The Authoritative Knowledge of Motherhood

Understanding the Evolving Relationship Between Mothers and their Medical Practitioners During Childbirth in the 1970s and 1990s United States

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Research Master's Thesis in History

Abstract

Childbirth culture in the twentieth century has been a growing area of study since the 1970s. In the 1980s, anthropologist Brigitte Jordan developed the concept *authoritative knowledge* while studying different cultures' child birthing methods. This theory states that in a hierarchical situation, such as doctor-patient, some knowledge is legitimized while other knowledge is delegitimized. The combined interdisciplinary notions of authoritative knowledge, expertise, and autonomy are used to understand late twentieth century childbirth culture and add to the historiography of the history of knowledge. Using traditional historical sources and innovative methodologies, this thesis aims to answer the question: How did the distribution of authoritative knowledge between mothers and their practitioners change in the 1970s and 1990s in the United States?

This thesis discovered that in the 1970s, authoritative knowledge was achieved by mothers outside the hospital delivery room by their consumer actions. However, once they were in the hospital, the doctor still had full authoritative knowledge. In the 1990s women were capable of seizing authoritative knowledge within the delivery room, but only if they gave a performance of expertise. The additional personnel in the delivery room, including the father and nurses, played a large role in the mother's success or failure in establishing their authoritative knowledge.

Acknowledgments

This thesis would not have been possible without the help of so many people. First, I would like to thank my advisor Willemijn Ruberg for her constant help and support. Historical childbirth culture was a subject matter that I had previously never thought of for a thesis topic until Willemijn asked if it interested me. After a little bit of research, I became very passionate about this subject matter. The more I read, the more excited I became, and Willemijn was there to help me through all the steps of taking a vague idea and morph it into a concrete research proposal. I would like to thank her for her constant willingness to read and provide valuable feedback for anything I wrote and help in keeping the fire of excitement alive in this project. In addition, I would like to thank Jacco Pekelder for his consistently positive attitude in our thesis lab. He was an excellent thesis lab coordinator who always had new outside-the-box questions paired with the total belief that we could, and would, finish our theses.

I would also like to thank the women of the Splendor of Truth Catholic Home Educators group for sharing their birth stories with me and helping me become aware of the struggles that faced women in childbirth. Their candor enabled me to find importance in my research.

Finally, I would like to thank all my friends and family who have listened to me rave about this subject matter. Thank you for the paper proofing, pretending to be my presentation audience and overall constant mental support throughout this whole process. In particular, I would like to thank my husband, Antoni, for his undying interest and questions through countless late-night chats. Lastly, I would like to dedicate this thesis to my mother, Patrice, my constant support, cheerleader, and expert, who taught me to love history and has always encouraged me to follow my passions.

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INTRODUCTION

"Joyous and moving" were the words Marjorie Karmel used in her 1959 best-selling book *Thank You, Dr. Lamaze: A Mother's Experience in Painless Childbirth* to describe her unmedicated childbirth in France under the care of Dr. Fernand Lamaze.[1] This book set off a frenzy of excitement over the idea of natural childbirth. Although enthusiasm was growing for this "new" childbirth phenomenon, most women in the 1960s were still giving birth under general anesthesia, chloroform, or large doses of painkillers. At the same time, the doctor removed the baby manually with forceps. Then in the 1970s, the United States childbirth culture underwent a strong push towards more natural childbirth practices. By 1980, the vast majority of women were awake and aware during delivery. Hospitals abolished many of the demeaning bodily "prepping" before delivery, and women seemed able to choose their level of medication. Perhaps most radically, doctors began to allow fathers in the room with the delivering mother. Some couples even decided to have their baby at home or in a birth center.[2]

Then, in the 1990s, childbirth changed again. New medical technologies were invented and became mainstreamed in the 1990s. Some women were still having home births and natural births, but a growing number of mothers were choosing to use a new drug, the spinal epidural. Other technologies allowed medical professionals and the mother to see and hear the baby. If the fetus appeared to be in distress, the doctors could choose to perform a Cesarean section (C-section) to remove the infant surgically. Childbirth was no longer only headed toward natural birth but was diverging into different philosophical branches simultaneously.[3]

So how many of these changes were due to the mother's desire for reform? How much control did she have over her own childbirth experience? What, if any, were the specific limitations to this control? When was a mother able to exercise the most authority? When the least? These questions and more will guide my research to understand childbirth culture reform in the 1970s and 1990s.

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[1] Marjorie Karmel and Alex Karmel, *Thank You, Dr Lamaze*, New edition (London: Pinter & Martin Ltd., 2005).
[2] Jacqueline H. Wolf, *Deliver Me from Pain: Anesthesia and Birth in America* (JHU Press, 2009), 136–67.
[3] Wolf, 168–96.

Research Questions

How did the distribution of authoritative knowledge between mothers and their medical practitioners change in the 1970s and 1990s in the United States?

- How did society, scholars, and medical experts perceive this change?
- Why and when did this change take place? (If it did.)
- How has technology in childbirth influenced or superseded the authoritative knowledge of the practitioner and/or the mother, and how have mothers either accepted or resisted this intrusion?
- Were mothers able to use any authoritative knowledge in the actual delivery room?

Historiography

This thesis aims to research childbirth culture reform by diving deeper into the concept of knowledge. To achieve this goal, I needed to integrate many different fields of history and interdisciplinary subjects, but at its core, this research contributes to the growing field of the history of knowledge and expertise. Developing out of the history of science, the history of knowledge aims to understand the orders of knowledge, systems of knowledge, cultures of knowledge, and communities of knowledge.[4] Historian Peter Burke points out that the history of knowledge does not just focus on the academic or learned knowledge, as intellectual history does, but that of everyday, popular, indigenous, practical, and implicit knowledge.

Within this field, the subfield of *expertise* is exceptionally important to this thesis. Science and technology studies scholars and psychologists have been studying this concept for the last twenty years, prompting history of knowledge historians to integrate expertise into their field as well.[5] One of the first psychological and scientific notions of expertise, as defined by K. A. Ericsson in 2002, was "not simply a matter of possessing 'talent,' but is the result of a dedicated application to a chosen field… Many thousands of hours of deliberate practice and

[4] Peter Burke, "Response," *Journal for the History of Knowledge* 1, no. 1 (July 15, 2020): 7, https://doi.org/10.5334/jhk.27.

[5] To look more closely at the idea of expertise from a psychology point of view check out: Jean Bédard and Michelene T.H. Chi, "Expertise," *Current Directions in Psychological Science* 1, no. 4 (August 1, 1992): 135–39, https://doi.org/10.1111/1467-8721.ep10769799; Michelene T. H. Chi, Robert Glaser, and Marshall J. Farr, eds., *The Nature of Expertise* (New York: Psychology Press, 2013), https://doi.org/10.4324/9781315799681; To look more closely at expertise in the natural sciences check out: Harry Collins and Robert Evans, *Rethinking Expertise*, *Rethinking Expertise* (University of Chicago Press, 2008), https://www.degruyter.com/document/doi/10.7208/9780226113623/html.

training are necessary to reach the highest levels of performance."[6] In the 2010s, other scholars in the social sciences diverged from this idea and explained expertise to be something you do rather than something you have.[7] The social science form of expertise fits better with the conceptualization of the history of knowledge, as they both aim to look beyond the academic confines for knowledge and expertise and broaden to include various types of knowledge and actors of expertise. Therefore, this performance of expertise will be the notion integrated into this thesis and explained further in the theory section of this introduction.

This thesis will further add the concepts of *authoritative knowledge* and *bodily knowledge* to the various other types of knowledge already found within the history of knowledge as information systems that fit agreeably within this field. While bodily knowledge is already an established concept within the history of the body, particularly in the work of Barbara Duden, in this field, it principally focuses on the evolving cultural perception of the body.[8] Instead, this thesis will use a definition used in anthropological childbirth studies, which outlines bodily knowledge as the invariable inherent knowledge of one's own body.[9] Authoritative knowledge is also an anthropological concept denoting different hierarchical systems of authority that the theory section of this introduction will further explain. By taking this interdisciplinary approach to these concepts, this thesis could significantly add to the history of knowledge's repository of historical theory. These concepts have been used by historians previously, but not as an underlying theory for a whole historical study to better define and integrate these concepts for the history of knowledge, in the way this thesis aims to do. This innovation thereby bolsters this thesis's value, not only to the historiography of childbirth but to the history of knowledge as a whole. Furthermore, this thesis disembarrasses subject matter that has been traditionally confined to women's history, thus aiding in the resolution of a prevalent issue highlighted in women's history.[10] In taking this history of knowledge approach to childbirth culture, this thesis will breathe new life into a crucial historical debate while simultaneously introducing it to a new audience.

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[6] K. Anders Ericsson, "Attaining Excellence through Deliberate Practice: Insights from the Study of Expert Performance," in *The Pursuit of Excellence through Education*, The Educational Psychology Series (Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers, 2002), 21–55.
[7] E. Summerson Carr, "Enactments of Expertise," *Annual Review of Anthropology* 39, no. 18 (2010). This concept will be more fully explained in the theory section
[8] Willemijn Ruberg, *History of the Body* (Red Globe Press, 2020), 80.
[9] Carole Browner H and Nancy Press, "The Production of Authoritative Knowledge in American Prenatal Care," in *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, ed. Carolyn F. 1947- Sargent and Robbie E. Davis-Floyd (Berkeley: Univ of California Press, 1997), 113–27.
[10] Arina Angerman et al., *Current Issues in Women's History* (London, UNITED KINGDOM: Taylor & Francis Group, 2012), http://ebookcentral.proquest.com/lib/uunl/detail.action?docID=1101375, 10.

The intersections between the histories of motherhood, medicine, and technology are incorporated into the history of knowledge historiography on childbirth for this research. These three fields are well established within historical research and give years of theory and study to bolster the budding concepts of the history of knowledge in this thesis. Thus an introduction to these three historical fields follows to clarify the various lenses used in the forthcoming research.

History of Motherhood

While this thesis's primary focus is on the act of childbirth, it is contextually important to understand the historiographical debates surrounding motherhood and the twentieth-century laboring mother's cultural environment. Historian Angela Davis aptly states that motherhood is a crossroad at which many different fields meet, including education, health care, economics, and state intervention.[11] Furthermore, this thesis operates under the principle that there is little truly 'natural' about the institution of motherhood since it is so thoroughly embedded within social and cultural practices.[12] These outside forces impact the cultural traditions of motherhood and dictate what it means to be a "good" mother. These expectations and ideas about being a good mother, or even a "good enough" mother, have been subjected to societal scrutiny and cultural negotiation with increasing intensity since the mid-nineteenth century under the guide of scientific and medical experts.[13]

Post-Freudians branded the mother as wildly powerful, and every one of her actions, large or small, directly affected the future well-being of her child. Under the influence of the psychoanalytic phenomenon in the interwar period, social and medical experts created a clear "good" versus "bad" mother dichotomy in the public mind.[14] These same experts also claimed that they, not mothers, knew best how to birth and rear children.[15] If a mother did not comply with prescribed societal norms, she could be labeled a "bad" mother and subjugated to mother

[11] Angela Davis, *Modern Motherhood: Women and Family in England, 1945–2000* (Manchester University Press, 2013), 6.
[12] Ellen Ross, *Love and Toil: Motherhood in Outcast London, 1870-1918* (Oxford, UNITED STATES: Oxford University Press, Incorporated, 1993), http://ebookcentral.proquest.com/lib/uunl/detail.action?docID=4700836.
[13] Held L and Rutherford A, "Can't a Mother Sing the Blues? Postpartum Depression and the Construction of Motherhood in Late 20th-Century America.," *History of Psychology* 15, no. 2 (2012): 107.
[14] Susanne Klausen, "'Birth in Transition': Medicalization, Gender Politics, and Changing Perceptions of Childbirth in the United States and Late Imperial China," *Journal of Women's History* 25, no. 3 (2013): 243, https://doi.org/10.1353/jowh.2013.0027.
[15] Rebecca Jo Plant, *Mom: The Transformation of Motherhood in Modern America* (Chicago ; London: The University of Chicago Press, 2010).

blaming.[16] Throughout the twentieth century, this constant threat of damaging their children and becoming a "bad" mother proved to be the ultimate ammunition for experts to encourage mothers' acceptance of their authority. Mothers traded in their implicit, practical, and bodily knowledge on pregnancy, childbirth, and childrearing to better follow the prescribed actions of societal and medical experts. The act of childbirth was not exempt from the constant societal influence of "good" and "bad" motherhood. The acceptance, or rejection, of this cultural yardstick played a prominent role in childbirth reform, both in the 1970s and the 1990s.

Scholars have been unable to decide whether or not late-twentieth-century mothers had authority in the child birthing process. Many have stated that the reforms of the 1970s were superficial. They further argue that although the 1970s fixation on natural childbirth brought about women's ability to be awake, aware, and even unmedicated in childbirth, it also made mothers who were unable to have natural childbirth feel like failures.[17] Husbands were allowed in the room, but doctors could easily kick them out.[18] Doctors retained their control by tethering mothers via electronic fetal monitors (EFMs) and IVs, presenting choices as doomsday scenarios, and reiterating the "good" versus "bad" mom dichotomy. Thus most historians attest that mothers gained no authority. But is this accurate? In the 1970s, women successfully forced medical professions to do away with the enema, perineal shave, separate delivery rooms, and restraints. In 1980, mothers had their husbands by their sides and their babies in their rooms. By the 1990s, mothers could decide if they wanted a C-section, epidural, natural childbirth, or a combination.[19] The disparity between the achievements of 1970s childbirth reformers and the scholarship which disputes these same women's authority is baffling and remains an unanswered question in childbirth historiography that this thesis aims to answer.

History of Medical Experts and Childbirth

Apprentice-trained women called midwives were the primary attendees at births throughout the majority of western history. Physicians were only called upon when either the

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[16] Denise Sommerfeld P, "The Origins of Mother Blaming: Historical Perspectives on Childhood and Motherhood," *Infant Mental Health Journal* 10, no. 1 (1989): 16.
Denise Sommerfeld states that the failure to untangle motherhood from its intricate network of internal and external factors resulted in the tendency to accuse mothers with less than positive attitudes toward childrearing for any problems with their children's physical or psychological well-being

[17] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New Haven: Yale University Press, 1989), 262.

[18] Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave* (Chicago, United States: University of Chicago Press, 2010), 148, http://ebookcentral.proquest.com/lib/uunl/detail.action?docID=602617.

[19] Wolf, *Deliver Me from Pain*, 167–96.

baby or the mother had died, requiring the physician to either remove the dead fetus through a parceled extraction or perform a maternal post-mortem cesarean section. In this way, obstetrics was fused with technology from the beginning. As physicians developed new technologies, such as the forceps around 1730, their presence became more common in the delivery room, allowing for the first medicalized childbirth instances to occur.[20]

Sociologist Catherine Riessman defines medicalization as a process in which medical practice becomes "a vehicle for eliminating or controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms."[21] While many times increased medicalization can be an advantageous event, giving doctors a better way to articulate and fix a pathology. Nevertheless, when the medical field medicalizes natural processes rather than pathologies, it can have detrimental consequences. One such effect addressed by Riessman is the 'deskilling of the populace' as experts begin to 'manage' and 'mystify' human experiences.[22] Mystification became especially apparent in the birth process when medical experts started to expect women to consult them before and during childbirth to understand experiences that women have historically understood on their own.[23]

At the turn of the twentieth century in the United States, midwives attended fifty percent of births,[24] with less than five percent of births taking place in a hospital.[25] Synchronously, the obstetrical field underwent a convergence of obstetrical methodology in physicians and midwives. Previously, medical care existed in a pluralistic system that contained the knowledge of barber surgeons, homeopaths, folk healers, midwives, and other empirically based practitioners, who were all considered authoritative in their respective areas.[26] Then, in the first twenty years of the twentieth-century, society insisted on institutionalizing and consolidating medical knowledge. Subsequently, experimental science dismissed empathy and nurturing as feminine and therefore negative, and embraced objectivity and clinical detachment as

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[20] Elizabeth Newnham, Lois McKellar, and Jan Pincombe, *Toward the Humanisation of Birth*, ed. Elizabeth Newnham, Lois McKellar, and Jan Pincombe (Cham: Springer International Publishing, 2018), 83, https://doi.org/10.1007/978-3-319-69962-2_1.
[21] Catherine Riessman, "Women and Medicalization: A New Perspective," *Social Policy* 14 (February 1, 1983): 3–18.
[22] Ibid
[23] Sarah Jane Brubaker and Heather E. Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," *Sociology Compass* 3, no. 1 (2009): 217–44, https://doi.org/10.1111/j.1751-9020.2008.00183.x.
[24] Susan E Stone, "The Evolving Scope of Nurse-Midwifery Practice in the United States," *Journal of Midwifery & Women's Health* 45, no. 6 (November 1, 2000): 522–31, https://doi.org/10.1016/S1526-9523(00)00084-2.
[25] Held and Rutherford, 111
[26] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 15.

masculine and therefore positive.[27] These medical professionals and medicalization changes would interact with the cultural influences which had programmed mothers to listen to experts, causing severely medicalized childbirth in the mid-twentieth century.

Many scholars tend to vilify these obstetricians as a group diametrical to mothers, especially in the area of maternal autonomy. They argue that these doctors wanted to perform childbirth their way, with heavily sedated women alone in a delivery room, because it was faster and more convenient.[28] Feminist historians often contend that historical childbirth medicalization was a method of female oppression by the male obstetrician. Then once civil suits became popular, doctors were more interested in avoiding a lawsuit than they were in allowing someone else, such as the mother, to have control of the birth.[29] These same scholars argue that it was not until the theorization of "bonding" between mother and baby that doctors accepted some delivery room reforms.[30]

This view of obstetricians is problematic for several reasons. First, while the mid-twentieth century child birthing was oppressive to women, it was unlikely that the doctors arbitrarily designed it that way. Instead, terrible maternal mortality in the 1920s inspired doctors to find a solution. Based on the success of poor-house maternity wards in medically side-stepping maternal complications, medicalizations seemed to be the best elucidation.[31] Maternal and infant survival rates rose dramatically due to the introduction of penicillin and structured sterilization in the 1920s. However, these medical procedures were married to birth methods that included general anesthesia, heavy drugs, and forceps infant removal that were not conducive to maternal and infant survival but actually dangerous. Unfortunately, these procedures were packaged together and taught doctors to see a pregnancy-equals-pathology perspective and reform as a dangerous intrusion. [32] Additionally, scholars who suggest childbirth reform only took place after doctors accepted bonding theory unfairly pacify women's movements in the 1970s and 1990s.

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[27] Kline, *Bodies of Knowledge*, 4.
[28] Kline, 36; Wertz and Wertz, *Lying-In*, 195.
[29] Wolf, *Deliver Me from Pain*, 183.
[30] Wertz and Wertz, *Lying-In*, 219; Patrizia Romito, "The Humanizing of Childbirth: The Response of Medical Institutions to Women's Demand for Change," *Midwifery* 2, no. 3 (September 1, 1986): 139, https://doi.org/10.1016/S0266-6138(86)80004-3.
[31] Roosa Tikkanen et al., "Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries," *The Commonwealth Fund*, November 18, 2020; Robert Morse Woodbury, "The Trend of Maternal-Mortality Rates in the United States Death-Registration Area, 1900-1921," *American Journal of Public Health* 14, no. 9 (1924): 738–43.
[32] Wertz and Wertz, *Lying-In*, 138.

By delving into the relationship between mothers and practitioners, this thesis will examine what role medical practitioners, including doctors and midwives, played in this reform and how it interacted with women's movements. Physicians Thomas Szasz and Marc Hollender suggest that there are three basic models of patient-practitioner relationships. 1) The Active-Passive relationship is typified by an unconscious or nearly unconscious patient and a physician with total authority. 2) The Guidance Cooperation model is where the physician is the commandant who guides the patient, and if the patient is good, they take the guidance meekly. 3) The Mutual Participation relationship where the practitioner and patient work together towards a common goal.[33] Scholars largely agree that early and mid-twentieth century physician-mother relationships were the first Active-Passive model but disagree whether childbirth reform has been able to help mothers move beyond the Guidance Cooperation relationship to the Mutual Participation. This thesis will attempt to contribute to medical history scholarship by better understanding patient-physician relationships within childbirth experiences viewed from societal and individual perspectives to determine where the childbirth of the 1970s and 1990s fell on the Szasz and Hollender scale.

History of Technology and Childbirth

Technology plays a contentious part in twentieth-century childbirth history, sometimes regarded as a tool of medical experts and sometimes as a nearly autonomous expert. How did technology achieve such a lofty authoritative position, especially in the minds of childbirth actors during the 1970s and 1990s period? Philosopher Don Ihde's book *Technology and Lifeworld* addresses these questions by proposing that when society is introduced to new technology, it mediates people's relationship with the world positively or negatively.[34] How women and medical experts view this interaction is the central technological question this thesis will examine.

In deciphering the positive or negative filter through which different groups saw technology, this thesis will scrutinize the effects of medical technology in society, particularly on the childbearing women themselves. In her studies of childbirth reform in the twentieth century, historian Elizabeth Newnham argues that historical mechanization in childbirth among

[33] Thomas S. Szasz, "A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship," *A.M.A. Archives of Internal Medicine* 97, no. 5 (May 1, 1956): 585, https://doi.org/10.1001/archinte.1956.00250230079008.
[34] Don Ihde, *Technology and the Lifeworld: From Garden to Earth* (Bloomington: Indiana University Press, 1990).

an increasingly technological world connected the ideologies of patriarchy with capitalism to create a hegemonic world view.[35] She further stated that historical medicalization led to the cultural inclination and generalized positive social bias for technological usage whether or not its use will be of benefit.[36] This thesis will explore these theoretical viewpoints and critically examine if and how this theorized cultural inclination toward technology applies to the natural childbirth movement. These factors played a role in the tug-of-war between highly medicalized and utterly natural childbirth, beginning with the natural childbirth movement in the 1970s and gaining increasingly nuanced positions in the 1990s.

The 1970s were dominated by a push for more natural child-birthing methods, driving scholars to try to understand the subsequent seduction of a technologically medical birth. Even after the natural birth movement, anthropologist Robbie Davis-Floyd argues that in the United States, the society based its dominant beliefs and practices around birth on the "technocratic model" of reality, which they acquired in the Scientific Revolution. During this revolution, Davis-Floyd states, the "machine replaced the organism as the underlying metaphor for the organization of man's universe."[37] In *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States,* anthropologist Brigitte Jordan states that highly specialized technologies, which are the exclusive property of medical specialists in biomedical births, serve to reproduce social inequalities rather than perform any specific medical function. She further claims that medical technologies and their users exploit these inequalities in ways that are not possible when the technologies employed are universally available.[38] Additionally, Davis-Floyd states that medical experts routinely perform obstetric practices that are not "scientifically" grounded in hospitals but instead are "highly symbolic rituals" to reaffirm the dominant technocratic model.[39]

However, historian Cecilia van Hollen finds it overly simplistic and functionalist to state that obstetricians construct procedures purely to reproduce dominant cultural values.[40] Hollen's critiques are highly astute, and this research will follow her lead in applying a critical historical eye to anthropological theory. While the studies of Davis-Floyd and Jordan provide compelling theoretical arguments, they are not entirely rooted in historical context. Therefore, this study

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[35] Newnham, McKellar, and Pincombe, *Toward the Humanisation of Birth*, 77–78.
[36] Newnham, McKellar, and Pincombe, 81.
[37] Robbie E. Davis-Floyd, *Birth as an American Rite of Passage: Second Edition, With a New Preface* (University of California Press, 2004).
[38] Brigitte Jordan, *Birth in Four Cultures.*, 3rd ed. (Montréal: Eden Press, 1983).
[39] Davis-Floyd, *Birth as an American Rite of Passage*.
[40] Cecillia Hollen van, "Perspectives on the Anthropology of Birth," *Culture, Medicine and Psychiatry* 18 (1994): 501–12.

will expand upon Jordan and Davis-Floyd by utilizing these anthropological theories to understand a historical research question. How did the distribution of authoritative knowledge between mothers and their practitioners change in the 1970s and 1990s? Furthermore, as a sub-question within this historiography of technology, how has technology in childbirth influenced or superseded the authoritative knowledge of the practitioner and/or the mother, and how have mothers either accepted or resisted this intrusion?

Historiographical Conclusion

This thesis aims to draw from the three historical fields, history of motherhood, history of medicine, and history of technology, to understand the history of childbirth. Within childbirth, the dichotomies of "good" and "bad" mothering, "natural" or "interventionist" cross-sectioned with "positive" and "negative" in medical technology, and that of "choice" and "compliance" in bio-politics, manifests into what historian Ros MacColl calls "organics" and "mechanics." MacColl describes organics as those dedicated to working with the uncertainty of birth, with minimal disturbances of the process of birth, and mechanics as those who desire more intervention in the birth process to better control the spontaneity.[41] When looking closely at the multitude of actors, motivations, and outcomes of childbirth during these decades, the dichotomist model proves to be reductionist. Davis-Floyd suggests people invested in childbirth fall into three groups: people who want childbirth to be natural, those who want it to be technological, and those "in-between."[42] While this is more realistic than polarized dichotomies, it is still more useful for discourse than practice. To this point, Newnham proposes a continuum, with total intervention-free birth at one end and maximum medicalized birth at the other, with women, midwives, and obstetricians in the middle, maintaining a dialogue about what is best for individual women.[43] To further add to Newnham's work, this thesis will attempt to jettison the battle between organics and mechanics and instead consider a myriad of motivations and birthing experiences on a birthing process continuum.

Theoretical Approach

The fields of women's history, medical history, and the history of technology are all well-established fields used in this research. Newer fields, such as the history of experts within the

[41] Mary-Rose MacColl, *The Birth Wars* (Univ. of Queensland Press, 2013).
[42] Davis-Floyd, *Birth as an American Rite of Passage*.
[43] Newnham, McKellar, and Pincombe, *Toward the Humanisation of Birth*, 4.

history of knowledge, are also essential to this thesis, yet lack large bodies of historical theory. Therefore, this thesis will use interdisciplinary theories of knowledge and authority to further add to the history of knowledge and expertise and help shape historical theory in this field.

Expertise

This thesis operates using the theory of expertise made explicit by anthropologist E. Summerson Carr, who stated that expertise is something people do rather than something people have or hold. Furthermore, expertise is inherently interactional because it involves the participation of objects, producers, and consumers of knowledge.[44] Science researcher Stephen Hilgartner takes this theory one step further, stating that experts need to convince their audience of their authority, and then that audience has the right to either accept or reject that authority.[45] This thesis intends to apply the social science theory of expertise to the practitioner-patient relationship within the childbirth experience. While the performance of expertise from practitioner to mother is apparent, this thesis will also look for evidence of expert performances from mothers during these decades of childbirth reform.

Summerson Carr has several criteria for one to be considered an expert. He states that people become experts by forming familiar, albeit asymmetrical, relationships with people and things, and learning to communicate this familiarity from an authoritative angle. They may do this by having an intimate relationship with a valuable class of cultural objects and using jargon to signify their expertise. The doctor is the individual who most obviously performs expertise due to them using medical tools such as stethoscopes, forceps, medical jargon, and wearing their white coat. Perhaps mothers may have also used different cultural objects, popular jargon, or skills they learned in Lamaze birth classes to display their expertise.

Carr also states that if expertise is enacted, it is also fundamentally a *process of becoming* rather than a *crystallized state of being or knowing*, i.e., one can learn to be an expert. While doctors undergo training, testing, and ceremony that bestows them both knowledge and performative objects, such as a white coat and the letters MD, to display their expertise, what do mothers do? And do doctors respect performances of expertise more than the "intuitional" experience of bodily knowledge?

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[44] Carr, "Enactments of Expertise," 18.
[45] Stephen Hilgartner, *Science on Stage: Expert Advice as Public Drama* (Stanford, CA: Stanford University Press, n.d.); Wiebe E. Bijker, Roland Bal, and Ruud Hendriks, *The Paradox of Scientific Authority: The Role of Scientific Advice in Democracies* (MIT Press, 2009).

Finally, Carr states, "Would-be experts work to establish their expertise not so much by trying to out-denote each other, in verbal or written displays of what they know about an object of mental interest. Instead, they must engage in less predictable, real-time performances, which often take the form of one-upmanship."[46] This study will look into the actual "one-upmanship" that mothers and doctors performed to retain or gain expert status. This thesis will attempt to discover if and how women could perform expertise over the childbirth experience and their bodies enough that doctors chose to accept this authority and relinquish some childbirth control to reform. Delving into the changing dynamic relationship between doctor and patient, this research aims to see if the total performance of expertise shifts from doctor to mother in the 1970s and 1990s. When comparing the decades, this thesis will take another player into account, technology. How did the role of technology change the expertise dynamic between women and their doctors? And how did doctors treat the expertise of medical technology compared to that of their patients? Did doctors defer their expertise due to technological contradiction?

Authoritative Knowledge

The dynamic relationship created by the concept "authoritative knowledge" is the primary theory used in this thesis. In the late 1970s, anthropologist Brigitte Jordan conducted cross-cultural studies on the childbirth practices of various cultures, including the Yucatan, Sweden, the Netherlands, and the United States. Through this study, she developed the term "authoritative knowledge." She found that unilateral knowledge systems exist in many situations with people moving freely between them, using them either in sequential or in parallel fashion for particular purposes. One such system could be a collaborative work association or a group of friends. In hierarchical situations, however, one kind of knowledge gains ascendance and legitimacy. The consequence of this legitimation is the devaluation and often even dismissal of all other types of knowing. When comparing childbirth methods, she found, unsurprisingly, radically more medicalization in the United States compared to the other cultures, even after the natural childbirth movement. She argues that in American hospital births, medical knowledge overrides and delegitimizes all other potentially relevant sources of knowledge, including the women's prior experiences and the knowledge she has of her body. Jordan conducted much of her studies in the 1980s, and as an anthropologist, she has created

[46] Carr, "Enactments of Expertise," 19.

an overarching theory that she argues proves universally. This thesis aims to contextualize these claims to test if they are valid for the surrounding decades of the 1970s and 1990s.

Jordan's studies show the United States as only delivering a highly medicalized child-birthing experience without looking at out-of-the-hospital experiences. She argues that the United States is woefully technological due to her cross-cultural comparative lens. This thesis, however, aims to put that viewpoint in a historical context better to understand the trends of technological and natural childbirth while also including instances of home birth and birth center births.

Later, in a 1997 book chapter, she states that all participants devalue non-medical knowledge during American hospital births, *including the woman herself*, who comes to believe that the route chosen by the medical professional knowledge is best for her.[47] She states, "Some kinds of knowledge become socially sanctioned, consequential, even "official," and are accepted as grounds for legitimate inference and action. In some groups, differing kinds of knowledge come into conflict; in others, they become a resource for constructing a joint way of seeing the world, a way of defining what shall count as authoritative knowledge." This thesis will investigate the validity of these claims, looking to see if women comply with the medical professional's path set out for them or if they diverge.

