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The American (Birth): A Valuable Pain

Ellen Holt

WGS Senior Capstone

Prof. Jennifer Nelson

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Prof. James Krueger

Table of Contents

Dedication

To my loving parents, this one is for you.

Hope II, by Gustav Klimt

Acknowledgements

I am fortunate enough to have many people to include in this section who have edited, listened and supported me throughout the entire process of this capstone.

To my advisor Professor Jennifer Nelson, thank you for your constant support and assistance throughout this entire project. It has been indispensable to my progress and sanity.

To the other members on my defense panel, Professor Amy Moff-Hudec and Professor James Krueger- I truly appreciate the extra time and help you have given to me. I know how precious that extra time is.

To my best friend A.J. Fazzio for your continuous ability to see the humor amid the chaos and countless drafts.

And finally to my friends and family for their encouragement and love.

Thank you, thank you, thank you!

Introduction

Who I Am and Why You Should Care

For the past year the back seat of my orange 2007 Honda Fit has been filled with various birth books. The titles span from acclaimed authors Richard W. Wertz and Elizabeth C. Wertz, *Lying In: A History of Childbirth in America*, to more contemporary authors such as, Christa Craven's *Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement.* Should the random passerby happen to glance in, they might assume the owner of such a mom-mobile is in the second trimester of her pregnancy, glowing with anticipation at her blooming belly. Instead to their confusion they would find me, twenty-one years old, a lacrosse stick in hand, and very much not expecting.

Despite my lack of personal experience with my topic I believe it is still essential for the reader of this paper to understand my unique background and perspective, as it inevitably forms and colors my research. I am a senior at the University of Redlands where I will be graduating with a degree in Women, Gender and Sexuality Studies and a minor in Biology. People often ask me what I plan to do after college with my "unique" major, and by people I mean my Dad. There are days I, too, question my decision to change from focusing strictly on the hard sciences that pre-med tracks demand to a major that requires substantially more work and significantly less respect.

I made the decision during my second year of college when I began to crave something more than the hard science and mathematics textbooks that mitosis and calculus held. While my classes were rigorous academically and my work study on campus and college sport yielded little free time, I still felt incomplete in my studies. On the recommendation of an English professor I took a class from the Women and Gender Studies department, laughing with my friends at the

stigmas surrounding the department. Immediately, I found the missing piece. I became swept up in the passion and activism of the students as my professors pushed me outside of my small bubble, questioning social constructs and *why* and *how* they persisted. Suddenly I realized I had found my place. From that point on I began to reshape my career focus, expanding from the hard sciences into my passion for women's health. Currently I am working towards completing the prerequisites necessary for a Women's Health Nurse Practitioner degree, after which I eventually plan to pursue a career in public health for reproductive rights, specifically reproductive rights in the realm of proper health care access for all women. I chose this career path because I feel a public health degree lacking without a practical hands on experience in medical health.

Topic Inspiration:

Grief inspired my interest in the medicalization of childbirth. I am not grieving myself, but am intrigued with the idea of grief as a valuable emotional pain, a pain to be experienced and lived through and not lessened by pills promising clouded bliss. Upon the recommendation of my advisor I attended a lecture at the University of Redlands discussing the Limitations of Medicine. Michael Cholbi Professor of Philosophy at California State Polytechnic University, Pomona opened the conference with a description of grief as, "a valuable pain," a phrase that months later still speaks to me and continues to prompt questions. This idea first brought me to question the pain of birth and wonder if the pain perhaps has a greater purpose than discomfort.

Pain undeniably serves a purpose. It is a signal to the brain that somewhere in the body discomfort persists. It is not a final signal, but rather the existence of pain proves the existence of something still striving to function. Without the presence of pain the true degree of distress cannot be perceived.

Before attending the lecture I perceived birth as an operation that occurred in hospitals with doctors and nurses working in tandem to relieve the laboring woman who lay connected to beeping machines looming over her starkly white hospital bed. Her ankles would be raised above her head in stirrups as she sweat and heaved the being pushing out from between her thighs. In my mind, a birth devoid of the technology and services that a hospital provided bordered on self hatred or, at the very least, a large miscalculation of time taken to travel to the delivery room. Birth outside of a hospital without the comforts of technology and large doses of medication only occurred through dramatic accident, never purposely. Labor pain, it would seem in American society, requires immediate action to remedy the disruption and serves as a catalyst for swift medical intervention. From this concept of pain during childbirth, I then began to question why anyone would choose to experience birth pain when countless options offered assured relief? In the absence of that pain, were there unseen consequences? Is birth now safer under the medicalized model of care? And if so, safer for whom? This idea of a birth as a valuable pain with a purpose other than extreme discomfort first inspired me to research the medicalization of childbirth and question the preferred predominating practices.

Goals of Project:

This capstone takes on the task of analyzing how the American cultural perception of pain during birth has impacted and continues to impact access to prenatal care, birth planning and the birth experience. To achieve this end, I first follow the historical evolution of the birth model in America from a woman-centered, natural event to a timed medical procedure occurring under the required supervision of a physician in a hospital- a system essentially forcing prospective parents to make contact with a hospital. Additionally, I will compare the predominating and preferred method of the United States medicalized birth model to the midwifery model. The dual analysis

of the medical model and the alternative model offered by midwives will provide an understanding of the wide disparity of how American women experience and perceive their individual childbirth experiences. The evolution of America's historical and cultural perception of childbirth pain suggests that society has deeply altered the modern understanding of birth, and perhaps not for the better.

