birth I am eagerly anticipating as this goes to print.

## **Acknowledgments**

Thank you hardly seems a sufficient response for the support, both personal and professional, I have received on the long journey to completing this dissertation. The professional guidance and compassionate mentorship of my adviser, Sue Weinstein, has, in many ways, provided the fertile ground out of which this project emerged. From my very first graduate seminar at LSU down the often-circuitous route to the research I eventually claimed as my own, she managed to remain unwaveringly supportive of my ideas and my writing, a gift I am certain has made me a better scholar and a better teacher. Irv Peckham and Jackie Bach have been equally encouraging, and their insightful feedback on the earliest stages of this research challenged me and enriched my writing. Barbara Heifferon provided many helpful suggestions on chapter drafts, as well as invigorating conversations that have inspired me to keep going, even after the dissertation is done. I am indebted to Jenell Johnson for countless conversations about my work, for suggesting exactly the right books at exactly the right time, and for introducing me to the field I now claim as my scholarly home. Her mark on this project is unmistakable, and I am grateful for her influence as a scholar, teacher, and mentor. My dissertation committee on the whole provided me the freedom to pursue the ideas that interested me most and a contagious enthusiasm for where that pursuit might take me: both have been essential to my continued engagement with the project. Other professors have contributed much to the formation of my scholarly identity along the way, especially Zetta Elliott, Nichole Guillory, Kerri Jordan, and David Miller.

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over tea with Cara Jones, this journey would certainly have been a lonelier one. Most especially, Kristi Richard Melancon and Jessica Ketcham Weber have been my anchors throughout my tenure at LSU; without them, this project would surely not have gotten written. Equal parts writing group and dear friends, they kept my child, read my work, and saw me through to the very end: I love them both.

Especially in this last year of writing, many people have fed and sheltered my family and me as we have traveled from Jackson to Baton Rouge. The home of Ashley Jones-Bodie and Graham Bodie became a home away from home for Josie and me: delicious food, care and friendship for my daughter, and inspiring conversations nourished me in ways I did not even know I needed. Shelley Massengale was a second mother to my child on many trips: by welcoming a third daughter into her already-full household, never saying she was too busy even if she was, and making us feel like part of her family, she made the trip to Baton Rouge both easy and pleasurable on numerous occasions. Ed and Felicia Song have cheered me on since I first met them. They have cared for my family in so many ways over the years and have buoyed our spirits with rich conversation, wonderful meals, and the gift of their friendship. We miss them dearly.

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## **Abstract**

In this project, I use a rhetorical-cultural approach to examine the multiple and often-contradictory messages circulating in contemporary American culture about the event of childbirth. Though many feminist scholars have shown how professional obstetrics' view of physiological birth shapes medical practice and women's experiences in hospitals, few have asked what the American public is learning about birth outside of the hospital, or why that knowledge might matter. In order to fill that gap, I trace a dominant narrative that positions institutionalized biomedical knowledge and technology as the exclusive producers of health and safety for birthing women and their babies in popular film and television, in the making of medical research and policy, and in the way the insurance industry frames women as consumers or recipients. I argue that it is not just in the delivery room that this ideology gets communicated, nor are birthing women the only ones affected by its messages. Rather, my analysis illustrates how this narrative has seeped into the fabric of how American society as a whole understands and engages with medicine, women's bodies, and science. In the final chapter, in order to explore a growing resistance to this ideology, I turn to the discursive construction of birth in online media. Read alongside the mainstream narrative, the rhetoric in these online spaces illustrates how the stakes of this debate are not just about who gets to decide where and how women should have their babies, but ultimately over who gets to interpret and apply science. The battle over birth in this country is, as this dissertation shows, also a battle over the public's understanding of institutionalized medicine's exclusive claims to scientific knowledge. By exposing the ways that narratives about and within that system function to sustain it, and illuminating the ways that the organizing power of new media is generating resistance to that system, this project seeks to intervene in conversations about the cultural meanings of childbirth,

about meaningful and ethical health care, and, ultimately, about the production and circulation of knowledge about science, medicine, and women's bodies.

## Chapter One

### Introduction: Charting the Discourses of Childbirth and Medicine

“Birth *matters*. . . . What happens to a woman, how she is treated, how she experiences her birth have consequences for how she experiences her body, her sexuality, her child, her family. . . . Birth matters in shaping a woman’s sense of herself, her own body, her own sexuality, but also her relationships with others. Birth matters in how we as a society, as a community of people, look at women and at motherhood. We in America think of birth on the one hand as a basically medical procedure, and on the other as the ‘arrival’ of a baby. We forget, we are unable to see through the medical trappings, that birth is far more than that.”

—Barbara Katz Rothman, “Introduction,” *Laboring On: Birth in Transition in the United States*, Simonds, Rothman, and Norman xvi.

“Science, in general, generates too much hope and too much fear, and the history of the relationship between scientists and non-scientists is fraught with passions, sudden bursts of enthusiasm, and equally sudden fits of panic. If the public could be helped to understand how scientific knowledge is generated and could understand that it is comprehensible and no more extraordinary than any other field of endeavor, they would not expect more of scientists than they are capable of delivering, nor would they fear scientists as much as they do. This would clarify not only the social position of scientists in society, but also the public understanding of the substance of science, of scientific pursuits and of the creation of scientific knowledge.”

—Jonas Salk, “Introduction,” *Laboratory Life*, 13.

In the fall of 2009, an Arizona woman expecting her fourth child attracted a lot of media attention for going against the decree of her local hospital. Joy Szabo had all three of her other children at the northern Arizona hospital closest to where she lived. Her second child was delivered by cesarean section; her third birth was what the medical profession calls a VBAC (vaginal birth after cesarean), and that is the method of delivery Szabo planned with her fourth child too. Seven months into her pregnancy, however, her doctor informed her that hospital policy had changed, and the hospital would no longer allow her to have a VBAC. The “procedure” was now deemed too risky. When Szabo and her husband met with the hospital

CEO to discuss the matter, the CEO told them that if Szabo would not consent to scheduling a cesarean, she would get a court order forcing her to have the surgery. The Szabos decided to take their business elsewhere, but the closest hospital that would allow VBAC was five hours away in Phoenix. Szabo decided to move to Phoenix at the end of her pregnancy in order to be able to deliver vaginally. In the process, blogs picked up the story, and it eventually made its way to Elizabeth Cohen, the senior medical correspondent at CNN. She reported on the Szabos' decision in October, and then wrote another story when Szabo delivered a healthy baby vaginally in December (Cohen, "Mom Won't Be Forced"; Cohen, "Mom Fights").

At the heart of the controversy surrounding Joy Szabo's birth are questions about what constitutes risk, what information hospital policies are based on, and who determines the conditions of birth that are appropriate for individual women and their families. The hospital claimed that they based their policy on the guidelines provided by the American College of Obstetricians and Gynecologists (ACOG), but when interviewed for the CNN segment, a spokesperson for ACOG said the hospital had misinterpreted the guidelines, which ACOG purports are based on the latest scientific evidence about the safety of VBAC. Why would a hospital reverse its policy over the course of just a few years? If the safety of VBAC has been subjected to the rigors of scientific research, why is there disagreement in the health care community about how best to apply the findings of such studies? Why does science have any bearing on the act of childbirth anyway?

The answer, of course, is that in the twenty-first century United States, childbirth has, for decades now, been an increasingly medically and technologically mediated event. From the moment a woman suspects that she is pregnant, she relies on the technologies of medicine to see her safely through to the birth of her child. As Marika Seigel has argued, this state of

technologically mediated pregnancy is one women must opt out of and not into: prenatal care with a medical professional, the diagnostic paraphernalia that are a routine part of that care, and technologically managed birth in a hospital delivery room are a regular part of life for 99% of pregnant American women. The remaining 1%—those who opt out—choose to birth out of the hospital with a midwife or without assistance from any professional. Science has a great deal of influence over childbirth because most women experience it through the mediation of professional obstetrics, a discipline that defines itself as grounded in scientifically based policies and practices. Yet, as the quotes that begin this chapter indicate, the general public understands little about either the potential meanings of childbirth or of the capabilities—and limitations—of science. How the event of childbirth and the discipline of science should relate to each other is a hotly contested issue, rife with the politics of women’s reproductive bodies, the adherence to medical authority, and the location of knowledge about a bodily process that does not fit neatly into a clinical category. Neither always pathological nor always free from the potential for harm, childbirth remains a slippery category for the medical profession.

The lack of meaningful cultural knowledge about childbirth does not stem from a silence surrounding reproduction but from a dizzying array of contradictory messages. From well-dressed “baby bumps” that grace the covers of glossy magazines to a proliferation of pregnancy narratives on television and in film, birthing bodies are more visible in American popular culture than ever before. At the same time, news headlines report rising rates of cesarean section, contradictory medical opinions on issues like Joy Szabo’s VBAC, a medical malpractice crisis for obstetrician-gynecologists, and lobbying efforts by the American Medical Association to make traditional midwifery illegal. Popular narratives that reflect a fascination with the bodily process of human reproduction seem to be multiplying, while meaningful

information for actual pregnant women about where, how, and under whose care to have their babies is confusing and overwhelming. We, in the contemporary United States, see pregnancy and birth all around us, but how much do we know about it? How is childbirth imaged and talked about in mainstream culture, within the medical community and the health care industry, and by women themselves? How do we know what we know and how is that knowledge influencing the American public's understanding of and engagement with professional medicine, health care, and women's reproductive bodies? By investigating the discursive practices at work in producing knowledge about childbirth in contemporary American culture, this project seeks to answer those questions.

### **Situating Myself on the Map: How I Got Here**

I have always been a skeptical patient. Raised by a woman who routinely administered whiskey, honey, and lemon juice for a sore throat, freely dispensed maternal wisdom in place of phoning a physician, and only occasionally followed the advice of doctors even when she took me to see them, I come by my skepticism honestly. So, when I got pregnant with my first child, I assumed the woman who gave birth to me and to three other healthy children would have some sage advice. I never imagined it would be, "Listen to your doctor."

Of course, even if she had offered a different perspective, the dizzying array of medical information circulating in advice books and among my friends was enough to send me scurrying to an expert for the "real answers" to my questions about what was happening to my body. Women had been doing this for all of human history. How could I have lived for nearly three decades (and have earned a graduate degree) and know so little about having a baby? Why did no one around me seem to know very much either?



One night, some time in the middle of my second trimester, I sat at home alone and watched an episode of the popular medical drama *Grey's Anatomy* that featured the story of a pregnant woman whose fall in the bathtub caused her to miscarry. I cried with her as she delivered her dead baby—a combination of pregnancy hormones and the skillful emotional manipulation particular to that genre of television, no doubt—but had forgotten the episode by the time I woke up the next morning. Two days later, I slipped in the rain-slicked hall outside my classroom, and I fell. It was late in the afternoon and my doctor's office had already closed. I could not get my friend who was an ob-gyn resident on the phone. I opened my computer to do some quick searching online about the impact of falls on babies in utero, but the first horror story I clicked on prompted me to quickly close the laptop. After a long, anxiety-filled night, the nurse at my doctor's office assured me that unless I had fallen on my belly, or from a great height, there was no reason to worry. And yet, the image of the fictional patient on *Grey's Anatomy* sobbing as she labored to deliver a baby she knew was not alive was difficult to dislodge from my subconscious. It was that moment that I realized: most everything I thought I knew about pregnancy and childbirth I had learned on television. It was, after all, the only place I had ever seen it: I had watched Annie and Nina Banks deliver their babies at the same time on *Father of the Bride, Part Two*; I had observed each of the births on *Friends*; and I vividly remembered the opening sequence of *Look Who's Talking* coinciding with my junior high sex education class. What I could not remember was any other educational experience—either in everyday conversations with people I knew or from my schooling—that taught me anything significant about childbirth.

And so, as a scholar trained to analyze narratives and discourse, I began to pay attention. I read. I listened. I thought about the ways pregnancy and birth were discussed and imaged in

literature, on television, at the movies, in my grocery store checkout aisle, in the waiting room at my doctor's office, by friends and family, by women writing online. Because I was looking for it, birth was suddenly everywhere, but the messages about how to understand it, much less how to go about doing it, were confusing and contradictory. I wanted to know what we, as a society, knew about birth, and I wanted to know how we knew it. That question led me to this project.

My perspective has inevitably been influenced by my own experience as a pregnant and birthing patient. After scouring advice literature from perspectives as varied as the midwife-authored *Ina May's Guide to Childbirth* and Vicki Iovine's *The Girlfriend's Guide to Pregnancy*, and reading *Our Bodies, Ourselves* and other feminist critiques of the biomedical model of care, my identity as a skeptical patient and as a feminist converged, and I decided that an unmedicated birth with as few technological interventions was the best choice for me and my baby. I chose a doctor in a "natural-birth-friendly" practice and the hospital known for its willingness to accommodate women who wanted to give birth without many medical interventions. I hired a doula<sup>1</sup> and rented a birthing tub, went to childbirth classes and watched videos of women giving birth in the water on YouTube. I took my prenatal vitamins and faithfully attended my usually-five-minutes-long prenatal appointments. So, when I arrived at the hospital after quietly laboring at home in my bathtub, I was ecstatic to hear the nurse report that I was already seven centimeters dilated—I was close! I was less than ecstatic to hear her report that my baby was no longer in a head down position and that they would prep me for surgery immediately.

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<sup>1</sup> A doula is a non-medical professional who supports women through labor and usually offers childbirth education.

My baby girl was born healthy, with a perfectly round c-section head, the nurses told me. I left the hospital with a scar on my abdomen and many questions about what had happened. I had only skimmed the chapters about breech birth; my baby had been head down for my entire pregnancy, and it only occurs in around 3% of all term pregnancies. When my doctor arrived at the hospital, she did not ask me whether I wanted to have surgery; she wheeled me into the delivery room and said, “I’m sorry. I know this wasn’t what you planned.” I do not know that I would have done anything differently if she had asked me; I am not sure that I would have done anything differently even if I had known that many midwives and older physicians believe vaginal breech birth is a good option under the right conditions (one of those, I learned later, is that the caregiver is experienced with breech deliveries, which my doctor was not). Recovering from major surgery while caring for a newborn for the first time is not how I pictured my earliest days of motherhood. However, I learned from my experience that there is a vast middle ground between the two extremes my antepartum reading had defined, between empowering, “natural” childbirth and doctor-directed “routine” childbirth laden with technological interventions.

Was my c-section medically necessary? That depends on whom you ask; there is no clear-cut answer about the safety of delivering breech babies vaginally. What is clear is that my experience was dictated by the context of my medical care: there are not many hospitals where I would have received anything other than the procedure my doctor performed. What is also clear is that this experience, and my still-present conflicted feelings about it, led me not to surer ground and certain answers to the questions provoked by *Grey’s Anatomy*, but to more complicated questions. I realize that these questions are intensely personal for many women; I share my story not to suggest that I am the only one who has ever been influenced by the way

her birth played out, nor to undermine or discount the experiences of women who view the American biomedical system differently than I will present it here. Whatever personal experiences readers may have, I hope they will read with an open mind: the questions that inspired this project were inevitably shaped by my own journey, but my conclusions are grounded in careful research and analysis. Ultimately, what I have learned is that despite the fact that women have been birthing babies for as long as humans have existed, we in the twenty-first century still have much to learn about what—and how—that simultaneously everyday and extraordinary occurrence means. In my view, we need more conversations about how such meanings are made, about how we have come to know what we know about birth and its medical, scientific, and technological trappings, and about how we might create different, better systems of knowledge about not only birth, but also medicine and health more broadly. In this dissertation, I aim to participate in such conversations and to suggest possible conversational directions for the future.

### **Rhetoric, Feminism, and Science Studies: Entering the Interdisciplinary Conversation**

One of the goals of this project is to argue for a more interdisciplinary approach to constructing knowledge about childbirth. As a rhetorician, I will make a case for the importance of rhetorical analysis in getting at the how of medical and scientific meaning-making. However, I also want to make clear that I am not arguing for rhetorical analysis as the only or the most important method, but as a complement to other forms of disciplinary inquiry, both in the humanities and social sciences where rhetorical scholars most often reside, and in the sciences, where productive cross-disciplinary scholarship has been slower to take hold.<sup>2</sup> My project will benefit from, build on, and sometimes take issue with scholarly perspectives from a range of

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<sup>2</sup> Some collaborative scholarship among feminist scientists and non-scientists offers a promising counterpoint to this trend, and I will review the broad field of feminist science studies shortly.

disciplines; I am less interested in claiming the superiority of rhetorical analysis as a mode of inquiry than I am in using rhetorical analysis as one tool that might offer some answers to complicated questions about how American society, views, treats, and makes sense of the messy process of childbirth. Of course, I hope too that my work will enrich my discipline, that rhetoric, as a field of inquiry, can benefit from the kind of boundary-crossing embedded in my project. Inevitably, my argument will be influenced by my disciplinary training as a rhetorician, but it will also be greatly enriched by the perspectives of anthropologists, sociologists, literary and cultural studies scholars, historians, medical researchers, feminists, and scientists, as well as by the perspective of people writing and talking about birth issues outside the boundaries of scholarly disciplines, especially in online spaces.

Such an interdisciplinary approach has been central to the body of scholarship lately called science studies or science and technology studies, and more recently, to the subfield of medicine studies.<sup>3</sup> These interrelated and overlapping endeavors all draw on the same basic principle: that knowledge produced in the sciences is not simply an objective reflection of a discrete and knowable reality, but a construction that emerges from a particular place, time, and confluence of social forces. The work of Thomas Kuhn and Bruno Latour and Steve Woolgar has been influential in shaping this mode of analysis, as has been the work of feminist scholars analyzing the production of scientific knowledge. Kuhn's *The Structure of Scientific*

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<sup>3</sup> The naming of these fields is still in process; some scholars lump them together under the heading Technoscience Studies, and the creation of a recent journal called *Medicine Studies* indicates that the development of that field as a separate but related effort is well underway, which I will attend to in the next section. I am delineating between science studies and medicine studies primarily because, following Katherine Montgomery Hunter, though I am interested in the relationship between science and medicine, I do not accept the definition of medicine as a science "as science is commonly understood" (xvii). To foreground that distinction, I separate the literature review into scholars working primarily on scientific issues and those working primarily on medical issues. That distinction is admittedly murky and shifting.

*Revolutions* uses scientific history to demonstrate that science as a discipline, and specialties within the sciences, have come into being by developing and adhering to what he calls paradigms. For Kuhn, each scientific revolution, or shift in disciplinary understanding of a particular problem, is the result of a crisis that precipitates a paradigm shift. Where his argument bears import for science studies is in his assertion that such paradigm shifts are not simply the result of the discovery of a more accurate or logical method, but rather the cumulative result of some adherents of a new paradigm persuading their colleagues both that the old paradigm is no longer useful and that their new paradigm is the most scientifically sound: “To discover how scientific revolutions are effected, we shall therefore have to examine not only the impact of nature and logic, but also the techniques of persuasive argumentation effective within the quite special groups that constitute the community of scientists” (94). This component of his theory immediately invited rhetoricians into the study of scientific processes, especially scientific texts. He also made a broader case for the interdisciplinary study of science, in order to return the debate of scientific problems to an interdisciplinary conversation: “Although it has become customary, and is surely proper, to deplore the widening gulf that separates the professional scientist from his colleagues in other fields, too little attention is paid to the essential relationship between that gulf and the mechanisms intrinsic to scientific advance” (21). In other words, one thing that has been lost as the paradigmatic model has evolved historically is that an increasingly specialized science has advanced primarily within the confines of scientific disciplines; neither the public’s nor the non-scientific academic community’s understanding of or agreement with such advances has had much influence over what comes to be commonly accepted as scientific knowledge.

Latour and Woolgar, in their landmark study, *Laboratory Life*, also point to science as a social process. They use an ethnographic approach to describe the social workings of a scientific laboratory, focusing on the everyday activities that generate what eventually come to be accepted as scientifically discovered facts. A large part of that process is what they call “agonistic,” or persuasive: the testing of such facts among many others through discussions of experiment results, analysis of other, competing assertions of fact, and debate among colleagues (237). Through this process, one fact emerges as the true description of reality, and it becomes unassailable. Their argument, in the end, is that science is “widely misunderstood,” and is not the practice of “certain individuals” with “special abilities. . .to obtain greater access to a body of previously unrevealed truths; rather. . .scientific activity is just one social arena in which knowledge is constructed” (31). The process of knowledge construction in science is not that different from the process in other disciplines, including their own, write Latour and Woolgar: it is primarily about creating order out of disorder through the use of language, and particularly, through tactics of persuasion.

Though their focus is on the social influences on scientific processes, both Latour and Woolgar’s “agonistic field” and Kuhn’s paradigmatic explanation of science history gave ample room for rhetoricians—whose primary focus is on methods of persuasion—to enter the conversation. Rhetoricians of science have often focused on the rhetorical structures that give scientific facts their persuasive power, especially at key historical junctures, and the object of inquiry has often been either texts circulating in the scientific community or the public discourse related to that circulation.<sup>4</sup> Focusing on rhetorical structures alone, however, misses an important opportunity to embed texts within their particular historical location and to

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<sup>4</sup> For an overview of this kind of work, see Scott, *Risky Rhetoric*, Chapter Two.

illuminate the ways texts work in, with, and against larger cultural arrangements. What rhetoricians have to offer science and medicine studies is an analysis that demonstrates the way language and the material conditions of the world work together to create meaning, but only if context plays a key role in that analysis. As Leah Ceccarelli has argued,

When engaged in critical practice, rhetorical scholars are neither radical relativists nor strident realists; instead, they must always strike a middle ground position between these two extremes. Texts from either the technical or public sphere, when scrutinized through the lens of rhetorical inquiry, are neither reducible to ‘mere’ words nor understood as straightforward reflections of some deeper reality; instead, the scholarly practice of rhetorical criticism always treats texts as a convergence of discursive opportunities and material constraints. (316)

In order to fully explore that convergence, paying attention to what J. Blake Scott calls the extra-textual events in the production of meaning generates a fuller understanding of the material piece of Ceccarelli’s reciprocal arrangement. The perspective of feminist science studies, which insists on historical contingency and on the materiality of embodiment, is a useful antidote to the problem of giving either a text or its author too much agency in determining meaning.

Early feminist scholarship aimed at critiquing the sciences emerged out of the women’s studies movements in the 1970s, often centering on the gender inequality in scientific work, the potential gender bias in the kinds of questions asked (and not asked) in scientific inquiry, and the gendered nature of the interpretation of scientific findings (Keller 28-30).<sup>5</sup> Implicit in this work is the idea that the subject position of the scientist matters to the conception of rational fact he will report and that the “understanding of science as a social process” compels a

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<sup>5</sup> I am broadly summarizing here: Keller’s 1982 essay offers a fuller discussion of the possibilities and limits of the early work in feminist science studies. For a more recent sketch of the field, see Nina Lykke, “Feminist Cultural Studies of Technoscience: Portrait of an Implosion,” and Maureen McNeill, “Roots and Routes: the Making of Feminist Cultural Studies of Technoscience.”



reevaluation of science's exclusive claims to objectivity, rationality, and truth by considering the "social and political context" out of which particular scientific claims emerge (31-32). One of the contributions of a feminist perspective—one that is central to my purposes in this project—is to bring the body into sharp focus as a site of knowledge production. The work of Donna Haraway has been particularly influential here, as she has insisted on grounding feminist theories of technoscience in both the material realities of embodiment and in the culturally and discursively constructed nature of those realities. The body, for Haraway, is not a "blank page for social inscriptions," but a "situated" one, "always. . .complex, contradictory, structuring, and structured," always located in a particular historical reality ("Situated Knowledges" 592; 589). This view of the body has implications for scholarship both because the scholar must always situate herself and offer only her "partial, locatable, critical knowledges" as one alternative to the "view from above, from nowhere" that has marked the genre of scientific research (584; 589) and because the object of study must also always "be pictured as an actor and agent, not as a screen or a ground or a resource, never finally as slave to the master that closes off the dialectic in his unique agency and his authorship of 'objective knowledge'" (592). Haraway's work strikes a middle ground between radical social constructivism and positivist scientific rationalism:

Feminists have to insist on a better account of the world; it is not enough to show radical historical contingency and modes of construction for everything. Here, we, as feminists, find ourselves perversely conjoined with the discourse of many practicing scientists, who, when all is said and done, mostly believe they are describing and discovering things by means of all their constructing and arguing. (579)

The reason for this insistence is that, for Haraway and others, deconstructing the scientific enterprise is not a worthy goal in and of itself. Rather, she is after using critique to reshape science: "We need the power of modern critical theories of how meanings and bodies get made,

not in order to deny meanings and bodies, but in order to build meanings and bodies that have a chance for life” (580). In other words—and Latour and Woolgar also make this point—pointing out the social constructedness of science should not render it meaningless; it should make possible a more realistic understanding of what it is and what it can do.

### **Medicine Studies: Theoretical Foundations and Methodology**

The impetus behind the social critique of science also opens up the possibility for other disciplinary perspectives to participate in and ultimately strengthen the process of constructing knowledge about bodies and the material conditions under which we diagnose, treat, and care for those bodies in the American medical system. That goal has been the central one of humanities scholars working in the fields of health and medicine, and both my theoretical perspective and my methodology are influenced by their projects, especially those of J. Blake Scott, Susan Merrill Squier, and Katherine Montgomery Hunter.

Hunter takes a similar methodological approach to the practice of medicine as Latour and Woolgar did to scientific research, and she arrives at a similar conclusion. After spending two years in three hospitals following doctors, residents, and interns through the daily activities of clinical medical education, Hunter argues that the practice of medicine is primarily an act of interpretation, of listening to and decoding narrative elements in order to create a new story, or a diagnosis. Similar to Latour and Woolgar’s argument about science, she finds the practice of medicine to be widely misunderstood: though medical professionals construct knowledge in similar ways to those in other disciplines, especially literary criticism in which Hunter is trained, the public assumes them—and they expect themselves—to be scientists with special access to a discrete body of knowledge that holds the truths of the human body. The problem with this conception of medical practice is that “no matter how scientific it may be, medicine is

not a science as science is commonly understood: an invariant and predictive account of the physical world. Medicine's goal is to alleviate present suffering" (xviii). The misplaced identification of medicine as a science has "led to mistaken expectations on the part of both physicians and patients and, ultimately, to less than optimal care of the ill and to impoverished lives for physicians. It encourages physicians and patients alike to focus narrowly on the diagnosis of disease rather than attend to what is even more necessary, the care of the person who is ill," or in the case of maternity care, the care of the person giving birth to a new human being (xix). Hunter's articulation of what medicine is and is not informs much of my analysis concerned with bringing the narratives of science, medicine, and women's bodily experiences to bear on one another. Important also is her contention that fostering a better public understanding of medicine's potential and limitations could do much to improve the current state of health care. The strongest influence from Hunter's work, both on my project and on the field of medical humanities in which she works, is the emphasis on narrative, on ferreting out the stories that make meanings for us out of complex bodily processes and the mediation of them by medicine and its technologies.

That focus on narrative pervades the work of Susan Merrill Squier as well. In her work on what she calls "liminal lives," she has argued that narratives and their literary elements circulating in different arenas can best serve as productive sites of analysis when examined in relation to the material realities they represent:

Considered as working objects, narratives exist in a reciprocal relation to the lived bodies that are their ultimate referent: both constituting and being constituted by them. Narratives thus provide an alternative to the impossible attempt to distinguish nature from culture, science from society; a site where we can productively consider their mutual imbrication and cogeneration. (*Liminal Lives* 16)

This is where humanities scholars—those trained to study the symbolic realm of cultural knowledge—can offer something particular to the fields of science and medicine studies. Squier concentrates on the distinct field of literature, though she defines it broadly, and argues that the perspective of literary scholars is an important one to include in science and medicine studies precisely because literature and science have both been historically constituted by their mutual exclusion. In other words, each discipline defines itself by what it is not, an exclusion that has limited our thinking and prevented us from seeing the ways that the two could “unsettle not only each other but also their mutually opposed relation” (44). For Squier, literature and science are not the discrete entities our disciplinary organization has made them out to be, but are always working together to produce knowledge: “Whenever we see literature (culturally scripted as the domain of subjectivity), we should expect that there’s also science (the culturally accepted home of objectivity). For. . .literature and science operate together in culture and society to produce subjects and objects” (43). She uses the example of P.D. James’s novel, *Children of Men*, and a research article in the *British Medical Journal*, both published in the same year. The novel depicts a world where human fertility has ended, and the youngest living person is now eighteen years old. The research article presents data from a study concluding that male fertility is steeply declining, and, Squier notes, prompted many anxious responses from the scientific community. Rather than see the simultaneous publication of these two texts as “coincidental,” Squier instead argues that we should see them tapping into and drawing from the same broad arena of cultural fears and anxieties about globalization, environmental concerns, and human reproduction. In this way, then, she hopes to dislodge the categorization of science and literature as “discrete and unlinked” entities by bringing the two disciplines to bear upon one another. Much of my methodology is indebted to Squier’s commitment to tracing narrative elements

from one cultural realm to the next, not to observe the “inherent qualities of a claim, theme, trope, or process,” but instead to trace “their trajectory and the way that they are put in play” in order to analyze how their different deployments “[shape] how we weight their accuracy, efficacy, or truth value” (46). Though I have not limited my selection of texts to those emerging from the domains of literature or science (nor does Squier), I am similarly interested in the ways that narratives about childbirth and medicine work differently in different contexts, genres, and discourse communities. In order to approach the question, “How do we know what we know about what it means to have a baby?,” it is, as Squier puts it, the “trajectory” of where those meanings are located and the ways they can be brought to bear upon one another that promise the most compelling—if always partial, incomplete, and unstable—answers.

If Squier’s method of analyzing a trajectory of narratives has given me a way to think about which texts to analyze, J. Blake Scott’s careful elaboration of what he calls a “rhetorical-cultural analysis” has provided a helpful way of figuring out not only how to make sense of them, but also why to approach texts this way. Scott brings together rhetorical analysis and cultural studies methodology to productively “cross-pollinate” one another (32) in order to achieve a “nuanced analysis of various rhetorical actors, power relationships, and the interaction of historically specific cultural movements” (25). In other words, Scott suggests putting the tools of rhetoric to work for cultural studies purposes. Implicit in his alliance with cultural studies is the belief that humanities research on scientific and medical disciplines can, by exposing problematic scientific and medical practices, also work to change them. Scott writes that the rhetorical-cultural scholar must view “technoscience’s conditions of possibility. . .in terms of dynamic networks; these networks are defined through their functions and measured by their effects; and the goal of critiquing these effects is to shape new and improved conditions”

(21). Also, the point of situating texts within their historical and political context is to use rhetorical analysis to better understand the particular cultural milieu such texts are a part of: “Rather than gesturing toward larger cultural entanglements as a way to situate and elucidate texts, a rhetorical-cultural study examines specific texts as a way to situate shifting cultural entanglements. The trajectory of a shifting intertext, rather than specific texts, becomes the primary object of study” (25). What that means for the chapters that follow is that context plays a key role in understanding rhetorical analysis; each analysis of texts from a particular discourse community begins by charting the shifting intertext, or the historical specificity, necessary to understand how the texts under consideration fit into—and shed light on—a broader picture.

The underlying tenet linking the work of Scott, Squier, Hunter, and others in the fields of science and medicine studies is that by looking carefully at the ways knowledge is produced about and within medical and scientific disciplines, humanities scholars can productively contribute to the public’s understanding of and engagement with scientific and medical knowledge. This perspective seems especially important in negotiating the textual and material terrain of American obstetrics, a specialty that traffics heavily between the designs of nature and the imposition of culture. To borrow an image from Haraway, I am not so much interested in pinpointing that boundary as I am in analyzing the traffic for challenges to the established order it might engender (*Primate Visions*). My project here is to use the embodied and medicalized processes of childbirth as a lens through which we might more clearly see such traffic at work in a particular historical moment. To put it simply, I will attempt to map out the trajectory of narratives working to produce knowledge about childbirth in the first decade of the twenty-first century in the United States. Once I have drawn the basic contours of that map, I will focus in on smaller, more detailed regions, fleshing out the narratives particular to various discourse

communities and the contexts in which they have been used. In each chapter, I will be more specific about the methods I use for each of those discourse communities, especially how and why I chose certain texts. For each, however, I will use the tools of rhetoric—a discipline concerned with how texts work to affect their audiences—to draw out from those texts and their circulation a tentative understanding of the ways that knowledge about childbirth is produced and of the ways that knowledge might be shaping the public’s view of institutionalized medicine and women’s reproductive bodies. By unearthing the narratives circulating not just about birth, but also about the authority of professional medicine, the power of medical technology, and the role of scientific research in shaping medical practice and individuals’ relationships to health care, I intend to reframe discussions of birth through a more interdisciplinary lens. Moreover, I hope to use my analysis of childbirth discourses as a model to demonstrate that how science and medicine are articulated can have a weighty effect on material lives and to show that critiquing the way that articulation works can begin to trouble its persuasiveness.

Though much of the work in feminist science studies and rhetorical studies of science and medicine has focused on reproductive politics and technologies<sup>6</sup>, few rhetoricians have turned their attention to the bodily process of childbirth and its scientific, medical, and cultural trappings.<sup>7</sup> I hope my project will fill that gap and bring this medically and technologically mediated event into larger conversations about the ways our cultural construction of biomedicine shapes our experiences of material reality.

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<sup>6</sup> See, for instance, Squier, *Babies in Bottles*; Ginsburg and Rapp, *Conceiving the New World Order*; Franklin and Ragoné, *Reproducing Reproduction*, and Lay, Gurak, Gravon, and Myntti, *Body Talk: Rhetoric, Technology, Reproduction*.

<sup>7</sup> Mary M. Lay’s book, *The Rhetoric of Midwifery*, is a notable exception, one to which my project is indebted.

## A Review of the Literature on Childbirth

Of course, childbirth has hardly escaped scholarly attention altogether, and here, I offer a brief review of the literature on childbirth, work my project both benefits from and builds upon. Social science literature, particularly sociology, anthropology, and history, has attended to the cultural meanings inscribed on the birthing body, especially since the 1970s. Much of this work focuses on the professionalization of obstetrics and the increased use of technological intervention in the birthing process. Sociologists Richard W. Wertz and Dorothy C. Wertz were among the first to produce a sustained historical critique of this kind, and their 1977 study, *Lying-In: A History of Childbirth in America* remains one of the most comprehensive narratives of how the shift from home to hospital came to be the norm. Their narrative works to revise what they call the “success story of modern medicine” to reveal a more complex web of power, economics, and a confluence of social forces that has resulted in a system where birth “*routinely* requires the arts of medicine to overcome the processes of nature,” often to the detriment of women (emphasis in original, xvi). Within the field of anthropology, Brigitte Jordan’s 1978 study *Birth in Four Cultures: A Cross-Cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States* catalyzed a wave of feminist anthropologists who interrogated the culturally constructed meanings associated with birthing practices, often through the lens of what Jordan calls “authoritative knowledge.”<sup>8</sup> At the same time, feminist sociologists were also turning their attention to birth: the work of Nancy Stoller Shaw and Barbara Katz Rothman focused on the construction of power and knowledge in American hospitals, while E. Ann Oakley studied the changes in maternity care in the United Kingdom. Anthropologist Emily

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<sup>8</sup> For an overview of work they call the “anthropology of birth,” see Robbie Davis-Floyd and Carolyn F. Sargent’s “Introduction” to *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*.



Martin compellingly argued in the 1980s that professional medicine's view of women's reproductive processes, as evidenced by the language used in medical textbooks, in journals, and in interviewees' experiences, is based on a metaphor of mechanical production: "The woman's body is the machine and the doctor is the mechanic or technician who 'fixes' it" (54). Robbie Davis-Floyd, who has been writing about reproduction and medicine for nearly two decades, theorized what she called "technocratic" birth as an elaborate set of rituals, a "rite of passage" designed to communicate core cultural values to birthing women, especially that technology is superior and should be used to overcome the processes of nature, that their bodies are fundamentally flawed, and that physiological reproduction is inherently dangerous. Historian Judith Walzer Leavitt offered a revisionary history of the often-told story of medical men wresting control of birth from women by showing how women have always influenced the models of birth that rise to power. More recent work in the social sciences includes an ethnographic account of traditional African American midwifery in Virginia (G. Fraser), a history of anesthesia (Wolf), cultural analyses of specific obstetric practices like amniocentesis (Rapp) and fetal ultrasound (Taylor), and returns to earlier conceptions of power, knowledge, and medicine (Simonds, Rothman, and Norman; Davis-Floyd and Sargent).

In the field of literary studies, scholarship particular to representations of childbirth is relatively sparse. Mothering has received a great deal of attention from feminist literary scholars, as has reproductive politics; far less attention has been paid to the maternal body. Adrienne Rich's widely anthologized essay, "Alienated Labor," and Julia Kristeva's "Stabat Mater," both written in the late 1970s, articulated the need for what Kristeva called a "maternal subjectivity" in literary studies, including the bodily experience of maternity. The unarticulated space of maternity exists largely because the maternal body occupies such a liminal space,

according to Kristeva: pregnancy is the “threshold between culture and nature,” unable to be subsumed by either the signified or the biological essence (182). The inability of existing discourses to speak to this condition are not inconsequential— “silence weighs heavily none the less on the corporeal and psychological suffering of childbirth and especially the self-sacrifice involved in becoming anonymous in order to pass on the social norm” (183). Rich’s larger project in *Of Woman Born*, published just one year before Kristeva’s essay, is to distinguish between the feminist act of mothering and the patriarchal institution of motherhood. As part of that project, she makes the case that dualism—especially the body/mind split—will never serve the interests of women, that we should be able to find ways to “think through the body,” without remaining trapped in patriarchal demands on it (284). In her attempt to make sense of her own bodily experience of maternity, she describes hospitalized childbirth as a metaphor for the oppression of women in general: “No more devastating image could be invented for the bondage of woman: sheeted supine, drugged, her wrists strapped down and her legs in stirrups, at the very moment when she is bringing life into the world” (171). Since Kristeva and Rich first articulated the need for more thinking about how to include the embodied experience of childbirth in feminist theorizing about maternity, relatively few scholars in literary studies have attended to that project.

Part of the reason for that, according to some scholars, is that literature has often reproduced the cultural silences surrounding the birthing body of particular historical periods. Michelle Tarter points as far back as Judeo-Christian beliefs about the uncleanness of the female body and Aristotelian dualism, which posited the body and nature as feminine, clearly subordinate to masculine rationality and culture, to find the source of patriarchal attitudes towards women’s bodies (20). Identifying the cultural forces and textual patterns that have

contributed to the persistence of such attitudes is one way some scholars have worked to reclaim the maternal body. Krista Ratcliffe, for instance, writes that the first step in liberating the maternal body from its marginalized position in discourse is to draw attention to the narrative silences surrounding birth, to dig into the ways that literary and cultural texts have evaded maternal experience. In literature, argues Ratcliffe, this silencing happens most often when male writers have “remov[ed] birth from the physical realm and render[ed] it metaphorical” (49) and when they have objectified birthing women and erased their perspective from the account (51). Patricia Yaeger also finds attending to the literary silences of birth an important component of establishing what she calls a “poetics of birth.” She suggests (re)constructing a narrative around such silences, interrogating the meanings embedded in emptiness, to “supply ourselves with new meanings, structures, codes, and other modes of symbolic power” in order “to invent a story of birth with the power to supplement women’s lost voices” (267-68). Another component of such a poetics would locate the spaces that unearth a “reproductive unconscious,” that point to reproductive anxiety or “cultural contestation or struggle” (267-68). Reading maternity into texts where it remains unarticulated, reclaiming metaphors of birthing to reveal when they erase women’s labor, recovering women’s bodies from positions of objectification or erasure—for feminists working with canonical literature, these have been some of the ways they have rewritten the silences surrounding the birthing body.

Another way, and the one feminists interested in maternity have turned to most often, is to look to representations of birth by women writers. The edited collection, *This Giving Birth*, takes as its purpose this very recovery. Michelle Tarter’s essay, “Bringing Forth Life from Body to Text” explicitly identifies the reclamation of birth narratives as the primary goal of the book:

“In honoring this process, we may only dream of how woman-centered narratives and inscriptions of childbirth will benefit society at large” (33-34). Tess Cosslett’s 1994 study *Women Writing Childbirth: Modern Discourses of Motherhood* also works toward drawing attention to woman-centered birth stories, focusing on the ways in which women writers’ accounts of birth complicate, and sometimes reinforce, the dominant, totalizing narratives of the medical establishment on one hand and the often essentializing rhetoric of natural childbirth on the other. Alice E. Adams’ *Reproducing the Womb: Images of Childbirth in Science, Feminist Theory, and Literature*, published just one year after Cosslett’s study, continues in this vein, using the construction of birth in women’s writing, particularly speculative fiction, to revise problematic notions of mothering, the body, and reproduction she finds in literature, theory, and scientific discourse. Her work places women’s imaginative accounts of reproduction in dialogue with prevailing theoretical and scientific discourses in order to insert a maternal subjectivity where it is missing. More recently, in *Bodies in a Broken World: Women Novelists of Color and the Politics of Medicine*, Anne Follwell Stanford sees childbirth as one of many bodily experiences represented in fiction by women of color as a critique of biomedicine; Mary Ruth Marotte has argued that women’s literature portrays pregnancy as a state of captivity that can paradoxically both empower and destabilize women’s sense of subjectivity; and Cristina Mazzone has demonstrated through an exploration of the physical stages of maternity that have carried particular meanings at particular times—maternal impressions, quickening, the changing body, parturition—how culture has inscribed meanings on pregnancy and birth that fit with larger cultural trends and attitudes towards women.

This project will build on this small but rich body of scholarship on childbirth and extend the focus of analysis across disciplines and beyond the birthing room. As my review

shows, much of the scholarship specifically devoted to childbirth emerges out of a fairly static disciplinary boundary: the social sciences have produced research that has been primarily concerned with the material conditions of birth, while literary studies has been mostly concerned with the symbolic representation of childbirth; there has been little cross-over between the two arenas.<sup>9</sup> My project has been informed and enriched by much of this work, as it has taught us a great deal about the conditions and the representation of childbirth and medicine. Where I see my project intervening in this discussion is in connecting representation with its potential effects on material bodies, discourse with the knowledge it produces, and science and medicine with the narratives that give them meaning. A foundational premise for my study is that more purposeful interdisciplinarity can contribute to a fuller, richer understanding of childbirth and what it can mean for our engagement with medicine, science, and physiological human reproduction and can begin to unsettle the boundary between the “real” and the representational in order to bring them to bear on one another. Before I begin that project, of tracing the trajectory of childbirth and medicine through contemporary culture, I will briefly sketch the historical movements necessary to understand how we have arrived at the particular context of birth practices in the twenty-first century.

### **Background: How We Arrived at this Conversation about Birth and Medicine**

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<sup>9</sup> Helena Michie and Naomi Cahn’s *Confinements* is a notable exception: they trace discourses of fertility and infertility across many disciplinary boundaries in the tradition of Women’s Studies, where they both make their academic home. Mazzoni and Adams also both use scientific and cultural discourses to illuminate their literary analyses in productive ways. However, this work is rarely taken up by scholars in other disciplines; though the individual texts themselves include some interdisciplinarity, the conversation, as I see it, has remained fairly enclosed within each disciplinary home. That may be due, in part, to the reluctance in the mainstream feminist movement (and Women’s Studies as its academic counterpart) to deal with issues of bodily maternity, as Mazzoni argues, or to the science-literature divide Squier points to. My hope is that by locating the conversation about childbirth squarely within medicine and science studies, rather than as a separate (and marginal) issue, those disciplinary boundaries will start to give way.

By “this” conversation about birth and medicine, I mean one that emerges out of the contemporary context of birth in the United States. As mentioned earlier, the vast majority of American women give birth in a hospital attended by a medical professional; in 2008, according to the most recent CDC report, 99% of women gave birth in a hospital, and 91.3% of those births were physician-attended. The remaining 1% gave birth at home (66.3%) or in a free-standing birth center (28%). Midwives attended 8% of all births, including certified nurse-midwives’ attendance at hospital births, and traditional and nurse-midwives’ attendance at home and at freestanding birth centers (Martin et al. 2008). The vast majority of women also experience high rates of medical intervention, and many give birth by major abdominal surgery. Birth certificate data shows a 32.3% cesarean rate for 2008, one that has risen dramatically in just a few decades: the rate in 1965 was just 4%, by 1994, it had reached 21%, and since that time it has climbed at a steady pace (Wolf; Menacker and Hamilton). According to the 2005 *Listening to Mothers Survey II*, a survey tool designed to collect statistics about pregnancy and birth from women, rather than from institutions, the majority of women experience continuous electronic fetal monitoring, one or more vaginal exams, epidural or spinal analgesia, and urinary catheter. “Notable minorities” also experience medical labor induction (34% of the women surveyed), artificial rupture of membranes, episiotomy, and the use of narcotics (Declerq et al. 4). Though the rates of preterm birth and low birthweight babies have slightly decreased in the last few years (Martin et al. 2008, 20), rates are still concerning to public health experts. The maternal and infant mortality rates, though relatively low compared to the rest of the world, are still higher than those in most industrialized countries (Wagner). Especially troubling is the racial disparity in birth outcome: African American women are four times more likely to die from childbirth-related causes than are white women in the United States and their babies are

twice as likely to die before their first birthdays (Hoyert 8-9). They also experience cesarean section at higher rates than any other racial or ethnic group and have much higher rates of preterm birth and low and very low birthweight babies (Martin et al. 2008). In general, birth is highly medically managed by the profession of obstetrics, but due to some of the concerning statistics listed above, a growing birth advocacy movement indicates increasing discontent with the current state of maternity care. The titles of three books published in the last few years indicate the tenor of some current discourses on maternity care: *Pushed: The Painful Truth about Childbirth and Modern Maternity Care*; *Born in the USA: How a Broken Maternity Care System Must Be Fixed to Put Women and Children First*; and, simply, *Birth Crisis* (Block; Wagner; Kitzinger). Nonprofit organizations dedicated to reforming maternity care and hospital birth abound: the Center for Childbirth Choices, Childbirth Connection, the International Cesarean Awareness Network, as well as a grassroots campaign to legalize certified midwives in all fifty states. Additionally, blogs and social media devoted to childbirth reform have proliferated in the last few years, a phenomenon I will discuss in more detail in Chapter Five.

So how did we get here? The traditional story told in light of medical and scientific progress indicates that once upon a time, childbirth was a very dangerous event for women and babies, then doctors took over and began delivering babies in hospitals, and birth ceased to be a risky affair.<sup>10</sup> The logic implied by this narrative is that childbirth was dangerous because it lacked medical management, and obstetrical control and the hospital environment were the things that vastly improved birth outcomes. A more careful look at the big picture of history, however, has told a slightly different story.

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<sup>10</sup> For an example of the way this kind of narrative works, see Dr. Richard Aubry's introduction to the 1985 popular advice guide, *What to Expect When You're Expecting*.

Until around the 1750s, childbirth was almost exclusively a female affair: men were excluded from the birthing room, and parturient women were surrounded by family members and other women in the community, including midwives, when it was time for their children to be born. It was, without a doubt, far more dangerous than it is today; however, most historians and sociologists of medicine agree that the danger of mortality, for women and children, was caused by a range of factors, including very high fertility rates and a lack of safe, reliable contraception; the inability to diagnose or treat infection, especially with antibiotics; little knowledge about the physiological mechanisms and potential complications of birth; and poorer health in general, especially a lack of disease control for common causes of death like tuberculosis (Leavitt; Starr; Wertz and Wertz). During this time, most American women's adult lives were marked by the biological experiences related to their fertility; white women as the result of early marriage and repeated pregnancies (Leavitt), African American slave women as the result of forced procreation to increase the slave population (Solinger). Both groups of women experienced many physical complications as the result of years of continuous childbearing, including vaginal fistulas, incontinence, and prolapsed uteri, all of which contributed to even more painful and complicated deliveries (Leavitt 29-30). Though it is impossible to determine exactly how many pregnancies women endured or how many deaths resulted, the cultural attitudes towards the event of birth indicate that it was shrouded in the possibility of death, for mother or child. Leavitt writes that "childbed deaths were so familiar to Americans, from the eighteenth century to the twentieth century, that fearful anticipation characterized the common and realistic attitude towards pregnancy" (27). It is no wonder, then, that many women welcomed the possibility of scientific medicine and professional expertise to alleviate some of that anxiety.



The female birth attendants who generally supported women through childbirth were sometimes traditional healers, sometimes experienced mothers who had attended other women, and “granny” midwives in African American communities. Until the nineteenth century, many of these women would have had little to no formal education and no access to formal midwifery training; their training in attending births would have been experiential (Rooks 20-21). Most of the midwives practicing in nineteenth-century America who did have formal training were European immigrants and had been educated in urban midwifery schools in Italy, Germany, or France. For the most part, American midwifery was a community-based vocation, steeped in tradition and passed on from one generation to the next as younger women observed their elders attending births. Gradually, over the course of the nineteenth century, medical men began to enter the birthing room in greater numbers; midwives and female attendants still retained control, but they sometimes called male doctors to assist if there was a complication (Wertz and Wertz 43). The development and use of forceps in 18<sup>th</sup>-century England was instrumental in providing access to birth for medically trained men: they had a tool they could use that midwives did not have. Partly as a result of male doctors’ increased use of forceps at birth, which proved they could do something to help, and partly as a result of an increased value in formal education, the all-female domain of birth gradually shifted. Towards the end of the nineteenth century, middle- and upper-class families more frequently chose male physicians to attend their births, and midwives were left to care primarily for women in lower social classes, especially in rural areas (Rooks; Leavitt).

