Childbirth is often the most meaningful and creative experience of a woman's life. Yet is is also physically painful and can be dangerous, both for mother and child, which is why most American women in the last half century have given birth in hospitals.

But today women are faced with a serious and sensitive dilemma. They recognize the safety of a hospital setting, but they also no longer choose to ignore its sterility, impersonality, and often inhumane professionalism. In fact, the pregnant woman feels the same disillusionment with the health care establishment as the rest of the public. People want the comfort, compassion, and emotional security of a home, as well as an assurance of expert treatment. They want to have choices about the medical care they receive, from the selection of a physician or a hospital to the kinds of pain-relieving drugs available and what their effects might be. In short, all these are issues, which are not so complicated as to be incomprehensible, but issues which women — and men — can question and understand.

The medical establishment is not unaware of the dilemma. Among other innovations, many physicians and hospitals now permit or encourage natural childbirth and family-centered maternity care. Many are dealing seriously with the psychology of their patients. But until the entire profession allows the patient to have real choices (including that of allowing the doctors to make the choice) one can only explore alternatives.

A pregnant woman should tour her local hospitals (if more than one is available) before deciding what kinds of options exist. She should know something about what happens on arrival at the hospital. For example, she should know that she will generally be treated as though ill, that she will probably be taken upstairs in a wheelchair. In delivery, as in any operating room, the table is narrow, odors medicinal and lights bright. Nurses may be supportive or their attitudes may be cool. If a woman persistently explores the avenues open to her, she is more likely to create the possibility for a safe and fulfilling childbirth experience.

[GETTING READY]

"If you ask Swedish doctors why they think Sweden has a lower infant mortality rate than the U.S., they begin with the statement that more than 90% of pregnant women in Sweden pay their first visit to their physician during the first three months of pregnancy."

--David Rutstein
The Coming Revolution in Medicine

The most important element of prenatal care is gaining a clear knowledge of the facts a woman should consider when selecting a physician or a hospital. That means a woman must ask the right questions. Is the OB-gyn primarily interested in gynecology rather than obstetrics? A General Practitioner who is interested in obstetrics may actually provide better care. How many babies does he deliver per year? A good load is about 200. A woman should not be afraid to obtain a second or third opinion and, if a physician resents this, he or she is not the type of understanding human being a pregnant woman needs. Is the physician in a group practice? For some women, this may provide security in case the doctor is away at the time of delivery. Does he show compassion and answer questions fully? Is he aware of new techniques such as natural childbirth? Many women reported going through months of hard work getting ready for natural childbirth only to be knocked out at the last minute because the physician reneged on his promise not to use anesthesia. Also essential to know are the policies of the hospital with which the physician is connected. Says Kerry Mazzone, president of the Childbirth Education Association in San Francisco, "Women don't chose their OB's carefully. It's usually word of mouth. If he's nice and talks smoothly they think he's fantastic and as soon as she's in labor, despite any agreement, he numbs her from the waist down."

Generally the more flexible physicians will be associated with the more flexible institutions. Some women may want to choose the hospital first. Are its policies flexible? Is the atmosphere at all compassionate? Are stillbirth and abortion cases placed in the same room with normal mothers? Are nurses supportive? A 1967 national study of the American College of Obstetrics & Gynecology found that most deficiencies in maternal care were associated with small hospital size, few deliveries per year (to 500), and a lack of teaching affiliations: 25 percent of hospitals required over 40 minutes to prepare for an emergency Caesarean section; 43 percent couldn't administer blood within less than 30 minutes notice; and 30 percent required more than four hours to prepare for a transfusion.

If a woman is considered to be a high-risk pregnancy, she should be aware of hospitals with advanced technology, such as intensive care units, laboratory facilities, supportive services, follow-up clinics, and personnel. In the most ideal situations, the woman has established rapport with her physician from the family planning stages — often the case with middle-class mothers, 9/10 of which are not high risk.

In sum, both the physician and the hospital should expound a philosophical and medical flexibility, taking the form of an honest explanation of options, as well as complete respect for *her* choices. Unfortunately for most women the birth experience itself becomes the sole test of this honesty.