Methodology:

Feminist methodology and techniques were used to address and meet the goals of this project through the use of feminist standpoint theory. Feminist standpoint theorists make three principal claims: "(1) Knowledge is socially situated. (2) Marginalized groups are socially situated in ways that make it more possible for them to be aware of things and ask questions than it is for the non-marginalized. (3) Research, particularly that focuses on power relations, should begin with the lives of the marginalized" (Harding 2009). I believe adopting these feminist standpoint claims and applying them to the project will have direct relevance and provide an understanding of pain as a potentially valuable experience during labor rather than something to be universally avoided. Women are central to childbearing yet there remains minimal research on their personal experiences and reasons for using different delivery methods. If women's role as the primary yet marginalized participant in childbirth is going to be analyzed, such theoretical work is necessary in order to fully understand the complex historical attitudes towards childbirth and determine the shifting roles, trends and experiences of women.

Why does this research matter?

Infant mortality has long been considered an indicator of a nations health and well-being. Among developed countries the United States has one of the highest infant mortality rates. In 1960, the U.S. ranked 12th in infant mortality but by 2006, its international ranking had plummeted to 31st (Singh GK, van Dyck PC). Today, the United States has an infant mortality rate of 5.67 infant deaths per 1,000 live births compared to similarly developed European countries such as Italy, France, and Spain that have an infant mortality rate of less than 3.30 per 1,000 live births (CIA 2015). Important context to consider while looking at this data is the socioeconomic and demographic differences between the U.S. and European countries as they largely affect infant mortality rates. In the United States the infant mortality rate (infant deaths per 1,000 live births) range from 5.1 for non-Hispanic white women, 11.3 for non-Hispanic Black women, 8.1 for American Indian or Alaska Native women, 4.2 for Pacific Islander women and 5.1 for Hispanic women (CIA 2015). The large difference in infant morality rate suggests a tremendous inequality between racial and ethnic groups as not all benefit equally from U.S. childbirth care. Income inequality also inevitably dictates access to health insurance and health services in the U.S. and acts as a direct correlation between lower incomes and lower infant morality rates.

An additional correlation to the high infant mortality rate disparity between the U.S. and European countries with similar wealth and technological advances is the cultural approach to childbirth and preferred birthing methods. American births occur predominately in a hospital with a physician attending whereas European births typically employ the midwifery model. In 2012, U.S. physicians attended 86.1 percent of all hospital births with certified midwives attending only 7.6 percent of all hospital births. Out-of-hospital births totaled 1.4 percent in this

same year (Martin 2012). In the U.S., midwives attend roughly 8 percent of births, whereas midwives attend up to 75 percent of European births (Keefe 2013). Varying cultural perspectives combined with the difference in health care coverage account for a significant portion of the disparity in the resulting obstetric outcomes. Health insurance plans in the United States typically do not cover midwives or birthing plans outside of a hospital. More often than not, women and their partners cover the cost of births attended by midwives or out-of-hospitals births completely out of pocket. Despite the noticeable correlation between European countries use of the midwife model and their subsequent lower infant mortality rates, American women overwhelmingly prefer to deliver in a hospital believing it to still be the safer option. My question is why?

Review of the Literature/Background:

Before I begin to fully discuss the presence of pain in birth and its catalyzing element in shaping American birth culture, I provide context on the history of birth in the United States from the mid-eighteenth century to today and explain how the current structure of birth care originated, why it continues to exist, and why the accepted normalized model of birth centers around a hospital.

Brief History of Birth in the United States

-1750 Colonial Period

History is often told through a subjective lens which is affected by whose perspective the historian features. The history of maternity care is no exception. Throughout extensive literature review, I have found only one constant universally agreed upon truth about the history of maternity care in the United States, that as far as I am aware remains correct,

-women give birth.

Until the mid eighteenth century American women primarily gave birth with the assistance of other women in the comfort of their own home. The women who assisted were sometimes relatives or friends but typically a trained midwife was present to administer care. Instead of isolation and confinement in a hospital room, childbirth in colonial America was considered a social event (Wertz and Wertz 1977). Tina Cassidy in her book *Birth: The Surprising History of How We Are Born,* describes how multiple women would gather around and gossip as they prepared the house for the event. Childbirth during this time remained "humanized as it kept the woman in the center and in general, respected nature and culture" (Wagner, 26). The term midwife, literally means "with woman"-a very apt definition of the role they play (Cassidy 2006). Midwives were typically women for propriety's sake and also because of their past personal experience with birth (Cassidy 2006). Usually, midwives were older or past childbearing age. This age gap not only served for the purposes of wisdom about childbearing but it also allowed the midwife more time to help the new mother because she had no young children of her own to care for.

Midwives were trained solely through apprenticeship and observation as there was no formal schooling for midwifery, or schooling for women at all for that matter. Cassidy recognizes how, two centuries ago, midwives were major figures in their communities performing a multitude of tasks; "they harbored unwed mothers, performed abortions, baptized babies by squirting anointed water in utero, prepared the dead for burial, served as pediatrician during the baby's first year and looked after the sick using herbal or folk remedies" (Cassidy 2006, 28). Across cultures, midwives or their titled cultural equivalent can be found performing similar duties and serving similar social status within their community. Often the women performed the duties for little or no pay but were instead presented with gifts or grace by the

mothers. Cassidy adds that additional methods of payment for midwifery services could be in the form of "food, clothes, animals, a jug of molasses or the promise of a service in return" (Cassidy 2006, 28). Here it seems the "profession" of birth care began with an exchange of commodity for the midwife's services.

Pain relief during this era consisted of resources that were readily available at the home. These home remedies included brandy or wine as an anesthetic, string and scissors to cut and tie the umbilical cord, and lard to massage the perineum throughout labor to reduce the risk of tearing (Cassidy 2006). The perineum is the soft tissue area between the vagina and anus that is susceptible to tearing during labor because of the intense stretching. Other natural remedies to prevent tearing, in addition to lard, included, olive oil and manual massaging. Similar to the views held by midwives today, these midwife birth attendants viewed childbirth as a natural process that only rarely required intervention or interference to ensure safety. Instead, the role of the midwives was to minimally intervene and ensure the safety and comfort of the mother as much as possible.