Furthermore, her findings suggest that the sanctioning of knowledge is done so that all participants see the current social order as a natural order, that is, the way things are and should be.[48] This concept will arise time and again within the history of childbirth. It first appears in the early 20th century, with the dismissal of all other types of authority in exchange for doctors' and hospitals' authority.[49] Therefore the traditional kind of consultation between doctors takes on a "natural" "common-sense" hierarchy. The doctor knows about medicine, and the patient does not, ergo it is "right" or "natural" that the doctor should make the decisions and control the course of treatment, where the patient should comply and cooperate. This continued doctoral authority can be seen in the dismissal of midwives in the 1970s and 1980s period.[50] More importantly for this study, the devaluation and dismissal of mother's knowledge of their bodies in exchange for medical authority is a construct challenged by the natural childbirth

[47] Brigitte Jordan, "Authoritative Knowledge and Its Construction," in *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, by Carolyn F Sargent and Robbie Davis-Floyd (Berkeley: Univ of California Press, 1997), 58.
[48] Jordan, 59.
[49] Wertz and Wertz, *Lying-In*, 295.
[50] Christa Craven, "Claiming Respectable American Motherhood: Homebirth Mothers, Medical Officials, and the State," *Medical Anthropology Quarterly* 19, no. 2 (June 2005): 194–215, https://doi.org/10.1525/maq.2005.19.2.194.

movement in the 1970s. This thesis will study how women challenged this "natural" hierarchy and devaluation of non-medical knowledge by disregarding the idea that birth is medical, and therefore under the doctors' jurisdiction. While Jordan's study continues to view little authoritative knowledge on the part of mothers, this may be because she did not compare it to the total lack of authority women had in the 1950s and 1960s. Thus, exemplifying how important it is to contextualize rises in authoritative knowledge with historical, cultural norms. This mold of authority and devaluation is something this study will further explore in the increase in medicalization in the 1990s. Here the questions are, "whose knowledge is being ascended? And whose is being devalued?"

Perhaps even more interestingly, in the 1980s, Jordan examined the highly specialized technologies of birth and determined that in the United States maternity hospitals, the knowledge of the physician and the machinery is valued above the embodied knowledge of a woman in labor.[51] This thesis will test Jordan's conclusion in a historical setting. While Jordan has found this true compared to other, less technological countries, this thesis will examine if it holds in a historical comparison. The routine taking of fetal heartbeats only began in the early 1970s, and the use of an electronic fetal monitor (EFM) happened in only fifty percent of births by 1979.[52] Thus, this thesis will examine women's assertion of authoritative knowledge over technology at its introduction in the 1970s and when it was normalized in the 1990s.

Robbie Davis-Floyd also addresses what she calls births based on a "technocratic model" of reality, but she is not as fatalistic as Jordan. She states that this model is inherited from the Scientific Revolution and is a hegemonic system of biomedical birth that is either internalized and accepted *or resisted* by physicians, midwives, and especially women during pregnancy and childbirth. Davis-Floyd goes so far as to state that many obstetric practices in the 1980s were not "scientifically" grounded but highly symbolic rituals to reaffirm the dominant technocratic model.[53] While this is a bit of an extreme stance on unnecessary medical intervention, it will be interesting to apply this theory, published in 1992, when episiotomies, a surgical cut in the vagina made right before delivery, and sometimes even enemas were routine, to the later 1990s, when these were less normal.[54]

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[51] Jordan, *Birth in Four Cultures.*
[52] Judy V. Schmidt and Patricia Robin McCartney, "History and Development of Fetal Heart Assessment: A Composite," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 29, no. 3 (May 1, 2000): 295–305, https://doi.org/10.1111/j.1552-6909.2000.tb02051.x.
[53] Davis-Floyd, *Birth as an American Rite of Passage*.
[54] Schmidt and McCartney, "History and Development of Fetal Heart Assessment."

Autonomy

Authoritative knowledge addresses the relationship between practitioner and mother, the theory of expertise addresses how this knowledge is believed or performed. Finally, the third central theory employed is autonomy. Autonomy is used to understand women's basic outcry for childbirth reform in this thesis. While autonomy can be a somewhat complicated subject, the simplistic definition utilized in the philosophy textbook *Autonomy* by Andrew Sneddon, and thus this thesis, summarizes autonomy as personal self-rule. So the question of how much autonomy a mother in childbirth has will boil down to how much individual control or self-rule she has. Another form of autonomy that will help shape this thesis is the idea of moral autonomy. Again, Sneddon's simple definition is that moral autonomy is people making choices or performing actions based on the moral assessment of their options. Therefore morally autonomous action is deliberately performed out of the sense that it is morally permissible or demanded.[55] Moral autonomy is a theme that will repeatedly appear in this thesis, as both mothers and practitioners attempt to exert their moral autonomy within the childbirth process. Doctors, in particular, were likely subject to moral autonomy. They were aware of the previous maternal mortality rates and felt they needed to exert their moral autonomy for the safety of everyone, even if that meant exerting their will over the mothers.

Theoretical Conclusion

Thus the theoretical concepts applied to childbirth culture in the 1970s and 1990s are expertise, authoritative knowledge, and autonomy. In most scenarios, mothers employ autonomy, and medical personnel perform expertise, though this thesis will explore whether mothers can use expertise. Finally, authoritative knowledge is the legitimatized knowledge and authority in a hierarchical setting. Therefore, the mother, with her autonomy, and the medical practitioner with their expertise fight for authoritative knowledge in a tug-of-war in both the larger societal birth culture and the intimate relationship between two individuals.

Sources & Methodology

This thesis is broken into two main parts, with different sources and methodologies used for each one. Part one dives into the larger societal and medical discourse surrounding

[55] Andrew Sneddon, *Autonomy* (London, UNITED KINGDOM: Bloomsbury Publishing Plc, 2013), http://ebookcentral.proquest.com/lib/uunl/detail.action?docID=1206938.

childbirth reform, looking at the reactions of the social groups of mothers and medical experts. This section utilizes secondary sources to build a framework to understand how the American public and medical experts felt about childbirth culture. Primary sources are also used in this section to add historical viewpoints from both mothers and medical experts. They are medical journals, newspapers, magazine articles, and movies or shows that discuss childbirth in a removed sense. These works do not refer to real individual childbirths but rather the overall trends, or even an imagined stereotypical or dramatized birth. This section focuses on the greater societal debates surrounding childbirth reform and leaves the individual stories and case studies for part two.

In the first chapters, with the first in the 1970s, and the second in the 1990s, the focus will be on how widespread childbirth reform was. Did it permeate the public, medical and fictional realms of media? And how did society respond to these changes? Are they regarded as positive or negative? Is the credit, or blame, for the changes placed at the mother or the practitioner, or even a third party? Whose authority causes these changes? Next, how do the medical professionals react? Is there a change in authoritative knowledge as perceived by society and the medical community, and is technology acknowledged as a catalyst or hindrance to this change?

These sources will be treated with critical discourse analysis as outlined by a similar study on Australian childbirth newspaper articles in Australia in the 2010s by Meredith McIntyre.[56] This methodology acknowledges that articles such as these do not represent reality but rather create a version. Furthermore, the work of Michel Foucault stresses that discourse is 'an instrument in the social construction of reality and that this construction can be viewed as a total stem of knowledge and power.[57] As this thesis focuses on the construction and performance of such authoritative knowledge, analyzing social discourse is an integral part of understanding how that authority is perceived and achieved in the delivery room.

The second part of the thesis, consisting of chapters three and four, focuses on the stories of actual child birthing experiences. In chapter three, the 1970s motherly perspective is comprised of mother's letters, autobiographies, and interviews. This chapter problematizes the genres of biography and autobiography, while highlighting narratives that provide powerful

[56] Meredith J. McIntyre, Karen Francis, and Ysanne Chapman, "Shaping Public Opinion on the Issue of Childbirth; a Critical Analysis of Articles Published in an Australian Newspaper," *BMC Pregnancy and Childbirth* 11, no. 1 (June 28, 2011): 47, https://doi.org/10.1186/1471-2393-11-47.
[57] Michel Foucault and Anthony M. Nazzaro, "History, Discourse and Discontinuity," *Salmagundi*, no. 20 (1972): 225–48.

insight into what was considered normal, abnormal, disempowering, or empowering to mothers in an American 1970s delivery room. The third chapter focuses on the perception of authoritative knowledge and demonstrates that the authenticity of legitimized knowledge was often untested.

The fourth chapter also focuses on the delivery room events, this time for the 1990s. This chapter also analyzes home videos posted on YouTube. The analysis of home video is very typical in media studies and is becoming more utilized in anthropology and sociology but has rarely, if ever, been used in historical research on childbirth. This research further problematizes biography and autobiography genres, as the camera can be handed off, quickly switch its intended audience, and have moments of authenticity. Therefore, these home videos will be analyzed as a genre of their own. While this chapter will, of course, be focusing on the relationship as seen between the mother and the practitioner to discern the distribution of authoritative knowledge, it will also establish primitive rules of the genre.

Conclusion

Thus, this thesis attempts to marry classic historical research with interdisciplinary studies and the innovative methodological analysis of birth home videos. While many scholars have written about childbirth reform, few have focused on the changing relationship between practitioner and mother, and none have utilized the array of sources found in this thesis. Furthermore, Jordan's theory of authoritative knowledge is well-founded, but her 1980s assessment of the mother's lack of authoritative knowledge is not rooted in historical context. Meaning that although mothers in the 1980s United States may not have had as much authoritative knowledge as mothers in the Netherlands in the 1980s, according to Jordan's research, this does not answer the question as to whether American mothers gained or lost authoritative knowledge from the natural childbirth movement onward. Her cross-cultural anthropological snapshot does not allow for a historical trend to be established. This thesis aims to fill that void. Therefore the following four chapters will each play a part in answering the question: How did the distribution of authoritative knowledge between mothers and their practitioners change in the 1970s and 1990s in the United States?

PART ONE

SOCIETAL PERSPECTIVES: UNDERSTANDING THE PERCEPTUAL TENSIONS BETWEEN THE SOCIAL GROUPS OF MOTHERS AND MEDICAL PRACITITIONERS

Chapter 1, 1970s: *The Natural (Read: Prepared) Childbirth Movement*

Determining the authoritative knowledge distribution of birth culture in the 1970s

Introduction

On September 17, 1971, a popular sitcom called *The Odd Couple,* about two divorced men living together, released an episode called "Natural Childbirth." In this episode, one of the men's niece Martha arrives nine months pregnant. Her husband in Germany is in the army, and she has run away from home because she wants to have a natural childbirth against her family's wishes. A childbirth class instructor jokes that this situation is very typical in her profession. While this episode pokes some fun at the hippie stereotype and the trendiness of natural childbirth, it presents Martha as a perfectly normal young woman who just wants to have her baby her way. She says, "I don't want to sleep through the most exciting experience of my life." to the applause of other natural childbirth class attenders. A female doctor, who checks Martha, says that she thinks a hospital is the safest option, but she will not tell Martha what to do. The 1971 audience may have still been shocked by the idea of natural childbirth, yet the episode presents it as a controversial but achievable desire.[58]

This chapter will specifically address why childbirth reform occurred in the 1970s by utilizing secondary sources to understand how scholars and medical experts perceived these reasons. It lays a foundation of understanding surrounding women's autonomy, medical professionals' expertise, and the perception of technology during this decade. This chapter will examine the overarching arguments made between mothers and medical practitioners as groups rather than focusing on individual experiences.

The introduction explained Hollender and Szasz's basic models of patient-practitioner in-depth, which this chapter will apply. Most certainly, the unconscious births in the early and mid-twentieth century were part of the Active-Passive model, where the physician had total control. This chapter will examine how women could move out of that first tier and at least into the second of Guidance Cooperation. In this model, the patient is at least awake while the

[58] Hal Cooper, "Natural Childbirth," *The Odd Couple* (United States: Paramount Television, September 17, 1971).

practitioner guides her. If she is a good patient, she will take his direction compliantly. In both the first and second tier, the authoritative knowledge rests with the physician. The third relationship of Mutual Participation, in which the practitioner and patient work together toward a common goal, is what many reformers wanted, yet, many scholars argue they were unable to achieve. Is this true? This thesis will fill this historiographical gap by applying the idea of authoritative knowledge within the practitioner-mother relationship to understand how women could navigate this tiered system. Did having a Mutual Participation relationship mean sharing authoritative knowledge?

Historians record mothers involved in childbirth reform as primarily middle-class to affluent white women. However, this thesis will also attempt to involve women so often cut out of the narrative, including those of lower socioeconomic status and different ethical backgrounds. Likewise, many historians have only focused on the influence of the second feminist wave on childbirth, but this thesis will contribute to the historiography by problematizing this notion and widening the scope of actors.

Methodology

This chapter aims to understand the societal, scholarly, and medical understandings of childbirth reform in the 1970s and why it happened. By separating the mother's actual delivery room experiences from all the other writing about childbirth reform, this thesis aims to find where and how reform actually took place and how this affected the relationship between the practitioner and the mother. Therefore, this chapter will focus on the tensions and discourse between the social groups of mothers and medical practitioners. Furthermore, third-party perspectives, including social science scholars and journalists, will add further context and highlight the societal perspective. This chapter will examine newspapers, medical journal articles, and social science studies to bring together this picture. Furthermore it will focus on how doctors and society also viewed changes to the authoritative knowledge relationship between doctors and mothers in the 1970s.

Overall, this chapter is using close discourse analysis as described by Foucault. He states that discourse actively constitutes or constructs society using knowledge and power.[59] This construction of power is a core principle in this thesis, making it very appropriate as a methodology for these sources. According to Foucault, a researcher should view discourse as a total system of knowledge that makes a multitude of true statements possible while

[59] Foucault and Nazzaro, "History, Discourse and Discontinuity."

articulating a particular truth and then maintaining the effects of that truth.[60] This chapter will examine the separate discourses of these different sources to grasp and compare the competing systems of knowledge surrounding childbirth.

One source that will be subjugated to classic historical discourse analysis are newspapers. Historian Meredith McIntyre warns that historians must remember that newspaper articles do not represent reality but create a new version. This fact is the very reason that this thesis is using newspaper articles.[61] These created realities will help build an understanding of dramatized public opinion on childbirth reform and how controversial new childbirth methods were. Particular attention will be paid to pieces with interviews of medical experts about their opinions about childbirth reform. Each newspaper article attempts to make a unique angle; thus, the articles will be seen as pieces of a puzzle rather than authorities on societal feeling.

Medical journal and social science journal articles written by medical experts and scholars in the United States will deliver a very different piece of relevant information. They will unveil what was thought of as "best practice" in childbirth in the 1970s, by whom, and how that changed over time. These articles were connected with prominent journals and chosen for their subject matter. Many medical articles were studies comparing the medical outcomes of different child birthing approaches, while the scholarly articles often focused instead on mother's satisfaction. Most scholars and medical experts only expect other scholars or medical experts to read their journal articles, so they may offer insight into doctor-to-doctor opinions on childbirth practices.

The questions of this chapter are how society, especially the societal groups of mothers and medical professionals, viewed childbirth reform in the 1970s? How did third parties view changes in authoritative knowledge dynamic between mothers and practitioners? Is there a change in authoritative knowledge perceived by society and the medical community?

The Beginnings of Reform

Even as women continued to comply with hospital procedures into the 1950s and 1960s, the rumblings of childbirth reform were beginning. Much of this had to do with narrowing the lofty spiritual connotations of the Victorian ideology of moral motherhood to the model de-sentimentalized "mom."[62] The later post-war period saw the rise of "natural motherhood."

[60] Foucault and Nazzaro.
[61] McIntyre, Francis, and Chapman, "Shaping Public Opinion on the Issue of Childbirth; a Critical Analysis of Articles Published in an Australian Newspaper."
[62] Plant, *Mom*.

Natural motherhood was more than just the female reliance on motherly instinct. Rather it was an ideal based in scientific research that supported maternal authority over childbirth and infant care that suggested that technological meddling could harm the evolutionarily perfect "natural' connections between mother and child.[63] In this rich environment, the Lamaze method was introduced to the United States by Marjorie Karmel in her book *Thank You, Dr. Lamaze,* in 1959. With the risen acceptance of "natural motherhood" in parenting and psychology circles, women became very eager to integrate this naturalness into the child birthing arena.[64]

Natural motherhood was not the only reason women wanted reform. The growing awareness of universally poor treatment of women in maternity wards also played a part. A 1957 article in the *Ladies Home Journal* asked about "cruelty in maternity wards" and received hundreds of responses. Hospital policy separated women from their husbands, who were not well updated. Nurses restrained women, hand and foot, to tables and stirrups. Nursing also strictly reprimanded mothers for the slightest infractions, such as wiping the sweat off one's face or making noise.[65] The *Ladies Home Journal* article was a significant moment, as it allowed mothers to realize that they were not alone in their experience and could assess rationally, after the moment of childbirth, how this was really a cruel way for medical personnel to treat laboring women.[66]

By 1970 the psychoprophylatic method, also known as Lamaze, became such a popular topic of conversation that one 1970 newspaper article opened with the line, "If you were to overhear a group of women conversing over tea, you would undoubtedly learn about the psychoprophylatic method of childbirth (better known as the Lamaze technique), the advantages of breastfeeding, and Dr. Ginott's latest views on bringing up children."[67]

With growing popularity, women had been working toward childbirth reform for nearly twenty years with little change. The 1970s, however, proved to be the decade women would have the chance to have more say in childbirth processes. Different groups of women wanted childbirth reform for a combination of reasons, some ideological, some practical. This section will outline the various reasons different women were highly motivated to seek childbirth reform according to newspapers, magazine articles, journals, and secondary sources.

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[63] Jessica Martucci, "Why Breastfeeding?: Natural Motherhood in Post-War America," *Journal of Women's History* 27, no. 2 (2015): 112, https://doi.org/10.1353/jowh.2015.0020.
[64] Martucci, 112.
[65] Wertz and Wertz, *Lying-In*, 171.
[66] Wolf, *Deliver Me from Pain*, 126.
[67] Roberta Tumbleson, "Women Voters: Who Needs Them?," *The Providence Sunday Journal*, January 11, 1970.

Groups of Mothers and Mothers in Groups

Perhaps the most well-known group associated with childbirth reform in the 1970s was the feminists, and rightly so, as they and their writings were critical to the movement.[68] In the early 1970s, these women began educating themselves about the female body, noting the importance for all women to understand their bodies. The idea became widespread with the publishing of *Our Bodies, Ourselves.* This central focus on the female body and the importance for women to understand the scientific workings of their anatomy allowed for feminists to gain the ammunition they needed to demand more autonomy in the child-birthing process. It was also able to gain traction with other women and experts who were followers of the natural motherhood movement. Many women who did not identify with other areas of the Women's Liberation movement supported feminist childbirth ideology. Childbirth became a vehicle to demonstrate women's effectiveness and power.[69]

Feminists of the early 1970s were angry with how the medical profession and institutions treated women.[70] For example, Rothman points out that physicians mark a woman's pregnancy from the first day of her last menstrual period, which is the very day that she knows she is not pregnant. Alternatively, labor beginning times were marked when a laboring mother was admitted to the hospital, not when she said it started.[71] These were instances where medical experts dismissed the bodily knowledge of women even though these classifications denied logical explanation. As Jordan said, "The power of authoritative knowledge is not that it is correct, but that it counts."[72] Feminists particularly struggled with this medical authority over the female body because the majority of physicians were males. In 1973, only 30,600 women doctors made up about eight percent of that total number of physicians. The proportion of women obstetricians was likely even lower, as women often had trouble obtaining residences in such a lucrative field.[73] Ann Oakley portrayed medicalization as the desire of masculine doctors to exert control over women's bodies.[74] This medicalization of childbirth had stripped mothers of their autonomy, and therefore their authoritative knowledge. In an essay describing

[68] Kline, *Bodies of Knowledge*, 1. Difference feminists placed the female body at the center of their identity, whereas equality feminist sought transcend that biological barrier be deemphasizing the body
[69] Wolf, *Deliver Me from Pain*, 146.
[70] Wertz and Wertz, *Lying-In*, 196.
[71] Barbara Katz Rothman, "Childbirth as Negotiated Reality," *Symbolic Interaction* 1, no. 2 (Spring 1978): 126.
[72] Jordan, "Authoritative Knowledge and Its Construction."
[73] Wertz and Wertz, *Lying-In*, 219.
[74] Ann Oakley, *The Ann Oakley Reader: Gender, Women and Social Science* (Policy Press, 2005).

the different aspects of birth, Barbara Rothman argued that babies were presented as a product of the hospital rather than that of the mother.[75]

Furthermore, feminists called against the industrial-like processes in hospital maternity wards and urged for a social model of childbirth.[76] A Chicago Tribune reporter stated that before childbirth reform, doctors and nurses had carefully cultivated an atmosphere of busyness that discouraged women from taking any more of the personnel's time than necessary. The article says that the medical personnel made women feel embarrassed or afraid to seem overly dependent, and therefore, would not make their needs known.[77]

Feminists were not the only ones who felt this way. The maternity ward's management often angered women by thwarting their efforts to breastfeed. These were women whose beliefs adhered to feminist, traditional, countercultural, or practical desires. Mothers wrote that the augmentation of medical oversight and control of infant health contributed to societies' lessened faith in the abilities of women's bodies to feed their babies.[78] Women who held more traditional worldviews believed breastfeeding would bring the familial bonds closer together. Counterculturists saw it as an extension of natural childbirth and a spiritual experience. Highly educated women were also very likely to want to breastfeed, as they were in the process of reviving research on the benefits of breastfeeding. Many women also wanted to breastfeed for practical reasons, as formula could be an added expense some new mothers could not afford.[79] Whatever the reason, the industrialized nature of maternity wards made this breastfeeding goal very difficult to attain. Hospitals designed their wards to maximize efficiency and hygiene, and bottle-feeding fit into this routine far better than breastfeeding. As if this were not frustrating enough, doctors and nurses undermined a mother's autonomy by administering "dry-up" pills or injections without her knowledge or consent and gave newborns bottles directly after birth.[80] Physicians decided if they believed a mother "really wanted" to nurse, or if she was attempting to do so out of a sense of responsibility, they determined mothers did not need to have.[81]

Aside from the negative aspects of medicalization, many women also adhered to the notions of natural motherhood, subscribing to the ideas of instinctual maternal knowledge and the

[75] Rothman, "Childbirth as Negotiated Reality," 125.
[76] Carolyn Herbst Lewis, "At Home, You're the Most Important Thing: The Chicago Maternity Center and Medical Home Birth, 1932–1973," *Journal of Women's History* 30, no. 4 (2018): 45, https://doi.org/10.1353/jowh.2018.0041.
[77] Lewis, 41.
[78] Martucci, "Why Breastfeeding?," 113.
[79] Martucci, 114.
[80] Martucci, 119.
[81] Martucci, 118.

interconnectedness of biological mother and child.[82] Women with traditional worldviews saw natural motherhood as a way to strengthen familial bonds and further prevent the erosion of the nuclear family in American society.[83] Conversely, social science scholars thought the natural motherhood trend resulted from the desire for smaller families. Mothers felt that since they were only going to be "doing this once or twice, let's do it right, let's experience it as fully as possible."[84] For those belonging to the counterculture, natural motherhood cut out so many mainstream issues, and took energy in the form of truth or love, and put that energy in the form of a baby.[85]

Thus while feminists were often leading the charge, women from all different ideologies had a wide variety of motivations to seek childbirth reform. Experts and society had subjected women to the societal pressures of "good" versus "bad" motherhood their whole lives. Then finally, leaning on the dogmas of feminisms and natural motherhood, women concluded that "good" motherhood and childbirth might be different from what the medical establishments set up. Women wanted to be in control of their bodies, stop the industrialization of the maternity wards, strengthen maternal and familial bonds, breastfeed their babies, return to more natural motherhood, find spiritual meaning in birth, and find a way to achieve these goals cost-effectively. Different women were motivated by particular stimuli, but all were calling for a similar outcome. Women wanted to be granted more authority over both their bodies and their babies in maternity wards, and it all would start with more and more women coming together in childbirth education classes.

Education and Childbirth Classes

Women's desire to learn more about childbirth was stimulated by Marjorie Karmel's *Thank you, Dr. Lamaze*, in 1959, but information on childbirth was still hard to come by. In 1972, *The Birth Book*, and in 1973, *Our Bodies Ourselves* were published, helping women learn more about their anatomy and the mechanics of childbirth.[86] Still, reading of childbirth in books was not enough for many women who desired to be better prepared to insist on natural childbirth

[82] Joyce Peterson, "Baby M: American Feminists Respond to a Controversial Case," *Journal of Women's History* 28, no. 2 (2016): 107, https://doi.org/10.1353/jowh.2016.0020.
[83] Martucci, 121.
[84] Mary Doyle, "Approaches to Childbirth," *FCH/Perinatal Health Promotion*, 1978, 58.
[85] Wendy Kline, *Coming Home: How Midwives Changed Birth*, Illustrated edition (New York: OUP USA, 2019), 79.
[86] Kline, *Bodies of Knowledge*, 105.

for their deliveries. These women founded and attended child birthing classes and groups to teach mothers how to prepare for, and retain autonomy in, childbirth.

Lamaze developed from the psychoprophylatic methods generated by a Russian behaviorist and simplified by French Dr. Ferdinand Lamaze and was the most ubiquitous child education course.[87] Another popular course was the Bradly Method, which focused more on the *natural* part of natural childbirth and helped women cope with labor pains by mimicking the way animals cope. These classes became very popular exceptionally quick, as mothers were eager to become more active participants in childbirth. Doctors were also keen to have their patients attend these classes to understand better what to expect medically in delivery. One doctor stated, "An expectant mother can learn vital information at these classes which can contribute to her health and that of her child."[88]

A *New York Times* article credited childbirth classes as the primary reason women began to demand childbirth reform. It stated that in 1975, the majority of the country's 7,000 hospitals sponsored a prenatal course, while in 1970, the number was closer to ten percent.[89] Many women who attended these classes were educated, older, white women who became pregnant on purpose and planned to breastfeed afterward.[90] Prepared childbirth classes promised to teach "painless childbirth" and were often at least successful at helping mothers "handle" childbirth pain.[91]

What unexpectedly became very important to the overall childbirth reform movement is that these classes gave women a safe place to raise their concerns with childbirth practices with other mothers and the instructor. This forum-like setting further allowed these women to learn how to instruct the doctor about how they wanted their birth experiences to be. The classes were also a remarkable area for like-minded women to meet and create campaigns for other desires such as the increased training of midwives, the allowance of husbands in the delivery room, and to set up "family-centered" delivery centers that would seem more homelike.[92] Classes were able to further encourage this by including husbands in the class setting.[93] Basically, in these communities, authoritative knowledge was dispersed more equally between

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[87] Wertz and Wertz, *Lying-In*, 194.
[88] "Expectant Mothers Learn To Feel Good," *Oakland Post*, August 15, 1978, 133 edition.
[89] Richard Flaste, "American Childbirth Practices:Times of Change," *The New York Times*, November 7, 1975.
[90] Roger F. Leonard, "Evaluation of Selection Tendencies of Patients Preferring Prepared Childbirth | Ovid," *Obstetrics and Gynecology* 42, no. 3 (September 1973): 371–77.
[91] R. J. Stevens and F Heide, "Analgesic Characteristics of Prepared Childbirth Techniques: Attention Focusing and Systematic Relaxation," *Journal of Psychosomatic Research* 21 (1977): 429.
[92] Flaste, "American Childbirth Practices:Times of Change."
[93] "Expectant Mothers Learn To Feel Good."

mother and instructor, which allowed for the questioning of doctor's medical expertise. Furthermore, since expertise is inherently interactional,[94] speaking about medical processes without the doctor present allowed for the diminishing of expertise due to a lack of interaction.

Moreover, expertise is not a crystallized form of being or knowing, meaning that one could become an expert. Learning to become an expert is precisely what these women were doing in the childbirth classes. While they were likely not as well versed as doctors about childbirth after a simple course, they felt much more like an expert. They felt like someone who was capable of speaking levelly with another expert rather than the subject of the doctor's expertise. Studies showed that this was successful, as women who took these classes were more likely to have fewer analgesics and anesthetics.[95] Some medical studies even indicated that if a woman wanted less pain medication, taking childbirth classes was the primary differential variable,[96] so it appears that these performances did indeed prove helpful to women who wanted more natural childbirths. This chapter will discuss how a mother's expertise performances could occur outside the delivery room, while Chapter Three will investigate how mothers may have made these performances in the delivery room.

Ironically just as childbirth classes cemented their popularity, people began to notice a shift in some classes' philosophy. Since hospitals hosted many of the classes, they were not authentic Lamaze classes, but rather classes run by nurses who taught some Lamaze breathing methods. Some scholars suggest that this overlap compromised the childbirth classes, making them just another tool of medicalized indoctrination.[97] When Bradley classes attempted to push back against this by requiring all instructors, including nurses, to be certified, the nurses grew very frustrated and stated that they must not "allow lay-professional groups to control our profession by requiring us to be "certified" to teach childbirth education."[98] Lamaze was less extreme in its stances and thus became the standard childbirth preparation class in many hospitals.[99] Rather than help new mothers fight for authoritative power or teach them to perform expertise, these classes prepared mothers to accept the medical personnel's authoritative knowledge over the mother. As the governing body of Lamaze stated,

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[94] Carr, "Enactments of Expertise," 118.
[95] Stevens and Heide, "Analgesic Characteristics of Prepared Childbirth Techniques: Attention Focusing and Systematic Relaxation"; M. Hughey, "Maternal and Fetal Outcomes of Lamaze-Prepared Patients.," *Obstetrics and Gynecology* 51 (1978): 643–47.
[96] Kathleen L. Norr et al., "Explaining Pain and Enjoyment in Childbirth," *Journal of Health and Social Behavior* 18, no. 3 (1977): 260–75, https://doi.org/10.2307/2136353.
[97] Wolf, *Deliver Me from Pain*, 136.
[98] Christine Sullivan Cranston, "Childbirth Education Certification: Who Needs It?," *Journal of Nurse-Midwifery* 24, no. 3 (June 1979): 38.
[99] Rothman, "Childbirth as Negotiated Reality," 128.

"Examinations will be given either rectally or vaginally, again depending on hospital rules or individual physicians, but it is not for the parturient to decide who should or should not examine her during labor."[100] Thus the complicated nature of 1970s childbirth reform is revealed. Even as mothers were working so hard to learn the tools to assert their knowledge and authority, some of the very institutions they believed were helping them were only further reinforcing the sanctioned doctor-patient "natural hierarchy" found in Jordan's studies.

Thus, childbirth classes gave mothers communities with which to come together to learn about the anatomy of childbirth, how to navigate the hospital systems, and which doctors mothers could trust to follow her desires for more natural childbirth. They also allowed mothers to congregate with other like-minded women to form a community from which each mother could garner support. Since both expertise and authoritative knowledge are concepts that require the acceptance of others, these classes could help mothers perfect their performative actions they could then utilize in the realm of consumer movements. However, the childbirth classes were not always a perfect solution. Some hospitals began to host their childbirth preparation classes that included medical socialization that groomed mothers to be more accepting of hospital intervention rather than insist on entirely natural birth.

1970s Social Movements

Childbirth education classes were not the only tool women used to help them push childbirth reform. The Women's Liberation Movement was a vocal body that gave women the ability to have a platform. As it was also a hot button issue, the Women's Liberation Movement media and scholars linked it inseparably to childbirth reform, gaining a broader platform for childbirth reform discourse. Even women who did not identify with all the agenda points of the women's movement.