THE POOR: REVERSE SELECTION

For women with low educational and income levels, or who live in rural areas without access to selection of an obstetrician or hospital, there are currently no extensive prenatal programs. Ideally there should be an attempt to recruit pregnant women, provide transportation to clinics or hospitals, or send medical teams to their homes as is done in countries such as China, the USSR, Sweden, Denmark or Czechoslovakia. Many clinics affiliated with urban teaching hospitals are so poorly funded that outreach workers are overloaded with follow-up care alone.

Suzanne Armes/Jeroboam

by Melissa Sones

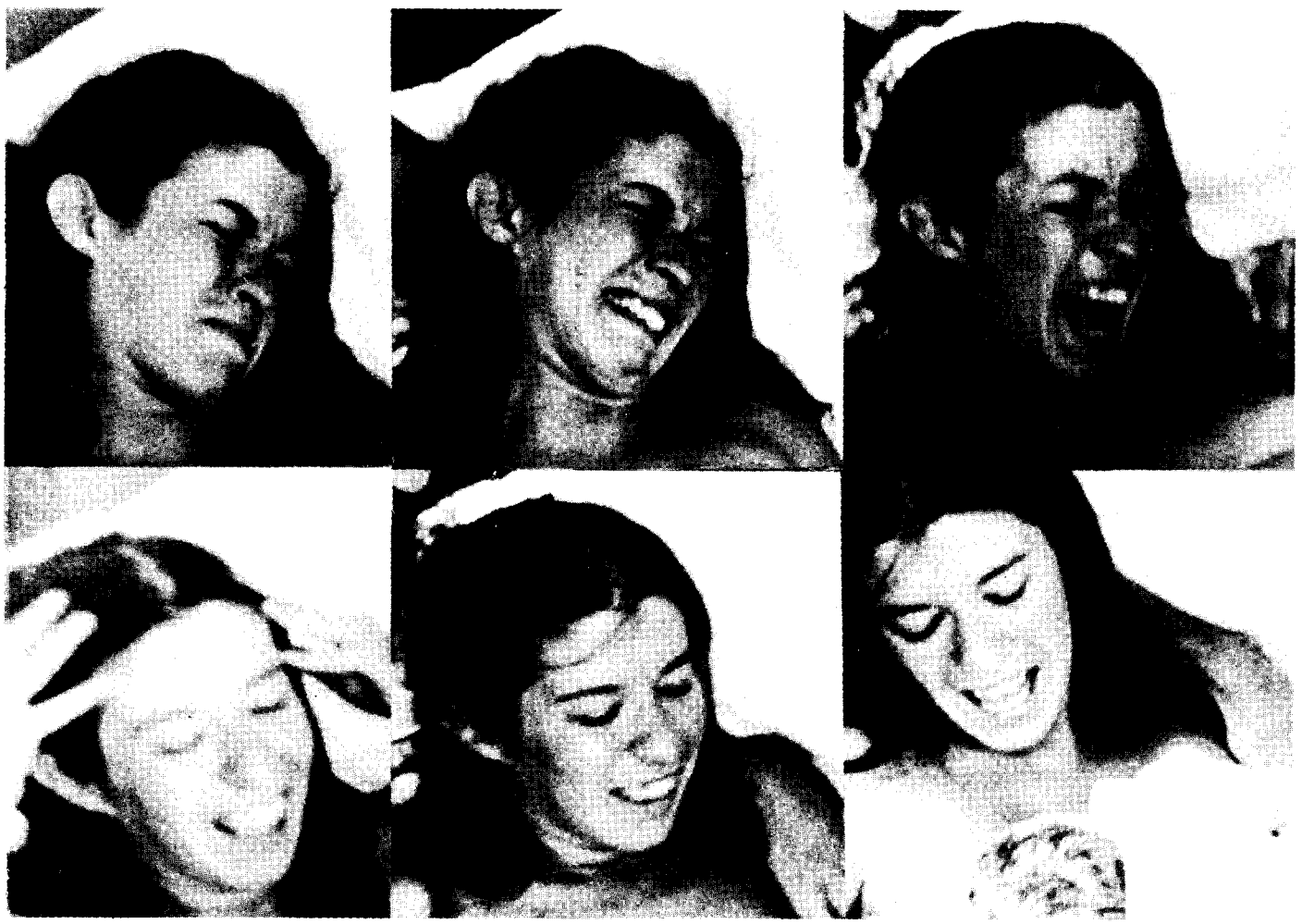
In rural areas a few small programs exist such as the Frontier Nursing Service, the first of its kind in the U.S., which was initiated in 1929 as a privately-funded non-profit mobile unit to meet the needs of mothers and babies in the Kentucky mountains. The staff are primarily nurse-midwives trained either abroad, in missions, or in its own graduate school of nursing and midwifery. Nurses travel by jeep within a five-mile radius: first prenatal checkups are given at clinics, while the final ones occur in the woman's home, and all babies are delivered in hospitals. The fee is minimal and includes a layette if paid in advance.