Historians are quick to point out, however, that formal education did not necessarily make for a skilled birth attendant. Many male doctors who had had training in the “new midwifery” had never seen a birth before they began practicing. Also, Victorian notions of

propriety prevented male physicians from looking at what they were doing; they often examined women with their hands under a sheet, while diverting their gaze away from the woman (Wertz and Wertz). Especially since they relied on forceps to demonstrate their expertise (and the reason women should pay extra fees for their attendance), these conditions created a problem: “Physicians who had been trained to use forceps only on manikins and who were required by custom to perform the operation without the benefit of sight ran considerable risk of creating new problems for women whose obstructed labors they tried to ameliorate” (Leavitt 46). In fact, until obstetric science improved so that doctors had a better grasp of the physiological event they were dealing with and until physicians learned from bacteriologists that washing their hands between exams could prevent infection,

almost any intervention by the physician created the potential for harm. If a birth could not proceed without help, the physician provided a life-saving service not available elsewhere. If, however, as was statistically more probable, labor was proceeding normally and physicians intervened anyway, their actions introduced dangers not otherwise present. (47)

Infection, especially puerperal or “childbed” fever, was the most pervasive cause of maternal mortality, and instead of alleviating that danger, when doctors moved birth into hospitals, many scholars believe they increased it. In the last decades of the nineteenth century and early into the twentieth, physicians knew that infection was a problem, but there was widespread disagreement about the cause of it. They focused on maintaining cleanliness, but what this meant and how to achieve it remained a mystery (Leavitt 156-59). Even so, the promise of cleanliness—and therefore, safety—is what drew many women into the new hospitals of the early twentieth century in the 1920s and 30s. The promise of safer birth did not immediately come to fruition; in fact, despite some hospitals’ elaborate prophylactic routines designed to eradicate puerperal fever, including giving the patient an enema, shave, bath, and

regular doses of quinine, maternal mortality due to infection did not start to significantly decline until the 1930s and 40s (Wertz and Wertz). The hospital provided an environment where asepsis alone was not enough: because doctors believed the quicker they got the birth over with, the more likely they would avoid harm, they intervened regularly and often caused wounds that served as breeding grounds for bacterial infection. The combination of frequent operative deliveries, the possibility of doctors spreading germs from patient to patient during internal exams, and careless antiseptic routines created an environment where infection was far more likely to occur than at home. A better understanding of how to create a sterile environment and the availability of antibiotics to treat infection eventually brought the infection rate in hospitals down, but by that time, many midwives had ceased practicing and most women were attracted to the hospital for what they believed would be a safe, modern, and painless birth (Leavitt; Wertz and Wertz).

If cleanliness was one feature of hospital birth that initially communicated that hospital birth would be safer, the routine systemization of birth women found when they got there cemented the hospital's promise of a scientifically-based, expertly managed affair where safety, and eventually the elimination of pain, were paramount. Joseph B. DeLee is the obstetrician credited with developing what is now called the active management of labor, and his method was explicitly based on a belief that labor and delivery was inherently a "pathologic process" (qtd. in Leavitt 179). In the first issue of the *American Journal of Obstetrics and Gynecology*, DeLee wrote, "So frequent are these bad effects [of damage during labor] that I have often wondered whether Nature did not deliberately intend women should be used up in the process of reproduction, in a manner analogous to that of salmon, which dies after spawning?" (qtd. in Leavitt 179). His procedure involved routine use of the forceps, aided by an episiotomy (a cut

made to the perineum with surgical scissors to widen the vaginal opening). Wertz and Wertz describe his regimen this way:

The procedure he commended involved sedating the woman and allowing her cervix to dilate, making a cut of several inches through the skin and muscles of the perineum. . .applying forceps to lift the fetus's head over the perineum while monitoring the fetal heart via stethoscope, using ergot or one of its derivatives to contract the uterus, and then extracting the expelled placenta with a 'shoehorn maneuver.' Finally, the doctor should stitch up the perineal cut. (142)

DeLee recommended this procedure for every single laboring woman, and it came to be the norm in many hospitals by the 1930s (Wertz and Wertz).

While DeLee advocated for doctors to proactively intervene in every step of labor, upper- and middle-class women clamored for the hospital to offer them more than safety: they demanded the elimination of pain and suffering. When first-wave feminists, suffragettes, and other women of privilege heard of something called "Twilight Sleep," a German technique that promised painless birth, they demanded American doctors make it available to them. Doctors were at first resistant, as those that had attempted to replicate the process had deemed it "unreliable and unsafe" (Wertz and Wertz 150). By the 1930s, however, the highly publicized experiences of women who had been overseas to try it out and the organized effort by women to get their doctors to provide it was enough to convince the medical profession (Wolf 46-47). Twilight Sleep involved injecting women with morphine at the onset of labor, and then giving them doses of an amnesiac drug called scopolamine. "Altogether," write Wertz and Wertz, "the procedure dulled the awareness of pain, and perhaps more important, removed the memory of it" (150). The forces that drew women out of their homes and into the hospital were many and complex, but they were eventually successful. By 1945, around 70% of women delivered in hospitals, and by the 1950s, that number had increased to over 90% (Wertz and Wertz 134-35).

In the course of a few decades, birth had gone from a home-based, woman-directed affair that generally employed both a community of female attendants and, for women who could afford them, the services of physicians, to an event orchestrated by physicians, mediated by their technologies and drugs, and located within the walls of the hospital. Women no longer determined who was present at birth, and many of them did not remember the experience at all. I do not want to romanticize the pre-hospital era; certainly, there was nothing ideal about the dangers women faced as a regular part of their biological life. However, like Leavitt and other historians, I also think it is a mistake to see the move from home to hospital as one of unquestionable progress. The story is far more complicated than that, and it is important to account for what was lost in the transition, in addition to what was gained. Traditional midwifery was obliterated in many places, women lost knowledge about the birth process that once was a regular part of community life, and they also gave up much of the control they once had to determine the setting, attendant, and procedures they desired for their births. There is little doubt that many medical advances of the twentieth century made birth safer in some ways for some women; some of the technologies and treatments made available have saved the lives of mothers and babies who would have otherwise not survived. There is also little doubt that they did not do so without altering the birth process in other, less beneficial ways, but those did not become obvious until well into the twentieth century.

Systematized and heavily drugged birth, in which the woman was more a “supporting player,” physically present but “in all other respects. . .absent,” continued to dominate routine maternity care for most of the 1940s and 50s (Wolf 104). In 1958, the *Ladies’ Home Journal* published a series of letters from women who reported abusive conditions in hospital labor and delivery rooms; eleven years later, the Boston Women’s Health Book Collective first published

*Our Bodies, Ourselves*, and brought the medical establishment's treatment of American women into public discourse; a decade after that, Barbara Ehrenreich and Deirdre English exposed the gendered biases implicit in "expert" advice directed at women in the two pamphlets that would become the feminist classic, *For Her Own Good: Two Centuries of the Experts' Advice to Women*. The overlapping Women's Health Movement, natural childbirth movement, and home birth movement of the 1960s and 70s were additional evidence that women were dissatisfied with the care provided to them by obstetricians. One tangible result of this period was a resurgence in home birth midwifery; I will attend more fully to that history in Chapter Four. In hospitals, administrators and medical professions made some concessions in response to the critiques leveled at them from these groups, including allowing fathers, partners, and other companions into the delivery room, and, as anesthesia developed, awake-and-aware, rather than unconscious, became the new norm for delivery. Hospitals used newly developed marketing strategies to compete as the most "comfortable and caring" place to deliver, but the changes were mostly cosmetic. The maternity "ward" became the maternity "center"; delivery rooms were redecorated to appear more "home-like," complete with drapes to carefully mask the standard technologies that remained a part of routine birth; and women were offered options like wearing their own clothes rather than a hospital gown, and playing music and dimming the lights during labor (Wolf 150). Incorporating techniques of "natural childbirth" in place of standard obstetric procedures, however, never took hold in hospitals (167). By the 1980s and 90s, backlash against the feminist movement more broadly, and against the purported inconvenience and suffering of natural childbirth more specifically, contributed to many women's acceptance of the routine scheduling and management of birth once again, especially since the introduction of the epidural, an anesthetic technique administered by another medical

specialist, the anesthesiologist. Epidurals became widely available in the mid-1980s and allowed women to remain awake while numbing the sensations of the lower half of their body; they have remained one of the most standard features of hospital birth since that time.

In my view, we are in the midst of another period of unrest and dissatisfaction with maternity care. Partly because of the climbing cesarean rate, of another renewed interest in traditional midwifery, of women's abilities to gather and share information about their experiences through digital technology and social media, and of a broader, more pervasive sense of discontent with an expensive and profit-driven health care system, women are once more advocating for different and better treatment during their birth experiences.

### **Where We Go from Here: Definitions and Chapter Outline**

One by-product of the critique of professional obstetrics' management of birth is a discourse that can be divisive and polarizing, so I want to define the terms I am using before I begin my analysis. At the heart of the controversy surrounding maternity care are two different philosophies of birth, and those have been labeled in different ways. One emerges out of the tradition of non-medical midwifery. Often called the midwifery model of care, in this paradigm, birth is a normal, physiologic process for most women, and women are the primary decision makers in determining the setting and management strategies for labor. The other emerges out of the practice of obstetrics. Barbara Katz Rothman was one of the first feminist critics to label this view, and she called it the techno-medical model of care; Robbie Davis-Floyd altered that slightly to the technocratic model. Because I am interested in placing my analysis squarely within medicine studies, I will rely on the broader phrase "biomedical model" to describe this philosophy, indicating that I believe this view of pregnancy and childbirth emerges out of the general belief system that undergirds institutionalized medicine as it is practiced in the United

States. Eliot George Mishler defines the biomedical model of care as one that rests on four primary assumptions: “the definition of disease as deviation from normal biological functioning. . .; the doctrine of specific etiology; the conception of generic diseases, that is, the universality of a disease taxonomy; and the scientific neutrality of medicine” (3). The way this model gets adapted to obstetrics is that it focuses the clinician on the potential for pathology, or disease, and relies on a set of standard, or “generic,” procedures to manage labor and facilitate physician-directed delivery. In the extreme version of this framework, pregnancy itself is a “deviation from normal biological functioning,” and so a sign of abnormality and disease, rather than of health. In my view, ideally, these two models would work collaboratively—the biomedical model is necessary for and good at detecting and treating disease when it exists, and the midwifery model works best for healthy women with few complications.

Another area of contention emerges out of the range of professionals trained to care for birthing women. Obstetricians are medically trained in both obstetrics and gynecology, the surgical specialty that deals with pregnancy, birth, and the postpartum period and the specialty that deals with women’s reproductive systems across the lifespan, respectively. Certified nurse-midwives (CNMs) are trained first as registered nurses and then, in a graduate program, in midwifery. They offer well-woman care across the lifespan, family planning services, and care for pregnant women who are considered to be healthy, or low-risk. They also attend labor and delivery. Some CNMs practice alongside OBs in hospital-based practices; others attend births in freestanding birth centers (non-hospital alternatives to home birth) or in women’s homes. Traditional midwives, also sometimes called lay midwives, fall into a range of categories: the nationally recognized credential is the Certified Professional Midwife, or (CPM), but because legal recognition of non-medical midwives varies so widely from state to state, they are also



called Direct Entry Midwives, Certified Midwives, and Licensed Midwives, depending on the context. These practitioners have typically been through an alternative educational route (not nursing or medical school) and have trained by apprenticeship. Traditional midwives typically attend women at home or in birth centers.

Despite the names of the two most prevalent philosophies of birth, there are midwives who favor a more medical model of birth and doctors who practice a more midwifery-based model of care; the profession of the caregiver does not necessarily determine the kind of care, nor are these models always as distinct as I have drawn them here. Some caregivers are using a combination of the two models—family physicians, for instance, will sometimes focus on the holistic health of the mom (physical, emotional, and psychological) within the context of her family but also favor heavily managed labor; some OBs, on the other hand, are too busy to provide the kind of individualized care offered by the midwifery model, but they might be more inclined towards letting labor start on its own and progress without intervention. The setting in which caregivers practice also affects the model they can adapt: in busy labor and delivery units at large hospitals, the one-to-one caregiver-to-birthing woman ratio demanded by the midwifery model of care is simply not feasible. The controversies I will map out in the coming chapters will illustrate the clashes between these two paradigms and the discourses those clashes engender.

Though it would be impossible to trace all of the nodes of meaning-making about childbirth in contemporary culture, I will attempt to map out what I see as the most influential discursive practices shaping the material conditions of birth in the United States and the narrative threads that link those practices together. In Chapter Two, I will consider the construction of medicine, maternal subjectivity, and technological authority depicted in

mainstream popular culture. By looking closely at narratives about the physical, medical, and social processes of pregnancy and birth as they are depicted in television medical drama and in romantic comedies, I argue that viewers are being socialized to understand the biomedical model of childbirth, located either in the hands of doctors (on television) or in the efficiency of technology (in film), as the ultimate guarantor of health for birthing women and their babies. In both media, movie-going and television-watching publics are learning that a particular version of technologically-mediated and doctor-directed childbirth is the unquestioned norm: these texts produce healthy mothers and healthy babies whose healthy outcomes narratively depend on high-tech medicine. I also consider documentary as a potential narrative counter-point to the dominant view presented in mainstream texts.

In Chapter Three, I turn to the ways meanings about childbirth are produced within the medical community. I focus my analysis on a series of government-sponsored reports and workshops dedicated to generating scientifically-based guidelines for the use and interpretation of electronic fetal monitoring (EFM). By mapping the discursive moves made by researchers writing about and evaluating the technology, I show how, even in the midst of a persistent lack of so-called “evidence,” the generic constraints of research-based medical knowledge prevent practitioners from fully accounting for the continued reliance on EFM in obstetric practice.

In Chapter Four, I examine the larger system that shapes such practice standards by directing attention to the discourses of health insurance. This analysis considers the way institutional documentation works to instruct women on how to use their health care by categorizing some patients as recipients and others as consumers. I focus on private insurance and Medicaid communication in the state of Florida, situating my analysis of those texts within that state’s particular medical climate. I argue that the pervasive discourse of health care

consumerism belies an industry that makes decisions about care based not on health but on economics and therefore sends mixed messages to women about how best to use the services available to them: the story of consumerist choice is strongly undercut by the realities of profit-driven industry.

In Chapter Five, I turn to the community of maternity care advocates writing about birth issues online. I examine the potential and the limits of social media to talk back to institutional obstetrics in two instances, one in which activists interfered in a survey project designed to collect information from physicians, and another where consumers were invited to attend a conference sponsored by the National Institutes of Health. By teasing out the narrative threads linking the discussions surrounding each event, I demonstrate how a community with historical roots in the consciousness-raising groups of the 1970s is appropriating discourses of science to challenge professional medicine's exclusive claim to knowledge about childbirth.

Finally, in the Conclusion, I summarize the project's main arguments and suggest some possible directions for continuing interdisciplinary conversations surrounding medicine and the social meanings of childbirth.

Mary M. Lay, Laura J. Gurak, Clare Gravon, and Cynthia Myntti have argued that "studying the language and the technologies used to describe and represent the body, and those reproductive technologies that diagnose, treat, and control it, reveals essential cultural and social attitudes toward women and reproduction" (8). My purposes here are to attend closely to the discursive practices at work in describing, representing, and circumscribing the particularities of childbirth and the biomedical management of it in the first decade of the twenty-first century. By unearthing the narrative strands that work together to "signal which knowledge systems take on authority within our culture. . .and which images of birth,

motherhood, and bodies direct our choices and actions” and connecting them to the material conditions they reflect and produce, I intend to use rhetorical-cultural analysis to destabilize the ideological foundation on which those narratives rest (10). Scholars working in medicine studies have argued that humanities research on health care can offer a much-needed perspective on a world that sees itself in increasingly technological and scientific terms. That need is perhaps even more acute in the contemporary field of American obstetrics, where the primary caregivers for healthy women are highly trained biomedical specialists, where the costs of care are among the highest in the world, and where women’s knowledge and desires often are pitted against a powerful institution. In order to make meaningful changes in such a system, the premise of this dissertation is that we must first understand how narratives about and within that system function to sustain it.

## Chapter Two

### Scripted Birth: Television, Film, and the Reproduction of Biomedical and Technological Authority

“Why am I using pop-culture examples when I want to talk about actual patient experiences? Because these are the stories we as a society tell ourselves about doctors and medicine. They’re very nice stories. They make us feel good about having to go to the hospital one day, where gruff but kind surgeons and sassy nurses will take care of us. They tell us doctors are amazing people who do what they do out of basic decency and a desire to help. And of course, many doctors are like that, or try to be. But there is a problem with these stories, these scripts—mainly, that the patient herself is pushed into the role of extra. The patient is to be the quiet and cooperative plot device, lying in bed, smiling bravely around her respirator as she gratefully clutches the doctor’s hand. Whatever their personal quirks, in the end the patients, *Do What They’re Told*, even if it seems unnecessarily painful or contradictory, and that’s what saves their lives. (See: every episode of *House*.)”  
—emjaybee, “Collateral Damage: A Patient’s Experience of Defensive Medicine”

As Chapter One demonstrates, despite a decades-old feminist health movement and a small-but-vocal contemporary maternity care reform movement, institutionalized obstetrics continues to dominate the care of birthing women. In a recent book-length critique of that dominance, former WHO Maternal and Infant Health officer Marsden Wagner argues, “By embracing a medical model of birth and allowing obstetricians control of our maternity care, we Americans have accepted health care for women and babies that is not only below standard for wealthy countries but often amounts to neglect and abuse” (5). Wagner offers a wealth of data to support his characterization of maternity care and articulates his suggestions for overhauling the current system, and his arguments and proposed solutions will not surprise anyone familiar with birth activism and feminist critiques of maternal health care—namely, to turn the care of healthy women experiencing pregnancies free of complications over to midwives and to let obstetricians handle high-risk patients.

In a cultural milieu where critiques like Wagner's are garnering more public attention, one question that remains largely unexplored is why, in the midst of such vehement opposition, so many American women still give birth in hospitals under the care of obstetricians. Part of the answer certainly lies in the economic and political power wielded by professional medicine and in the scarcity of other viable options in many parts of the country, as we will see in the coming chapters. But another part of the answer—the part that has received little attention—lies in the way American culture has come to understand the physical process of childbirth, not through science textbooks or prenatal education, but through our cultural narratives about having a baby. Scholars from a variety of disciplines are studying how medicine and media work together to create knowledge about life, death, disease, and bodies, and their work has shown how much the public learns about medicine from the popular media (L. Friedman *Cultural Sutures*; Reagan, Tomes, and Treichler; Turow). Most of that scholarship, however, is focused on disease, and the media's imaginings of childbirth—especially as a medical event—have gone virtually unremarked. That may be, at least in part, because such imaginings have been scarce until very recently. In this chapter, I will consider narratives of pregnancy and birth that have appeared in mainstream popular culture around the same cultural moment, roughly between 2005 and 2008, especially those in television medical drama and in mainstream romantic comedy.

In 2005, ABC launched a new medical drama, one that followed a group of surgical interns through their residency programs. Currently airing its seventh season, *Grey's Anatomy* has garnered yearly critical acclaim, one of the most sought-after primetime time slots, and some of the highest per-spot advertising revenue, largely because its audience draws heavily from the highly coveted 18-49 year-old female demographic. In the second season of the show,

a new cast member, Dr. Addison Montgomery, played by Kate Walsh, joined the show. Cast as one of the country's premier neonatal surgeons, Dr. Montgomery is also an obstetrician; with the addition of her character to the cast came a series of pregnancy-related patient narratives spanning the two seasons she was a regular on the show, from 2005 to 2007.

Just as Addison Montgomery left *Grey's Anatomy* to star in a spin-off medical drama called *Private Practice*, a rash of pregnancy-themed films showed up in theaters across the country. In 2007, three films that each received some measure of critical and box-office success drew their narrative drive from the events surrounding unexpected pregnancy. Jason Reitman and Diablo Cody's indie-turned-major release *Juno*, which won an Academy Award for Best Screenplay, focuses on a teenage girl and her decision to give her baby up for adoption; Judd Apatow's mainstream box office hit, *Knocked Up*, explores unexpected parenthood for an unlikely pair in their twenties, largely from the father's point of view; and Adrienne Shelly's less popular but widely reviewed independent film, *Waitress*, follows an unhappily married woman through an unwanted pregnancy in the small-town South. Pregnancy also occupied the attention of documentary filmmakers during this time period: Ricki Lake's *The Business of Being Born* and Debra Pascali-Bonaro's *Orgasmic Birth* were released on DVD in 2008 and 2009 respectively.

According to the Centers for Disease Control and Prevention, more babies were born to American women in 2007 than ever before, the first time that the birth rate has exceeded the baby boom, which peaked in 1957. The data from that report generated a lot of media attention: two of the most reported-on statistics include the 31.8% of women who gave birth by cesarean section, the highest percentage ever, and the continued increase in birth rates for teens and

unmarried women in their twenties and thirties.<sup>11</sup> The connection between the latter statistics and the media representation of unplanned pregnancy<sup>12</sup> made its circuit around the mainstream media and the blogosphere, and thanks to a series of related news stories speculating on this connection, one can now find a Wikipedia entry for the “Juno Effect.”<sup>13</sup> What has gone virtually undiscussed, and what I will take up in this chapter, is the relationship between popular culture representations of pregnancy and the implications of the first statistic: the increasing reliance on medical technology in childbirth.

### **Cultural (Medicine) Studies and Representations of Childbirth**

Cultural studies scholars, of course, have been arguing for decades that popular representation has a weighty effect on material life. Stuart Hall calls this process the “cultural circuit”: representation, especially through mass media, is one way meanings are produced in a culture, and through the interpretation and consumption of the images and narratives produced in such representation, “our material interests and our bodies can be called to account, and differently implicated, depending on how meaning is given and taken, constructed and interpreted in different situations” (10). Teasing out how that give-and-take process operates is

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<sup>11</sup> Martin et al., “Births: Final Data for 2007,” 3-4. The teen birth rate, after a decade-long decline until 2005, had climbed five percent over a three-year period to 42.5 births per 1,000 teenagers in 2007. The birth rate for unmarried women increased by 4 percent from 2006 to 2007, and the proportion of all births to unmarried women reached a record high of 39.7%. As I pointed out in Chapter One, the c-section rate climbed again in 2008 and 2009, but the birth rate for all groups except unmarried women declined slightly.

<sup>12</sup> The media buzz about teen and unplanned pregnancy came not just from these films, but also from celebrity narratives like that of 16-year-old Jamie Lyn Spears, teen mom and sister to pop icon Britney Spears, and that of former Alaska governor Sarah Palin’s daughter Bristol, whose pregnancy became public just as Governor Palin announced her bid for the vice-presidency in the 2008 election. Television series like *The Secret Life of the American Teenager*, the news coverage of a so-called “pregnancy pact” at a high school in Massachusetts, and frequent forays into pop culture by the National Campaign to Prevent Teen and Unplanned Pregnancy have made this topic a hot one during this time period.

<sup>13</sup> See, for example, Pesca, “In Cluster of Teen Pregnancies, ‘Juno’ Comes to Life,” and Kingsbury, “Pregnancy Boom at Gloucester High.”



especially important for those working to critique and intervene in debates about science and medicine; not only does much of what the public learns about those disciplines come in the form of popular media, but as a number of scholars in science and medicine studies have argued, the institutions of science and medicine themselves are also being shaped by mainstream representation. Leslie J. Reagan, Nancy Tomes, and Paula Treichler's recent collection, *Medicine's Moving Pictures*, for instance, is based around the simple notion that since the advent of mass media, the public has always learned about health, bodies, disease, and medicine from watching television and films, and that a "symbiotic relationship" between medicine and mass media enables such representations to exert a significant influence on "health-related public debates and controversies" (2).<sup>14</sup> Susan Squier's argument for seeing literature and science as reciprocal entities always working together to produce knowledge reminds us that that fictional representations of science and medicine serve an epistemological function, as they are shaped by scientific knowledge, and in turn, are shaping the scientific arena in which such knowledge gets made (*Liminal Lives* 43). The kind of texts I am focusing on here are the visual narratives of film and television, but what interests me in Squier's reciprocal arrangement is the connection between cultural narratives of birthing women and the practice of obstetrics: how are medicine and popular texts working together to produce knowledge about what it means to give birth? How might the meanings produced in the media of film and television affect the material conditions of birthing American women?

In order to explore these questions, I will focus my analysis in this chapter on pregnancy narratives in the first three seasons of *Grey's Anatomy*, which aired from 2005 to 2007; on the cluster of pregnancy films in 2007; and on the documentary, *The Business of Being Born*,

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<sup>14</sup> Lester J. Friedman's *Cultural Sutures: Medicine and Media* and Lisa Cartwright's *Screening the Body: Tracing Medicine's Visual Culture* are also based around this premise.

widely released in 2008. By revealing the ways that *Grey's Anatomy* is narratively structured to invite audiences to identify with and invest emotionally in the lives of doctors rather than patients, I will first demonstrate how the show constructs physicians as subjects who work out their personal and philosophical problems through their interactions with patients, figured primarily as objects. This script suggests that the dominant ideology undergirding obstetrics—that pregnant women are objects for the practice of medicine, rather than subjects to be trusted to make their own decisions—perhaps stems from a general view of physicians as actors and patients as the acted-upon. To fully trace the way this plays out on the show, I will look closely at two pregnancy narratives, one involving a pregnant patient and the other involving a pregnant doctor. In the next section of the chapter, I will turn to *Juno*, *Knocked Up*, and *Waitress*. I will show how, despite more progressive messages about the meanings of motherhood and family, these romantic comedies tend to replicate the biomedical model's insistence on birth as a crisis to be managed and medical technology as the best resource to manage it. Though each film offers subtle challenges to the clichéd images of terrifying hospital births in earlier comedies, by locating what anthropologist Brigitte Jordan calls “authoritative knowledge” in medical technologies, those challenges are subsumed by the overall message that routine hospital birth produces healthy babies and happy mothers. Ultimately, despite some challenges to a dominant narrative, I argue that popular fictions aimed at a wide variety of audiences are not just socializing pregnant women to fear birth and invest an inordinate amount of trust in institutional medicine and biomedical technology. They are also socializing the general television-watching and movie-going public—including medical professionals—to reinforce those messages. In the final section of the chapter, I will consider *The Business of Being Born* as a counter-narrative to

the mainstream version of medicine and childbirth, analyzing it for narrative solutions it offers for managing—and representing—the bodily act of reproduction.

If cultural fictions are one place where challenges to the status quo can germinate, then part of the reason birth has remained squarely under the domain of institutionalized medicine is likely because until very recently, artistic imaginings of pregnancy and birth have been marginalized, or exiled altogether, as feminist literary scholars have pointed out (Ratcliffe; Cosslett; Tarter; Yaeger). Elaborating on Mary O’Brien’s argument in *The Politics of Reproduction*, literary critic Patricia Yaeger writes that of “the most socially charged of our ‘natural’ functions—eating, sex, death, birth,” only birth remains without a theoretical system “designed to remake our wishes and our bodies”; the other three have “received extensive philosophical investigation” and “have become bases for major systems of thought that have changed our ideologies as well as our bodies” (265-66). Sex, for instance, O’Brien argues, has been given the philosophical weight of Freud, while the basis for thinking about death and what it means in society has been reimagined by Sartre and the existential philosophers. Pregnancy and birth, from the perspective of the mother, remains largely unexplored, which, for both O’Brien and Yaeger is because it is the only one of those functions that belongs exclusively to women.

As I mentioned in Chapter One, in the late 70s, Julia Kristeva and Adrienne Rich both articulated the ways this silence operates in feminist discourse, but since then, only a handful of feminist scholars in the humanities have taken up Kristeva’s challenge to establish a discourse that engages with representations of “those particularities of the maternal body” and “the

corporeal and psychological suffering of childbirth” (182-83).<sup>15</sup> The historical marginalization of birth within the Western literary tradition is underscored by a pervasive social taboo regarding discussions of the bodily experience of maternity: “Pregnancy, childbirth, and breastfeeding are still, in many communities—including the academic ones I have belonged to—unspoken, perhaps unspeakable,” writes literary critic Cristina Mazzoni (3). Considering the ways the Western literary tradition has marginalized imaginings of pregnancy and birth,<sup>16</sup> the social mores that prevent the bodily experience of birth from being seriously discussed in many public and private forums, and the cultural shifts that moved traditional birth knowledge from female community and family networks to male-dominated institutions nearly a century ago, where are contemporary Americans learning about the physiological processes and cultural meanings of childbirth? Outside of our own lived experiences, many of us must be learning about having a baby in the place where narratives and images of it are most widely circulated: in popular culture.

### **Medicine and Maternity in Primetime**

One of the most logical places to look for images of childbirth, perhaps, is in popular depictions of hospitals, especially primetime medical drama. Dramatizing the workings of the medical system has been a staple of primetime television since the medium matured into a form of mass communication and entertainment in the early 1950s (Vandekieft 216-17). Early shows

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<sup>15</sup>For a summary of those who have responded to Kristeva and Rich’s call for a maternal discourse, see Chapter One, 29-30.

<sup>16</sup>Though there is now a small but vibrant body of women’s novels, short stories, and poetry that try to fill in some of the silences surrounding birth and feminist literary scholarship dedicated to the study of those texts, this work is still fairly recent. For a lineage of discourses of childbirth in the Western literary tradition, see Tarter, “Bringing Forth Life from Body to Text: The Reclamation of Childbirth in Women’s Literature.” Even in the work that does exist, however, there has been very little attention paid to mainstream culture’s imaginings of birth in film or on television.

like *Dr. Kildare* and *Dr. Christian* introduced a formula for the genre, where the action “focus[ed] on doctors facing acute-care situations in high-tech hospital settings,” a formula which, at its core, has remained relatively stable over the last sixty years (Turow and Gans-Boriskin 264). Joseph Turow and Rachel Gans-Boriskin argue that despite the “tyranny of the formula,” which still shapes medical drama today, late 20<sup>th</sup> and early 21<sup>st</sup> century shows have adapted to the changing health care landscape contemporary American audiences would expect by transforming the hospital from a “free-flowing temple of healing” to an “existentially scary place for patients and physicians alike” (264-65). They contend that portraying physicians at the mercy of institutional forces destabilizes the absolute authority earlier iterations of the genre granted them: “By the 21<sup>st</sup> century, then, a formula built on characterization and plots that celebrated the power of the physician had morphed into one that increasingly led writers and producers to depict an existential angst resulting from their inability to dominate in the ways, and with the tools, that the formula prescribed.” (279). As the genre changed, “at least one result that the formula’s originators could not have foreseen was a dark message that questioned the ability of doctors to make sense of the world for their patients and themselves, let alone to exert authority over it” (279). Elena Strauman and Bethany Crandell Goodier agree that newer dramas reveal more of the flawed humanity of television doctors than did their predecessors and have traded in idealism for realism, absolute certainty for moral ambiguity. They see that shift in positive terms, contending that a show like *E.R.*, one of the earliest examples of more realism, “can still engender faith in some individual physicians who, although fallible, act in the best interests of their patients” (128).

Physicians have demonstrated concern about the kinds of messages these shows send: in a *New England Journal of Medicine* article, for instance, doctors cited the frequency with which

patients treated with CPR on *E.R.*, *Chicago Hope*, and *Rescue 9.1.1.* were successfully resuscitated compared with rates of success from real emergency rooms as a reason that patients and families might come to the emergency room equipped with unrealistic expectations and false hope (Diem, Lantos, and Tulsy). As Lester Friedman points out, these representations could also affect physicians who “may perform CPR, even when they realize the futility of such treatments, because families expect the procedure from watching medical television shows” (“Introduction” 5). That the shows have the potential to shape doctors’ views of themselves, their profession, and their patients seems obvious—in an interview on National Public Radio, television personality and physician Mehmet Oz called *E.R.* his “other medical school”—and recent articles in medical education journals suggest using the shows as a springboard for discussion in medical school classes, particularly in thinking through issues of ethics and professionalism (“Dr. Mehmet Oz”; White; Lim and Seet). What, then, is a show like *Grey’s Anatomy* communicating about doctors’ views of themselves and their profession and about the general public’s interaction with health care? What might it communicate about the particular event of childbirth?

In order to explore how *Grey’s Anatomy* encourages audiences to view doctors, the practice of medicine, and, especially pregnancy and childbirth, I will look closely at a sample of episodes that aired during the show’s first three, and most popular, seasons. By paying particular attention to the narrative structure of the show, to the location of “authoritative knowledge” (Jordan), and to the construction of pregnancy and childbirth in the medical environment, I will argue that despite presenting the main characters as deeply flawed individuals, the show produces doctors as the subjects and patients as the objects, a construction which shores up the doctors’ ultimate authority even in the midst of—or perhaps even because

of—the chaotic environment of the hospital system and the complex ethical dilemmas presented there. Audiences are invited to follow the development of the doctors over the course of many months and years, while patients, whose stories usually occupy only a portion of a single episode, become the vehicles through which much of that development takes place. To determine what that structure means for the show’s treatment of pregnancy and childbirth, I will review the doctors’ overall attitude towards obstetrics and the pregnancy-related cases featured during these three seasons. Finally, I will closely read two stories of uncomplicated pregnancies, a patient’s and one of the doctor’s, alongside one another to demonstrate that the view of birth depends on the identity—and subjectivity—of the birthing woman. In other words, only when the pregnant woman is also a doctor is there room for anything other than physician-directed delivery.

Created by Shonda Rhimes in 2005, *Grey’s Anatomy* is currently in its seventh season, and it has remained one of the most popular shows on network primetime. Rhimes serves as the executive producer and head writer for the show, frequently penning pivotal episodes, and retaining tight control over all aspects of casting and narrative development. One of Rhimes’ oft-discussed trademarks is what television critics call “color blind casting,” a process in which no character’s racial or ethnic identity is specified during auditions, and the actor who best fits the role is chosen. For *Grey’s Anatomy*, this method yielded an ethnically diverse cast, though race as a subject is rarely broached during the show. What becomes clear from the narrative structure of the show is that what matters most in understanding the characters is not race, gender, or sexual orientation; it is simply that they are doctors. Professional identity is the identity that matters.

Each episode opens with a voiceover, almost always the voice of Meredith Gray, one of the interns and the main character of the show. The general way this narrative device works is that she lays out a theme for the episode, usually echoed in the episode's title, that serves as a frame for understanding the stories contained in the episode. The opening monologue provides a narrative thread that links the doctors' personal lives and professional trials with the circumstances of the cases they encounter in the hospital. Then the voiceover concludes the episode, closing in the frame and tying the threads together. For instance, in episode six of season three, entitled "Where the Boys Are," Meredith's voice opens the show: "As surgeons, we are trained to detect disease." As the voiceover continues, the action in the hospital begins, each scene punctuated by Meredith's narration until the title song begins. She continues,

Sometimes, the disease is easily detected. Most of the time, we need to go step by step. First, probing the surface, looking for any sign of trouble. A mole or a lesion, or an unwelcome lump. Most of the time, we can't tell what's wrong with somebody just by looking at them. After all, they can look perfectly fine on the outside, while their insides tell us a whole different story.<sup>17</sup>

The outside/inside theme she lays out serves as the frame for understanding each narrative that viewers will encounter in the show. Further, she also both excludes and includes the audience in her "we." By providing an antecedent in the first line, surgeons, she seems to be focusing exclusively on doctors. Then, as it becomes more obvious that she is speaking both literally and metaphorically about disease—both by the abstractness of her language and by the images that appear on screen as she's talking, images not of diseased patients but of relationships between doctors—the "we" becomes more inclusive. Literally, surgeons "can't tell what's wrong with somebody just by looking at them"; metaphorically, none of us can see inside another person or

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<sup>17</sup> All transcriptions are my own, though I confirmed them with those on *The Television Transcripts Database*, <http://www.tvtdb.com/greysanatomy>, contributed by Eliza, Brandee, and Katie.



ourselves to detect the disease—physical, emotional, or psychological—that may be hiding there. In this way, the metaphor invites viewers to identify with the “we” of the first sentence—“surgeons”—in order to better understand the relational dimensions of the show, and implicitly, the relational aspects of their own lives. The audience is invited to participate in the learning process along with the surgical interns, residents, and attending physicians by seeing the metaphorical underpinnings of the practice of medicine.

The unsuspecting teachers in this metaphor are the patients and their illnesses, as Strauman and Goodier point out: “As the doctors struggle to understand and treat a patient’s condition, they are forced to grapple with lessons that parallel their personal lives” (129). The show is constructed in such a way as to emphasize the lives, dilemmas, and character development of the doctors, rather than of the patients. Inside the frame, the patients often become vehicles through which the doctors can work out a problem; their stories parallel some event in the doctors’ lives so that the doctors—and the audience—can come to a deeper understanding of themselves. In this way, the patients are objectified: they serve a narrative purpose, but they are not treated as characters in their own right. The audience knows them as the doctors do: by their symptoms. Audiences learn the details of their cases as read from their charts and presented by the doctors and see them only in the hospital environment. Though interactions between doctors and patients often reveal more personal information, by inviting the audience to identify with the surgeons, the gaze fixed on the patient is clinical and diagnostic.

In this episode, one patient narrative that provides a lesson for Meredith is a sexual reassignment surgery scheduled to be performed by the plastic surgeon, Mark Sloan. The dialogue between Meredith and Dr. Sloan emphasizes this connection, as their interactions with

the patient and her wife are interspersed with a dialogue about Meredith's relationship with another doctor, Derek Shepherd. Following the news that the patient, Donna, has developed breast cancer as a result of the hormones she has been taking, Meredith asks Mark, "So what happens with Donna now?" ("Where the Boys Are"). He immediately brings the conversation back to their lives and how the framing theme applies to them, and Meredith follows his lead:

MARK: She goes back to being an unhappy man who's stuck with a penis. There are millions of us out there.

MEREDITH: You're unhappy with your penis?

MARK: I could be a lot less unhappy. Maybe it's good that [Derek]'s taking some space. Maybe you two aren't meant to be together. Look, Derek. . .on the outside he holds it all together, but he's damaged goods Meredith. It's my fault. I damaged him. Maybe forever. You don't want to drink from a poisoned well, do you?

Donna, the patient, has also participated in this outside/inside trope by talking about how though she may look like a man on the outside, she is really a woman inside. During surgery, the two narratives get conflated as Mark says, "People don't come to me to fix what's on the outside, they come to me to fix what's on the inside. And if that means giving someone a straighter nose, or bigger breasts, if that helps a person get by, I don't run. I don't hide. I don't take space." His gaze, held squarely on Meredith, indicates that he is using the medical narrative to talk about the difference between himself and Derek, while operating on a patient. As he and Meredith share a drink at the episode's close, we understand that he is inviting Meredith to let him "fix" her, to help her "get by." But she learns her lesson from the patient's wife, Vicky, who confides in Meredith about why she stayed with her husband after he decided he was a woman:

You asked before why I came back the first time. I tried not to. I went on dates. I had a lot of great first dates with guys who were planning to stay guys. And you know you have a great date and you want to tell your best friend about it. My best friend is Daniel. Donna. Then you have a few bad dates and. . .she's my best friend. She knows me. She loves me. She's my husband. At the end of the day, it's Donna. Even when she hurts me. Even when I hate her.

By episode's end, when Meredith leaves Mark alone at the table and agrees to give Derek another chance, audiences understand that Vicky might as well have said, "At the end of the day, it's Derek. Even when he hurts you." The final voiceover makes this plain, as the images Meredith narrates over are of her and the other doctors in a bar, living their social lives, working out their relational problems. She says,

Not all wounds are superficial. Most wounds run deeper than imagined. You can't see them with the naked eye. And then there are the wounds that take us by surprise. The trick to any wound or disease is to dig down deep and find the real source of the injury. And once you've found it, try like hell to heal that sucker.

The deep wounds are certainly referring to the patient cases in both physical and emotional ways—Donna's cancer, which she refuses to stop feeding with her hormone treatments; another patient's emotional wounds he tries to heal by getting attention from his parents for swallowing Monopoly pieces; a pregnant patient who loses her baby when she falls in the bathtub—but the attention as the frame closes is on the doctors, whose stories will continue to develop in the next episode. The patients all are healed or not in the course of forty-three minutes; cases closed, narrative threads tied in neat little bows. The audience, now directly addressed as "you," is further incorporated into the perspective of the surgeons, whose lives implicitly matter most in the narrative construction of the show.

When pregnancy is part of the patient's story, the show generally features unusual or high-risk conditions, in keeping with the show's focus on surgical practice. Obstetrics, as a specialty, is regularly marginalized and dismissed as unimportant by the interns and attending doctors alike. One of the interns, Cristina Yang, for instance, gives this reason for not continuing an unexpected pregnancy: "Look, you know what happens to pregnant interns. I'm not switching to the vagina squad or spending my life popping zits. I'm too talented. Surgery's my life" ("Raindrops Keep Falling"). Casting obstetrics and dermatology as specialties for less

talented interns, her disdain for maternity care is echoed by other interns as well. When Alex Karev, the tough, smart-mouthed wrestler from a troubled background, interns for Addison on the ob-gyn rotation, he complains, though it turns out he is good with babies. He tries to hide his interest in the specialty, asking the intern who has taken his place, “O'Malley, how's it feel to be the new gynie grunt?” (“Let the Angels Commit”). But he eventually seals his fate when he steps in to assist with the cesarean delivery of twins. His new attending plastic surgeon tells him, “You say you want a career in plastics, but you can't tear yourself away from the baby catchers long enough to show me you want it.” Obstetrics is less desirable as a surgical specialty, and yet, one of the ways that the show softens Alex’s image and shows his sensitive—and feminine—side is through his work with newborn infants, especially one he finds he can help breathe better by laying her on his chest. Working with mothers and babies, then, serves a narrative purpose, and so these cases are especially useful for characterizing the doctors who work on them.

Pregnancy and birth become medical events like the other cases within the same episode, necessary to manage with a high level of specialized medical care and part of the narrative frame. In the episode described earlier, “Where the Boys Are,” one of the other main patient storylines focuses on a young woman in her eighth month of pregnancy named Jaime Carr who comes in with her husband to treat her broken wrist. The emotional climax for the episode occurs when the obstetrician has to tell her that the ultrasound shows that her baby has died from the fall, followed by a birth scene, in which the woman pushes out and then holds her dead baby. The imagery provides a glimpse into how terribly wrong pregnancy can go and the emotional consequences of that happening, for the patient and her husband, but also for her doctors. Audiences are invited to see the event as tragic on both counts, but more screen time is

spent on the physician's response to the news than on the couple's. When Addison first learns that the baby no longer has a heartbeat from the ultrasound, rather than telling them, she leaves the room. Another doctor finds her in the bathroom, sobbing, and later, the two of them watch the couple through the window, lamenting how terrible it is to have to give such happy people such terrible news. Addison says, "They are a happy couple. Look at them. They love each other. They should have everything. Happy people should have happy things happen to them. And I have to tell them." She is contrasting their happiness with her own sadness: in the prior episode, her divorce has been finalized, and she is mourning the loss of her own happiness with her husband. We understand that she is crying for them and for her, and this becomes even more clear several episodes later when she tearfully reveals that she aborted a baby eight months earlier.

Jaime Carr's miscarriage, clearly a freak accident and not a narrative of the normative course of pregnancy, is one of several storylines that highlight high-risk or otherwise strange and unusual cases featuring pregnancy and childbirth. These include a woman with two uteruses carrying twins with different due dates, and, it is revealed by the doctor, two different fathers ("Let the Angels Commit"); a 47-year old woman pregnant with her first child and having to decide to undergo chemotherapy to save her own life or allow her pregnancy to come to term and save the life of her baby ("Save Me"); a woman carrying quintuplets who are born with a host of health issues ("Much Too Much"); two train accident victims who are carrying babies conceived using the same donor sperm ("Into You"); and a man experiencing what appears to be "hysterical pregnancy" in sympathy with his pregnant wife, but turns out to be an abdominal growth called a teratoma ("Something to Talk About"). None of these storylines represent uncomplicated pregnancies, and it is implicit that these cases are high risk: why else would they

be treated by surgeons? The birth scenes in all of these cases are portrayed as other surgeries are—life or death situations in which the doctors must be in complete control.

If this is the general pattern of birth-related narratives on the show, then the deviations from the pattern are significant. Two such deviations provide a useful look at the way the show constructs “normal” pregnancy, and they also illustrate the foregrounded subjectivity of physicians and subsequent objectification of patients that forms the basic narrative structure described earlier. The pregnancies of a patient named Rebecca and of chief resident Miranda Bailey are the only uncomplicated pregnancies depicted in the first three seasons of the series. Rebecca’s story begins as she is already in labor. Dr. Addison Montgomery walks into her room and asks, “How’re we doing guys?” (“What I Am”). Alex Karev, her intern for the day, gives a report, “She’s at 8 centimeters, but the baby’s still at minus 3 station.” Already, this patient is being treated differently than others; usually, when audiences meet a patient for the first time, an intern reads their full name and information from their chart, so that viewers can understand what they are being treated for. Rebecca, whose name we do not learn until a later scene, is clearly in labor, a condition that apparently needs no introduction. Alex’s assessment of her progress alerts viewers to the reason her story is part of the patient line-up for the episode: when asked how they should proceed, he responds, “We monitor the baby's progress. If the descent stops entirely during active labor, then we perform a c-section.” Her response to his progress report, “Not on me you don’t. I’m sorry, Dr. Karev, but Jeff and I have a natural birth plan,” tells viewers that she has specific desires for her birth. It does not, however, explain why she is on the surgical floor of a hospital attended by a neonatal specialist. Other episodes show patients with high-risk conditions transferred to Addison’s care because she can help them, but nowhere else do we see her attend prenatal visits or otherwise work with pregnant women who

are not considered high-risk or in an emergent state. Are audiences to assume that a woman with a “natural birth plan” requires the expertise of a specialist? Is wanting a birth that deviates from the medicalized norm to be understood to place a woman in the “high risk” category? Her wishes for a natural birth are undermined by both Alex and Addison at every given opportunity. When Alex reports that the baby has not descended, the patient’s husband says, “So what do we do? Pattern breathing? Squatting?” Alex rolls his eyes and says, “Dude. Squatting?” In the conversation that follows Rebecca’s protest against a section, Addison and Alex continually exchange knowing, condescending looks, indicating both their doubt and their displeasure with having to deal with a patient asserting her wishes:

ADDISON: I promised we would do what we can. But if your labor intensifies and the baby doesn't descend. . .

REBECCA: Well then we wait until he does. Right? I'm not having a c-section.

ALEX: A c-section is actually the safest way—

REBECCA: To what? Avoid a lawsuit?

ADDISON: We don't have to decide right now.

REBECCA: I'm not going to miss out on an experience my body was made for just because it's more convenient for you.

Neither of the doctors suggests anything that might help her baby descend—like getting out of bed and letting gravity assist, for instance—and neither seems to regard her wishes as anything other than non-professional ignorance. The patient comes across as defensive and combative, repeating that she has a “birth plan” as if it were her battle cry. In response, the doctors’ meaningful glances, exchanged across her laboring body, indicate that they clearly know better than she does. They discuss the dilemma later in the episode, outside the patient’s room.

ADDISON: I want you checking the fetal monitor every thirty minutes.

ALEX: What's the point? The baby's nowhere near where he needs to be and you know you're going to have to cut her open. So why not get it over with?

ADDISON: That's not what the patient wants and it's our job as doctors to balance the desires of the patient against the risk of complication, so if the patient wants a natural birth. . .

ALEX: So if the patient wants a natural birth, it's not surgical. So why not just cut me loose and let me in on a surgery I might actually learn something in.

Addison's expressions and tone of voice clearly communicate her annoyance at having to "balance the desires of the patient against the risk of complication," and that exasperation reaches a climax during the next scene when she goes in to check on Rebecca. Rebecca is clearly in more pain, sweaty and breathing heavily, screaming and crying through contractions.

ADDISON: You're fully dilated, but the baby is only at minus 2 station.

REBECCA: We just need more time.

ADDISON: We don't have it Rebecca. His heart rate is slowing with each contraction. If he starts having late decels. . .

REBECCA: Is he having late decels?

ADDISON: Not yet, but. . .

REBECCA: Then stop trying to scare me into having a surgery I don't want. I have a birth plan. Look, I'm not going to be one of those weak-ass women who give all that up the minute things start to get scary.

ADDISON: Rebecca, a birth plan is just that: it's a plan.

The conflict intensifies and ends with Rebecca yelling at Addison to get out of her room.

During the exchange, the doctor looks primarily at the chart and the monitor; only when Rebecca becomes irate does the doctor actually look at the patient. Later, after a nurse finds Alex and shows him the printout from Rebecca's monitor, he looks alarmed and then runs to find Addison.

ALEX: You planning on killing a woman today?

ADDISON: What?

ALEX: The c-section you should have performed on Rebecca this morning? At this point it may be too late. For her and the baby. Nice work, Doc.

ADDISON: Get an OR and an anesthesiologist. We're doing a crash c-section right away.

*The scene cuts to Rebecca's room.*

ADDISON: He's in distress. We have to get you into the delivery room and get him out right now.

REBECCA: No.

ADDISON: This is no longer a conversation. I am your doctor, and I am responsible for your life and your baby's life. And I am not about to lose either one of you. Are we clear?