For example, a newspaper article written by Gail Mignacca in 1970 started with the sentence, "As a mother of two preschool children, I, too, find life so rewarding and hectic that women's lib does not always make sense to me." She was writing in reply to a previous article by a woman who generalized the second feminist wave as anti-mother. Mignacca stated that she found this generalization problematic because she agreed with the Women's Liberation movement's objection to the overuse of medication during labor and delivery and the impersonal attitudes in many city hospitals. Mignacca was a mother who had already found a

[100] Rothman, 130.

way to deliver her babies unmedicated but emphasized what she found truly important was "a total awakening and aware participating method, assisted by a husband, allows childbirth to be performed with a dignity and joy that is an inherent right of every expectant couple."[101]

Thus, most women were happy to have the social apparatus supplied by the second feminist wave paired with childbirth classes to help them find the befitting practitioners for their childbirth desires. The longing for reform included women liberationists, breastfeeding housewives, counterculturists, poor women attending free clinics, and many more. In 1971 alone, 400,000 couples were looking for nonmedicated childbirth options.[102] Correspondingly, Jordan states that authoritative knowledge is knowledge within a community that is considered legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions by people engaged in accomplishing the tasks at hand.[103] The social network of childbirth reform provided women the community Jordan is referring to, within which women could discuss and legitimize mother's autonomy and decision making around childbirth.

The Consumer Movement

The consumer movement played a vital part in childbirth reform's success. Women found that the more demanding and assertive they would be around conservative medical people, the more they were likely to be disliked or even punished. Thus, rather than be labeled the "difficult patient," and disregarded anyways, they decided to shop for doctors that would better fit their needs.[104] Mothers began operating through the networks built through childbirth classes and the women's liberation movement to frequent the doctors and hospitals willing to help them give birth the way they wanted, rather than attend their local hospital as their mother might have. As more mothers pursued their desired childbirth experience, hospital administrators realized how vital pregnant women were to their financial success.[105] As sociologist and feminist, Susan Brownmiller noted, "group pressure becomes a powerful weapon inside movements for societal change."[106] In order to facilitate this group pressure, women formed many mother-centered groups. Some grew to be national groups, such as the La Leche League,

[101] Gail Mignacca, "Childbirth with Dignity and Joy," *The Providence Journal*, October 8, 1970.
[102] Kline, *Coming Home*, 37.
[103] Ibid.
[104] Kline, *Bodies of Knowledge*, 129.
[105] Wolf, *Deliver Me from Pain*, 151.
[106] Peterson, "Baby M," 119.

which promoted natural motherhood and breastfeeding.[107] Others were small local groups, like the Traditional Childbearing Group in Boston, which helped women create a network to find doctors who supported natural childbirth and promoted prepared childbirth classes.[108] Many mothers formed groups to promote maternal awareness and protection of the newborn from the depressant effects of drugs.[109] These assemblies helped mothers to become more decisive in their consumer demands and advance their authoritative knowledge.

These consumer movements helped women to see childbirth as an evolving practice where the traditional institutions must examine their methods in the light of consumer pressure.[110] Rather than accept all doctors' expertise equally, women employed consumer authoritative knowledge to decide which practitioners were best for them. These practices displayed how women's consumer knowledge and everyday life exigencies were vastly integral to a mother's selectivity in designating specific biomedical knowledge as legitimized and others as debatable. The doctors who were not opposed or openly embraced Lamaze became very popular. While women were gaining authoritative knowledge in the consumer realm, they did not seem confident in their ability to change doctor's minds to employ natural childbirth methods in the actual delivery room. On account of this, Pam Bescher, the founder of the D. C. Chapter of the governing body of Lamaze, the ASPO, noted how crucial obstetrical support was. "The key to the thing lies with the doctor. If he is supportive, you'll get through."[111] This quote suggests that if mothers chose the wrong doctor, they might have no support or power. While helping doctors who supported Lamaze gain popularity certainly put pressure on their more traditionally minded colleagues, it seems women did not have a great deal of authoritative knowledge in the delivery room, giving some credence to scholars' critique of 1970s childbirth reform as superfluous.

Homebirth: A Consumer's Choice

While some women wanted to change the maternity system from within, others decided to leave the system altogether. In the 1970s, the percentage of hospital births reached an all-time high of 99.4%. By 1977, the rate of home births had doubled.[112] If women could not have the

[107] Martucci, "Why Breastfeeding?," 120.
[108] Regina Lewis, "Going Back to Natural Child Births," *Bay State Banner*, December 10, 1978.
[109] John S. McDonald, "Obstetric Anesthesia," *University of Colorado School of Medicine* 21, no. 2 (June 1978): 490.
[110] Doyle, "Approaches to Childbirth."
[111] Kline, *Coming Home*, 36.
[112] Kline, 3.

authoritative knowledge relationship they desired with their doctors in the hospital, they found natural childbirth advocating doctors, or midwives, to aid in home birth. As lay midwife, Fran Ventre stated, "Change…would not come from within the institutional establishment, but rather from the outside channels of alternatives."[113]

Some doctors were able to tap into this natural childbirth market and delivered babies in their offices. These births were much more natural than hospital births, but they still often included shaving, the lithotomy position, and even episiotomies.[114] Thus women went beyond the medical field to find a lay midwife to help them give birth. The usage of lay midwives or women who learned to "catch" babies through experience rather than by pursuing a medical degree is an extraordinary example of consumer authoritative knowledge. These women were so sure of their bodies' own ability to give birth correctly and safely with the experience-fueled expertise of the midwives to assist them that they forewent the "safety net" of licensed medical personnel. As sociologist Raymond DeVries argued, "A license isn't really a guarantee of expertise…Medical licensing diminishes any accountability to people, the 'consumer,' in favor of accountability to a licensing board."[115] Women sought to gain this accountability back and were determined to use the individuals they considered experts, whether they were licensed or not.

Feminists, such as Barbara Rothman, saw homebirth as a challenge by women against the rise of medicalization in obstetrics. Demedicalizing birth was not a goal only for mothers choosing home births but midwives as well. "It wasn't specifically midwifery that drew me," a Washington D.C. Midwife Jo Anne Myers-Ciecko explained. "It was the whole thing very personal, and just, you know, demystifying the whole process."[116] Members of the counterculture movement, such as Ina May, saw childbirth as a catalyst to spiritual transcendence, and opting for birth out of the hospital heightened the sacred aspect of birth and enhanced the spiritual maternity-infant bond.[117] Other women wanted to strengthen traditional familial bonds, and have the opportunity to breastfeed their babies.[118] While the majority of these women were upper or middle-class white women, there were also a significant number of women of color who had homebirths because they were denied hospital-based obstetrical

[113] Kline, *Coming Home*, 42.
[114] C. Anne Ritchie and Lee Ann B. Swanson, "Childbirth Outside The Hospital - The Resurgence of Home and Clinic Deliveries," *MCN The American Journal*, no. November/December (1976): 374–77.
[115] Kline, *Coming Home*, 144.
[116] Kline, 168.
[117] Kline, 64.
[118] Kline, 32.

care or were admitted but could not assume the same quality of care as white mothers.[119] Beyond requiring less intervention, home births were also much cheaper than hospital births. A hospital birth could cost thousands of dollars, while a home birth with a midwife could cost between $150-500.[120] Thus, home birth attracted many women from a lower socioeconomic status, including women of color, demonstrating that this movement was not *only* middle-class white women.

While these groupings' reasonings may have differed, they all felt they had the authoritative and bodily knowledge to oppose medical advice and the medical system and "risk" homebirth. Most of these women had had their first babies in hospitals and suffered such poor experiences that they chose homebirth for subsequent pregnancies. Other women chose homebirth after professional hospital experience. Midwife trailblazer Marion McCarney noted that many women who sought out lay midwives were nurses in maternity wards who desired more control over their births. These women understood the way hospitals worked and the likelihood that they would have no control over their process if they chose to give birth there.[121] Homebirth focused on giving women control of the birthing process; as homebirth advocate and mother Ester Herman stated, "In general, we are an intelligent group of women who want to govern our own bodies. We want our bodies free as we experience the bringing of precious life into this turbulent world."[122]

Of course, doctors often denied being the reason that women were choosing to leave the hospital. Some believed that home births would be sought after no matter what care medical personnel provided in hospitals, and thus it was essential to have well-trained medical professionals who knew how to deal with home births available.[123] Another obstetrician stated that the real problem in maternity wards was not disrespectful doctors but non-compliant patients.[124] Both these quotes attempt to deflect the blame from doctors' actions, but the second demonstrates an unwillingness to release any authoritative knowledge and viewed non-compliance to their expertise as a critical issue. At the same time, placing the blame for problematic maternity wards on the mother automatically places some responsibility, and therefore authority, on the mother and her actions. If the mother had no autonomy, she would not be able to be non-compliant, and if she had no authoritative knowledge, she would be

[119] Lewis, "At Home, You're the Most Important Thing," 37.
[120] Lewis, "Going Back to Natural Child Births."
[121] Kline, 63.
[122] Kline, *Coming Home*, 44.
[123] Kline, *Coming Home*, 180.
[124] Kline, *Coming Home*, 255.

unable to create a "problem" in maternity wards. While this quote is attempting to paint mothers with negativity, it genuinely demonstrates the growing authority of mothers.

The idea of "good" and "bad" mothers is especially apparent in the use of midwives and home birth. Midwives and homebirth advocates of the 1970s argued childbirth was not a medical event, but a natural one[125] and thus should not be subjected to medical professional's discretion. Of course, medical officials and the state problematized this ideal. In response, these authoritative bodies contended that they were better equipped to make decisions regarding childbirth and mothering practice by accusing mothers they deem delinquent of "bad" behavior toward or concerning their children. However, rather than cow to these institutions who would brand them as "bad" mothers, home birthers of the 1970s believed firmly in their knowledge that homebirth was the best option for them, and therefore, performed expertise over their experiences and bodies.

Medical Expert's Reactions to Reform

Reformed childbirth of the 1970s was not accepted or acceptable to everyone. While some, such as Clayton T. Beecham, a Pennsylvania obstetrician who wrote an opinion piece for *The Female Patient,* connecting natural childbirth with domestic violence and divorce,[126] were emphatically opposed. Some doctors could not understand how it would be possible to give so much individual attention to each laboring woman. One doctor compared natural childbirth to "making a Rolls-Royce," stating it was unrealistic for most hospital settings.[127] Other doctors were against the intrusion of power by women. One obstetrician from St. Louis argued that allowing for patient authority in the delivery room would forsake society's stability to please militant feminists.[128] Another doctor from Virginia complained, "Patients nowadays want everything under the sun… I've trained for medicine, and I've been a professional for years, and I know more about what's best for the patients than they do."[129]

Nurses also struggled with this "new breed" of mothers who questioned their authority, especially when it came to childcare after the birth. Mothers who had studied bonding theory demanded their babies spend more time in the room and less in the nursery. One nurse comments, "This new breed of mothers will no longer accept the answer from a nurse that her

[125] Kline, 129.
[126] Wolf, *Deliver Me from Pain*, 164.
[127] Wertz and Wertz, *Lying-In*, 195.
[128] Wolf, *Deliver Me from Pain*, 149.
[129] Flaste, "American Childbirth Practices:Times of Change," 2.

actions are "hospital policy" or "doctor's orders"…However, the nurse's responsibility for maintaining the infant's body heat has not changed."[130] This quote demonstrates the growing tension between the mother's desires and medical policy. In this particular quote, the fight for authoritative knowledge between doctor and mother use the nurse as a go-between. Before 1970, the nurses listened exclusively to the doctors, but as women began to take on more of a consumer role in the birth process, mothers became not just patients, but the nurse's clients, and thus more important to please.

Medical Experts' Acceptance of Childbirth Reform

Even though many women chose to leave the hospital for home births, the vast majority still desired to give birth in a hospital with doctors. They just wanted to do so humanely. The general director of the Maternity Center Association in New York, Ruth Lubic, called for all medical professionals to respond to the demands of mothers. She stated, "The home should not be the only place where a family can experience worth and togetherness."[131]

Many doctors agreed with Lubic. Even though natural or prepared childbirth could undermine their authority within the delivery room, some doctors saw the importance of motherly authority and autonomy. Their efforts, along with mothers' movements, played a large part in achieving real reform. In the late 1970s, medical professionals wrote nearly endless articles on the effects of psychoprophylatic childbirth preparation. The vast majority of these studies found that prepared childbirth did not necessarily reduce the pain of childbirth but instead made it far more manageable for the mother to endure and thus required her to undergo far less anesthesia.[132] These studies were numerous, well-read, and very likely to influence physicians' actions when assisting childbirth. Nevertheless, the majority of doctors were not vying for motherly authoritative knowledge but somewhat willing to allow reform as

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[130] Suzanne Arms, *Immaculate Deception: A New Look at Women and Childbirth in America* (Toronto: Banton Books, 1977), 105.
[131] Ritchie and Swanson, "Childbirth Outside the Hospital - The Resurgence of Home and Clinic Deliveries," 377.
[132] Rosemary Cogan, William Henneborn, and Frederick Klopper, "Predictors of Pain during Prepared Childbirth," *Journal of Psychosomatic Research* 20, no. 6 (January 1, 1976): 523–33, https://doi.org/10.1016/0022-3999(76)90053-2; Sheila Kitzinger, "Pain in Childbirth," *Journal of Medical Ethics* 4 (1978): 119–21; Hughey, "Maternal and Fetal Outcomes of Lamaze-Prepared Patients."; Susan Doering and Doris R. Entwistle, "PREPARATION DURING PREGNANCY AND ABILITY TO COPE WITH LABOR AND DELIVERY," *American Journal of Orthopsychiatry* 45, no. 5 (October 1978): 825–38; Niels Beck and Lawrence J. Siegel, "Prepared Childbirth: The Pregnant Couple and Their Marriage Preparation for Childbirth and Contemporary Research on Pain, Anxiety, and Stress Reduction: A Review and Critique," *Psychosomatic Medicine* 42, no. 4 (1979): 429–50; Barbara Davenport-Slack and Claire Hamblin Boylan, "Psychological Correlates of Childbirth Pain," *Psychosomatic Medicine* 36, no. 3 (June 1974): 215–25.

long as it remained under their jurisdiction. In this way, doctors did not want an actual change in authoritative knowledge, but they were willing to allow some input from the mother with the understanding that they could rescind it at any time.

One such example was that of the presence of fathers in the room. Some doctors vehemently opposed the inclusion of the husband to the birth team. Dr. Robert Nelson Jr., the chairman of the Washington D.C. Medical Society obstetrician committee, stated, "There is less confusion, less chance of contamination, less traffic with fewer people. This is, let me stress, an operating room."[133] Other obstetricians and hospitals required formal preparation before allowing the father to attend the delivery, extending the doctors' authoritative knowledge even to the father's observational skills. [134] A nursing supervisor in Boston stated, "Historically, the mother has the baby by herself, and after delivery, she goes one way, the baby goes another, and the father is left altogether…We thought, what an unnatural way to handle maternity care."[135] The nurse is giving credit for the change in maternity care to the hospital. Throughout her article, she spoke in passive voice unless she referred to how the hospital has made changes, demonstrating how the hospital staff saw themselves in charge of reform rather than the mothers.

Other doctors did not see the natural childbirth process as threatening, as they did not allow women beyond the Szasz and Hollender's Guidance-Cooperation tier. These doctors found that the well-informed women who took prepared childbirth classes had an excellent rapport with the obstetrician and were generally a calm and cooperative patient "who exhibits minimal psychologic overlay." Dr. Meek of Washington D.C. was one such doctor. He stated that natural childbirth required "a tremendous amount of trust between doctor and patient."[136] If they felt this trust, however, doctors were happy to allow these women to use less analgesia to get through their labors.[137]

Whether or not doctors wanted to facilitate actual reform, hospitals were desperate to attract women who wished for more natural childbirths. Newspapers and even television programs denoted which doctors were willing to make an effort to please the delivering mother.[138] One doctor noted the consumer revolution that was changing medicine and placed the focus of

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[133] Kline, *Coming Home,* 36.
[134] Romito, "The Humanizing of Childbirth," 139; "WHDH-TV to Televise Actual Child's Birth," *Bay State Banner*, February 9, 1971.
[135] "WHDH-TV to Televise Actual Child's Birth."
[136] Kline, *Coming Home,* 37.
[137] McDonald, "Obstetric Anesthesia," 491.
[138] "WHDH-TV to Televise Actual Child's Birth."

childbirth practices on individual humanity and dignity rather than absolute science.[139] Near the end of the 1970s, hospitals facilitated this by installing labor-delivery-recovery (LDR) rooms where women did not need to move during their hospital stay. These rooms had bright wallpaper, colorful bedspread, plants, cupboards, and drapes, with all the hospital supplies near the head of the bed or within reach but out of sight. Nevertheless, fetal monitoring, IVs, anesthesia, and even forceps were used when deemed necessary. Mothers often were very accepting of these medical interventions because hospitals built the room to allow the infant to stay near the mother and therefore facilitate breastfeeding and infant bonding.[140] Doctors were accepting of the infants remaining in LDRs because of infant bonding theory. Medical researchers released studies in the 1970s which discussed the imperative implications of infant skin-to-skin contact and mother-infant proximity in the first hours of a baby's life. For adequate bonding to occur, the studies suggested that hospitals should encourage contact in the delivery room, rooming-in, breastfeeding, and family visits to the nursery.[141]

These LDR rooms are a perfect metaphor for the childbirth reform of the 1970s. Changes were being made, and childbirth was becoming more comfortable, happy, and family orientated. However, when it came to medicine, women still were at the mercy of the doctor's expertise.

Medical Reactions to Natural Childbirth Results

Two doctors in 1978 agreed that they could not remember any such vigorous debates amongst doctors than those about natural birth methods. According to one group of doctors, natural childbirth was one of the most significant advances in modern medicine, and to the other, it was a primitive and medically unacceptable practice.[142] This polarization within the medical community likely influenced the polarization of discourse surrounding childbirth practices.

Even while the medical discourse surrounding natural childbirth continued with very extreme sides, in reality, most childbirth reform happened on a continuum. Many doctors allowed their patients to give birth with less medication while still performing an episiotomy and using forceps if they deemed it was necessary. Other women tried to incorporate Lamaze

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[139] Flaste, "American Childbirth Practices:Times of Change."
[140] Doyle, "Approaches to Childbirth."
[141] James Garbarino, "Changing Hospital Childbirth Practices: A Development Perspective on Prevention of Child Maltreatment," *American Journal of Orthopsychiatry* 50, no. 4 (1980): 592.
[142] Wolf, 165.

breathing methodology with childbirth while still using Demerol or other painkillers.[143] Women continued to vie for authoritative knowledge with their medical experts, but as this section demonstrated, many professionals were opposed, so women were forced to become creative. The use of nurses as a go-between is very scarce in the literature, but just from the small snippets found, they seemed to have been a critical player in the authoritative knowledge tug-of-war. While the women in LDRs were not performing as experts in every aspect of childbirth, they could establish authority over nurses, and they continued to use consumer choices to create better and better outcomes.

Once doctors began to perform more natural childbirths, they were shocked by the results. What may have started as an allowance to please some of their patients turned into medical precedent when physicians began delivering newborns with excellent color, reactions, and respirations for the first time in their career.[144] Doctors' moral autonomy began to overpower their trained historical viewpoint of birth as pathology and encouraged them to accept more natural childbirth methods in their delivery rooms.

Thus the medical professional reaction to the natural childbirth movement in the 1970s was undoubtedly diverse. Many doctors continued to resist mother's encroachment on their medical territory vehemently. Other doctors were happy to go along with the reform, but often only so long as they could remain in control. These doctors accepted mother's consumer authoritative knowledge to frequent the most family-orientated facilities and their autonomy to allow them to be awake and on lower anesthesia, but they ultimately rejected mother's bodily knowledge to give birth without medical intervention. In this way, they "one-upped" the mother's expertise to know what is best for her and further fortified themselves as the ultimate expert on childbirth. Whether or not doctors wanted childbirth reform, they were shocked by the highly positive results from women who had less anesthesia during labor. These medically irrefutable outcomes greatly benefitted the childbirth reform movement as a whole, helping women become one step closer to the real-time re-legitimization of their knowledge.

The Role of Technology

Technology played a large part in different people's decisions to accept or reject childbirth reform. People who positively perceived technology tended to resist reform. Technology had the potential to cement doctor's role as the expert, as medical technology could function as

[143] Wertz and Wertz, *Lying-In*, 195.
[144] Wolf, *Deliver Me From Pain*, 163.

cultural items demonstrating the doctor's authoritative knowledge and expertise. Central to this debate was the introduction of electron fetal monitors (EFM). One article stated that the monitor not only allows the doctor to follow the baby's progress but also reassures the parents of the baby's viability.[145] Of course, those opposed to even more obstetric control over birth found the EFM intrusive and negatively viewed the technology. Rather than seeing EFM's leading to better surveillance, they saw the monitors contributing to "medical jumpiness."[146] Other complaints about the fetal monitor included that it was often wrong, confined women to bed, and transformed the labor room into an intensive care setting similar to the ICU.[147]

How mothers perceived technology in the 1970s also provides insight into the authenticity of reform. They were resistant against anesthesia, episiotomies, enemas, and medical machinery, but technologies such as prenatal drugs often slipped through their resistance, demonstrating how deeply rooted the acceptance of highly medicalized scenarios as "normal" was. A 1979 newspaper article confirmed this by stating, "It is commonly believed that fewer drugs currently are being used in childbirth because "natural birth" has become so popular." Nevertheless, they state the findings of several studies that found women's drug intake during pregnancy and childbirth actually increased by fifty percent from 1973 to 1977. It goes on to state, "women have little voice in deciding which if any drugs they will consume."[148] Since the childbirth process *appeared* to be less technological, perhaps with less anesthesia and no forceps, the women did not seem to notice.

Furthermore, this quote highlights the very scary inadequate consent to drug consumption 1970s childbirth. Even the American Academy of Pediatrics Committee released a statement that said, "The physician *should* discuss with the patient, *whenever possible* before the onset of labor, the potential benefits and side effects of maternal analgesia and anesthesia."[149] This was hardly a firm edict for the doctors to follow, nor a glowing endorsement of motherly authoritative knowledge. One of the childbirth drugs that was still in circulation in the 1970s was Scope. Under the influence of Scope, women would flail and become violent to the point of needing to be strapped down. One nurse noted, "A woman can't handle herself as well with Scope. She has no control." Some women desired a more natural family-orientated childbirth, but their doctor still administered Scope. In these instances, the doctor would allow the woman

[145] "WHDH-TV to Televise Actual Child's Birth."
[146] Flaste, "American Childbirth Practices:Times of Change," 1.
[147] Monica N. Starkman, "Psychological Responses to the Use of the Fetal Monitor During Labor," *Psychosomatic Medicine* 38, no. 4 (1976): 269.
[148] Victor Cohn, "Childbirth Drugs Found to Affect Babies," *The Washington Post*, January 16, 1979, 1.
[149] Cohn, 2. (Emphasis Added)

to thrash and scream throughout her Scope-filled labor. Then when the baby was about to be born, the doctor would administer a regional anesthetic, used the Scope antidote Antilirium to wake the mother, bring the father into the delivery room, and then deliver the baby. In this way, the doctor could say the mother gave birth awake with her husband present.[150]

Concerns and controversy also shrouded induced labor. Dr. Louis Hellman from the Department of Health pointed out that the advantages of inducing labor were often clearly laid out while the disadvantages were downplayed or not considered.[151] In some hospitals, the doctor would schedule the mother's nine-month appointment, and then if he were on call that same day, he would send her directly from the appointment to the hospital to be induced. Inductions in these scenarios were usually not done for any medical reason but for the convenience of the doctor's hours.[152] This lack of respect for women's right to consent demonstrates a false sense of authoritative knowledge. Even if the mother's birth exemplified a Mutual Participation model, it is empty, as the woman's autonomy is being manipulated and denied.

1970s mothers continued to push for reform, but the complications of various technologies often clouded these movements. Even while women had negative connotations with certain drugs or technologies that would restrict their autonomy, new technologies gained warmer welcomes, although they were nearly as restrictive to women's authority. Women's authoritative knowledge was not only thwarted by doctor's positive reactions toward technology but by society's and their own positive biases. Although the use of forceps decreased, EFM usage increased. Mothers accepted new technology because it represented a change in childbirth. Unfortunately, the technological changes did not garner an abundance of reform but rather tricked mothers into believing in a false increase of autonomy and, therefore, empty authoritative knowledge.

Conclusion

This chapter focused on the social groups both fighting for and resisting childbirth reform in the 1970s. Childbirth reform clearly permeated copious aspects of society, appearing in newspapers, social science studies, and medical research. Reform was regarded both positively and negatively in all these mediums, demonstrating a struggle between mothers and doctors

[150] Joan Rapfogel, "The Baby Factory," *D Magazine*, September 1976, 10, http://www.dmagazine.com/publications/d-magazine/1978/september/the-baby-factory/.
[151] Jane E. Brody, "Inducing Labor in Childbirth: Pernicious Practice," *The New York Times*, March 10, 1976.
[152] Rapfogel, "The Baby Factory," 12.

and in-fight in the medical professional community. Society noticed and commented on the changing dynamics between mothers and doctors and noted higher levels of authority in mothers than ever before.

So was there a shift in authoritative knowledge between mothers and practitioners in childbirth? The evidence in this chapter suggests there was at least in the preparatory realm of childbirth. Women's belief in their authoritative knowledge gave them the power and confidence to demand changes from hospitals and doctors. They used their influence as consumers to encourage hospitals to allow more natural birth methods or leave the mainstream hospital environment and have their babies at home or in birthing centers. Women took and taught classes to educate themselves and others on how to navigate the hospital system to achieve how they wanted their birth process to look. Mothers even revived the midwifery practice by their demand for more family-centered care. In the introduction, the three-basic model of patient-practitioner relationships was introduced. Mothers could come together and build a maternal authoritative knowledge that redefined the classic "good" and "bad" mother categories. "Good" mothers were well-informed consumers who actively pursued the best options for their children. "Good" mothers could now be those who did their research, took childbirth classes, and found a doctor who was willing to deliver their baby without anesthesia. Clearly, the 1970s childbirth reform successfully moved mothers from the Active-Passive relationship to the Guidance Cooperation model in the hospital.

Nevertheless, doctors still seemed to retain control, and technology helped them to do so. While mothers were very excited by doctors' acceptance of bonding theory and having their husbands remain with them in LDRs, doctors replaced old technology with new technology. Technological advancements allowed doctors to sustain their placement as childbirth experts by using them as cultural items to perform their expertise. Mothers remained helpless in the face of these performances.

How did this translate to authoritative knowledge in individual childbirth cases? Were women able to get past being a "good" patient who took direction docilely? Were medical experts still entirely in power here? When it came to the actual hours of delivery, who held the authoritative knowledge? These are the questions a closer look at individual women's birth memoirs in Chapter 3 will answer.

Chapter 2, 1990s: *Medical Interventions are ~~Bad~~, ~~Good~~, the Mother's Choice*

Determining the authoritative knowledge distribution of birth culture in the 1990s

Introduction

Although the TV show *Friend's* Phoebe's 1998 childbirth is extreme, as she is the surrogate of her brother's triplets, the episode "The One Hundredth" still gives an excellent impression on the ideas about childbirth in the 1990s.[153] Phoebe arrived in the hospital after her water breaks but before she is having any contractions. The whole crew is allowed back with her. They could come and go as they pleased until Phoebe is fully dilated and ready to deliver. Then the doctor asks everyone but the father to leave. At the beginning of the episode, jokes are made that assume Phoebe's Lamaze class attendance. In this episode, Phoebe can switch her doctor, not once but twice, to receive the care she wants. The camera shows Phoebe hooked to a fetal monitor and IV, but her acting and screaming during contractions make it appear she is giving birth without an epidural. When Phoebe begins pushing, she is in an elevated hospital bed with no stirrups. Once Phoebe has the triplets, they find that one baby they thought was a boy on the sonogram is actually a girl. This whole episode is fascinating in terms of 1990s childbirth because it displays the natural childbirth of multiples, which are routinely done by C-section, and the failure of technology.

As seen in the last chapter, childbirth reform was at the forefront of many twentieth-century women's minds. By the 1990s, however, new technologies threatened to keep childbirth firmly in the realm of medicine, but this time while paying lip service to women's autonomy and choice. This decade witnessed the rise of epidurals, inductions, and Cesarean sections in unprecedented amounts. Hospitals continued to push alluring programs to attract more mothers, as the frequent use of expensive technologies led to rising hospital birthing costs.[154] Thus at the same time, home births and midwife births also continued to grow. Both sides

[153] Kevin Bright, "The One Hundredth," *Friends* (United States: NBC, October 8, 1998).
[154] Pamela K. Stone, "A History of Western Medicine, Labor, and Birth," in *Childbirth Across Cultures: Ideas and Practices of Pregnancy, Childbirth and the Postpartum*, ed. Helaine Selin, Science Across Cultures: The History of Non-Western Science (Dordrecht: Springer Netherlands, 2009), 279, https://doi.org/10.1007/978-90-481-2599-9_4.

champion women's "choice in childbirth," even while actively disparaging the opposing viewpoint. The combination of hospitals needing birthing women to continue to grace their halls as consumers, women's continual pursuance for reform, and practitioners' realization that some autonomy could be returned without relinquishing all, created significant changes in childbirth culture by 1990. Gone were the separate labor and delivery rooms, the knock-out medication, and bodily restraints. Husbands were allowed in the room, women could choose their level of pain medication, and perhaps most importantly, babies could remain with the mother. Some women appeared to be content with these changes; others seemed to want more. Yet, even what "more" was varied for different women, as some wanted more convenience and medical interventions, while others wanted more bodily authority and control. Why did this divergence take place? How had a movement so singularly focused in the 1970s toward natural childbirth become so fractured in the 1990s? Had the reformations of the 1970s achieved its goals by the 1990s? Was this divergence due to increased mother's authority, or the opposite? Were these women fully aware of the consequences of their actions?

Scholars have viewed the shift toward more technocratic births as both instances of women's choice and doctors' desires. Wertz and Wertz argue that this shift toward more technological deliveries began in the late 1980s, not as a push from feminists' choice or doctors' power, but out of a desire by both parties to have a "perfect child" and "perfect birth." Thus, they argue that mothers still desired the natural, simplistic, and beautiful births they pursued in the 1970s, but in the 1980s and 1990s, women were willing to trade natural childbirth for assurances both doctors and women felt only technology could provide. Anthropologist Robbie Davis-Floyd also agrees with the new emphasis and increased reliance on technological knowledge. She states that for some, accepting a technocratic birth was empowering because they felt that they were participating in American culture and values. In doing so, they are also comforted that their life had not assigned them to the less-valued realm of nature or those who could not attain or afford technology.[155] Davis-Floyd was not the only scholar to focus on mother empowerment. Jacqueline Wolf argues that women conferred the power and control they felt in natural childbirth by taking charge of their labors to the epidural's ability to allow laboring women to maintain their composure and socialize normally. She argues that by the end of the century, women did not want to engage in a birthing experience that would be a central life experience but rather a planned, efficient event with limited pain.

[155] Davis-Floyd, *Birth as an American Rite of Passage*.

This claim in itself is controversial, as home births and midwife-assisted births continue to rise throughout the 1990s.[156]

Finally, Wolf argues that doctors influenced some women who had more medicalized births in the 1990s by paying lip service to the idea of women's empowerment, but in actuality, they desired a higher level of control over childbirth.[157] Cecilia van Hollen likewise argues for a reassessment of the execution of women's choice in the process of accepting the technocratic model and the extent to which agency is in and of itself empowering.[158]

While these scholars point to different motivators and catalysts, they all see a back-slide in childbirth culture from the 1970s to the 1990s toward more medicalized births. This chapter will delve into this claim by performing a similar discourse analysis to chapter one. As that chapter looked to the larger social discourse between mothers and practitioners on the societal level in the 1970s, so too will this chapter for the 1990s. This chapter will further examine whether the generalized increase of medical technological intervention or specifically the undesired use of medical technological intervention as the top authority had the power to supersede women's autonomous knowledge in the 1990s.