Currently the most extensive and advanced model of regional perinatal care in the United States is in Wisconsin, pioneered in 1968 by Dr. Stanley Graven, Professor of Pediatrics at the University of Wisconsin Medical School. Seven centers have now been established so that 90% of Wisconsin's population is within a hour's drive of a center. The newborn mortality rate among Milwaukee's low-income population has now been halved. Rural areas have also experienced dramatic drops. The newly formed Great Plains Organization for Perinatal Care now plans 17 future centers to be developed in the area. But generally there are too few adequate, funded prenatal projects.

NATURAL CHILDBIRTH

Natural childbirth, considered somewhat of a fad in the 1960s, has now become popular and even political. The past five years have seen a major change in attitudes of obstetricians, largely as a result of the demands of the women's movement and a shift toward a more natural style of life in American society. The term "natural childbirth" was coined by Dr. Grantly Dick-Read in 1933, in his book *Childbirth Without Fear*. Read believed that pain was psychologically oriented and a consequence of centuries of biblical misrepresentation, and therefore fear and muscular tension, the primary sources of pain in childbirth, could be eliminated by demystifying the birth process. He replaced the term "uterine pain" with "uterine contraction" and advocated the presence of the father in the delivery room and exercises such as painting during labor contractions to relax vaginal, skeletal and perineal muscles.

The Lamaze method is one of pain relief by conditional reflex based on the work of the Russian scientist Pavlov. The "psychoprophylactic method," as it is called, was first observed by Fernand Lamaze, a French obstetrician, at a gynecological conference in Paris in 1952. After a trip to Russia to further study the techniques, Lamaze modified the Russian method, adding a rapid accelerated breathing technique and established a very successful program in France known as Childbirth without Pain.



Photographs by Ed Baker and Rick Bennis

[LABOR AND DELIVERY]

"I will greatly multiply thy sorrow and the conception; in sorrow thou shalt bring forth children."

"Curse of Eve" Genesis 3:16

Until the middle of the 19th century the pain of childbirth was indisputable and even sanctified. But, with the introduction of chloroform, and later "twilight sleep" with a combination of morphine and scopolamine, an era of drug use was launched. While many of the drugs have indeed helped to alleviate pain, many have been found to be dangerous and women are resisting their indiscriminate use. Each option should be carefully considered.

LABOR PAIN

Tranquilizers – the mildest medication, which tends to relax tension and produce drowsiness. Examples are Librium, Valium, Equanil, and Miltown.

Barbiturates – can be harmful to the baby and slow down breathing and reactions of both mother and child. Examples are Seconal and Nembutal.

More important than the relaxation and breathing techniques for the practice of childbirth in this country is his revolutionary philosophy. It is a psychological, rather than medical, form of pain relief, for it emphasizes the strength of a woman emotionally and intellectually for childbirth. Its three primary concepts are: 1) complete understanding of the processes of labor and birth in order to alleviate fear and tension; 2) muscular relaxation to easy delivery; 3) a conditioning process by which pain is displaced from a central to peripheral location in a woman's consciousness by substituting another center of concentration. The new center is the body function of breathing.

Morphine and Scopolamine – these are given hypodermically, inducing what is known as "twilight sleep". The mother awakens after her child is born and has no recollection of the beauty of giving birth. Morphine, an analgesic, deadens pain and creates an overpowering urge to sleep when given in large enough quantities. Scopolamine, an amnesic and hallucinogen, erases all memory. If given too soon, these can stop labor completely. If given too late, the child's respiratory center can be affected and he/she can die of asphyxia. Today, the most popular drug for relief of labor pain is a combination of Demoral (a synthetic morphine-like compound) and scopolamine.