The next and final time Rebecca is shown on screen, she is being handed her newborn baby. Looking gratefully at Addison, she says, “Thank you” very sincerely, and those are the last words we hear her say. Never is there an explanation of what happened or why the emergency c-section was needed to save her life. The audience is to understand that it did, and that the patient is grateful that the doctor took control and rescued her from her own irresponsible and ignorant desires.

Chief Resident Miranda Bailey’s pregnancy is the only storyline to date that features one of the main cast members giving birth, so we might expect that the events surrounding her labor and delivery would offer a different view. For one thing, by the time she goes into labor, the audience knows her well: her character is well-developed and sympathetic; as the resident in charge of the interns who are the main characters of the show, she gets a lot of air time. So when she shows up to the hospital after two weeks of bed rest, yelling at her interns as if it were any ordinary day, her announcement that her contractions are ten minutes apart and her water has just broken seem to come out of nowhere. Her labor lasts for the course of two connected episodes, and the scenes that show her laboring and giving birth stand in stark contrast to those featuring Rebecca, who wears a hospital gown and never moves from her bed. Bailey wears her own bathrobe, walks and squats and sways on an exercise ball, and talks to her colleagues between pauses to breathe through her contractions. She sounds like her normal self, saying things like, “A boy the size of a 10 pound bowling ball is working his way out of my body. Can you get me something for that? Can you get me a new vagina?” (“It’s the End”). The doctors respond as if they are interested in Bailey’s labor as her friends and not as physicians. Each of the male doctors who passes by her room acts scandalized by the sight of her cervix being examined, and they hover outside her room as if they were expectant fathers, rather than

surgeons. Addison points this out after she comes out of Bailey's room, saying, "Well, the gathering of men outside the delivery room. How midcentury of you." When they ask how she's doing, Addison responds, "Taking it like a woman. Six centimeters dilated. Fifty percent effaced and refusing all pain meds which I think is stupid but I'm not in labor." She does not roll her eyes or condescendingly look concerned; she acts as if Bailey is a free agent to make her own decisions, another stark contrast to the treatment of Rebecca, who is portrayed as crazy and irresponsible for "taking it like a woman." Most obviously, Bailey is treated as an individual, and that individuality makes her not just another patient in labor. In fact, Bailey's birth would be a non-event if it were not for the other storylines in these two episodes that heighten the drama and cause complications for her.

Those two episodes, "It's the End of the World" and "(As We Know It)" aired at the midpoint of season two and earned Shonda Rhimes an Image Award and an Emmy nomination for Outstanding Writing in a Dramatic Series. The main storyline involves a man who comes in to be treated for a gunshot wound when doctors discover that he has live ammunition lodged in his chest. A paramedic with her hand inside his body is preventing him from bleeding out, and, at the same time, keeping the ammunition stable. The secondary storyline, and the one that makes Bailey's labor especially dramatic, involves her husband. Unbeknownst to her, he has been in a car accident on the way to the hospital and is having brain surgery in the operating room next-door to the one where the bomb squad is trying to decide how to prevent an explosion. In this way, the drama of Bailey's birth is heightened not by labor or medical complications, but by the fact that the other doctors want to keep from her that her husband is in mortal danger. Bailey wants to wait for her husband to get there to push the baby out, and the pain we see her in as she is managing her contractions seems as emotional as it does physical—

she keeps saying that she does not want to do this by herself and calling her husband on her cell phone over and over.

In the midst of all of this chaos, she still refuses pain medication and maintains her sense of self, making decisions about what she will and will not do. When Addison tells her “there is no shame in an epidural,” she fires back, “Epidural increases the possibility of a c-section.” This position is an interesting one for a surgeon to take; during Rebecca’s labor, Alex indicates that he believes surgery is the safest way to have a baby. Bailey thinks differently: “Women all over the world do this at home with nothing more than a pair of scissors and a bucket of hot water.” When another surgeon responds, “Women all over the world also die giving birth at home every single day,” he earns not agreement from the other doctors but scathing looks from Addison and Bailey. As the only one among them who has ever gone through this, Bailey earns more credibility than even Addison as her obstetrician, but, as should be clear from the contrast with Rebecca’s story, only because she is also a doctor, only because she is considered a peer to the other doctors.

In the second of the two episodes, Bailey is refusing to push, and Addison is trying to find an operating room. She is no longer willing to abide by Bailey’s wishes and draws the scenario in life-or-death terms in a conversation with the chief of surgery:

ADDISON: She won't let me examine her but from what I can tell her contractions are 40 seconds apart and she's refusing to push. The baby could go into distress and if she doesn't come out of this and soon, then I'm gonna need an OR to do an emergency c-section.

RICHARD: I can't give you an OR Addie! I don't have an OR to give. Can't you convince her to push? Bailey's rational.

ADDISON: She's not Bailey right now! She's a woman in labor whose husband is in surgery next to a bomb.

RICHARD: So is yours.

ADDISON: This is about Bailey. I need an OR.

RICHARD: I don't know what to tell you.

ADDISON: Look Richard, we have about an hour to change Bailey's mind and then I'm going to need you to get me an OR. Build me an OR. Find me a helicopter to fly me to any OR in the city. Otherwise instead of having a baby, she'll be losing one. (“(As We Know It)”)

Importantly, Addison attributes Bailey’s irrational state not simply to the fact that she is in labor, but that she is in labor under such stressful circumstances (by this point, Addison has told Bailey that her husband is in surgery). She also does not blame Bailey: Addison admits the gravity of the situation—that Bailey could lose the baby—but she places that responsibility on the chief, not on Bailey. George tries to talk to Bailey, to reason with her, but she insists that she needs someone to drive her home, that she is not having the baby without her husband. He goes to Addison to try and figure out a way to help.

GEORGE: Dr. Montgomery-Shepherd. What are we gonna do? I mean about Dr. Bailey. Can, can we drug her?

ADDISON: Against her will?

GEORGE: No. Well . . .yes. Can't we force her to push? If we declare her temporarily insane.

ADDISON: Ah. You want me to declare Miranda Bailey, Miranda Bailey incompetent? Do you think that will help? Do you think that will make her more inclined, more comfortable giving birth?

This exchange demonstrates how careful they are to treat her as an individual: she is not a patient, she is their friend and colleague, whom they know well and care for. Never, in the case of Rebecca, does Addison indicate that she cares whether Rebecca is “comfortable giving birth” or suggest that there might be psychological factors at work in the fact that her baby has not descended, such as the apparent dismissal of her wishes by her doctors. In Bailey’s case, both Addison and George want to help her by supporting her, rather than by treating her, which Addison admits they cannot do against her will. George, finally motivated to do something to help her, goes into her room and gets right beside her bed. While rubbing her arms with a damp washcloth, he says,

Dr. Bailey, I'm surprised at you. I really thought. . .this is not how I thought you would do this. You're Dr. Bailey. You don't hide from a fight. You don't give up. You strive for greatness. You Dr. Bailey, you are a doer. And, I know your husband is not here and I know that there are a lot of things going on here that we have no control over. But this. This we can do. Okay? Okay. Let's have this baby.

He gets behind her and helps her sit up and holds her hand while she pushes, encouraging her and supporting her. The images of George cheering her on and holding her hand as he climbs into bed behind her demonstrate the stark contrast between Bailey's and Rebecca's birth: it is not medicine that helps Bailey push her baby out, it is emotional support, the very thing the doctors do not think to offer Rebecca.

On one level, the difference between the two births highlights the fact that labor progresses and ends differently for different women, that plans do not always go as patients want them to. Further, the contrast between how the two women are treated by the doctors could even point to the positive effects of emotional support during labor, the psychological factors at work in determining the course of a woman's experience, and the importance of valuing the woman as an individual. However, Rebecca's gratitude and the message that Addison was clearly in the right to get in her face and tell her she was having a c-section challenges such a reading. Most significantly, because Rebecca's primary identity is "patient" and Bailey's identity is "doctor," their stories are not really parallels at all. Audiences are not encouraged to see them in the same way because the narrative does not invite viewers to imagine Rebecca as a fully developed character, an individual capable of making her own decisions, nor does it ask viewers to see Bailey as anything other than Bailey, certainly not as a patient in need of medical control. While Bailey's story provides a welcome alternative to the high-risk cases more prevalent on the show and a counterpoint to Rebecca's failed "natural birth plan," it does not challenge the portrayal of medical authority and control implicit in the narrative construction of

the show. In the end, with the exception of Bailey's delivery, the pregnancy narratives on *Grey's Anatomy* work to shore up the subjectivity and decision-making power of physicians and the necessity of that power to control and manage the potentially dangerous process of childbirth.

### **Birth at the Movies**

If in primetime medical drama's imaging of birth, doctors are figured as the subjects, films about pregnancy at least offer a space for the subjectivity of the pregnant women to take center stage. The conversations such films participate in, however, are less explicitly about medicine and more about family, motherhood, and gender. E. Ann Kaplan has argued that pregnancy- and family-centered films of the eighties and nineties largely reinforced a "motherhood ideology" representative of backlash against the advances of feminist movements of the 60s and 70s. By demonstrating the incompatibility of work and motherhood, suggesting the threat of female sexuality to maternal roles, and, at the same time, affirming new, more sensitive roles for fathers, many mainstream films about parenting, according to Kaplan, worked to reinstate the importance and value of the white, middle-class patriarchal nuclear family and reinscribe a fixed linkage between ideal femininity and proper motherhood (123-124). So with a rash of pregnancy-themed romantic comedies appearing in the last few years, most notably *Juno*, *Waitress*, and *Knocked Up*, all released in 2007, one might hope that the baby-having shtick would get an update for the 21<sup>st</sup> century. But has it?

In some ways, yes, each of these films makes some revisionary moves. Especially the female-penned *Waitress* and *Juno* image the mother-to-be in ways that challenge stereotypical assumptions about femininity and motherhood. The sharp-witted and street smart Juno, played by Ellen Page, has the mark of a teenage girl bucking traditional codes of femininity: her

pregnant belly often protrudes beneath vintage tees and plaid work shirts, she likes seventies rock and slasher films, and in perhaps the most modern move by writer Diablo Cody, Juno is imaged as a sexual agent. About the night she conceived, she tells her girlfriend: “The act was premeditated. . . .I’ve been thinking about it for a year.” Less clear is why such a savvy teen would have premeditated sex without considering birth control, but still, perhaps evidenced most explicitly by the fact that she, not her parents, chooses to give the baby up for adoption, Juno is a girl who makes her own decisions. *Waitress*’s small town pie baker Jenna Hunterson, too, is working against stereotypical representations of pregnant women. Hardly the glowing mother-to-be, Jenna, played by Keri Russell, hates her husband, is not excited about having his baby, and initiates an affair with her obstetrician. She goes so far as to call herself the “anti-mother,” telling her doctor: “It’s an alien and a parasite. It makes me tired and weak. It complicates my whole life. I resent it. I have no idea how to take care of it.” The end of the movie certainly complicates this portrayal, glossing over the economic and emotional consequences many women suffer for carrying children they did not plan: as soon as she sees her newborn baby girl, Jenna is empowered to leave her horrible husband, end the affair with the doctor, and open her own pie shop. Still, Jenna’s sexual awakening, which takes place while she is pregnant and mostly on her terms, challenges dominant ideas about motherhood and sexuality. The pregnant protagonists in these two female-authored films are imaged as subjects, not objects; agents making choices to shape their own destinies, often challenging stereotypical images of motherhood in doing so. Even Judd Apatow’s androcentric *Knocked Up* refuses to glamorize expectant parenthood and pushes audiences to question conventional notions of family and marriage, though it treats its women as little more than “humorless uptight killjoys,” as Katherine Heigl, the actress who plays the pregnant Alison, has described them (O’Rourke).

*Knocked Up* is less an intervention in narratives about ideal womanhood—many critics have pointed out the film’s less-than-progressive gender politics—than it is a recasting of the romanticization of expectant parenthood found in many pop culture narratives.<sup>18</sup> Apatow’s film is careful to acknowledge that the road to unplanned parenthood is neither romantic—illustrated by a hilarious sex scene in which Ben, played by Seth Rogen, cannot go through with intercourse because he is afraid of hurting the baby—nor easy to travel with a person one barely knows, a welcome counter to the current media fascination with glamorized celebrity baby lust.

What all three films offer, in terms of revision, emerges most clearly in the endings: happily ever after may come—none of the films breaks with that generic romantic comedy convention—but it is achieved not through marriage or the reinstatement of a nuclear family, but with tentatively hopeful webs of meaningful relationships, whether that’s four stoner guys waiting in the hospital lounge to welcome a new addition to their tribe, an unlikely new mom and dad learning how to be partners, or single mothers holding babies they have chosen to raise alone. That is not to say these depictions are unproblematically progressive; certainly, they simplify many of the difficulties women face in carrying children they did not plan and offer overly romanticized pictures of parenthood in the tidily uplifting endings. While *Waitress* does present a working class identity, the casts in all of these films are overwhelmingly white; it is hard to imagine that a film like *Juno* would have painted quite so rosy a picture of teenage pregnancy had the heroine been of color.<sup>19</sup> Many critics have also complained about the films’ collective squeamishness about abortion—*Juno* is the only one to actually utter the word. If the

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<sup>18</sup> See, for example, Megan O’Rourke, “Katherine Heigl’s *Knocked Up*: The Demise of the Female Slacker”; Dana Stevens, “Unplanned Parenthood: What *Knocked Up* Gets Wrong About Women”; and Katha Pollitt, “Not Quite Knocked Out by *Knocked Up*.”

<sup>19</sup> For a compelling discussion of the ways race has influenced the representation of mothers, see Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*.



films approach reproductive choice cautiously and if the overly simplistic happy endings send mixed messages about unplanned parenthood, at least, in both cases, the potential for questioning the status quo is present. As progressive as they may be in these ways, however, conversations about parenthood, family values, and gender politics are not the only ones these films are participating in. By depicting the physiological processes of pregnancy and birth and the medical management of them in doctor's offices and hospital environments, these representations are also constructing particular views of American medicine. It is here, in the reproduction of the birthing body, that I see the films engaging in their most ideological work, though this element has gone largely unremarked by critics. Where the films seem most unequivocal, and therefore most thoroughly in thrall to the dominant ideology, is not in the social politics of the films, but rather in the quiet affirmation of technology as the producer of "normal" pregnancy and childbirth.

The labor and delivery scenes that end each movie, as I will show shortly, appear to offer little more than a few minor adjustments to the birth conventions in earlier comedies, nothing terribly different from the chaotic drive to the hospital, hysterical screams, and terrifyingly painful pushing scenes that mark movies like *Look Who's Talking*, *Father of the Bride Part 2*, and *Nine Months*. Indicative of this consistent trope, David Edelstein dismissively remarked in his review of *Knocked Up*, "If you've seen one funny delivery scene, you've seen them all." However, it is not just in the delivery room that this ideology gets played out; the familiar paraphernalia of "normal" pregnancy codes these characters—and prepares audiences to understand them—as ideal consumers of the biomedical model of birth. In the same way that medical dramas produce scripts for the doctor-patient dynamic, how these films visually and narratively construct the physical experience of carrying and birthing a child—from pregnancy

test to the pushing stage—contributes to the production of knowledge about pregnancy and birth in our society. By anchoring the narrative around familiar technologies—specifically, disposable pregnancy tests and fetal ultrasound—in order to tell the story of normative physiological reproduction, the films produce pregnancies (and ultimately healthy women and babies) that depend on knowledge secured from medical technologies.

The first of those, and the scene-opener for two of the three films, is the drugstore pregnancy test. Collectively, the films' reliance on the test for unquestionable confirmation of pregnancy suggests an overwhelming superiority of knowledge provided by technology over other kinds of knowledge. To be sure, the characters suspect that they are pregnant by interpreting bodily signals—Juno misses a period and Alison throws up—but, eventually, positive markers on plastic sticks are the things that produce certain knowledge. The ubiquity of the home pregnancy test suggests that the way one *knows* if she is pregnant is not by reading her body's signs or through any sort of intuitive knowledge; rather, the decisive diagnosis comes from a consumable technology. Linda Layne has argued that pregnancy tests actually work in some ways to “disempower women by deskilling them, devaluing their self-knowledge, and enticing them to squander their buying power on frivolous consumer products” (61). The affirmation of the superiority of the test over bodily knowledge is particularly emphasized in *Juno*; a teenage customer in the drugstore tells her, “Is your nipples real brown? That's how you can tell.” Coded by her speech as below Juno in class status, the unnamed girl's appeal to bodily knowledge is the butt of the joke: Juno rolls her eyes, dismissing the possibility that there are other ways of confirming her pregnant state, and therefore shoring up the store-bought technology's advantage over any bodily signs. One way that the consumption of the test works, however, according to Layne's analysis, is that women often do not trust the tests; they still

need a doctor to offer the official pronouncement of pregnancy, and so the test is an inessential purchase. In the fictional narratives, however, the women do immediately trust the test results. Juno, for instance, makes an appointment first with an abortion clinic, and later, after deciding not to terminate the pregnancy, with an adoptive couple and their attorney, based solely on the test's affirmative reading: the knowledge the test provides determines the course of her actions. Alison, too, decides to tell Ben that she is pregnant based on her trust in the test results. Jenna takes a single test, reads the results, and declares, "Two definite lines, there's no mistaking them." Those two lines immediately inspire, "I Don't Want Earl's Baby Pie." The collective result of these instances is the message that a positive pregnancy test represents unquestionable knowledge; the test is how each woman *knows*. Contrary to the women in Layne's study, who need the pronouncement by a human authority figure, the emphasis in the films is on the superiority of knowledge gleaned from technology. The test, then, becomes a temporary stand-in for the doctor and the establishment he represents, the first consumable product that ushers each woman into the trust in technology she needs to become an ideal consumer of the biomedical model of birth. Buying the test at the drugstore and implicitly trusting its results begins each woman's journey towards a normal pregnancy dependent on official medical knowledge obtained through technological means.

Attending regular prenatal visits with an obstetrician is the next step in this journey, but the most consistent depiction of prenatal care in the films revolves not around the characters' relationship to a doctor, but around the use of another technology, the fetal ultrasound. *Waitress* is the only one of the three films in which the doctor is a developed character, and that is because he and Jenna become romantically involved, not because her relationship with him

provides any essential knowledge about pregnancy.<sup>20</sup> Alison sees so many ridiculous doctors that they become a conglomerate caricature, and the actual doctor is completely absent in *Juno* until we glimpse the top of her head during the delivery scene; she has not a single line in the whole film. In this way, the figure of the doctor is important—he or she is an implied presence, if not an embodied one—but that presence is only part of the whole biomedical machine. More ubiquitous and consistent in these narratives are the technologies of prenatal care, especially the ultrasound. This representational pattern suggests that pregnant women’s relationships to their obstetricians may vary, but the technologies they encounter will consistently provide the knowledge they need.

Feminists have long been critical of the ultrasound, especially as the images have been used by the anti-abortion movement to try and define the fetus as a fully human subject, because the image alone separates the fetus from its home within the mother’s body: “Fetal imagery epitomizes the distortion inherent in all photographic images: their tendency to slice up reality into tiny bits wrenched out of real space and time” (Petchesky 268). In all these films, however, the representation of ultrasound—especially the scene where the doctor or a technician takes the ultrasound—relies not on the stand-alone image of the fetus, but, instead, on the administration of the technology as a reflection of what is happening inside the woman’s body. Though *Knocked Up* does use an isolated ultrasound image to mark the passing of time according to the weeks of pregnancy, those images occur only after the scene where Alison receives her first ultrasound in the doctor’s office. Jenna and Juno both are the focal points in the sequences where they receive their ultrasounds; audiences see the fetus reflected on the ultrasound monitor from the vantage point of the mothers. These instances serve not the ideological function

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<sup>20</sup> Quite the opposite, in fact; as Jenna’s ob-gyn, Nathan Fillion’s funniest lines in the movie come as he is bumbling through a prenatal visit, often giving out no real information at all.

Petchesky describes, where the fetus is granted subjectivity and valued above and without the mother, but fall more in line with Squier's description of fetal images in women's literary texts: "We can turn to literature to find an alternative representation of the fetus that is both more workable and more accurate: the concept of fetal/maternal relations as a border, a creative space of contestation" ("Fetal Voices" 18). In one sense, the visual representation of ultrasound in these films retools the story of the individualized floating fetus by including the mother's body within the ultrasound frame, showing the use of the machine and focusing on the connection between the image on the monitor and the device positioned over the mother's belly.

Narratively speaking too, both *Knocked Up* and *Waitress* participate in alternative representation; the ultrasound scene is working against not only the romanticized, isolated fetus, but also against the stereotypical moment of recognition, where parents are in awe of their unborn child and feel connected to it for the first time.<sup>21</sup> As the doctor points out the heartbeat of Alison's fetus, she bursts into (unhappy) tears and Ben looks alternately horrified and confused. On encountering the image reflected from her belly, Jenna sarcastically says, "Glory be, hallelujah," followed by, "It don't really look like much at this point. It certainly don't look like no baby."

On one level, these scenes are revising romantic notions of the power inherent in sonographic pictures to woo unwilling women to feel affection for the images projected on the screen. The framing of the ultrasound with the mother always in the picture also refuses any notions of fetal subjectivity outside of the mother's body. At the same time that the use of the ultrasound is engaging in these conversations about the mother's relationship to the fetus,

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<sup>21</sup> The ultrasound scene in *Juno* is more in line with the typical sentimentalized moment, though it is Juno's stepmom Bren who becomes emotional, not the pregnant teen herself, part of the movie's subtle delineation of who is a suitable mother and who is not.

however, it is also quietly affirming the mother's relationship to medical technology without acknowledging that there even is a conversation to be had. None of the women in the films receives an onscreen explanation for why the ultrasound is necessary or what, exactly, the ultrasound is meant to communicate. The arrangement of these scenes assumes that audiences will take for granted the necessity of an ultrasound, and that like the women onscreen, they will trust the machine to deliver unquestionable knowledge that the unborn babies are growing and healthy, that the pregnancies are all "normal." Birth activists and midwives are critical of the ultrasound because doctors often rely heavily on the information produced by sonograms. For example, gestational age and fetal weight are often used to prescribe labor induction, even though weight can be off by more than two pounds and gestational age can vary by as many as five days in either direction (Nahum).

In these representations, though, the size and due date of the baby are vague referents that are not related to how labor and delivery play out. The knowledge that the ultrasound communicates in these scenes is simply that what these women see on the screen confirms the existence and health of a fetus. In *Juno*, for instance, the pregnant teen uses the printout of the image to prove to the adoptive parents that the fetus is healthy; furthermore, she confers the rights to the child on them by giving them the picture. Juno tells Vanessa as she hands her the picture, "It's a baby. It's *your* baby." The possession of the ultrasound image symbolizes their rights as parents to the child; it serves not only as scientific evidence of the baby's existence, but also of the fact that Juno is submitting herself to the expected medical surveillance in order to ensure the continued health of the child. The path to a routine medically managed birth begins with a technology the woman can purchase and administer herself and leads to a technology she expects and submits to by attending regular obstetrician-directed prenatal care.

The final step in this journey may be the hospital delivery room, but the audience has been ushered into an implicit and unquestioning trust in the routine technologies of pregnancy and birth from the beginning. The simple fact of the ubiquity of the pregnancy test and the fetal ultrasound, especially in light of the varied representations of the importance of the actual doctor, demonstrates a continued reliance on medical technology to depict the course of “normal” pregnancy: medical surveillance through the expected technologies is simply part of how the filmmakers assume audiences will understand pregnancy to work.

This reliance on technology plays out across a backdrop of pregnancy as normal and healthy; these women experience only the most expected of physical symptoms (like nausea and vomiting), they continue in their normal work and school routines right up to the day they give birth, their weight gain appears only in the acceptable breast and belly spots, and the pregnant body often appears not just healthy, but even glamorized. In fact, the knowledge provided by these technologies assures viewers that these women are experiencing “normal” pregnancy: routine biomedical surveillance is narratively linked to a healthy mom and baby. Only when the act of birth is mentioned do the films remind viewers of the cultural squeamishness around women’s reproductive bodily processes. The hilarious exchange between Alison and her producers at E! exemplifies this juxtaposition: when Jack and Jill suggest that Alison host her own celebrity interviews during what they call “maternity month,” Jack shrugs his shoulders and says, “Apparently, people like pregnant,” while Jill deadpans her surprise: “It grosses me out when I know people are pregnant cause then I think about the birth. Wet.” The film is satirizing, while participating in, our culture’s simultaneous fascination with pregnancy and aversion to childbirth. That aversion to childbirth—and the subsequent need for medicine to

step in and control it—becomes even more clear once the pregnant protagonists enter the hospital.

In some ways, the representations of childbirth in *Juno*, *Waitress*, and *Knocked Up* seem to offer an endorsement of the biomedical model that undergirds the American maternity care system: the on-screen birth scenes rely on the same tropes that portray childbirth as a universally terrifying and unbearably painful experience and modern obstetrics as the taken-for-granted knight in shining armor needed to control and manage it. However, each film does offer moments that also seem to subtly challenge, or at least poke fun at, the dominant view. In the end, though, despite such moments, the affirmation of technology throughout the film combined with the visual and narrative arrangements of the labor and delivery scene subsumes any challenge to a cultural norm so deeply invested in medical authority and technological control. Viewers are left with what they have been prepared to expect: healthy women and babies produced by the technologies of institutionalized medicine.

In *Juno*, the birth scene, which begins with the typical water breaking and subsequent frantic rush out the door, veers quietly off script once they arrive at the hospital. For one thing, the doctor is referenced rather than seen. Audiences get a glimpse of a silver-haired bespectacled woman only once, when Juno starts to push, and she never speaks; she is an absent presence, an authority figure whose characterization is totally insignificant. But the labor and delivery itself is barely more than a glimpse; a mere 37 seconds after Juno arrives at the hospital and clowns around with her friend Leah in wheelchairs, she is pushing the baby out. In between, viewers see her cursing through a contraction, begging for the “spinal tap thing,” and learning that the doctor has determined she is not dilated enough to have it yet, because, as her stepmom explains, “Doctors are sadists, honey; they like to play god and watch lesser people suffer.”



Then, in the very next shot, she is pushing. The camera does not linger on her sweaty, screaming face for long: audiences are aware that she is in pain, certainly—her facial expression alone gestures towards the many women who have performed this agony on screen before her—but through a tightly composed sequence, in which the camera pans gently around to focus not on Juno but on her supportive and encouraging female companions, and at the same time, drowns out the sounds of her pain with a folksy, upbeat Kimya Dawson song, the visual representation of delivering the child is almost anti-climactic. On the one hand, the brevity and economy of the scene diminishes its import: this is not a fear-inducing instance where viewers are left wondering why on earth any sane woman would ever go through labor. The focus on her stepmom and friend, rather than on the doctor (who, though she is a woman, is not part of the support system), offers a welcome picture of woman-supported birth. At the same time, the uneventfulness of it also serves to naturalize this version of birth—in a hospital, lying in bed, hooked up to an IV, Juno’s hospital delivery appears as an unquestionable norm.

If the birth in *Juno* is shot to normalize and minimize the birth experience, *Waitress* seems designed to create exactly the opposite effect. Though after her water breaks, it takes only about three and a half minutes for Jenna’s baby to emerge, the labor sequence feels like it lasts much longer, an effect created partly by the completely black screens that interrupt the scene’s continuity. Mostly, though, this scene is prolonged by the near-unrelenting focus on Jenna’s face, furrowed with agony and fear, and breathing so heavily and consistently that it is easy to forget she has been given an epidural. Her performance is so exaggerated and the way her body is on display so emphasized that the orchestration of the delivery could easily be read as satire. From the pointy-hatted nurse with the stop watch, who never addresses Jenna directly but speaks to the doctor about her; to the obnoxious, camera-wielding husband; to the room full

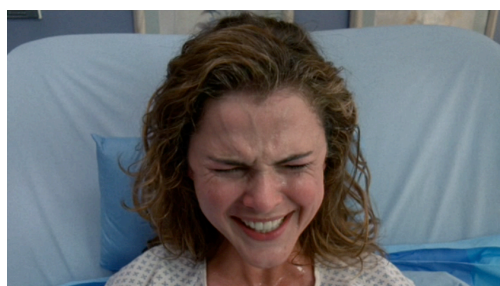
of residents whose silent clinical gaze falls not just on Jenna's body, but also on the audience because the scene is shot from Jenna's vantage point, Jenna's laid out body, tucked neatly into her hospital bed, recalls images from the sheeted woman in the Monty Python sketch, "The Meaning of Life" (the one that features the "machine that goes ping"). But is the satire pointed at childbirth itself, critiquing any romanticized notions of the experience offering empowerment for women, or is it pointed at the objectifying and overly managed version of birth offered at hospitals like this one? The answer, of course, depends on the audience, but unless viewers bring alternative experiences or philosophies of birth with them to the theater, the moment sunlight breaks through the window and a smile breaks across her face when Jenna first holds her baby quickly shores up the mainstream notion that a carefully managed birth produces a healthy baby and a happy mother.

So it is with the satire in the labor sequence in *Knocked Up*: the exaggeration and humor are there, but who or what serves as the punch line is not so obvious. It might appear that the most explicit critique is aimed at the doctor: authoritarian to the point of ridiculousness, he yells at Alison, dismisses her birth plan, and then when she protests, threatens to walk out and leave her unattended. Satirizing him is complicated, though, by the authority viewers invest in medical technology: the doctor may be unreasonably mean, but when he rushes into the room and manually turns the baby because the fetal monitor is beeping wildly, he is clearly the one in charge, and audiences are led to see him as the hero who saves the baby. There, the critique seems aimed at Alison, and any woman who dares to exert agency and decision-making power during childbirth: by hooking her up to an IV, surrounding her with men telling her what to do (even the nurse), and refusing to acknowledge her wishes or her knowledge, the fact that she wants to give birth without medication seems not brave but masochistic. Because of the way the

scene plays out, over nearly 20 minutes of footage, by the time viewers see the baby, it is easy to forget that in the early part of labor, Alison was quite successful in managing her contractions: she draws a bath, lights candles, and creates a relaxing environment that seems to be calming her and helping her to manage the pain. In one way, her arrival at the hospital and the doctor's treatment of her, rather than the event of birth itself, are the things that strip her of any agency, which could be read as a critique of hospital birth. More likely, however, because of how pervasive American culture's trust in medical authority and technology—a trust we have been assured of throughout Alison's pregnancy—audiences breathe a sigh of relief that she learns to shut her mouth and listen to the doctor; otherwise, who would make sure her baby arrived safely? Of course, what most viewers will remember about the birth scene in *Knocked Up* is not the representation of medicine, but the view of the baby's head crowning, which occurs not once but three times, to the shock and horror of all who witness it. The visual representation of the baby's head bulging through the vagina seems an apt symbol for the overall attitude towards birth present in the film: we should turn this crazy, messy process over to an expert.



**Figure 1: Ellen Page as the birthing Juno, cheered on by her best friend and step-mom**



**Figure 2: The exaggerated expression of Keri Russell as Jenna Hunterson in *Waitress***

What is important to note in these representations is that regardless of how many small ways the narrative offers alternatives or challenges to the dominant view—Alison's

management of labor with water and relaxation, Juno's female support team, Jenna's satiric breathing—because the visual representation still cloaks each woman in the paraphernalia of medicalized birth and traps her on her hospital bed screaming at the top of her lungs, the women's bodies collectively appear as homogenized in birth as their filmic predecessors (Figure 1 and Figure 2). Especially since technology has been marked throughout each narrative as the unquestionable dispenser of knowledge, the steady pace towards technologically negotiated birth appears natural and inevitable.

### **Documentary as Counter-Narrative**

Despite this consistent image of the birthing body in romantic comedy<sup>22</sup> and the uncritical authority invested in physicians on primetime television, or perhaps in answer to these cultural scripts, a few counter-narratives have cropped up, especially in documentaries. One, *The Business of Being Born*, was produced by Ricki Lake and Abby Epstein the same year *Juno*, *Waitress*, and *Knocked Up* were released in theaters.<sup>23</sup> Inspired by the differences in her own birth experiences—one hospital birth she describes as traumatic; the second, at home, she characterizes as “empowering”—Lake's project is to explore why, if birth can be a positive life-altering event, more women are not clamoring for it to look that way for them. The film makes the argument that the biomedical model of birth strips women of choices and imposes an

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<sup>22</sup> Romantic comedies centering around pregnancy that have come out since 2007 continue to represent birth as homogeneously frightening and best managed by medical professionals. The naturalization of medical technology is exacerbated by the fact that so many of them—*Baby Mama*, *The Back Up Plan*, *The Switch*, *Miss Conception*—focus on women trying to get pregnant using in vitro fertilization or artificial insemination.

<sup>23</sup> Two other documentaries about birth released in the last few years are *Pregnant in America* (2008), focusing exclusively on the filmmaker and his wife, and *Orgasmic Birth* (2008), which follows several women as they experience their births as ecstatic and empowering (despite the title, only one of the women in the film actually experiences orgasm during her labor, though the sexuality of birth is a frequent topic of discussion among the experts featured in the film. The overall message seems to be that birth can be pleasurable).

uneven power disparity on women for whom there is no good medical reason for intervention. Lake and Epstein build a case for the recovery of “normal birth” in several ways throughout the hour and a half documentary. First, they historicize, especially by revealing some of the more unsavory elements of the professionalization of obstetrics. Footage of women on scopolamine, for instance, experiencing Twilight Sleep, shows pregnant women fitted into what look like straight jackets, their heads and faces completely covered, and then strapped to beds with lamb’s wool, so that the restraints would not leave marks on their arms and legs. Medical anthropologist Robbie Davis-Floyd comes on screen to explain that women entered the hospital, were given the drug and strapped to beds where they were left, sometimes in their own excrement, for days, until a doctor came in and removed their babies with forceps.

In the film, the images of these women from the 1930s and 40s, strapped down and literally unidentifiable one from the other, are juxtaposed with images of more modern hospital births. The second layer of their argument involves demonstrating how unnecessarily controlled the contemporary medical environment is and how dehumanizing it can be. Testimony from birth advocates, scholars, women who have had bad experiences, and medical professionals helps to paint the picture of routine hospital birth as a set of procedures designed with the interests of hospitals, insurance companies, and physicians in mind, rather than the interests of mothers and babies. Voices of experts saying things like, “Basically, what the medical profession has done over the last 40 or 50 years is to convince the vast majority of women that they don’t know how to birth,” and explaining that the reason for rising cesarean rate is due mostly to obstetricians’ fear of litigation, narrate over images of women who are strapped to hospital beds, hooked up to monitors and breathing through oxygen masks, fearfully taking orders from doctors, looking not all that different from their scopolamine-induced predecessors.



**Figure 3: Twilight Sleep delivery**



**Figure 4: Contemporary hospital delivery**

The words of women who have been in those positions also tell the story of a system that is set up to erase differences between women and treat them in ways that are not beneficial to their health or to the health of their babies. This combination of birthing women's testimonies, perspectives from professionals, and footage from real hospitals paints a bleak picture of what birth is like for most women. Then, the film then turns to alternative birth stories. The contrasting imagery in the film comes from long sequences of individual women's labors: the filmmakers follow women who have spoken to the camera about why they chose home birth or why hospital birth was so traumatic through the process of choosing midwives, attending prenatal visits, and eventually, delivering their babies. The birth scenes could hardly be more different than the ones in the majority of pregnancy-themed films or on primetime television. The women in *The Business of Being Born*—all New Yorkers from a variety of ethnic backgrounds—are in their own clothes (or, by the end, in no clothes at all), in their own environments. It's often dark or dimly lit, soft music plays in the background, and the women move constantly, walking, squatting, leaning against walls, swaying on exercise balls; they often use water to relieve pain and are massaged by their partners or the midwife; and most of

them push their babies out with concentrated expressions and groans, but no blood-curdling screams; one of them even laughs as her baby emerges (Figure 5).



**Figure 5: Home birth delivery**

How could these women's births look so different from those imaged in other films and on primetime television? Is the way mainstream popular culture has defined the normal experience of childbirth, in line with professional obstetrics' view, really that far off the mark, or are the women in *The Business of Being Born* somehow exceptional? Statistically, these questions are not difficult to answer: the women whose births are featured on the documentary are part of that 1% of American women who give birth outside of a hospital. As we learned in Chapter One, the majority of the remaining 99% have high rates of intervention that would align their birth experiences more closely with the picture of birth depicted in the more mainstream cultural fictions.<sup>24</sup> But is that because birth needs to be so carefully managed, or is it because women have been socialized to understand birth as a scary process, the control of which they must abdicate to experts?

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<sup>24</sup> Martin, et al., "Births: Final Data for 2007," 24; Wertz and Wertz, 135; Declerq, et al, *Listening to Mothers II*.

Many advocacy groups are attempting to correct what they see as medical mismanagement by mobilizing around increased support for out-of-hospital birth, a view *The Business of Being Born* implicitly supports; the only birth story that ends in a standard hospital setting is director Epstein's c-section for a breech baby at 34 weeks. However, as Helena Michie and Naomi Cahn have argued, home does not function equally as a place of power and resistance for all women (20-21), nor is a non-standard birth economically viable for many women, especially since both Medicaid and private insurance coverage for out-of-hospital birth varies widely from state to state.<sup>25</sup> While documentaries like *The Business of Being Born* offer an important critique of the biomedical model of birth, as long as the narrative solution presented is available only to women of a certain class status or regional location, more alternative stories are needed. If, as Michie and Cahn argue, popular narratives function as “instruments of acculturation, telling us in subtle or not so subtle form what is acceptable and what is not, what it means to be a part of the culture that produces” those narratives (3), then we need more representations of women from a variety of backgrounds whose births do more than reduce them to objects at the mercy of medical technologies in our mainstream cultural imagery. At the very least, we need the tools to critique those images.

### **Popular Culture as Socializing Ritual**

Nearly twenty years ago, medical anthropologist Robbie Davis-Floyd argued that routine hospital birth (what she calls technocratic birth) functions as a set of rituals, a “rite of

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<sup>25</sup> Under the recently passed Patient Protection and Affordable Care Act, the facility fee for freestanding birth centers is to be covered by Medicaid; the bill also specifies that nurse-midwives will be reimbursed at the same rates as physicians. Both are indications that health care reform could potentially increase access to non-standard care, but the fees for midwife-attended home birth are not part of the reform, nor are they often reimbursed by private insurers (Beard). I will discuss insurance coverage of different types of care providers in more detail in Chapter Four.



passage,” that “work[s] to convey the core values of American society to American women,” namely, “American society’s most fundamental beliefs about the superiority of technology over nature” (2). What my analysis of these popular culture texts suggests is that this ritual is enacted not just in actual hospital births but also in the fictions we create about hospital births, that long before any woman enters the delivery room or any doctor picks up a scalpel to cut a cesarean section, they both have learned the cultural codes of the ritual they are participating in. If, as Davis-Floyd contends, “Ritual is a powerful didactic and socializing tool. To grasp its inner workings is to have a choice in our response to the rituals that permeate our daily lives” (9), then we must pay attention not only to the ways rituals operate in our daily lives but also to how we are socialized to understand their meanings by the stories our culture tells us about them. In other words, if we are serious about reforming maternity health care so that it more clearly institutes what is best for mothers and babies, we must pay attention to the messages circulating about what childbirth is and how it should function. As Squier puts it, “We must link our contemporary medical strategies for modifying things and people with our strategies of representation,” (*Liminal Lives* 10) and I would add, with our strategies of critiquing popular representations already in circulation.

If some romantic comedies are beginning to destabilize a monolithic picture of “what family looks like,” then perhaps, one day, versions of birth like those depicted in Lake’s documentary will start to trouble the image of “normal birth” that accompanies those narratives. Perhaps, one day, romantic comedies will take the fissures in ideal womanhood begun in characters like Juno and Jenna Hunterson and follow them all the way into the delivery room. Perhaps one day, doctors on television will treat their laboring patients with the same humanity and compassion that allowed Miranda Bailey’s baby to be born safely on *Grey’s Anatomy*, the

way she chose. Until then, pointing out the ideological work in mainstream representations of pregnancy and birth remains an important part of the conversation surrounding maternity care reform. If we know women and medical professionals are learning about what birth looks like by tuning in to television and going to the movies, then working to expose how the cultural construction of obstetric authority in such texts occurs at the expense of women's autonomy and, sometimes, bodily integrity, could have implications for the ways women are allowed to experience their reproductive bodies if and when they decide to bear children and for the ways doctors interact with laboring women. Sustained discussion and critique of such representations, especially to reveal the ideological work being done by depictions of birth on television and in other popular culture narratives, points us towards the kinds of questions we might ask about the ways in which popular culture and the institution of medicine might be shaping one another and working together to generate a cultural logic that positions biomedical professionals and their technologies as the exclusive producers of health and safety in the event of childbirth.

### Chapter Three

#### Science Matters: Medical Research and the Challenge of Evidence-Based Maternity Care

“Medical evidence is like snow, and every patient is a snowflake.”  
—J.D. Kleinke, “Catching Babies Blog Series: Refusal, Rights, and Balance”

“Altogether, ever advancing science has created a sense of control over what once had been a very insecure time for families and their caregivers. The idea that following the current best medical evidence will virtually guarantee best outcomes is an appealing extension of that new found power over nature, but is a belief system that is inherently flawed, and that fact is often not appreciated by those who are captivated by its seduction. . . . The fetal heart rate tracing is poured [sic] over like tea leaves or cast bones, and the doctor becomes the shaman. This belief system has been preached to future physicians and obstetricians, who passed it along to their students until the whole culture of childbirth medicine became steeped in a religious-like belief in the power of the fetal monitor, labor curves, ultrasound measurements and the like. This belief is similarly conveyed to patients who are assured that if their pregnancy was managed according to the protocols developed by trusted researchers, their babies would be delivered without fail and without harm. Reality, however, has proven otherwise.”

—Henry Dorn, MD, “The Trap of Overselling and Underdelivering”

One way to attempt to answer the question raised in Chapter Two—how might medicine and popular culture be influencing what narratives about childbirth get circulated—is to look closely at the way knowledge is produced and communicated within the medical profession, especially in the area of medical research. What we will see, by examining the discursive construction of medical knowledge, is that the thread that links the popular investment in technological knowledge with the values undergirding medical research about childbirth is a persistent narrative that positions science as the definitive basis for medical practice and decision-making and technology as the most effective means of guaranteeing health and safety.

## The Challenge of Evidence-Based Medicine

The public discourse surrounding health care in the twenty-first century, particularly since the election of President Obama, has tended towards a cry for less costly, more evidence-based medicine.<sup>26</sup> The call for medicine to base its practice on scientific evidence is not new, of course,<sup>27</sup> but the political push for health care reform has renewed the public interest in a scientific model of health care in which doctors are expected not just to determine the best course of treatment, but also to educate their patients about the scientific evidence supporting their clinical decisions.<sup>28</sup> One definition of evidence-based medicine describes it as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett et al 71). This conception of medical care positions physicians as experts in science, skillfully assessing the data in order to apply it correctly to individual cases.

Maternity care reformers have acutely focused on evidence-based medicine as a primary goal for the standard care of birthing women. Childbirth Connection, a national non-profit focused on advocacy and research to reform maternity care states as its mission “to improve the quality of maternity care through research, education, advocacy, and policy. . .to promote evidence-based maternity care” and serve as “a voice for the needs and interests of

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<sup>26</sup> President Obama’s commendation of Intermountain Healthcare’s cost-saving and evidence-based ethic, for instance, has generated a lot of media attention. See David Leonhart’s piece in the *New York Times Magazine*.

<sup>27</sup> In fact, one of the most oft-cited sources of unbiased scientific evidence in medical research are the meta-analyses published by the Cochrane Collaboration, a non-profit effort that grew out of Archie Cochrane’s condemnation of obstetrics, his own specialty, as the least scientific practice. He championed the randomized controlled trial as the key to establishing a broad base of evidence-based medical practices. In the 1980s, gathering data on pregnancy and childbirth was the first effort by what would become an internationally renowned organization.

<sup>28</sup> Another related, but sometimes competing discourse in health care debates is the consumer model of care; more on that discourse follows in Chapter Four.

childbearing families” (“Vision”). In a report co-sponsored by the organization entitled, “Evidence-Based Maternity Care: What It Is and What It Can Achieve,” authors Carol Sakala and Maureen P. Corry write,

Evidence-based maternity care uses the best available research on the safety and effectiveness of specific practices to help guide maternity care decisions and to facilitate optimal outcomes in mothers and newborns. . . .There remains a widespread and continuing underuse of beneficial practices, overuse of harmful or ineffective practices, and uncertainty about effects of inadequately assessed practices. (21)

One of the most frequent critiques of American obstetrics, in fact, is that its standard practices are not based on scientific evidence that shows those practices are the most beneficial to mothers and babies.<sup>29</sup> But what does such “scientific evidence” look like? On what is it based? How is it articulated and disseminated? In this chapter, I will look at the discursive formation of evidence: how and where it takes shape, how it is constructed rhetorically, and what work it does in shaping medical knowledge and practice.

One of the procedures often used to illustrate the charge that obstetrics is not practicing evidence-based medicine is the use of a cardiotocograph (CTG) machine to continuously monitor the fetal heart rate and uterine contractions during labor, a procedure known as electronic fetal monitoring, or EFM (Goer, *The Thinking Woman’s Guide*). Using the case of EFM, I will examine how such a technology has remained nearly ubiquitous in hospitals around the U.S. for over 30 years, despite consistent claims that the scientific evidence shows it to be of little benefit for mothers and babies. I will argue that the controversy over EFM presents a challenge, both to professional obstetrics and to maternity care reformers, to negotiate the tricky terrain that emerges when the conclusions of scientific evidence come in conflict both with

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<sup>29</sup> See, for example, Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed*, 50-52.

systemic forces that make some practices better suited to the hospital environment than others and with core beliefs undergirding the practice of obstetrics. In the case of EFM, though the evidence indicates that a less advanced technology is as beneficial and less likely to cause harm, the use of the alternate method requires more human resources in the form of nursing care. This conclusion stands in sharp conflict with the financial and structural constraints of hospital labor and delivery units, as well as with what some scholars call a “technological imperative,” that shapes the belief system of professional medicine (D. Rothman; Gillick). In light of these challenges, I will argue that accepting evidence-based medicine as a partial and incomplete possibility might allow us to imagine a more multifaceted approach in determining the best standards of practice for the care of birthing women.

### **Conceiving Medicine as Science: The Problem of Maternity Care**

One of the first moves towards destabilizing the ultimate authority of evidence involves examining what meanings are attached to “science” and “evidence” in the discipline of medicine. As we saw in Chapter One, one of the contributions of the interdisciplinary scholarship of science studies is that it has become commonplace within that scholarly community to say that there exists no discrete body of knowledge called “science,” that science is as discursively and socially constructed as anything else. However, that commonplace has not had the same kind of influence on the way the public understands science or medicine. Nor has it taken hold in professional medicine: as Kathryn Montgomery Hunter’s work shows, clinical medical education trains doctors to see themselves as scientists basing their clinical decisions on a body of discrete, knowable truths about the human body.

The evidence-based medicine movement seems a contemporary example both of the misunderstanding Hunter describes and of the way that Latour and Woolgar’s articulation of the

social constructedness of scientific facts has not seeped into public discourse, at least about science-based medical practice.<sup>30</sup> Jerome Groopman, in his popular account of the process of medical decision-making, *How Doctors Think*, bemoans the latest turn toward evidence-based medicine. He describes his interns and residents as disinterested mathematicians, relying more on clinical algorithms and practice guidelines than on actually listening to patients' stories. "Today's rigid reliance on evidence-based medicine risks having the doctor choose care passively, solely by the numbers. Statistics cannot substitute for the human being before you; statistics embody averages, not individuals," writes Groopman (6). Philosopher Maya J. Goldenberg critiques the movement on different grounds, namely that any notion of medical decision-making based strictly on an agreed-upon body of evidence promises to erase the "culture, contexts, and the subjects of knowledge production from consideration, a move that permits the use of evidence as a political instrument where power interests can be obscured by seemingly neutral technical resolve" (2622). The pretense of neutrality is dangerous, Goldenberg argues, not because doctors and medical researchers are evil conspirators who desire to wield their power over patients rather than heal them, but because such a pretense prevents doctors and patients alike from examining valuable subjective elements that could have important consequences in health care decision-making. Unmasking medicine's subjectivity does not mean throwing out rationality altogether; rather, it allows those subjective elements to become part of the process of constructing knowledge:

Scientific inquiry cannot be value-free because cultural and social values make knowledge possible. These values must, of course, be subject to examination and critique, ideally by those from outside the community who do not share those cultural assumptions. In addition to demonstrating empirical adequacy, scientific

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<sup>30</sup> Latour later argues that the principle has been taken up in other, more alarming ways, like the campaign to disprove global warming. See "Why Has Critique Run Out of Steam?" for his analysis of some of these troubling directions.

beliefs must be subject to public scientific inquiry, where the background assumptions motivating the investigation are explicitly recognized and therefore subject to the same critical scrutiny to which 'good empiricists' subject their knowledge claims. (2627)

It is the illusion of a value-free science (leading to a value-free medicine) that makes the persistent specter of evidence so appealing as a way to reform obstetrical practice. If only physicians would base all their clinical decisions on the objective facts of science, then the treatment of birthing women would improve, the thinking goes. As Goldenberg points out, this logic leads to a false notion of objectivity, and the loss of context obscures important parts of how knowledge gets made and how that process contributes to its meanings. However, focusing on the process alone, without attention to what knowledge might emerge from it, is also to lose too much. In "Why Has Critique Run Out of Steam?", Latour laments the failure of social critique to effect meaningful change in the public discourse of science, and also, in the world.