A Divergent Reform

The question of diverging attitudes toward childbirth has been woefully understudied, as most research only points to an increased medicalization without addressing the growing minority of natural childbirth enthusiasts. Again taking the tiered system of Szasz and Hollender, the 1990s saw women in the Active-Passive, Guidance Cooperation, and perhaps even in or approaching the Mutual Participation model. The question remains whether mothers found themselves in these tiers due to physician preferences or their own. Maybe it was an erosion of the consumer authoritative knowledge women gained in the 1970s or a further progression of mother's authoritative knowledge in even more delivery room decisions by asserting autonomy and bodily knowledge.

Moreover, Jordan argued that in American hospitals, medical knowledge superseded and delegitimized other potentially relevant sources of knowledge, such as women's prior experience and the knowledge she has in the state of her body. The mother herself comes to devalue her knowledge in the face of medical knowledge, believing the professionals can best

[156] Eugene Declercq, "Trends in Midwife-Attended Births in the United States, 1989-2009," *Journal of Midwifery & Women's Health* 57, no. 4 (2012): 10, https://doi.org/10.1111/j.1542-2011.2012.00198.x.
[157] Wolf, *Deliver Me from Pain*, 272.
[158] Hollen, "Review Article," 505.

chart a course of action for her. While the examples she uses are from the 1980s, she writes as though her theory of medicalization is a universal truth also found in the 1990s. This chapter will assess the historical context to determine how authoritative knowledge between practitioner and mother changed from the 1970s to the 1990s.

In contrast to the 1970s, some women wanted a say in the childbirth process to avoid natural childbirth. Many saw natural childbirth as ruthlessly barbaric. As one mother stated, "I honestly cannot comprehend anyone wanting to do this natural and 'experiencing' it. To me, it's not the pain, the idea is to have a healthy baby."[159] One magazine article wonders if natural childbirth advocates declined Novocain when having a cavity filled.[160] Interestingly, this directly links childbirth to pathology similar to gynecology. In 1999 a column in the *Boston Herald* stated, "More and more women have decided that there is nothing noble about writing one's way through labor and delivery."[161] That same year a *New York Times Magazine* article wrote, "Advocates of drug-free childbirth tout the experience as if it were an extreme sport - no pain, no gain." Women who elected for high levels of intervention were often quite vocal about their decision to do so and sometimes disparaging of others who did not, but the demographics of childbirth studies show they were not the trendsetters of the 1990s, as scholars treat them. [162]

Some of these women were individuals who had already given birth once before using natural childbirth methods. Rather than feel exhilarated and alive, they found their birthing experiences to be incredibly painful. These women often felt cheated or lied to by natural childbirth advocates or natural childbirth classes. Natural childbirth was fine for those who wanted to pursue it, but they believed not every woman should feel like that was their only or "right" choice.[163]

Natural Childbirth

Still, natural childbirth was a choice that many women continued to make in the 1990s despite its drop-off in literature. Many feminists still saw the unnecessary use of medical technology as destructive to women's chance to maintain control over birth and participate in natural female bodily processes.[164] Some women who desired natural childbirth in a hospital

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[159] Sarah Jane Brubaker and Heather E. Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," *Sociology Compass* 3, no. 1 (2009): 231, https://doi.org/10.1111/j.1751-9020.2008.00183.x.
[160] Joel Achenbach, "At Least Childbirth Doesn't Hurt Your Wrists," *Orlando Sentinel*, May 16, 1993, 22.
[161] Wolf, *Deliver Me from Pain*, 176.
[162] Wolf, 172.
[163] Wolf, 176.
[164] Brubaker and Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," 220.

setting did not focus on the concepts of control and authority but rather the presence or absence of analgesia or anesthesia.[165] These women were far more likely to accept large amounts of intervention as long as they were able to remain unmedicated. In this way, again, there is the presence of "allowed" autonomy from the doctor, deflating the woman's authoritative knowledge. For many other women who wanted a natural childbirth, this was not enough. They desired childbirth without medication, perineal shaves, enemas, internal monitors, and an increased allotment of time to bond with the baby.[166] Due to these criteria, some concluded that actual natural birth only ever happened outside a hospital setting.[167]

While homebirth was not as widely publicized as in the 1970s, there was actually a larger percentage of home births in the 1990s.[168] The ability for women to more easily reach the tier of Mutual Participation on the Szasz and Hollender practitioner-physician model attracted many women who felt control was a significant priority in their birthing experience. The choice for homebirth was an extension of the consumer movements developed in the 1970s but with an even greater need for staunch authoritative knowledge. Now that some time had passed since the resurgence of homebirth, medical professionals and legislatures were even more vocal in opposition. One doctor even stated it was the earliest form of child abuse.[169] Legislation continued to make home birth more difficult by restricting licensure for lay midwives, restricting mother's legal access to homebirth midwives who were entirely out of mainstream medicine.[170] Thus mothers who still chose home births, especially those with lay midwives, had to be even more sure of their authoritative knowledge to behave so blatantly against the mainstream without the momentum of the natural childbirth movement to propel them onward.

Some women who were not ready to take the full plunge to home birth instead had birth center births attended by midwives. Hospitals were also eager to build birthing centers that were adjacent or attached to the main hospital. After opening two such centers in DePaul, the president stated, "The birthing experience is one of our main opportunities to please the mother. If we please her, we'll be the provider of choice for the whole family."[171] Birth centers

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[165] Brubaker and Dillaway, 221.
[166] Peggy Anne Field, "Parents' Reactions to Maternity Care," *Midwifery* 1, no. 1 (March 1985): 37–46, https://doi.org/10.1016/S0266-6138(85)80052-8.
[167] Brubaker and Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," 220.
[168] Declercq, "Trends in Midwife-Attended Births in the United States, 1989-2009."
[169] Wertz and Wertz, *Lying-In*, 292.
[170] Craven, "Claiming Respectable American Motherhood," 195.
[171] "Baby Boom: Area Hospitals Court Expectant Mothers in Hopes of Forming Long-Term Relationships as Health Care Providers," *St. Louis Commerce*, July 1, 1998, 2.

continued to gain popularity in the 1990s, and by 1999 there were 160 centers in operation.[172] In a comparative study between hospital births and birth centers, women were much more satisfied with birth center care.[173] These centers, however, were often only available to those who could pay for them, as they were often not covered by health insurance.[174] Even so, one study demonstrated that having centers staffed by mixed professionals of CNMs and physicians provided the greatest satisfaction and lowest cost per visit,[175] sometimes even sixty-five percent less expensive than hospitals.[176] This pricing meant that people who could not afford high-quality healthcare could choose to have birth with a midwife in a health center. A CNM named Donna Rodrigues commented, "I responded to the need for this type of service, especially in immigrant communities that may not have the language skills or access to quality health care."[177]

Thus, while many scholars point out that natural childbirth tapered off after the 1970s, this evidence suggests that natural childbirth was still very much an option women often chose in the 1990s. What had changed was that women were less trusting of the hospital system to respect their natural childbirth wishes. They knew that they would need to exert strong will in the hospitals, and therefore had better chances at home or in a birth center. This evidence illustrates that women were still willing to trust their bodily knowledge and thus exert authoritative knowledge in a world of even more technology.

The Importance of Choice

The largest group of 1990s birthing women argued that the actual birth experience did not matter so much as their say in it. Several studies in the 1990s showed that very similar birth experiences, in terms of technology, location, and length, could have extremely different satisfaction rates perceived by the mothers. Women who believed mothers should choose their interventions pointed to studies that displayed higher reported satisfaction in mothers who retained some control over their care, were sustained by another person, had relief from pain,

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[172] Susan E Stone, "The Evolving Scope of Nurse-Midwifery Practice in the United States," *Journal of Midwifery & Women's Health* 45, no. 6 (November 1, 2000): 538, https://doi.org/10.1016/S1526-9523(00)00084-2.
[173] Ulla Waldenstrom et al., "The Childbirth Experience: A Study of 295 New Mothers," *Birth* 23, no. 3 (September 1996): 144.
[174] Wertz and Wertz, *Lying-In*, 285.
[175] Arden Handler et al., "Women's Satisfaction with Prenatal Care Settings: A Focus Group Study," *Birth* 23, no. 1 (March 1996): 32.
[176] Stone, "A History of Western Medicine, Labor, and Birth," 278.
[177] Achenbach, "At Least Childbirth Doesn't Hurt Your Wrists," 4.

and had her attendants accept her personal birth philosophy during the birth experience.[178] These women, like those in the 1970s, wanted to gain control of the authoritative knowledge relationship. In one study, approximately forty percent of birthing women wanted to have a say about when hospital personnel would be present, and whether or not the doctor would induce labor and order an enema.[179] If they were able to establish a level of authoritative knowledge, they might have chosen to relinquish some medical control to the medical professional. For example, in an intervention such as internal fetal monitoring, which would confine a mother to the bed, the mother wanted to have the free choice to decide whether she would be monitored. This choice would be a performance of expertise, and therefore a display of authoritative knowledge. Yet, if she chose to have the internal monitors placed, this would be a return of medical control to the doctor. Consequently, the mother would actively decide to slide from a Mutual Participation relationship to a Guidance Cooperation model. The question scholars often raise, however, is how authentic the woman's choice was. Regularly, doctors greeted the woman who chose to have interventions with acceptance but resisted those who did not want them.

A popular way for women to establish this communication before the actual delivery was to create birth plans. While there is little study into the effectiveness of birth plans on 1990s births, constructing one at least ensured that women did their own research into their options and potentially had preliminary talks with their practitioners about it.[180] Most importantly, the use of birth plans might have helped deal with consent issues that continued to rack medicated births.

Even with a birth plan, many 1990s women were painfully aware of how hard asserting authority is for laboring mothers within a hospital, so they would hire a doula. These doulas would act as someone who accepted the mother's authoritative and bodily knowledge, thus giving the mother more confidence in her ability to give birth. They could comfortably go toe-to-toe with medical experts as the mother's advocate, as they were not currently in the throes of labor and had attended prior births. Doulas helped women navigate the hospital environment and stay true to their childbirth plan, especially for an unmedicated birth. They sometimes even

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[178] Jude Kornelsen, "Essences and Imperatives: An Investigation of Technology in Childbirth," *Social Science & Medicine*, Building Trust and Value in Health Systems in Low- and Middle- Income Countries, 61, no. 7 (October 1, 2005): 1496, https://doi.org/10.1016/j.socscimed.2005.03.007.
[179] Field, "Parents' Reactions to Maternity Care."
[180] Stephanie J Brown, "Communication and Decision-Making in Labour: Do Birth Plans Make a Difference?," *Health Expectation* 1 (1998): 106.

helped with the childcare after the baby had been born.[181] Studies found that doulas helped women to have shorter labors and tolerate pain better but were sometimes inaccessible because they fell outside the realm of medical insurance. Still, as they grew in popularity, some hospitals provided free doulas for laboring mothers.[182]

By the 1990s, most women did not believe in one singular birth experience that all women should be trying to attain as they did in the 1970s with natural childbirth. Instead, they wanted to have the option to choose their level of intervention. Mothers were better informed than ever before, and they felt they could be the expert of their own birth experience. However, they also knew that this could be an onerous concept of which to convince their doctors. Therefore they created birth plans and hired doulas to give them more tools to gain authoritative knowledge. Birth plans acted as both a piece of cultural material and jargon usage that Carr points out as expertise importance. Doulas were for mothers as nurses were for doctors. Doulas displayed their competence in their profession while still deferring to the mother's wishes, thus fulfilling the interactive requirement for expertise and thereby further legitimizing her knowledge and desires as an expert.

Authenticity of Authoritative Knowledge

Women in the 1970s were socially creative and relied heavily on their power as a consumer to achieve profound childbirth reform. In the 1990s, hospitals were willing to respect the authoritative knowledge of women as consumers in many areas of birth. As one hospital CEO stated, "The birthing experience provides for a potential lifetime relationship with an individual and a family, and that's economically beneficial for a hospital." Certainly, the hospital had become awaken to the consumer demands of mothers and promoted their consumer authoritative knowledge in the hopes of keeping their business. Before building new wings, hospitals held focus groups with mothers to build what mothers legitimately wanted. Hospitals promoted childbirth classes, labor-delivery-recovery (LDR) rooms, vegetarian menus, and even doula services to make themselves more attractive.[183] Hospitals became aware that mothers desired to make even more choices about their birthing process, and thus presented them with non-medical options, such as wearing pajamas rather than a gown, playing music,

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[181] Dian Weaver Dunne, "Founder of Doula Service: 'We Mother the Mother' an Aide to Childbirth," *Hartford Courant*, November 12, 1998, sec. B1.
[182] "Baby Boom: Area Hospitals Court Expectant Mothers in Hopes of Forming Long-Term Relationships as Health Care Providers."
[183] "Baby Boom: Area Hospitals Court Expectant Mothers in Hopes of Forming Long-Term Relationships as Health Care Providers."

dimming the lights, having multiple support people in the room, and allowing the baby to remain their entire stay in the mother's room.[184] Undoubtedly, the 1970s consumer movement to change childbirth had been successful on some level. Yet the question remains: since many of these choices could be considered second-tier desires compared to the fight for control with the obstetrician over the anatomically essential aspects of delivery, such as medication, birthing position, and which interventions are necessary, how authentic was women's ability to gain true authoritative knowledge in the 1990s?

Scholars have pointed out that medical professionals often steered women toward their interests rather than fully explaining all the women's options.[185] Especially with more uneducated women, doctors could present choices so that women often "chose" to surrender a large amount of control to the doctor. For example, if labor was going longer than a doctor may like, the doctor may make the mother "choose" between augmenting the labor with drugs or causing intense harm to the baby. Yet studies have shown that the recording of labor times was a hospital construct as the hospital only recorded labor from the mother's hospital admittance rather than her first contractions. In this way, they negated the mother's bodily knowledge to know when her first contractions were and asserted their medical expertise as to when labor was too long. Doctors then might perform a c-section even if the EFM recorded no fetal distress.[186] Doctors also used the second-tier choices to encourage women to trust their doctors to make the medical decisions. Once a mother chose one form of intervention, it often led to subsequent interventions, sometimes called the "cascade of intervention."[187] This cascade could leave the woman feeling that because her body could not "correctly" give birth, she may be unable to care for her newborn correctly.[188]

Sometimes mothers trusted their consumer authoritative knowledge much better than their bodily knowledge. Mothers who meticulously chose their obstetrician felt that to distrust their doctor's instruction was to doubt themselves. As one mother said, "There comes a point where you feel not trusting your doctor is not trusting your judgment because you put time in selecting him, and should you begin to doubt him, you lose confidence in your own ability to make sound

[184] Wolf, *Deliver Me from Pain*, 150.
[185] Wertz and Wertz, *Lying-In*, 290.
[186] Meredith Goad and David Hench, "Changing Attitudes Cut Rate of C-Sections Women Are Urged to Be Patient as More Doctors Agree That Natural Birthing Is Usually Best," *Portland Press Herald*, July 6, 1998, sec. 1A.
[187] Newnham, McKellar, and Pincombe, *Toward the Humanisation of Birth*, 46.
[188] Field, "Parents' Reactions to Maternity Care."

judgments."[189] Thus a woman's consumer actions could have potentially caused her to diverge from her birth plan unnecessarily due to the trust she placed in her doctor. In this example, the mother could potentially slide from Mutual Participation to Guidance Cooperation but not because of her authoritative knowledge to do so, but because she has fully surrendered her authoritative knowledge to the expert she has chosen.

Increasing legal liability and the threat of malpractice litigation also shaped care management, creating an environment where many choices and options purported to be available for parents did not genuinely exist.[190] In other areas of birth, there were still unnecessary customs that restrained women's autonomy. One such example is that women were still not allowed to eat during labor, despite studies that showed women were stronger during labor and that babies had higher Apgar scores* in the fed group.[191]

Even for women who were willing to turn their birth experience over to their doctor fully, studies showed that they struggled with emotional distress when they had poor communication with medical personnel. Women did not care whether the doctor was male, female, or of their ethnic background; they just wanted the doctor to answer their questions.[192] In one study, forty percent of women left the hospital with unanswered questions about their labor and delivery.[193] However, unlike early twentieth century hospitals, 1990s hospitals were working to make this less often of a reality. The vice president of Planning and Marketing for Unity Health stated, "Across the nation, people are looking for a more personal type of birthing experience...We need to be responsive and to anticipate what that means in terms of access of our physicians and hospitals."[194] Unfortunately, this personalization depended greatly on socioeconomic status. For example, in one study at a lower socioeconomic free clinic, women were asked how they wanted to give birth, yet they had not had any real time to talk over their options with a practitioner, nor access to classes that would inform them of their options, and thus did not

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[189] Ellen Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," in *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, ed. Robbie Davis-Floyd and Carolyn F Sargent (Berkeley: University of California Press, 1997), 148, https://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=8684.
[190] Elaine Zwelling, "Childbirth Education in the 1990s and Beyond," *Journal of Obstetric, Gynecologic, & Neonatal Nursing Clinical Issues*, June 1996, 428.
[*] The Apgar score describes the condition of the newborn infant immediately after birth and, when properly applied, is a tool for standardized assessment 18. It also provides a mechanism to record fetal-to-neonatal transition. Apgar scores do not predict individual mortality or adverse neurologic outcome
[191] Leslie Ludka and Catherine Roberts, "Eating and Drinking in Labor," *Journal of Nurse-Midwifery* 38, no. 4 (August 1993): 205.
[192] Handler et al., "Women's Satisfaction with Prenatal Care Settings: A Focus Group Study," 33.
[193] Field, "Parents' Reactions to Maternity Care."
[194] "Baby Boom: Area Hospitals Court Expectant Mothers in Hopes of Forming Long-Term Relationships as Health Care Providers."

have enough information to make such a decision. This lack of assertiveness from under-educated mothers reinforced the idea that patients were too ignorant to make meaningful choices in the clinic staff.[195]

In some cases, hospital consumer policy could potentially strengthen mother's authoritative knowledge, especially those that gave women the right to choose their birth preferences. Similar to doctors presenting manipulative choices, hospital policy could also diminish motherly bodily knowledge. In an effort to stop inductions, some hospitals developed a policy not to admit women if they were not in "True Labor."[196] Rather than allowing that labor sometimes took longer than medical books taught and either permitting the mother early or allowing that hospitals should not admit women until their contractions were so many minutes apart, hospitals denied women's bodily knowledge. By calling more progressive labor stages "True Labor," they were delegitimatizing the early labor pains the mother was having that prompted her to go to the hospital. Therefore mother's bodily knowledge and authoritative knowledge had the potential to be delegitimatized by the medical establishment at the very earliest stage of the child birthing process. Furthermore, if a mother chose to go to the hospital "too early," she may be turned away for not being in "True Labor," or the doctor might admit her and start her labor clock, and use his expertise and moral autonomy to manipulate the mother into allowing him to augment her labor to conform to obstetrical labor length policy. Whether or not the mother was admitted to the hospital, the labor was still the same, yet both the obstetrical and hospital procedures disregarded this reality for their authoritative knowledge. As Jordan says, authoritative knowledge does not need to be objectively correct to be accepted as legitimate.

Authentic choice and, therefore, authoritative knowledge could be difficult to come by in the 1990s. There were many ways in which hospitals and obstetricians influenced mothers into believing they had choices, but in actuality, they were being manipulatively given options or only offered real choices in relatively superfluous items. Ironically, mother's complete trust in their consumer expertise also had the potential to undercut their delivery room authoritative knowledge. These mothers were sure of their ability as consumers, likely from years of experience, but did not trust their bodily knowledge enough to feel they could be an expert in the delivery room. Poor communication and delegitimatizing policy also played prominent

[195] Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," 141.
[196] Goad and Hench, "Changing Attitudes Cut Rate of C-Sections Women Are Urged to Be Patient as More Doctors Agree That Natural Birthing Is Usually Best."

roles in the mother's inability to make informed stances and perform expertise. All these instances display traps within which women hoping to attain authoritative knowledge could fall. Chapter four will take a closer look at whether or not individual women could sidestep these traps and find authentic authoritative knowledge in the delivery room.

Medical Experts' Reactions

As with the 1970s, doctors had extremely diverse responses to childbirth reform in the 1990s. Doctors were aware that women wanted to continue to have more and more say in their child birthing process, but they expected the mother to be very vocal if she desired this. For the first time, it seemed authoritative knowledge on the mother's part was up for debate. A resident at Tulane Medical Center stated in 1993, "if the patient brings to the relationship with the physician a sense of what she wants in her health care, she can be a more active participant."[197] Physicians believed it was up to the mother to support a communicative relationship with her physician, not the other way around.

Even so, doctors continued to be frustrated with the idea of having to share the control of childbirth. One physician stated, "I get angry because I think aggressive patients come with many misconceptions, and they are sort of putting all the things that they've heard about and all their other experiences…They still want an unwritten guarantee that they are going to have a healthy baby with no interventions, and I can't provide that."[198] This statement is packed with data on the complicated interactive nature of a mother's authoritative knowledge. First, women who wanted to give birth a certain way, here without interventions, were labeled as aggressive patients. The doctor anticipatedly labeled authoritative mothers as aggressive undoubtedly colored her communication and attitude toward them and their birth plans. Second, these women pulled from peer experiences and their own prior experiences. Carr states that experience is one of the main ingredients of creating an expert, and these mothers' budding expertise challenged the doctor's expertise in an uncomfortable way that genuinely angered doctors. Finally, this quote demonstrates that doctors felt the weight of moral autonomy within childbirth, and this was why they desired to stay in control. This doctor could not make any guarantees at all in reality, but she emphasized that she could not make this guarantee *without*

[197] "Changing Styles in Childbirth," *New Orleans Magazine* (New Orleans, United States: Renaissance Publishing, October 1993), 2.
[198] Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," 148.

interventions, insinuating that she may have been able to have made it with interventions. Scholars often emphasize mothers' desire for a perfect baby and their willingness to submit to interventions to make this happen, but few point out that the origin of this philosophy may come from the doctors themselves. This doctor, at least, seemed to believe that increasing interventions would raise the likelihood of a healthy baby.

Of course, doctors were not opposed to helping mothers receive the care they wanted, but sometimes they just believed they knew what mothers wanted most. As one physician stated, "Patients who come in with a list of demands end up getting inferior care both medically and probably in other ways [like] support…The support personnel are so annoyed by the demands…they tend to rest the patients and probably cannot be as supportive."[199] Again, this quote demonstrates that doctors and all medical personnel believed themselves to be experts over mothers, and mothers who thought they knew what they wanted effectively only established themselves as difficult patients. The difference here from the 1970s is that nurses did not strap these women to the table. Instead, that the staff "probably cannot be as supportive" suggests that the mothers continued with their unsupported birth plans despite the resentment.

Another example of the growing consumer excitement around LDRs also displayed doctors' feelings of expertise over the mother, even on second-tier decisions. One obstetrician stated he believed the excitement around labor-delivery-recovery-postpartum rooms (LDRP), where women were not required to move at all during their hospital stay, was a "hype." He went on to say, "I think they care about comfort, coziness, open visiting hours, and quality of care." While these were undoubtedly aspects of birthing that women also usually desired, the popularity of rooms allowing for a more home-like experience where medical personnel did not shuffle women about was evident.[200] Here, even the popularity of second-tier decisions frustrated doctors, as they genuinely believed they knew best what mothers wanted and how to give it to them.

Insurance agencies were another group that frustrated doctors by making demands they felt were not backed by expertise. In the 1970s, these administrators helped promote mother's authoritative knowledge by reconfiguring their hospitals and staff to curate to their birthing desires. By the 1990s, however, insurance agencies sometimes undermined that newfound authority. Insurances were all for more natural births, since interventions were often costly, as long as there was no room for a lawsuit. Thus when mothers began to elect for epidural

[199] Ibid
[200] "Baby Boom: Area Hospitals Court Expectant Mothers in Hopes of Forming Long-Term Relationships as Health Care Providers." 24.

anesthesia to help with labor, insurance companies denied women's claims stating there was no medical need for treatment.[201] Interestingly, the attempted eradication of motherly autonomy in removing their access to epidurals caused doctors to back their authoritative knowledge. The American College of Obstetricians and Gynecologists (ACOG) and the American Society of Anesthesiologists (ASA) issued a joint Committee Opinion in 1993 stating, "Maternal request is a sufficient justification for pain relief during labor."[202] Thus providing the mother with authority over her pain treatment based on only her bodily knowledge. Again, the fight for mothers to be allowed to say "yes" to epidurals automatically strengthened her ability to communicate "no" or demand other less medically invasive choices, such as the rejection of an enema or shaving. Furthermore, this allowance for mothers to choose an epidural was essential for many individuals. For example, studies showed epidurals greatly improved the experiences of mothers with a history of sexual abuse, preexisting vaginismus, or mental impairment.[203]

Moral Autonomy in Different Disciplines.

When patients did insist on their own decisions, doctors sometimes felt caught in between what they considered their moral obligation of acting in the mother's best interest and the ethic of respect of her freedom of choice. One obstetrician said, "Once somebody comes in and they're starting to progress, but they're not quite in labor, we may rupture their membranes, or we may give them Pitocin. We start intervening, and we start interfering with nature." Obstetricians knew that they were interfering with nature, but they felt the need to perform expert actions to demonstrate their expertise. In doing so, they believed they placated their patient and assured her an expert was treating her.[204]

Anesthesiologists, in particular, struggled with this dilemma because they saw their primary mission to be the relief of pain and suffering of not just mothers but all patients.[205] Many felt to allow a woman to choose to be in pain went against their moral autonomy. These doctors struggled to understand that a much smaller population of women wanted all their pain taken away than they thought. One anesthesiology study was surprised to find that only four

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[201] Wolf, *Deliver Me from Pain*, 177.
[202] Ibid
[203] Tekoa King, "Epidural Anesthesia in Labor," *Journal of Nurse-Midwifery* 42, no. 5 (October 1997): 379.
[204] Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," 142.
[205] Andrew Ross, "Maternal Satisfaction with Labor Analgesia," *Bailiere's Clinical Obstetrics and Gynecology* 12, no. 3 (1998): 500.

percent of women ranked the capacity to cope with pain as a significant factor to their overall satisfaction with labor, while forty-five of the mothers felt the feeling of pain essential in the experience of childbirth.[206] Doctors believed that women who wished to decrease medical intervention as much as possible and strive for a more natural birth were in a more extreme minority.[207] While it was technically a minority, studies such as the one noted above demonstrate it was not the fringe population so many believed it to be.

Many of these reasons were why an ever-increasing number of women continued to choose midwives, along with others. Midwives were also thirty-forty percent cheaper than doctors and had a better chance of having fewer interventions. "We want to give you the kind of birth experience that you want."[208] Stated Marie Hayes, a CNM at the New England Medical Center. CNMs of the 1990s did not see themselves only as natural childbirth advocates but instead advocates of the notion that the mother have the birth she desired. Jo Anna Rorie, a CNM and pioneer of midwifery in Boston, stated:

> We all practice within the culture of the hospitals. If a woman says no medication, we're committed to that. We'll be their labor support person. We'll rock them, massage them, talk to them, give them warm showers - we'll do everything we can to relieve and distract them from the pain naturally. But if they want the epidural [local anesthesia], we'll make sure that they get it. We don't abandon the must because they stray from a plan they wrote out months before the delivery. We do not deny the woman the medication if she wants it.[209]

Here, the midwives spent time with the mothers before finding a viable birth plan and providing epidurals if the woman changes her mind. The mother is in control, although she must rely on the expert to administer her medication. Furthermore, the use of warm showers suggests that midwives did not heavily monitor these mothers or confined them to bed. Later in this same article, Rorie states that insurance companies are asking hospitals where their midwives are. This shift in consumer demand for midwives in the hospitals demonstrates again that mothers' consumer authoritative knowledge creates reform. Moreover, the increased number of women who chose to give birth to midwives signaled to doctors and hospitals that mothers wanted more control in the actual birthing process. Mothers wanted improved assurance that they would have the ability to get up and move around without compromising their power to request medication if the labor began to be too intense.

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[206] Ibid
[207] Zwelling, "Childbirth Education in the 1990s and Beyond," 429.
[208] Crystal Hubbard, "Hub's Midwives Offer Alternative to Traditional Hospital Childbirth," *Bay State Banner*, November 2, 1995, sec. 13.
[209] Hubbard.

Similar to the 1970s, 1990s medical experts had diverse opinions on how much say a mother should have in childbirth. The main difference is that most doctors in the 1990s suggest that they are pro-mother's-choice, even while their actions may hint at a higher preference for control. This emphasis on the mother's ability to choose treatments that doctors preferred them to have, such as c-sections or epidurals, was incredibly important. It gave mothers a reinvigorated ability to choose what they wanted for their delivery, even if it was not the choice their doctor may have desired them to make. Doctors campaigning for mother's choices cemented that ability for mothers in public opinion and thus, gave mothers a laity that agreed she had the authoritative knowledge. Whether or not she could take this conceptual authoritative knowledge and apply it to individual encounters in the delivery room will be examined in Chapter 4.

The Role of Technology

Hospitals in the 1990s worked to make women and their husbands "participants in the birth process."[210] Although this meant mothers were not the central player, many were willing to surrender some control to collaborate with medicine's new birth technologies. The highest demographic for elective C-sections were well-educated professional women who believed the technological control would guarantee a smooth birth and that the baby would be perfect.[211] Cultural bias toward technology was even more substantial in the 1990s, as more and more women regarded technology positively, consequently further complicating the authoritative knowledge relationship between doctors and mothers.

While elective C-sections were arguably a choice that would require authoritative knowledge, this was not always the case when technology was involved. Instead, medical personnel could use technology to subvert the mother's authoritative knowledge. Suddenly doctors made choices based on their dialogue with technology and completely bypassed the mother. Technology became both a cultural tool to help doctors perform expertise and an authority in its own right that was in dialogue with the obstetrician about what to do. Mothers were often unaware of these potential consequences and continued to have very positive biases toward new technologies.

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[210] Wertz and Wertz, *Lying-In*, 258.
[211] Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," 135.

Epidurals

One such technology was epidurals. Perhaps this focus is because epidurals had a ubiquitous appearance in 1990s newspapers and magazines similar to natural childbirth in the 1970s. Some women felt that the pressure of whether to use an epidural or not came from interacting with other women. One mother said, "women talk about, you know, 'Are you going to do it naturally or not?"[212] A newspaper article by Don Mills states that natural childbirth had fallen out of favor with birthing women due to the proper advancement of the epidural. Mills compares epidurals to other forms of painkillers, stating, "Epidurals give more complete pain relief, with fewer bad effects on newborns than narcotics such as Demerol or Fentanyl." He also quotes a director of obstetrical anesthesia, Barbara Leighton, who states natural childbirth may increase chances of postpartum stress and depression because "labor really hurts a lot."[213] Even more highly praised than the original epidural was the late 1990s so-called "Walking Epidural." The mother could control this form of pain relief with a drip that allowed the mother to continue feeling and using her legs.[214] Throughout the 1990s, doctors recommended epidurals as an appropriate, low-risk alternative for women who wanted to experience childbirth without pain.[215]

Epidurals were not without their controversy, however, as other articles were very antagonistic toward epidurals. One article quoted a male doctor who stated he was wary of epidurals but felt he could not articulate that since he had never given birth. This same article stated all the dangerous side effects of epidurals and warned that the International Childbirth Education Association should not routinely recommend epidurals.[216] In 1990, an obstetrician of Allentown, Dr. Connie Yen, expressed no issue with the epidural, "There's no harm to the baby as far as I know." She said, "and the mother is awake, so she knows what's going on."[217] The 1990s saw a plethora of studies performed to confirm such assumptions. While direct harm to the baby was rare, medical researchers discovered several complications. These led scholars and medical professionals to ask whether or not mothers are fully informed not only of the direct consequences of epidurals but the indirect consequences of it.[218]

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[212] Brubaker and Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," 231.
[213] Don Mills, "In Praise of Epidurals," *National Post*, December 31, 1998, sec. B5.
[214] "For Childbirth: New Pain Relief Technique Debuts," *Los Angeles Sentinel*, April 11, 1996, sec. A11.
[215] Ann Wlazelek, "Easing Some of the World of Labor Osteopathic Offers Epidurals Full Time," *Morning Call*, October 15, 1990, sec. B.
[216] Nancy Imperiale, "Is 'no Pain' a Gain? Childbirth Educators Causation against Trend toward Epidural Anesthetics," *Chicago Tribune*, November 22, 1992.
[217] Wlazelek, "Easing Some of the World of Labor Osteopathic Offers Epidurals Full Time."
[218] Newnham, McKellar, and Pincombe, *Toward the Humanisation of Birth*, 26.