Historically pain in labor was attributed to divine punishment and seen as a normal or even necessary process. Mirroring the Old Testament's story of Adam and Eve in the Garden of Eden where God punishes Eve by increasing her pain in childbirth, declaring "I will greatly multiply thy sorrow and thy conception; in sorrow thou shalt bring forth children" women in early America acknowledged the pain as deserved punishment for their sins (Genesis 3:16). Actions to eliminate this pain would directly defy God.

Birth of Medicalization

The age of the midwife remained unobstructed and woman-centered until the mid eighteenth century. Physicians in the years before 1750 were few and far between and their

presence at birth was typically associated with death. If a physician was ever called to attend a birth, his presence was likely necessary to remove a deceased fetus or a fetus that could not be delivered without first killing it (King, 2007). However, around the mid nineteenth century men began to hold a role in birth as the "male midwife" (Wertz & Wertz 1977). By adopting the female title male physicians could now be involved in deliveries without the stigma or moral taboo of impending death.

Moreover, male-midwives became increasingly successful through the use and invention of instruments or tools, a task many female midwives refused to undertake believing the natural process perfectly efficient. The mere possession of specialized tools and instruments "implied an ability to do something, and the user of the tool had an implied ability to use it for the betterment of a given situation," allowing male-midwives to effectively upstage female midwives (Hardy 2012, 12). To further their superior claim and increase personal revenue, male midwives began to promote tools as promising a safer, quicker and less painful delivery (often, especially early on, a false claim). The growing cultural belief that technology is better than nature became a crucial factor to the change in birthing processes. As the presence of male physicians during birth became common place women transitioned from sitting on a midwife's birthing stool to delivering in a bed for the sake of modesty. The problem of women lying horizontal to deliver is that she no longer has force of gravity to expedite the delivery. For Victorian women especially, unflattering positions during labor became a cultural taboo. As social consequences trumped physical consequences, women bowed to society's dictates that they be passive ladies,

With the introduction of male physicians into the childbirth practice, medical institutions barred women from applying, effectively pushing midwives out of the obstetric field and ending the "age of the midwife." Physicians began campaigning against midwives denouncing their

practice as “ignorant” and “dirty” and typical to deliver bungled births to eliminate competition (Cassidy 2006).

The use of instruments not only created a pathway for men to (literally) penetrate the birthing realm but simultaneously shifted the perception of pain of childbirth. Childbirth no longer existed as a natural process but became regarded as a medical problem requiring the necessary management of physicians. Joseph B DeLee, a famous obstetrician during the early 1900s believed pain was dangerous to anyone who experienced it and thus must be eradicated. Although, as a man, he had never experienced birth firsthand, DeLee compared the birthing process to “falling on a pitchfork, and birth for the baby [as] so painful and harmful that delivery was akin to its head being crushed in a door” (Cassidy 2006, 79). To reduce this unspeakable trauma, DeLee promoted the use of what he called a “prophylactic forceps operation,” which ironically seem to cause more pain and trauma than anything else. Once the woman was sedated DeLee would perform a large episiotomy, a cut in the muscle and skin of the perineum to widen the birth canal. After he would then insert forceps and pull out the baby. DeLee maintained the belief that if unaided the birth process would surely kill the mother, or worse the fetus:

> So frequent are these bad effects, that I have often wondered whether Nature did not deliberately intend women to be used up in the process of reproduction, in a manner analogous to that of the salmon, which dies after spawning (DeLee 1920).

DeLee’s procedure and view of childbirth remained popular for decades after. While childbirth has always posed a danger to the mother’s life, this danger *increased* with the medicalization of childbirth. Now a normal birth had the assumed potential and likelihood to go disastrously wrong.

Although male midwives and physicians often claimed to prospective mothers that the use of tools in birth eased if not eliminated pain, others suggested their presence caused further harm

and increased mortality rates, both maternal and infant. Scully (1994) quotes Dr. Samuel Gregory in 1884 stating,

> The introduction of men into the lying-in chamber, in place of female attendants, has increased the suffering and dangers of childbearing to women, and brought multiplied injuries and fatalities upon mothers and children (Scully 1994).

Prior to the discovery of antiseptic unnecessary interference of tools led to increased danger and death of the mother often from puerperal fever.

The First Maternity Hospital

Early American maternity hospitals were established for charity in the seventeenth and eighteenth centuries to help eradicate the problems of disease and injury of the poor following the industrialization era. Unlike the maternity wards of today where all socioeconomic classes default to receive care, these institutions were places where only the indigent or unmarried women labored because they could not afford another option. On a social level, a maternity hospital labeled as a place of charity dissuaded many paying patients from laboring there because it represented low social status. Homeless, poor women and prostitutes unable to pay for labor charges were invited to labor in the maternity hospital as a free alternative. For the medical profession, early maternity hospitals provided obstetricians subjects for clinical research and training that they were unable to receive from proper paying clients who still gave birth at home. Although the services provided by the new hospitals were free, they came with a price of fatal infection as well as the first experimentations of induced labor. Physicians validated what many historians deem inhumane treatment of the poor for the betterment of birth and the advancement of obstetrics education (Hardy 2011).

Before the knowledge of Louis Pasteur's germ theory in 1861 that living microbes, not spontaneous generation caused infection, physicians treated patients without gloves and without

washing their hands in between patient examination. The uncleanliness increased the risk of infection and fatality (Wertz & Wertz 1977). Upon examination the bacteria would travel from the physician's fingertips through the woman's cervix and into the bloodstream, or sometimes straight to the placenta (Cassidy 2006, 58). The infection known as puerperal fever, or childbed fever, became rampant in early maternity wards, accounting for as much as 40% of maternal fatalities in America up until the 1920s (Wertz & Wertz 1989). Unsurprisingly, physicians blamed women themselves for contracting childbed fever with a multitude of reasons ranging from breast milk gone astray to the woman's own vaginal fluids or even to a woman's poor morals. In 1877 the president of the Gynecological Society in America reasoned the majority of patients laboring in the early maternity wards were unmarried, gave birth ashamed of their condition and were anxious for their future and as a result were more apt to become infected. By the 1880s the medical world slowly began to accept the research around puerperal fever which led to increased sterility and hygiene throughout hospitals (Wertz & Wertz 1977).