He writes,

The mistake we made, the mistake I made, was to believe that there was no efficient way to criticize matters of fact except by moving away from them and directing one's attention toward the conditions that made them possible. But this meant accepting much too uncritically what matters of fact were. . . .Matters of fact are not all that is given in experience. Matters of fact are only very partial and, I would argue, very polemical, very political renderings of matters of concern and only a subset of what could also be called states of affairs. (231-32)

What Latour seems to be after, and what seems useful in the case of evidence-based medicine, is not to dismiss scientific evidence altogether, but to see it as one piece, and not the totality, of the basis for medical decision-making. One way to get at what some of the other pieces are is to consider the ways that medicine generally, and obstetrics specifically, is not a precise science.

This premise is, as I showed in Chapter One, one of the central tenets in the newly formed interdisciplinary field of medicine studies. However, obstetrics presents a special problem for scholars working in medicine studies in that most obstetrical patients are not ill, and



so diagnosis and treatment do not proceed in the usual way. Both Hunter and Groopman describe the successful physician as one who carefully listens to the patient's story, assembles all of the available clues, and arrives at a diagnosis and course of treatment best suited to who the doctor understands the patient to be and what condition she believes him to be suffering from. But pregnancy is not an illness in the same way that the flu is an illness. As Marika Seigel puts it, "I say, 'I am pregnant.' I do not 'have' pregnancy or 'come down' with it, as I might a cold; it is not something extraneous to me. At least grammatically, pregnancy is me, another identity, an unfamiliar role, a new state of being, a transformation" (10). It is not, then, a disease or a diagnosis. Pregnant women may suffer from a variety of symptoms—nausea, breast pain, abdominal cramps—but the primary role of the obstetrician is not to alleviate the suffering caused by those symptoms; it is, rather, to ensure that the body is healthy enough to sustain the life of another, whose body and health the obstetrician must also safeguard. In this way, the obstetrician is not so much a detective, trying to figure out what is wrong with her patients (Hunter), as she is a watchwoman, carefully looking for signs of trouble.

The public health push in the first half of the twentieth century that encouraged all women to enroll in regular prenatal care was based on the idea that such watchful expertise could help lower the infant and maternal mortality rates and reduce the number of babies born with disabilities. In many respects, prenatal care and the battery of tests that come with it have done just that: more women now know in advance if their baby is likely to be born with an anomaly of some kind, and many of them do not carry those pregnancies to term. Additionally, conditions like hypertension and diabetes that can cause special problems for women carrying babies can be managed more carefully if they are detected early in pregnancy. However, such surveillance also helped usher in the age of technologically managed birth: as the films

discussed in Chapter Two demonstrate, women learn to rely on medical technologies very early in pregnancy. That preparation culminates in labor and delivery, an event marked by the near-universal use of similar technologies to manage the process in American hospitals. The reason for such heavy reliance on technology in hospital births is partly a result of the economic organization of U.S. maternity care, as I will discuss in the next chapter. It is also, however, partly due to the unique way obstetrics has been defined—both the way it has defined itself as a specialty and what the public has come to expect from it—as a scientific discipline dedicated to producing perfect babies. Richard Wertz and Dorothy Wertz argue that this conception of obstetrics did not really take hold until the 1980s, but that once it did, parents—and later, courts—expected obstetricians to use the technical tools at their disposal to perform miracles so that no family ever experienced a birth-related tragedy. As the history of fetal monitoring will show, routine birth is designed with that primary goal: to prevent a “bad outcome.” The problem, of course, is that on the one hand, eliminating tragedy from the birth process altogether is not a realistic goal, and on the other, if the entire process is designed to entrust physicians to prevent a catastrophic outcome, then weighing the benefits and risks of different procedures becomes the sole—and burdensome—job of the physician, without regard for the individual woman giving birth. It also becomes a decision made solely in the context of the medical establishment and under the constraints of the organizational structure of hospitals, without the benefit of other perspectives.

By looking closely at the documents produced at key moments in the development of a technology designed for just such a purpose—to prevent catastrophe—I will demonstrate how particular views of science and technology undergird and influence medical research, policy, and practice in obstetrics. I will first give some background information on electronic fetal

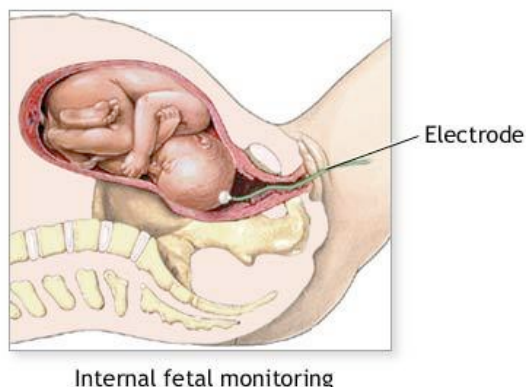
monitoring and outline its incorporation into routine maternity care. Next, I will look closely at the documents produced at the behest of two national organizations: a report commissioned in 1979, the first attempt to synthesize the available research on EFM in order to evaluate its effectiveness, and a group of documents published in the journal *Obstetrics and Gynecology* between 2008 and 2010, as a result of a national conference dedicated to building consensus around the use of EFM. By comparing the themes that emerge at two critical junctures in the technology's history, I will argue that two related influences on the discipline of medicine make it extremely difficult to change practice: one is a deep investment in the value of technology to eliminate death from the birth process, and the other is a commitment to the existing economic and organizational structure that constrains what kinds of changes are possible to imagine.

### **Background: Conceiving a New Technology**

Monitoring the fetal heart rate and the strength of uterine contractions with machinery capable of recording those signals continuously can be done with an external monitor, an ultrasound device with two sensors or transducers, each strapped to a woman's belly (Figure 6), or with an internal monitor, a pair of electrodes connected to a CTG machine that pass through the woman's cervix and attach directly to the infant's scalp (Figure 7).



**Figure 6: Illustration of a woman hooked up to an external monitor (Julie, “Electronic Fetal Monitor”)**



**Figure 7: Illustration of the electrodes attached to a baby's head during internal monitoring (A.D.A.M.)**

The terms “electronic fetal monitoring” and “fetal heart rate monitoring” are often used interchangeably to describe either method. External monitoring has traditionally been used in the beginning of labor, before a woman’s amniotic sac has ruptured, and internal monitoring takes its place once her amniotic sac is no longer in tact. Sometimes caregivers will rupture the membranes early in labor in order to place an internal monitor. Both methods produce a printout of the heart rate pattern of the fetus and of the pattern of the mother’s uterine contractions.

Listening to an infant’s heart rate during labor and delivery has been standard practice for most of the twentieth century. Technology to monitor the fetal heart rate electronically was initially purported to aid practitioners in preventing neurological damage and death to fetuses due to asphyxia, or lack of oxygen, during labor and delivery. Developed in the 1950s and 60s, the technology was especially targeted as a way to reduce cerebral palsy (CP), a term used for non-progressive neurological disorders that appear in infancy or early childhood and permanently affect movement of the muscles. According to the National Institute of Neurological Disorders and Stroke, a subgroup of the NIH, the belief that CP was caused by lack of oxygen during labor and delivery originated with a nineteenth-century physician named William Little, who assumed that early or complicated deliveries experienced by many women who gave birth to babies with CP was the cause of the disorder. As early as 1897, Sigmund Freud postulated that the complicated deliveries might instead be a symptom of neurological damage already begun in utero, rather than the cause of such problems. However, Little’s theory prevailed, and for most of the twentieth century the medical profession and the public believed that CP originated, and could therefore be prevented, at the time of birth. Researchers in the 1980s, through an analysis of over 35,000 patient records, found that “complications during

birth and labor accounted for only a fraction of the infants born with cerebral palsy—probably less than 10 percent” (“Cerebral Palsy”). Since then, the wording of EFM’s purpose in professional documentation has shifted: instead of preventing CP specifically, more recent studies tend to focus on the use of the technology to detect infants at risk for “encephalopathy,” a general term used to describe brain damage caused by oxygen deprivation, and for metabolic acidemia, a diagnosis used to describe infants with lower-than-normal blood pH and low Apgar scores at birth, or as one researcher put it, “lack of fetal vigor” (Larma et al.; Parer et al.). Regardless of the diagnosis, the medical literature indicates that physicians rely on EFM to tell them when babies need to be emergently delivered because they are at risk for some sort of long-term disability or death. Birth advocates, on the other hand, complain that the technology does not offer reliable information, all while restricting women to their beds, limiting mobility, and increasing the use of other technological interventions, especially cesarean section, vacuum extractor, and forceps. They also argue that it is used indiscriminately, regardless of other risk factors that might indicate it to be necessary or of the woman’s desires for her birth.

EFM has been the source of controversy not only in the birthing room but also in the courtroom. Because of its promise to prevent tragic outcomes in birth, when such an outcome occurs and doctors are sued, EFM recordings are often admitted as evidence. Ob-gyns pay higher malpractice insurance premiums than doctors in any other specialty—\$56, 546 per year in 2002 (Donn 4)—and are far more likely to get sued than any other physicians besides surgeons, for whom the risk is the same.<sup>31</sup> However, though critics claim that obstetricians rely on EFM in order to prevent claims of medical negligence—to protect themselves, in other

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<sup>31</sup> A report published by the American Medical Association in 2009 showed that 69.2% of obstetricians had been sued at least once in their career, and the number of claims filed per 100 ob-gyns was 215 (Kane 7).

words—the recordings can often work against them, showing that there was, in fact, a problem that went undetected, for instance, or that a doctor did not act quickly enough when an abnormal reading showed up on the monitor. A 2008 article suggested that changing practice patterns regarding EFM, especially improving communication between nursing staff and physicians, was a primary way to reduce malpractice litigation (Clark, Belfort, Dildy, and Myers). The technology, then, has multiple sites of meaning production and the perception of its use depends heavily on the context. However, as the following case study will show, context—at least in the production of meaning in the medical community—goes largely unacknowledged.

### **Evaluating Technology: The 1979 NCHSR Report on EFM**

In 1979, after electronic fetal monitoring technology had been in widespread use for about a decade, the National Center for Health Services Research commissioned a report to review the published literature and evaluate the costs and benefits of the new technology. In the foreword to the report, then-Director of NCHSR Gerald Rosenthal called the use of EFM “increasingly controversial,” and described the technology as “an interesting case study in view of the current policy debate concerning the evaluation and control of medical technology” (iii). He continued,

Although EFM is an important technique, it has even greater significance as an example of how little is known about many technologies used in medical practice. . . . Because there are few formal mechanisms for determining which medical technologies should be evaluated, almost any medical technology can be introduced into the health system for immediate purchase and use. (iii)

Indeed, that case study is even more interesting in retrospect. Thirty years after the publication of the report, the debate about the routine use of EFM continues. Despite the fact that most published research states the same basic conclusion—at best, it is difficult to measure improvements in any of the purported outcomes; at worst, EFM is a technology that

practitioners use primarily for their own convenience and hospitals rely on for legal protection—it remains nearly ubiquitous in labor and delivery units and consistently warrants the attention of researchers and national committees. In the story of how that can be so, in the midst of a public outcry for evidence-based health care and a government push for reduction in unnecessary medical technologies, lies a picture of medical practice dealing with the daily tension between what journals endorse as the best scientific evidence and the care of individual patients by individual physicians in specific, varying contexts. A careful look at the language of the 1979 report—what questions the researchers ask, what conclusions they draw, how they frame their recommendations—reveals that a critique of a medical technology, if publicized only after its incorporation into routine practice, may well be too late to change the patterns of use already set in motion.

H. David Banta and Stephen B. Thacker begin their report with a brief history of the development of EFM. They move quickly from the first efforts by physicians to detect signs of distress by listening to the fetal heart rate in the late nineteenth century to 1957, when Dr. Edward Hon used an abdominal ultrasound monitor to obtain an electronic recording of a fetal heart rate. A year later, they report, Hon concocted a device that he could pass through a laboring woman's cervix in order to clip electrodes to the baby's scalp, a direct way to obtain an electrocardiogram (ECG) from the fetus. They also describe the method of fetal scalp blood (FSB) sampling used as an additional monitor of fetal well-being: caregivers slip a scalpel into the cervix and take a sample of blood from the baby's scalp to measure the blood pH. They end with an indication of how little is known about how often each of these three techniques are used, either in isolation or in combination, asserting that based on the limited evidence available, they "believe that the vast majority of obstetric services now have the equipment, and

that over half of the labors are monitored electronically” (*Costs and Benefits* 1). In the concluding section of the report, Banta and Thacker end with this pronouncement, “In light of the increasing concern with the costs of medical care, all of society, especially the medical profession, must be concerned with the widespread use of an expensive technology such as EFM in the absence of scientific evidence as to its benefits” (18). This frame, from inception to evaluation, maintains a cautionary tone: Banta and Thacker are careful to acknowledge that the technology has not been put through enough scientific rigor—from Dr. Hon’s initial development of the technology in his home workshop and use of it on patients the same day to the dearth of randomized controlled trials demonstrating that its use improves the patient outcomes it was supposedly designed to diagnose.

However, in the section of the report entitled, “The Future of EFM,” the tone is surprisingly optimistic: “Improvements in EFM, both in technique and interpretation, are possible. . . .A great deal of work is being done to improve interpretation of FHR tracings. . . .A variety of other methods of monitoring have been suggested as having promise” (16). The laundry list of other technologies in development is reminiscent of what Jeanne Fahnestock has called the “wonder appeal” of scientific discoveries accommodated for non-scientific audiences (336). The message in this section seems to be, we have not perfected this yet, but that does not mean we cannot with the proper innovation. What makes possible the coexistence of skepticism and optimism in this report—and, as I will show later, in the consistent attitude towards EFM in the last thirty years—is at the heart of the relationship between science and medicine: a tension between human and machine, between rationality and emotion, between objective truth and subjective knowing, between diagnosing and healing, between statistical mass and individual case. To illustrate those tensions, I will show how the exclusive focus on science as the measure



of a technology's benefit limits what is possible to know about it. Especially because biomedical science is based on the notion that medicine can find a way to improve any and all pathologies, a strong undercurrent of a belief that technology can work if it does not already prevents medical researchers from considering other alternatives. Also, by removing the construction of scientific information from its historical context, what Latour and Woolgar call the "agonistic field" is constrained to a monolithic focus on a single object. This relentless pursuit of measuring a single technology not only obscures the import of other confounding factors, it also ignores the specific—and multiple—contexts in which that technology is used. In particular, it ignores the women on whose bodies and babies electronic fetal monitoring is performed.

### **Context Matters: Historicizing the Adoption of EFM**

In tracing the development of the technology that could detect and record fetal heart tones from inside the mother's body, Banta and Thacker's one-page overview is obviously not meant to be comprehensive: they focus on the moments in history when discoveries were made that led to other discoveries, in order to show the evolution of a single technology. However, by filling in some historical context surrounding the evolution of EFM, we gain a more nuanced view of how the technology went so quickly from one doctor's home workshop to a prominent place in nearly every hospital delivery room across the country. For starters, the 1950s occupy a unique place in the history of hospital development: according to historian Rosemary Stevens, the period between the post-World War II 1940s and the implementation of Medicare and Medicaid in 1965 was a time of great expansion, especially for community hospitals. The support for expansion was predicated on what Stevens calls the "powerful themes of postwar life," including: "the belief in the techniques of science as a liberating, rational solution to the

problems of everyday existence; the importance of a sense of belonging, with growing emphasis on human relations; and ‘togetherness,’ fostered through membership in organized groups, activities, and rituals” (227). What happened, Stevens argues, is that with the help of federal subsidies under the Hill-Burton Act and federal tax incentives, many small voluntary hospitals were constructed or expanded and became centers of their local communities, defined by autonomy and individualism and proof of the community’s ability to take care of its own. Each hospital, then, in order to maintain such a sense of individualism and to compete with teaching hospitals in urban centers, needed to demonstrate its high-technology capabilities. As surgical and obstetric patients made up the majority of hospital admissions in these smaller hospitals, expanding the technologies in the labor and delivery ward offered a chance to prove that smaller hospitals had everything necessary to provide the best—usually defined as the most scientific—care to its community. Combined with the postwar focus on scientific achievement as the pinnacle of a successful national identity, the image of high-tech hospitals newly broadcast to the masses via television (on shows like *Ben Casey* and *Doctor Kildare*), the rapid growth of the private insurance industry, and the number of local, voluntary hospitals, the climate was ripe for both medical professionals and the public to welcome any scientific invention that appeared to improve efficiency in medical care (Wolf). This process could happen relatively unhindered by government regulation at this point, as well; not until the late 1970s did the federal government develop an agency to evaluate and regulate the use of medical technologies (Banta and Thacker, “Policies”).

Improving efficiency in the maternity ward is one thing EFM technology was nearly guaranteed to do: before its implementation, monitoring heart tones required each laboring woman to have a nurse come and listen with a handheld device at least fifteen minutes of every

hour. With EFM, instead, nurses could hook up the machinery when a woman was first admitted, perhaps switch to internal monitoring after her membranes ruptured, but otherwise, periodically check the monitor printout to make sure the baby's heart rate showed no abnormalities. From a central station, nurses could simultaneously monitor many women, a benefit both in terms of staffing—fewer nurses required—and in terms of record-keeping: the monitor could keep a continuous paper record of the baby's heart tones throughout labor, something even the most skilled nurse could not do. So, when Banta and Thacker begin the analysis section of their report by stating, "Although the ultimate measure of efficacy is improved patient outcome, such improvement is often assumed for diagnostic procedures if the information obtained is reliable and valid. Therefore, evaluating the efficiency of EFM includes considering the quality of the information obtained" (*Costs and Benefits* 10), the juxtaposition of efficacy and efficiency seems significant. If efficacy is a measure of whether EFM can accomplish its intended purpose—the patient outcomes referenced here include reducing intrapartum mortality and the incidence of cerebral palsy and other neurological conditions caused by lack of oxygen to the fetus—then efficiency indicates whether the technology can provide reliable information quickly and with a minimal amount of effort on the part of hospital staff.

During the 1950s, hospital maternity wards had good reason for wanting to increase efficiency, according to historian Jacqueline Wolf: the Baby Boom. Wolf describes the generation who became parents between 1946 and 1964 as a remarkably homogeneous bunch: "Virtually all individuals married. When they married, they customarily married young and then had three or four children during the first few years of their marriages. Most stopped having children by their mid to late twenties" (107). What this meant for labor and delivery wards, of

course, was that they were busier than ever: by the 1950s, the move from home to hospital was complete, with over 90% of women choosing to birth in a hospital. The spike in the birth rate, combined with a more general cultural acceptance of medical authority, meant women were going into hospitals to have babies in large numbers, and once they got there, they turned the affair over completely to their physicians (108). Wolf characterizes this period as one of medical paternalism and modern convenience; doctors assured women that their labors would be pain-free if they would just let the doctor take care of everything. To make good on this promise, as we saw in Chapter One, doctors relied on a host of anesthetics that often left women unconscious for most of their labors, chemical induction agents that sped up labor, and the routine use of episiotomy and forceps to get the baby out (114-30). All of these interventions were part of the larger national focus on convenience, argues Wolf, evidenced by everything from TV dinners to pop-top cans (117). The value of convenience paired with industrial efficiency borrowed from the principles of scientific management (Perkins) created a hospital environment where “preplanned, meticulously managed” births were desired by both physicians and parents (Wolf 118). Monitoring the baby electronically fit right into this routine; hooking up the machine became another procedure women came to expect from technologically progressive and modern birth. At the same time, it fit into the convenience paradigm, allowing physicians to stay out of the delivery room unless a nurse detected a problem on the monitor, and allowing hospitals, overburdened by an increased patient load, to maximize their staff.

This intervention, however, was meant to prevent problems by allowing physicians to know when a baby needed to be delivered immediately. What the medical research Banta and Thacker review does not consider is whether the conditions of birth might have caused the abnormalities the monitor intended to detect. They write, “Both late and variable decelerations

[the abnormalities detected by EFM] often can be eliminated by changes in position, maternal oxygen therapy, or cessation of oxytocin, which by itself can produce abnormal FHR patterns” (10). Their report does not indicate that these solutions could suggest that modern obstetric birth practices were causing these problems: rather than rolling unconscious women over to their side when the monitor showed abnormalities, for instance, why not abandon the practice of drugging women and laying them on their backs for hours? Instead of stopping the flow of oxytocin once the baby showed signs of distress, why not stop using it routinely to induce and augment low-risk labors? These are questions that Banta and Thacker do not address, even in their suggestions for what needs further study. They state simply that “the physiologic basis for FHR [fetal heart rate] changes is not known” (5). The report authors do not consider the ways in which routine hospital birth might have other harmful procedures built into it; perhaps they take for granted that heavily managed birth is an unquestioned norm. Interestingly, they attribute a kind of obstetric bias to the authors of the studies they are reviewing:

The obstetric literature reflects the commonly held belief that more information will lead to a better outcome. The technical advances required and the demonstration that reliable recording could be done seems to have blinded most observers to the fact that this additional information will not necessarily produce better outcomes. (24)

They question that assumption—that information necessarily leads to improved outcome—but do not consider that they themselves could be influenced by their medical context. Their conclusion, “Nonetheless, many obstetricians justify the procedure because they believe it to be a reliable indicator of normality” (24), is ironically indicative of their own acculturation. That a woman, drugged, strapped to a bed, hooked up to multiple machines, giving birth to a baby with wounds in its head from blood sampling and spiral-shaped electrodes resembles anything like “normality” is telling. Of course, the normality here refers to the health of the fetus, but the use

of “normal” to describe such a technologically managed affair as birth in the 1960s and 70s reveals the authors’ acceptance of the routine as the norm. That pattern has apparently continued among researchers studying EFM: as late as 2007, when the Cochrane Reviewers updated their meta-analysis of research on the technology, they note that there are “no reported data suitable for subgroup analyses” on whether the use of oxytocin or supine positions in labor, among other things, could trigger fetal distress (Alfirevic, Devane, and Gyte 9).<sup>32</sup> And, in the latest ACOG Practice Bulletin, which I will discuss shortly, a section listing medications and their potential affects on fetal heart rate includes epidural analgesia, narcotics, and cocaine, but none of the drugs used to induce or stimulate labor.

The other bias Banta and Thacker do not account for in the development and early research of the technology is economic: their history of Hon’s innovative invention fails to mention either that he founded a company to produce the machinery commercially or that “he also conducted the company’s research and development studies, managed its marketing department, and supported its technology in court” (Perkins 133). According to one scholar, at the beginning of EFM’s commercial life, over half of Corometrics stock was held by men who were promoting its use through their own research and medical practice (Kunisch, qtd. in Perkins 133). According to Barbara Bridgman Perkins, in academic centers, where the adoption of EFM happened most rapidly, companies like Corometrics (which eventually was bought by GE) funded the study and use of the new technology, a strategy that quickly ushered it in as a new standard procedure. “While testing was certainly necessary. . .there was a fine line between using a technology to investigate its benefits and hazards and developing it as a standard of care,” she argues (135). If Hon and his original research team were economically invested in the

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<sup>32</sup> My own search, for example, returned only one study that examined the connection between FHR abnormality and oxytocin induction. See Simpson and James.

production of the technology, it is difficult to imagine their research conclusions not being influenced by their stake in its success. Banta and Thacker revise that omission in an article published later in 1979, where they list Corometrics as one of the primary private investors in the technology and indicate that the company allocated most of its funding to the University of Southern California, where Hon and his researchers were working (“Policies”). They also suggest that “this phenomenon of financial support to research by vested interest groups is common in medicine but is also one that introduces an element of bias that needs to be recognized” (932). As summarized in the official government report, the articles by Hon and co-authors appear as part of the record of scientific research, representative of objectively assessed measures of the technology’s efficiency and efficacy.

### **Genre Matters: The Limitations of Scientific Research**

Historical context and individual bias play a role in how a technology’s effectiveness is interpreted; so too does the structure of scientific research itself, especially the primacy of the randomized controlled trial (RCT) and the single focus on one variable to the exclusion of other so-called “confounding factors.” In fact, when other factors may be shown to influence the study of the technology being evaluated, the study’s validity is called into question. Banta and Thacker point to one controlled trial that compared two groups of women, one monitored by EFM, the other by auscultation: “The study design required rather close nurse-patient contact in the auscultated group. For this reason critics have felt that the outcomes may reflect more the intensity of the nurse-patient relationship than the relative impact of auscultation versus EFM” (*Costs and Benefits* 9). This criticism assumes that it is possible to separate the technology from its method of administration. Close contact with a nurse could be one of the benefits of auscultation; conversely, having human contact replaced by a machine could be a negative

consequence of EFM. Especially during an era when women were complaining that labor and delivery were alienating, isolating events because they were often left alone for hours without any explanation about what was happening (Wolf; Leavitt; Wertz and Wertz), it is easy to imagine that having the presence of a single caregiver could make a significant difference in the way women coped with their labors. Instead of seeing the study as proof that human contact might be a good antidote to fetal distress, however, the study is dismissed on the grounds that it is not sufficiently scientific.

What are sufficiently scientific, considered the “gold standard” of scientific research, are randomly controlled trials, the very structure of which reduces the women participating in the study to objects, stripped of all individuality so as to best compare with other women in the study. In the largest RCT to date on EFM, for example, about 13,000 women were assigned to either intermittent auscultation or continuous internal monitoring. Which procedure they were exposed to was based on the contents of a blank envelope pulled out of a stack that randomly assigned them to one of the two groups (MacDonald et al). How was the study presented to them? How was their choice to participate constructed? Did they agree to participate in the trial because they did not have strong preferences about their births, or because they knew they would have little say in how their birth would play out anyway?<sup>33</sup> From the information presented in the research article describing the study, it is impossible to answer these questions. What we do know is that the structure of the randomized trial cannot take women’s preferences into account; there is no room for their individuality to play a role in how they are treated. The 13,000 women in the trial become bodies, objects upon which to test the technology.

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<sup>33</sup> In her study, “Birth and Social Class,” for instance, Margaret K. Nelson concludes that women in the lower socioeconomic strata of her sample do not make willful decisions about their care in the hospital because “they do not believe they can determine what is going to happen to them” (169).



The ethics of RCTs have been heavily debated especially among bioethicists<sup>34</sup>, but ideally, RCTs in medical research involve subjects who are ill and for whom there is no best course of treatment. In such cases, the rationale for the ethics of such trials is that those individuals would not be better off outside the study, regardless of the group they are randomized to (Gifford). Of course, enforcing such a standard includes evaluating what constitutes any individual patient's well-being, which inevitably varies from person to person. Yet, in the case of EFM, RCTs are designed to test the efficiency of a diagnostic technology, not to find the best treatment for an incurable illness. The risks of each technology are not equal: listening to a baby's heartbeat with a stethoscope is a much less invasive procedure and carries virtually no risks, while internal monitoring requires the stripping of membranes, a procedure that introduces the possibility for infection and the use of electrodes which can injure the baby's scalp (Banta and Thacker, *Costs and Benefits* 13). Especially in light of the results of the Dublin trial—the women in the EFM group underwent more cesarean sections, more operative vaginal deliveries, and the only outcome that differed was a reduction of neonatal seizures, a difference which did not impact how many infants from each group sustained long-term neurological injury (about the same number in each group)—it is difficult to see how women in either group would not have been better off had they been given individualized care best suited to their needs.

The Dublin trial, still, remains the one most cited in meta-analyses because its authors studied the largest population of women. However, the assumption that the size of the study alone makes the findings generalizable is a problem too: the rate of cesarean section was 2.4% for the continuously monitored group and 2.2% for the auscultated group, statistics that hardly

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<sup>34</sup> See, for example, Gifford; J. Anderson; and Wendler.

seem comparable to the current situation in the United States, where one in three of all women will undergo surgery to deliver their babies. The study was conducted in the early 1980s in Ireland: context, again does not come into play when the results of the study are considered for their scientific validity.

Scientific validity, however, is the accepted measure of medical practices, and that guideline shapes not only what answers are included in the final analysis, but also what questions can be reasonably asked. The answers provided by Banta and Thacker to the questions about the accuracy of the technology are pretty clear: they find that EFM seems to be fairly good at showing when labor is normal and the baby will be healthy, but pretty bad at showing when there are true problems. In at least half and often more of the labors studied in the literature, EFM would lead to a diagnosis of “fetal distress,” and then the Apgar score would show a perfectly healthy baby (*Costs and Benefits* 11). FSB (fetal scalp blood) sampling is equally imprecise, but in the opposite way: ph levels are often shown to be healthy when the baby is born with problems. Additionally, the two do not match: when FSB indicates a baby to be healthy, EFM often shows abnormalities. When it comes to affecting actual outcome, Banta and Thacker are quick to admit that it is difficult to know very much. They explain the rise in the cesarean rate in the four studies they examine, but they also admit that the c-section rate is “complex” and could be attributable to other “secular causes,” like a more conservative attitude toward breech presentation, increase in the diagnosis of CPD (cephalopelvic disproportion), and increase in repeat cesarean sections (7). Yet, they write, in trials that compared groups monitored with EFM and those monitored with intermittent auscultation, the cesarean rate was higher for the EFM group, an indication that the use of the technology is having an impact on the increased use of surgical delivery. Measuring neonatal outcomes is similarly complex:

because intrapartum death was a rare event by the late 1970s, a very large trial would be necessary to demonstrate any marked difference a technology could make in preventing it. They also point out the multiple, and often uncontrollable, factors at work in the rare event that a death occurs: “The contribution of multiple causes to perinatal mortality found here and in other studies underscores the fact that there is a limited number of cases where intervention during labor and delivery could be expected to be helpful” (8). This admission suggests both the limits of technology, an acceptance of the fact that medicine cannot save all babies, and the limits of knowledge, that there are some things that medical research simply cannot tell us.

However, despite such uncertainty about outcomes, the recommendations for where to go from here suggest that the way to solve uncertainty in medicine is to conduct more research, refine the technology in question, and develop more technology to test and refine. Using an older, more low-tech method instead is mentioned briefly: “EFM with or without FSB sampling has been compared to auscultation in only four RCT’s. With the likelihood that auscultation is of some benefit, it must be considered a strong possibility that EFM is no better than auscultation” (20). If that possibility were seriously taken into consideration, what would happen? Are they suggesting the profession consider limiting EFM to certain labors, or even abandoning it altogether? However uncertain the outcome report seems—both in terms of efficiency and efficacy—the limitation to reviewing only scientific literature to arrive at conclusions about what should happen next is that the only acceptable solutions must fit within the scientific paradigm. Questions that might influence caregivers’ and women’s perceptions of the technology, including what counts as a “good” or “bad” outcome, what risks are acceptable, or what goals, values, and beliefs might influence the decision-making process for either party,

go unanswered because they cannot be answered within the acceptable framework of scientific research that produces the “evidence” on which policies and practices are to be based.

Ultimately, according to Banta and Thacker’s assessment of the available medical literature, EFM can tell doctors when the fetus is doing fine, but it is remarkably bad at predicting when the fetus is doing poorly. What happens if the technology is wrong in the first case has more severe consequences than what happens if it is wrong in the second case, and so, from a doctor’s perspective, it may be worth intervening more often to prevent the chance of a single bad outcome. Yet why doctors choose this technology, in the face of such “evidence” of its unreliability is a question that goes unasked and unanswered. It does not fit the conventions of scientifically knowable information. The question of what women might want or how they might feel about the technologies imposed on them during birth does not either: except for a tiny section called “Maternal Reactions,” discussion of mothers as actual, differentiated individuals does not fit the conventions of the genre.

### **Mothers Matter: Where Is the Woman in this Report?**

In the introduction to their report, Banta and Thacker describe the routine use of EFM as “controversial,” citing “questions about its efficacy, safety, and cost. . . raised by women’s groups, in recent newspaper articles, in U.S. Congressional hearings, and in the medical literature” (iv). They further state that “the spread of EFM is part of the increasing dependence on technology in medical practice. Questions about the use of new technology in obstetrics have been raised both by women’s groups and some physicians who point out that birth is a normal process” (iv). In retrospect, it is easy to assume that the anonymous “women’s groups” they reference were part of the thousands of women across the country gathering locally to share information about their bodies, their health, and their encounters with the medical

establishment, in order to “take back their bodies” from medical professionals (Wells; Davis). Published just six years after the passage of Roe v. Wade and the first mass publication of *Our Bodies, Ourselves*, the report was commissioned in the wake of a very influential women’s health movement that had already begun to shape medical practice, albeit slowly and begrudgingly (Wolf). Despite this context, the report draws little attention to the individual women whose labors and deliveries have been affected by the use of this new technology, largely because the conventions of the report require them to rely on published research within the scientific community to draw their conclusions. On women’s concerns about their births, there was very little.

In the section on “maternal reactions,” Banta and Thacker begin by stating that “in the medical literature maternal reactions are usually expressed through the obstetrician” (20). They go on to list some of those obstetrician-reported reactions, including, that “mothers should be taught to accept EFM”; that “EFM can cause anxiety, but many women suffer anxiety during labor” (so presumably, the anxiety suffered specifically from EFM is not worth worrying over); and “EFM properly explained to the patient may reduce maternal concern” (13). There is little in any of those descriptions that appears to represent actual women’s feelings about the technology. They do quote the authors of one study who believe that the close human contact with nurses in the auscultated group they studied had a positive effect: “The authors have the impression that the reassuring psychological atmosphere caused by personal nurse interaction and the absence of the recording machine in auscultated patients contributed to the excellent infant outcome in auscultated patients” (Haverkamp et al 118, qtd. in Banta and Thacker, *Costs and Benefits* 14). Again, this is speculation on the part of the researchers and outside the field of what can be scientifically measured.

The only published research on mother's feelings about EFM at the time of the report was survey data on "patient acceptance" and interviews conducted with 25 women. The findings of both studies were mixed between positive and negative reactions; though many women reported discomfort with and fear of the equipment, 92 percent "liked the medical and paramedical support associated with EFM" (14). But what does that mean? That being monitored helped them feel supported through their labors? That physicians and nurses were successful in teaching mothers "to accept EFM"? That the technology was "properly explained" so that it "reduce[d] maternal concern"? Or, that they associated medical attention they received from doctors and nurses with the administration of the technology? In some studies, in an effort to reduce "confounding factors" and level the playing field between intermittent auscultation and EFM, women in both groups were given continuous care by a nurse, a practice that is not part of the regular administration of the technology. Such survey results, especially from such a small population, are difficult to interpret without further information about what kind of support was offered to women monitored using EFM.

The way Banta and Thacker conclude this section is by explaining why medical professionals should be concerned about the mother's reaction to the technology: "a negative maternal reaction could have an adverse effect on the fetus" (15). To prove this, they cite "monkey studies" that show that stress hormones lead to abnormal heart rates and subsequent episodes of asphyxia. "The physiologic response to maternal anxiety could, for example, explain the higher rate of abnormal FHR patterns during early labor in the EFM patients in the first Colorado RCT" (23). The genre of the scientific literature review simply does not leave room for them to take into account the perspectives of women as autonomous human beings who might have preferences about their bodies and medical treatment. Women's preferences

regarding their medical care, goals for their births, or emotional well-being are not factored into the import of “maternal reaction”; what matters is that certain reactions could negatively impact the fetus because that is what can be measured scientifically.

How does the technology affect women’s bodies, the measure that *is* captured in the scientific literature? In the maternal outcomes section, they write, “In physical terms, EFM is of no benefit to the mother. . .instead of reducing risk, EFM increases risk to the mother” (19). The risks they list are worth quoting in some detail:

Mortality and morbidity are higher among women undergoing EFM. Lacerations of the mother or the placenta from the electrodes can occur, and uterine perforations from the catheter have been reported. Cesarean section is associated with a maternal mortality rate 3 to 30 times that found among vaginally delivered mothers. . . .Cesarean section also leads to morbidity and mortality associated with anesthesia, anesthetic psychosis, urinary tract infection secondary to foley catheters, operative trauma to other organs, supine hypotension, pulmonary embolus, sepsis, wound healing, hernia, bowel obstruction, hemorrhage, respiratory infection, and pneumonia. . .Both EFM and cesarean section increase the risk of maternal infection. (13)

These risks to her person are notwithstanding the long list of risks to the baby, which include “laceration by either the electrode or by the knife that punctures the scalp,. . .rectal-vaginal laceration, fatal hemorrhage, subgaleal abscess, osteomyolitis of the skull, gonococcal abscess, persistent bacteremia, and fatal bacterial and herpetic sepsis” (19). Despite all of those ominous possibilities, the technology also ensures that women will remain in bed, which prevents them from using non-drug methods of pain relief (like water, walking, and massage) or “Lamaze techniques,” as Banta and Thacker point out (20). In the 2007 Cochrane Review, any measure of these kinds of effects is still missing: “There were no reported data suitable for analysis for the use of nonpharmacological methods for coping with labour, amniotomy, perineal trauma, inability to adopt preferred position in labour, dissatisfaction in labour and postpartum depression” (Alfirevic, Devane, and Gyte 9). Filtering mothers’ views of the

technology through their obstetricians hardly seems a useful way to ascertain what effects the use of this technology during labor might have on actual women, but aside from the physiologic risks listed here, including women's perspectives in the discussion is simply not part of how medical research is conducted. If the tools of medical research cannot adequately measure maternal outcomes, one possible solution is to include the methods of other disciplines, especially those from sociology and anthropology, where the methodology requires researchers to talk to the subjects. Integrating those methods could better provide insight into "maternal reaction" to the technology and more productively include women as decision-making subjects whose perspectives on EFM use matter in the medical evaluation of its effectiveness. Banta and Thacker, however, constrained by the genre of the literature review, restrict the "literature" they consult to that produced within the discipline.

The rhetoric of this earliest report demonstrates that in critiquing a technology already in widespread use, the perspective of medical science, because it ignores context and is influenced by a belief system heavily invested in technological innovation, is not enough to challenge the widespread use of a technology, especially once it filters into standard practice. Banta and Thacker, in an article for the *American Journal of Public Health* published just a few months after the report, articulate some of these challenges. Their focus is on how government policy and regulation can better prevent technologies from entering the marketplace before their efficacy is proven—an effort that Banta has been working towards for the last three decades—but they point to some of the contextual factors that could have given a richer account in the official evaluation of the technology, particularly informed consent and the obstetrical mindset: "Since obstetricians are convinced that EFM is efficacious, it seems to us that true informed consent is not being offered, because patients receive their information from a biased source"



(“Policies” 934). They also word their evaluation of EFM more strongly in the journal article: “The evidence indicates that EFM is of little if any proven benefit to low-risk patients than regular auscultation, and that EFM is a costly and dangerous procedure [sic]. Thus, its diffusion and routine use demonstrate a failure of public and private policies” (934). Its routine use also, however, demonstrates the failure of the “evidence,” when articulated only through a biomedical paradigm, either to work against beliefs as powerful as the technological imperative that drives medical thinking or to challenge a status quo as deeply entrenched as obstetrics’ core organizational structure.

### **Progress?: Three Decades of Refining and Reevaluating EFM**

Have attitudes towards EFM changed in the last thirty years? In 2008, the National Institute of Child Health and Human Development convened a workshop, in conjunction with the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, to “revisit nomenclature, interpretation, and research recommendations for intrapartum electronic fetal heart rate monitoring” (Macones et al. 661). A summary of the conference findings was published in the September 2008 issue of *Obstetrics & Gynecology*, and ACOG released two new practice bulletins based on the conference recommendations, one in July 2009 and another in November 2010. Together, these three documents represent the general thrust of American obstetrics’ most current views of the use of EFM.

The conference summary, especially in comparison with the Banta-Thacker report commissioned by a different government agency thirty years prior, dispenses with the question of whether EFM is the most effective technology to use and takes up the question of how its results should be interpreted and translated into practice. This question rests on the assumption that EFM is in widespread use and will remain so for the foreseeable future. Gone are concerns

about the technology's efficacy in reducing perinatal mortality or infant disability; in their place are concerns about nomenclature, categorization of results, and consensus on how to act in the presence of various heart rate patterns. The conference is a follow-up to a series of similar workshops held in the 1990s that resulted in the first set of "standardized, unambiguous definitions for fetal heart rate (FHR) tracings" (Macones et al. 661). The stated goal of those earlier workshops was to "allow the predictive value of monitoring to be assessed more meaningfully and to allow evidence-based clinical management of intrapartum fetal compromise" (661). It seems that even by the 1990s, the use of EFM was so firmly established that questioning its widespread use was not a concern of the workshop participants; rather, they sought to minimize problems of misinterpretation and misdiagnosis that resulted from such heavy reliance on it.

The 2008 report continues in this vein. The introduction to the workshop summary contextualizes the results by referring to the series of conferences in the 1990s and summarizing the consensus established among international groups in clinical guidelines based on the new definitions and classifications. The explicit goals of the 2008 workshop were: "to review and update the definitions for FHR pattern categorization from the prior workshop"; "to assess existing classification systems for interpreting specific FHR patterns and to make recommendations about a system for use in the United States"; and "to make recommendations for research priorities for EFM" (662). Nowhere in the report is the alternative method of monitoring—intermittent auscultation—mentioned, nor are the preferences of patients taken into consideration. The bulk of the brief report quantifies and defines terms used to evaluate FHR patterns, like how many beats per minute are necessary to establish a normal baseline pattern in a ten-minute window of time, or how long a decrease in the heart rate must last to be

classified a “prolonged” deceleration (663). The primary new contribution of the report is to establish a three-tier system of classification, in which FHR tracings are labeled Category I, II, or III, and appropriate clinical interventions at each level are described: Category I represents a normal pattern, and no intervention is required; Category III represents an abnormal pattern and warrants “prompt evaluation”; Category II falls in the middle, representing those patterns that are “indeterminate” and therefore need further surveillance and reevaluation (664).

In the concluding section, “Research Recommendations,” the authors point out that “there has not been a wealth of research on EFM. With the high penetrance of this technology into obstetric practice, well-designed studies are needed to fill gaps in knowledge” (665). This admonition is similar to Banta and Thacker’s call for more research in 1979. However, the gaps in knowledge pointed out in the 2008 report have less to do with whether such high penetrance of the technology is necessary or warranted, and focus instead on finding ways to deal with the “indeterminate” category of tracings. One of the last recommendations is telling in terms of the direction EFM is heading: after suggesting more studies on how EFM educational programs are working, the authors write, “Although computerized interpretation systems have not developed as rapidly as anticipated, studies are needed on the effectiveness of computerized compared with provider interpretation, including the analysis of existing data sets” (665-66). The implication is that reliance on EFM is a standard part of obstetrical care, regardless of what the research shows about its effectiveness; technologies are going to continue to develop and be integrated into practice; and as a result, the profession should develop procedures to improve their usefulness. In other words, technological development is inevitable, so physicians can either get on board or be left behind.

Through the lens of EFM’s history, it is not difficult to imagine the way computerized interpretation could take hold: the company that produces it sponsors a trial to test its use in some large academic hospitals, the physicians who participate see the way that the technology could improve efficiency, and before it has been proven to improve health outcomes, the systems are marketed to all hospitals as the latest and most accurate way to interpret and record FHR patterns. Already, technological developments have made it possible for OBs to monitor EFM readings from their mobile phones. In July 2010, the FDA approved the use of AirStrip Remote Patient Monitoring, a device by which *Health Leaders Media* marvels, “providers can view these waves from wherever they happen to be—while treating another patient or attending a soccer game” (C. Clark). Questioning whether reading the FHR is the most useful measure of the infant’s health, much less whether monitoring continuously using a CTG is the best way to do it, seems almost quaint at this point, even if those questions have not yet been satisfactorily answered by research. This is where medical progress seems determined by technology: once a device becomes a part of the standard of care, the only trajectory possible under the biomedical paradigm is to continue innovating and refining it. Under such inevitability, evidence-based medicine simply means using the scientific method to figure out how best to manage and utilize the most advanced technologies available. Use of the technologies themselves is not up for debate.

The Practice Guidelines issued by ACOG in the wake of the 2008 workshop bear this out, though they do leave room for alternative practices should individual physicians wish to use EFM technology more conservatively than is currently the norm. Two sets of guidelines form the basis for the most current recommendations for U.S. physicians, one entitled, “Intrapartum Fetal Heart Rate Monitoring: Nomenclature, Interpretation, and General

Management Principles,” and another, “Management of Intrapartum Fetal Heart Rate Tracings.” The latter, published in November 2010, is primarily an outline of how clinicians should react when faced with fetal heart rate patterns that fall under each of the three categories established at the 2008 conference; it simply provides clinical recommendations based on the new three-tier system. The former practice guideline is more comprehensive and more indicative of the most current professional attitude towards EFM espoused by American obstetrics, so that is where I will focus the remainder of my analysis.

The introduction provides a good glimpse into the way technological determinism seems to undergird the official position on EFM. The authors begin by specifying how routine the procedure has become: “In the most recent year for which data are available, approximately 3.4 million fetuses (85% of approximately 4 million live births) in the United States were assessed with electronic fetal monitoring (EFM), making it the most common obstetric procedure” (ACOG, “Intrapartum” 192). They establish its ubiquity, and therefore, the reasoning behind continued efforts to streamline and improve its usage. Further bolstering the need for continued conversation about EFM, they admit its problems: “Despite its widespread use, there is controversy about the efficacy of EFM, interobserver and intraobserver variability, nomenclature, systems for interpretation, and management algorithms.” They emphasize the primary controversy, one not discussed in the 2008 conference proceedings: “Moreover, there is evidence that the use of EFM increases the rate of cesarean deliveries and operative vaginal deliveries [those using forceps or vacuum extraction to remove the baby].” The stated purpose—“to review nomenclature for fetal heart rate assessment, review the data on the efficacy of EFM, delineate the strengths and shortcomings of EFM, and describe a system for EFM classification”—appears rhetorically linked to the relationship between the technology and

the increase in operative delivery, so that the purpose of the literature and terminology review is to rein in the rising c-section rate at least partially caused by routine EFM use.

If we look only at the frame, the background paragraph and the summary of recommendations and conclusions, a conflict between what the research shows and the state of current practice emerges—similar to the conflict between the strong measure of critique and optimism about improvement in the 1979 report. The “Background” begins with an explanation of why the fetal heart rate is important to understanding the condition of a fetus during labor, including known and unknown causes of asphyxia. The authors point out that in one study, 63% of pregnancies with fetal asphyxia had “no known risk factors” (192). They are showing why clinicians would want to be able to reasonably assess whether a “fetus is well-oxygenated”: to prevent injuries to the baby due to lack of oxygen. They reiterate the prevalence of the technology’s use, restating the 85% of labors in 2002 that were monitored via EFM. They also repeat the caveat that the technology is not perfect, but in a bit more detail: “Despite the frequency of its use, limitations of EFM include poor interobserver and intraobserver reliability, uncertain efficacy, and a high false-positive rate” (193). It is only one sentence, buried between the presentation of the necessity of assessing fetal oxygenation and the description of how the method works, but it is packed with doubt. To put it another way, though nearly all physicians rely on this technology, we do not have proof that it works, it often predicts problems where there are not any, and not only do different caregivers interpret the recordings differently, but the same caregiver often interprets the same results differently at different moments in time. There is no follow-up to explain why it remains in use in spite of these seemingly major limitations, just a paragraph matter-of-factly describing the difference between internal and external monitoring. One possible reading, according to the order of the information presented

in this section, is an acknowledgment that detecting problems during labor is important, especially since problems that result from lack of oxygen often do not have an identifiable cause. For lack of a better instrument to measure that oxygen deprivation when it occurs, clinicians rely on EFM, even though it clearly has its problems. Since it is the best option available, the profession might as well come up with agreed-upon terminology, classification systems, and management strategies to help them cope with a less-than-ideal situation.

That reading seems plausible, until we get to the section that fleshes out those concerns. One way this document differs from the 1979 summary of the literature is that it clearly defines what is meant by “efficacy” with regard to EFM: “The efficacy of EFM during labor is judged by its ability to decrease complications, such as neonatal seizures, cerebral palsy, or intrapartum fetal death, while minimizing the need for unnecessary obstetric interventions, such as operative vaginal delivery or cesarean delivery” (195). No longer a measure of whether the technology can provide reliable information on a consistent basis, the measure Banta and Thacker suggest many physicians used to judge the technology’s worth in their early analysis, this most recent practice bulletin clearly states that the measure of effectiveness is completely related to outcome, both negative fetal outcome and unnecessary procedures performed on the mother. How efficacious is EFM, according to this definition? The summary of results from the meta-analysis include that routine use of EFM increased the cesarean rate and increased use of both forceps and vacuum extractor, while failing to reduce perinatal mortality or the risk of cerebral palsy. It did, however, reduce the risk of neonatal seizures in one study. In other words, the highest quality scientific literature available shows that while EFM increases a woman’s chance that she will have an operative delivery, the only benefit it offers is a reduction in the risk of neonatal seizures. There is no further information to weigh those risks against the benefit; is a

neonatal seizure a life-threatening occurrence? What are the risks to the mother in operative delivery? The audience for this document, practicing physicians, would be expected to know the answers to those questions. For families trying to make sense of the literature themselves, or juries attempting to make sense of a malpractice case, this information alone provides little help in weighing the risks and benefits against one another.

What the authors of the bulletin do offer is more information about the outcomes EFM does not seem to affect. With regard to cerebral palsy, they write, there is an “unrealistic expectation that a nonreassuring FHR tracing is predictive of cerebral palsy”; in fact, the false-positive rate for EFM predictions of CP is “extremely high, at greater than 99%,” but that is not necessarily because the technology is faulty, but because most cases of CP are caused by events unrelated to labor and delivery. They state that “only 4% of encephalopathy can be attributed solely to intrapartum events” (196). In other words, what clinicians once expected the technology to be able to prevent is not really possible in the first place.