Medical experts also reacted strongly to the epidural. The sheer number of studies done in the 1990s surrounding the connections between epidurals and c-sections, epidurals and satisfaction in birth, epidurals and complications, and epidurals and labor lengths suggests that doctors actively investigated epidurals to assess whether they could have contentious outcomes.[219] Medical professionals seemed unable to determine how much an epidural affected the mother's participation in labor, and therefore had mixed views. Some said there was no interference with mother's participation[220] others pointed to women's potential inability to "bear down."[221] These studies created differing reactions in various medical expert specialties. Anesthesiologists significantly downplayed the potential problems, while midwives overemphasized alternatives to epidurals.[222] Thus the mother's choice for or against an epidural could be potentially manipulated by the medical professional she chose. Again, this demonstrates that even though a birth may appear as a Mutual Partnership, authoritative knowledge may be lacking, or the other way around.

Electronic Fetal Monitoring

Doctors already socialized mothers to technology in their prenatal period, priming them for the use of technology during birth. Women tended to respond positively to technological prenatal care, including the fetal stethoscope and ultrasonography, because it made them feel closer to their fetus.[223] Due to this medical socialization in prenatal care, women were already more conditioned to allow for additional technology in childbirth, including electronic fetal monitors, even with internal monitors. These technologies kept mothers trapped in beds lying exclusively on their backs and could create anxiety over ordinary moments of fetal distress. Due to this, The American Committee of Obstetricians and Gynecologists put forth a study that recommended against the routine usage of electronic fetal monitoring in 1988. However, even

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[219] ACOG technical bulletin, "Dystocia and the Augmentation of Labor," *International Journal of Gynecology & Obstetrics* 53 (1996): 73–80; King, "Epidural Anesthesia in Labor"; Paul Youngstrom, Sybil Baker, and Jackie L Miller, "Epidurals Redefined in Analgesia and Anesthesia: A Distinction with a Difference," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 25, no. 4 (May 1996): 350–54; Orina H. Mann, "Informed Consent for Epidural Analgesia in Labor," *Journal of Nurse-Midwifery* 42, no. 5 (October 1997): 389–92; Peter Salmon and Nicholas C. Drew, "Multidimensional Assessment of Women's Experience of Childbirth: Relationship to Obstetric Procedure, Antenatal Preparation and Obstetric History," *Journal of Psychosomatic Research* 36, no. 4 (1992): 317–27.
[220] Wlazelek, "Easing Some of the World of Labor Osteopathic Offers Epidurals Full Time."
[221] Youngstrom, Baker, and Miller, "Epidurals Redefined in Analgesia and Anesthesia: A Distinction with a Difference."
[222] Mann, "Informed Consent for Epidural Analgesia in Labor," 391.
[223] C. H. Browner, "Situating Women's Reproductive Activities," *American Anthropologist* 102, no. 4 (2000): 773–88, https://doi.org/10.1525/aa.2000.102.4.773.

some doctors on this committee admitted they would continue to use EFM to avoid potential bad outcomes.[224] These doctors confessed their concern that medicine has been too focused on scientific achievements in rare pathological birth than normal births, but still, it was seen as too risky not to monitor.[225] Other doctors felt they could continue to provide family-centered care while still maintain constant monitoring.[226]

For all doctor's concerns about EFMs, nurses, and even aides in wards with nursing shortages, usually performed the actual monitoring. Some nurses enjoyed the use of EFM because new technology helped increase their status as medical professionals.[227] Unfortunately, although nurses were the primary users of EFM, they were often trained on the job and relied on intuition to help them with their reading.[228] EFM then gave nurses the ability to "prove" to the doctor when they believed something needed their attention.[229] Since nurses felt that the technology improved their communication with the attending obstetrician, it became imperative to them to ensure the mother consented to be monitored. In this instance, the struggle for authoritative knowledge between the nurse and doctor placed the mother in the undesirable position of being used as a cultural item or tool. While the EFM machines were the literal tool used by nurses, the mother's compliance and consent also became a metric with which doctors could judge their nurses. Furthermore, this gave mothers another medical expert with whom she had to contend. Finally, rather than listening to the mother, the EFM allowed nurses to effectively bypass the mother's bodily knowledge and assert her expertise by telling the doctor about the mother without involving her. In this example, the nurse could enforce a more Active-Passive practitioner-patient relationship even though the mother is awake and aware.

Cesarean Sections

The last item of technology discussed in this chapter is the Cesarean section (C-section). These were a widely controversial procedure in 1990s birthing culture. The controversy stemmed from both mothers who perceived doctors as too C-section eager and those who

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[224] Wertz and Wertz, *Lying-In*, 260.
[225] Wertz and Wertz, 292.
[226] Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," 149.
[227] Wertz and Wertz, *Lying-In*, 260.
[228] Marie-Josee Trepanier et al., "Evaluation of a Fetal Monitoring Education Program," *Journal of Obstetric, Gynecologic, & Neonatal Nursing Clinical Issues* 25, no. 2 (January 1995): 137.
[229] Margarete Sandelowski, "Retrofitting Technology to Nursing: The Case of Electronic Fetal Monitoring," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 29, no. 3 (May 1, 2000): 317, https://doi.org/10.1111/j.1552-6909.2000.tb02053.x.

insisted on elective c-sections as a standard choice of care. For doctor's C-sections were also often regarded as only an inconvenience to the mother that was always worth it to control for the best possible outcome when there was any form of abnormality. Mothers who underwent this procedure were sometimes surprised with the complications and risks associated with cesareans their doctor never informed them about prior to their decision.

Cesareans were a perfect example of American positive technological bias. The 1990s saw a massive rise in maternal demand for elective C-sections that was not always agreed upon by practitioners. Elective C-sections played such a significant role in cesarean statistics that low-risk women only had slightly fewer sections than high-risk women.[230] While some doctors supported women's right to choose a cesarean, others were vehemently opposed. These physicians said, "maternal choice alone should not determine method of delivery." "Patients do not have rights to impose their wishes at all cost," "obstetricians are more than technicians," and "unnecessary cesarean section should be avoided."[231] Some doctors were frustrated with their colleagues' nonchalance when it came to c-section risks. One doctor ridiculed that in medical literature, c-section patients appeared immune to pulmonary embolism and infection compared to other surgery patients.[232] On the mother's side, studies showed mothers had much higher rates of satisfaction with planned procedures.[233] These satisfaction rates are fascinating, as the mother and doctor responded to elective C-sections similar to how their 1970s counterparts reacted to natural childbirth. The difference was that instead of fighting for a birth closer to Mutual Partnership, these women wanted an Active-Passive birth. These women's expertise about themselves, including their ability to handle pain, how spontaneous birth would fit into their lifestyle, etc., gave them the desire to vie for authoritative knowledge in the medical decision making. The statistics suggest that mothers were successful in this realm, but the individual relationships surrounding cesareans will be more closely examined in Chapter 4.

Due to the growing normalcy of C-sections, in the late 1990s, rates rose higher than most doctors and mothers desired. Dr. Hector Tarraza, the chief of the Department of Obstetrics at Maine Medical, who helped to found a Cesarean Section Project in an attempt to lower C-section rates on the east coast, emphasized the pressure on doctors while insisting it was time

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[230] Leah Albers and David A. Savitz, "Hospital Setting for Birth and Use of Medical Procedures in Low-Risk Women," *Journal of Nurse-Midwifery* 36, no. 6 (December 1991): 331.
[231] Samuel Lurie, *The History of Cesarean Section* (Nova Science Publishers, Incorporated, 2013), 112.
[232] Wolf, *Deliver Me from Pain*, 180.
[233] Lurie, *The History of Cesarean Section*, 110.

to "get back to the fundamentals."[234] Like later 1970s doctors, late 1990s doctors understood the positive and negative consumerism connected to childbirth and attempted to position themselves in places best suited to help (and remain attractive to) their patients. Since dystocia, meaning the labor was not progressing fast enough, and fetal distress were the most common reasons for C-sections, hospitals established programs such as the "True Labor" one spoken of earlier. [235] Of course, these programs demonstrated how arbitrary some medical classifications were, causing anxiety and frustration in mothers.[236]

Cesarean sections in the 1990s were an example of Active-Passive relationships between practitioner and their patient. Mothers were incapable of moving, seeing, or feeling any part of the birth, and therefore at the doctor's mercy. Yet what is so interesting about 1990s C-sections is that a large proportion of them were elective. Of course, even with C-sections, some doctors would highly encourage women to consent to one, and such women were encouraged to have a repeat cesarean rather than attempt a vaginal delivery.[237] Nevertheless, many women chose a C-section based only on their desires. This choice was incredible as it displayed that mothers as a group gained authoritative knowledge over a highly controversial and major medical procedure. While this authoritative knowledge was choosing to give control to the medical expert and trusted their expertise, doctors legitimized the mother's knowledge that led her to her decision. Whether or not elective c-sections are in the mother's or baby's best interest, whether the procedure is perfectly safe, or leads to many complications, and whether or not scholars believe mothers should have as many c-sections as they do, does not matter for the purpose of this thesis. What is important is that in elective c-sections, the mother's knowledge is being legitimized and acted upon by her practitioner. The mother's legitimization shows a clear shift in their dynamic relationship from the 1970s to the 1990s.

Technology Conclusion

With newly found authority, mothers were frustrated in their desire to make their own choices but struggled to find information concerning these choices. Many felt there was too much emphasis on pregnancy and birth complications and not enough emphasis on the

[234] Goad and Hench, "Changing Attitudes Cut Rate of C-Sections Women Are Urged to Be Patient as More Doctors Agree That Natural Birthing Is Usually Best."
[235] ACOG technical bulletin, "Dystocia and the Augmentation of Labor," 75.
[236] Goad and Hench, "Changing Attitudes Cut Rate of C-Sections Women Are Urged to Be Patient as More Doctors Agree That Natural Birthing Is Usually Best."
[237] ACOG technical bulletin, "Dystocia and the Augmentation of Labor," 74.

normality of it, and technology only compounded this issue. [238] The lofty position technology held within American society made it even more difficult for even skeptical women to reject it outright.[239] An excess use of technology could often look as though the mother was getting the best and most expensive care possible. With technological recommendations, a physician's endorsement could carry the force of a command, and even a nurse's suggestions carried a heavy weight.[240]

Technology was viewed far more positively by mothers in the 1990s than in the 1970s, and therefore, its influence on mother's choices within childbirth fundamentally changed. The technologies that mothers hated most, including Scope drugs, forceps, and delivery room table restraints, were largely eradicated, and procedures such as enemas and episiotomies were on their way out as well. The new technologies helped the mother feel closer to her baby, as in ultrasounds and EFMs, epidurals helped them have birth awake without pain, and cesarean sections could save the mother and infant from a bad outcome. The more technology used, often the better care the mother would believe she was receiving. Yet even with all these positive attitudes toward technology, the connection between lower control for mothers and higher uses of technological interventions was obvious. Studies also continued to show a cascade of interventions that could be set off by early use of technology, such as Pitocin, epidural, or EFM. This chapter has shown how groups of mothers reacted positively and negatively to technology concerning their authoritative knowledge. However, the play of technology on the intimate relationship between an individual mother and her medical expert will be further explored in Chapter 4.

Conclusion

The sources in this chapter suggest that mothers could have some authoritative knowledge, but it depended on their education, their desire to adhere to their birth plan, and what they wanted knowledge over. Mothers were susceptible to doctors "helping" them make decisions that ensured control to the doctor. This was especially true for women who were not educated in these choices. If these women knew what they wanted, however, and had the support to keep to these choices, they could retain authoritative knowledge in their births. This hypothesis will be tested in the fourth chapter.

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[238] Field, "Parents' Reactions to Maternity Care."
[239] Browner and Press, "The Production of Authoritative Knowledge in American Prenatal Care," 127.
[240] Ibid

In the 1970s, this research found a shift in authoritative knowledge from the practitioner to the mother, especially in consumer movements. Women could move from the Active-Passive relationship to the Guidance Cooperation model, and in-home births, sometimes even the Mutual Participation. The 1990s have demonstrated a further overall shift in that direction, but in a much more complicated way. Mothers sometimes returned some of their control to the medical professional to pursue other goals, such as convenience, technology, painlessness, and ensuring the best possible outcome. Many of these women knew that they could have more control over their birthing process but chose instead to trust the medical expert's judgment. Interestingly, I would argue this solidifies the doctor's authority as an expert but also displays some autonomy, and in the case of elective c-section, even authoritative knowledge to the mother. Furthermore, the choice to say "yes" to increased interventions opens up a mother's ability to choose "no" in a way not previously seen.

While the history of childbirth historians continually speaks of the lack of authoritative knowledge found in 1990s women, women in the 1990s did not feel this way. Articles demonstrate that although sometimes overwhelmed by the choices, women felt they were more empowered and able to demand more personalized care than before. Moreover, despite scholars' attention to the growing numbers of epidurals and c-sections, an increasing number of women chose to give birth with midwives. Many 1990s women were hopeful that childbirth would return to a more woman-led experience.[241]

Since some women decided to relinquish their immediate control, mothers were in a seat of authoritative knowledge over the whole birthing process that had not previously existed. In the 1970s, women fought to move from the Active-Passive relationship tier to the Guidance Cooperation model successfully. However, it seems they were only able sometimes to have a birth that was with Mutual Participation, and that was almost always a homebirth. In the 1990s, women were spread throughout all three tiers with Cesarean sections, epidural births, natural births, and home births, with many women choosing their own tier. This is an example of authoritative knowledge, as it is the mothers rather than the doctors who control the physician-patient relationship. Finally, in the 1970s, the tier in which a mother's birth process happened was largely reliant on whether they were in a hospital or at home. In the 1990s, mothers seemed able to more easily request an epidural with a midwife or natural childbirth in the hospital.

Thus, after analyzing the medical, scholarly, and societal discourse surrounding natural childbirth, I have developed a hypothesis that I will test in the following two chapters. In the

[241] Stone, "The Evolving Scope of Nurse-Midwifery Practice in the United States."

1970s, women were able to exert some authoritative knowledge outside the delivery room in consumer movements and education, but once in the delivery room, they were only able to employ the authority allowed them by the practitioner. Thus, if the birth was a home birth, the mother could have a Mutual Participation in her birth, but that was only because her practitioner allowed it. If she chose the wrong practitioner or location, her birthing wishes might be dismissed, and thus her authoritative knowledge was essentially empty. Conversely, I hypothesize that in the 1990s, women had far more actual authoritative knowledge. While the consumer movement was still critical, women could more easily exert their birthing desires *if* they had the education and confidence to do so. Mother authoritative knowledge in the 1990s was still not something easily earned, especially from the wrong practitioner, but women could fight for their rights if they were so inclined to do so.

PART TWO

MATERNAL PERSPECTIVES: UNDERSTANDING MATERNAL ROLES IN CHILDBIRTH FROM THE MOTHER'S PERSPECTIVE

Chapter 3, 1970s Memoirs: *Is it All in the Planning?*

Detecting the time and place of 1970s Authoritative Knowledge

Introduction

As shown in the last two chapters, childbirth reform was a widely discussed phenomenon in both mother and practitioner circles. The newspaper articles, television shows, and movie scenes demonstrate that childbirth was an acceptable and often talked about subject with a wider audience as well. In the first chapter, this thesis has demonstrated how consumer methods, childbirth education and classes, women's support groups, doctoral administration organizations, and maternal bonding theory all played a role in childbirth reform in the 1970s. Likewise, public statements made by mothers demonstrated how important choosing the correct practitioner was for women who wanted to experience natural childbirth. The second chapter examined the growing diversity in women's child-birthing desires in the 1990s due to failed natural childbirth, contentment with reform, emphasis on women's choice, and growth in appreciation for highly medicalized childbirth. This chapter also analyzed the development of the "birth plan" and the importance of practitioner choice.

In both these chapters, the notable instances of autonomy and control seem to come from what the woman does in her prenatal period to ensure her desired childbirth experience. A crucial missing component, however, is that of what actually happens during labor and childbirth. If women chose to give birth in the hospital, did that automatically ensure their cooperation with the doctor? How often is the consent of the mother not asked? How often are requests of the mother denied? If women chose to give birth at home to experience natural childbirth, how much authoritative knowledge did they have? Is the area of authoritative knowledge for a mother determined by her prenatal action alone?

In order to better understand these questions, the following two chapters will examine the moments of birth, with this chapter focusing on the decade of 1970. In order to understand how women felt about their birth experiences, this chapter will analyze instances of recorded interviews, such as excerpts from secondary sources or newspaper articles, and stories written for personal memoir sections of books like *Silent Knife* or *Spiritual Midwifery*. These stories will give insight into the mother's 1970s birth experience and how they remembered the birth. All the books and articles used were still published in the 1970s; therefore, the other 1970s

movements and experiences may taint the memories, but later decades do not impact them. In particular, this chapter will look for remembered dialogue between the practitioner and the mother, as well as moments that could be categorized as "power struggles." This chapter hypothesizes that in the 1970s, all of a mother's authoritative knowledge gathering happens before the perinatal period. Even for natural and home births, the expectation is that the doctors or midwives will have more authoritative knowledge than the mother and that her autonomy will come not from her bodily authority but from what the practitioners allow her to have.

Method

The primary sources used in the following two chapters straddle the two genres of biography and autobiography, often problematizing the idea of these genres as two distinct historical methodologies. Some of the sources used are interview exerts, which would fall under the umbrella of biography, while others are paragraphs taken from letters or autobiographical pieces written for publication inside a book. Nevertheless, even while these pieces have been self-written, thereby placing them in the autobiography genre, they were first edited and spliced by the original book author, compromising some of the original autobiographical nature and problematizing the rules of the genre overall.

More than ever, biography finds itself at the center of historical studies, though it is heavily critiqued. Instead of calculating numerous aspects of a single life, biography has become an instrument for social research.[242] Biographies were previously used almost exclusively by novelists or journalists, but they have gained more acceptance as they are a vital tool for the social and cultural historian to engage in "research from below," in a way very few other genres allow. Sociologist and philosopher Pierre Bourdieu, a pioneer of biographical work, notes that biographies create a 'biographical illusion' as they create and denote a reality that is largely disconnected from the societal influences each individual is dealing with at that moment. He states that historians must attempt to recreate this contextual background and acknowledge the problems and difficulties.[243] The biographical sources used in this chapter can be further problematized as they are usually interview excerpts or newspaper clippings.

The interviews potentially enable the relationship between the ideal and the realities of childbirth to be examined, as explained by historian Angela Davis, who used oral history as

[242] Hans Renders and Binne De Haan, *Theoretical Discussions of Biography: Approaches from History, Microhistory, and Life Writing* (Leiden, NETHERLANDS, THE: BRILL, 2014), 61, http://ebookcentral.proquest.com/lib/uunl/detail.action?docID=1688666.
[243] Renders and De Haan, 63.

her primary method in *Modern Motherhood*.[244] Differently from Davis, however, this thesis did not have the time or the means necessary to conduct primary oral histories independently. Furthermore, many of the women who gave birth in the 1970s are growing older and more challenging to find. Therefore, this thesis utilized interviews done by historians and anthropologists and then published in their studies or books. While this allows the researcher to still read and analyze these women's interviews, the excerpts are draped in the secondary source author's analysis and perhaps even shaped to fit it. Context or subsequent questions that might have been useful for the particularities of this thesis are lost. In order to attempt to combat these biases, the original interviewee's words with contextual material were cut from the lengthier prose and reanalyzed at a later date. Even so, biographies, particularly those of oral history, create realities as the interviewees have had time since the event and can create a narrative and maintain a level of composure that removes the oral history from the events of the past.[245] Thus, rather than believing these interviews demonstrate universal "truths" about 1970s childbirth, the goal is to understand how women may have felt about their experiences, even after the fact. Furthermore, this chapter aims to analyze what types of realities they desired to build through these interviews and why.

The second main form of biography used in this thesis is that of newspapers. Though less severely than oral history, newspapers also created a version of reality that would most appeal to their readers, rather than an authentic representation of reality.[246] The written discourses found in newspapers create a total system of knowledge that allows for a plethora of factual statements while still creating an angled reality and maintaining that angle on these truths.[247] As a form of biography, newspaper stories also necessitate taking the context of the text within the preponderant social environment at publication and the contextual environment of contemporary analysis. Finally, it is essential to mention that newspaper editors deemed the stories in their papers as "noteworthy." Those interviewed for a newspaper may have an overpowering component of composure to their narrative than historical interviews to aid the article's angle to elevate their social status.

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[244] Davis, *Modern Motherhood*.
[245] Penny Summerfield, "Culture and Composure: Creating Narratives of the Gendered Self in Oral History Interviews," *Cultural and Social History* 1, no. 1 (January 1, 2004): 69, https://doi.org/10.1191/1478003804cs0005oa.
[246] McIntyre, Francis, and Chapman, "Shaping Public Opinion on the Issue of Childbirth; a Critical Analysis of Articles Published in an Australian Newspaper," 16.
[247] Ibid

The other sources used in this chapter fall under the umbrella of autobiographies or ego documents. While autobiography also has to do with recovering the past in a "history from below" perspective, it is often laid on the shifting, partial, and contested set of personal or collective memories, thereby also making autobiographies versions of reality.[248] The aspects of creating a welcoming identity while hiding or even destroying unwanted identities must be very seriously taken into account while analyzing.[249] This composure or erasure of the narrative must be contextualized as a constructed reality, even more so because many autobiographies are not meant to be published but rather written for private or familial usage. However, the autobiographical pieces in this thesis are meant for publication. Thus the right to establish authenticity or validity is not the autobiographer's alone.[250] Furthermore, these autobiographies are pulled from secondary sources who have already used the writer's reality to further their own constructions. In many ways, the researcher layering blurs the lines of biography and autobiography. There is no way of knowing what the original researcher has already edited to contextualize these stories to fit their narrative best. Therefore, while these sources provide rich information about childbirth in the 1970s, they also problematize the genres of autobiography and biography in a way that suggests some adjustments to the rigidity of genre distinction within historical methodology.

Finally, as defined by historians Hans Render and Binne de Haan, biographies and autobiographies should not be studied to fit into a greater context in a representative way, but rather to what extent a person was distinctive and influenced his context. They also argue that biographies are closely related to microhistory, which dictates that however singular a person's life may be, the value of examining it lies not in its uniqueness but in its exemplariness.[251] When discussing autobiography, historian Penny Summerfield also warns about the thorny problem of 'typicality' in applications of representativeness. She points out that methodological problems arise from these attempts, as the only available respondents are culturally self-selected.[252] Thus, this chapter does not revere these stories as representative or unique but aims to grant access to the experiences and memories of a few 1970s mothers. They

[248] Penny Summerfield, *Histories of the Self: Personal Narratives and Historical Practice* (Routledge, 2018), 4.
[249] Arianne Baggerman, "Autobiography and Family Memory in the Nineteenth Century," in *Egodocuments and History : Autobiographical Writing in Its Social Context since the Middle Ages*, by Rudolf Dekker (161-173, 2002), 163, https://repub.eur.nl/pub/17065/.
[250] Summerfield, *Histories of the Self*, 4.
[251] Renders and De Haan, *Theoretical Discussions of Biography*, 7.
[252] Summerfield, *Histories of the Self*, 148.

are not meant to be the final truth about every mother in this decade, but instead, display which processes have been missed in historical practice that is more remote from lived experience.

The Stories

Although the 1970s have been idealized as a great time of reform, these personal stories demonstrate how different birth experiences could be depending on the location, practitioner, and conditions. While doctors did not knock any of these women unconscious the way their mothers likely were, there were undoubtedly still women who had very controlled births. Although some of these stories demonstrate a lack of authoritative knowledge on the mother's part, the mothers' comments about their births often showed their desire for something different for the following pregnancy and how they planned to accomplish that.

Expecting Intervention

Many women who gave birth in the 1970s were aware there would be some level of intervention in their births and were expectant of that or even welcomed it. While natural childbirth was a massive trend that change childbirth culture in the United States, in the 1970s, it was also still a very new concept. Many women were cooperative with hospital interventions because it was what they expected, and it demonstrated a level of "care" for them.

Induced labor was a familiar way for women to give birth by the early 1970s. Although there was a downward trend in usage, many doctors still scheduled these women's deliveries for his convenience. For example, one woman who gave birth in Fort Worth's Children's Hospital went to her nine-month prenatal appointment. At the appointment, her doctor asked if she would like to be induced, "It was summer, and it was hot. I had another baby to worry about - who was going to take care of him. My doctor asked if I would like to be induced, and I said, 'Yes, I think I can get in tomorrow or the next day.' So I did. He said that I was ready, and so I thought I was ready too."[253] In this story, the mother did not originate the idea to be induced, and she relied on her doctor's expertise to tell her that she was ready, but also she used her own autonomy to feel ready herself. This mother did not indicate if she was exposed to natural childbirth methods or education. Even if she had, these methods did not concern her at least as much as the heat and arranging childcare for her firstborn. Sometimes the scholarship

[253] Rapfogel, "The Baby Factory," 8.

makes it seem that every woman was a natural childbirth enthusiast, but many women, such as this one, had other priorities.

Many women knew there would be some level of intervention in their births, and they thought they could easily accept such interventions until after they happened. One such mother went to the hospital in labor with positive expectations of care. She said, "Actually, I loved being taken care of." When speaking of how she looked forward to giving birth in the hospital, she also did not mind that they sent her husband home while she labored. Once her contractions began to grow stronger, a nurse came to her room and told her that they would make her feel more comfortable. She gave the mother two pills. In the mother's story, she never mentions a doctor coming in to explain what the pills were, how they would affect her, or what the side effects may be. Hours later, the nurse awoke her to watch the birth of her daughter, who was grey and needed to be placed on oxygen immediately. The mother then states that she suffered from postpartum depression, "When I took Linda home, I began coming unglued…I was hospitalized for three weeks, and relatives had to take care of the baby. I remember wondering if she was really my baby." These experiences gave her a new perspective on natural childbirth, "Before my birth, I thought only dummies do it without drugs. All I wanted was the end product, a baby. I feel very different now."[254]

The natural childbirth was not a movement of "no pain, no gain," but one of promoting fewer interventionism births for the mother and infant's safety. Even women who did not go into their first hospital birth as a natural childbirth advocate often became one through their experience. This story displays a childbirth experience that falls somewhere between the Guidance-Cooperation and Active-Passive models on the Szasz and Hollender scale. This mother had no authoritative knowledge, no expertise, and she did not even want that authority. She was happy to abide by the societal "good" mother role and listen obediently to the medical experts. Only after her poor experience did she begin to question those in charge. This story demonstrates a rejected performance of expertise on the medical personnel's part. This mother had accepted her practitioners' authoritative knowledge because society had legitimized his knowledge, and she even delegitimized natural childbirth advocates by calling them "dummies." Nevertheless, after her birth experience that caused postpartum depression, the mother rejected the practitioner's expertise over birth, feeling "very different." While this is not a gain in this woman's individual authoritative knowledge, this story demonstrates how

[254] Arms, *Immaculate Deception*, 50.

natural childbirth advocates as a group gained authoritative knowledge over the medical establishment.

Desiring Natural Childbirth in the Hospital

Unfortunately, just because a woman was a supporter of natural childbirth, she could not count herself as protected from intervention in the delivery room. Perhaps one of the most famous instances of failed natural childbirth in the 1970s is the story of Joan Haggerty. Haggerty's story is so well known because *Ms. Magazine* published it in 1973. Haggerty had given birth to her first child in a British clinic, where she received lots of support for her decision to have a drug-free birth. Afterward, she moved back to the United States and became pregnant again. She wanted to recreate her British birth experience in particular by not using stirrups, and most importantly, remaining drug-free. A private clinic assured her the staff was trained in Lamaze, and the doctor would "probably" allow her husband to stay. When she finally went into labor three weeks past her due date, the medical staff dismissed the authoritative knowledge she thought she had so carefully cultivated. She had five different doctors performing internal examines during her contractions. One was concerned about the baby's heart rate, so he inserted an internal monitor during a contraction without her consent. When she cried out a curse word in pain, a nurse quickly admonished her with an outraged, "Language!" and a slap on the wrist.

Haggerty was determined to continue to persevere with a Lamaze birth. Despite all the distractions, she tried to continue her breathing with her husband. When the nurses wheeled her into the delivery room, however, the obstetrician barred her husband from the entrance. Once alone, the nurses tied Haggerty's legs in stirrups and bound her wrists to the table. She attempted to sit up and demanded to be released. Dismissing not only her authoritative knowledge but also her autonomy and dignity, the nursing staff laughed at her attempts. Although she was not fully dilated, the doctor implored her to push and manually manipulated her cervix to deliver the baby. Haggerty described the experience as "just plain hell."[255]

Haggerty was not the only natural childbirth advocate to struggle with a hospital undermining their authority. Helen went to the hospital determined to use her learned breathing methods to help with her contractions. Her doctor came in and said, "There is no way you can control contractions with breathing." He then offered her the choice of a spinal or IV drugs, emphatically telling Helen she needed the shot. Here Helen's authoritative knowledge is not

[255] Kline, *Bodies of Knowledge*, 129.

only questioned but dismissed. The doctor stated that his knowledge is legitimized and tells her that hers is not. He also uses medical jargon to implement his expertise. She is not sure of her bodily knowledge enough to deny her doctor's expertise, and he is quick to assert what he has decided she *needed* not as an opinion but as a definite point. In doing so, he performs one-up-manship that ultimately cows Helen into taking the painkillers. Helen then slept for two days; she did not remember her delivery and rarely thought of her baby.[256]

These women were not alone in their experience. Many other childbirth stories demonstrate the same stripping of authoritative knowledge in women who felt manipulated into having a Cesarean section. One such woman, named Sue, also wanted to pursue natural childbirth. When she arrived in the hospital, the nursing staff adhered her to a fetal monitor despite her protest. They assured her it would "only be for an hour," but the monitor was never removed. Sue noted that the monitor was not accurately displaying what she was feeling in her body. "So I know [the fetal monitor] is (or can be) quite inaccurate."[257] She states. Here, her misgivings toward the medicalized aspects of her birthing experiences can be felt, as well as her attempt to assert her bodily knowledge. In this instance, however, the doctor's acceptance of the expertise of technology trumps her knowledge while simultaneously making her even more distrusting of her environment. Even so, the authority of the hospital space refrains her from removing the fetal monitor, despite her desire not to wear it.