During this era birth became principally an issue of illness to be treated, rather than treating a person. Wertz and Wertz 1989 note the shift stating,

> Doctors were on the lookout for trouble in birth. That seemed to them to be their primary purpose…[and] they found a lot of trouble- so much, in fact, that they came to think that every birth was a potential disaster and that it was best to prepare woman for the worst eventualities (Wertz & Wertz 1989).

As doctors increased their control, women in turn acceded to believing the new methods safer. The transition of birth into the maternity ward can be seen as both a triumph and failure for birth in America. The transition allowed physicians to make great strides in the advancement of technology and pain management in the medical sense. However, while arguably well intentioned the same transition created severe repercussions for those unfortunate enough to have

no better option than to be attended by physicians experimenting with obstetric practices.

Move from Home to Hospital

The move from home to hospital was a major factor in ultimately determining who would control birth. Although less than 5 percent of women delivered in hospitals in 1900, by the 1920s 30 to 50 percent of the births in major cities took place in hospitals (Wertz & Wertz 1989). By 1939 nearly half of all women and 75 percent of all urban women were delivering in hospitals (Wertz & Wertz 1989). The increased popularity of hospital births was prompted by a combination of the fear of danger in birth and physicians promise of a painless birth with the popularization of "Twilight Sleep". This hospital-based technique involved a cocktail of morphine at the beginning of labor, an amnesiac drug called scopolamine, which caused the woman brief amnesia during the middle of labor and a dose of ether or chloroform to relieve pain caused by the birth of the head towards the end of labor (Wertz & Wertz 1989). Done together Twilight Sleep effectively dulled awareness of pain, and perhaps most importantly, removed the memory of labor itself. When American physicians first tried the German discovered procedure in 1900 they deemed it unreliable and unsafe. American women however saw the procedure as the antidote to labor that they had been craving. If they had the financial means many women would travel to Germany to receive the promised painless bliss. By the 1920s however women with feminist and suffragist sympathies began to initiate a consumer demand for Twilight Sleep, campaigning that the procedure liberated women from labor's suffering. Brochures highlighting Twilight Sleep advertised the medical benefits as abolishing the need for forceps, shortening the first stage of labor, reducing the time of recovery and hemorrhaging, helping lactation but, "above all it removed the fear of pain, which had kept many women from having children"

(Wertz & Wertz 1989).

The gradual acceptance of Twilight Sleep coupled with the knowledge and discovery of household germs that could potentially affect mother and baby helped transitioned more and more patients to delivering in hospitals' regulated sanitary walls. Additionally, hospital births provided mothers with postpartum support for up to three weeks. The hospital therefore offered women many attractions. It promised to remove the physicality of birth from the home, provide constant nursing care, rest, security, and most importantly a painless delivery. Middle and upper class women began to define birth safety as a matter of who attended birth and the space where the birth occurred.

Poor women in these large cities were forced to turn to hospitals and their fees because no other option for care during labor existed. Midwives had become dated or were prohibited from practice. Home deliveries were now a rare practice for private physicians who preferred to assist with birth surrounded by the technological comforts of the hospital (Wertz & Wertz, 1989).

Interestingly, rates of maternal and infant morality did not improve with the shift from home to hospital. The issue became a national concern in 1933 when the White House Conference on Child Health and Protection issued a report-*Fetal Newborn and Maternal Mortality and Morbidity*-which recorded an increase in infant mortality and birth injuries by 40 to 50% from 1915 to 1929 (White House Conference on Child Health and Protection 1933). Upon evaluation the report found two main reasons for mortality. The first was that women received little to no prenatal care. The second was excessive intervention by physicians (Wertz & Wertz 1989). Additionally, after a series of letters to the editor about the brutality of birth in maternity wards while women were under the twilight sleep, women began to fear the acts on their bodies more than the fear of pain (Block 2007).

This common theme of iatrogenesis, an illness caused by medical treatment and then consequently 'fixed' by more medical treatment, throughout the history of birth in America will be fully explored in the second section of this paper.

Natural Birth

The phrase 'natural birth' can often be misconstrued. For the purposes of this section I will use the term natural birth to refer to births with minimal to no medical intervention. Due to the previously stated study on the detriment of excessive intervention by physicians as well as hospitals stringent routines and standards, women questioned the predominating medical birth practice and began a shift towards natural childbirth. Wertz & Wertz suggest that medicine not only pushed women toward considering natural birth but also gave women a secure platform to question the process for the mother's personal benefit. Medicine itself tamed the stigma of birth's impending death by technological ability to anticipate abnormality, prevent it and usually overcome it (Wertz & Wertz 1989). In this contrasting view medicine simultaneously pushed women to question the medical birth process as well as opened dialogue for natural birth.