If the technology offers little in terms of measurable benefits and increases the chance that a woman will have to undergo surgery, is there not a better way to obtain the information needed to assure physicians that the fetus is fine? The answer—“Given that the available data do not show a clear benefit for the use of EFM over intermittent auscultation, either option is acceptable in a patient without complications”—seems to clearly indicate that yes, there is another option (196). Yet, there is little information about intermittent auscultation, especially compared with the wealth of journal articles on EFM. The professional association of nurse-midwives has a practice bulletin for using the less invasive method of listening, but ACOG does not. Why are there no conferences dedicated to improving this method or establishing consistent terminology to help clinicians determine when there is a problem? Why is there not sufficient



data to come up with similar guidelines for practice? The practice bulletin answers that question in two ways. First, auscultation is resource-intensive: “Logistically, it may not be feasible to adhere to guidelines for how frequently the heart rate should be auscultated. . . .The most common reason for unsuccessful intermittent auscultation included the frequency of recording and the requirements for recording” (196). A shortage of nursing staff on labor and delivery floors is not named, but the implication is that the technology is too labor-intensive to make much logistical sense. The second reason is that “intermittent auscultation may not be appropriate for all pregnancies. Most of the clinical trials that compare EFM with intermittent auscultation have excluded participants at high risk of adverse outcomes, and the relative safety of intermittent auscultation in such cases is uncertain” (196). If such studies comparing the two technologies excluded high-risk patients, though, how do they know which one is better for that population? The recommendation that follows, “The labor of women with high-risk conditions (e.g. suspected fetal growth restriction, preeclampsia, and type I diabetes) should be monitored with continuous FHR monitoring,” indicates that EFM is clearly superior for high-risk patients, but what that is based on is not made clear. In the conclusion section of the article, this recommendation falls under the lowest level of evidence, Level C, which is nothing more than expert opinion. In the body of the report, however, it appears as an unequivocal guideline. The newer, electronic technology is assumed to be better because it is more efficient, more widely used, and less difficult and resource-intensive to administer. That that assumption might constitute bias in the scientific evaluation of EFM goes unacknowledged.

### **How Evidence Is Produced Matters**

The problem with using scientific research as the sole basis for medical care is not that scientifically derived information is irrelevant. The problem has three components: first, the

insights of medical research alone are not enough to give a full, contextual evaluation of the experiences of human beings and medical technologies. More interdisciplinary perspectives could enrich our understanding of the use of different technologies in different contexts.

Second, the knowledge constructed by medical research is sharply contoured by the perspectives and biases of medicine, including the assumption that scientific knowledge is complete and authoritative and the belief that technology, if studied and refined enough, can eventually achieve whatever medical successes are desired, including the elimination of death and tragedy from the process of carrying and bearing children. In the case of EFM, these two assumptions together prevent researchers from asking questions that could destabilize EFM's central place in the birthing room or undermine the status quo by suggesting that the very structure of high tech birth might not be the most beneficial. Considering the ways that a medical perspective might shape the way "evidence" gets made could have implications for how we talk about what scientific evidence means and what kind of weight it carries in defining standard maternity care. Third, the formation of evaluative knowledge only within the confines of the medical research community prevents widespread systemic critique that might come from outside. As long as evaluations of technologies in obstetrics are confined by the current biomedical model of streamlined childbirth, imagining other possibilities remains limited. The material consequences of the attitudes represented in the relentless pursuit of science are that women do not get to make decisions about their health care; that each birthing body is treated in terms of its potential for catastrophe, rather than as an individual; and that physicians are constrained by the system they are in, rather than free to imagine a better, more healthful process.

## **Chapter Four**

### **Consumers, Recipients, and the Rhetoric of Choice: Maternity Coverage in Private and Public Health Insurance**

“The ONLY way that I knew that Medicaid would cover my home birth was by calling and asking. Even then, they had to go ask someone else before I was given an answer. If the women aren't proactive, then they have NO CLUE they are entitled to options in how they birth.”

—Britt, message to the author

“In my humble opinion, if insurance companies and Medicaid realized the cost saving associated with Home Birth and Midwives for low risk women, they would be pushing this as a viable alternative. There is no additional facility fee, no anesthesia, healthier babies. Win/Win/Win situation. Unfortunately, there are nowhere near enough midwives.”

—Felicia, message to the author

“I had no problems with Medicaid at all (except for that one weird phone call) and I was treated very well by everyone. I felt the treatment this time was better than my last two deliveries when we had insurance even. I did not have to pay or file for anything. I think all the providers and hospital did all paperwork. So, now it's my job to spread the word, because that seems to be the way we are learning about Medicaid and coverage, is word of mouth. That's how I got all my info (other moms) then my midwife. I went online to find out if we qualified and it was too confusing so I just applied and we were approved for coverage.”

—Vanesa, message to the author

As we saw in Chapter Three, what medical research appears to suggest as the best practices for attending women in labor may have little bearing on the realities many women across the country face when they go to the hospital to have a baby. The gap between research and policy guidelines, practice standards, and hospital regulations is produced by a number of forces, including medical education, tradition, and, perhaps most importantly, economics. It would be easy to look at the conclusions of the last chapter and blame doctors: Why are they not practicing according to what the most current research suggests is most beneficial to mothers and babies? Why would they continue to utilize technologies that have been proven not to be

beneficial or even to cause harm? As this chapter will show, doctors are players in a much bigger system: they do not practice obstetrics in a vacuum, but under a host of cultural, professional, and economic pressures. Much of the literature on the medicalization of childbirth focuses on a disparate power dynamic in the doctor-patient relationship as the primary cause of continually skyrocketing rates of technological intervention with little measurable benefit to the health of women and children (B. Rothman; Oakley; Jordan). What I will argue in this chapter is that focusing on that power dynamic alone misses an important opportunity for institutional critique: the current health care system in the United States is much bigger than practicing physicians, who are part, but not the totality of, a matrix of powerful corporate, government, and not-for-profit entities, especially the private health insurance industry and government-funded maternity care programs under Medicaid. Looking at the narratives that undergird those systems helps to flesh out a more complicated picture of the institutional forces working to create knowledge about childbirth and its medical management. Additionally, because insurance discourse may be one of the first textual encounters pregnant women have that addresses them as patients, it plays an important role in positioning women within the other biomedical discourses we have looked at. Before I get to the analysis of such discourse, I will first explain a bit about how and why I arrived at the case studies that follow. Next, I will show how the theoretical perspective in this chapter fits within the rhetorical-cultural strategy I have employed so far, especially by adding the lens of professional and technical communication to illuminate the texts analyzed here.

### **Situating Insurance on the Map: Methods and Theoretical Lenses**

Few rhetorical scholars have looked at health insurance discourse, and none, that I am aware of, have studied the particulars of maternity coverage. Because I am interested in the way

economics and discourse are working together to shape the conditions of maternity care, the work of former health care consultant and independent feminist scholar Barbara Bridgman Perkins provides a useful theoretical base for studying the economic factors at work in structuring maternity care. In *The Medical Delivery Business: Health Reform, Childbirth, and the Economic Order*, Perkins argues that at the heart of the core problems with health care in the United States lies the definition and organization of American medicine as a corporate business, modeled after industry, rather than as a service-provider. Further, she argues that maternity care provides an exemplary look at how that definition shapes care and the funding of care in ways that are not health-promoting, including “running the labor and delivery unit like an assembly line, turning childbirth into an intensive care situation, managing labor pharmaceutically, and admitting well babies into intensive care units” (156-57). All of these routine practices are primarily the result of business ideology, rather than the result of evidence that they improve the health of women and babies, according to Perkins’ extensive research.<sup>35</sup> This is where the feminist critique of maternity care, especially as articulated by the Women’s Health Movement and the Boston Women’s Health Book Collective, of which Perkins was a part, has been limited. By focusing on the doctor-patient relationship or the individual attitudes of obstetricians, feminists have missed an opportunity for trenchant institutional critique centered on economics, writes Perkins: “Although dominance (gender and professional) does play an

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<sup>35</sup> For example, she shows how many technologies became integrated into the “standard of care” through the same process we saw with EFM in Chapter Three: pharmaceutical companies would market a technology to a group of physicians, those physicians would purchase the technology for their practice or hospital, and others would follow suit. As soon as the technology became ubiquitous in teaching hospitals, it became part of the standard way to practice almost by default because hospitals had invested financially in the technology and now they had to bill insurance companies to pay for its operation and to bring in new revenue. Perkins cites this pattern over and over again, from EFM to neonatal intensive care units to synthetic oxytocin.

important role in patient-doctor relationships and therefore has a strong impact on personal birth experiences, it does not sufficiently explain medical practices” (11). Perkins’ contention that ideology is neither determined by, nor exists apart from, the social milieu in which it operates is a good reminder for rhetoricians that focusing on discourse alone can miss an important opportunity to show how discourses function to produce material effects, as I argued in Chapter One. However, it is important not to discount the role discourse plays in shaping institutions and their practices. Perkins writes,

I agree with Emily Martin’s association of active management with production metaphors of industrial and capitalist production—up to a point. But, as with other paradigm/intervention associations, it was not that the metaphors drove practices. Oxytocin use itself shaped the metaphors; active management prescribed oxytocin to strengthen uterine contractions and correspondingly diagnosed dystocia as a problem of inadequate contraction. This focus on uterine contraction ignored other factors contributing to a prolonged labor, such as resistance of the cervix and birth canal. Metaphors of production were just as much the result of structuring labor and delivery units like production units and using technology to enhance productivity as they were its cause. Like the use of forceps, episiotomy, cesarean section, and intensive care before it, active management theory and practice coevolved with the economic organization of obstetrics. This means that reforming medical practice requires re-forming this organization. (155)

I quote at length here because I think Perkins’ admonition to consider the economic organization of the medical system is an important one, often missing from feminist critiques of childbirth, but I would like to revise her concept of co-evolution to fall more in line with Blake Scott and other scholars who combine cultural studies approaches with the rhetorical study of medicine: paradigms and the language that sustain them do not simply evolve alongside one another at the same time, they produce and constitute one another. Put another way, I agree with Perkins that we cannot reform medical practice without re-forming its economic organization, but I would add that such reform might begin with destabilizing the discourse that undergirds and contributes to the continued dominance of such organization. To that end, analyzing how

commercial insurance and Medicaid rhetorically figure pregnant women in their policy discourse might be a way to start to unearth the assumptions and ideologies shoring up the current economic structure of maternity care.

So how does insurance discourse address women? What rhetorical work does it do? In the case studies that follow, I will be looking at both the public face of private insurance and Medicaid—the way they present themselves to the general public—and at the communication directed at the individuals who are enrolled in each one’s insurance program. These kinds of texts are generally the purview of professional and technical communication—a field that deals with texts created in a professional environment with the express purpose of outlining the terms of use for the professional services rendered by that profession. Marika Seigel argues that as pregnancy has become increasingly technologically mediated—a mediation we saw in the popular culture representations discussed in Chapter Two—pregnant women correlatively “need instructions” in order to navigate the path from drugstore pregnancy test to electronic fetal monitor (11). She reads pregnancy manuals in particular as “documentation,” or “written materials. . .that support a particular technology or technological system” (12). The “instructions” implicit or explicit in such documentation, Siegel argues, “configure users in particular ways: they might determine who can and cannot effectively access and use a particular technology; they might reflect sexist and racist cultural beliefs. . . .Instructions are one of the things that determine how we use technology and in turn how technology uses us” (12-13). Insurance policy and its varied incarnations, from the private policy of an individual subscriber to the public “summary of services” of a government program, can be read to function in this way: as a set of instructions for how to use one’s health care. Embedded in those instructions, as my analysis will show, is a narrative that positions some women as meaningful

decision-makers, active participants in determining the course of their care, and relegates others to the receiving end of care, dependent beneficiaries whose choices matter little if at all. The conflict between this narrative and the actual material constraints of private insurance and the relative freedom of choice many Medicaid users are allowed reveals an industry operating at odds with its stated purpose.

Tracing how that conflict plays out in insurance discourse requires a narrow focus on a very localized context: the specific legal climate, medical culture, and availability of state-based insurance programs all contribute to a wide range of maternity care options and limitations depending largely on where a woman lives. Because I was interested in both the documentation of private companies and state-based programs directed at the general public and in the communication between insurance programs and individual enrollees in those programs, I started my narrowing process by soliciting individual policies from women. I was most interested in the states where the cesarean rates were extremely high or extremely low, hypothesizing that insurance coverage might partially explain the disparity in such rates. I posted a request for insurance policies outlining maternity coverage on the Facebook page of one of the online communities I followed for Chapter Five, and the blogger who runs that page reposted the request on her blog, *The Unnecesarean*. I received policies from about a dozen women in ten different states, and as I sifted through them, I read what I could find about the particular culture of birth in each state and corresponded with some of the women about their experiences with maternity coverage in their state. The state of Florida immediately piqued my interest: home both to some of the most progressive midwifery laws in the country, including a legal requirement that insurers must cover the services of licensed midwives, and to one of the highest cesarean rates (38.5% in 2008), I was intrigued by what appeared to be a greater array



of choices for birthing women alongside extremely high rates of obstetrical interventions (some hospitals in southern Florida have c-section rates as high as 72%). A Florida woman sent me her Aetna policy, and I began corresponding with her, with other women who had used Florida Medicaid to pay for their births, with practicing midwives in the area, and with officials from the Florida agencies that administer the Medicaid program. I used much of that communication to situate my analysis of the Aetna policy and the Medicaid documentation I gathered; the perspectives of many of these women influence the context section that precedes the case studies.

The discursive representation of private and public maternity coverage in a single state cannot, of course, represent the state of health insurance nationally. What I offer here, instead, is a close look at the way such discourse operates in a very particular context and how the rhetoric within that context figures women in the economics of maternity care. In order to compare the kinds of messages women encounter depending on how their medical care is funded, I will look at the discourses of the private company, Aetna, alongside the discourses of Medicaid and how they function in the state of Florida. I will argue that the rhetoric of consumerism implicit in much of the communication from Aetna and the rhetoric of assistance implicit in Medicaid documentation work to create two ideal pregnant patients: the ideal consumer and the ideal recipient. Neither kind of patient is empowered by this idealized address, especially since such a characterization is often undermined or even directly contradicted by the provisions and limitations outlined in the programs. In order to set the stage for this argument, I will first offer some general background information on Medicaid, private insurance, and the funding of maternity care. Next, I will give a brief overview of the birth climate in the local context I am focusing on.

As I examine how these discourses shape the choices individual women make about their maternity care, it is important to remember that there is a large group of women left out of the discussion—those without insurance who are not eligible or do not choose to enroll in Medicaid. Many of these women are undocumented immigrants. Also, in some states, especially those where the income level for Medicaid is relatively low, a growing number of women who do not receive insurance benefits from their employers but make too much money to qualify for Medicaid are unable to afford the steep premiums associated with private policies that include maternity coverage. How either of these groups encounters—or avoids—the maternity care system is an important area for further study but is outside the scope of my analysis here. Additionally, I will focus on one of the earliest decisions women make about their health care after learning they are pregnant: what health care provider to see for the duration of their pregnancy and the birth of their child. Insurance discourse certainly influences many, many other aspects of care, including how many prenatal visits women attend, what kinds of procedures and tests they receive, and how long they can stay in the hospital after the birth. Malpractice insurance discourse also influences physicians and the kinds of women they choose to attend, the kinds of births they will oversee, and the kinds of procedures they will and will not perform, whether patients are aware of this factor or not. Clearly, there is much to learn about how the rhetoric of this third party system works to shape the care of birthing women, and much more research into this piece of the maternity care picture is needed. What I am after here is a beginning, a small case study that can point towards the kinds of questions we might ask of this discourse and the ways we might read it to start to piece together some answers.

## **Financing Maternity: Some Background on Economics and the Structure of Care**

Generally, pregnant women in the U.S. have two options for maternity care coverage: a private insurance company, either paid for by an employer or by the woman as an individual policy-holder, or state-based Medicaid, a federally mandated program that requires states to offer coverage both to women already receiving state-based assistance and to uninsured or underinsured women whose income level would typically not qualify them for other kinds of government welfare programs. For many women with private insurance, their choices about caregivers are constrained by the company's contractual agreement with certain in-network providers or its participation in managed care groups like HMOs. For women with Medicaid, their choices are constrained by which providers in their area have agreed to take a certain percentage of Medicaid patients and by the number of Medicaid enrollees already being cared for by providers who do accept Medicaid. Both groups are also further influenced by a prevalent public discourse of health care consumers and welfare recipients and by the regulatory environment in their state. In addition to circumscribing the actual choices available to women, insurance discourse also encourages women to view their choices—and their ability to make those choices—in particular ways.

How maternity care gets paid for anywhere is a highly complex issue, involving rates of reimbursement, widely varying costs assessed for the same services, and the tangle of entities that stand to profit from the way costs are assessed and collected. By focusing on choices available to women about what kind of care provider they may choose, I hope to show how the economics of the current model of maternity care influences the options available to women. Advocates of midwifery care for women have long asserted that midwives offer a low-cost alternative to an increasingly expensive portion of the U.S.'s health care economy. Data

obtained from the Agency for Healthcare Research and Quality for 2008<sup>36</sup> shows that charges billed for pregnancy, birth, and newborn care (\$98 billion) “far exceeded charges for any other hospital condition in the United States” (Childbirth Connection). Additionally, maternity care services totaled 53% of Medicaid’s national bill, an increase of 47% from 1997, and the most expensive portion of Medicaid’s total expenditures at \$41 billion. While Medicaid footed the bill for 41% of all maternity-related hospital stays, private insurance covered 52%, leaving 7% of such fees unpaid or paid by individual patients. Maternity-related charges made up 35% of private insurance’s total expenditures, for a total of \$50 billion in hospital charges to insurance companies (Childbirth Connection). During the debate over health care reform in 2008, the *Los Angeles Times* published a piece by Jennifer Block, in which she argued that “the most cost-effective, health-promoting maternity care for normal, healthy women is midwife led and out of hospital” (“Midwives Deliver”). Citing the high costs of hospital birth (between \$7,000 and \$16,000 per birth for a total of \$86 billion in 2006) and the frequency with which it occurs, (maternity is currently the most common reason people are admitted to the hospital across the board) she argued that one of the antidotes to rising costs with no definable benefit to the health of women and babies is to turn the maternity care system “upside down” by turning the care of the majority of low-risk, healthy women over to midwives, especially those trained to offer out-of-hospital care.

But who would stand to benefit from the reduction of those costs is not so clear. For one thing, childbirth is the most common reason for hospitalization, but the way hospitals make money from all of those patients is through billable services, especially the administration of

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<sup>36</sup> The latest data publicly available on the AHRQ website is from 2006. Roxanne M. Andrews, author of the statistical briefs published by the Healthcare Utilization and Cost Project, provided updated data to Childbirth Connection.

tests, procedures, and technologies (Steinberg). The standard of care touted by midwifery proponents utilizes less of those revenue-producing services. Additionally, women utilizing the services of nurse-midwives in a hospital environment might take up more of their caregiver's workday—because midwives typically attend both labor and delivery, unlike obstetricians—and occupy a hospital room for longer, if labor is allowed to progress on its own timetable. In other words, midwifery care is less “efficient” in terms of getting the most billable services as quickly as possible out of each woman's birth. Susan Hodges and Henci Goer make this point in a 2004 article, in which they argue that because midwifery brings in less revenue for hospitals than high-tech procedures performed by medical specialists, like cesarean section and infant stays in the Neonatal Intensive Care Unit (NICU), hospitals are less likely to offer those as equitable choices. When it comes to the price tag for a particular birth, how that cost affects the patient is difficult to pinpoint. The majority of financing for maternity care happens not by a traditional fee-for-service model in which a provider bills a consumer for his services and she sends in a payment but through a combination of patient-paid out-of-pocket expenses, insurance reimbursement or Medicaid payment, and negotiated rates determined by managed care organizations (R. Stevens 11). Hodges and Goer argue that this is the primary reason so many hospitals are doing away with nurse-midwifery services: because they do not bring in enough money. Historically, some hospitals solved this problem by providing the services of nurse-midwives only to uninsured patients or those on Medicaid (Perkins 107). Because most women are not paying for their births out of their own pockets, they might not notice the cost difference unless they have a significant share-of-cost to pay after insurance has paid its part. Even still, those questions—which caregiver will cost less—are typically not made explicit; if women want to use that factor to make decisions about who to see, they have to take the initiative to

ask. Many critics have long argued that the health care industry incentivizes high-tech specialty care and financially discourages the “low-tech, high touch” model of care midwives specialize in,<sup>37</sup> but as long as third parties are the ones paying the bills, cost-effectiveness is not likely to be much of a concern for the patient.

The cost of birth also is misleading in how it affects providers financially. The price of a home birth averages \$3,000-4,000, but that entire fee is usually a set rate paid to the midwife for prenatal care, the birth, and two postpartum visits, and it does not vary according to how long labor lasts or what procedures she has to perform. A hospital birth, by contrast, bills separately for each technological intervention, and disperses the fees collected to different entities. An obstetrician may be reimbursed \$1500 for attending an uncomplicated vaginal birth, around half of what an out-of-hospital midwife will be paid, but that amount is only a fraction of the cost of the entire birth and does not include what the doctor has billed the patient’s insurance company for each prenatal visit or what the hospital bills for each procedure administered. Patient volume is a factor too, as most midwives practicing out of the hospital will limit the number of patients with due dates in the same month, while most hospital labor and delivery units are designed to facilitate as many births as quickly as possible. And, many midwives do not accept private insurance because of all the problems they have had with billing (Felicia), so many of their patients may pay out-of-pocket, even if it would have cost them nothing to go to the hospital because insurance would have covered it.

So why is saving money not a concern for the third party that usually pays? Why are insurance companies and Medicaid not pushing the kinds of births that cost less? There is no

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<sup>37</sup> This is one of the basic premises of the Transforming Maternity Care Project. A special issue of *Women’s Health Issues* details the project’s overall goals and demonstrates the ways the current economic organization of maternity care incentivizes technology at the expense of care.

simple answer to that question, but at least part of the answer lies in the complicated relationship between insurance companies, hospitals, and managed care organizations that obfuscates determining a simple figure for the “cost” of a birth. If a hospital bill that a patient receives indicates that her birth cost \$7,000, what it will not always indicate is that the HMO her insurance is part of only pays a fraction of that cost, based on previously negotiated rates of reimbursement, or how those funds are dispersed to different specialists and departments. It also will not indicate that in order to keep those negotiated rates—profit-makers for the insurance companies—many managed care organizations enter into contracts with certain providers by agreeing to exclude others (Perkins 89). This push-and-pull between hospital administration and billing services, state agencies that administer Medicaid, HMOs, insurance provider networks, private practice physicians, and specialists usually takes place behind the scenes, without the knowledge of or input from the so-called “consumer” who receives the care.

Of course, it has not always been this way. This model of health care financing, based around hospitals, insurance, and managed care organizations, is largely the result of how American medicine defined itself in the early days of its professionalization and how that definition has shifted according to the economic climate of the times (Starr; Perkins). Health insurance as a form of payment has its roots in a group of schoolteachers in Dallas, Texas, who agreed to pay Baylor Hospital fifty cents per month each in 1929 in exchange for up to twenty-one days of hospital care a year. Hospital administrator Justin Ford Kimball needed a way to secure financial stability for his institution, and many Americans were eager to avoid the kind of debt medical bills could rack up if illness struck them or their families (Fein 10-11). Other hospitals across the nation took note of Kimball’s prepayment system, and soon the Blue Cross health plans were born. Small group plans with agreements at a single hospital quickly

expanded into multi-hospital plans offered to large groups of employees, both to eliminate competition among hospitals in uncertain economic times (Cunningham and Cunningham; Starr 296) and to comply with the American ideology of “free choice” (Fein; R. Stevens; Starr).

One important feature of the hospital plans is that they covered only the costs of hospitalization, so as not to interfere with the practice of individual physicians (Starr 196). Some physician groups, despite the adamant protests of the AMA, arranged prepayment plans with certain industries as early as the 1930s, but those instances were localized and had little effect on the overall organization of medical care until decades later (302). The protection of physicians’ autonomous ability to determine payment was the primary concern of medical societies, and they fought off intrusion by a third party payer system for many years. However, with the growth of hospital-based insurance, national conversations about compulsory government-run insurance, and a smattering of renegade physician groups that bucked the system and organized their own cooperatives and prepayment plans, compromise proved the best strategy for the medical profession to retain control over the payment of medical services. As a result, doctor-controlled insurance, in the form of Blue Shield plans, started to gain ground in the late 1940s.

After the war, commercial insurance took off and quickly overtook the Blue plans in the number of subscribers it served. Sociologist Paul Starr explains that this happened for primarily two reasons: one, commercial insurers could offer employers a variety of kinds of insurance and negotiate a package, whereas Blue Cross/Blue Shield was limited by its nonprofit status to funding medical care only. Second, commercial insurers instituted the practice of rating groups according to risk and providing a sliding scale of premiums to employers, based on the health and age of their work force. This competition was more than the Blues could take, since they



had committed to spreading the risk across local populations through community ratings, a benevolent but less cost-effective strategy (327-31). Soon, they adapted their model to look more like commercial insurance's risk-based rating. That move solidified the profit-maximizing model of third-party payment for medical care that allowed doctors and hospitals to retain control of their fees while insurance companies attempted to enroll the lowest risk population at the highest premiums possible. This model remained more or less consistent until government pressure to contain costs gave birth to the managed care organizations of the 1990s.

In a recent historical account of Medicaid from 1965-2007, David G. Smith and Judith D. Moore argue that it is impossible to understand the politics of government-funded health care without viewing it through the lens of private insurance's role in providing (and not providing) coverage to particular populations. Medicaid was not created until 1965, as a part of the Social Security Amendments to the original 1935 Social Security Act, long after commercial insurance had firmly established the employer-sponsored and for-profit payment system. The 1935 Social Security Act essentially "created the welfare state," a move significant for health care both because of the distinct lack of provision for health coverage in the original bill and because health coverage for the poor and uninsured was eventually created based on already-existing categories of aid (6). The opposition from the American Medical Association to a health insurance provision in the original social security package convinced President Roosevelt not to include it in the bill (8). In place of any federally funded health coverage grew the commercial insurance industry, and with it, a system of payment for medical care based primarily on employment. Those left without coverage, especially marginalized workers like those with agricultural and domestic jobs, the unemployed, and the elderly and seriously ill, became the target population for Medicaid (9).

Another important feature of social security that continues to impact Medicaid and other forms of aid is that due to pressure from southern states, all eligibility and benefit levels were left up to each individual state, rather than federally regulated (10). Obviously, attitudes towards reproduction and motherhood would affect how coverage for pregnant women figured into the program, and in the civil rights era when Medicaid was created, racial politics played a big part, especially in the south. Also influential in how Medicaid has been received by the general public is its strong ties to other forms of welfare, “which associated Medicaid with the complexities and indignities of welfare eligibility determination and means testing. . . . This association with welfare and its stigmata continues—in both the minds of the public and Medicaid recipients—and is a significant barrier to enrollment, even today,” argue Smith and Moore (16). Not until the 1980s, with the passage of the Child Health Assurance Program (CHAP), was maternity coverage for a wide array of women—not just single mothers who were already on welfare, but also low-income or uninsured women pregnant for the first time and low-income or uninsured pregnant mothers in two-parent families—mandated for inclusion in state Medicaid programs.

When it comes to maternity care, Judith Rooks argues that because “Medicaid set limits on the amount it would pay for specified medical services and did not allow physicians to charge more,” few obstetricians opted to participate in the program at its onset. As a result, programs were created to match the services of nurse-midwives with Medicaid-eligible women who needed maternity care. With the implementation of the Family Planning Services and Population Research Act of 1970, the federal government began funding some nurse-midwifery education programs through the Children’s Bureau, the Division of Nursing, and later, the Maternal and Child Health Bureau, with the hopes of staffing family planning services with

nurse-midwives. The combination of these two factors placed nurse-midwives as major players in reproductive health services for Medicaid-eligible women for much of the 1970s and 80s (Rooks 52-53). In the 1980s, much public health attention focused on increasing access to prenatal care and reducing the number of low birthweight infants. With the increased availability of Medicaid funding to pregnant women as a result of the 1984 CHAP, essentially, maternity care, like the rest of the health care system, operated as a two-tier system, serving those with private insurance and those without. Rooks reports that a Guttmacher Institute study in the mid-80s showed that 40% of Medicaid patients sought maternity care in the offices of private physicians, but without data for what kinds of providers those women saw, it is impossible to know how many of them were funneled to the less costly services of nurse-midwives and nurse practitioners. Additionally, 29% of women on Medicaid sought care at hospital clinics and 23% at health departments, both places likely to have nurse-midwives or nurse practitioners providing the majority of care (193). Medicaid, because it funded care at a fraction of the cost private insurance could pay, provided coverage for the most high-risk population at the lowest cost, a situation that would appear unlikely to secure the highest quality care for the most at-risk population. However, nurse-midwifery programs adapted and began training their students to work in the kinds of environments where they would most likely find jobs. Over time, and with the addition of government-sponsored programs like WIC (Women, Infants, and Children) and educational initiatives promoted by organizations like the March of Dimes, women attending prenatal care in publicly funded clinics often encountered care that was in fact specially designed to reduce some of the risks low-income women faced.

Managed care took over in the 90s, changing the traditional fee-for-service model that had placed the doctor in charge and maximized health services. Managed care, on the other

hand, focused on cost-savings and maximizing profits, as many HMOs were for-profit corporations, combining the previously not-for-profit hospital systems with commercial insurance and physician groups (Rooks 117). Medicaid too, to take advantage of the cost-savings promised by managed care, began turning its programs over to HMOs. Many states applied for federal waivers to allow them to use managed care organizations to organize their patient base, and the waivers were mostly granted (118). Ironically, this disrupted the two-tier system because managed care organizations began serving both Medicaid and private-paying patients, while many public hospitals and health departments—entities that had large Medicaid budgets—lost their largest paying patient population. For pregnant women, Medicaid’s use of managed care meant that they were, for the first time, offered a greater array of choices about their maternity care. Unfortunately, this change did not bode well for high-risk patients, as they no longer were enrolled in programs specially designed to meet their needs, and the private physician model of care—focusing strictly on physical symptoms and allocating a minimal amount of time for each prenatal visit—often produced worse outcomes for at-risk women, according to several studies published in the late 90s (119-22).

What all of this history indicates is that maternity care providers have adapted to whatever situation funding of that care created, but the changes have been primarily determined by economic forces, rather than by concerns for the health of women and children. This state of affairs is the result of how American medicine has defined itself, as Perkins argues, as a business modeled after corporate industry, designed to profit from the sale of goods and expertise, rather than as a service provider structured to promote and preserve health. That structure, combined with the pervasive public discourse of health care consumerism, places women with private insurance in the position of purchasers of the goods and expertise for sale;

women on public benefits, however, are figured as charity cases, recipients of whatever care the health marketplace sees fit to give them.

### **Pregnant in Florida: Maternity Care in the Sunshine State**

So what does this organization and its discourse look like in Florida? The state's inclusive midwifery laws mandate the licensure of direct-entry, or non-nurse, midwives through the Department of Health and require the inclusion of those licensed midwives in insurance coverage. Insurance regulation also specifies that women shall not be "required" to "give birth in a hospital" by their insurers' policies, and that Medicaid will cover the costs of home birth (Florida Statutes). The state is home to one of the country's nine accredited midwifery schools and a number of other traditional midwifery education programs, around twenty free-standing birth centers, and about a hundred practicing licensed midwives who attend out-of-hospital births (Florida Friends of Midwives; Florida Dept. of Health 11). Despite all of those things, which seem to indicate a greater array of choices for women giving birth, at least in terms of kinds of care available, Florida boasts the second highest rate of cesarean section in the country and high rates of infant mortality, preterm birth, and low birthweight infants, especially among African American women (a pattern consistent with the rest of the nation, though Florida's rates are at the high end of the spectrum) (Martin et al. 2008; March of Dimes). Though it is impossible to fully account for what appears to be a paradoxical state of affairs, there are several key factors that help to give a fuller understanding of the state's birth culture, especially with regard to women's choices about their health care provider.

First, traditional midwifery in Florida, though relatively progressive when compared to the rest of the U.S., had a hard-fought battle to earn its current status and is still a form of care few women will encounter. As in other parts of the southeast, African American "granny"

midwives attended many women, especially among the state's large rural population, until well into the 1930s. The Department of Health estimates that around 4,000 midwives were practicing in Florida in the first third of the twentieth century, but when the medical profession began to establish its claim over childbirth and to encourage women to come to the hospital to give birth, the regulation of those midwives—in the form of a 1931 law requiring midwives to be licensed and supervised by the state—slowly decreased the number of legally recognized midwives until only 191 held licenses in 1964 (Denmark 213-14). In her history of African American midwifery in Florida, Debra Anne Susie points out that until the 1931 statute was passed, the midwives were working with county departments of health, who kept them updated on the latest obstetric trends and decrees from the state department (63). Once the state department gained control and asked the midwives to travel to Tallahassee for training and inspection, many midwives simply could not afford to cooperate (44-45). The medical community “tolerated” the granny midwives who served rural African American women, one obstetrician told Melissa Denmark, “because they were taking care of black people and [the OB community] didn’t care what happened to black people” (213). Susie explains that the law was intended to gradually phase out midwifery, concentrating on those practicing in places where they were in competition with doctors, and eventually replacing rural-based lay midwives with medically trained nurse-midwives to care for poor women (44-45). By the 1960s, when a new generation of educated, white middle-class women began demanding to have their babies in an environment other than the strictly controlled hospital maternity ward, the midwifery they supported emerged from a different cultural context. The legal battle that ensued for the next thirty years or so may have ensured legitimacy for this new “hippie” midwife, but the concessions made—particularly that licensure required a three-year associate’s degree from an

accredited midwifery program—completed the eradication of the granny midwife tradition physician groups had begun at the beginning of the century (Denmark 214-15). So, while midwifery as a tradition may appear to have a continuous history in Florida—it never died out altogether—the continuity is fraught with racial and class politics.<sup>38</sup>

The grassroots effort to update the 1931 law for the 70s-era midwife was long and contentious. The outdated statute was finally updated in 1982, called the Midwifery Practice Act, and it outlined a licensure procedure that granted midwives the freedom to practice fairly autonomously, as long as they graduated from a three-year course of post-secondary education and passed a state licensing exam (Denmark 223). In 1984, due to a last-minute rider added to the 1982 law that called for a “Sunset Review” of the law in just two years, the legislature gave in to pressure from the American Medical Association and voted to suspend licensing. It was not until 1992, with the strong support of Governor Lawton Chiles, that the suspension was lifted, and the state law was updated again, this time with “relatively broad” guidelines for practice, “based on World Health Organization standards and successful European direct-entry midwifery programs” (246). Part of the legal battle included insurance: in 1988, lobbyist Beth Swisher helped push through a bill that required insurance companies to reimburse midwives, and later, Medicaid reimbursement for birth centers and home births was also written into law (252-53). One concession the midwifery advocates had to make was that in exchange for Medicaid coverage of home birth services, they were required to carry medical malpractice insurance (253).

Though Florida appears to have a progressive stance towards traditional midwifery relative to the rest of the U.S., and especially to other southeastern states, still, midwives report

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<sup>38</sup> For more on the way this struggle played out, see Susie, *In the Way of Our Grandmothers: A Cultural View of Twentieth-Century Midwifery in Florida*.

that insurance companies reimburse them at low rates, if at all, and that they cannot afford to take on many Medicaid patients at a time because the state program reimburses only about a third to a quarter of their total fees (Mary Ann; Felicia).<sup>39</sup> Doctors and hospitals too have had their share of complaints about the rates at which they are reimbursed for care, especially time-consuming services like attending a woman who wants a VBAC (vaginal birth after cesarean). But the client volume of a midwife makes the reduced rate more of a burden for her, especially since there are so few in practice, relative to the population. Despite what seems to be a strong and vibrant community of support for traditional midwifery, out-of-hospital birth in Florida still remains an option accessed by a small minority. In 2006, the Florida Department of Health midwife report shows that only 1069 birthing women (out of 236,802 total) opted for an out-of-hospital birth under the care of a licensed midwife. Nurse-midwifery, too, as an alternative to obstetrics, has grown in recent years but still falls well below the number of ob-gyns attending births in the state, and one study indicates that at the rate currently practicing CNMs are retiring, there will soon be a shortage (Jevitt and Beckstead). Some midwives say that this is because women do not know what their options are; others point out that there are not enough midwives to go around.

Another reason, however, must be related to cost: though the laws on the books suggest insurance companies are required to treat midwives and birth centers equally in terms of reimbursement, many women I spoke with using private insurance said no birth center or licensed midwife was included in their network of providers. Others said they had to dig and dig for information about reimbursement for a home birth, often getting few answers from the

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<sup>39</sup> As this dissertation goes to print, in fact, the Florida Legislature is proposing a 20% cut to fees for birth centers and midwives paid by Medicaid, a move that could further reduce the number of midwives and birth centers that accept the state-based insurance (Felicia).



company until they received the bill. One Blue Cross/Blue Shield subscriber wrote that the birth center she used “had a hell of a time billing them but they eventually paid up” (Julie, “Re: Your Study”). However, for the care she received after she had to transfer to the hospital: “They paid thousands to [the doctor] and the hospital without a peep.” Another woman describes the bill for her first birth, a planned home birth-turned cesarean of \$26,000. According to her bill, her insurance company paid for \$20,000 of the cost, and she was left with \$6,000 to pay out-of-pocket. With her third child, she had a similar experience—home birth turned cesarean—but this time was enrolled in Medicaid, and the government program footed the entire bill. What the bills she received do not show, however, is what fraction of the cost Medicaid actually paid, or what rate her insurance company negotiated to pay with her first birth. What she sees is that the government-funded program paid every cent without giving her any trouble; with her first birth, she was still getting calls from the midwife because insurance refused to pay a portion of the cost. By contrast, “Medicaid definitely made this pregnancy the most stress free financially. . . .And no phone calls afterward that we owe more and more.... no surprises” (Vanesa). Despite the letter of the law, insurance companies and state-based programs can still sharply influence a woman’s choices about what kind of maternity care to choose, especially by the way such choices are presented.

Clearly, there are a host of factors at work in shaping the contours of maternity care in Florida. One of those is how such care is paid for, both because caregivers are constrained by economic forces and because women are constrained in their choices about which caregiver to see. However, the use of insurance to pay for maternity coverage is not simply a business transaction, it is also a series of discursive exchanges, of one discourse community communicating with others, of the health insurance industry communicating not only with

pregnant women and their families, but also with health care providers and the general public. What the following analysis will show is that beneath any explicit list of services available to women based on their insurance status, lies a powerful discourse that identifies what kind of patient they are, based largely on how their care will be paid for. My argument is that this discourse acts as another constraining force by delineating which women should be proactively making meaningful decisions about their care and which ones should be grateful for whatever care they receive.

### **“Be a Smart Health Care Consumer”: Aetna and the Rhetoric of Consuming Care**

Aetna is a Fortune-100 company and one of the four largest health insurance providers in the U.S. Only since the 1990s has health insurance been its main business, when it merged with U.S. Health Care and purchased Prudential Health Care and NYLCare Health Plans. In 1999 Aetna had 21 million U.S. members, making it the largest provider of health benefits in the country. For the past three years (2008, 2009, and 2010), *Fortune* magazine has named the company the most admired company in the Health Care: Insurance and Managed Care category (“Aetna History”), and the company currently has 37 million enrolled members (“Aetna Facts”). According to the “Facts about Aetna” page linked on the company’s website, “Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, and disability insurance, and employee benefits. Dedicated to helping people achieve health and financial security, Aetna puts information and helpful resources to work for its members to help them make better-informed decisions about their health care” (“Aetna Facts”). The image of the informed health care consumer looms large in industry discourse, as we will see, and also in the language of consumer advocacy groups—organizations like Childbirth Connection are based around the idea that informed pregnant women should be able to make meaningful decisions about their

health care (“Vision, Mission, and Beliefs”). Saras Henderson and Alan Petersen argue that the “language of consumerism. . .in health care” reflects the “expectation that citizens should play a more active role in caring for themselves as ‘clients’ or ‘consumers’” (1). Henderson further defines “consumers as people who are able to make their own decisions about the care they receive, express opinions about the care and evaluate the care” (105). To put it simply, good consumers are informed consumers. This theme of the informed Aetna member is a central tenet to the rhetoric of health care consumerism, an idea that plays prominently throughout Aetna’s public profile online.

The main graphic of Aetna’s home page is a rotating series of pictures, presumably of customers, with captions running beneath the images that point users to four different tools available to Aetna members: Aetna Mobile, Aetna SmartSource, Member Payment Estimator, and Personal Health Record. In one image, a baby with big blue eyes and a red and white striped hat looks upward, and the caption below reads, “We’ll empower, not overwhelm.” The graphic directs users to the SmartSource tool, a member service that provides “personalized health search results based on your individual profile and plan.” Each of the tools seems designed to customize and personalize the corporate site for its users, indicating that health care, and the funding of it, is highly individualized. The SmartSource screen, for instance, opens with the tagline, “Your search for health information: Now it’s personal” (Figure 8).

Each tool screen also contains the, “Not a member?” tagline, with links to options for purchasing plans or accessing employer-based benefits. The overall message of this flashy part of the site instructs users to maximize their health care by utilizing all of the state-of-the-art technology Aetna has created to make the experience of health care provision a user-friendly

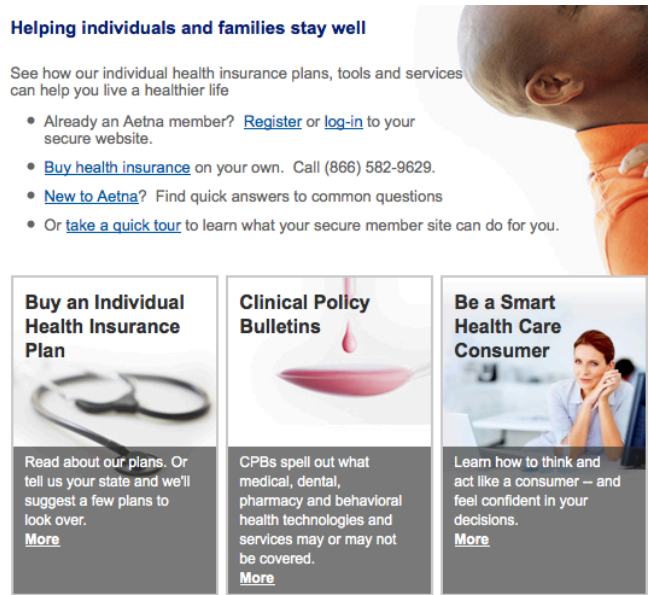


**Figure 8: Screen capture of the SmartSource tool for Aetna members.**

one. By customizing the website and making available the use of mobile applications, the website gives users tools for becoming smart health care consumers. The implicit message for Aetna users is that utilizing technologies designed especially to help them maximize their benefits is one way they can take ownership of their health care and start to make “better-informed decisions.” Of course, such technologies offer only the limited choices outlined by particular plans, options typically negotiated not by individual enrollees but by employers who pay for most of the coverage. The “consumer,” in this way, navigates a set of options predetermined almost completely outside of his or her control. Nancy Tomes has argued that this illusion of choice is representative of the disconnect between the figure of the consumer and the realities of the medical system: despite the fact that the “consumer health revolution of the 1960s and 70s has expanded important facets of patient choice, their decision making continues

to operate within a uniquely constructed, highly specialized marketplace over which they have comparatively little control” (88). The individualized member tools on the Aetna site, however, clearly communicate that control is exactly what consumers gain by enrolling in Aetna insurance and taking advantage of the customized options created “just for you” (“Aetna SmartSource”).

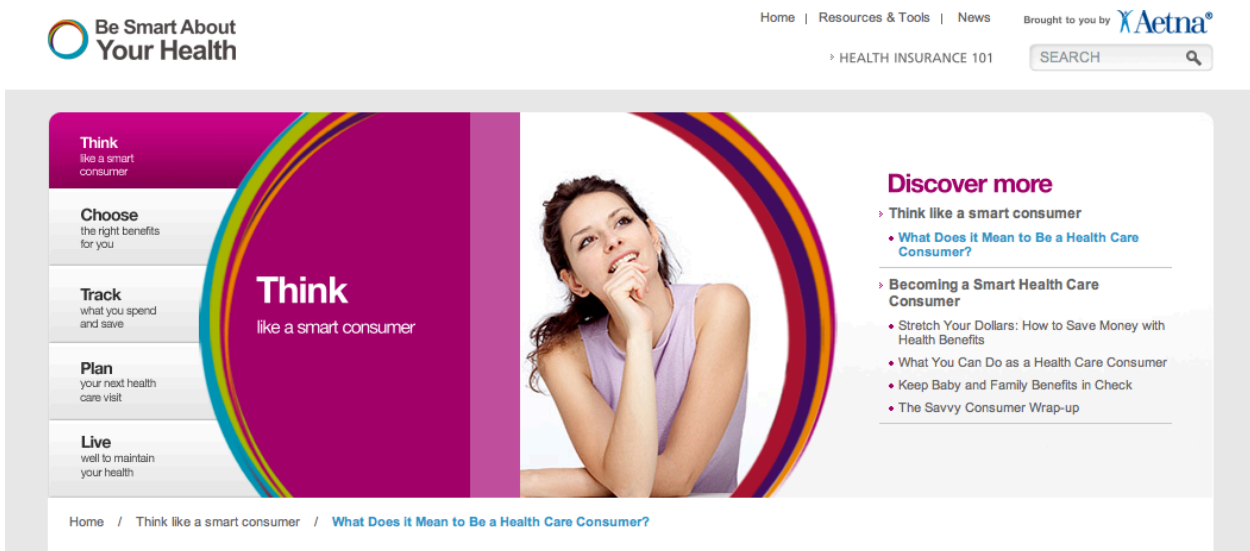
The ideal of the consumer runs consistently throughout the Aetna website. Beneath the large, alternating imagery of member tools, which are the most eye-catching images on the site, the next-largest menu of options appears in three large boxes (Figure 9).



**Figure 9: The menu for Individuals and Families using the Aetna site**

The first advises users to “Be a Smart Health Care Consumer.” Clicking on the link takes users to a separate site, [besmartaboutyourhealth.com](http://besmartaboutyourhealth.com). The information presented there serves as a prime example of the underlying assumptions and ideology running beneath the rhetoric of health care consumerism, the first of which is that consuming care necessarily means holding health insurance. The title of the guide to “becoming a smart health care consumer” is “Health Insurance 101,” suggesting that consuming care and using insurance are the same thing. Of

course, in the current model of health care operating in the U.S., that holds fairly true, but the equation of the two precludes users from imagining any other way for them to “consume care.”



**Figure 10: From Aetna's Be Smart About Your Health site**

A close look at the first step outlined in this crash course to smart consumption—“Think like a smart consumer” (Figure 10)—exemplifies a second assumption: that consuming health care is comparable to consuming other goods in the capitalist marketplace.

For the first time since people traded chickens for house calls, Americans are focusing on how they use and pay for their health care. No matter what you think about health care reform—love it, hate it, couldn't care less—one thing is certain. It has brought to light the fact that health care has never worked like other businesses. (*Be Smart*)

The implication is that it should:

Think about buying a car. We spend weeks thinking about which car to buy. Then we do research, and go on test drives. We go online to check quality and safety measures. We ask friends and family for advice about what to buy and what to avoid. We compare prices at local dealerships and online to look for the best deals. After all of that, we buy a car.

# What Does it Mean to Be a Health Care Consumer?

*For the first time since people traded chickens for house calls, Americans are focusing on how they use and pay for their health care.*

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But when our family doctor says, "You need surgery," we wait to be pointed in the right direction. We should ask:

- Which hospital has the best results?
- What surgeon is the best at this procedure?
- How much of the cost will my [health plan](#) cover and how much will I pay?

Armed with information, you can review your choices and make wise decisions.

> **A smart consumer**

> **Small decisions**

> **Big decisions**

> **Track your spending**

Being a smart health care consumer means looking at health care as a business. It's in your best interest to be informed about the quality and costs of what you're buying, just like any other purchase you make. Why?

Greater awareness can help you:

- Find high-quality care
- Stay safe
- Reduce your costs

If any of those sounds good to you, read on.

**Figure 11: Aetna's list of ways to be a smart health care consumer**

This, then, is the way it looks to be a smart consumer, researching options, testing them out, and then making a purchase (Figure 11). “But when our family doctor says, ‘You need surgery,’ we wait to be pointed in the right direction. We should ask: Which hospital has the best results? What surgeon is the best at this procedure? How much of the cost will my health plan cover and how much will I pay? Armed with information, you can review your choices and make wise decisions.” Purchasing surgery, in this parallel, becomes an equivalent process to purchasing a car. Of course, insurance itself actually renders that comparison useless (despite the obvious differences, like one is not likely to put her life in danger by purchasing the wrong car or not

having the funds to purchase a car at all) because there is no third party between an individual consumer and her local car dealership determining whether she can shop there without a financial penalty, which dealers will accept her as a customer, or which cars are available for her to purchase, conditions built into the insurance-consumer relationship.