When it came to other aspects of medical authority, such as her internal exams, Sue understood the reasoning but also was frustrated by the lack of care for the mother. "There were so many manual checks for dilation by different nurses, doctors - you name it, and almost always during contractions. I understand this is supposed to be easier for them but does not do much toward the mother-to-be's concentration and relaxation." Later, the obstetrician asked Sue to push although she did not feel the need to "bear down," resulting in her doctor ordering x-rays to try to understand the problem. Sue said, "By now, I was losing control, being passed around so much." Next, the doctor attempted a forceps delivery, but that failed. Finally, Sue agreed to an emergency C-section, replicating a sentiment frequently felt by mothers at the end of an arduous experience, "I was beginning to just want 'that thing' removed as if he were only a rock or something."

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[256] Arms, *Immaculate Deception*, 86.
[257] Nancy Wainer Cohen and Lois J. Estner, *Silent Knife : Cesarean Prevention and Vaginal Birth after Cesarean, VBAC* (S. Hadley, Mass. : Bergin & Garvey Publishers, 1983), 41, http://archive.org/details/silentknifecesar00cohe.

This sensation of needing something removed was a sentiment shared by other mothers as well. Deborah felt that she was no longer carrying her baby, but a host to some sort of parasite or infection, "The magic lump in my tummy was suddenly a disease that must be cured at all costs in with great speed, and my baby was an incidental byproduct, like a tooth handed back after it's been pulled for causing a toothache." This disenchantment could have indeed been one of the reasons women who underwent such experiences felt cheated out of their birthing experience. Again, the medical institution misconstrued a mother's bodily knowledge. She had come into the hospital feeling positive about her pregnancy and fetus, and then the atmosphere of medicalization in the hospital directed her to harbor more negative feelings towards her fetus and delivery. These feelings could fester and cause mothers to then suffer from postpartum depression for months afterward.

Women who wanted to pursue natural childbirth were often chided or guided into accepting some form of medication. A woman named Jean attempted to pursue natural childbirth, but her doctor told her, "There's no reason for you to be a martyr. If you're hurting badly, tell Dr. Richards. You're not going to lose face if you take a little Demerol."[258] As most women "hurt badly" in labor, this set natural childbirth mothers up for failure, believing they were doing something wrong if they were hurting. Furthermore, this comment has an overtone of condescension, as the doctor speaks down to Jean about not being a "martyr" and telling her she will not "lose face." The reasons for her choice to pursue natural childbirth are as superfluous as wanting to join an elite club of "tough" mothers.

In many cases, women desired to take more authoritative knowledge for themselves by having a natural birth or even a homebirth, but they were challenged harshly by their medical experts. One New Jersey woman, Jocelyn, wanted to attempt a vaginal birth after cesarean (VBAC), which was highly discouraged by her obstetrician. Finally, her doctor agreed, but only if she would consent to another c-section as soon as anything deviated from normal. "This idea terrifies me," she said, "since it smacks of the typical type of patronizing that obstetricians have always given women to shut them up. I'm terrified that once I'm in the hospital in labor, I will be badgered and bullied into consenting to anything the doctor wants to do." Even more harshly, when Jocelyn broached the idea of a homebirth, her doctor laughed at her "foolish notion."[259]

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[258] Arms, *Immaculate Deception*, 122.
[259] Cohen and Estner, *Silent Knife*, 41.

Some women felt later that they had such little authoritative knowledge due to a lack of experience. 1970s mother May said, "My physician told me I had CPD.* I was young, inexperienced, and uneducated. The fact that I only labored two hours didn't strike me as being an unfair trial of labor until later, unfortunately!"[260] The mother, Sue, who was directed to bear down prematurely above, said, "I realize we could have asserted ourselves more, but it hit us with no warning, and we were scared that something was terribly wrong."[261] The use of fear-mongering by physicians to get mothers to comply also appeared in many stories. A mother named Shirley had a straightforward experience with this type of manipulative choice, "When I went to the hospital, I was informed for the first time that my child was in the breech position and a cesarean was needed. I was completely taken off guard and very upset, but they asked me what was more important, 'a healthy baby' or 'a normal birth.'" In these instances, the sentiment of "If I had only known…" can be felt in the women's stories. Sue ended her story with the sentence, "The worst thing is I wonder, deep down inside, "what if" - what if I refused to have another c-section and it really was warranted? And on and on." The reason these women were unable to better advocate for themselves was twofold. First, the doctors imposed their expertise over the mothers through jargon and their belief in their authoritative knowledge. Second, the mothers in these stories feel they lack an essential building block of expertise: experience. They could not effectively use cultural items or jargon back toward the medical practitioner since they do not possess any—just another reason why so many of these negative hospital experiences are those of first-time mothers.

These stories are also peppered with instances of women's bodily knowledge that is challenged or dismissed by their doctors. Dianne from Arizona said, "My labor began 'two weeks late' according to the doctor, although it was the day I predicted." Sue also stated, "I went into labor 2 1/2 weeks late…I actually could have been right on time according to my own calculations." Another mother, Tammy, said, "My doctor wouldn't listen to me. He insisted my dates were off. I made a total of seven trips to the hospital for tests. I was going nuts. When it was all over, the doctor said I was probably right."[262] All these women felt confident about their due date, yet because of the doctor's calculations, they were labeled "post-term" pregnancies, automatically moving them out of the realm of "normal." The doctor admits

* Cephalopelvic disproportion (CPD) is a pregnancy complication in which there is a size mismatch between the mother's pelvis and the fetus' head. The baby's head is proportionally too large, or the mother's pelvis is too small to easily allow the baby to fit through the pelvic opening.

[260] Cohen and Estner, *Silent Knife*, 43.

[261] Cohen and Estner, 41.

[262] Cohen and Estner, 43.

his calculations were incorrect in the last story, but the woman had already undergone a c-section. In another birth, a mother was sure that she could feel herself in labor, but the doctors did not believe her. "I was sure I was in labor, but the doctors didn't think so because I was only two centimeters dilated after 8 hours of contractions." In this case, the mother was grateful to be finally hooked up to a newly developed machine called the electronic fetal monitor, which showed her contractions. "I was glad the monitor was there to prove that I was really in labor." This anecdote is an example of mother's bodily knowledge falling not only below the expertise of the doctor but also that of technology. Even though the EFM was a very new machine at this time, and not without its issues, the doctor automatically believed the monitor, whereas the mother had been laboring for hours but still held no credibility.

Similar to births in the 1950s and 1960s, the ability to immediately, or at least quickly, see and touch their newborn was precious to many mothers, and the inability to do so was a key motivator for change. During her C-section, Sue asked to be allowed to hold him while she was being worked on and received a resounding "No!" So she then asked someone to inform her husband that the baby had been born. Her husband was not informed for some time later, and even then, he was only allowed to look at him through the nursery window. Sue stated frustratedly, "There was no reason for the delay; our son was not sick. His first Apgar score was eight; in five minutes was nine.* A nurse told me that is good for a C-section baby." Another woman, Bim, had a uterine infection, but even after her infection had been treated, she and her newborn were isolated separately for three days. Two years later, her son was very clingy and had "only slept through the night about four times in his whole life." Clearly familiar with the theorized long-term effects of bonding theory, she wondered, "How much of that has to do with his birthing I guess we may never know."[263]

The sentiment of these memories is also exemplary as to why women decided to make changes in their childbirth planning. Sue states several times throughout her story that all she wanted was a natural childbirth, and her bitterness toward her C-section is palpable, "I am so very bitter. People say, "just be glad you are both healthy, and now you have a son"; - I am, I am! And that does make me feel guilty. But I also feel cheated and do not trust doctors since we had really trusted this one."[264]

The childbirth reform in the 1970s set women up to believe doctors would respect their authoritative knowledge more highly in hospitals, but many found this not to be the case.

* Apgar scores give the oxygen levels of baby's after birth.
[263] Cohen and Estner, *Silent Knife*, 42.
[264] Cohen and Estner, 43.

Sometimes the doctor even told the mother she could give birth naturally, but then changed his mind once in the delivery room. A Fort Worth mother named Joan Rapfogel wrote of her experience in an article called "The Baby Factory," where she stated that she developed a natural childbirth plan after attending child birthing classes. Her doctor stated that this plan should be doable, barring any emergencies. However, as she drew nearer to her due date, her doctor wanted her to induce her labor at a convenient time. His irritation with her was so apparent that she was relieved that the obstetrician on call was not her doctor when she spontaneously went into labor. Nevertheless, her labor was longer than that doctor's shift, and her doctor came on her case. She found her doctor rude and continually whistling, which made concentrating on her breathing techniques difficult. Joan's doctor encouraged her to "get this show on the road" and receive some medication. Frustrated and in pain, Joan conceded.

When receiving the epidural, Joan asked her doctor to pause as she was about to have a contraction, and she was afraid to move while being poked. Her doctor paused his whistling long enough to tell her that "indeed one contraction comes after the other" before proceeding with the epidural. The obstetrician then gave Joan Pitocin to speed her labor, with her main point of contact, a delivery nurse who confessed it was her first day on the job. Joan began giving birth unbeknownst to anyone until the head nurse returned to check later, after giving her a second dose of anesthesia. Still, even with the baby emerging from the birth canal, Joan was wheeled to the delivery room where her daughter was disentangled from the umbilical cord by a surgical nurse. The doctor did not arrive until after the birth had already taken place. Joan was then wheeled away from her newborn to recovery, where she was left. Five hours later, Joan could still not move her legs and was terrified. When she explained this to her doctor, he scolded, "If you had done what I told you to do in the first place, this never would have happened." and left her in recovery. Feeling did not return to her legs for fourteen hours. Joan states, "The day I left the hospital, I left my doctor too."[265] Experiences like Joan's exemplify the lack of authoritative knowledge women still had in the 1970s.

While not all birth experiences were outright negative ones, these stories denote that women in the 1970s still had very little authoritative knowledge in the delivery room. Even though they had gained expertise in the consumer realm, medical professionals still disregarded mothers in the delivery room. Some of this stemmed from first-time mothers' lack of experience or unsureness in their bodily knowledge, but mostly it seemed to come from medical professionals' skillful performances of one-up-manship and expertise. Women were ill-

[265] Rapfogel, "The Baby Factory," 1–5.

equipped to go toe-to-toe in a battle of expertise with people who were so convinced of their expertise. Childbirth education was still a newly incorporated concept, and women were usually not wholly familiar with all the medical jargon doctors would use and thus could struggle to object informatively. Moreover, doctor's performances of one-up-manship using technology created anxiety in mothers, making them more likely to comply with the doctor's request.

After Birth in the Hospital

Hospital births also did not set women up for success when they returned home with their babies. Many of them also struggled with postpartum depression because of these experiences. Helen was depressed afterward, stating, "As soon as we got home, I became depressed. I thought Adam [the baby] was cute, but I must admit there were no maternal feelings. I was too overwhelmed with anxiety to really care about him."[266] Women did not feel attached to their babies because of the trauma inflicted on them in highly medicalized birth settings. The baby was removed by the hospital rather than delivered by the mother, which tinkered with women's emotional and mental well-being postnatally. Aside from postpartum depression, nursing was also challenging for some hospital babies. One mother recalled, "I tried to nurse at home, and my son took one look at me and screamed the next two days. He'd gotten used to rubber nipples and formula in the hospital."[267] Since babies were fed by nurses in the hospital nursery rather than by mothers, babies quickly acclimated to bottle feeding. The hospital's lack of respect for the mother's authoritative knowledge in deciding what is best for her child subverted the mother's desire to breastfeed.

Subsequent Births

Many of these upset resilient women still wanted to have more children, even after these experiences. They had learned from these experiences what they did not want and planned to alter their future child birthing experiences. Dianne explained her desire for a VBAC stating, "I plan on delivering my next baby vaginally. If my doctor doesn't agree to it, I'll simply find someone who will." This quote evinces the consumer authoritative knowledge uncovered in Chapter 1. These stories also demonstrate how women ended up with home births. Mother Ilene also desired a natural childbirth in a hospital, but after participating in some doctor

[266] Arms, *Immaculate Deception*, 86.
[267] Arms, 107.

shopping, she made a more radical decision, "I've found a doctor who says he's willing to treat me as a normal pregnancy. He said if anything happened, it would probably occur before the onset of labor. However, his standard procedures for delivery are no eating, episiotomy, spinal anesthesia, breaking the water, and a c-section if I'm past my due date. If I need a c-section, my husband will not be allowed. I'm thinking of a home birth. This decision brings me peace."

Here Ilene has learned how the birth culture in the 1970s works and where she as a mother fits in it. She has learned that she likely will not win the authoritative knowledge she desires with her doctor. Nevertheless, she does know where she has authoritative knowledge in the consumer realm. She hopes a midwife will respect her bodily knowledge at home, and she trusts her expertise that a natural childbirth is best for herself and her future baby. Rather than vie for authoritative knowledge with her doctor in the delivery room, Ilene chose to leave the medical institution all together.

Hospital Victories

All these negative stories give some insight as to why women were so eager to change childbirth culture. They also show instances where the mother's authoritative knowledge failed them. Many of these women attempted to plan their birth in the hopes that it would be natural and empowering. However, once they were in the hospital space, they lost these plans, and the doctor's authority easily outranked them. Even the "choices" presented to the mothers were disempowered and empty. Furthermore, when a woman would still attempt to assert her authority, as with Joan Haggerty, she was outright overruled by the medical staff. These experiences push many of the women here to become determined to better plan the next time around. This in itself shows reform. Rather than concede to a future filled with doctors' choices, these women were determined to try to do it their way the next time. They resorted to more drastic consumer methods, including homebirth. Finally, even within these stories, while the overall authoritative knowledge high score may still reside with the doctors, small victories were made. Sue's husband was able to fight his way into her recovery room after her C-section. Judy in New Jersey said that she felt she was at her doctor's mercy, but also that she convinced her doctor to give her a spinal rather than general anesthesia for her c-section and fought to have her husband next to her in the operating room. She states that this was a first for that hospital. Jeanne's doctor wanted to x-ray her pelvis during labor, "When I refused, he exploded into a tirade about dead babies and brain damage."[268] While this is not the sort of confidence a

[268] Cohen and Estner, *Silent Knife*, 43.

mother wants before delivery, her *refusal* is extraordinary. Thus, while the 1970s saw the surpassing of a mother's authoritative knowledge take place outside the delivery room, small victories were being made every day, even in negative birthing situations.

Not every hospital birth was a negative birth experience. One mother who was a part of the counterculturists Farm commune decided to have her baby in a hospital with Dr. Hargrove. Carolyn begins her story by stating that her birth experience was the "most incredible experience I had ever had." Dr. Hargrove did not require Carolyn to take any painkillers, and Carolyn focused on Ina May's instruction, "Don't think of it as pain, Think of it as an interesting sensation that requires all your attention." Carolyn felt as though midwife, doctor, and herself were working as "one intelligent consciousness, brought together and united on the energy of birthing." This is the definition of a Mutual Participation birth. Ina May had asked to deliver the baby, but Dr. Hargrove stated that he could not allow it because of hospital policy. This story insinuates that although it was a Mutual Participation birth, it is only because Dr. Hargrove, in his authoritative knowledge, allowed it to be so. He still controlled the birthing room and everyone inside it. He still held the authoritative knowledge.

Hospital birth in the 1970s was medically less interventionalist than births in the 1950s and 1960s, but women still maintained very little control over their bodies and their births. In the only truly natural birth found for this chapter, Carolyn was not alone but had Ina May, who was able to act as a doula for her. The other women in this chapter did not have that support. Some had doctors who were willing to "try" natural childbirth, but likely when they saw the pain that labor caused their patient, they felt morally obligated to overrule her authoritative knowledge and assert his expertise. Technology worked both against and for these mothers. However, even when it worked for them, the technology held more authority than mother's bodily knowledge or expertise. Doctors and nurses used technology as a cultural object to perform their expertise, but they also treated technology as an expert whose authoritative knowledge medical experts could treat as objective truth. Mothers fought so hard for reform using their consumer wiles, but they still had very little control or authoritative knowledge in the delivery room.

Home Births

Home births became increasingly popular and enjoyed in the 1970s by all different types of women. One demographic that is often overlooked in studies but appeared in these memoirs is that of immigrants. In 1978 the Bay State Banner Newspaper reported the birth of African

immigrants Ibrahim and Shafia Bossman's baby Majeedakenza. Bossman was also a nurses' aide and a teacher of prenatal classes for the Traditional Childbearing Group. While Shafia worked in hospitals, she opted to have not only Majeedakenza but also Abdul Latif, her firstborn two years earlier, at home due to American birthing culture. She stated, "Having a baby is treated like it's a sickness in this society. You go to the hospital; they sedate you to the point where you don't know what's happening. Strangers tell you who can be present, and once the baby's born, they regulate the times he or she can be by your side." Shafia was not the only one in her family who felt this way; Ibrahim also commented, "In this country, the medical system is built on profit. People need to get back to traditional ways. Homebirth is a time of family union; each birth is different and unique. In hospitals, personnel practically say the father is too dirty to get close to the child." Shafia gave birth using what the newspaper called "birth attendants" and the help of her husband. The couple was experienced with natural childbirth even before they were pregnant, as they affirmed they had witnessed many births while still living in Ghana.[269]

There are so many invaluable elements within this one story, making it valuable to break it down. First, Shafia and her husband are both immigrants, which is crucial because they have not been indoctrinated to believe that childbirth is pathological. Already, just in believing this, the necessity for a medical professional such as a doctor diminishes. Another memorable facet of their immigration status is that both have previous experiences as spectators to natural childbirth. This experience demystifies the childbirth process and gives them more expertise than other couples. Next, Shafia's personal beliefs about the American system are confirmed as she works in the hospital. She also sees how many women in the classes she taught wanted more natural births, and how many struggled with this in the hospital. They also see home birth as an act that strengthens the family union. Finally, the positive experience and outcome of the birth of Abdul Latif further emboldened Shafia in a sense of not just authoritative knowledge over her attendant but of expertise over her entire experience. This sense of expertise can be seen in her performance of nonchalance, drinking tea and laughing, to project her complete control and serenity with her childbirth choices.

As seen with Shafia, some women chose home birth because it made birth a family affair. "I recommend home birth for everyone. It's an experience which your family will treasure."[270] said one mother. Another couple, Helen and John Morarre, decided to have a home birth

[269] Lewis, "Going Back to Natural Child Births."
[270] Ibid

because they were Christian Scientists. Rather than using a midwife, a doctor and nurse attended Helen. While it is unclear whether they used medical interventions, the couple still exclaimed how marvelous the experience was. "Your baby and your husband are with you all the time. It's wonderful." Helen later remarked.[271] Another positive the Morarres pointed out was the lack of transportation require. "There was no rush from home to hospital and no adjustment from hospital to home."[272] While among the other reasons, this one may seem unimportant, it was compelling enough that it was later integrated into hospital systems in the form of LDRs. Laboring women did not like to have to move.

As seen in the previous sections, many women chose home births after having bad hospital birth experiences. Homebirth was promoted as a much easier, more intimate experience than that in the hospital. One Dorchester mother said, "I watched my baby enter the world and held her close immediately afterwards."[273] In 1967 self-proclaimed hippie Joanne Santana had a very disempowering birth in the hospital at the age of twenty-one. In 1970, she found that she was pregnant again and decided she would not have her second birth in the hospital. Santana visited several lay midwives and even bought a child birthing manual before settling on a labor and delivery nurse who had done home births. Joanne says that her second birth was so easy and beautiful it was a "major turning point in her life."[274]

Nearly as popular of a reason as poor hospital experiences, many women wanted to experience proper natural childbirth without any medication or intervention. After a successful breeched 1971 California home birth, counterculturists Carolyn Brown claimed, "this is the only way to have a baby…It is so groovy not to be doped up. I feel I have super-awareness."[275] Many counterculturists felt psychedelic or telepathic occurrences during childbirth. Women who gave birth on the commune the Farm with Ina May as her midwife had these types of experiences regularly. One such mother, Sheila, was assisted by May and another woman, Mary Louise. During her labor, she stated that she switched bodies with Mary Louise, and the midwife did a couple contractions "for her" and "had been able to feel it all" until the baby was crowning.[276] While this is very different medically from a woman who allows her doctor to knock her out with painkillers and deliver the baby with forceps, the concept of the mother

[271] Kline, *Coming Home*, 33.
[272] Ibid
[273] Lewis, "Going Back to Natural Child Births."
[274] Kline, *Coming Home*, 70.
[275] Flannery Burke, and Jennifer Seltz, "Mother's Nature: Feminisms, Environmentalism, and Childbirth in the 1970s," *John Hopkins University Press* 30, no. 2 (Summer 2018): 63.
[276] Ina May Gaskin, *Spiritual Midwifery: Fourth Edition*, 4th edition (Summertown, Tenn: Book Publishing Company, 2002), 39.

giving her control to her attendant in an Active-Passive Relationship model is very similar. Although Mary Louise and Sheila switched their consciousnesses back before the complete birth of the baby, this could be seen as similar to doctors who woke their patients just before delivery as well. Again, this is another example of how authoritative knowledge was not often awarded to mothers in the delivery room, even on counterculture commune where the woman gave birth in a Caravan.

Perhaps not an immediate reason women thought of receive home births, but instead a result that would encourage further childbirth reform was the recovery time difference. Joanne Santana was amazed at how much easier her non-episiotomy birth was. "This time, I could sit right up, no stitches," she said, "you know, it was just incredible."[277]

Women chose to have homebirths with various motivations, but many of these resulted in the mother's control over the happenings of the birth. Women in these scenarios were considered the expert, and their birth attendant respected their authoritative knowledge in choosing their birthing location and method. Although medical experts attend them, it takes an expert decision by the mothers to decide to diverge from mainstream medical society and believe the benefits of homebirth greatly outweigh the risks. For all of these women, experience played a large part in this decision making. The experience of others in their cultural community who had either positive homebirth experiences or negative hospital experiences shaped the mother into an expert on what is not suitable for her body. On all these occasions, the mother performed expert actions and decision-making. Regardless, if there were complications in these births, the midwife would be forced to transfer the mother to the hospital. The medical personnel would likely strip her of her expertise, and she would be as Joan Haggerty was, thus strengthening the notion that expertise is an interactive concept that others must accept.

Discussion

These stories demonstrate the actual experiences of women in childbirth in the delivery room during the 1970s. They often paint a much less rosy picture than that painted by looking at all the reforms and birthing changes made in the 1970s. Before the 1970s, women remained mainly on the bottom tier of control, in the Active-Passive relationship, as they were almost always knocked out through birth. In the 1970s, Active-Passive relationships still indisputably

[277] Ibid

existed, though sometimes ironically under the guise of natural childbirth. As can be seen, by these stories, women would labor and then be told it was time to take pain medication, and then instead of medication that just helped them deal with the pain, these mothers would be nearly comatose. Sometimes they were awoken just before birth, but they were still only observers in their own birthing experiences. Although Active-Passive births still happened, most 1970s births appeared to be the second tier, Guidance-Cooperation. Mothers remained awake as long as they were willing to comply with what the practitioners thought was best. Some mothers were able to find opportunities for Mutual Participation births, but those mostly happened with home births.

In all three of these tiered births, however, one item remained the same. The practitioner, not the mother, chose these relationships. Women were able to employ their authoritative knowledge through consumer movements that helped them choose doctors or midwives willing to aid the mothers in giving birth in the way they wanted. For some women, this meant accepting interventions. It was attempting natural birth for others, and for a few, it was even pursuing home births. They had very little ability to diverge from the medical path the obstetrician chose for them since the mother only had as much autonomy as the practitioner allowed her to have, and therefore, in reality, the mother had very little authoritative knowledge. This lack of authentic control is exhibited in stories where the mother had an intended birth plan, which sometimes the doctor even agreed to, but then in the delivery room, they were powerless to enact it because the doctor did not allow it. Furthermore, in births where the women hold bodily knowledge about what they are feeling, or even their due date, they are incapable of making the practitioner act accordingly, even to the point of being strapped down or drugged without consent. If a woman had a birth plan with one practitioner but then actually went into labor and delivery with a different person, she was helpless to stick to her original plan because she held no reliable, authoritative knowledge in the delivery room. Only the birth attendants had veritable control.

Mothers could be controlled literally, with arm restraints and isolation, as several of the mothers in these stories were. Conversely, medical personnel could strong-arm mothers into compliance by leaning on societal rhetoric already built into these women's lives. Mothers, especially new mothers, would have been very worried about being a "good" mother or a "bad" mother, and doctors could pull at this notion to set up consenting questions to seem like a choice between being a "good" mother or a "bad" mother. Questions such as the one Shirley's doctor asked her, "What's more important, to have a normal birth or a healthy baby?" set mothers up only to have one real choice. The idea of "good" and "bad" could also be mirrored

in the hospital setting by labeling the mothers as "good" or "bad" patients. While being a "good" or "bad" patient did have the social pressure to unnerve mothers into compliance, these labels did allow the medical staff to treat the mothers differently, such as nurses strapping Joan Haggerty to the delivery table.

Interestingly, in-hospital births technology played a role in both subverting the mother's authority and boosting it. With Sue, nurses who told her that the monitor would only be on "for an hour" despite her vocal desire not to wear it at all performed a show of one-up-manship, and Sue accepted their expertise. This is also the only instance of protest from Sue's story, so she probably felt unable to argue with the medical personnel afterward. On the other hand, her husband was able to fight his way into the delivery room, displaying how important it was for these women to have access to a support person. Contrarily, sometimes technology allowed women to prove their bodily knowledge. Just as nurses used the EFM to prove their intuition to the doctors, a mother who could feel she was in labor proved she was with the EFM. This kind of proof was a double-edged sword, as it proved the mother's bodily knowledge but also instilled the technology's expertise rather than her own. Finally, technology, especially complex machinery, required consent forms for the doctor to perform the procedure, allowing the mother a more accessible opportunity to say no. The need for consent was seen in Jeanne's refusal of an x-ray her doctor wanted to take of her pelvis. The doctor's angry "tirade" is also informative, as it displays how few women were legitimately able to achieve this. Furthermore, Jeanne's rejections demonstrate that doctors were more likely to respect a performance of expertise, i.e., a show of one-up-manship by not signing the consent forms, than the intuitional expertise of bodily knowledge.

Conclusion

The disparity between consumer rights, which led to massive childbirth reform, and the lack of authentic, authoritative knowledge inside the delivery room is why I think there is such discrepancy in the literature concerning 1970s childbirth reform. Historians and anthropologists alike have agreed on why childbirth reform seemed to have developed so many new policies, but in actuality, the reforms often felt superficial. I propose that the reason is that mothers held authoritative knowledge as consumers, were trusted to know what they wanted, and how to choose their birthing location and practitioner. Only home births with untrained lay midwives were problematic enough to be illegal, and even so, this was an authoritative knowledge struggle between the legislature and the mothers/midwives, not between the

mothers and midwives. Hospitals spent millions of dollars renovating maternity wards, building LDRs, and even birthing centers to accommodate motherly wisdom on birthing locations and rituals. Mothers even gained authoritative knowledge over birthing details and created lists that let the facility know precisely what they wanted. However, once the mother entered labor, her authoritative knowledge was abruptly revoked in favor of the practitioner. The obstetrician took charge, and those in attendance, including nurses, fathers, and even the mother, must abide by their say-so or suffer the consequences. They could kick fathers from the room and strap mothers to the table. In home births, midwives regarded the bodily knowledge of the mother as far more authoritative than it was in the hospital. Nevertheless, if a mother in a home birth needed to move to the hospital, she did not retain her authoritative knowledge. Therefore, her bodily knowledge and authority stemmed from her midwife's allowance rather than her own delivery choices.

If authoritative knowledge is something bestowed upon by the expert, then it in itself is empty. Rather than an aspect of authoritative knowledge, it becomes the performance of expertise by the expert. Thus in order to retain authoritative knowledge against an expert, the laity must not only be content with the allowance of their autonomy but the actual seizure of expertise for herself. Only in this way is she able to also perform expertise one-up-manship and legitimately enter the authentic struggle for authoritative knowledge. In the 1970s, the vast majority of mothers were never able to gain this level of expertise. However, their reformation in the consumer realm helped to elevate the mother's authority. Thus, mothers gained some authoritative knowledge outside the delivery room, but for most women, the total performance of expertise did not shift from the doctor to the mother in the 1970s. Therefore, the next chapter will dissect 1990s narratives and home videos to see if mothers were able to stand on the shoulders of their 1970s sisters to claim expertise and, therefore, authoritative knowledge in the delivery room at last.

Chapter 4, 1990s Home Videos and Memoirs: *I Think I Call the Shots*

Discerning between autonomy, expertise, and authoritative knowledge in the 1990s

Introduction

This chapter focuses on the stories of childbirth from the mother's perspective, those found in home videos. As in the last chapters, secondary sources, anthropological studies, and newspaper articles are used in this fourth chapter, albeit differently. Rather than understanding the way scholars and society understood the dynamics in childbirth, this chapter will only use personal stories of childbirth, and they will be used to supplement the principal source used, home video.

At the end of the second chapter, I developed a hypothesis about the shifting authoritative knowledge dynamics between the medical practitioner and mother. I stated that in the 1970s, the authoritative knowledge shifted from being solely on the practitioner to a more shared element between the practitioner and mother. This was done in a number of ways, including consumer practices, utilizing group support, and pursuing educational classes, for various motivations. In the 1990s, this shift between practitioner and mother was more complicated, and mothers sometimes returned some of their gained authoritative knowledge to pursue other goals, such as convenience, technology, and ensuring the best possible outcome. Some women were still unaware of their lack of authoritative knowledge due to their contentment with the reforms made in the 1970s movement. Other women may have felt they had authoritative knowledge and control in birth, only to have been steered by doctors toward methods they better controlled. Do women only have as much authoritative knowledge as they are allowed? Must all the reform take place outside the delivery room (doctor-shopping, education, support)? Or can women assert this knowledge at the moment? My hypothesis: In the 1990s, women had more authoritative knowledge in the delivery room than they even knew. They could choose to have authority, but medical practitioners would not give it to them; they would have to take it for themselves.

Method

The most common historical sources used to study childbirth include interviews, magazine articles, talks, biographies, newspaper articles, and rarely even blog posts. However, there is another valuable ego document source that historians have underutilized in this subject: the use of home videos on YouTube. While these sources have issues, which will be addressed, they also prove to be a rich primary source, recorded in an effort on the participant's part to save "the moment," often accompanied with mini interviews between the recorder and the recorded as well. While other more traditional historical primary sources are used in this thesis for context, the focus of this chapter will be the analysis of 1990s home video births published to YouTube.

At the end of the 1980s, Brigitte Jordan analyzed a single birth video in a complex breakdown. This video comes from a larger project, "A Comparison of Supported versus Directed Care during the Second Stage of Labor," which ran from 1986 to 1989. Jordan argues that this video demonstrates that when birth becomes technologically dependent, knowledge becomes hierarchically distributed. This thesis will check this assessment to see if it holds in the 1990s and if technology is accurately the primary factor or not. This video is professionally shot and transcribed. Perhaps this creates a larger sense of composure the way professional interview may, as Summerfield mentions.[278] Even so, this video can be well trusted for its authenticity, even if the subject is moderately composed. Furthermore, while Jordan chooses not to use it beyond stating the woman's age and the birth is her second child, there is likely contextual meta information about the woman that could be useful for analysis.