Dr. Grantly Dick-Read became instrumental in the early natural childbirth movement during the 1940s with his publication, *Childbirth Without Fear*. Read believed that while some women do benefit from the use of anesthesia, the constant use of anesthesia and routine episiotomies were often unnecessary and caused more harm than good to both mother and child. He argued against the regimented medical care as the assumed one birth model designed to fulfill the needs of all American women (Caton 1999). Shortly after Read's views became popularized, French doctor Ferdinand Lamaze recognized a new technique in the 1950s that promised to eliminate pain without medical intervention. The Pavlovian theory of conditioned reflexes

became the foundation for what is now commonly referred to as the "Lamaze method"-a breathing method that allowed women to condition themselves to interpret contractions as painless through rapid shallow breathing. Today some scholars reject the Lamaze method suggesting it "had the unfortunate side effect of greatly altering a woman's natural experience of birth from one of deep involvement inside her body to a controlled distraction" (Block 2007). However, it remains a popular technique in birthing classes. While Read promoted birth without fear, Lamaze promoted birth without pain. Instead of solely trusting nature to run its course, or becoming the passive object of a physician, women once again held a level of autonomy during birth.

Return of the Midwife

The twentieth century's popularization of both Lamaze and Read brought back a consumer demand for the midwife. As an alternative to giving birth under the strict regulations of a physician at a hospital, some laboring mothers now wanted to give birth at home, in a birthing center, or in a hospital but under the care of the midwife.

In 1925 Mary Breckenridge founded the Frontier Nursing Service (FNS) in Hyden Kentucky. Breckenridge first became introduced to the profession of nurse-midwifery while vacationing in France and England and sought to bring the profession back to America. The FNS was unique in that it consisted of training midwives and certified nurse-midwives (CNMs). The combination of traditional midwifery with modern scientific training began a new bridged form of maternity care. By 1954 the FNS assisted in over 10,000 births and recorded with a lower maternal mortality rate of 9.1 deaths per 10,000 births than the national maternal mortality rate of 34 deaths per 10,000 live births (FNS 2012). The establishment of the American College of

Nurse-Midwives formally incorporated the nurse-midwife as a profession in 1955. Today, certified nurse-midwives practice in hospitals, clinics and birthing centers.

Obstetric Care Today

Feminists of the first half of the 20th century campaigned for increased anesthesia and increased technological medical intervention yet only a few decades later feminists in the 1960s and 1970s began to vehemently advocate for a resurgence of the natural birth model. The contrasting trends prompt the reader to shout loudly in frustration, "WHAT THEN DO WOMEN WANT??" The irony is real dear reader. I believe though that it is an irony worthy of further consideration. Today two contrasting trends surrounding birth persist; the increased medicalization model and the natural birth movement.

Epidural

In the 1970s the culture of childbirth changed again with the invention of plastics, allowing flexible nylon catheters to inject anesthetic and opiate on the spinal nerves. The injection effectively blocked all sensation from the waist down while still allowing the woman to conscious during birth. Prior to the 1970s anesthetic would be injected directly into the spinal fluid. Originally called the "spinal", this technique is so strong it can be used for cesarean section as well as completely numb women form the waist down for two hours. Use of epidural anesthesia in childbirth at big city hospitals sky rocketed from 22% in 1981 to 66% in 1997 and is estimated at over 90% today (Block 2007, Cassidy 2009). Today proponents of the natural childbirth movement recommended that physicians use lower doses of medicine in epidurals, called "light epidurals" that allow women the ability to move their legs and still feel contractions.

The epidural affected the popularity of the natural childbirth movement by providing

women a compromise. Women's desire to be awake and aware during labor was met and to sweeten the deal, they also didn't have to feel pain. But in the absence of that pain there have been side-effects. Block cites the many grievances associated with the epidural: "it lengthens labor, necessitates artificial oxytocin, increases the likelihood of vaginal tear or episiotomy, ups the chance of cesarean section and disrupts breastfeeding" and often a drop in blood pressure is a common side effect of epidural anesthesia (Block 2007, 171). Something else to consider is that these side effects often separate the mother and baby immediately after birth so the baby can be tested and possibly treated with prophylactic antibiotics. Many childbirth activists note epidural increases the risks of drugs passed to the fetus through the placenta with the epidural. Yet as safe and effective the epidural is at relieving pain, new research is pointing out the chemical link between pain and labor progress.

Chair of the Certification Council for Lamaze International, Judith Lothian notes the failure of the natural childbirth movement in the face of the epidural stating, "basically what we said is that pain is an unnecessary side effect and you come to childbirth education classes to learn ways to deal with it other than having nitrous oxide and scopolamine" (Block 2007, 172). The notion that pain was unimportant, a psychosomatic response that had no physiological role further encouraged women to use a method to actively control birth pain. Lothian argues that pain is important and central to the progress of normal birth, not a side effect (Block 2007).

Cesarean Section

Historically the decision of a Cesarean section entailed a careful weighing of the risks and benefits of the procedure, with the risk being absolute. The procedure was typically done as a last ditch effort only after the mother was dead or dying. Eventually as technology and medicine progressed with anesthesia and germ theory, other less fatal reasons for the cesarean section

emerged such as a deformed pelvis or obstructed labor. In 1882 Max Sanger is credited with performing the first successful modern version of the C-section by suturing the uterine and abdominal wall with silk threads (Wertz & Wertz 1977). Even as the risks of doing C-section decreased it was not until the late 1970s that the risk-benefit analysis favored the surgery. Reasons for the shift include a host of cases for breech babies, multiple births at a time, diabetes, a greater number of older women giving birth, body image issues, fear of childbirth (tokophobia), scheduling convenience for both the mother and physician, and institutional policies prohibiting vaginal births after cesarean (VBAC). In 1970, 1 in every 20 births in the U.S. was a C-Section, compared to the steep increase less than 20 years later in 1987 with 1 in 4 births a C-section (Mitford 1992). Today the C-section rate in the U.S. is 32.2% (National Center for Health Statistics). Interestingly in 1985 the World Health Organization declared no justification for any region to have a C-section rate over 10-15% (WHO 2010). This number correlates with the births likely to require surgical intervention to save the life of the baby or the mother. Once the rate is above these numbers, C-sections are being done in non-emergency situations. Additionally, their reasoning was based on C-Sections association with increased risk of short-term adverse outcomes for the mother and higher costs of healthcare systems (WHO 2010). In the U.S. C-sections typically cost three times as much as vaginal births, prompting some scholars to question if physician malpractice is perhaps an attribute to the increased rates.