It is difficult to access specific information about those conditions on the corporate site because it varies so widely from plan to plan and from state to state. Unlike Medicaid, which has a single *Summary of Services* booklet for every service covered, private companies can negotiate different schemes of coverage for different groups of employees and for individuals, based on differences in risk pools, deductibles, monthly premiums, out-of-pocket limits, and other financial differentials. What does provide more detailed information about coverage is the policy booklet individual policy-holders receive, which outlines the terms of coverage for a particular plan. The individual policy provides a useful look at how the ideal of consumerism plays out when members need to use their insurance to pay for health care services. Many of the booklets are no doubt very different, especially for different plans and in different geographical locations. As a sample of a user guide for one individual's health care, I will look at one Aetna policy-holder's "Certificate of Coverage." She is part of a group plan provided by her employer in Florida.

The first page reads like a kind of contract, beginning by defining what the document is and what it does: "This Certificate of Coverage ('Certificate') is part of the Group Agreement ('Group Agreement') between Aetna Health Inc. hereinafter referred to as HMO, and the Contract Holder. The Group Agreement determines the terms and conditions of coverage. The Certificate describes covered health care benefits." What is significant about this initial contract language is that the individual who holds the certificate is not the contract holder, but is a



member covered under the group agreement. In other words, the member is entitled to the terms of service outlined in the certificate but is not a decision-making partner in determining the conditions of the group agreement: “HMO agrees with the Contract Holder [the employer] to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this Certificate. Members covered under this Certificate are subject to all the conditions and provisions of the Group Agreement.” All of the benefits outlined in the policy have been worked out between two parties, and the individual “consumer” is not one of those parties.

The section following this defining introduction is in bold and all capital letters and marks the first instance where the policy-holder is addressed directly: “Read this entire certificate carefully. It describes the rights and obligations of members and HMO. It is the contract holder’s and the member's responsibility to understand the terms and conditions in this certificate.” The rest of the ninety-page booklet is divided into sections outlined in the table of contents, except for nearly thirty pages of amendments and a five-page schedule of benefits, which make up a large portion of the policy but are not named in the table of contents. The bulk of the document, in other words, delineates what choices are available, how they will be covered (in full or partially), and the ways in which members should go about obtaining them. Put another way, it details the conditions for consuming.

The first section, “HMO Procedure,” serves as the explicit user guide, instructing members how to go about accessing their health care benefits. Step one: choose a doctor, a “Participating Primary Care Physician.” The policy is careful to state that “the choice of a PCP is made solely by the Member,” but that choice is restricted by which doctors are “participating providers,” those listed in “HMO’s Directory of Participating Providers.” This choice is an important one, as the definition section of the PCP indicates that this person serves as a sort of

gatekeeper to the full range of benefits and services covered by the plan by coordinating care, “either by providing treatment or by issuing referrals to direct the Member to another Participating Provider.” This provider determines what the consumer can purchase with his or her coverage, and what she cannot: “Except in an Emergency Medical Condition or for certain direct access Specialist benefits as described in this Certificate, only those services which are provided by or referred by a Member’s PCP will be covered.” The part the consumer plays after she has chosen her PCP is to “consult with the PCP in all matters regarding the Member’s medical care.” Members are also responsible for knowing which services are covered by the policy so they can refuse treatment that falls outside of those benefits (or incur the cost of that treatment): “If the Member’s PCP performs, suggests, or recommends a Member for a course of treatment that includes services that are not Covered Benefits, the entire cost of any such non-covered services will be the Member’s responsibility.” The last section on PCPs explains that choice of PCP is limited by the fact that contracts with providers are subject to change, including termination, as well as to limits to the numbers of HMO patients they can take on. However, members are free to change PCPs, according to this section, whenever they choose through the submission of a form (though such a change is subject to review and approval). In order to use the benefits wisely, according to this first set of instructions, then, it appears that the most important choice plan members make is in choosing their primary care provider in the first place and then monitoring the choices that provider makes for them to ensure that they comply with the coverage outlined in the rest of the program.

The following sections, Method of Payment and Eligibility and Enrollment, inform the users about how different costs will be charged and covered, including deductible, out-of-pocket maximums, and copayments and describe eligibility requirements for the member and any

dependents to be covered, along with the procedure for enrolling new members. The “Covered Benefits” section details what services are covered in different categories of illness and condition. This section begins with an important disclaimer: “For the purpose of coverage, HMO may determine whether any benefit provided under the Certificate is Medically Necessary, and HMO has the option to only authorize coverage for a Covered Benefit performed by a particular Provider.” So, even if consumers choose a good primary care provider who chooses treatments for them consistent with the benefits outlined, the HMO still has the last word. How does medical necessity get defined? The HMO’s definition relies on the standard language of services most likely to be beneficial rather than harmful in treating a particular condition or disease; it must also, according to the definition, be the most cost-effective, “no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.” The major factor in determining medical necessity, however, has less to do with the explicit definition than with who makes the final determination about whether a procedure or service fits the definition. In this case, the policy makes it clear that the final decision will be made by “HMO’s Patient Management Medical Director or its Physician designee.” That person, who works for Aetna, will consider a variety of factors in making such a determination, including medical research “in peer reviewed medical literature,” the policies and guidelines of “nationally recognized health care organizations,” expert opinions, “professional standards,” and the member’s attending doctor’s opinion. What is not listed as a part of the consideration: the member’s choice in the matter. Medical necessity is, to put it mildly, a hotly contested category between patients and care providers, especially in the area of maternity care. What constitutes a “medically necessary” cesarean section, for instance, has for some time been

whatever surgery the doctor scheduled or the patient requested, regardless of the clinical reason cited in the chart (“failure to progress,” for instance, has come under attack for being a code diagnosis for “I’m ready to go home”). Conversely, many physicians, when asked about the rising cesarean rate, cite “maternal request” as a growing factor: does a woman’s request for surgery constitute a medically necessary procedure? In the case of Aetna members, this defining clause indicates that the HMO has the final word in deciding whether any given procedure is medically necessary, and therefore the final word in deciding whether or not they will pay for services, even if they are outlined in the list of benefits. Women’s choices and the choices their primary care providers make are both discursively constructed as secondary to the arbiter of the funds, the third party payer.

What instructions do pregnant women specifically receive about how to use their health care? What is outlined in the “Maternity Care and Related Newborn Care Benefits” is fairly general: “outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by Participating Providers.” Implied in the lack of specificity is that services and procedures are likely to be covered only if they comply with the HMO’s determination of medical necessity during pregnancy and birth. Further, the benefits summary states, “The Participating Provider is responsible for obtaining any required pre-authorizations for all non-routine obstetrical services from HMO after the first prenatal visit.” What role does the pregnant woman play in this pre-authorization? Is she to assume that her provider will not recommend any treatments or procedures that her insurance will not cover? Who determines what counts as “non-routine obstetrical services”? What role does consumer choice play in what is covered or not covered? For instance, some hospitals will offer the services of a doula to support a woman during labor, and this service often takes the place of epidural anesthesia (women who choose to

birth without pain medication often are the ones who request or hire doulas). Epidurals are used in around 95% of births nationwide and would certainly be considered “routine”; doula services, while on the rise, are generally out of the purview of “obstetrical services,” despite the fact that studies show them to be effective in decreasing the time spent in labor and the use of technological interventions (Hodnett et al). Which one counts as a “medically necessary” service, likely to be covered by insurance? The policy leaves questions like this one open to whatever the most common practice is and whatever the company decides, regardless of what the woman or her care provider “chooses.” Another choice that appears to be available is the choice of different kinds of care providers: “Services may be provided by Participating nurse-midwives, midwives and/or birth centers if available in HMO’s Service Area. “ However, despite the listing of “midwives and/or birth centers,” in compliance with Florida law, the policy-holder who sent me her Certificate of Coverage reports that no licensed midwives are listed as participating providers, nor are birth centers, despite the fact that there are both in her “service area” (Ginny).

Additionally, in the exclusions section of the policy, a list of items that are “not Covered Benefits except as described in the Covered Benefits section of this Certificate or by rider(s) and/or amendment(s) attached to this Certificate,” is the simple exclusion, “Home births.” The home birth exclusion is a nationwide Aetna policy warranting its own Clinical Policy Bulletin in which it cites the position of ACOG as reason that home births are not “medically appropriate” and will not be covered by Aetna (“Aetna Clinical”). A note at the beginning of the policy bulletin states that “coverage of home births will be considered when mandated by law under plans subject to state mandates,” but in Ginny’s individual policy, that information is not available. Offering to cover the services of midwives but excluding home birth can, in some

service areas, be a contradiction in terms: many licensed midwives only attend home births, and none practice in hospitals, which leaves a birth center birth as the only covered option. Not all service areas contain a birth center, but most do contain at least one licensed midwife, the services of whom Florida law states must be covered at the same rate as an in-network provider if no other licensed midwife is included in the provider network. In fact, several of the birth centers in Florida post information about how to contact insurance companies to let them know of their non-compliance with state law, particularly in excluding midwives and birth centers from provider networks, in the hopes of appealing and getting them to cover services. So far, if there have been any appeals made to Aetna, they have not changed their policy to correct the non-compliance; Ginny, the Aetna member I spoke with, is planning to appeal to get them to cover the services of a licensed midwife the next time she has a baby.

Despite a deep investment in casting Aetna policy-holders as health care consumers able, even obligated, to make wise decisions about the “purchase” of different health care services, the actual contractual agreement between the insurance company and an employer who has purchased an Aetna group plan for employees, renders meaningful choice a complicated game of choosing the right HCP from a list of limited options and double-checking that provider to make sure she is complying with the terms of coverage set by the insurer. Certainly enrolled members of Aetna make choices, but what choices are theirs to make and what constraints and limitations are placed on those choices, make them hardly the “free” choices implied by capitalist consumerism. Indeed, in some cases, even Aetna policy holders are simply recipients of medical care ordered by their physicians and beneficiaries of Aetna’s payment for that care, two categories usually reserved for people enrolled in government-funded insurance programs rather than for those “consuming” the services of commercial insurance companies.

## **“Health Coverage for Selected Categories of People”: Florida’s Medicaid Program and the Rhetoric of Assistance**

Medicaid, created by the 1965 Social Security Amendments, is a joint state and federal health insurance program for specific low-income populations, including those over the age of 65, those with disabilities, children, and pregnant women. Medicaid is distinct from Medicare, created under the same legislation. Medicare is funded solely at the federal level and age is the only criteria for eligibility; anyone over the age of 65 can enroll, though the program only pays 80% of any given medical cost. Medicaid, by contrast, allows each state to handle the administration of the program as it sees fit, but the basic criteria for enrollment are limited income and financial resources. Funding is provided partly by the federal government—the amount varies from state to state—and partly by the state budget, while the state provides oversight, administration, and regulation of the program. In Florida, the program is administered by the Agency for Health Care Administration, but eligibility is determined by the Department of Children and Families. Pregnant women whose income does not exceed 185% of the poverty level and who are without health insurance, or without health insurance that provides maternity coverage, are eligible for the program. The income level was raised in 1996 in an effort to increase access to prenatal care for women not eligible for other state benefits but without adequate insurance to cover prenatal care and birth. The program is also in the process of being reformed, so the administration looks different in the five reformed counties: Broward, Nassau, Baker, Clay, and Duval. The basic difference is that these reform sites are experimenting with enrolling all pregnant women in an HMO, rather than having their benefits provided directly by the state agency. Non-HMO enrollees are further divided into two categories, based on their income level: Non-SOBRA and SOBRA. SOBRA patients are those who are enrolled in Medicaid only for the duration of their pregnancy (a condition made possible by the Sixth

Omnibus Reconciliation Act of 1990) and not enrolled in any other state benefit programs. Non-SOBRA patients are receiving benefits under the Temporary Assistance for Needy Families program (TANF), which means their income level is at or below the federal poverty level. A third category of women are considered high risk patients and are enrolled in a separate program that directs them to contracted specialists in nine perinatal risk centers across the state, facilities and providers contracted to receive higher reimbursements in exchange for taking on a larger high-risk patient load (A. Anderson). None of those subcategories are immediately apparent from the public information available about the Medicaid program on the web; all health benefits provided through the state government (rather than the federal Medicare) fall under the simple heading of Medicaid.

Unlike private insurance, which many women have as a result of their or their partner's employment, Medicaid requires that women actively seek it out and apply for it, a process that users are likely to pursue only if they know about the program and believe that they are eligible. If they search for information online, accessing information about the Florida Medicaid program is not difficult, but because so many different state agencies are involved with the program, information is scattered across different websites, making it a challenge to determine where to begin. The analysis of Medicaid documentation will differ slightly from the analysis of the Aetna texts, primarily because nearly all of the information available to enrollees in the program is also publicly available on the web. I will start with the readily accessible documentation that gives general information about the program and about how to enroll; next, I will look at the application materials; and finally, I will look at what users can find that compares with a private insurance list of benefits if they are willing to dig through the substantial number of PDF documents listed on various Medicaid-related sites.



The Agency for Health Care Administration (AHCA) is responsible for running the program, and links to its sites are likely to be at the top of the list in a search engine request for “Florida Medicaid.” On the “Welcome” page, users encounter a mixture of business rhetoric that mirrors some of the consumerist discourse we saw on the Aetna site and the rhetoric of assistance characteristic of welfare discourse more generally. The opening definition of the program both defines its parameters and identifies the population of people it serves, and it specifies that the determining factor for receiving the “medical assistance” the program offers is socioeconomic status, or understanding one’s family to be “low-income,” and therefore eligible for government assistance. The next paragraph implies a parallel between this government program and other kinds of insurance:

In Florida the Agency for Health Care Administration (AHCA) is responsible for Medicaid. We are the equivalent of the corporate head office. The Department of Children and Families acts as our agent by enrolling people in Medicaid. We contract with other state agencies and private organizations to provide the broad range of services that Medicaid offers its participants. (“Welcome”)

The industry language—corporate office, agent, contract, broad range of services—might be intended as a counterpoint to the initial categorizing that defines Medicaid enrollees, demonstrating that health coverage through Medicaid is “equivalent” to that of a commercial company, just as AHCA is “equivalent” to a corporate head office. It might also be a reflection of the direction the program is heading: increasingly, commercial companies, including Aetna, are contracting with state governments to act as managed care organizations for the dispensing of Medicaid services, so the program is becoming a hybrid of the for-profit business model and the state-funded social welfare model. Sanford Schram has described the primary discursive referent of welfare to be dependency, an idea at odds with a culture that “does much to engender privatization, that is the idea that most issues are best handled privately, through market

exchanges” (35).<sup>40</sup> Perhaps the move to merge the public provision of health care with the private sector reflects a shift intended to remove the stigma of “dependency” from state-funded health care. Significantly, the welcome page address does not assume that users of the site are Medicaid enrollees or applicants; the only “you” addressed is in the paragraph about Medicaid providers, pointing health care providers to the place where they can apply to serve Medicaid recipients. The speaker is the state agency, “we,” “the equivalent of the corporate head office,” but the intended audience appears to be a mixed one. In describing the group of people eligible for Medicaid, they are called “recipients” in the paragraph addressed to providers and “participants” everywhere else, a slippage perhaps indicative of a merger still in transition, or of an uneasy relationship between public benefits and private industry.

If users of the site are looking for instructions about eligibility specifically for maternity care, they will not find them easily on the AHCA site. Instead, the main page points users to the *Summary of Services* document, which I will get to shortly, and to the Department of Children and Families site for information about eligibility and applying for the program. One way users are instructed to utilize the DCF site and the services that might be available to them is by placing themselves in the correct category (Figure 12). In order to gather more information about their eligibility, users must click on a link that corresponds to the category that best identifies them: low-income families with children, children only, pregnant women, non-citizens, aged or disabled, medically needy, or in need of help but not eligible for full Medicaid.

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<sup>40</sup> Schram traces what he calls the “privatization of public assistance” in welfare policy related to food and housing assistance, but instead of using the infrastructure of private industry to distribute government benefits, as is the trend in health care, the cuts to food and housing have instead fueled a growing “network of substitute services, often in the form of private aid” (61).


**DCF Home**

**ACCESS Florida Food, Medical Assistance and Cash**

- **General Information About Medicaid**
- Eligibility Requirements
- Medicaid for Low Income Families With Children
- Medicaid for Children Only
- Medicaid for Pregnant Women
- Emergency Medical Assistance (EMA) For Non-Citizens
- Medicaid for Aged or Disabled
- Medicaid Cards
- Medically Needy (Share of Cost)
- Medical Help for Those Who Are Not Eligible for Full Medicaid

**ACCESS Florida Food, Medical Assistance and Cash**

**Medicaid**



Medicaid provides Medical coverage to low income individuals and families. The state and federal government share the costs of the Medicaid program. Medicaid services in Florida are administered by the **Agency for Health Care Administration**.

Medicaid eligibility in Florida is determined either by the Department of Children and Families (DCF) or the Social Security Administration (for SSI recipients).

DCF determines Medicaid eligibility for:

- Low income families with children
- Children only
- Pregnant women
- Non-citizens with medical emergencies
- Aged and/or disabled individuals **not** currently receiving Supplemental Security Income (SSI)

**Medicaid for Low Income Families With Children**

Children up to age 18 and their parents or caretaker relatives may be eligible for Medicaid if the family's countable income does not exceed the income limits and countable assets are not above \$2,000.

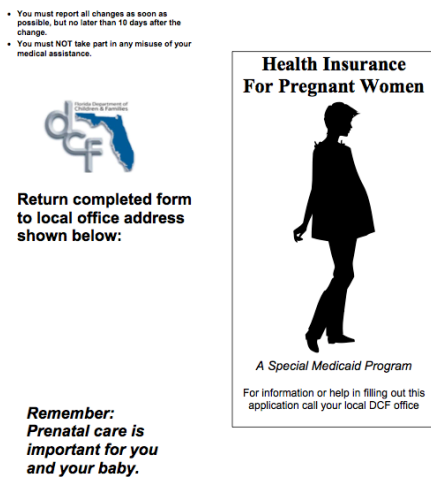
**Figure 12: A user's journey to accessing Medicaid begins by determining what category she might be eligible for (“Medicaid.”)**

Clicking on the link for pregnant women directs users to access the “Family-Related Medicaid Programs Fact Sheet” for more information, a document that continues this scheme of categorization. Each section of the 15-page document is divided into subheadings, according to eligibility classification. The opening pages of the document instruct users to determine which programs they—the audience is specified as “families with dependent children and pregnant women”—should apply for, and consequently, which sections of the rest of the fact sheet will be relevant for them. Pregnant women have two options initially: they can apply for presumptive coverage that is effective immediately, as long as they apply with a “Qualified Designated Provider (QDP)” and are not already receiving Medicaid, or they can use the DCF application for Medicaid for Pregnant Women. No information about what a QDP is or how to find one is given on the overview page, but under the Medicaid for Pregnant Women page,

users learn that QDPs include “County Health Departments, Regional Perinatal Intensive Care Centers, and other state approved providers,” and that the presumptive eligibility applications are available in those locations. Further, “PEPW is a temporary coverage for outpatient prenatal services. It does not include labor and delivery costs. This is the quickest way to get Medicaid.” Implicit in the two categories are women who need prenatal care immediately, either as a result of a change in insurance status or of an unexpected pregnancy, and those who have time to apply before they need care. Women in the second category need a proof of pregnancy with a due date to complete their application, so another factor could be whether they have the funds to cover that initial clinical fee or not. Both will have to fill out the same application eventually to determine whether they will receive coverage or not, a decision based exclusively on income: “Family gross income must be less than 185% of the Federal Poverty Level for the size of the family.” The third and final method of application is directed at those “women who wish to apply for other benefits, such as Temporary Cash Assistance or Food Stamps and/or Medicaid for other family members.” The application for this group is the standard one on the DCF Medicaid page, and a link is provided. The income chart on the last page shows that pregnant women and children are in one of the highest income brackets eligible to receive coverage from the Medicaid program, less than 185% of the poverty level, or \$2429 per month if the woman is single; \$3400 per month for a family of four. Only children under the age of 1 can be in a higher bracket, up to 200% of the poverty level. The categorization, then, further emphasizes the role that income level plays: women defined as being “in poverty” get a separate application, which lumps in their medical care with other welfare programs, while women “above the poverty level” (but still defined as “low income”) are eligible both because of income and because they are pregnant. Implicit in this categorization too is that medical care for pregnant women is

important enough to include those with incomes higher than the poverty level; their status as recipients depends on their status as soon-to-be mothers.

The actual application and the two pages of informational material that accompany it reiterate much of the fact sheet, but this time, the information is addressed directly to the pregnant woman and includes advice as well as information about the program. In this way, the application materials serve as an early user guide for women who might be eligible for the program. To begin, the application continues to emphasize the specialness of the program. Titled “Health Insurance Application for Pregnant Women: A Special Medicaid Program,” the first words on the application page indicate the need to set this program apart from other state benefits. This pattern continues throughout the document: it proclaims, “This Medicaid form is only for pregnant women,” and “Health Insurance for Pregnant Women” appears in large bold letters above a black silhouette of a pregnant woman with the subheading in smaller italicized letters “A Special Medicaid Program” beneath her (Figure 13).



**Figure 13: From the Medicaid application for pregnant women**

Part of what the “special” designation does is to deemphasize the association with “regular” Medicaid or “regular” welfare. What gets emphasized instead is not the higher income bracket

allowed for the program, but the physical condition it provides for: pregnancy. Part of the reason for both the raised income level and the special treatment of pregnant women is evident in the advice scattered in text boxes on the last two pages of the application. Beneath instructions for where to return the completed form, for instance, is an admonition addressed directly to the pregnant woman: “Remember: Prenatal care is important for you and your baby.” And, again on the last page: “Early and regular prenatal care can help you have a healthy baby. Visit your doctor, midwife or clinic as soon as you think that you might be pregnant. This coverage can help you pay for this important care. If you are pregnant, you may qualify for this special Medicaid Program.” The public health push for increasing access to prenatal care, especially for low-income women, runs beneath these direct addresses, and gives an implicit justification for the specialness of the program.

Figure 1 – Number of Deliveries for Florida by Medicaid Status, 2003-2007

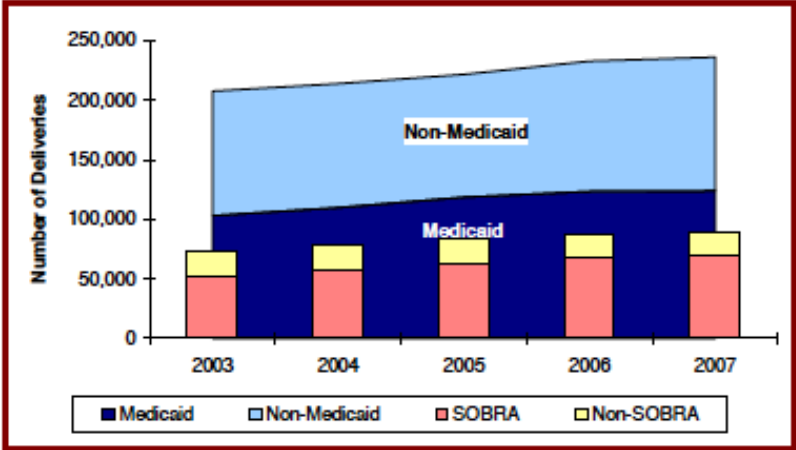


Figure 14: The number of women enrolled in Medicaid just for the duration of their pregnancies (the SOBRA category) has been steadily rising (Maternal Child Health).

What is not mentioned but is part of the picture is how many pregnant women find themselves underinsured; especially those without employer-sponsored insurance or with individually purchased private policies are faced with exorbitant premiums for the addition of

maternity coverage and usually a one-year waiting period before they can use it. Aetna, for instance, offers individual plans, but maternity coverage is not included unless there are complications that require emergency medical care. Women without insurance in the income bracket between poverty level and the upper limit comprise the largest group of Florida's Medicaid recipients, and their number has increased steadily to 56.4% in 2007 (Maternal Child Health). Clearly, this "special" program is meeting a need: 52.2% of all deliveries in Florida were paid for by Medicaid in 2007 (Figure 14).

The application stresses the specialness of the program, indirectly emphasizing the value the state places on prenatal care, and, at the same time, distancing the program from "regular" welfare and the social stigmas it may carry. So how does the application instruct women to access this very important prenatal care? Primarily, it does so by advising them to consult officials. For instance, "If you need help in finding medical care, call 1-800-451-2229." And, "After your Medicaid is approved, you may receive a letter that assigns you to a Medicaid HMO. If so, you may call Medicaid Options at 1-888-367-6554 to see if you can disenroll or stop the assignment" ("Health Insurance"). The second column contains information under the headings, "Income Limits for Medicaid Assistance for Pregnant Women" and "Information we need to process your application." Nowhere does the application indicate that applicants will receive a packet of information detailing their benefits, nor does the website contain individual policy information (only users who are also receiving other benefits can log in to see personalized information about their account). In fact, approved applicants receive a benefits card and instructions for activating it, but information about available providers or services they can access are not included in the personalized information they receive after enrollment (Vanesa; Brit).

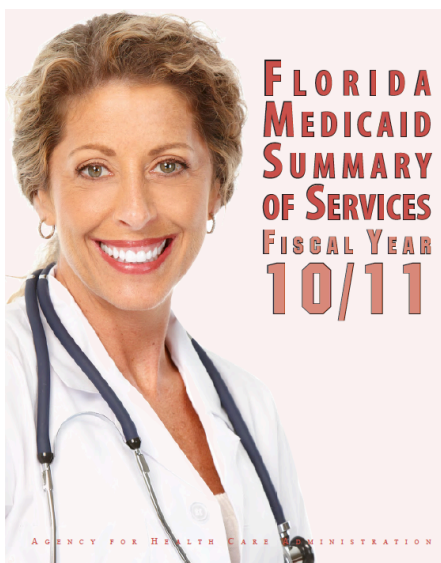
That information is available on the website in two places, in the *Summary of Services* booklet and the *Provider Reimbursement Handbook*, but both of those documents are included under the links for Providers and not included in the list of links for recipients. I spoke with several women who used Medicaid to cover their pregnancies, and they all said the way they found out what was covered and not covered was either by talking with Medicaid employees on the phone (“after being on hold forever”) or by being willing to spend time researching on the internet. If Medicaid enrollees want to educate themselves about their options, the information they need to do so is not addressed to them, which could send the message that they need not make decisions by themselves; instead, they should rely on the assistance of officials.

The *Florida Medicaid Summary of Services* contains at least some of the information these women were looking for, especially that Medicaid covers the services of participating licensed midwives and birth centers. The *Summary of Services* booklet looks a lot like a policy handbook mailed out by a private insurance company: it is illustrated with pictures of health care providers and patients and it contains the basic details of coverage for different medical conditions, including limitations and exceptions.

The significant difference is the audience, hinted at by the picture on the cover of the booklet (Figure 15). In the introductory paragraph, “Purpose of the Summary of Services,” users learn that the booklet:

is intended as an introduction to Medicaid for new Medicaid employees and for staff working in other programs, agencies, and departments. Everyone should refer to the Florida Medicaid Provider General Handbook, or the service-specific coverage and limitations and reimbursement handbooks, for more detailed information about Florida Medicaid. Individuals may contact their local Medicaid area office for more details about covered services.





**Figure 15: The cover page to the *Summary of Services* booklet**

In other words, health care providers and Medicaid employees are explicitly invited to use the *Summary of Services* and the other, more specific documentation available on the web about services and reimbursement. “Individuals,” on the other hand, are invited to contact a Medicaid official, not to seek out more detailed information on their own, though it is publicly available. Implicit even in this stated “purpose” is that the intended users are not people enrolled in Medicaid, but the officials who will interpret and disseminate the information for program enrollees. Combined with the lack of individualized documentation provided to enrollees in the Medicaid program, this setup sends the message that their care will be allocated by a Medicaid official, rather than freely chosen from a menu of options, as private policy suggests. Becoming an “informed consumer” is not part of how Medicaid instructs its participants in the communication directly addressed to them.

If pregnant women come across the *Summary of Services* document and ignore the fact that it is not addressed to them, they can find even more specific and detailed information than

in the Aetna policy, at least in terms of kinds of providers. In the Table of Contents, under Florida Medicaid Covered Services, there are headings for both Birth Center and Licensed Midwife, but not for any other maternity-specific services. Physician Services and Hospital services both contain scant information about pregnancy-related coverage, including the limit of “Ten prenatal visits per recipient, per pregnancy” afforded under the birth center and midwife headings, as well as “four additional visits. . .for high risk pregnancies,” and “two medically necessary postpartum visits per recipient, per pregnancy” (78). Also included under the physician heading is the exception, “The provider may request prior authorization for reimbursement for medically necessary services in excess of the service limitations.” These are important details, especially if, at the conclusion of ten visits, pregnant women are responsible for paying for the remainder of care they need. Standard prenatal care, as outlined by ACOG, includes between twelve and fifteen visits, depending on how many weeks gestation a woman is when she has her first visit, and how long her pregnancy lasts (the standard of care is that women see a provider once a month until 28 weeks, once every two weeks until 36 weeks, and once a week after that). If this information is outlined for providers, perhaps providers to Medicaid patients are responsible for communicating the way their prenatal care schedule will work, or perhaps the officials women are supposed to contact will explain how the allocation of ten visits usually works. Either way, such information is not provided in documentation provided for pregnant women, which suggests they are not the ones charged with managing their own care.

Besides the list of covered benefits for each kind of provider, other valuable information in the *Summary of Services* is included in the introductory section, which outlines the different managed care options and what they mean for enrollees in the program. I did not find the

managed care options available to Medicaid recipients articulated anywhere as clearly as they are in the *Summary of Services*, a document not intended for recipients (Figure 16).

**SECTION III** Florida Medicaid MANAGED CARE PROGRAMS

MEDICAID OPTIONS –  
NON-REFORM ENROLLMENT

DESCRIPTION

Medicaid contracts with a private company who operates a toll-free Medicaid Options Helpline to help recipients enroll or disenroll in Medicaid managed care programs available in their area:

- Medicaid Provider Access System (MediPass)
- Minority physician networks (MPNs)
- Health maintenance organizations (HMOs)
- Prepaid dental health plans (PDHPs)
- Provider service networks (PSNs)

Recipients who wish to receive information regarding their managed care options may call the Medicaid Options toll-free Helpline at (888) 367-6554.



MANAGED CARE

ELIGIBILITY

The following Medicaid recipients are NOT eligible to enroll in a Medicaid managed care plan:

- Recipients who reside in an intermediate care facility for the developmentally disabled, nursing facility, state mental hospital, or state-operated residential program.
- Recipients who are 20 years of age or younger and are enrolled in Children's Medical Services.
- Recipients 17 years of age or younger who are in the Statewide Inpatient Psychiatric Program.
- Recipients who receive hospice services.
- Recipients who are enrolled in a Medicare or private health maintenance organization (HMO) or have other health care insurance, such as TRICARE (formerly known as CHAMPUS).
- Recipients who are only eligible for limited Medicaid under such programs as the Family Planning Waiver, Medically Needy, or Qualified Medicare Beneficiary coverage groups.

AUTO-ASSIGNMENT

Florida law mandates that most Medicaid recipients must enroll with a managed care plan. Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a managed care option. If recipients do not select an option within 30 days, they are automatically assigned to a managed care plan.

12-MONTH ENROLLMENT PERIOD

Most recipients who enroll with a managed care plan are enrolled for a 12-month period beginning on the date of enrollment. They have 90 days from the date of enrollment to try the plan and request a change. After the initial 90 days they must remain with their plan for the next nine months.

Only plan changes for "good cause" will be allowed during these nine months. Each 12 months thereafter, recipients will receive notification of their open enrollment period, which is when they may change plans for the following year.

**Figure 16: The *Summary of Services* booklet contains detailed information about each different managed care program available.**

In that light, it is interesting that so much of the language surrounding managed care that comprises Sections III and IV of the booklet revolves around empowering patients to make their own health care choices, especially in the section dedicated to Medicaid reform. Here's a summary: "Medicaid Reform has been developed to allow Medicaid recipients to take control of their health care, provide recipients more choices, and enhance their health through

knowledge and incentives to engage in healthy behaviors.” The list of principles sound remarkably similar to the tenets of consumerism implicit in Aetna’s public profile: “Patient responsibility and empowerment; market decisions; bridging public and private coverage; sustainable growth rate.” The stated purpose of these principles is to “empower Medicaid recipients, provide flexibility to providers, and facilitate program management for government.” In the non-reform section on managed care, each of the five kinds of managed care organizations gets its own description, as listed in the image above. The reform effort includes HMOs and provider service networks (PSNs), so the information in the reform section about those organizations is similar to their description in the non-reform section. The difference is how the information is framed: in the reform section, these organizations are explicitly designated to help patients become more empowered.

They also have a few additions. For one, HMOs contain “Quality Enhancement” components of the reform program that are not included in the non-reform plans, such as this one for pregnant women:

The health plan shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the health plan’s prenatal and postpartum programs. The health plan shall coordinate its efforts with the local Healthy Start care coordinator to prevent duplication of services. (36)

Also different is the reimbursement policy, which prepays contracted providers “at a fixed monthly rate per member per month,” also known as a “capitation rate” (37). A final addition is the “Enhanced Benefit Account Program”:

The purpose of the Enhanced Benefit Account (EBA) program is to offer incentives to recipients enrolled in a Reform plan to participate in wellness activities also referred to as healthy behaviors. When recipients participate in approved healthy behaviors, they earn credits that can be used to buy over-the-counter health-related items at pharmacies. Recipients can earn a maximum of \$125 in credits per state fiscal year (July 1 through June 30). (40)

The language in this section is closest to the efforts by Aetna and other commercial insurance companies to involve their enrollees in taking charge of their health and their health care, and it may indicate that the rhetoric of consumerism is well on its way to taking over government-subsidized insurance as well. Yet, the way this information is presented in the *Summary of Services* is in a document that explicitly defines itself as a handbook for providers and Medicaid employees, not for patients.

The detailed information that could direct women to make a wide range of choices about their care, including accessing different kinds of providers and settings for their births, is buried in communication not addressed to them as participants in the program. How such options will be presented by the Medicaid officials they are supposed to contact certainly could have a big impact on what kinds of choices women will make. The bigger problem, however, is that the documentation provided to them does not communicate that such decisions are theirs to make, nor does it indicate that they have such a wide array of available options. Despite the consumerist rhetoric present in the reform sections of the *Summary of Services* booklet, women are addressed as applicants and then as recipients dependent on the knowledge of officials to receive their benefits. This paradox is a striking contrast to the way Aetna addresses members of its program as consumers with a vast selection of choices waiting to be accessed by the myriad of individualized technological tools available, and then limits those choices with behind-the-scenes negotiations that render some providers acceptable choices and others out of reach. Neither setup aligns very closely with the promise implied by addressing women as consumers—purchasers in a capitalist marketplace, able to freely choose the services and providers best suited to their needs. Nor, however, does this documentation render women simply beneficiaries of arbitrary choices already made on their behalf. Pointing out the ways

that the narratives undergirding each system of payment belie the realities women using those programs face could perhaps point towards the kinds of systemic change necessary to restructure the economics of maternity care.

### **An Alternative Model of Care and Coverage: The JJ Way**

In Winter Garden, Florida, just west of Orlando, a midwife named Jennie Joseph is trying to change birth outcomes for women in central Florida's "minority and indigent" populations, two groups at great risk for premature birth, low birthweight babies, and infant mortality. She practices what she calls "The JJ Way" at The Birth Place, a freestanding birth center designed to provide a non-hospital alternative for labor and delivery. She also runs a non-profit called Commonsense Childbirth, an organization striving "to ensure access to timely maternity healthcare particularly for minority, low-income, uninsured, and underinsured women; and to provide practical, social, educational and emotional support, resources and referrals as a means to improving the chances for a positive pregnancy outcome" ("Overview"). The philosophy of the birth center is that "every woman deserves a health baby," and a grant-funded study of one hundred uninsured or underinsured women cared for by The Birth Place indicates that they are closer to making good on that philosophy than nearly anywhere else in the country. Though the sample was small, of the African American women cared for by The Birth Place midwives, every one of them gave birth to a full-term, normal birthweight infant. The report summarizing the findings of the study contends that not one of the women in the study experienced any disparity: their outcomes were as good, or better, than the white women included in the study, and better than outcomes of white women nationally ("Commonsense").

Part of what makes The Birth Place possible are the Florida laws that require Medicaid to reimburse them for their services, but at the rate of reimbursement, what they are doing does

not seem sustainable. In any given month, 65-75% of the patients at The Birth Place are Medicaid patients, and the state program reimburses them for only about a third of the cost of each birth (McRay). That leaves just a fourth of the other patients, paying out of pocket or through private insurance, to make up the difference. When I asked Kaevon McRay, Director of Operations for The Birth Place, how they were managing to keep the doors open, she said, “Only by the grace of God.” Some months are better than others, and occasionally financial donations help, but for the most part, it is difficult for the center to make ends meet. Low-income women in the Winter Garden community are freely choosing to birth there in large numbers: McRay said they have not had to do any marketing or community outreach in years, that word of Jennie’s practice has gotten out. The local Health Department also sends women to The Birth Place because they offer such high-quality prenatal care for free. If the outcomes consistently look so different from those of other maternity care providers, it seems that public health advocates would take notice. But it is not just the quality of care that matters. Ultimately, how it is funded may determine whether it remains accessible to a population that could most benefit from it.

Jennie Joseph and the staff at The Birth Place are providing high-quality care to women who ordinarily might not receive it, but it is difficult to imagine duplicating those results unless funding for that care is consistent and comparable to what providers receive from private insurance or individuals paying out of pocket. The Birth Place has contracts with several private insurance companies that pay closer to the cost of the birth, a set portion of the cost negotiated as part of the contract. But how do women enrolled in those insurance plans know that The Birth Place is available to them? How do they know that the kind of care they will receive there

has such consistently positive outcomes? The Department of Health may be referring women who cannot pay, but it is unlikely that HMOs are referring away paying customers.

Under the current system, care providers need private patients to survive financially because there is still a two-tier payment system, which usually leaves those with Medicaid in the second, and lower, tier. There must be a middle ground between profit and health, and the discourse of consumerism seems to be doing little to achieve that balance. Positioning pregnant women as shoppers in a free marketplace of care options is hardly reflective of the reality most women face. Tomes has argued that this disconnect is largely the result of how the “patient/consumer empowerment movements” of the 1960s and 70s “had difficulty sustaining a focus on the larger macroeconomic dynamics of the medical-industrial complex” (101). Forty years later, those same dynamics are in even greater need of sustained critique. If women are going to be able to choose options for care different from the standard OB-directed model of care they will find in most hospitals, the funding for such alternative care must be structured to make that an equitable and available choice. The narratives undergirding that funding too must abandon a hierarchical characterization of women, in which some are entitled to all the choices the market has to offer, while others must accept the care allocated them by government officials. Neither categorization empowers women as long as the system they are participating in is set up to value profit over their needs. Especially as President Obama’s Affordable Care Act starts to take effect, maternity care reformers need to pay particular attention to the economic structure of care and to the narratives that sustain it.



## Chapter Five

### Laboring against the Machine: Social Media Users and Discourses of Resistance

“Blogging is, quiet [sic] literally, an empowering practice—but mainly within the boundaries of the blogger’s blog. . . .Rather than romanticizing motherhood blogging for its potential to transform mothering as we know it, let’s love it for what it is—a private, meaning-making ritual which is open to public view” (11; 16).

—Judith Stadtman Tucker, “Small World: Maternal Blogging, Virtual Friendship, and the Computer-Mediated Self”

“A good deal of vibrant and effective public discourse in the forms of social activism and resistance occur online. . . .such discourse has had noticeable effects on society, and. . .it is therefore worthy of careful study by rhetoricians” (3).

—Barbara Warnick, *Rhetoric Online: Persuasion and Politics on the World Wide Web*

“My reading [infertility blogs] brought with it a familiarity with my own body and its processes that I never achieved in my eighth grade sex ed. class. . . .The Internet teems with anecdotal accounts of women who are able to empower themselves to manage their own medical care based on their ability to connect with other women. In this respect, many women’s blogs are being used as feminist tools” (174).

—May Friedman, “Schadenfraude or Mittelschmerz? Or, Why I Read Infertility Blogs”

In the previous chapters, we have seen how insurance discourse works to frame the event of birth, how the circuit of medical research and medical policy shape the conditions women will encounter if they give birth in hospitals, and how childbirth is represented in popular culture. For the final chapter, I will turn to the voices of individual women (and a few men), some who have given birth, others who work as caregivers for birthing women, some who are self-proclaimed “birth junkies,” and others who are concerned about women’s relationships to medicine and health care more generally. One consistent feature of the discourses I have examined so far is that they are all generated by institutional forces: popular media is disseminated by media conglomerates; insurance policy, medical research, and official

medical guidelines emerge from a whole tangle of institutional forces in the web of the biomedical machine. So where are the places for women to talk back to these institutionally-created and often profit-driven narratives? If pregnant women want to have more control of their births than they will typically be offered in the standard OB-directed medical model, where do they find information and support for doing so? Where are the spaces for women to tell their own stories of what childbirth means and who should make decisions about how to manage it? Obviously, there are many answers to these questions: women have always shared information and support with one another in informal ways, talk among friends and family, around kitchen tables and in coffee break rooms, has been a powerful source of meaning-making in women's lives. As we saw in Chapter One, however, the ways in which the arrangement of women's health care has shifted in the last century has meant that women no longer routinely rely on other women in their communities to answer questions about their reproductive health. In the 21<sup>st</sup> century in the United States, women rely increasingly on medical professionals for answers to questions once provided by family members, friends, or women healers in the community. As this chapter will demonstrate however, as many women have become dissatisfied with the answers and treatment provided by those medical professionals, they have sought stories and information elsewhere. A growing grassroots movement committed to reforming biomedical maternity care has developed a network of blogs, message boards, and email list-servs dedicated to sharing information and providing a place for women to tell the stories of their experiences with birth and (or) medicine. In these online communities, stories once told in the more private, personal spaces of diaries, letters, and kitchen tables have moved into the public, shared space of the world wide web.<sup>41</sup>

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<sup>41</sup> Elizabeth Ellis traced this lineage of women's writing in her presentation, "'Time-Stamped':

## Women and the Technologies of Gathering: Roots and Contexts

More patients of all kinds are seeking information online, and this phenomenon has tended to rankle the medical profession. In 2009, the Society for Participatory Medicine was organized, largely around the work of the late Dr. Tom Ferguson, whose white paper, *E-Patients and How They Can Help Us Heal Health Care*, lays the philosophical foundation for the group. In the “Declaration of Participation,” that foundational belief is summarized this way: “the internet would give us access to information and access to each other, and with that combination, we the people could be well-informed enough to become potent partners with our health professionals.” Other health professionals have not been so optimistic about e-patients. In a survey of patients who regularly use the internet to find health information, one study found that they typically encountered two types of clinicians, those who were supportive and encouraging of their gathering information, and those Ferguson calls “internet-hostile,” who are clearly uncomfortable with patients accessing information without their guidance and prefer the more traditional expert-layperson model of health care (41). A recent post at the popular doctor blog *KevinMD* entitled “Patients Google Their Symptoms, Doctors Need to Deal With It”; a *Time* article by a New York physician who describes “Googling patients” as “suspicious and distrustful, their pressured sentences bursting with misused, mispronounced words and half-baked ideas”; and a study published in the *Journal of Medical Internet Research* in which doctors described internet-using patients as “irritating” and “nightmare[s]” demonstrate that annoyance may be a common reaction to informed patients (Pho; Haig; Ahmad et al). In their application of the e-patients idea to maternity care, Amy Romano, Hilary Gerber, and Desirre Andrews argue that such hostility is often exacerbated in the area of obstetrics, especially

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Memory, Material History and the Digital Archive,” at the Rhetoric Society of America conference in May 2010; for a more general genealogy of blogging, see Gurak et al.

around controversial issues about the best way to give birth. The reason so many women are able to access information contrary to the advice they get from their physicians, they continue, is because of the vibrant social network of birth advocates<sup>42</sup> using digital technologies to share information.

In this chapter, I intend to provide a small glimpse of this community of mostly women using digital technologies to gather and share information in order to resist institutional control over an intimate event in their lives, the birthing of their children. I will show how this gathering and sharing engenders not an anti-technology stance, a critique often implicit in the stereotypes of “natural” mothers, but a more complicated relationship to the tools of an increasingly technocratic society. In other words, many women are using technology to resist technological control, and the discourse they use to do so reveals important ideas about women’s relationships to their bodies and to science, medicine, and technology in the 21<sup>st</sup> century U.S.

In her 2007 book, *Pushed: The Painful Truth about Childbirth and Modern Maternity Care*, former *Ms. Magazine* editor Jennifer Block ends her investigation of the maternity care system by pointing out the near silence from the organized feminist movement to the problems in maternity care. What has grown in that silence, she writes, “is a ‘birthing rights’ movement. . . .Across the country there are ‘birth circles’ and ‘birth meet-ups’ in which women swap books and watch birth videos. . .and ‘facilitators’ talk to pregnant women about the realities of hospital labor management and the politics of home birth” (268). One of the midwives Block interviewed for the book compared these groups to the “underground networks

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<sup>42</sup> Terminology within this community varies and has been heavily debated among participants. The most frequent way participants in these discussions describe themselves is as advocates, so I am following their lead.

that led women to safe abortions before *Roe V. Wade*” (268). Since Block’s book came out, that “birthing rights” movement has taken to the internet, and those videos and stories have become publicly available. Are such stories, as Judith Stadtman Tucker’s quote in the epigraph indicates, merely “a private, meaning-making ritual which is open to public view,” unlikely to have any effect outside “the boundaries of the blogger’s blog”? Or, are the stories shared in these spaces doing something more, participating in the “vibrant and effective public discourse in the forms of social activism and resistance” described by Barbara Warnick, discourse that is having “noticeable effects on society”? From a rhetorical perspective, stories that have an audience are always doing something. What these particular stories are doing, from a feminist perspective, is charged with the politics of women and medicine, of scientific and experiential knowledge, and of gender and discourse. That politics is deeply rooted in the history of the women’s health movement.

In Chapter One, I showed how the shift from midwife-attended home birth to doctor-attended hospital birth also shifted the locus of knowledge about women’s reproducing bodies from women themselves to the medical profession. In the mid-twentieth century, around twenty years after the majority of births had moved into the hospital, a network of groups around the country launched a stringent critique of what feminists saw as a male-dominated, often-misogynistic and paternalistic medical system. The movement took many forms and had its share of dissension and power struggles—not unlike the larger Women’s Liberation Movement—so describing it as one, unified movement has its problems. However, regardless of the political position of the various groups, they shared one basic belief: that women must be educated about their bodies in order to resist the monopolized control of biomedicine. One manifestation of that belief was the circulation of a variety of print-based texts, including the

papers that eventually became *Our Bodies, Ourselves (OBOS)*. One of the major critiques women's health activists lobbied at obstetrics and gynecology was that the medical system sought to control and sanitize the "natural," and often messy, bodily processes of women's lives (Morgen). Childbirth was at the top of the list of those natural processes, accompanied by menstruation, lactation, menopause, and other physiological functions particular to female bodies. Activists argued that such functions were signs of health, rather than disease, and that women, not doctors, should be the primary agents in determining the strategies for managing their bodily processes (Ehrenreich and English).

The critique specifically aimed at medicalized birth catalyzed around the publication of letters from readers of *Ladies' Home Journal* in the 1950s describing the gruesome details of the ways they were treated in hospitals during parturition (Huff). One result of the activism that followed was a resurgence in home birth midwifery and the outright refusal of many birthing women to allow doctors to oversee their births (Gaskin). Another result was continued scrutiny of regular obstetric practice, perhaps best represented by a series of exposés published in the 1970s including *The Cultural Warping of Childbirth* by Doris Haire; *Immaculate Deception: A New Look at Women and Childbirth in America* by Suzanne Arms; and the often-anthologized chapter on childbirth in Adrienne Rich's *Of Woman Born: Motherhood as Experience and Institution*. In Chapter One, I argued that the natural childbirth movement suffered from the dual blows of the 1980s backlash that challenged the larger Women's Liberation Movement and the cooptation of the feminist notion of "choice" by hospital marketing departments to mean choosing the ambience of one's room rather than making meaningful decisions about one's medical care. What I want to suggest in this chapter is that the current childbirth advocacy movement represents a resurgence in feminist health activism reminiscent of the Women's

Health Movement of the 1970s. As they did when consciousness-raising groups were the preferred method of communication, women are coming together to share information and support each other as they assert their own authority over their bodies and their relationships to the medical establishment. They are also participating in what Sandra Morgen has called the “print-based consciousness raising” of the Boston Health Book Collective. They are just doing it largely from behind their computer screens.

### **Of Networks and Enclaves, Feminisms and Rhetorics**

Media studies and communications scholars have been hard at work in the last decade or so, trying to tease out the ways that online communication is affecting our 21<sup>st</sup>-century society. One common feature of much of this scholarship is an attempt to delineate the ways that the availability of publishing platforms has created “citizen journalists” (Barlow; Tremayne). Many scholars see this development as a harbinger of hope for democracy, that information in the hands of the people will mean more power for the people (Shirky; Barlow; Jenkins and Thorburn). On the other side, some scholars and popular writers have claimed that the internet will be the end of everything from literacy to civilization as we know it (Birkets; Baurlein; Keen). My purpose here is neither to tout all online communication as democratizing and worth celebration nor to bemoan the glut of drivel one can find by clicking from site to site. Rather, I am interested in looking at user-generated content online as “rhetorical artifacts,” as described by Laura J. Gurak and co-authors, by paying attention to the “social, cultural, and rhetorical features and functions” of online texts that engage with issues surrounding maternity care and birth politics. To that end, I will continue to rely on Blake Scott’s method of rhetorical-cultural mapping outlined in Chapter One by turning that lens towards the circuit of childbirth narratives created by users of digital technologies at two particular kairotic moments.