The videos used in this thesis will defer from Jordan's as an amateur videographer shot them for an amateur audience. Contextual information is rarely given in the descriptions. There is often no demographic information given, although if listened to closely, most clips give clues to valuable information such as how many children the mothers already have. Another issue is that even the longest of these videos has some editing and some scenes cut. This is also determined by what the recorder deems worthy of recording and is telling. All the videos viewed for this thesis, as most birthing videos on YouTube, depict "good outcomes." Very few women had c-sections, and none of the videos had babies with serious complications. That selection works very well for this analysis, however, as the focus of the entirety of the thesis is on normal, low-risk births. Finally, it can also be complicated trying to discern which

[278] Summerfield, "Culture and Composure."

philosophical group these women belonged. While this might be a shortcoming, it also grants veracity in the idea of a continuum rather than isolating viewpoints.

While video analysis is a well-known methodology, most video analysis focuses on professionally shot video, whether that is movies, tv shows, or historical footage. Less methodological development has been done in the analysis of home video, particularly those posted to YouTube, especially from a historical perspective.[279] Geographer Robyn Longhurst created a study analyzing the spatial relationships in YouTube birth videos. Her work, however, focused on more contemporary videos designed for YouTube publication. The videos used in this thesis are dissimilar as they were most likely not shot for publication.

Therefore, to successfully analyze these videos as a separate genre, methods from interdisciplinary studies were utilized, but a central analytical focus was derived from the realm of ego document. Video media analyst Sarah Pink reminds researchers that video is not a neutral selection of reality but rather 'fictions' or constructed narratives.[280] These constructions are evident in these YouTube videos, as the camera operator chose when to begin filming, when to cut, and on what to focus the camera. In this way, these videos can also be reviewed as autobiographies. They are often shot for posterities sake, frequently with the camera operator narrating the video about what is essential for the future viewers to know. These videos are part of a more extensive family archive built to preserve a shared family identity.[281] Furthermore, because YouTube is a newer service, these videos most likely survived and were posted because the bond between generations was strongly felt.

The Stories

It would be far too optimistic to state that all women in the 1990s had authority in the delivery room. Some women could not utilize their authoritative knowledge because they were under-educated on navigating the hospital system. While doctors were not physically restraining patients as they did in the 1970s, some women were still highly suggestible by their doctor's advice. In 1996, teenaged Carla's doctor advised her to have an epidural by suggesting that she knew the girl did not "like pain."[282] This is a particularly fascinating reason for a doctor to persuade someone to receive an epidural. First, the doctor suggested she knew her patient very well, perhaps even better than the girl knew herself. Second, it shows that this particular

[279] Robyn Longhurst, "YouTube: A New Space for Birth?," *The Feminist Review* 93 (2009): 48.
[280] Sarah Pink, *Doing Visual Ethnography*, 2nd Edition (London: SAGE, 2006).
[281] Baggerman, "Autobiography and Family Memory in the Nineteenth Century," 163.
[282] Brubaker and Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," 229.

doctor probably thought most women should receive epidurals because who did like pain? Thus, even when doctors felt they were looking out for their mother's individual preference, they also were guilty of lumping all mothers together in a universal experience.

Low Authority, Low Control

While some memoir interviews focused on larger areas of authoritative knowledge, other interviews and videos demonstrate that the struggle for authority in the delivery room was a constant push and pull over both large and small items. After mothers made these small victories, they often became more vocal and engaged, but their "losses" could be equally affecting, just in the opposing perspective. One such story was that of a family physician who was having birth in the hospital, despite her belief that hospitals were not an ideal location for having babies. "I felt I could control who was in the [labor] room and by breathing techniques. I music - Bach to rock. I picked ____ Hospital despite the fact that I think it's a terrible environment for having a baby. It was so familiar…a comfort to me having a baby someplace where I really knew the territory…I think it is the same idea people have when they want to have a home birth." The mother has demonstrated an overarching desire for control in her delivery room and the desire to have a home-like birth in this short exert. Along with this, she illuminates the small details, which were choices won by her 1970s reformation sisters, such as the music that helped her feel she was in control of the situation.[283]

Doctors knew that mothers wanted this control in the delivery room and therefore had to be wily coaxing mothers to comply with them. One way doctors and nurses were able to convince mothers to do what they, the medical professionals, wanted her to do was to tell her it was good for the baby. In one video, a long-laboring mother is becoming exhausted and uncomfortable. She asks the nurse assisting her if she has to leave the oxygen mask on as she pulls uneasily at the straps. The nurse says, "Yeah, it's good for the baby." The mother plops her head dejectedly back on her pillow and laughs weakly. The doctor then says, "She's a good sport." to the nurse.[284] This comment is made over the mother's head, loud enough for her to hear, but is also clearly not directed at the mother. Often in these videos, doctors and nurses spoke to and about the mother like a small child or pet. The compliments of "good girl," "You're doing super," are common, as well as comments made about the mother as if she is

[283] Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," 144.
[284] The History of the Smith Family, *Birth of Sara Smith in 1990! Also Sean Singin and Bathtub Time!*, YouTube, 2016.

not there, “She’s a strong woman,” “She’s doing a great job.” Alternatively, in this case, “She’s a good sport.” “Good sport” is extra intriguing because it indicates that this mother is willing to play along. She does not fuss; she does not fight; she does what is asked of her. In the end, this mother gave up her authoritative knowledge to the doctor, which the doctor saw as complementary.

Some women were uninformed about what was happening around them in the delivery room, making it very difficult for them to have authority, even while doctors were not actively withholding authority from them. One such mother was a 1997 southern African American birthing teen named Keisha, who stated the doctor gave her some type of sleep-inducing pain medication during birth, but she was unaware and undisturbed by the distribution. Perhaps most interestingly, she considered her birth to be natural because she did not receive an epidural.[285]

The lack of consent for pain medication that was not an epidural was also true in the videos. In one birth where the mother wanted to have a natural childbirth, her doctor gave her a numbing agent without asking her or her consent. The mother had been yelling through her contractions and also occasionally saying tiredly, “I can’t do no more.” To this, the doctor responded positively,

> “Those contractions, you gotta use them. As much as you don’t like them, they’re there to help you that’s what helps get your baby out. Just bear down. You’re doing alright, I’m just talking to you. You have your baby a little bit at a time. If he came out fast, he’d be tearing you up and tearing him up. Your baby’s going to be fine. Breath in that oxygen, don’t fight it, just work hard.”

Even while coaching, he is commanding her to use her oxygen. Oxygen masks were a theme throughout all the videos that medical professionals wanted to see mothers using, but mothers, already being so uncomfortable, often resisted. These were cultural items testifying to the doctor’s authority over the woman’s body. After the doctor’s monologue of positive coaching, he then leans down and gives the mother a vaginal shot. “What are you doing, Doc?” the mother tiredly asks, indicating she was neither informed nor consented. The doctor replied, “Just giving you a numbing agent in case I need to do some stitches. You know, like when you go to the dentists, and they give you something to numb you while they work on your mouth? Same medicine.” Thus the doctor undermined the mother’s autonomy by giving her a shot she neither asked for nor gave consent to while simultaneously mentally and physically prepping her for an episiotomy.[286] Furthermore, the comment comparing childbirth to the dentists

[285] Brubaker and Dillaway, “Medicalization, Natural Childbirth and Birthing Experiences,” 229.
[286] Dewayne Sanders, *The Birth of Brittany January 21st, 1994*, YouTube, 2016.

exposes the doctor's attitude toward natural childbirth. It also discloses the doctor's conviction that his position was the baby remover, as a dentist might remove a tooth.

High Authority, Low Control

Other women did not need the doctor to tell them to have interventions, but they sought them out. Anesthesiologists were notorious for suggesting medical interventions to other mothers, and this anesthesiologist made no exception for herself. She wanted all the monitoring possible and delivery to take place in a separate delivery room. Furthermore, she was mentally prepared for an operant delivery. She said:

> I wanted to optimize it for the baby. I don't really care about the birth experience like a lot of patients do - into soft lights, soft music garbage. For me, it was getting a good baby. I've seen too many times where patients are so concerned about it being a lovely experience for them that this has overridden the desires for having a good baby, and they put themselves and their birth experience in front of having a "good" baby come out and having the best care for that baby."[287]

This quote exemplifies when the mother's authoritative knowledge tells her to relinquish control to the doctor. While the use of fetal monitors and the delivery room may be aspects of delivery the doctor would prefer, that does not take away from the fact that these are the mother's choices. This passage also demonstrates the concept seen in the literature, where women were willing to have higher instances of intervention in order to guarantee a "good" baby.

High Authority, High Control

In instances where women had high levels of authority, they often relied on embodied knowledge or the experiences of others to guide their decisions. Embodied knowledge provided a standard against which biomedical recommendations were assessed.[288]

Some women were surprised by how much say they were allowed to have. One mother, Valerie, stated, "I think they [the doctors] could have tried to take more of a stand-in terms of whether or not I was going to get an epidural or not, but they really handed it over to me. They

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[287] Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," 144–45.
[288] Browner and Press, "The Production of Authoritative Knowledge in American Prenatal Care," 122.

gave that to me, and they made suggestions. That was really what I wanted."[289] Again, this demonstrates how important it was for women not to control the delivery if they didn't want to necessarily, but to have a say in what was happening. These sorts of conversations were apparent in the YouTube videos as well. In 1999 Lauren's Birth, the mother has already had an epidural, but she explains to the nurse that she is feeling some sensation, and she asks the nurse, "What do you think?" The nurse responds, "Tell me what you think. You're the one who has to put up with it. I don't have to put up with it." When the mother does explain that she is afraid to get another epidural, the nurse responds, "You're afraid to get more, or you're afraid to get another one? We probably won't do another one at this point, but we can give you a little bit more medicine." This is a highly collaborative conversation. The mother knows what she wants, but she is unsure medically how to get there. The nurse knows the medical options available but does not push any of them on the mother.[290]

Likewise, in this study's only home birth video, the mother has a say in many aspects of the birth. This is due to the midwives giving more open-ended answers to the mother's questions. In one home birth video, after the birth, the mother says, "Do you want me to try nursing her now? Or wait a few minutes?" Clearly giving the power to the midwife. Nevertheless, the midwife says, "She'll probably nurse now if you want." It is not a yes or a no. It is just information given to the mother to choose what she wants to do.[291]

In both these instances, the nurse or midwife is the most "expert" person in the room. In instances where a higher-level expert is there, such as the doctor, the nurses sometimes chose to remain the mother's advocate. In Lauren's Birth, the same nurse as above demonstrates some moments of camaraderie with the doctors, but in most instances, she is the mother's advocate. For example, after Lauren is born, she is placed on the mother's chest for a moment before a nurse whisks her to be cleaned up. The mother is lying down while her legs are still in the stirrups as the doctor is stitching her up, and she cannot see her baby. The nurse comes bedside and speaks softly to her before raising the head of the bed. The doctor barely notices as he is too busy at the "business end" of the mother to worry about if she can see her baby.

The mothers who feel they have the authoritative knowledge are obvious just by the persona they give off. They are usually multiparous women, and that experience gives them expertise. They may instruct the nurses about what they like, and they speak with the doctor as an equal. After her birth, one such woman stated, "Easiest birth I ever had," mentioning that it only lasted

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[289] Brubaker and Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," 230.
[290] Greg Burnett, *1996 Easter 1999 Lauren Birth*, YouTube, 2019.
[291] Breezy Photography, *My Homebirth 1991*, YouTube, 2020.

two hours. This mother is obvious with her tone, body language, and the way she directs her LDR room that this was her birth, and others are just here to assist her in a kind but firm way.[292]

Already, a wide variety of births can be seen in the 1990s. In the 1970s, births were confined to realms of "low authority, low control" and rarely, "low authority, high control" if a midwife or an understanding doctor attended the mother. In the 1990s, women diversified in both their levels of authority and control. As the following sections will demonstrate, having a birth with high authority and high control was still quite a feat in the 1990s, but it was not unattainable, nor was it determined by birthing location.

Additional Actors in the Room

One of the most terrific parts about using YouTube videos in this manner was that the mother and medical practitioner were not the only ones with input on the situation. These videos allowed for the analysis of many other people present and assessed their roles in the birthing process. How did these individuals aid or depreciate the mother's authoritative knowledge?

Fathers

Fathers are a captivating person to watch in these child birthing videos, and they appear capable of either undercutting the mother's authoritative knowledge or strengthening it. In the birth of Emily, the father feeds the mother ice chips and rubbing her back. She begins her birthing experience relying on Lamaze breathing, but the camera is later informed she received an epidural. It is unclear whether this was in her original birth plan, but the father is very supportive of her decision either way. "I think epidurals are wonderful. I don't know why anyone would want to do natural childbirth."[293] He says. While this is dismissive of other women's choices, that does not matter because it supports his wife's choice.

Other fathers are very quiet throughout. In the home birth, the father sits on the bed next to the mother the entire time she is laboring, though he is reticent. The couple kisses lovingly and often. The only time he says anything to the mother is when she is crowning, assuring her she can do it as she does not realize that the birth is almost over. After she finishes, the father congratulates her and tells her what a great job she did. Here the father also supports the mother's authoritative knowledge by insinuating that she does not need his input. The mother

[292] Craig Tebbs, *Tebbs Family Natalie Birth 1998*, YouTube, 2017.
[293] Les Oliver, *1996 Emily Holt's Birth*, YouTube, 2020.

in the home birth labors loudly and is in constant communication with the midwife. The father merely displays his support and love for the mother and then congratulates her afterward, acknowledging the work was entirely hers.[294]

The father's presence had a peculiar effect on male doctors. These doctors seemed grateful to have another man in the room and often seemed unable to help themselves from making jokes while the mother was delivering. These jokes were primarily harmless, things like "You're working harder than he'll ever work."[295] However, these remarks created an inside joke bubble between the father and doctor, excluding the mother. In another video, both the anesthesiologist and the obstetrician laugh with the father at how uncomfortable the mother is. The mother is yelling things like, "I just want it out. I can't stand it." "I really just need it gone. Take it out. Oh, I should've had a c-section."[296] The mother was a reserved woman, and these sudden outbursts seemed out of character. They, therefore, were a source of uncomfortable mirth for the men in the room.

In this same video, the anesthesiologist looks uncomfortable while the obstetrician examines the mother, demonstrating why male doctors sometimes made jokes. The men's desire to ease the growing tension in the room is palpable even through the screen. The doctors joked with the nurses, and male doctors joked with the fathers, and everyone spoke to the mother as if she was a professional athlete or a small child.

Doctors

Doctors had many different types of relationships with their patients in the 1990s. While the time doctors spent with mothers was supposedly longer than in the 1970s, the YouTube videos show that most of the labor was spent with the nurses, with the doctors only coming in after transition. This was true because the videos that did not show the actual pushing and expelling of the baby might not capture the doctor at all. Most doctors had light-hearted, friendly relationships with the mothers until the mothers even slightly questioned their authority. Then the doctors either became very serious, as one telling a mother she was receiving a lidocaine shot if she needed an episiotomy,[297] or laughed at the mother's concern, such as one telling the not to worry about the doctor vacuuming her child out.[298] Doctors spent

[294] Breezy Photography, *My Homebirth 1991*.
[295] Sanders, *The Birth of Brittany January 21st, 1994*.
[296] Burnett, *1996 Easter 1999 Lauren Birth*.
[297] Sanders, *The Birth of Brittany January 21st, 1994*.
[298] TheDoughertyFamily, *Ethan's Birth [March 2, 1998]- TheDoughertyFamily*, YouTube, 2010.

the majority of the time speaking to the mother in coaching tones. Rather than repeat the word "push" as nurses did, doctors relied on more complex coaching, including instructing mothers to visualize the wave of contractions and that her baby was waiting at the end of all the labor.[299]

Nurses

The nurse's job in these videos was to insert the doctor's authoritative knowledge even when the doctor did not say anything. In the "Birth of Brittany," the mother is having a natural childbirth, and as she can feel herself crowning, she says, "Oh, that hurts," and reaches down to feel her own body. The nurse admonishes her, "Keep your hands out of there, hon. Keep your hands up." Not only is the mother disallowed from touching her own body, but the nurse's incredulous tone of voice and the use of "hon" is as one might tell a small child to keep their hands out of their pants. Language and tone were consistent tools used by nurses to display their authority.[300] This was obvious in the written sources as well. One woman, who was herself a nurse and had her baby rooming with her, woke up to a nurses' aide wheeling her baby out of the room at two o'clock in the morning.

> "The aide said she was taking the baby to be weighed. I said, 'That is at six. Bring the baby back!' I mean, some women don't know they can keep the baby with them. That is why I wanted a private room - to have more control…I know the head nurse; you have to know people. The overall feeling was that these are the rules, and we don't bend them."

The woman went on to say first time mothers with no medical experiences "wouldn't have a prayer" because they did not know how to navigate the system.[301] Nurses attempted to have authoritative knowledge over the mothers, but a knowledgeable mother could easily trump a nurse.

Nurses often fell at the bottom of the authoritative knowledge ladder. In one video, a nurse tries to limit the number of people in one of the maternity rooms saying, "Only grandparents are supposed to be in here, only grandparents and dads so." However, the family ignores the nurse, and the extra family members remain in the room. This instance displays the mother's authoritative knowledge not only as a mother but as a patient. It is her room, and she feels that she has the right to say who can be in it. The same goes for who has the right to hold her baby.[302] Fascinatingly, this is a c-section mother, so she may have used authoritative

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[299] Burnett, *1996 Easter 1999 Lauren Birth*.
[300] Sanders, *The Birth of Brittany January 21st, 1994*.
[301] Lazarus, "What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth," 144.
[302] EricSchnVids, *1990 August 8th - Jacob Is Born*, YouTube, 2016.

knowledge to have an elective c-section. If this is true, it makes sense that she feels that she has the authority to ignore the nurses.

While mothers often held authority over nurses, fathers did not appear to feel the same sense of authority and would usually do what the nurse asked, without question, and quickly. One such example is a C-section birth where the father presents his new baby to the family waiting in the hallway. He is with his family hardly one minute before the nurse says, "We're going to need to get him in the nursery." The father does not ask why but merely turns over the baby. Once the nurse places the baby in the incubator, the father stands with his hand on the plexiglass. The baby remains in the bed for a long time before any nurses measure him while the father takes photos to show the mother.

The idea that the baby needs to go into an incubator immediately and that body heat is not warm enough is a common theme in these hospital births. While the temperature change from the womb to the room must be startling, warmth is something that never shows up in their literature or videos as an issue for homebirth babies. Before the baby is transferred to the mother's room, he is given a bath and dressed in a diaper, onesie, and hat.[303] Thus her baby will already be a little person delivered by the hospital when she sees him, rather than a product of her body.

Nurses could be excellent cheerleaders and advocates for the mothers as well. They were often the ones to congratulate the mother on the birthing process and her baby in general. Nurses often said sentences such as, "Ya'll did perfect. She's a beautiful baby."[304] Rivetingly, this was a 1996 first-time mother who chose an epidural birth and whose birth experience probably would have fallen on the Guidance-Cooperation tier.

Midwife

In the YouTube videos, there was only one home birth, which is representative of the percentage of home births but did make it difficult to make any comparative statements about midwives. That said, this midwife looked and acted like a secondary source stereotype. The midwife was very quiet and gave almost no indication of her preferences for the mother. She listens to the mother's contractions and the fetal heartbeat with a stethoscope occasionally, as well as a rare internal check. It is only until the last moments of delivery that she begins actively coaching the mother to slow her pushes so that the mother does not tear. The mother begins to

[303] 980912 Zack's Birth
[304] Oliver, *1996 Emily Holt's Birth*.

cry that she "Can't do it." Because so many other family members are in the room, including the father, older children, and several adult women friends, the midwife does not need to be her cheerleader. Instead, she concentrates on easing the baby out of the vagina. She carefully maneuvers the baby out of the mother without an episiotomy or tearing. The baby is then placed immediately on the mother's chest, where she stays until the mother asked for someone to take her because she needed a drink and a breath. Only then does the midwife cut the cord, clean up the baby and weigh her. As previously stated, many other people are inside the room watching the birth, but the midwife almost only communicates with the mother. This intimacy noticeably creates a little bubble around the mother and the midwife, who speak in hushed tones to each other.[305] They are noticeably teammates, and the mother is in charge. This birth was clearly an example of Mutual Participation.

Personnel Conclusion

Each of these individuals played a different role inside the delivery room, and their roles aided or harmed the mother's confidence in her fight for authoritative knowledge. In the best-case scenarios, these people helped 1990s mothers to perform expertise toward the doctor. Alternatively, at the very least, they offered support to the mother and respected her autonomy and personhood. In the worst-case scenarios, they undercut the mother's autonomy, bodily knowledge, and authoritative knowledge by speaking around her, admonishing her, or supporting the doctor's decisions against her own. Both nurses and fathers could fulfill both roles and flip between the two when they felt it was necessary. These videos demonstrate that each person present in the room can "cast their vote" to the person whose knowledge they feel should be legitimized. Mothers expected their husbands to side with them, and doctors expected nurses to side with them. Thus when a father or nurse would cross to support the opposing knowledge, this held heavy weight in the authoritative knowledge scale and would require substantial expertise performance to regain the lost ground.

After Birth

How the baby is treated immediately after birth shows how far maternal reform had come from the 1970s. How long the mother holds onto the baby indicates how much authoritative knowledge she has over the process. In the home birth, the baby is immediately placed on the

[305] Breezy Photography, *My Homebirth 1991*.

mother's chest with the cord still attached inside. The midwife does all the nasal suctioning of the baby on the mother's chest, as well as the initial wipe-offs. The baby is not removed from the mother's chest until the mother indicates she is ready for someone to take her.[306] In the birth of Sara, the baby is also immediately placed on the mother's chest, where the baby Sara is cleaned and suctioned. In this video, the mother is crying after what has been a very tiring labor. A nurse reaches to take Sara, but the mother holds her for one extra moment before giving her to the nurse. This little scene showed how many mothers felt like patients who must be obedient until they have their baby. Then, even the quietest and submissive mothers, such as the one in this 1990 home video, become more performative with their authority and motherhood, like this mother holding on to her baby a moment after the nurse clearly wanted to take her.[307]

In another video where the mother gave birth seemingly unmedicated in a beautiful LDR by a female medical practitioner, the baby is also placed on the mother's chest right after the birth and stays on the mother for the next twenty minutes. No nurse came to take the baby away, and the mother did not surrender the infant. The mother held the baby the whole time she delivered the placenta and received stitches for either tearing or an episiotomy. This is the longest a baby is held on the mother's chest directly after birth, including the home birth.[308]

In the video Jacob is Born, the mother has a C-section. Directly after the section, the baby is given to the father, who brings him into the hallway for the grandparents to see. The father is in the hallways for about a minute before the nurse tells him they need to take the new baby to the nursery to be cleaned and weighed, etc. The baby is shown through the glass of the nursery for hours. It takes a while before the nurses get around to weighing the baby, and then afterward, he goes right back into his incubator. The baby is not on oxygen or an EKG machine. There is no indication that the nurses believed there was something wrong with the baby. The family in the hallway expresses the desire to meet him, but none can hold or touch him. The nurses do not bring the her baby until the next day. She sits waiting in bed with both sets of grandparents waiting for her new baby to be brought. Several hours go by while she waits. Once the nurse brings the baby in, she says that anyone who wants to hold him has to put on a yellow trauma gown, creating yet another level of distance between the adults and the baby. Interestingly, when the grandparents want to ask the firstborn Eric, a toddler, to do something with the baby, they always look to the mother for assurance. In fact, any questions about

[306] Breezy Photography.
[307] The History of the Smith Family, *Birth of Sara Smith in 1990! Also Sean Singin and Bathtub Time!*
[308] Lovejoy Home Videos, *1990 Elizabeth Is Born*, YouTube, 2017.

holding, unswaddling, or taking photos of baby Jacob are directed to the mother. In this audience, she is clearly the authority. This is another example of the mother gaining more authority when she is around her older children because she no longer feels like a *patient*, but rather she is a *mother*.[309]

In many early 1990s videos, the nurse takes the baby from the LDR for measurements and their first bath. In the 1990 Elizabeth is Born video, the day after the baby was born, the nurse gave her a quick, robotic bath in the nursery. The nurse commented to the baby, "You are a *screamer*!" as the father records from the side, and the mother is nowhere in sight.[310]

Conversely, in the 1996 birth of Emily, the baby is weighed and bathed in the LDR room. The nurse is noticeably gentler, but even so, a man who appears to be a grandfather says, "You're handling her a little bit rough over there." The grandmother replies, "Nurses are usually a little rougher than Mamas because they've seen more of them."[311] Even so, the nurse slows her bathing down. Just by moving the bathing to the LDR room, the family has more control over the baby's treatment. Their acknowledgments of the nurse's actions are enough to make her hypervigilant to how her treatment may be perceived. She slows down her bathing technique to abide more closely to what the family may want.

When hospitals allowed family members into the LDRs and moved babies from the nursery to stay with the mother, the family was better positioned to perform surveillance on the medical professionals. The surveillance allowed more people to assess and question the authoritative knowledge of the medical professionals. If the family, even if they are not the mother, questioned the authoritative knowledge of the medical professional, it would automatically bring the legitimacy of their knowledge into question. Expertise has to be a constant performance, but in this video, the nurse is unsure of her expertise over the baby's bathing. Furthermore, the family members' authoritative knowledge concerning the baby is a societally legitimized one, further making the nurse question her own expertise.

Perhaps even more interestingly in this instance is the fact that it is the grandfather who says something. There is a good chance that he did not get to see his children born and therefore is the least medically socialized to childbirth, and therefore the most likely to find something wrong with the medical rituals. Those who have been medically socialized, the parents and the grandmother, accept that this is how nurses handle babies. They think nurses must know what they are doing because they are the experts.

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[309] EricSchnVids, *1990 August 8th - Jacob Is Born*.
[310] Lovejoy Home Videos, *1990 Elizabeth Is Born*.
[311] Oliver, *1996 Emily Holt's Birth*.

Bonding is another often cited theme in the literature that appeared in these videos. In most births, the baby is placed on the mother's chest either immediately or moments after birth. Mothers can be seen with their gowns pulled down after birth to have some skin-to-skin contact with their babies. Even the mothers who had c-sections unswaddle their babies and hold them against their chest to initiate bonding.[312] Most women in these YouTube videos are shown breastfeeding, and no babies are shown with a bottle. Medical professionals even assist the mother with breastfeeding when she asks for help. Breastfeeding was clearly seen as *a* if not *the* normal option for mothers.

After the mother has delivered her baby, the mother's struggle for authoritative knowledge is still not over. However, she is no longer just a patient; she is a mother. This transformation is evident in most of these videos. The only instances where the mother does not immediately express more authority were the epidural births where the mother had exhausted herself. Nevertheless, even in the c-section videos, the mothers had increased authority when their babies were brought to them. This maternal authority also extends to the other family members present in the LDR, and their invested interest in the baby places added pressure and surveillance on hospital staff. Finally, these videos demonstrated how pervasive bonding theory and breastfeeding had become, placing more maternal authority back in the mother's bodily knowledge.

Technology

Technology was also a central theme in all these videos. Many of the videos started with a shot of the EFM output before even showing the mother as if that EFM output showed she was really in labor rather than the woman sitting in the hospital bed.[313] Aside from the home birth, every single birth utilized fetal monitoring. In almost every video, "push" is the most common word. The nurses and doctors were often not even looking at the mother as they said: "push." Instead, they are fixated on the monitor, trying to time the pushing with the arc of the contraction. Especially when the mother expressed fatigue, she is all the more emphatically encouraged to push.

Some women rather use technology than their authority in the delivery room. Donna wanted to have an epidural, and she wanted her doctor to take control. She stated, "He [the doctor] had medical knowledge, and so he could decide what to do from his experience."

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[312] Angie Bennett, *980912 Zack's Birth Sept 12 Nov 12, 1998*, YouTube, 2020.
[313] Vincent DeVito, *1995 August Nicole Birth*, YouTube, 2019.

Important to also note that Donna goes on to say, "To be perfectly honest, it wasn't my decision [to have any of the interventions], I had nothing to do with that."[314] While she trusted the doctor to make the "right" decision as to what interventions he would use, it also shows that when mothers gave authority to the doctor, then the mother lost total control. Thereafter, the doctor was quite likely to utilize interventions at his disposal.

When comparing the memoirs to the YouTube videos, the memoirs do not do justice to how little bodily control women had with an epidural. Women who had the epidural are placed in stirrups, draped, and often needed nurses to place their legs in the correct position because they could not move. The total numbness of their lower body was apparent by how these women relied on the nurses and doctors to inform them when to push. In many of these videos, the nurse or doctor can be seen glancing at the monitor constantly and then saying, "Okay, you're having a contraction now, time to push," and then counting for the mother.[315]

In one birth, the mother first has a mild epidural, but she still feels uncomfortable, so the anesthesiologist gives her more medication. She continues to be very uncomfortable, moaning in bed and yelling that she just "wants it out" and she "just can't stand it anymore." The anesthesiologists asked her, "How's the pain? Is it any better?" The mother replies, "No, I don't know what it's doing." Again the anesthesiologist asks, "Was it better or worse than an hour ago?" Here the father undermines the mother's authoritative knowledge by answering for her, even though he cannot feel the mother's sensation, "This is the best one, I think." The father is clearly uncomfortable with the state of his wife. The doctor again asks the mother, "How do you feel?" The nurse also asks, "She's the most comfortable time of any?" At the same time, the father says, "Yes," and the mother says "No." The anesthesiologist laughs and says to the father, "That's kinda how I feel when they tell me there's a mechanical problem and they're fixing it as we speak." The mother continues to say that she just cannot stand it and that she "wants it out," all while maintaining that she is not in any pain. This mother was probably not expecting the epidural to feel so odd, and she is struggling to bear down. At the end of the video, the mother has to have an episiotomy and considerable help to deliver the baby. When the video zooms on the mother's face after the birth, she looks exhausted.[316]

Other women thought that they would have a natural birth, but the pain of labor became more than they could handle. A twenty-eight-year-old first-time mother stated, "I was going into my first delivery thinking that I would definitely be the hero and do this without the

[314] Brubaker and Dillaway, "Medicalization, Natural Childbirth and Birthing Experiences," 230.
[315] Burnett, *1996 Easter 1999 Lauren Birth*.
[316] Burnett.

epidural. As it turns out, I had a very long labor and did get an epidural and really enjoyed the last few hours of labor, when the pain was getting intolerable."[317] Often these mothers did not feel that they were giving up their authority because, at least in this case, the mother decided to receive an epidural. While not all labors ended as pleasantly as this one, the option to request an epidural at any time was an important aspect of the mother's authoritative knowledge standpoint.

Long labors also seemed to be a contributor to mothers giving up their authoritative knowledge. Even in videos where the mother initially seemed to begin with ample amounts of control, as the labor progressed and felt too long for the women to bear, mothers were much more willing to give up their authority and even autonomy. This sentiment was pervasive in epidural births where the woman was directed to push for hours. Sometimes by the end of these labors, the mothers would be begging the doctor that they just "want it out."[318] These mothers were also the least outwardly emotional after the birth.