Possible risks or consequences of a C-section include scar tissue, adhesions, uterine rupture, placenta implantation (where the organ grows into the uterine scar or through the scar), an inability to eat for a day or more after labor, limited mobility and a painful recovery for six weeks or more after procedure. Similar to an epidural there can be failed initial attempts at breast-feeding because the hormone prolactin is not released upon birth.

For the emerging child additional risks also occur. Domiguez-Bello et al. (2010) report that during birth a baby is exposed to a "wide variety of microbes [bacteria], many of which are provided by the mother during and after passage through the birth canal [vagina] (p. 11971)." When a baby is born via cesarean they are not exposed to this bacteria and this difference can "contribute to variations in normal physiology or to disease predisposition (p. 11971)."

Yet while C-sections are properly seen as a necessary and life-saving option for laboring mothers with certain conditions, the elevated rate within the U.S. can not solely be attributed to these certain conditions alone. Elective and cosmetic C-sections play a large role toward the higher instance of the procedure in U.S. statistics. A significant portion of women who worry that a vaginal birth will stretch out their vaginas, making sex less pleasurable for their partner as well as making their genitalia visually unappealing, opt for elective C-sections.

The phrase, "Too Posh To Push" was coined after Victoria Beckham (a.k.a Posh Spice) had an elective cesareans in 1999, 2002, and 2005 which she coincidentally scheduled around her husbands soccer schedule. The trend is popular among other high profile celebrities including, Madonna, Sarah Jessica Parker, Kate Hudson, Brittany Spears, Beyoncé, and Angelina Jolie.

Tokophobia, the new psychiatric diagnosis for the fear of giving birth, is also listed as a possible reason for opting for an elective C-section (Block 2007). It is ironic that an invasive procedure cutting though the abdominal and uterine wall with its attendant risks and consequences to both mother and emerging child is seen as a relief to this fear.

The history of birth in America had fluctuated from minimum to no intervention as a predominately women-centered event to maximum intervention supervised by predominately

male physicians. While I argue that the medicalization of birth was and is usually pursued for well-intentioned purposes, the outcome of the medical model leaves something better to be desired by the mother, her partner and the baby than the options and knowledge currently available.

SECTION TWO:

Valuable Pain: Historical Significance of Pain in Childbirth

As I mentioned earlier there remains a deeply rooted discrepancy in the recounting of the history of childbirth depending on whose perspective is featured. One perspective features the triumph of medicine with emphasis on the benefits of induced labor, Twilight Sleep, and a continued increase in medical intervention including C-section. Yet, simultaneously, the same history also underlines the loss of female autonomy by those who recount historical midwifery practices. The conflicting historical perspectives simultaneously exist in tandem. Those who view birth as a primarily physiological and natural occurrence bitterly contest, "obstetric anesthesia is unique in medicine in that we use an invasive and potentially hazardous procedure to provide a humanitarian service to healthy women undergoing a physiological process" (Wolf 2009, 2). Those who emphazise the potential for pathology during birth contend, "there is no other circumstance where it is considered acceptable for a person to experience severe pain, amenable to safe intervention, while under a physician's care" (Wolf 2009, 2). One group calls the birth experience healthy, while the other calls it unhealthy. For the final portion of this paper I offer an alternative to this historical disagreement with a third narrative. In this section I argue that the American perception of birth—ultimately focusing on the fear and management of pain during birth—has shaped and deeply altered our modern understanding of the birth experience.

Consequently, the fear of pain during birth has limited access and knowledge to other forms of prenatal care and birth planning.

Pain and Fear of Birth

Pregnant women have long tried to manage the pain of childbirth. Ancient Egyptians and Indians used opium from which physicians would later derive morphine. Indigenous people of the Andes ate coca leaves, the predecessor to cocaine, while the Greeks munched on willow tree bark, the early form of aspirin. Women have eaten sacred flowers, consumed wine and poppy juice and sought a higher power through hypnotizing and positive persuasion. They have pleaded with their God and even committed to a life of abstinence. Some scholars suggest the Wise Men's gift of myrrh to baby Jesus may have dually been to ease Mary's labor pain (Cassidy 2006). Across generations and cultures women have tried antidotes such as acupuncture, hypnosis, massage, water injections, holy water injections, aromatherapy, cold baths, and hot baths—all to avoid the pain of birth.

While across cultures most women have sought to actively decrease the sensation of pain, or at the very least make an effort to manage the pain, the experience of pain is particular to an individual. An individual anticipates and reacts to pain based on, "innate personality traits, ability to tolerate discomfort, religious beliefs, access to social and emotional support, social status, immediate environment, past experience, learned expectations and cultural nuances" (Wolf 2009, 2).

Additionally, cultural expectations often dictate how that pain is expressed. Cultures where a woman is expected to express labor pain in silence experience the sensation differently than cultures where screaming and yelling is accepted (Wolf 2009). The Scientologist religion

mandates that women and everyone else assisting should remain quiet during labor to benefit the emerging child. In labor wards of Tokyo and in rural villages of Benin, Africa a silent stoic endurance of labor pain can be a woman's avenue to gaining social prestige (Cassidy 2006).

Although it is acknowledged that pain is particular to the individual and culture, the treatment of labor pain in the U.S. predominately centers on the medical model. The current Western conception of pain within the medical model as a purely physiological occurrence unaffected by a cultural lens or personal history and requiring immediate full alleviation has had enormous, and I argue negative, impact on U.S. birth practices. Even if identical in medical conditions, individuals experience pain through many different lenses making sweeping generalizations about the best method to alleviate pain difficult, yet the predominating option for women seems to urge women toward one choice.