The central hub for these discussions is a network of blogs authored by birth advocates, so texts published in blog format make up a significant portion of the case study analysis that follows. Much scholarship about online discourse categorizes blogging as a particular genre and the blogosphere as a new public sphere (Warnick; Tremayne; Barlow). Research on blogging up to this point tends to define blogs by their form: time-stamped entries that appear in reverse chronological order, usually containing links to other online content either in the posts themselves, or in a sidebar list of other blogs called a blogroll (Gurak et al.; Tremayne). Early scholarship on blogging tended to categorize blogs into two genres: the “filter” blog, where a blog author chooses certain information from other sources to highlight, sometimes with commentary, sometimes without, and the “personal” blog, an online diary of sorts where blog authors tell stories about themselves and their lives (Tremayne). More recently, in order to avoid making generalizations about a space that contains such diversity of writing and that changes constantly, scholars have narrowed down the blogosphere by focusing on blog communities or networks, groups of sites that link to one another and generally cover the same kinds of topics (Ratliff; Barlow). As Aaron Barlow writes, “It is impossible to cover all of the blogosphere. It is too big, too dynamic, and too responsive to change for anyone to say much about it beyond ‘this is what I found in this particular place at that particular time’” (ix). The network model provides a useful way to study online texts written about the same event, as I will do, but I will also extend my focus to account for the continued integration of other social media platforms such as Facebook and Twitter into online communication. Instead of focusing on birth blogs as a genre, in the case studies that follow, I will trace online conversations about a particular event as they travel from blog posts and subsequent comment threads to message boards to Facebook to Twitter to online talk radio to more mainstream media outlets. Henry



Jenkins calls this trajectory “convergence. . .the flow of content across multiple media platforms” (2). In their work on blogs about mental health, S. Shyam Sundar and co-authors define blogging as a “collective effort” that can offer a counter-narrative to mainstream media stories about health and disease. I extend that collectivity, following Jenkins, to include a variety of digital media users engaging in participatory culture around issues related to childbirth.

Clancy Ratliff demonstrates one way that this collectivity works in her description of how infertility bloggers mobilized to defeat a bill in the Virginia House of Representatives that would have required pregnant women to report fetal deaths, even miscarriages, to police within twelve hours of the occurrence. Part of her project is to describe the blogosphere as a public space and to identify infertility blogs particularly as a genre. She argues that the network of blogs focused on infertility constitutes a rhetorical enclave prone to “groupthink,” but that the particular case of the bloggers’ responses to a political situation demonstrate that the enclave has another dimension and can serve the public interest. Of the infertility bloggers and the case of HB 1677, Ratliff concludes, “[This] is only one case of an expressivist public sphere’s meaningful intervention into deliberative political discourse, but it calls for continued study of the rhetorical nuances of women’s personal writing online” (142). This chapter both takes up her call for continued study of women’s writing online and takes issue with the characterization of such spaces as enclaves. Ratliff draws on Trish Roberts-Miller’s elaboration of the way an enclave works in the web: as a space devoted to conversation among likeminded individuals controlled by one author, not, as she had hoped, to debate amongst equals. However, describing a network of blogs as an enclave is complicated by Jenkins’ concept of convergence. If we consider the nature of digital technology and social media, calling any group of online spaces

dedicated to similar subjects an enclave—even if their hyperlinks and comment threads link them to one another and even if there appears to be little diversity in the perspectives represented—requires drawing boundaries around particular online spaces in ways that users may or may not adhere to. It seems highly unlikely that many blog readers get their information about particular subjects only from those blogs, especially when it comes to issues about their health. Even if some do, however, they also bring with them knowledge from their own social context and personal history, as well as a variety of interactions with other information sources, including the “official” story of the biomedical model that is so thoroughly engrained in American popular cultural narratives, in medical discourse, and in insurance rhetoric, among other places. Also, conversations that appear in comment threads may not accurately represent the “whole story” of who is reading; many blog readers do not comment at all, and some correspond with blog authors privately, contributing their perspectives to the discussion in less obvious ways.<sup>43</sup> Blogs and other social media outlets are one source of information among many that readers may choose to engage. For these reasons, it is nearly impossible to make assertions about how “readers” or “users” will interact with the information they find, as Barbara Warnick has pointed out. What I will do, instead, is to look carefully at some of the conversations that are out there, to try to piece together what fragmented story emerges out of the convergence around particular real-time, real-world events.

The enclave label is problematic not only from the perspective of considering the constraints of technology and the varying contexts of users, however, but also from a feminist

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<sup>43</sup> Jill Arnold, creator of the blog, *The Unnecesarean*, suggests this may be especially true for issues in health care: many doctors and other professionals involved in health care correspond with her privately, and their perspectives often weave their way into her posts. That is not always obvious by scrolling through the comments; it may appear that no one from the medical profession is paying attention.

perspective. If blogs about childbirth have their roots in the consciousness-raising groups of the 70s and the women's groups who distributed pamphlets and newsletters like those that became *OBOS*, then the formation of what some may consider an enclave might be necessary to resist such deeply entrenched discourses as those in biomedicine. Though the network of birth blogs has a different, and more explicitly activist, character than infertility blogs as Ratliff describes them, it is precisely in the act of unifying around a similar ideology of birth—the very thing that could cause some critics to dismiss the community as an enclave—that allows these women to accomplish any political action. Additionally, the power discrepancy between individual women and the biomedical institutions that control the conditions of their health care, as we saw in Chapters Three and Four, hardly lays the groundwork for a “debate amongst equals,” even if representatives of those institutions were to participate in discussions of childbirth advocacy (as they sometimes do). Nancy Fraser has argued that in a stratified society, what she calls “subaltern counterpublics” are especially necessary when the power disparity between one group and the dominant culture is so large. She also argues that their publicness also precludes labeling them as enclaves: “Insofar as these arenas are publics they are by definition not enclaves—which is not to deny that they are often involuntarily enclaved. After all, to interact discursively as a member of a public—subaltern or otherwise—is to disseminate one's discourse into ever widening arenas” (67). Particularly in the cases I will look at, much of the force driving women to action is their shared belief that they, and not any medical institution, should be the primary decision-makers when it comes to where, with whom, and under what conditions they will give birth. That belief is up against some deeply entrenched institutional and economic interests; cordoning off space to collectively resist those interests may necessitate discussion rooted in the same ideological commitment to resistance. Defining such spaces as enclaves

prone to groupthink not only disregards the typical conventions of digital media usage, it risks having feminist activism dismissed as merely the “private meaning-making rituals” of a few, which so happen to be open for “public view” (Tucker). Rather, I will use case studies of two moments of activism to demonstrate that birth blogs and the social media stream circulating around and through them are “feminist tools” engaging in “vibrant and effective public discourse in the forms of social activism and resistance” (M. Friedman 174; Warnick 3).

### **Method: Following the Intertextual Circuit into Cyberspace**

In order to tease out the ways that online media is enabling and catalyzing birth activism, I will continue to follow the overall methodology outlined in Chapter One by traveling what Blake Scott calls the intertextual circuit, chasing discussions of birth where they exist online. Following Warnick and Ratliff, I will construct case studies, limiting my focus to texts devoted to discussing specific events in a given time frame. In the first case study, the nonprofit activist organization The Big Push for Midwives orchestrated an online response to a home birth survey posted on the website of the American College of Obstetricians and Gynecologists, clearly intended only for its members. In the second case, birth advocates participated in and wrote about a three-day conference put on by the National Institutes of Health about vaginal birth after cesarean (VBAC). In order to piece together the ways that digital media gave women a chance to intervene and participate in these two events, one that took place only online and one that also took place in the material world, I followed the online conversation about both as they were happening and bookmarked relevant posts and comment threads. When I returned to the bookmarked sites months later, I also used search engines to uncover other information related to each event that occurred in places other than my primary research sites. I then identified what Clancy Ratliff calls “hot spots,” or blogs central to a discourse community

online, and followed links from post to post and from commenter identity to post (many of the commenters are also bloggers). What becomes clear even from this description is that both of these events instigated a conversation, not a series of isolated writings. In each case, many of the bloggers respond to one another by referencing other posts, and several posts contain lists of links related to the events. Many of the commenters who were not also bloggers left comments at a number of blogs, contributing different ideas to different discussions, or reiterating a single position throughout the linked discussion. For the textual analysis that follows in each case below, I focus on blog posts and comment threads because that is where the most extensive discussions occur. However, I want to reiterate that these discussions are further enhanced by the use of other social media outlets that provide venues to direct readers to the blog conversations and ways for fellow advocates to form a more tangible social network, by becoming friends on Facebook or followers on Twitter (Figure 17).



**Figure 17: This is a “network map,” showing the connections among Twitter users who used the #nihvbc tag the week of the conference. The blogger who posted the image pointed out how many of the users overlap, demonstrating the interconnectedness of the community (at least as defined by their social media usage) (Smith).**

Facebook, Twitter, email list-servs, and message boards often served as the engines that got the word out quickly—that promoted action—while the blogs provided a venue for the participants in the action to analyze the event after it happened. Looking at these two events side by side shows both the limits and the potential of online activism: in the first case, we will see how social media users engage in an action that has little potential to instigate a dialogue with the institution at which the action is directed; yet, at the same time, the conversation following the action relies on discourse that challenges institutional authority primarily by disrupting the boundaries between data and narrative, between scientific and experiential knowledge, between objectivity and bias. In the second case, members of the birth advocacy community online participated in a dialogue structured by a government-run agency. Though not invited as official members of the press, their writings before, during, and after the event preserve their influence on the conversation in the digital archive. Especially as the primary topic revolves around women’s rights within the health care system, the conversations emerging around this event illustrate the way that the current medico-legal system is set up to position the interests of many women in conflict with the interests of physicians. Further, they show that discourse based on general rights, rather than on the specific context of the American medical system, is insufficient to overcome that conflict without widespread systemic critique.

### **A Case of “Bad Data”: Women Respond to ACOG’s Home Birth Survey**

In August of 2009, the American College of Obstetrics and Gynecology (ACOG) posted a survey on the front page of their website entitled “Complications Related to Home Delivery” (Figure 18). The opening description read:

### Complications Related to Home Delivery

The American College of Obstetricians and Gynecologists is concerned that recent increases in elective home delivery will result in an increased complication and morbidity rate. Recent reports to the office indicate our members are being called in to handle these emergencies and in some instances have been named in legal proceedings. To attempt to determine the extent of the problem, a registry of these cases will be maintained at ACOG on a year-by-year basis.

If you have been called to attend, whether in the emergency room, operating room or labor and delivery suite, a patient who came to your hospital after an unsuccessful attempt at elective home delivery, please complete the following survey even if there was no adverse outcome. Include only current events after June 15, 2009.

State:	<input type="text" value="Select State"/>
Month / Year of Delivery:	<input type="text" value="Select Month"/> <input type="text" value="Select Year"/>
Gravida:	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 or more
Para:	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 or more
Maternal Age:	<input type="radio"/> Less than 20 <input type="radio"/> 20-25 <input type="radio"/> 25-30 <input type="radio"/> 30-40 <input type="radio"/> Greater than 40
Gestational Age:	<input type="radio"/> Less than 30 weeks <input type="radio"/> 30-36 weeks <input type="radio"/> 36-40 weeks <input type="radio"/> Greater than 40 weeks
Problem:	<input type="checkbox"/> Cord Prolapse <input type="checkbox"/> Obstructed Labor <input type="checkbox"/> Malpresentation <input type="checkbox"/> Multiple Pregnancy <input type="checkbox"/> Postpartum Hemorrhage <input type="checkbox"/> VBAC Rupture <input type="checkbox"/> Placenta/Abruption <input type="checkbox"/> Infection <input type="checkbox"/> IUGR <input type="checkbox"/> Preterm Labor <input type="checkbox"/> Prolonged Rupture of Membranes Other: <input type="text"/> (please list)
Fetal Outcome:	<input type="checkbox"/> Fetal/Infant Death <input type="checkbox"/> Fetal/Infant Major Injury <input type="checkbox"/> Maternal Death <input type="checkbox"/> Maternal Injury <input type="checkbox"/> Successful Delivery
Pre-Arrival Length of Labor:	<input type="text" value="Select Length of Labor"/>
Home Attendant:	<input type="text" value="Select Home Attendant"/>
This survey IS NOT collecting any identifying information from the respondents. To help detect accidental duplicate submissions, please select the numeric value of your birthday month + day. (optional)	For example: April (4) + 19 = 23. <input type="text" value="Select Value"/>
<input type="button" value="Submit"/>	



**Figure 18: Screen shot of the survey at the ACOG website before it went behind password protection**

The American College of Obstetricians and Gynecologists is concerned that recent increases in elective home delivery will result in an increased complication and morbidity rate. Recent reports to the office indicate our members are being called in to handle those emergencies and in some instances have been named in legal proceedings. To attempt to determine the extent of the problem, a registry of these cases will be maintained at ACOG on a year-by-year basis. If you have been called in to attend, whether in the emergency room, operating room or labor and delivery suite, a patient who came to your hospital after an unsuccessful attempt at elective home delivery, please complete the following survey, even if there was no adverse outcome. Include only current events after June 15, 2009. (qtd. in Jill-Unnecesarean; Figure 18)

The survey contained fields for State, Month/Year, Gravidity, Parity, Maternal Age, Gestational Age, Problem, Fetal Outcome, Pre-Arrival Length of Labor, and Home Attendant. The final field in the survey read, “This survey IS NOT collecting any identifying information from the respondents. To help detect any accidental duplicate submissions, please select the numeric value of your birthday month + day (optional).” Every field contained a predetermined list of answers to choose from, and the “Problem” field was the only one with a blank field available for respondents to enter text themselves (Figure 18).

On Thursday, August 27, 2009, the Communications Director for The Big Push for Midwives Campaign sent a message to members of the campaign’s email list alerting them to the ACOG survey and urging women to fill in the survey with their own birth information. The message read:

Tell ACOG your birth story! ACOG has a new database to collect anonymous data on “unsuccessful home births.” Let’s flood the database with entries on SUCCESSFUL home births! It will take less than five minutes, but having even 25 people do it will send a loud and clear message and may force them to take it down due to bad data. At the very least we can force it into the members-only area, where far fewer OBs will bother to fill it out. . . .Thanks for taking a few moments to do this action. It’s quick, easy and best of all – let’s [sic] ACOG know about all of the positive home births that happen every day! (qtd. in Jill-Unnecesarean)



The message also included specific instructions about what to fill in for each question. The call was circulated widely on other list-servs, message boards, Facebook, Twitter, and blogs authored by midwives and other birth advocates. Less than 12 hours later, the survey had been password-protected so that only ACOG members could access it. As this was discovered, participants in the online communities updated the message boards with announcements that the interference had worked (“Tell ACOG”; Figure 19).



**Figure 19: Message board at *Café Mom* where the Big Push message was posted (“Tell ACOG”)**

By the following Monday, after The Big Push sent out a press release with the title, “Viral Internet Campaign Exposes Bogus Research on the ‘Problem’ of Increased Demand for Midwife Care,” online news sources like *The Huffington Post* had picked up the story (Roth), and birth bloggers were following up with interpretations of the survey take-down and its implications, including passing around a tongue-and-cheek revision of the original survey, “Complications Related to Hospital Delivery” (Figure 20).

### \*Complications Related to Hospital Delivery\*

We at Doula Birth are concerned that high rates of elective hospital delivery have resulted in an increased complication and morbidity rate. Reports from clients indicate that doulas are being called in to try and prevent these emergencies, and in some instances doulas and doula organizations have even suggested legal proceedings against the hospitals and doctors that seem unable or unwilling to learn from and address the deficiencies of their practices. To attempt to determine the extent of the problem, a registry of these cases will be maintained by Doula Birth on a year-by-year basis.

If you have attended a patient who came to you after an unsuccessful attempt at elective hospital delivery, whether in the emergency room, operating room or labor and delivery suite, please complete the following survey even if there was no adverse outcome. Include only current events after June 15, 2009.

#### **Gestational Age at Induction:**

2nd trimester - 1 month before due date - 2 weeks before due date - on due date - she's late, she's late for that very important date

#### **Length of Labor Prior to C-Section:**

Scheduled prior to labor - less than 30 minutes - less than an hour - Seriously they let it go that long?

#### **Guesstimation of Fetal Weight Prior to Induction:**

Off by: less than a pound - 1-2 pounds - Greater than 2 pounds - "Ma'am based on the ultrasound we think you're carrying twins."

#### **Dilation Prior to Epidural:**

> 8 cm - 6-8 cm - 4-6 cm - 2-4 cm - 1-2 cm - why wait?

#### **Number of Hospital Attendants:**

A basketball team (5) - A baseball team (9) - A soccer team (11) - Bring on the marching band

*This survey \*IS NOT\* collecting any identifying information from the respondents. To help detect accidental duplicate submissions, please select the numeric value of your birthday month + day, divide by the square root of your home address, and subtract the absolute value of the ACOG minion that came up with their survey in the first place.*

For example: ((April (4) + 19) /  $\sqrt{5922}$ ) -  $\frac{1}{2} - 25\frac{1}{2} = -24.07$

#### **Problem:**

(check all that apply)

Convenience Induction

Artificial Rupture of Membranes

Augmented Labor/Pitocin to Distress

Defensive Medicine (e.g., procedures designed merely to prevent lawsuits)

Epidural Induced Fever

Episiotomy

Formula Supplementation

Healthy Baby Removed From Mother Post-partum

Healthy Baby Sent to Nursery

Iatrogenic Infection

Major Abdominal Surgery ("C-section")

No Continuity of Care

Profit Driven Healthcare (e.g., unnecessary tests/procedures)

Protocol Driven Healthcare (e.g., mandatory IV, monitoring, etc.)

High-tech/low-touch care

## Figure 20: Parody of the ACOG survey, created by doula Tabaré Depaep

A careful look at the blog posts and comments written in the week or so after ACOG removed the survey from the public domain reveals a consistent theme: the tension between science and narrative, between "data," often assumed to represent objectively true information, and "stories," which depend for their authenticity and usefulness on the ethos of the speaker. This tension emerges largely out of the professional animosity between obstetricians and midwives: one of the primary ways women criticized the ACOG survey was that it was unscientific, which seemed ironic coming from an organization that campaigns vigorously against midwife-attended home birth, purportedly because there is no good scientific evidence

to prove its safety. For an organization that claims to be dedicated to evidence-based medicine and the safety and health of women, the survey in question seemed disingenuous to many of the women who wrote about it. In the post where she included the screenshot of the survey before it went behind password protection,<sup>44</sup> Jill at *The Unnecesarean*, wrote:

After reading the angry comments from doctors on blogs like KevinMD.com a few months ago about online doctor rating sites, ACOG's survey made me laugh a little. One doctor asked, "Isn't our issue with pseudoscientific surveys per se that do nothing except provide advertising space for those 'fine young men and women (God knows, you got to love them') - as we say in the south - who turn a dollar based on the ignorance and ill will?" Another called them "unscientific crap." One person's crap is another person's attempt to paint an overly negative portrait of home birth and women's health care options in the name of protecting its members from unnamed phantom lawsuits, I suppose. (Jill-Unnecesarean)

Wendy, CPM, commenting on a post at *Our Bodies Our Blog (OBOB)*, points to the exact language of ACOG's opposition to home birth as evidence of their commitment to scientific rigor:

I find it particularly hypocritical of ACOG to claim in their Statement on Home Births that 'studies comparing the safety and outcome of births in hospitals with those occurring in other settings in the US are limited and have not been scientifically rigorous,' and then throw up a completely anonymous, unverifiable, highly-biased questionnaire on their website for use in collecting anecdotes.

Commenting on the same post, MomTFH agrees: "ACOG said it was planning on using the data to 'determine the extent of the problem.' Not only was their technique of soliciting stories on the internet from ob/gyns unscientific, but there is inherent bias in their call for submissions. Science fail." Part of what these women find troubling is what they view as ACOG's motivation for the survey, which they assume to be for the purpose of creating narratives and calling it science. (The survey itself does not make any claims about its scientific rigor, and there is no

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<sup>44</sup> She captured the screen shot of the survey during its brief window of public availability and kindly forwarded me the copy included here.

information available on the website other than the introductory language preceding the survey to indicate how ACOG plans to use the information collected.) The survey “fails” to meet the standard of science for these writers, both because there seems to be “bias” involved in the solicitation and because there is no way to identify the survey respondents to determine their reliability. Science, as it is figured here, represents unbiased information collected from credible sources.

Though this view of science—as a fixed body of information, accessible only if presented by a reliable, unbiased source—is implicit in many of the posts and comments about the ACOG survey, other uses of “science” in this conversation reveal it to be more fluid and subject to interpretation. Even as these women accuse ACOG of eschewing scientific methods of data collection, they also regularly interpret scientific data differently than medical institutions, an act that in itself points to the rhetorical nature of scientific knowledge. The blog *Science and Sensibility*, hosted by Lamaze International, for instance, is based on the idea that women can best prepare for their births by understanding how to read and interpret medical research. The authors regularly come to different conclusions than the professional medical community does. In her post about the ACOG survey, former editor Amy Romano writes about how “evidence” is a tricky beast of burden when it comes to home birth:

ACOG prefers to hold home birth to a standard of evidence to which hospital birth was never held. Even while actively compiling the lowest form of evidence on the supposed “perils” of home birth in a membership survey, ACOG repeatedly calls for a randomized controlled trial comparing perinatal death rates in the two settings, fully aware that such a trial is literally guaranteed never to happen. (“Home Birth”)

What Romano’s critique indicates is that any understanding of data, regardless of how it is collected, depends primarily on how that data gets communicated, not on what that data “really is.” In other words, science and the right to interpret it form a hotly contested space between

birth advocates and ACOG. If scientific evidence is subject to interpretation and misinterpretation, then, despite the figuration of science as a knowable (and implicitly static) entity, the very act of interpretation demonstrates that it is, instead, inseparable from the discourse used to communicate and understand it.

What rhetoricians of science have argued, of course, is that there can be no final separation of any discrete body of knowledge called science and the discourse used to communicate that knowledge. To recall Leah Ceccarelli's argument, "Texts. . .when scrutinized through the lens of rhetorical inquiry, are neither reducible to 'mere' words nor understood as straightforward reflections of some deeper reality; instead, the scholarly practice of rhetorical criticism always treats texts as a convergence of discursive opportunities and material constraints" (316). According to birth bloggers and commenters, the problem with ACOG—and with professional medicine in general—is that it purports to be a scientific enterprise, relying on "straightforward reflections of reality" to create its policies, rather than admitting that stories and their multiple interpretations play a part in medical practice as well. This implicit critique of medical science echoes Katherine Montgomery Hunter's formulation of medicine as a discipline in which narratives constitute the primary knowledge-making structures. What becomes clear from other responses to the ACOG survey is that birth advocates value storytelling as a powerful and much-needed addition to trustworthy scientific evidence in creating knowledge about birth and maternity care.

In fact, the way the call to corrupt the data collection methods of this survey is worded and discussed afterwards indicates that the way to interfere with the production of "bad" science is through the creation of narrative, to "tell ACOG your birth story." A quick look at the survey itself shows that there is no room for them to do any such thing: they can certainly fill in

answers to the questions, but with only one field available for user-typed entries, there is little room for storytelling. The assumption, then, is that filling in data for successful home births with answers that do not fit within the expected range of responses is itself a narrative act. It also implies that in the scope of the survey, ACOG will consider such responses “bad data,” as the press release calls it. The assumption is that what ACOG would consider “good data” will be authored by physicians and, importantly, that such data will provide evidence of unsuccessful home birth attempts. Many of the women writing about the survey indicate that they believe that ACOG is collecting this data for the express purposes of crafting anti-midwife, anti-home birth rhetoric, that multiple-choice answers to a supposedly scientific survey eventually will be woven into a web of stories they will use in their lobbying efforts against home birth. Commenting on the post at *OBOB*, Nicole Deggins writes:

I am very angry about the tactics ACOG is using to undermine women and this “survey” of sorts really seems to be unethical. It will hold no REAL weight as a research study yet we can be sure they will use the responses to formulate policies and create opinion statements that continue to scare women into the “what if” category. In light of the new study released from Canada it’s even more shameful. They are not even looking at the research yet call themselves a professional medical organization. They are operating more like a Birth Cartel if you ask me.

Emjaybee makes a similar point in the comments thread at *The Unnecesarean*:

This isn't “collecting data” this is an online survey. Which is the opposite of good data, because of how easy it is to skew. Nothing is verifiable, therefore there is no trustworthy data to be gleaned this way. And since doctors have those degrees and all, you have to assume they know this. And that therefore they are not actually interested in viable data, and were hoping for something to use as a political football.

Narrative, like science, becomes heavily contested territory. Whose stories matter in the meaning-making about home birth? Whose interpretation of the “data” counts? Rachel, posting at *OBOB*, for example, writes, “Such a survey can produce anecdotes about provider

experiences, but is unlikely to add much to the knowledge base about home birth and transfers in the absence of more comprehensive data collection – it’s simply not a well-executed scientific survey.” The problem is not narrative itself; the problem is that narratives of providers’ experiences are the only ones being collected. Many of the women who wrote responses to this incident seem to want their stories to matter too.

This desire to have their stories valued in creating a more accurate picture of home birth appears in the way many of the commenters frame their response to news of the survey with details from their own experiences. Commenter Heather Hall, for instance, writes a lengthy response to the *OBOB* post, indicating that the problem, as she sees it, is the lack of communication and collaboration between obstetricians and midwives. She writes that she is a midwife-in-training who has seen hospital transfers go badly because the physician refused to listen to the midwife or the caregiver, assuming instead that the mother had been poorly cared for: “Again and again, I have heard of women being abused when seeking medical assistance. I am one of these women.” She goes on to tell her very detailed story of being transported to a hospital after her home birth in order to have vaginal lacerations repaired and being isolated and subjected to many procedures without her consent by the attending OB. She concludes,

If only our medical providers would work in concert with our home birth midwives, they would see the good care we offer, and be less frantic when a transport needs to occur because they would have had the opportunity to meet the mother and review her case. People would be less hesitant to transport because the horror stories would be far fewer.

Both affirming the need for women’s stories to be heard and valued by the professional medical community and criticizing the circulation of “horror stories” among physicians, this commenter reveals that narratives are central to the way the maternity care system operates, especially the relationships among differently trained caregivers.

Not all of the bloggers or commenters were optimistic about the potential for telling their birth stories in the form of a survey to have any impact on ACOG. One blogger, Navelgazing Midwife, came to the defense of the organization, arguing that the survey demonstrates the extent of professional animosity OBs harbor against midwives. She revises the introductory language in the survey to more accurately reflect what she believed were the organization's intentions: "We know that we have to take homebirth transfers, but it puts us in an unfortunate place of cleaning up the midwife's mess. . .including our being sued when the midwife should be the one being sued, not us. Please fill out this short survey so we can demonstrate how pervasive this problem is." She starts her post with an enthusiastic report of what happened:

When us crazy natural birth folks got wind of this, we dashed to the website during its brief public moment and filled it out for our own births. As a midwife, I also filled it out for my July baby, a wonderful home-waterbirth. I know the HBAC [Home Birth After Cesarean] women flocked there, too. While I wish we'd had longer to make an impact, I love that we did make one so graphically that they felt they had to block us out. We are some noisy women! Hurrah for us!

She tempers that enthusiasm (or cues her tongue-in-cheek, depending on how one reads her tone) later in the post by trying to imagine, from the point of view of obstetricians, why this survey was put up in the first place: "While we all are thrilled with our wonderful homebirths and so many of us got our voices heard on their site yesterday, it is important to remember they have a reason, a valid reason, for wanting to hear from their constituency." That reason, according to this midwife, is litigation:

What has happened is some of the women who have transferred to the OB's care have had negative outcomes and sued the doctor. That has to be incredibly frustrating for them. Where does the line between midwife negligence and doctor negligence lie? . . . If you believe as I do that no one was responsible [for a bad outcome], that isn't the point. A mother with a sick baby tends to want to blame someone; who gets it? What I think happens is that doctors are sued much more because of the relationship aspects a midwife develops with her clients. It has



long been known that women rarely sue their midwives. If anyone sues midwives, it is the State. But, for a homebirth family, the doctor is an unwilling scapegoat.

The work of medical anthropologists like Melissa Cheyney illustrates why even one case of a doctor being sued because of a home birth transfer can be so impactful. Her research shows that in Oregon, where she lives and works as a midwife, there is a great deal of mistrust between doctors and midwives primarily because of what she calls the “birth story telephone,” in which doctors spread stories of home births gone wrong among each other that bear little, if any, relation to reality. In one case, a group of doctors reported that they had heard of three infant deaths within a year’s time as a result of home birth, but when pressed for details, they could not name the physician who had attended these events. After digging through hospital records across the state, Cheyney and her co-researchers found not a single case of infant death after a home birth transfer (Cheyney and Everson).

In the end, what participants in the birth advocacy community acted on in responding to the ACOG survey was the impulse to have their stories heard and valued. Women and midwives who have participated in home births particularly seemed to want to add their corrective narratives to the negative stories they feared would pour in from doctors. Many birth advocates also stated their wishes to demonstrate that ACOG is not a trustworthy organization because it uses claims of science only when it suits the needs of its constituents. The critiques of ACOG are not that they sought narratives to understand the issue of home birth safety. The problem is that they sought stories from the wrong sources for the wrong reasons, under the auspices of science. Birth advocates’ arguments call not for the dismissal of science in medical practice and policy but for a balance between scientific evidence and the importance of individual women’s stories.

Whether or not the so-called “bad data” will have any effect on how the survey results are used by ACOG remains to be seen. What is clear is that the creation of knowledge about childbirth is not the exclusive domain of an institution; online media makes it possible for women to circulate their own versions of what childbirth should mean, who should manage it, and how it should be articulated. They are also, as is clear from these discussions, invested in defining and redefining what we mean when we say “scientific evidence” and who has the right to interpret and disseminate it.

### Consensus or Conflict: The NIH Conference on VBAC and the Need for a Shared Discourse



**Figure 21: A post at *Science and Sensibility*, including a screen shot of a tweet the author sent during the first day of the NIH VBAC conference (Romano, “Will the NIH”)**

If the ACOG survey incident in August 2009 revealed that many women reading and writing about birth online want for their stories to matter in the creation of maternity care policy, a government agency-run event the following spring seemed like it might provide just such an opportunity. The National Institutes of Health convened a three-day conference in March 2010 dedicated to developing a consensus resolution on the safety and accessibility of

VBAC, or vaginal birth after cesarean. The NIH assembled a panel of experts who presented research findings and made recommendations, including journalist Rita Rubin, who was charged with presenting the stories of individual mothers affected by VBAC limitations.

The image shows a screenshot of the NIH Consensus Development Program website. At the top, there is a blue banner with the text "U.S. Department of Health & Human Services • National Institutes of Health" and "NIH Consensus Development Program" in white. To the right of the text is a green circular icon with a white arrow. Below the banner is a navigation bar with links: "Home", "About Us", "Previous Conference Statements", and "FAQs".

Below the navigation bar, there is a blue button that says "Pre-order This Statement". To the right of this button is a yellow graphic with a tree-like structure of icons representing various aspects of healthcare and child development, including a duck, a teddy bear, a stethoscope, a baby, a rocking horse, and a person. Below the graphic is the text "vaginal birth after cesarean: new insights" in orange and blue.

Below the graphic, there is a blue button that says "View Statement". To the left of the graphic, there is a list of links:

- Conference Home**
- Final Statement | PDF
- Program & Abstracts | PDF
- Archived Webcast Day 1 | Day 2 | Day 3
- Evidence Report
- Planning Committee | Panel
- Sponsors
- Agenda
- Additional Information

**Figure 22: Available archives of the conference proceedings on the NIH website**

Conference registration was open to the public, and the NIH utilized digital media to make the conference proceedings publicly available to anyone with an internet connection by streaming a webcast in real time from the NIH website. They also released a draft of the consensus statement online and invited the public to submit questions, revisions, or suggestions about any part of the document before the conference ended. A full version of the final consensus

statement, the evidence report, webcasts of thirteen hours of conference footage, and information about the panelists, sponsors, and conference planners is all archived at the NIH site (“NIH Consensus”; Figure 22).

In addition to the official record of the conference, one can also find reports of the experts’ testimonies and the final statement in traditional news media sources. However, an online search for “NIH VBAC conference” yields few links to professional news organizations. Besides results linking to the NIH site, most of the highest-ranking results point not to journalists’ coverage of the event (which were fairly widespread) but to discussion about the conference on blogs.<sup>45</sup> There was also considerable activity on Facebook during the conference, as well as what one blogger called “eleventy-billion tweets” with the #nihvbac hash tag (Walden).

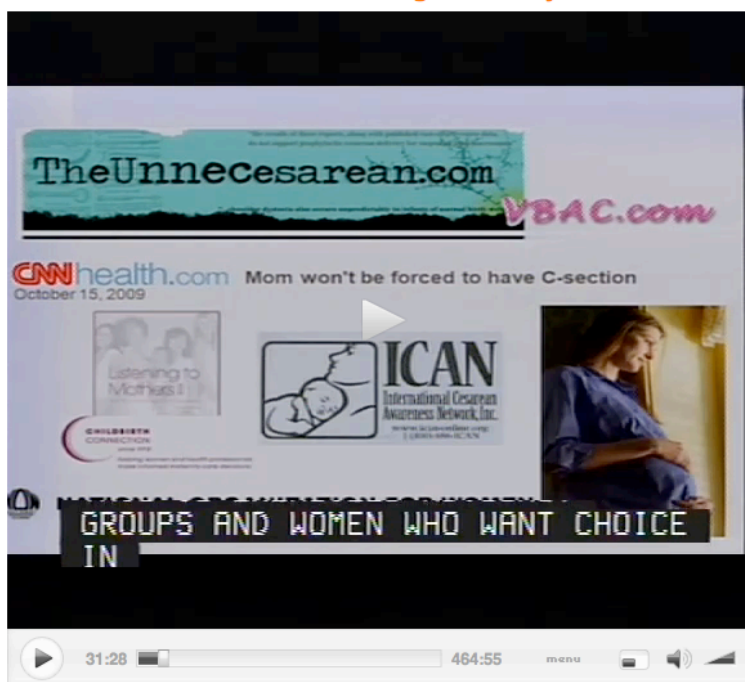
Many bloggers in the birth advocacy community attended the conference and others blogged and tweeted while watching the webcast in real time. The picture that opens this section (Figure 21) shows a blog post by Amy Romano at *Science and Sensibility*, one of the primary sites of conversation about the conference in the birth blogosphere (“Will the NIH”). The tweet she reproduces refers to a slide during the first Power Point presentation of the conference, in which the speaker, Caroline Signore, pointed to an energized population of women who are increasingly dissatisfied with their choices about birth after cesarean. To demonstrate this point, Signore stated that “their stories have been published widely in the national media, and there’s an active blog community in the internet” (“NIH Consensus - Day 1”). A blogger in the audience, Gina Crosley-Corcoran of *The Feminist Breeder*, snapped a photo of the slide

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<sup>45</sup> I realize that search engine results change constantly, so this claim is based on my use of three different search engines on a particular day; I have included screen shots of the results in the Appendix.

featuring the blog header of *The Unnecesarean* and logos from childbirth advocacy groups Childbirth Connection, VBAC.com, and ICAN, all of which maintain an online presence (Figure 23).

*NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights - Day 1*



**Figure 23: Power Point slide from Caroline Signore's presentation, showing that women are communicating their dissatisfaction with VBAC options (Romano, "Will the NIH")**

Crosley-Corcoran uploaded the photo to her Twitter feed and shared it with the author of *The Unnecesarean*; it was posted on her blog immediately (the post is time-stamped 8:13 a.m.), cross-posted on her Facebook Fan Page, and appeared on *Science and Sensibility* by the end of that day in the post pictured above (Romano, "Will the NIH"). What this small image and its circulation illustrates is both the immediacy digital media affords and its potential to instigate a public discussion. The slide shown was up on the projector at the conference for fewer than five seconds, and the blogging community was mentioned only once in seven hours and forty-four minutes of presentation and discussion from the first day. But for followers of *The*

*Unnecesarean*, of Romano's or *The Feminist Breeder*'s Twitter feed, it is possible that it seemed the panelists were acutely aware of women's writing online and that their contributions would be considered in the proceedings. Indeed, Romano asks in her post, "Have the NIH panelists been reading our blogs? And should they?"

As my analysis of the online record of the conference will show, regardless of whether the panelists themselves are aware of the birth blogging community, the discussions that occur in those spaces are now part of the discursive record, and they contribute to the story of what birth meant in March 2010, particularly vaginal birth for women with previous cesarean sections. What stories do those texts tell? It is impossible to answer that question with any sort of unified response, other than to say that there are clearly many contentious issues at work in determining the VBAC discourse, and there are clearly many people invested in shaping that discourse. The record<sup>46</sup> of the conference and its import on the internet includes: a "blog carnival" preceding the conference, hosted by the International Cesarean Awareness Network (ICAN), which features the stories of women for whom access to VBAC has been an important issue; a three-part blog talk radio show, dedicated to VBAC and the conference and hosted by Crosley-Corcoran of *The Feminist Breeder*; a network of blog posts and comments threads ranging across dozens of blogs; a stream of hundreds of tweets; and discussions on some of the blogs' Facebook fan pages and in the forums of websites like *Mothering.com* and ICAN. In order to determine which issues were most prevalent in the online debate, I read through the posts and comments threads I could locate, as well as through the tweets marked with the

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<sup>46</sup> Of course, nothing online can be considered an absolutely permanent record, as site owners can remove or revise content from the public domain at any time. I have preserved all of the pages I am analyzing in PDF.

#nihvbac tag, the Facebook discussion on *The Unnecesarean* fan page, and the discussion at the ICAN forums.

Before I get to the analysis of these texts, some background on the controversy surrounding VBAC will help provide the context for the perspective of the medical community and of the women unhappy with that perspective. As the cesarean rate in the U.S. has continued to climb, public health officials, childbirth advocates, and many obstetricians have expressed a desire to reverse that trend, especially because the optimal c-section rate recommended by the World Health Organization for industrial societies is 5-10%. The rate for 2008 was 32.3% in the United States.<sup>47</sup> One strategy for reducing that rate is to make efforts to limit the number of women undergoing surgery for their first births. The other, and the focus of the NIH conference, is to reverse the sky-high subsequent section rate: the percentage of women with prior cesareans giving birth via surgery in subsequent pregnancies was 92% in 2006. That number has climbed even more sharply than the overall cesarean rate, and the primary reason seems to be the medical and legal climate surrounding VBAC.

While there was a brief period in the 1980s when VBAC was considered a safe option by the medical community, a 1999 ACOG practice bulletin indicated that that view had shifted. The wording changed from “encouraging” VBAC to “offer[ing]” what they called a “trial of labor” for low-risk women (Block, *Pushed* 87). The use of the word “trial” indicates the wariness with which the obstetric community approached the issue: women attempting to birth vaginally would be on trial, constantly under surveillance. The shift between “encourage” and

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<sup>47</sup> In my summary of background information necessary to understand the responses to the conference, I am drawing this and all following statistics from the consensus statement produced at the conference (Cunningham et al.), and from the evidence report, *Vaginal Birth After Cesarean: New Insights*, commissioned by the NIH for the conference and published alongside the final statement on the conference website.

“offer” may seem slight, but the part of the bulletin that had far more wide-reaching consequences was the stipulation that any hospital offering VBAC must be equipped for an emergency cesarean “immediately,” rather than “readily” as the earlier guidelines stipulated (87). In practice, this would mean doctors would have to be on the hospital premises for the entire labor of a VBAC patient and that an anesthesiologist would need to be in house and an operating room ready and available at all times. That standard is simply too high for many hospitals to meet, and so in the last decade, fewer doctors have agreed to attend VBACs and many hospitals have unofficially banned the practice. According to the final document produced by the NIH panel, since 1996, about a third of hospitals and half of all physicians have stopped offering a trial of labor to a woman with a prior cesarean (Cunningham 8).

The reason for the special treatment of VBAC cases is the risk of uterine rupture, in which the uterine muscles separate, often at the scar site, during delivery. Though relatively rare, a rupture can be catastrophic, and perinatal death is one possible, though extremely rare, outcome.<sup>48</sup> However, as birth advocates have worked hard to point out and as the panel also found, the risks for repeat cesarean delivery are also worth considering. The controversy involves who decides how much and what kind of risks are acceptable and who bears the responsibility when risk becomes reality. One possible reason for the ACOG recommendation in 1999 was to protect physicians from being sued over a dead or injured infant after a VBAC attempt, and the panel emphasized the need for more research about the medico-legal factors

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<sup>48</sup> The review of existing research presented in the panelists’ statement found the rate of rupture for women who attempted a trial of labor to be around 4.7/1,000 women, and 6% of those cases resulted in perinatal death, though the researchers indicated that more research was needed to come to a firmer conclusion about the actual risk of rupture (*Vaginal Birth* 56). By comparison, the risk for repeat c-section is the risk of maternal death, at a rate of 9.6/100,000 (48).



constraining VBAC, including the impact of malpractice insurers who raise premiums or refuse coverage for doctors and hospitals offering VBAC (Cunningham et al. 32).

Obviously, arriving at a “consensus,” given the myriad of medical, legal, and ethical dilemmas tied up in the situation of women seeking medical care for pregnancies after a cesarean, is a tricky proposition. The extensive discussion on the blog I will look at points to the difficulty in debating these dilemmas primarily because the current medico-legal system is set up to position the interests of many women in conflict with the interests of physicians. It also, however, reveals the way that dialogue, especially dialogue that illuminates how terms are being used differently by different communities, can point towards the ways that discourse works to shape material conditions.

By far, the most prevalent responses from birth advocates contained two ideas: first, many bloggers and commenters express enthusiasm that the NIH’s review of the existing data corroborates the perspectives of most birth advocates in recommending that a “trial of labor” is a safe and reasonable option for most women with a prior cesarean. The second, less enthusiastic response, is that this recommendation is relatively meaningless without clearly defining the meanings of informed consent and refusal, liability and negligence, and the rights of both childbearing women and professional caregivers who attend them. At one of the most-commented-on posts, which garnered 99 comments in four days, the discussion centered on the question of the rights of pregnant women when it comes to VBAC and on malpractice insurance and liability issues for physicians attending VBACs.

A post written a few days before the conference began at *Science and Sensibility* by Henci Goer, author of *Obstetric Myths and Realities* and *The Thinking Woman’s Guide to Childbirth*, brings to light several key terms that play a role in defining this issue. Perhaps, the

post was intended to preemptively set the parameters for online debate before the conference even began. Based on her reading of the presentation titles and abstracts and what she knew of the presenters' positions on these issues, Goer speculated that the primary gap that would be left by the panel's findings would be in affirming a pregnant woman's absolute right to refuse surgery. In a post called, "The NIH VBAC Consensus Conference: Will It Pave the Road to Hell with Good Intentions," Goer reviews some of the literature related to VBAC and repeat cesarean, indicating that she believes the panelists will provide "solid, evidence-based information on for whom and under what circumstances VBAC is safest and most likely to end in vaginal birth." What worries her, however, and what she spends the rest of the post discussing is what she finds missing from the conference program: "any acknowledgment of a patient's fundamental right to refuse surgery." She goes on to list a number of rhetorical choices that illustrate the importance of establishing such a right, including the panelists' use of patient and provider "preferences"; the use of the term "procedure" to describe VBAC; and the language of maternal-fetal conflict that implies that a woman's choices would somehow be in conflict with the safety of her baby. Many commenters affirm her position, reiterating and expanding on some of these points. One writes,

I had my first baby as an emergency c-section but am hoping to have 5+ more kids, which would probably be impossible if I can't do VBACs [because the risks of complication increase with each cesarean]. The 'physicians preference' may not just result in me being denied the opportunity to avoid unwanted and possibly unnecessary surgery; it may deny me the option of choosing for myself how many children to have! (Maman A. Droit)

This comment points to the idea that preferences may vary according to different understandings of "risk"; the risk of having to limit one's family size may not be worth considering from the perspective of a physician who thinks of risks as those things that could happen immediately, like injury to the woman or baby. When a patient's preferences include

considerations of the long-term effects on her and her family and a physician's preferences are based on more immediate factors, making a decision based on both is difficult, especially if "risk" is defined by the doctor's perspective without any input from the woman.

On the idea of VBAC as a procedure, MacroMama writes, "If we have a right to give birth, we have a right to VBAC. VBAC is not a procedure, it is just birth. We have a right for pregnancy to come to its natural end via vaginal childbirth." The question, though, is whether women also have the right to medical care while they are experiencing the "natural end" to a pregnancy. Many medical professionals argue that they have the right to refuse to care for women in this situation, especially if their malpractice insurance does not cover that care. In this instance, VBAC is not considered a medical procedure by the birthing woman, but it may be by her caregivers and by insurers.

That discrepancy leads to the issue of rights. Goer is unequivocal in her position:

VBAC is a right, not a preference, a right, let me add, not abrogated by the clinician's opinion or its wisdom. It does not matter if you, me, and everyone on the planet were to line up and say to a woman VBAC is a bad idea in your case, she still has the right to say "no" to surgery. Clinicians and institutions must be brought to accept their ethical and professional obligation to provide best practice care to every woman wanting planned VBAC. If the conference fails in this task, then whatever it accomplishes, it will fall short of its duty to childbearing women with previous cesareans. ("The NIH")

While many commenters agree, one offers a dissenting opinion, based on the conflict between the right of the patient and the rights of different players in the system:

That [the right to refuse surgery] is a negative right, and it's very different than a "right" to have a VBAC. Moreover, doctors have a right to refuse to care for patients who will not take medical advice and hospitals have a right to refuse admission to those who will not sign a consent form for care. Most importantly, malpractice insurers have a right to deny coverage to obstetricians who perform VBACs. And it is that right that is responsible for the current situation. (Amy Tuteur, MD)

What she points to are systemic issues that cannot be adequately addressed by determining what women's absolute rights in this situation are without also considering how those rights will play out in the particular context of American hospitals. What emerges from the back and forth that this assertion catalyzes, some civil and well-reasoned and some bitterly divisive, is that one of the deeply rooted tensions working to frame this discussion of rights is a different understanding of doctors' roles and responsibilities and the assumption that "doctors," as a group, identify with and represent the medical system. Joy Szabo writes, "Ethically, the physician must respect the autonomy of their patient. In obstetrics, the patient is the mother. Not the insurance company, not the sue-hungry lawyers. Physicians are granted status in our society because they are assumed to serve the patients [sic] best interest, and not their own." Nicholas Fogelson, a practicing obstetrician, responds,

Henci has made a great point about negative rights, and that a hospital cannot tell you you aren't allowed to VBAC. This makes a great deal of sense and ought to be true, but it isn't. Hospitals are financial entities that need to make ends meet, and in many cases they lose money and rely on outside donations. The malpractice situation makes it such that providing VBAC is very expensive, with little financial return. While there are a million ethical/social reasons to provide VBAC, from a business point of view it may not make sense in some hospital's [sic] situations. Henci says that doctors and hospitals have an ethical responsibility to provide VBAC. While in an idealistic sense I agree, I am also willing to accept the financial reality of the situation. Hospitals do not have an ethical responsibility to lose money. Hospitals do not have an ethical responsibility to get their asses handed to them in court. Pretending these responsibilities exist and must be followed is to insist that some hospitals go out of business, which isn't good for people in general.

In a number of lengthy comments that follow this one, in response to questions and points made by other commenters, Fogelson repeatedly returns to the problems in the system that make VBAC a difficult thing for physicians to support. Others agree with him that physicians are not necessarily to blame for the lack of availability of VBAC, including a midwife who works alongside doctors in a hospital. She writes:

I personally know a number of obstetricians who wanted to continue to offer VBAC, believing in its relative safety, but were forced to discontinue this option for their patients due to the hospital not allowing it (the doctor would lose his/her privileges if s/he did not conform to hospital protocols), or because the increased insurance premiums charged for continuing to offer VBACs make it financially impossible to continue. The increase was \$60,000 in the case of one OB I know. We discussed whether she could continue offering VBACs “under the radar” by advising women to stay at home in labor as long as possible (not very responsible advice) and then refuse c-section when they came in to the hospital, thus forcing the OB to deliver the baby vaginally. The OB told me the insurance company had advised her that if she had too many “accidental” VBACs, her coverage would be terminated. I believe there are many OBs who, if they were truly free to do as they chose, would gladly offer VBACs. But with the current constraints placed upon them, requiring them to be continually present in the hospital for the duration of a VBAC labor, it becomes increasingly difficult to maintain a professional practice or have a personal life. (Birth Sense)

And yet, one commenter, Jennifer V., even after all of these responses, writes, “As always, change will not occur from within medical culture because, as seen on this page, some doctors just want you to believe that there really is no problem with the system, just difficult patients.” She conflates “doctors” with the “system” in a way that makes moving forward from that position essentially impossible, especially for individual physicians who want to participate in the discussion.

The cultural authority invested in physicians, as we saw in Chapter Two, is a powerful force shaping any discourse of medicine and health care. As the last quote above shows, if the public continues to understand doctors as the infallible arbiters of health and as controllers of, rather than participants in, the biomedical system, dialogue between medical professionals and patients is unlikely to produce anything other than assertions of one group’s rights against the other’s. However, in the space of the world wide web, dialogue is not limited to one blog or one comments exchange, and readers can follow a discussion throughout a network of related conversations. If those within the birth advocacy community continue to hammer out different meanings of terms like “rights,” “procedures,” and “risk,” what emerges is the way that fixed

meanings for those terms have been deployed in order to maintain the status quo. Discourse analysis, then, becomes a form of activism.