In between or even during contractions, the medical professionals are often manipulating the mother's vagina. The mother is often sitting exposed with her feet in or against the stirrups for an extended period with a medical professional between her legs constantly. In the 1990 birth of Sara Smith, this is so constant that the very timid mother asks, "Do you think you're going to have to do an episiotomy?" The doctor responds, "I don't know. You never really know until the very end. That's why the more I can do to help you not have one right now to thin that tissue, the smaller it will be." At the end of the video, the mother is draped for an episiotomy, but it is never confirmed whether or not she received one.[319]

Only one birth had an abnormal technological intervention, aside from a c-section, and that was the birth of Ethan in 1998, who was vacuumed from his mother's womb. The video begins in a bright LDR with the mother eating a lollipop and holding her three-year-old son. Ryan is very excited about his new sibling, and when the older child is in the room the mother has authority in it. She is not a patient but a mother. The video cuts, and the doctor in a shirt and tie breaks the mother's amniotic sac. Much later, the mother is pushing in stirrups with lights shining on her, and her doctor is at the foot of the bed in scrubs. After a little while, he recommends a vacuum delivery. "Not only from an anatomical standpoint, but it can be risky for the baby and for mom to push for two hours, three hours." When the mother asked about

[317] Nancy Imperiale, "Is 'no Pain' a Gain? Childbirth Educators Caution against Trend toward Epidural Anesthetics," *Chicago Tribune*, November 22, 1992.
[318] Burnett, *1996 Easter 1999 Lauren Birth*.
[319] Ibid

the suction strength, the doctor confirmed she would still be doing most of the work, and the suction would just help the baby down the birth canal. Up to this point, the conversation is very intimate and sincere. The doctor is taking the mother seriously as the executor of this intervention. Then the mother asks, "Would that hurt his neck?" This is a very similar reasonable question, but the doctor laughs and shakes his head, "No, no." Now the mother has lost her confidence in her management. The doctor's laugh asserted the doctor's expertise and the mother's lack of authoritative knowledge. Unsure now, she turns to her husband, "You would do it?" The next cut is to the mother draped and ready for vacuuming. The doctor says, "What we're going to do is we're going to have you push first, and then I'm going to give a little suction." Now, because the birth has become more emergent, and because the mother's authoritative knowledge was denied, the mother has gone from a Mutual Partnership model to a Guidance Cooperation birth.

When the baby is born, the doctor first cleans up the baby on his own lap and then clamps the umbilical cord so that the father can cut it, all while the mother is saying, "I want to touch him, I want to touch him." The nurse tells the mother, "You're going to touch him in a minute."[320] Here the ritual of cleaning the baby and having the father cut the cord has superseded the mother's desires. Similar to the 1970s women, as soon as the birth veers from normal, the mother gives up her authoritative knowledge. While this surrender of authoritative knowledge is done for the baby's benefit, it also limits the mother in non-emergent moments, such as the one outlined above.

Technology played both an authoritative and intermediary role in these 1990s births. The EFM maintains its role as an authority in the LDR. Doctors and nurses often look to the machine rather than the mother to understand how the birth is progressing. Other forms of technology, including oxygen masks, stirrups, draping, and bright lights, are physical reminders to the mother that this is a hospital and she should not have authority. Finally, technology the doctors felt is medically necessary for a safe birth, including episiotomies and vacuuming, were tools with which when the doctor clarified that the mother's knowledge is way out of its depth. The doctor used jargon and performative actions like laughing to convince the mother to accept his expertise. This is not to say that in emergent instances, the doctor should not be the expert, but rather this section aims to point out that doctors wanted mothers to accept their expertise as laity rather than decide, as an expert of her own body with legitimate knowledge, to accept the doctor's expertise.

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[320] TheDoughertyFamily, *Ethan's Birth [March 2, 1998]- TheDoughertyFamily*.

Discussion

Women seemed more capable of authoritative knowledge in delivery in the 1990s than previously (one woman even kicked her doctor out), but this is much more likely in natural birth as with an epidural the woman relied much more heavily on the professionals around her to tell her when to push. Another decisive indicator of authoritative knowledge was the position in which the mother was laying. When the mother was in a more seated position, she could more naturally interact with the doctors, nurses, and the baby's father. However, when the mother was more supine, the conversation often literally went over her head without her inclusion.

The importance of the delivery room nurse has not been well-reflected in the literature. The videos on YouTube show that nurses are very often the individuals who direct and spend the majority of the labor with the mothers. Nurses are often the people who talk through medicine options with the mother, help them with positioning, and ease their fears. Nurses could also be influential advocates for mother's authority in places where mothers were not even aware they could ask for things, such as seeing their baby right away. Likewise, nurses who were more concerned with their connection to the doctor spoke in hushed tones or side conversations. These asides had the potential to undermine the mother's authority to the doctor's before she even had the chance to speak with him. For example, nurses often reported to the doctors that "we're pushing!" as if the nurse is doing the same type and amount of work as the mother. While some literature has been written on nurses in delivery rooms, the authoritative knowledge relationship between mothers and nurses has not been studied. Furthermore, a closer look at the triangular relationship of authoritative knowledge between doctors, nurses, and mothers could be the subject of a fruitful future study.

Similar to the importance of nurses, the presence of the father was distinctive. In some instances, the father provides a light-hearted touch, is the woman's cheerleader and silent companion. In other videos, the father is sometimes another person who is subverting the mother's authority by telling her what to do. Moreover, the father sometimes also engaged in conversations that cut out the mother.

Most occurrences of the mother's authoritative knowledge required the initial catalyst to come from the mother. These often came in requests, such as a position adjustment or to be included in conversations. Sometimes, however, the mother's authoritative knowledge came from a medical professional, almost always a midwife or nurse. This happened when the mother would ask a question, like during the homebirth, "Should I breastfeed now?" or asking

about medication in Lauren's birth, "What do you think?" and the medical professional then turned that question back toward the mother. In the homebirth video, the midwife does this subtly by providing extra information to the mother but not advising her one way or the other. In Lauren's birth, the nurse is more direct, stating, "You're the one who has to put up with it." In both instances, the authoritative knowledge is placed back on the mother to decide for herself. This demonstrates that authoritative knowledge does not need to be a struggle, nor that expertise always has to delegitimize other knowledge.

Another interesting observation made apparent in these videos is the interaction of the medical personnel, the mother, and the mother's older children. Often shown in these videos are the previously had young children of the birthing couple coming to visit their new sibling. Once the older siblings are in the room, the mother takes on a more authoritative role. She shifts out of her position as "patient" into her familiar "mom" role. When her other children are in the room, the mother is more likely to dismiss the instructions of the nurses and proceed to do what she wishes.[321]

While this thesis has primarily treated the 1970s and 1990s as entities, these videos show a massive change from 1990 to 1999. In 1990, women were often immobilized by machines and attended mainly by nurses. Already by 1996, doctors spent much more time with mothers. Stirrups were there to support the mother's feet if she wanted them, rather than hold her open and exposed for extended periods. Another noticeable change from 1990 to 1999 was the sheer beauty of the rooms. The later decade rooms were almost all clearly LDRs, with drapes, lamps, rocking chairs, and wallpaper. Perhaps the most noticeable and meaningful change was the diminished use of the nursery. In the 1990s, most of the baby's cleaning, weighing, foot printing, etc., was done in the nursery and away from the mother. She would have a moment to see her baby after birth, and then she may not get her baby again until she was all stitched up and the doctor was finished with her. In later 1990s births, the incubator was kept inside the room, so all the necessary baby post-birth happenings could occur there, even the first bath, while the mother watched. The baby could then be immediately returned to the mother rather than left in the nursery. In some cases, the mother held her baby for several minutes while the doctor stitched her up before the nurses took the baby away.

[321] EricSchnVids, *1990 August 8th - Jacob Is Born*.

Methodology Genre Discussion

These videos display both biography and autobiography characteristics, further problematizing the distinctions made between these two genres, yet they are also their own genre. While the videographer certainly creates a version of reality, the composure of the videographer and subject vary greatly. In some parts of the video, the subject is wholly composed, and the action seen in the video is staged or rehearsed. This staging is apparent when younger siblings come to visit the new baby. Parents or other individuals may tell the child what to do or say. Sometimes the words, "Have him do it again," can be heard, although, to the viewer, it is a new scene. In these occasions, the child has already performed an action, and now the parents would like a repeat for the camera. This second recorded action is then composed, as it is no longer a genuine reaction but a rehearsed one. Thus the action is not even a version of reality but rather a representation of it.

The video is not entirely composed in other cases, but there are significant composure elements to the videography. This is usually before the birth, when the videographer is shooting different viewpoints and narrating their surroundings. One video that demonstrated this particularly well was Zack's Birth. This is a twenty-minute video, but the entire first half is the mother taking the camera in a tour of their new home. She is narrating the video to future baby Zack, showing him his crib, his room, his sister, and herself in a mirror. The mother speaks in motherese for almost the whole video and also directs her firstborn child in some actions.[322] This video clip does not appear to be rehearsed, but the mother and videographer had a clear agenda that results in highly composed subject matter. This type of shooting reflects autobiographical diaries quite closely.

Doctors also showed signs of composure during birth videos and could often be seen glancing at the camera. This can clearly be seen in the uncomfortableness of the anesthesiologist in Lauren's birth.[323] Doctors were expected to be composed as a performance of expertise even without a camera. Therefore their camera composure is less jarring than the mother's.

Even in these videos, however, the entirety was not composed. There are moments of incredibly authentic moments in every video that are surprisingly not cut from the larger video. These scenes demonstrate that home video is its own genre that cannot perfectly fit within autobiography and biography. While it is impossible to say if the subject matter of other home

[322] Bennett, *980912 Zack's Birth Sept 12 Nov 12, 1998*.
[323] Burnett, *1996 Easter 1999 Lauren Birth*.

videos would have the power to be as authentic since these women were in labor, their mental facilities were concentrating on other priorities than being composed for the video. Examples of this authenticity can be seen in Lauren's Birth when the mother is yelling, "I just want it out."[324] Very different from a composed mother telling the camera how much she is looking forward to meeting her new baby, this mother is struggling with labor and is more concentrated on delivering than she is on the camera. Another obvious video with this lack of composure is the homebirth. In this video, the mother is screaming in pain and exclaims, "That really hurt." when the birth is over.[325]

In some videos, the sexualized nature of birth is also more authentically shown than it would have been recorded in an autobiographical account. In the homebirth video, the videographer actually shows the woman's vagina as the baby crowns and then is born. The film continues to roll as the mother breastfeeds her daughter and delivers the placenta in a rush of blood. The older daughter exclaims at the sight of blood, but the family reassures her that this is a normal part of birth. The sexual and scary parts of birth have not been edited out, nor are they hidden from those in physical attendance. Some videos choose to cut out the sexualized portions of women's bodies, but others tape it unabashedly. Physical displays of affection between the father and mother were also often recorded in these videos. There is a clear message that the baby has come from both the father and the mother. The parent's authenticity as sexual beings who contributed to creating the baby being born is a clear theme throughout these home videos and was celebrated rather than hidden. This theme frequently comes across more robustly in the videos that show more of the authentic sexual nature of birth, including the actual moments of birth, the mother's vagina, or the mother openly breastfeeding the baby.

Therefore, the home video does share some aspects with biography and autobiography, but not completely. Some parts of the videos reflect biography, as the videographer is often not the subject of the video but rather acts as an interviewer or ethnographer. In other moments, they share aspects with autobiography as the videographer shows the audience what he would like them to see and narrates what is happening. The videographer can also edit and compose the home video to best tell the version of reality they want to tell. Finally, home videos fall outside both these genres as there are moments that seem beyond composure that are not edited out. Furthermore, sexuality and the female body are common themes celebrated in these home videos rather than taboo subjects that should be understood but not explicitly mentioned. These

[324] Burnett.
[325] Breezy Photography, *My Homebirth 1991*.

observations open new exciting opportunities for historical research to push the boundaries of methodological genres, problematize traditional procedures, and continue to develop new "rules" to the home video genre in order to best understand it for future research.

Conclusion

Perhaps the most exciting chapter of the thesis, this fourth chapter sheds new light on the overall conclusions of childbirth reform in the late twentieth century. Some of these 1990s stories vary from the 1970s ones more than others, but most have a noticeable difference in the authoritative knowledge of the mother. In these birthing experiences, sometimes medical personnel attempted to deny the mother authoritative knowledge, but she asserted her autonomy. However, this authoritative knowledge is not guaranteed, and the mother must perform expertise to gain it. Obviously, performing expertise in a battle of one-up-manship with a medical professional who is both accustomed to performing expertise and was not undergoing labor was an arduous task to execute, making it all the more impressive when mothers did. Doctors also did a better job including mothers in the decision-making process, though it is evident by the anger or mirth displayed by doctors when mothers question their decisions that to say doctors were willing to share authoritative knowledge to the mother is a stretch. They offered higher levels of autonomy, but doctors vaunted their expertise to ensure their hold on the authoritative knowledge when it came to decisions about interventions.

Even so, many times, mother's authoritative knowledge prevailed. They were finally able to shift some of the authoritative knowledge from the doctor to themselves after twenty years of hard work. At last, mothers could gain authentic, authoritative knowledge if they were willing to perform expertise, suggesting that the true decade of genuine personal childbirth reform was not the 1970s but the 1990s. Indeed, as can be seen with these videos and memoirs, women of the 1990s did not automatically share in the authoritative knowledge of the delivery room but were able to gain it by engaging medical professionals in battles of one-up-manship and performances of expertise.

Conclusion

Historians revere the 1970s and 1990s as periods of significant change in the United States childbirth culture, with the 1970s regarded as a decade dedicated to the natural childbirth movement. However, in her 1980s research, Jordan found American birth culture highly technological, interventionist, and limiting to mother's authoritative knowledge. This thesis began by attempting to understand the disparity between the childbirth reform championed by natural childbirth and Jordan's findings of highly technological American birth. The investigation led to the question: how did the distribution of authoritative knowledge between a mother and her practitioners change in the 1970s and 1990s? When reading the secondary literature, the subject matter became even more confusing. How could so many historians, including Kline, Wolf, and Wertz, who were renowned for their work on childbirth in the late twentieth century, only further contribute to this discrepancy? They stated that despite the momentous changes that took place after the natural childbirth movement in American childbirth culture, 1970s childbirth reform was superficial. This research set out to fill this historiographical gap.

All background research suggested that the birthing culture from 1930 to 1970 in the United States fell within the first category of the practitioner-patient relationship of Szasz and Hollender: an Active-Passive relationship. On this tier, the mother was unconscious or nearly unconscious and unable to assert any authority, thereby granting all control to the doctor. Cesarean sections also fall within this category. Reform helped mothers achieve the next tiers of Guidance Cooperation, where the practitioner guides, and the "good" patient obeys, and Mutual Participation, where both the practitioner and patient work together towards a common goal.

The first hypothesis drawn from initial secondary source research looked as though the historiographical gap might be due to different maternal cultures at odds. For example, for the 1970s, the first postulation was that scholars overemphasis on feminist contributions to childbirth reform might be the reason for the divergence between tangible reform in the 1970s and historians' superfluous findings. However, primary sources demonstrated that while more marginalized characters were often left out of the literature, many of these women rallied around childbirth feminist literature, which was exposed in the first chapter. Furthermore, while the motivations and experiences of different cultural groups of women may have been varied, such as counterculturists versus more traditional women, the groups themselves proved

to be more amalgamated than originally thought. Many counterculturists held traditional values, many traditionalists also identified as feminists, many feminists had practicalists implications, and many practicalists had counterculture viewpoints. This is not to say that all 1970s mothers were the same, but rather that their differences were not the reason for the historiographical discrepancy.

Likewise, the 1990s "groups" proved to be even more of a muddied continuum than Davis-Floyd or Newnham theorized. Women who desired natural births accepted more interventions than anticipated, and women who desired medical interventions understood the benefits of doing some things more naturally than forecasted. Additionally, women compromised or made choices to stand firmly on varying parts of the birthing process according to their motivations or goals. Even in the 1990s, authoritative knowledge was not freely shared except for in home births, so women had to decide whether having authoritative knowledge was a priority for them or if they were happy to follow the doctor's suggestions.

Finally, when comparing the social perspectives to the mother anecdotes of both 1970s and 1990s, the reason for the scholarly discrepancy became apparent. This thesis aimed to discover how the authoritative knowledge distribution between practitioner and mother changed in the 1970s and 1990s. What was found was that this shift in authoritative knowledge greatly depended on which phase in the child birthing process was being discussed.

Outside of the delivery room, the 1970s saw mother's authoritative knowledge make leaps and bounds. Mothers were gaining more bodily knowledge by taking educational classes and learning about their anatomy. Women wrote and read about childbirth experiences and then formed grassroots groups to formulate changes. Mothers employed this knowledge by shopping around for doctors or hospitals that would agree to their terms. If they could not find what they wanted, these mothers sometimes left the whole system and had a birth at home, or in a birth center, with a midwife. Women made many preparations in order to ensure a more empowering and positive birthing experience. Other movements, such as consumer rights, and feminism, gave women the ammunition they needed. Even medical experts' research of both the harm early twentieth-century birthing techniques had on babies and mothers, and the benefits of mother-infant bonding and breastfeeding contributed to 1970s reform. Nevertheless, when examining the personal narratives of these mothers, the incongruity was jarring. In the 1970s, mothers still did not have authoritative knowledge within the delivery room. Doctors who may have agreed to a birth plan had the ability to change it. Women were still given drugs without their consent or knowledge. Many questions were presented in a Machiavellian way. If mothers defied the doctor, they could be strapped down to the table.

Homebirth or birth center medical professionals usually allowed the mother more control over the birth, but this was because of her choices prior to the delivery, not choices she made during delivery. If a home birthing mother was transferred to a hospital, it did not matter that she previously had control; she would lose her authority in lieu of the doctor's. Women of the 1970s only had as much authoritative knowledge during delivery as their practitioners allowed them to have. Thus, despite the reforms made surrounding childbirth that affected childbirth, when Jordan assessed American authoritative knowledge in the early 1980s, she also found it lacking in the delivery room.

Fortunately for women, the 1990s were different. Although many scholars see the 1990s as a slide backward for women's authority during childbirth, this thesis argues the opposite. Based on the groundwork made by women in the 1970s, coupled with increasing research on the positive and negative effects of different types of childbirth, 1990s mothers found themselves in a much better negotiating place. Furthermore, some mothers were choosing to have more interventions, which ameliorated mother's decisions to have fewer interventions. Also, the leading painkiller for childbirth in the 1990s, the epidural, needed to be inserted into the spinal column, so nurses could not deftly put drugs in the IV without the mother's knowledge. While there is still some controversy about the legitimacy of a mother's ability to consent while in labor, the requirement for consent was still a leap forward from the 1970s. Authoritative knowledge was not easy for 1990s mothers to gain, as many of the narratives and videos demonstrated, but mothers were to able perform expert actions as drastic as kick nay-saying doctors out of the room.

Family members being allowed in the delivery room in the 1990s led to women's feelings of assurance and helped transform the mother from *patient* back to *person*. However, this was only beneficial when the father supported the mother's decisions, as his enforcement of the doctor's authoritative knowledge could effectively delegitimatize the mother's. Helpful nursing staff could sometimes prove to be the boost needed for mothers to find their voice and authoritative knowledge. Mother's delivery room authoritative knowledge in this decade was still very fragile and could either be strengthened by hospital staff complying with requests such as changing the bed height, helping the mother adjust her positioning, or allowing her to decide when to push. However, the mother's authoritative knowledge could also be squashed by denying such requests, medical professionals conversing as if she was not present, and long labors that drove mothers to desperation to deliver.

Technology had an intriguing role throughout both decades. In the 1970s, certain technologies were viewed very negatively, while others had mixed reviews. Forceps and

"knock-out" drugs fell into the negative arena, but new technologies like the epidural or electronic fetal monitor were judged less harshly. Even so, in the 1970s, the "best" form of childbirth was often deemed that which was as natural as possible.

In the 1990s, women had a more complicated connection with technology, as highly technological births were often seen as the height of medical care. Several technologies, such as the IV, EFM, or oxygen masks, were labeled "good for the baby" or "good for the mother," so they were obligately omnipresent. The elective C-section represented women's ability to make a radical technological choice. However, the ultimate measure of choice was associated with epidurals, as women equated natural childbirth with non-painkiller birth. Providentially, women's power to choose technology and intervention also gave her the option to refrain from using them. Doctors could not have it both ways. They could not argue that a mother did have enough autonomy and authority to order a major surgery or spinal catheter, but then argue she did not have enough authority to give birth without those or other interventions. Women making a stance with their consumer choices in the 1970s undoubtedly improved women's ability to take charge of medical choices in the 1990s.

The findings of this research humbled me. When the first round of secondary literature research was finished and the investigation of the reforms of the 1970s on the societal level for Chapter 1 began, I believed that scholars were overly cynical about the lack of reform in the 1970s. After all, medical reports positively compared natural childbirth to interventional childbirth methods, and articles spoke openly and positively about natural childbirth as an option for mothers. However, once 1970s women's memoirs were uncovered, most of the stories were either very positive home births or very negative hospital births, as with the stories from *The Silent Knife*. Therefore, since the preponderance of women in the 1970s did not have home births, it appeared that most women in the 1970s had negative and disempowering birth experiences. The research testified that their authoritative knowledge was ultimately denied even in scenarios where the mother fought back very hard.

Conceivably this could be explained as a confirmation bias, as perhaps only women who had exceptional experiences cared to write about them. So again, going into the 1990s YouTube videos, I was expectant to find higher levels of authoritative knowledge from the mothers. These videos were posted to family archives for safekeeping. They were not published to educate others of delivery room frustrations as many of the 1970s memoirs were. Thus the patient confirmation bias was most likely solved. There was a greater chance that these videos were posted as positive experiences since they were something the creators wanted shared with future generations. Nonetheless, the lack of authoritative knowledge used by these mothers was

surprising to me. Women were still largely at risk to operate as observers or participants rather than directors of their birth experiences. Other women, however, were able to successfully perform expertise and authentically harness authoritative knowledge. These findings required an adaptation to the original hypotheses to better capture the authoritative knowledge experiences of women in the 1970s and 1990s. My own surprise at my findings also instilled a sense of importance about this work in me, as the lack of agency of the mother in childbirth experiences in the twentieth century is an understudied topic. Furthermore, understanding how women could utilize their authoritative knowledge may be critical to furthering mother authoritative knowledge in contemporary delivery rooms.

Historiographical Contributions

This thesis added to many considerable areas of historiographical research. First, this research added to the historiography of childbirth in the United States and women's history. While women's history is full of works focusing on women's agency and women's health, this work adds to the historiography by combining the two notions. This research has also contributed to the historiography on childbirth and women's history, focusing on the feminist movements. According to these findings, true delivery room reform happened in the 1990s, when doctors regarded women's expertise more legitimately than in the 1970s. This revelation pushes back the age of childbirth reform much later and might explain why there are still so many issues in the United States maternity care.

In medical history, this thesis significantly adds to the theory of Szasz and Hollender's practitioner-patient relationship. In the 1970s, Mutual Participation was often limited to home births, although sometimes women could find tolerant hospital doctors. The 1990s saw women on all three tiers, sometimes choosing their own tier and sometimes sliding into one or another. As much as a continuum of intervention the birthing process proved to be, these tiers remained relatively rigid in birthing assessments. Furthermore, women could more easily slide from Mutual Participation to Active-Passive relationships than the other way around. This movement is due to women's authoritative knowledge. I found authoritative knowledge to be surprisingly separate from Szasz and Hollender's tiers, and it proved to play a larger part in decision-making than actual child birthing control. For example, a woman could be in the Mutual Cooperation tier, but if her doctor did not respect the mother's authoritative knowledge, he could have potentially diverged from her birth plan when he believed it was best. In the 1970s, this could be done by using bed restraints, and in the 1990s, it might be done with the

use of fearmongering, suggestions that sounded like orders, or laughing at the mother's concern. Of course, the most momentous difference between these two decades was that in the 1970s, the mother had a much more difficult time asserting her authoritative knowledge than in the 1990s. Likewise, in the 1990s, a mother could demand as much technology as possible, which would have placed her in the lower tiers of patient control. Even so, I would argue that this mother, whose birth plan was to have high levels of technology, had more authoritative knowledge than a mother who was on the Guidance-Cooperative tier because of her doctor's allowance. This technological mother had decided she knew what was best, and while she gave up her control and bodily knowledge, it was her trust in her authoritative knowledge that made her ask for these technologies. This was especially true if the mother insisted on technologies far above the routine or something the doctor might not have recommended, such as an elective c-section. The mother was not relying on the doctor's expertise but on her authoritative knowledge to know what was best for her birth experience. The answer to the question "Who is in charge?" is dependent on the practitioner-patient tier model, but the question, "Who allowed them to be in charge?" is answered by authoritative knowledge

This thesis's main historiographical contribution is the history of knowledge. Authoritative knowledge is a fundamental concept for this thesis and arguably for many other hierarchical situations outside of healthcare. In Jordan's early 1980s findings, she asserts that authoritative knowledge in United States births is largely lacking because of their technological nature. In this research, however, I found that technological intervention, while often directly correlated with women's control, sometimes, albeit rarely, was not correlated with authoritative knowledge, meaning that some women could retain authoritative knowledge even when they opted for more technological births. Likewise, not all women who had incredibly natural births had authoritative knowledge. Even their bodily knowledge could be something they were instructed to listen to by their midwife, not because they believed they were the expert themselves in the birth.

Therefore, although I employ authoritative knowledge as a valuable concept, when applied to a historical timeline where women's control in the delivery room has varied dramatically, it becomes clear that the connection between control and authoritative knowledge is more complicated than Jordan suggests. I argue that with a practitioner-patient relationship, the connection is not between authoritative knowledge and autonomy or control, as I initially theorized in my introduction. Instead, the proper connection is between authoritative knowledge and expertise. This research suggests only experts can achieve true authoritative knowledge (something that is not given but earned). Therefore, for a mother to achieve

authoritative knowledge in the birthing process, she must perform expertise over her own body, and the birth, convincingly enough that the medical expert acknowledges her expertise, and therefore re-legitimizes her knowledge. This is a piece missing from Jordan's original authoritative knowledge work, as she focuses only on the performative expertise of the medical experts, and their use of technology.

This integration of expertise theory with authoritative knowledge has the potential to apply to many other hierarchical systems in life, such as student-teacher, athlete-referee, or even parent-child. Due to its flexibility, this thesis adds greatly to the historiography of the history of knowledge. Expertise within the history of knowledge is a growing subfield, and this thesis could help add to the understanding of how expertise is developed, how experts interact with each other, and how experts act with non-experts or aspiring experts. Furthermore, this thesis aids in understanding expertise in individuals who are not classically trained experts, but rather have become experts from reading bodily cues, self-regulated research, and applying popular knowledge to their own experiences and the experiences of their peers. Just as the history of knowledge is separate from intellectual history by its inclusion of non-academic forms of knowledge, so too is this form of expertise separate from a scientific understanding of expertise. This thesis opens exciting new pathways into further research on "lay expertise" or "bodily expertise" within the realm of the history of knowledge.

Areas for Further Research

After concluding this research, several ideas for future endeavors come to mind. One interesting study would be to see how this late 1990s childbirth reform historically compares to other countries. The Netherlands and the United Kingdom are both obvious candidates since midwives still assisted most of their 1990s births. Another interesting comparison would be to look at other highly technological countries, such as Spain, to understand if there are connections between different doctor-patient relationships.[326] Another rousing research area would be to see how the authoritative knowledge dynamic displays itself in other doctor-patient relationships, such as geriatrics or oncology. Lastly, a deeper look into how fathers and nurses interact with their authoritative knowledge dynamics would be fascinating. A great deal of focus is put on the doctor-patient relationship when nurses are the medical professionals who

[326] Richard Johanson, Mary Newburn, and Alison Macfarlane, "Has the Medicalisation of Childbirth Gone Too Far?," *BMJ : British Medical Journal* 324, no. 7342 (April 13, 2002): 892–95.

spend the most time with the patients. Likewise, fathers are neither mothers nor medical professionals, yet they still feel they have the right to a say in the childbirth process. While some research is already done on these individuals, inserting the concept of authoritative knowledge as uncovered in this thesis to understand these individuals' relationship with both the mother and doctor and how their knowledge is hierarchically understood by all parties would be captivating.

Method Critique

Not only was this research eye-opening in a historiographical way, but it also adds to the creation of a methodology for a newer medium, the home video. These home videos proved to expand upon historical meanings of autobiography and biography while also establishing some rules for a new genre. While this genre was a fantastic goldmine of valuable information, the videos still had many limitations. As these videos were often conceived for family archives, they were shot with a storytelling purpose. These videos have a set story, with a clear starting point and ending point. Very rarely was the video continually recording, but rather the videos would start and stop, leaving the viewer unsure what happened in-between, or even if some scenes had already happened and then were re-enacted for the camera afterward. Planning, direction, and retakes all fall outside what the researcher can usually see, making the video seem perhaps more authentic, dramatic, or entertaining for the future audience. That being said, some scenes, such as the actual birth moments, were impossible to fake. While these videos are not entirely authentic representations of reality, similar to diaries written for a family archive, they also proved to be more authentic than these written works as the subject does not have time to reflect and edit the way a writer does.

Furthermore, unlike diaries, very intimate scenes of birth are shown. While most of videos angle the camera shot from the side or over the mother's shoulder, several videos give a more revealing side, or forward view, so that the entire birth is visible. Almost all the videos also show the mother breastfeeding, and the cherished moment when the mother holds the new baby for the first time. Rather than gloss over the most intimate moments, these videos often emphasize them, as long as they are essential to the story's plot. The birth is the reason for the video, so the birth is shown or the camera was turned on directly after the birth. Other aspects of the birthing procedure, such as internal exams, are usually cut from the video since their intimacy is unnecessary to strengthen the story but rather places the mother in an uncomfortably exposed position. Likewise, although we know from video dialogue that many

of the women had epidurals, none of the videos had the insertion of the epidural recorded. Thereby it is obvious to see which aspects of the birth the family felt were most important to the birth story. From a storytelling point of view, the medical procedures and interactions were all background to the mother and her infant. In this way, while the YouTube videos were an amazing wealth of information and should be used frequently for contemporary history in the future, they still have similar limitations to autobiographical works in their narrative nature.

Finally, this methodology was exciting because it genuinely was so cutting-edge. The earliest video was posted in 2015, and the most recently posted video used was from July 2020. This research was not even possible five years ago. Many more home videos and other older recordings will likely be posted to YouTube in the next five years. For this thesis, sixty-three videos met the 1990s birth criteria and were watched, with deep analysis done on about a dozen of them. Perhaps in five years, six hundred such videos will exist, providing access to both qualitative and quantitative research. Perhaps new ideas and demographics will emerge that historians have of yet to think. In other fields as well, YouTube home video analysis could provide a methodology for ground-breaking historical "research from below" as never seen before. Plus, the open-access nature of YouTube will allow scholars to watch and debate video interpretations easily. The mixture of biography, autobiography, and authenticity makes these home videos wildly exciting to analyze and jam-packed with data. This methodology was enjoyable to work with, and hopefully, more historians will turn to these home videos on YouTube as a regular source in the upcoming years.

Final Words

While this thesis is not claiming to rewrite all of childbirth or expertise historiography, it is a profound addition to understanding childbirth reform in the United States and the experiences of these mothers in the delivery room. By separating the memoirs from the scholarly pieces and newspaper clippings, this thesis was able to unravel the historiographical discrepancy between childbirth experience as a whole, and the change in authoritative knowledge in the actual moments of childbirth. This thesis was able to concretely articulate why scholars have felt there was a lack of real reform in maternity care in a way not done before. Finally, this thesis created and utilized a new historical methodology in analyzing publicly available home video by combining biographical, autobiographical, and video media studies. The insights and methodologies discovered here will prove helpful for future studies to come and help new mothers recognize how they too can claim their authoritative knowledge

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