Fear

A fear of impending pain has been found to increase the level of perceived pain when the event occurs. Studies about labor pain in particular observe that women's anxiety towards pain, expectation of pain while in labor and negative view of labor pain are associated with the most painful births (Wolf 2009, Harvey, Block 2007). Fear often leads to the release of the hormone epinephrine, also know as adrenaline, which can halt contractions and prolong birth (Caton 1999). Biologically therefore a woman's state of mind has considerable effect on labor. Grantley Dick-Read, one of the first proponents of the natural childbirth movement mentioned earlier in this essay, developed a theory of natural childbirth acknowledging the importance of a woman's state of mind before, during and after labor:

> Civilization and culture have brought influences to bear upon the minds of women which have introduced justifiable fears and anxieties concerning labor. The more cultured the races of the earth have become so much the more dogmatic have they been in

> pronouncing childbirth to be a painful and dangerous ordeal. This fear and anticipation have given rise to natural protective tensions in the body and such tensions are not of the mind only, for the mechanisms of protective actions by the body include muscle tension. Unfortunately, the natural tension produced by fear influences those muscles which close the womb and prevent the child from being driven out during childbirth. Therefore, fear inhibits: that is to say gives rise to resistance at the outlet of the womb, when in the normal state those muscles should be relaxed and free from tension. Such resistance and tension give rise to real pain because the uterus is supplied with organs which record pain set up by excessive tension. Therefore fear, pain and tension are the three evils which are not normal to the natural design, but which have been introduced in the course of civilization by the ignorance of those who have been concerned with attendance at childbirth. If pain, fear and tension go hand in hand, then it must be necessary to relive tension and to overcome fear in order to eliminate pain. (Dick-Read 1944 5-6)

In short, Dick Read is suggesting that the elimination or reduction of fear will correspond to an elimination or reduction of pain. Further Dick-Read attributes the root of fear as having manifested in the soil of civilization and the very institution that promises women a painless birth. It is important to note that Dick-Read did not promote an anesthesia-free birth for every woman. Anesthesia or pain medication for those unable to overcome fear should remain a necessary option for relaxing the mother, but perhaps shouldn't be the first recommendation for a healthy birth. Through a change in the mother's state of mind Read believed motherhood would be returned to women (Wertz & Wertz 1977).

Additionally, fear plays a crucial role not only during labor but for life after birth as well. Fisher et al (2006) report that the high prevalence of fear surrounding birth is also associated with a "increase in complications during pregnancy, higher rates of interventions, emergency and elective cesarean births, Post Partum Depression (PPD), Post Traumatic Stress Disorder (PTSD), and impaired maternal-infant connection" (Fisher et al pg. 65). These individual outcomes for a

woman impact her "role as a mother and interpersonal parental relationships" (65). How a woman perceives her birth experience therefore has direct implications on ensuring positive family functioning in the future (Hofberg and Ward 2003).

To eliminate this fear and with it the pain of childbirth, American culture turned, and continues to turn to, technological solutions— the very source Dick-Read attributes to the increased fear surrounding labor.

The Laboring Body as a Defective Machiene

The "medical model" shows us pregnancy and birth through the perspective of technological society and from men's eyes. Birthing women are thus objects upon whom certain procedures must be done. The alternative model…which I will call the "midwifery model" is a woman's perspective on birth, in which women are the subjects, the doers, the givers of birth. "

Barbara Katz Rothman, In Labor: Women and Power in the Birthplace (1982: 34)

It is important to address the concept brought forth by numerous secondary sources that during the initial shift to hospital maternity care, and overwhelmingly today, there has been a predominating social and cultural belief in America that technology is better than nature. More often than not modern day medical practices are unquestioningly believed to be superior to natural alternatives. This trend is further evident in the management and treatment of birth.

From the mid nineteenth century to the 1960s, physicians customarily administered general or regional anesthesia only at the end of second-stage labor, when the baby's head begins to crown. Meaning, the woman goes through the first stage of labor, transition (often the most difficult stage of labor), and the majority of the second stage of labor without anesthesia only to be rendered unconscious as the baby is born. Wolf notes the significance of the physician's experience as a witness "trumped the experience of the patient, highlighting the importance of

physicians' as opposed to patient's perceptions when formulating medical treatment" (Wolf 2009). The timing of obstetric anesthesia demonstrates the prevailing medical authority over patients—as physicians directed the timing of treatment for pain felt by patients.

The metaphor of medical practioners treating the female body as a machine is perhaps best explained by Emily Martin in her book *The Woman in the Body: A Cultural Analysis of Reproduction.* Martin discusses the shift from a natural rhythm of birth to the uterus as being held to a reasonable "progress" or "pace" that is not allowed to stop and start with its natural rhythm. In essence Martin acknowledges the deep symbolization embedded in the timing with her concept of the female body as a machine—described in stages of labor—a term doubly used to describe what men and women do in producing things for use and exchange in the home and market. Referring to the medical instruments that were used when male physicians began to replace female midwives Martin states, "in obstetrics the metaphor of the uterus as a machine combines with the use of actual mechanical devices, such as forceps, which played a part in the replacement of female midwives hands by male hands using tools" (Martin 2001, 54). Moreover, Martin acknowledges how the presence of pain medication while positively alleviating birth pain from the mother may in fact do more harm than good.