That is exactly what happened in the case of the VBAC conference. If Goer's post was intended to shape the discussion that was to come, it worked: nearly every blog post written by birth advocates in the days following the conference pointed to one moment in the final Q&A when Susan Jenkins, legal counsel for the Big Push for Midwives Campaign, participated in the following exchange with the ethicists on the panel:

SUSAN JENKINS: Ms. Zimmet, did the panel take into consideration any of the extensive legal and ethical literature on the issue of informed consent? Because to my understanding this morning—and to the great disappointment of many of the people in the audience—the panel did not take a position affirming that pregnant women should be considered persons with constitutional rights the same as any other adult persons and I am wondering. . . .Is the panel aware of the extensive, and very much pro-informed-refusal, literature among attorneys and law professors in this area?

SHEILA ZIMMET: Well yes, we did have conversations in that area. We focused on informed consent as a factor that influenced practice and patterns in access to trial of labor; we didn't see it as our task to resolve that issue and focus on that issue. We think we need to look at the informed consent issue and see what improvements there can be in communication between provider and patient, and tools that can be provided and developed to answer those issues, but we recognize that medico-legal issues involved in informed consent, constitutional issues and ethical issues really, are issues that are answered in a varying fashion in different states and we certainly weren't in a position to answer them in a consensus panel.

JENKINS: So in spite of Dr. Lyerly's ethical presentation yesterday, the panel is unwilling to affirm the ethical necessity of recognizing that a woman has an absolute right to informed refusal of a surgical procedure that may cause harm to her?

LARRY MCCULLOUGH: This is Larry McCullough, the ethicist on the panel. The claim that the right to refuse is absolute is a controversial claim, it's not at all settled in the law or medical ethics. And that controversy, which is considerable, is way beyond the scope of this group. We did however, strongly emphasize the need for an evidence-based, unbiased approach to the informed consent process to make sure women eligible for TOL [trial of labor] would be informed of that alternative and get the information they need to make their own decisions for themselves. There is a strong emphasis on the centrality of informed consent in our conclusions.

JENKINS: Dr. McCullough, just one quick follow up question, if I may, on that. The conclusions that are reached in the draft, at least the draft opinion that we saw this morning, indicate that the position of the committee is that only where it is considered “medically reasonable”—whatever that means—would the woman have a right to refuse. And the definition of medically reasonable. . .well, there is no definition of medically reasonable.

MCCULLOUGH: Well, actually, there is, and the concept is when the alternatives are roughly medically equivalent. What we said is that shared decision-making should be followed, where the physician refrains from making a recommendation and really helps the woman make a decision that reflects her values and preferences, which is the goal of the informed consent—

JENKINS: Right, and what if her values and preference is to say “no” at the end of all this?

KELLI MARCIEL: I’m sorry, this is Kelli, and we have a lot of people waiting on queue

JENKINS: That’s alright, they’re going to dodge the issue and that’s what I’m going to report to my readers. Thank you. (Courtroom Mama)

That portion of the Q&A was transcribed by a blogger who goes by Courtroom Mama, in her post at *The Unnecesarean* called “NIH VBAC Consensus Development Conference: Trojan Horse or Gift Horse?” and the sentiment her post expresses echoes Goer’s concerns posted a week earlier: outlining the rights of the pregnant woman to determine the course of treatment best for her and her family is an essential component to solving the problem of VBAC access. I have quoted the transcript from the conference at length because it reveals a conflict at the heart of this debate: the way birthing women are constructed in medical discourse and policy versus the way they themselves articulate who they are in relationship to the American health care system. But, is that the portion of the conference women would still be talking about days later if Goer had not written her post about the importance of the right to informed refusal? Would Susan Jenkins have asked that particular question if many Twitter users had not responded en masse to one panelist’s assertion that the rights of pregnant women were not a “settled matter” earlier that morning? Would *Reality Check*, a blog about reproductive rights, have devoted three separate posts to the conference if “rights” had not been framed this way?

While proving a causal link from one discursive event to another may not be possible (or desirable), what is clear is that the use of digital media to contribute the perspectives of birth advocates and individual women allows a more nuanced understanding of the significance of the conference than looking solely at the official institutional record of the event. And, the conversation continues: in July of 2010, a few months after the conference, ACOG issued a new practice guideline for VBAC, loosening up the restrictions on “immediately available” anesthesia, and making clear that “restrictive VBAC policies should not be used to force women to undergo a repeat cesarean delivery against their will” (“Ob-Gyns”). In the rhetoric of the press release, ACOG is careful to place the blame for the high cesarean rate and the decreasing VBAC rate elsewhere, stating that it “reflects the restrictions that some hospitals and insurers placed on trial of labor after cesarean (TOLAC) as well as decisions by patients when presented with the risks and benefits.” Yet, the organization also makes clear moves towards acknowledging the import of women’s perspectives in the decision-making process, with language like “shared patient-doctor decision making,” “the importance of patient autonomy,” and even considering the “context of [patients’] future reproductive plans.” How the practice guideline and the emphasis on women’s autonomy represented in the press release will affect individual hospitals, insurers, and physicians remains to be seen. But the discourse is there, and thanks to the birth blogging community, its relationship to their writings during and after the NIH conference did not go unremarked. Crosley-Corcoran wrote a post about the new VBAC guidelines the day after they were released. She concluded:

We did this. We made this change happen because we spoke up and insisted on being treated better. But the work is not done yet. Now, we must take this statement to our providers and hospitals and challenge those VBAC “Bans.” Send the statement to your sisters, coworkers, and friends who may be considering a VBAC. Write about it, talk about it, and keep spreading the



message until VBAC is no longer a four letter word. Change is coming. I can see it in the horizon. (“Breaking News”)

Whether or not ACOG would agree that their reassessment of VBAC was directly influenced by a grassroots effort coordinated by women writing online is beside the point. In the trajectory of VBAC discourse in 2010, the story is not simply the official word from an institution; it is a polyvocal dialogue made possible by digital technology and social media.

Not all online activism comes to such a tidy conclusion, of course. The ACOG home birth survey made only a brief appearance in the public sphere, and so far, the organization has not made explicit use of the results in any of its publicity surrounding home birth. It has, however, released a new meta-analysis of existing home birth data, the pre-publication publicity for which led with the study authors’ conclusion: “Less Medical Intervention for Home Birth Linked to Increased Neonatal Mortality” (Barclay). The abstract for the study, which was released months before the journal issue in which the article appeared, listed a number of other results, including that women who had planned home births were less likely “to experience lacerations, hemorrhage, and infections,” and babies born at home were less likely to experience “prematurity, low birthweight, and assisted newborn ventilation.” The single conclusion, however, was the “tripling of the neonatal mortality rate” the authors attributed to “less medical intervention during planned home births” (Wax et al). The Big Push for Midwives quickly issued a press release refuting the study’s claims and cited politics as the reason for the early publicity surrounding the article, especially legislative sessions in New York and Massachusetts, both poised to pass pro-midwife laws (“OB/GYN Journal”). The meta-analysis could also be interpreted as another strike in the divisive back-and-forth between midwifery advocates and professional medicine that the home birth survey represents.

Without the digital record of bloggers' reactions to the survey, its existence might never have been made public. The discourse surrounding the event provided the space for individual women, caregivers, and activists to engage in a debate about what constitutes the meaning of science in medicine and who gets to interpret and disseminate it. That conversation became even more pronounced in the aftermath of the Wax study; the discussions at *The Unnecesarean* and *Science and Sensibility* were largely about how medical research is conducted, what counts as valid data, and what kinds of bias discredit a study's conclusions (like including unplanned home births in the same category as midwife-attended home births, as one study included in the Wax analysis did). One blogger offered a study-by-study analysis of each study included in the meta-analysis (Birth Sense, "Tripled Risk"). Discussions like those, and the narratives they engender, seem far-removed from the portrait of the uninformed "googling patient" that seems to irk some doctors and from the idea of mythical bloggers who will take down American literacy with their ramblings imagined in the work of contrarians like Andrew Keen. They also are essential to scholars' understanding of how the public is engaging with medicine, science, and childbirth.

### **Integrating the Voices of Many**

Many of the epigraphs that begin the chapters of this project come from a group of blog posts that appeared on *The Unnecesarean* in January 2011. Published as a series on Defensive Medicine, the blog entries are authored by different players in the controversy over who is to blame for the growing trend of doctors making medical decisions in order to protect themselves from lawsuits, rather than to most effectively care for their patients. The perspectives of attorneys, patients, physicians, and advocacy groups are all represented, and they point to the diversity of opinion even within each of those categories. Three physicians, for example,

provided vastly different takes on why defensive medicine is a problem and on where the solutions should be found. These kinds of collaborative efforts to get at controversial issues in health care from as many angles as possible, along with those fostered by organizations like The Society for Participatory Medicine, provide promising places to analyze the discourse of health care from more perspectives than those of the biomedical institutions that usually control the conversation. They also provide an arena for scholars to analyze the ways that individuals are making sense of the complicated tangle of biomedical issues confronting twenty-first century Americans. The perspectives of scholars must be balanced with a careful attention to what non-academic citizens have to contribute to the discussion. More ethnographic research on how women engage with the messages all around them as they experience pregnancy and childbirth and more accounts of how health care professionals—not just physicians, but also labor and delivery nurses, nurse-midwives and traditional midwives, and those administering prenatal care in other settings like public clinics and health departments—understand the story of their profession and of the birthing women they encounter would help integrate more voices into the conversation. But there is a wealth of vibrant writing online about childbirth and medicine, and, I can only imagine, about many, many other issues related to health. The stories told in those spaces, and the rhetorical work they are doing to produce knowledge, are an important part of this conversation. More research on these communities, more explorations of the contours of the debates taking place in these online spaces, will help give us a fuller picture of the ways knowledge is being made about medicine and science and their interactions with human bodies.

## **Conclusion**

### **Birth Matters, Narratives Matter, Critique Matters**

The story of Joy Szabo that opens this dissertation is, in many ways, a story of the way social media can contribute to the public understanding of medicine and childbirth: senior medical correspondent Elizabeth Cohen, who covered the story for CNN, first learned about Szabo's dilemma by reading birth blogs (Arnold). Since then, stories in regular news media about VBAC and home birth have become more common,<sup>49</sup> and the cross-over between mainstream media, bloggers and activists, and medical professionals is blurring the lines between expert and lay person. Amy Romano, who started blogging for Lamaze International at *Science and Sensibility*, has left that post for a position with Childbirth Connection, a non-profit that, among many other initiatives, is working to promote better, more woman-centered research. One of their projects is to utilize digital media to make finding accessible information about maternity care easier for women and to provide a forum for health care professionals to implement meaningful change in the system. Medical economist and health information technologist J.D. Kleinke has recently turned his attention to maternity care, and as part of the publicity for a novel he wrote about ob-gyn residents called *Catching Babies*, he made his way not around mainstream media outlets but around the birth blogosphere. All of these are signs that the trajectory of knowledge-production about childbirth and medicine will continue to morph in new directions. The purpose of this dissertation is not to fix the particular cultural texts I have focused on as the main sites of meaning-making, but rather to encourage the same

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<sup>49</sup> *Time* ran a piece shortly after the Wax study was released, covering the controversy surrounding midwives and out-of-hospital delivery, one of several home birth stories the magazine has published in the last few years (Elton). Cohen continues to cover birth issues in her Empowered Patient column, including a favorable profile of a woman who stayed home to have her fourth child after three cesarean sections ("Mom Defies").

kind of close reading of other points along the path, and especially, to pay attention to the ways those points are linked by consistent narratives and disrupted by competing ones.

In health insurance discourse, we saw how the competing narratives of consumerism and managed care, welfare recipients and freedom of choice, illuminate a system of maternity care where decisions about care are often primarily economic rather than health-related. In the rhetoric of medical research and policy-making, the case of electronic fetal monitoring illustrates what happens when the narratives surrounding “evidence-based medicine” come up against foundational beliefs undergirding medical science, especially that biomedical technology, if refined enough, can always generate better results than non-technological modes of healing. That belief—in the ultimate power of technology to guarantee the health of women and babies—combined with a still-potent cultural authority invested in physicians, is a pervasive theme in popular culture narratives about childbirth, as depicted in recent film and on prime-time television. To return to a question I raised in the introduction—how do we know what we know about pregnancy and childbirth?—we at least partially know it by the stories our culture has told us about it, not only through the separate entities of popular entertainment, medical discourse, insurance documentation, and online advocacy, but also through the ways the narrative threads that lay beneath each of those discourses work against and with one another to produce a shifting network of meanings.

What I have suggested in this dissertation is that such multiple perspectives, especially in dialogue with one another, can productively challenge the boundaries of expert and layperson, subject and object, nature and culture, science and humanities, doctor and patient in order to imagine better, more humane conditions for health care and the practice of medicine. As Blake Scott has argued, “The main reason for troubling the boundaries of technoscience is to

recast those boundaries in more egalitarian and empowering ways. The main reason for analyzing the transformations of technoscientific networks is to more ethically reconfigure present and future networks” (30). By connecting representation with its potential effects on material bodies, discourse with the knowledge it produces, and science and medicine with the narratives that give them meaning, these analyses demonstrate that interdisciplinarity is crucial to furthering our understanding of how these relationships function, and ultimately, how they shape our lives. Rhetorical scholars have much to contribute to this project, especially by bringing such disparate stories together to analyze their import at particular times in particular contexts. What I have attempted here is to start to track the ways that narratives about the particular event of childbirth in the particular context of the first decade of the twenty-first century in the U.S. are working to shape the material conditions of birth for American women. That is not a unified story, and there is much work left to be done to understand the ways these stories might affect different populations of women differently. My hope for this project is that it might instigate more cross-disciplinary analyses and that it might productively contribute to an ongoing conversation about how to improve both the discourses of childbirth and the conditions such discourses reflect and shape in order to create more respect for birthing women and the choices they might make, to produce a more sustainable and ethical health care system to care for those women, and to look toward a plan for reform based on systemic institutional critique.

Birth certainly matters, as Barbara Katz Rothman’s epigraph eloquently reminds us. My contention in this dissertation is that how we learn about birth, how we come to know what we think we know about it, is a vital part of that mattering. Paying attention to that process, and carefully dislodging the ideological assumptions that lay beneath it, will, I hope, give us the

tools to create new cultural narratives that more fully account for the diversity of birthing women's experiences and that challenge the trenchant authority invested in biomedical institutions in order to build a better, more just maternity care system centered around the needs of individual women and their families.

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## Appendix: Search Engine Data

The following images are screen captures of results from three different search engines, AltaVista, Google, and Yahoo, using the search terms, “nih vbac conference.” The captures were all taken on September 22, 2010. They demonstrate that much of the coverage of the NIH VBAC Conference that turned up in these searches was published on blogs.

The screenshot shows the AltaVista search engine interface. At the top, there are navigation tabs for 'Web', 'Images', and 'News'. A search bar contains the text 'nih vbac conference' and a red 'FIND' button. To the right of the search bar are links for 'Advanced Search' and 'Settings'. Below the search bar, there are filters for 'SEARCH: Worldwide USA' and 'RESULTS IN: All languages English, Spanish'. A 'Sponsored Matches' section is visible, featuring an advertisement for 'Conference Nih Vbac' from Smarter.com. The main results section is titled 'AltaVista found 36,500 results'. The first result is 'NIH Vaginal Birth After Cesarean (VBAC) Conference' with a snippet about trends and patterns of VBAC availability. Other results include 'NIH Vaginal Birth After Cesarean (VBAC) Conference - Panel ...', 'Conference on Vaginal Birth After Cesarean (VBAC)', 'Panel Questions "VBAC Bans," Advocates Expanded Delivery ...', 'Science & Sensibility \* NIH Consensus Conference', 'Empowering Birth Blog: NIH VBAC Conference', 'NIH \* SpeakEasy', 'National Institutes of Health Conference Calls Vaginal Birth ...', 'BAC - NIH VBAC New Insights Conference 2010', and 'Science & Sensibility \* Let Your Voice Be Heard at the #VBAC...'. At the bottom, there is a 'Result Pages' section with a list of page numbers from 1 to 10 and a 'Next >>' link.

altavista Web Images News

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AltaVista found 36,500 results

[NIH Vaginal Birth After Cesarean \(VBAC\) Conference](#)  
Trends and Patterns of VBAC Availability in the United States ... Evaluating Professional Society Guidelines on VBAC. Emmanuel Bujold, M.D., F.R.C.S.C. ...  
[consensus.nih.gov/2010/vbac.htm](#)  
[More pages from consensus.nih.gov](#)

[NIH Vaginal Birth After Cesarean \(VBAC\) Conference - Panel ...](#)  
NIH consensus and state-of-the-science statements are prepared by independent panels of ... The NIH Consensus Development Conference on Vaginal Birth After Cesarean (VBAC) was ...  
[consensus.nih.gov/2010/vbacstatement.htm](#)  
[More pages from consensus.nih.gov](#)

[Conference on Vaginal Birth After Cesarean \(VBAC\)](#)  
The conference, sponsored by the NICHD and the NIH Office of Medical Applications of Research, brings experts together to assess the available scientific ...  
[www.nichd.nih.gov/news/resources/spotlight/030810-vbac.cfm](#)  
[More pages from nichd.nih.gov](#)

[Panel Questions "VBAC Bans," Advocates Expanded Delivery ...](#)  
Panel Questions "VBAC Bans," Advocates Expanded Delivery Options for Women ... NIH has conducted 122 consensus development conferences, and 33 state-of-the-science ...  
[www.nih.gov/news/health/mar2010/od-10.htm](#)  
[More pages from nih.gov](#)

[Science & Sensibility \\* NIH Consensus Conference](#)  
And it wasn't the NIH Consensus Development Conference on VBAC or the massive AHRQ ... The NIH press release about the VBAC Consensus Meeting includes only ...  
[www.scienceandsensibility.org/?tag=nih-consensus-conference](#)  
[More pages from scienceandsensibility.org](#)

[Empowering Birth Blog: NIH VBAC Conference](#)  
I spent all day today at the NIH VBAC Conference. You can catch the rest of the conference tomorrow on Webcast. My head is aching from listening to ...  
[empoweredbirth.typepad.com/empowering\\_birth\\_blog/2010/03/nih-vbac-conference.html](#)  
[More pages from empoweredbirth.typepad.com](#)

[NIH \\* SpeakEasy](#)  
Gina agreed to write for the NIH VBAC conference for RH Reality Check as an advocate, a ... When the NIH announced the VBAC conference, many activists, mothers, ...  
[blogs.alternet.org/speakeasy/tag/nih](#)  
[More pages from blogs.alternet.org](#)

[National Institutes of Health Conference Calls Vaginal Birth ...](#)  
NIH Conference Calls VBAC a "Reasonable Option," Stops Short of Ensuring Pregnant Women's Right of Informed Refusal. Report by Jessica Claire Haney ...  
[www.mothing.com/health/nih-conference-calls-vbac-reasonable-option](#)  
[More pages from mothing.com](#)

[BAC - NIH VBAC New Insights Conference 2010](#)  
New Insights Conference on VBAC, March 2010. We thank the NIH for making the complete videos available on their website: <http://www.videocast.nih.gov/PastEvents.asp?c=1>. ...  
[birthaftercesarean.com/Home/NIHVBACNewInsightsConference2010/tabid/277/Default.aspx](#)  
[More pages from birthaftercesarean.com](#)

[Science & Sensibility \\* Let Your Voice Be Heard at the #VBAC...](#)  
Let Your Voice Be Heard at the #VBAC NIH Consensus Development Conference  
[www.scienceandsensibility.org/?p=908](#)  
[More pages from scienceandsensibility.org](#)

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nih vbac conference

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Settings

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AltaVista found 36,400 results

[Stand and Deliver: ICAN VBAC carnival & NIH VBAC Consensus ...](#)

We will post the carnival on March 8th as the NIH Meetings begin. ... The NIH is holding a Consensus Conference on VBAC on March 8-10. I wish I could attend in person! ...  
[rxarixa.blogspot.com/2010/03/ican-vbac-carnival-nih-vbac-consensus.html](#)  
[More pages from rxarixa.blogspot.com](#)

[VBAC.com - a woman-centered, evidence based, resource.](#)

For women who had a cesarean birth, maternity caregivers, childbirth educators, doulas - a woman-centered, evidence-based resource for safe VBAC and lowering the odds ...  
[www.vbac.com/hottopic/nihvbacconference2010.html](#)  
[More pages from vbac.com](#)

[Citizens for Midwifery: NIH VBAC Conference](#)

**NIH VBAC Conference.** The NIH Conference on VBAC is currently in progress. Citizens for Midwifery's new president, Willa, is attending the conference ...  
[cfmidwifery.blogspot.com/2010/03/nih-vbac-conference.html](#)  
[More pages from cfmidwifery.blogspot.com](#)

[NIH VBAC Consensus Development Conference: Gift Horse or ...](#)

**NIH VBAC Consensus Development Conference: Gift Horse or Trojan Horse?** ... "but there are thousands of ideal VBAC candidates who are applauding the conclusions of the NIH panel. ...  
[www.theunnecesarean.com/blog/2010/3/10/nih-vbac-consensus-...e-gift-horse-or-troj.html](#)  
[More pages from theunnecesarean.com](#)

[NIH Post VBAC Conference Consensus Statement | Mamas on ...](#)

Following the 3 days of meetings and discussions on the whether or not VBAC is a safe birth option, the NIH has released a consensus statement highlighting the key ...  
[www.mamasonbedrest.com/2010/03/nih-post-vbac-conference-consensus-statement](#)  
[More pages from mamasonbedrest.com](#)

[The Feminist Breeder - NIH VBAC Coverage | TheFeministBreeder](#)

Live and archived coverage of the NIH VBAC Consensus Conference.  
[thefeministbreeder.com/nihvbac](#)  
[More pages from thefeministbreeder.com](#)

[Birthing Beautiful Ideas | NIH Consensus Development ...](#)

The NIH Consensus Development Conference on VBAC is fast approaching. ... 5 to "NIH Consensus Development Conference on VBAC: Ways to Participate from Work and Home" ...  
[birthingbeautifulideas.com/?p=1440](#)  
[More pages from birthingbeautifulideas.com](#)

[CFM - Supporting The Midwives Model of Care](#)

The 1980 NIH Conference on VBAC pulled together the research that encouraged widespread access to VBAC. ... Where did the recent NIH Consensus Conference on VBAC miss the mark? ...  
[cfmidwifery.org/Resources/itam.aspx?ID=149](#)  
[More pages from cfmidwifery.org](#)

[BAC - Articles](#)

2. The National Institutes of Health (NIH) Consensus Development Conference Statement and their recommendations regarding VBAC can be downloaded here. ...  
[birthaftercesarean.com/Articles/tabid/102/vw/1/ItemID/24/Default.aspx](#)  
[More pages from birthaftercesarean.com](#)

[NIH conference addresses vaginal birth after cesarean \(VBAC ...](#)

At a conference open to the public, the National Institutes of Health is presenting the research behind a consensus statement on vaginal birth after cesarean (VBAC) ...  
[communities.washingtontimes.com/neighborhood/reading-ingre...vaginal-birth-after-cesar](#)  
[More pages from communities.washingtontimes.com](#)

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nih vbac conference

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[Settings](#)SEARCH:  Worldwide  USA RESULTS IN:  All languages  English, Spanish

AltaVista found 36,400 results

[NIH VBAC Conference - Day 1 3/8/2010 - The Feminist Breeder ...](#)

TFB recaps Day 1 of the National Institute of Healths **conference** on Vaginal Birth After Cesarean **VBAC** with special guests Debra Bingham DrPH RH LCCE President-Elect ...  
[www.blogtalkradio.com/thefeministbreeder/2010/03/09/nih-vbac-conference-day-1](http://www.blogtalkradio.com/thefeministbreeder/2010/03/09/nih-vbac-conference-day-1)  
[More pages from blogtalkradio.com](#)

[Legal Rights and Protections for VBAC: Issues from the NIH ...](#)

While the NIH **VBAC** Consensus Panel took a strong stand in favor of increasing access to **VBAC**, many advocates were concerned that the consensus statement ...  
[givingbirthwithconfidence.org/birth/a-womans-guide-to-vbac...-nih-consensus-conference](http://givingbirthwithconfidence.org/birth/a-womans-guide-to-vbac...-nih-consensus-conference)  
[More pages from givingbirthwithconfidence.org](#)

[NIH Conference on VBAC'S - Continuing to Spread the Word ...](#)

Spreading the word from the NIH **VBAC conference**...It's now coming thru via AWHONN Vitals!!! This is at least a month old news to most birth junkies but. ...  
[obnurse35yrs.wordpress.com/2010/04/06/nih-conference-on-vb...-inuing-to-spread-the-word](http://obnurse35yrs.wordpress.com/2010/04/06/nih-conference-on-vb...-inuing-to-spread-the-word)  
[More pages from obnurse35yrs.wordpress.com](#)

[NIH Press Release: Panel Questions "VBAC Bans" - The Unnecesarean -](#)

NIH **VBAC** Consensus Development **Conference**: Gift Horse or Trojan Horse? ... "Declining **VBAC** rates and increasing cesarean delivery rates over the ...  
[www.theunnecesarean.com/blog/2010/3/10/nih-press-release-p...-questions-vbac-bans.html](http://www.theunnecesarean.com/blog/2010/3/10/nih-press-release-p...-questions-vbac-bans.html)  
[More pages from theunnecesarean.com](#)

[Once a Cesarean, Rarely a Choice | RHRealityCheck.org](#)

Gina agreed to write from the NIH **VBAC conference** for RH Reality Check as an ... When the NIH announced the **VBAC conference**, many activists, mothers, and ...  
[www.rhrealitycheck.org/blog/2010/03/09/oncecesarean-rarelychoice](http://www.rhrealitycheck.org/blog/2010/03/09/oncecesarean-rarelychoice)  
[More pages from rhrealitycheck.org](#)

[NIH Conference on VBAC: Sign up For Free Online Webcast of ...](#)

NIH **Conference** on **VBAC**; Sign up For Free Online Webcast of the Event ... Following the **conference**, a panel will prepare a consensus statement addressing the key ...  
[womenshealthnews.wordpress.com/2010/01/05/nih-conference-o...line-webcast-of-the-event](http://womenshealthnews.wordpress.com/2010/01/05/nih-conference-o...line-webcast-of-the-event)  
[More pages from womenshealthnews.wordpress.com](#)

[Birthing Beautiful Ideas | The NIH VBAC Statement Primer ...](#)

Remember way back in mid-March when I returned from the NIH Consensus Development **Conference** on **VBAC** with a heapload of inspiration and energy ...  
[birthingbeautifulideas.com/?p=1628](http://birthingbeautifulideas.com/?p=1628)  
[More pages from birthingbeautifulideas.com](#)

[NIH VBAC Conference - Day 2 3/9/2010 - The Feminist Breeder ...](#)

TFB recaps Day 2 of the National Institute of Healths **conference** on Vaginal Birth After Cesarean **VBAC** with special guest Susan M. Jenkins J.D. legal counsel for The ...  
[www.blogtalkradio.com/thefeministbreeder/2010/03/10/nih-vbac-conference-day-2](http://www.blogtalkradio.com/thefeministbreeder/2010/03/10/nih-vbac-conference-day-2)  
[More pages from blogtalkradio.com](#)

[Once a Cesarean, Rarely A Choice \\* SpeakEasy](#)

Gina agreed to write from the NIH **VBAC conference** for RH Reality Check as an ... When the NIH announced the **VBAC conference**, many activists, mothers, and ...  
[blogs.altemet.org/speakeasy/2010/03/11/once-a-cesarean-rarely-a-choice](http://blogs.altemet.org/speakeasy/2010/03/11/once-a-cesarean-rarely-a-choice)  
[More pages from blogs.altemet.org](#)

[NIH | Momotics](#)

Wednesday night wrapping up The NIH **Conference**, I had Joy Szabo on my radio show also. ... talk this week that didn't center around the NIH **VBAC Conference**, but ...  
[momotics.com/tag/nih](http://momotics.com/tag/nih)  
[More pages from momotics.com](#)

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nih vbac conference

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[NIH Vaginal Birth After Cesarean \(VBAC\) Conference](#) - Sep 13

The Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention provided additional **conference** development support. ...  
[consensus.nih.gov/2010/vbac.htm](#) - [Cached](#) - [Similar](#)

[NIH Vaginal Birth After Cesarean \(VBAC\) Conference - Panel Statement](#)

... for this **conference** typically combined VBAC and unsuccessful trial of ...  
[consensus.nih.gov/2010/vbacstatement.htm](#)

[NIH Vaginal Birth After Cesarean \(VBAC\) Conference - Program and ...](#)

NIH Consensus Development and State-of-the-Science **Conference** topics must ...  
[consensus.nih.gov/2010/vbacabstracts.htm](#)

[More results from consensus.nih.gov »](#)

[Citizens for Midwifery: Grassroots Network: NIH Consensus ...](#) - 2 visits - Sep 15

Mar 30, 2010 ... As most of you know by now, the National Institutes of Health (NIH) convened a Consensus Development **Conference** on VBAC (vaginal birth after ...  
[cfmidwifery.blogspot.com/.../grassroots-network-nih-consensus.html](#) - [Cached](#)

[Panel Questions "VBAC Bans," Advocates Expanded Delivery Options ...](#)

Mar 10, 2010 ... To participate, call 1-888-428-7458 (US) or 201-804-1577 (International) and reference the NIH VBAC **conference**. ...  
[www.nih.gov/news/health/mar2010/od-10.htm](#) - [Cached](#)

[Conference on Vaginal Birth After Cesarean \(VBAC\)](#)

Mar 8, 2010 ... The **conference**, sponsored by the NICHD and the NIH Office of Medical Applications of Research, brings experts together to assess the ...  
[www.nichd.nih.gov/news/resources/spotlight/030810-vbac.cfm](#) - [Cached](#)

[Yes, This \(from the NIH VBAC Conference\) « Women's Health News](#) - 6:53am

Mar 11, 2010 ... I think the NIH **conference** is another example of what we should consider when looking closely at the issue of the safety of TOL and VBAC, ...  
[womenshealthnews.wordpress.com/.../yes-this-from-the-nih-vbac-conference/](#) - [Cached](#)

[Empowering Birth Blog: NIH VBAC Conference](#)

Mar 8, 2010 ... I spent all day today at the NIH VBAC **Conference**. You can catch the rest of the conference tomorrow on Webcast.  
[empoweredbirth.typepad.com/.../birth.../nih-vbac-conference.html](#) - [Cached](#)

[Science & Sensibility » The NIH VBAC Consensus Conference: Will It ...](#) - 6:53am

Mar 6, 2010 ... The NIH VBAC Consensus **Conference**: Will It Pave the Road to Hell with Good Intentions?  
[www.scienceandsensibility.org/?p=1022](#) - [Cached](#)

[My Coverage of the NIH VBAC Conference](#)

Mar 8, 2010 ... I'll have more details later but over the next few days, please visit this page to find all my coverage of the NIH VBAC **conference** including ...  
[thefeministbreeder.com/my-coverage-of-the-nih-vbac-conference/](#) - [Cached](#)

[- Navelgazing Midwife Blog - What I learned watching the NIH VBAC ...](#)

Mar 19, 2010 ... Also, the statements made at the NIH **conference** by credible professionals about the financial motivators for or against VBAC alluded that ...  
[navelgazingmidwife.squarespace.com/.../what-i-learned-watching-the-nih-vbac-conference.html](#) - [Cached](#)

[NIH conference addresses vaginal birth after cesarean \(VBAC ...\)](#)

Mar 9, 2010 ... At a **conference** open to the public, the National Institutes of Health is presenting the research behind a consensus statement on vaginal ...  
[communities.washingtontimes.com/.../nih-conference-addresses-vaginal-birth-after-cesar/](#) - [Cached](#)



nih vbac conference

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[A detailed summary of the NIH conference on VBACs - Seattle ...](#) ☆

Mar 11, 2010 ... In 1980, the NIH Consensus Conference gave a "green light" to trials of labor in VBAC attempts--that is, not scheduling a repeat cesarean ...  
[www.examiner.com/.../a-detailed-summary-of-the-nih-conference-on-vbacs](#) - Cached

[NIH VBAC Consensus Development Conference: Gift Horse or Trojan ...](#) ☆ - 6:51am

Mar 10, 2010 ... There are a lot of wonderful things to say about the recent NIH VBAC Consensus Development Conference. Hopefully it will expand access to ...  
[www.theunnecesarean.com/.../nih-vbac-consensus-development-conference-gift-horse-or-troj.html](#) - Cached

[Citizens for Midwifery: NIH VBAC Conference](#) ☆

Mar 9, 2010 ... The NIH Conference on VBAC is currently in progress. Citizens for Midwifery's new president, Willa, is attending the conference and has been ...  
[cfmidwifery.blogspot.com/2010/03/nih-vbac-conference.html](#) - Cached

[NIH Consensus Development Conference to Address VBAC Issues ...](#) ☆

Mar 3, 2010 ... A consensus development conference scheduled for March 8-10 at the NIH campus in Bethesda, Md., will draw together a diverse group of ...  
[www.aafp.org/online/en/home/...care.../20100303vbac-conf.html](#) - Cached

[A Woman's Guide to VBAC: Navigating the NIH Consensus ...](#) ☆

As women who were lucky enough to attend the NIH Consensus Conference on VBAC in person (Kristen) or view the entire proceedings in real time by webcast ...  
[givingbirthwithconfidence.org/birth/a-womans-guide-to-vbac/](#) - Cached

[TFB Covering the NIH VBAC Conference](#) ☆ - 6:53am

Jan 28, 2010 ... TFB announces plans to cover the NIH VBAC conference, as well as the organizations scheduled to talk on her radio show during the ...  
[thefeministbreeder.com/tfb-covering-the-nih-vbac-conference/](#) - Cached

[Once a Cesarean, Rarely A Choice « SpeakEasy](#) ☆ - 6:54am

Mar 11, 2010 ... Gina agreed to write from the NIH VBAC conference for RH Reality Check as an advocate, a writer and a valued voice in birth activism. ...  
[blogs.alternet.org/speakeasy/2010/.../once-a-cesarean-rarely-a-choice/](#) - Cached

[NIH Post VBAC Conference Consensus Statement | Mamas on Bedrest ...](#) ☆

Mar 12, 2010 ... Following the 3 days of meetings and discussions on the whether or not VBAC is a safe birth option, the NIH has released a consensus ...  
[www.mamasonbedrest.com/.../nih-post-vbac-conference-consensus-statement/](#) - Cached

[VBAC Facts » VBAC in rural hospitals](#) ☆

Jul 22, 2010 ... The ability of rural hospitals to safely attend VBACs was extensively discussed at the March 2010 NIH VBAC conference. ...  
[vbacfacts.com/2010/07/22/vbac-in-rural-hospitals/](#) - Cached

[Full Circle Midwifery ~ VBAC FACTS](#) ☆

Mar 21, 2010 ... Be sure to review the risks and benefits of your options with a VBAC supportive practitioner. As the NIH VBAC Conference (2010b) concluded, ...  
[www.fullcirclemidwifery.com/2010/03/vbac-facts/](#) - Cached



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[Legal Rights and Protections for VBAC: Issues from the NIH ...](#) ☆

While the NIH VBAC Consensus Panel took a strong stand in favor of increasing access to VBAC, many advocates were concerned that the consensus statement did ...  
givingbirthwithconfidence.org/...vbac/legal-rights-and-protections-for-vbac-issues-from-the-nih-consensus-conference/ - Cached

[NIH Consensus Development Conference on VBAC This Week; Watch ...](#) ☆

Mar 8, 2010 ... Beginning today and continuing through March 10, the National Institutes of Health is hosting a consensus development conference on the ...  
www.ourbodiesourblog.org/.../nih-consensus-development-conference-on-vbac-this-week-watch-online - Cached

[NIH VBAC Conference | Facebook](#) ☆

Facebook is a social utility that connects people with friends and others who work, study and live around them. People use Facebook to keep up with friends, ...  
www.facebook.com/topic.php?uid=29802013804&topic=14799 - Cached

[Birthing Beautiful Ideas | NIH Consensus Development Conference on ...](#) ☆

NIH Consensus Development Conference on VBAC: Ways to Participate from Work and Home. Posted on March 06, 2010 by BirthingBeautifulIdeas. The NIH Consensus ...  
birthingbeautifulideas.com/?p=1440 - Cached

[Dou-la-la: The NIH VBAC Conference: Could have used more Shrimp](#) ☆ - 6:54am

Mar 11, 2010 ... As most of you reading this blog know, the NIH Conference on VBAC just wrapped. I tuned in to various bloggers' reports, got their updates ...  
dou-la-la.blogspot.com/.../nih-vbac-conference-could-have-used.html - Cached

[Announcing the ICAN VBAC Blog Carnival! | ICAN Blog](#) ☆ - 6:51am

Feb 21, 2010 ... We have invited bloggers to submit entries on the topic, "Why is VBAC a Vital Option?" [...] NIH Consensus Development Conference on VBAC ...  
blog.ican-online.org/2010/.../announcing-the-ican-vbac-blog-carnival/ - Cached

[Vaginal birth after caesarean - Wikipedia, the free encyclopedia](#) ☆

Vaginal birth after caesarean (VBAC) refers to the practice of delivering a .... the following recommendation emerging from the NIH VBAC conference panel in ...  
en.wikipedia.org/wiki/Vaginal\_birth\_after\_caesarean - Cached - Similar

[BAC - NIH VBAC New Insights Conference 2010](#) ☆ - Sep 15

Session Videos from the National Institute of Health New Insights Conference on VBAC, March 2010. We thank the NIH for making the complete videos available ...  
birthaftercesarean.com/.../NIHVBACNewInsightsConference2010/.../Default.aspx - Cached

[NIH VBAC Statement.indd](#) ☆

by VBA Cesarean - 2010  
deliveries, and vaginal birth after cesarean (VBAC), 1989-. 2007. Data from the National Center for Health Statistics. NIH Conference Statement. ...  
pdfs.journals.lww.com/.../National\_Institutes\_of\_Health\_Consensus.26.pdf

[Science & Sensibility » Some thoughts on practice guidelines and ...](#) ☆

Mar 3, 2010 ... Despite all of this, I'm actually rather optimistic about the NIH VBAC Conference. In my mind, the situation around VBAC has gotten so bad ...  
www.scienceandsensibility.org/?p=1011 - Cached



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**NIH Vaginal Birth After Cesarean (VBAC) Conference**

8:30 a.m. Introduction and Opening Remarks Alan E. Guttmacher, M.D. Acting Director Eunice Kennedy Shriver National Institute of Child Health and Human Development [consensus.nih.gov/2010/vbac.htm](#) - [Cached](#)

**NIH Vaginal Birth After Cesarean (VBAC) Conference - Planning ...**

NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights March 8-10, 2010 Bethesda, Maryland Conference Home Final Statement | PDF [consensus.nih.gov/2010/vbacplanners.htm](#) - [Cached](#)

**Empowering Birth Blog: VBAC**

I spent all day today at the NIH VBAC Conference. You can catch the rest of the conference tomorrow on Webcast. My head is aching from listening to fourteen ... [empoweredbirth.typepad.com/empowering\\_birth\\_blog/vbac](#) - [Cached](#)

**Citizens for Midwifery: NIH VBAC Conference**

The NIH Conference on VBAC is currently in progress. Citizens for Midwifery's new president, Willa, is attending the conference and has been able to pose questions about ... [cfmidwifery.blogspot.com/2010/03/nih-vbac-conference.html](#) - [Cached](#)

**NIH VBAC Consensus Development Conference: Gift Horse or ...**

Read the Subtext: ACOG's Position on Home Birth; For-Profit California Hospitals Perform More Cesareans than Non-Profits; So, About This Birth Rape Thing [www.theunnecesarean.com/blog/2010/3/10/nih-vbac...](#) - [Cached](#)

**Yes, This (from the NIH VBAC Conference) « Women's Health News**

Women's health news, politics, information, and resources from a medical librarian [womenshealthnews.wordpress.com/2010/03/11/yes-this-from...](#) - [Cached](#)

**NIH VBAC Conference - Day 1 3/8/2010 - The Feminist Breeder ...**

TFB recaps Day 1 of the National Institute of Health's conference on Vaginal Birth After Cesarean VBAC with special guests Debra Bingham DrPH RH LCOE President-Elect for ... [www.blogtalkradio.com/.../03/09/nih-vbac-conference--day-1](#) - [Cached](#)

**Science & Sensibility » The NIH VBAC Consensus Conference ...**

The NIH VBAC Consensus Conference: Will It Pave the Road to Hell with Good Intentions? [www.scienceandsensibility.org/?p=1022](#) - [Cached](#)

**Birth After Cesarean > Home**

NIH VBAC New Insights Conference 2010 ... 4/12/2010 4:44:00 PM by BADirector: What you need to know to "Just Say ... [birthaftercesarean.com](#) - [Cached](#)

**Science & Sensibility » NIH Consensus Conference**

First the good news: based on the presenters, it looks like the NIH VBAC conference will be a great improvement over the elective cesarean surgery travesty of four years ... [www.scienceandsensibility.org/?tag=nih-consensus-conference](#) - [Cached](#)

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[Independent Consensus Panel to Release Vaginal Birth After ...](#)

Conference Information: The NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights is free and open to the public. Monday, March 8, 2010 - 8 ...  
[www.nih.gov/news/health/mar2010/od-01.htm](http://www.nih.gov/news/health/mar2010/od-01.htm) - [Cached](#)

[Panel Questions "VBAC Bans," Advocates Expanded Delivery ...](#)

To participate, call 1-888-428-7458 (US) or 201-604-1577 (International) and reference the NIH VBAC conference. Audio playback will be available shortly after ...  
[www.nih.gov/news/health/mar2010/od-10.htm](http://www.nih.gov/news/health/mar2010/od-10.htm) - [Cached](#)

[TFB Covering the NIH VBAC Conference](#)

TFB announces plans to cover the NIH VBAC conference, as well as the organizations scheduled to talk on her radio show during the conference.  
[thefeministbreeder.com/tfb-covering-the-nih-vbac-conference](http://thefeministbreeder.com/tfb-covering-the-nih-vbac-conference) - [Cached](#)

[VBAC.com - a woman-centered, evidence based, resource.](#)

For women who had a cesarean birth, maternity caregivers, childbirth educators, doulas - a woman-centered, evidence-based resource for safe VBAC and lowering the odds of ...  
[www.vbac.com/hottopic/nihvbacconference2010.html](http://www.vbac.com/hottopic/nihvbacconference2010.html) - [Cached](#)

[Birthing Beautiful Ideas | NIH Consensus Development ...](#)

The NIH Consensus Development Conference on VBAC is fast approaching. This is an exceedingly important event not just for birth and VBAC activists but also for all women ...  
[birthingbeautifulideas.com/?p=1440](http://birthingbeautifulideas.com/?p=1440) - [Cached](#)

[VBAC Conference by the NIH](#)

VBAC Conference by the NIH. March 8-10, 2010 will have a consensus conference on vaginal birth after cesarean (VBAC). It will address questions, including:  
[www.birthactivist.com/2010/01/vbac-conference-by-the-nih](http://www.birthactivist.com/2010/01/vbac-conference-by-the-nih) - [Cached](#)

[National Institutes of Health Conference Calls Vaginal Birth ...](#)

The National Institutes of Health (NIH) convened a three-day Consensus Development Conference entitled "Vaginal Birth After Cesarean: New Insights," March 8-10, 2010.  
[www.mothering.com/health/nih-conference-calls-vbac...](http://www.mothering.com/health/nih-conference-calls-vbac...) - [Cached](#)

[Midwife Connection: A Midwife's Take on the NIH VBAC ...](#)

by William F. McCool, CNM, PhD, CRNP, FACNM This past week the NIH held a 3-day Consensus Conference examining the current situation in maternity care regarding vaginal ...  
[acnm-midwives.blogspot.com/2010/03/midwives-take-on-nih...](http://acnm-midwives.blogspot.com/2010/03/midwives-take-on-nih...) - [Cached](#)

[Dou-la-la: The NIH VBAC Conference: Could have used more Shrimp](#)

Birth advocate, postpartum doula, childbirth educator and birth doula-in-training, eventual lactation consultant, gradually gravitating towards midwifery itself.  
[dou-la-la.blogspot.com/2010/03/nih-vbac-conference-could...](http://dou-la-la.blogspot.com/2010/03/nih-vbac-conference-could...) - [Cached](#)

[NIH Consensus Development Conference to Address VBAC Issues ...](#)

[Mar 3, 2010] A consensus development conference scheduled for March 8-10 at the NIH campus in Bethesda, Md., will draw together a diverse group of experts to address key issues ...  
[www.aafp.org/.../20100303vbac-conf.html](http://www.aafp.org/.../20100303vbac-conf.html) - [Cached](#)

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**VBAC** «

But I can hope with the **NIH VBAC conference** we can start to see a change in the way that **VBAC** is handled nationally. Women have the right to real informed consent, and ... [www.birthactivist.com/category/vbac](http://www.birthactivist.com/category/vbac) - [Cached](#)

**Midwife Connection: Six Reasons to Be Optimistic about the ...**

by Judith Rooks, CNM, MPH, FACNM Many of you already know about the upcoming **NIH Consensus Development Conference on Vaginal Birth After Cesarean (VBAC): New Insights** ... [acnm-midwives.blogspot.com/2010/03/six-reasons-to-be...](http://acnm-midwives.blogspot.com/2010/03/six-reasons-to-be...) - [Cached](#)

**From the NIH VBAC Conference... - The Unnecesarean -**

Read the Subtext: ACOG's Position on Home Birth; For-Profit California Hospitals Perform More Cesareans than Non-Profits; So, About This Birth Rape Thing [www.theunnecesarean.com/blog/2010/3/8/from-the-nih-vbac...](http://www.theunnecesarean.com/blog/2010/3/8/from-the-nih-vbac...) - [Cached](#)

**VBAC | Mamas on Bedrest & Beyond**

**NIH Post VBAC Conference Consensus Statement** March 12th, 2010 . Following the 3 days of meetings and discussions between the **National Institutes of Health's Consensus** ... [www.mamasonbedrest.com/tag/vbac](http://www.mamasonbedrest.com/tag/vbac) - [Cached](#)

**NIH Consensus Development Conference on VBAC: New Insights ...**

Today begins the **NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights**, being held in Bethesda, MD. Why devote an entire three day [www.examiner.com/pregnancy-in-baltimore/nih-consensus...](http://www.examiner.com/pregnancy-in-baltimore/nih-consensus...) - [Cached](#)

**Stand and Deliver: NIH VBAC recommendations**

I was thrilled to hear that the **NIH Consensus Conference on VBAC** recommended increasing access to **VBAC**! Here is a link to the preliminary draft of the consensus ... [rixarixa.blogspot.com/2010/03/nih-vbac-recommendations.html](http://rixarixa.blogspot.com/2010/03/nih-vbac-recommendations.html) - [Cached](#)

**ABC reportback from NIH VBAC conference « Massachusetts ...**

Yet another pro-birth story on ABC (not to be all cynical about ABC, I'm just not used to birth getting GOOD coverage!): ABC reports on the recent **NIH VBAC conference**. [mfomnews.wordpress.com/2010/03/11/abc-reportback-from...](http://mfomnews.wordpress.com/2010/03/11/abc-reportback-from...) - [Cached](#)

**NIH Conference on VBAC'S ~ Continuing to Spread the Word ...**

Stork Stories... Birth & Breastfeeding. Birth Stories, Baby stories, Breastfeeding- Anything from over the last 35ys as an OB Neonatal Nurse CLC [obnurse35yrs.wordpress.com/2010/04/06/nih-conference-on...](http://obnurse35yrs.wordpress.com/2010/04/06/nih-conference-on...) - [Cached](#)

**NIH Consensus Development Conference on VBAC This Week; Watch ...**

Beginning today and continuing through March 10, the **National Institutes of Health** is hosting a consensus development conference on the topic of vaginal birth [www.ourbodiesourblog.org/blog/2010/03/nih-consensus...](http://www.ourbodiesourblog.org/blog/2010/03/nih-consensus...) - [Cached](#)

**Birthing Beautiful Ideas | The NIH VBAC Statement Primer ...**

Remember way back in mid-March when I returned from the **NIH Consensus Development Conference on VBAC** with a heapload of inspiration and energy to transform maternity care ... [birthingbeautifulideas.com/?p=1628](http://birthingbeautifulideas.com/?p=1628) - [Cached](#)

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## **Vita**

Jennifer Ellis West was born and raised in Clinton, Mississippi. She attended Mississippi College, where she majored in English. After brief stints as a waitress, floral designer, junior high teacher, and magazine editor, she made her way back to Mississippi College for a master's degree. During that program, she learned to love both the teaching of writing and the study of the way discourses shape the experiences of real people in the real world. She continued both pursuits during her doctoral work at Louisiana State University. The birth of her daughter in 2007 was the original inspiration for the research in this dissertation, and as this project goes to print in 2011, she awaits the birth of a second daughter. She and her husband have made their way back to Jackson, Mississippi, where she hopes to continue researching the cultural construction of knowledge about health issues. For her next project, she hopes to engage with the discourses of disparity, especially in the rhetoric of maternal and child health.