Barbara Katz Rothman, one of the three authors of *Laboring On: Birth in Transition in the United States,* recognizes the medical model follows a "cartesian model of the body as a machine [that] operates to make the physician a technician or mechanic" (Rothman). Rothman compares this model as adopting similar views to that of a car technician or mechanic that "fixes" the body when it breaks down or needs repair. Robbie Davis-Floyd and Elizabeth Davis further recognizes how the medicalization of pregnancy has associated the female body with a defective machine. This idea is supported by the commonly held belief that birth will be "better" and safer once this

defective birthing machine is connected to other diagnostic machines in better working order (Davis-Flyod and Davis 1996, 238). Amanda Hardy argues in order for the shift to occur from the traditional social childbirth at home and traditional midwifery to what would be labeled eventually as obstetrics, three assumptions needed to be socially accepted: "(a) technology is good, (b) science can improve nature, and (c) birth is a pathological event" (Hardy). Researchers have also found that high tech birth potentially leads to "a loss of self-esteem because it makes women feel that they have lost control over the most fundamental aspects of self" (Wertz & Wertz 1989).

Pain medication remains a necessary choice for women. However, it's application may have reverse and more destructive effects to the female body if in the absence of registered pain the female body becomes objectified as a non-autonomous defective and unfeeling machine.

Iatrogenic Birth

> iat·ro·gen·ic: resulting from the activity of physicians; said of any adverse condition in a patient resulting from treatment by a physician or surgeon; Induced in a patient by a physician's activity, manner, or therapy; referring to injuries caused by a doctor; an iatrogenic disorder is a condition that is caused by medical personnel or procedures or that develops through exposure to the environment of a health care facility. (www.thefreedictionary.com)

The notion of the iatrogenic condition of birth—that is, medical intervention causing an adverse condition and then curing that condition with additional medical intervention—is of worthy consideration when analyzing the predominating birth methods in the U.S.

When women arrive at a hospital after laboring at home for hours, many find that their labor progression drastically slows down, almost stopping entirely. The phenomenon is so common

that doctors and nurses call it the "white coat syndrome." Cassidy notes that for women, being among strangers and the unfamiliar can retard labor. Yet today women are expected to deliver in the very environment that their body naturally rejects. Often physicians diagnose the stalled laboring women with dystocia. Dystocia is a general term meaning the woman has spent a greater time in labor than hospital regulations or physicians are willing to allow. In the physician's point of view, the natural process has failed. Rothman attributes the dystocia diagnosis to a medical status stating "like any illness or any deviance… it is a position to which a person is assigned by those in authority" (Simonds et al 2007, 57). Diagnosis of dystocia quickly followed by a C-section 'fixes' the delayed labor completing the iatrogenic condition. At least, for the moment.

Wertz & Wertz record the early role of physicians' hands stating "puerperal fever is probably the classic example of iatrogenic disease—that is a disease caused by medical treatment itself" (Wertz & Wertz 1989). Wertz and Wertz argue that the physicians need to prevent puerperal fever directly contributed to birth's dehumanization:

> Doctors had to regard each woman as diseased, because birth provided the occasion and medicine the cause for infection. Excessive interventions only increased the chances for sickness and infection…each woman had to be judged a potential victim needing preventative and dehumanizing treatment. (Wertz & Wertz 1989, 128)

Scientific Benefits of Pain

Scientifically, there is a compelling argument that pain is chemically linked to the progression of labor and a healthy birth experience. During labor there is a complex interplay of hormones released. These hormones called endorphins, are natural opiates that have a number of physiological functions in labor, directly affecting both mother and baby. The endorphin oxytocin is responsible for the altered state of consciousness experienced at the end of labor that

women often describe as a "runners high" (Block 2007, 173). Adrenaline and nonadrenaline are also released and play a role in protecting the brain against the fear and anxiety of birth for mother and the stress of birth for baby. Additionally, the endorphins stimulate the release of prolactin, the hormone responsible for the initiation of lactation (Simonds et al 2007).

It is known that epidural anesthesia blocks endorphins as well as adrenaline. By taking away the pain, the endorphins don't get released and prolactin remains dormant. Studies have also shown the hormone prostaglandin, which promotes uterine contractions, drops with epidural anesthesia resulting in a less responsive uterus, a transverse fetus, lengthy labor, and increased risk of hemorrhage (Block 2007). Thus when women are not able to feel the pain and respond to it, they become more prone to injury. The eradication of pain simultaneously eradicates the body's ability to progress, necessitating artificial oxytocin and with it a cascade of more medical intervention.

In *Fish can't see water: The need to humanize birth,* M. Wagner observed "the way in which technology has been presented [in birth] as necessary to ensure safety, successfully glossed over any hint of iatrogenic outcomes" (Wagner p. 299). This observation points to the belief that technology is better than nature and additionally that any negative outcomes of medical intervention are presumed not to be the effects of that medical intervention.

Pain—Catalyst to birth history

The experience of women in birth in America has been understood in terms of pain; pain experienced and pain avoided. Often the treatment and management of the pain women experience is judged and treated by an outside source—if in fact one person can *ever* judge another's pain. Pain undeniably serves a purpose. It is a protective signal to the brain

communicating that discomfort persists. It also communicates important information such as to remove your hand from a cactus or avoid multi-tasking hair-curling and completion of an honors thesis. The pain of Victorian corseted life should have told women to light their corsets on fire and relieve their suppressed lungs. But as Block comments, "by the time they did, however, perhaps they could no longer distinguish between good pain and bad pain" (Block 2009, 171). The entire scope of pain had become inextricably linked with oppression, sexism and a lack of control. Women rejected all pain and with it the normal birth. Yet in the absence of that pain a valuable message was, and is, lost.

I want to clearly state that I am not campaigning for all women to forgo anesthesia or other medically oriented pain relief. I believe it can be a wonderful option for women if treated with respect and recognition for the information lost in the absence of pain. Rather I wish to bring attention to the ways in which society's perception of childbirth pain has deeply altered and limited those involved in the birth experience. What I propose for the future of birth care is an understanding of the birth experience as a valuable pain. If approached with recognition it can impart important information and critical life experience to the women, their partners, their emerging babies, and birth attendants. From this cultural perception of pain in American history this research concludes society has deeply altered the modern understanding of birth through the treatment and management of childbirth pain.

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