BIRTH PAIN

General anesthesia (or inhalation anesthesia) — These drugs affect the entire body, producing a state of total unconsciousness. The woman feels nothing, emotionally or physically, cannot push or see her child born. It takes effect immediately. Some general

(Continued on page 51)

Childbirth: A Feminist View

"I was in labor for 15 hours, while your father went to the office. I was totally knocked out the whole time. The first thing I asked when I came to was, What did I have? then, Is she healthy? and then, Can I see her? I walked down the hall and watched you howling in your bassinet behind a glass wall. I stayed in the hospital for eight days and fed you your bottle twice a day. On the way home from the hospital, your father dropped your formula on the sidewalk. I wasn't quite sure we were going to make it."

—my mother, about my birth in a private New York City hospital, 1950

Until very recently, most American mothers, including my own, accepted a standard, hospital childbirth as their biological destiny. They were grateful for the anaesthesia which eliminated the pain their own mothers suffered in childbirth writhing in agony on the kitchen table. They were relieved that all the latest equipment would save their newborns from danger. They were glad that their husbands were spared the discomforts of their labor and delivery. And they were forever indebted to the obstetricians who skillfully guided them through the mysteries of pregnancy and proudly brought their sons and daughters screaming into the light of day.

For several years now, spurred by the energy of the burgeoning women's health movement, with its emphasis on options and the woman's right to control her own body, health activists and consumers around the country have been questioning the American way of childbirth. Not oblivious to the medical advances of the past century, they have nevertheless refused to accept what is too often a trade-off between safe, doctor-controlled childbirth and humane, mother- and family-centered maternity care.

Thus they have challenged standard hospital procedure and worked to change it for the benefit of the whole family unit. In addition, they have sought viable alternatives to hospital births: home births, regional birth clinics, maternity homes. Each of these alternatives benefits the members of the new family in various ways; none is entirely without risks. The availability of these options to all expectant mothers, rather than the advocacy of one method over another, is crucial to the program for change. This choice—plus control over her environment and the procedure of her birth; maximum safety for herself and her newborn; and the integration of the birth experience into her own and her family's life—at least, say maternity care reformers, should be the expectant mother's rights.

Although the last half century has unarguably seen a significant improvement in infant survival, feminist critics argue that simultaneous exclusion of women healers, especially midwives, from the American childbirth establishment has alienated the mother from the person delivering her baby and has gradually dehumanized childbirth. In 1910, about 50 percent of all babies were delivered by midwives, most of whom were blacks or working-class immigrants. But as Barbara Ehrenreich and Deirdre English point out in their monograph *Witches, Midwives and Nurses,* this was "an intolerable situation to the newly emerging obstetrical specialty." Not only was every poor woman delivered by a midwife one less source of obstetrical "teaching material," but these women were spending an estimated $5 million a year on midwives—fees which could otherwise have been going to "professionals."

Thus, in the name of science and reform, American obstetricians launched their attack on midwives, ridiculing them as "hopelessly dirty, ignorant and incompetent." Midwives were held accountable for the prevalence of uterine infections and neonatal blindness due to parental infection from gonorrhea, two conditions easily preventable by techniques "well within the grasp of the least literate midwife": hand-washing to prevent the former, eye-drops, the latter.

According to *Witches, Midwives and Nurses,* not only were American obstetricians themselves careless about infections and neonatal blindness, but "they also tended to be too ready to use surgical techniques which endangered mother or child." Nevertheless, the doctors, not the midwives, had the power. Under intense pressure from the medical profession, state after state passed laws outlawing midwifery and sealing the doctor's monopoly on obstetrical practice. Since 97 percent of all ob-gyns in this country are men, the once intensely woman-centered experience of childbirth became male-dominated and male-controlled.

* * *

"I kept going to the clinic with labor pains, and they kept sending me home. The baby was a month overdue. When I finally began having contractions with terrible pain, they told me, 'Stop screaming. Your time isn't here yet.' Finally, a doctor who had trained in Europe saw me and said, 'Oh My God! This woman is going to die. It's a breech birth!' He took me to the delivery room, strapped me down, and the nurses began pressing on my stomach to induce labor. The doctor did an episiotomy all the way to my rectum, which was painful and later became infected. The baby was manipulated and pulled out. It was the most gruesome, bloody and horrible experience of my life. Two years later I had to have a hysterectomy because of it."

—a Chicano mother about the birth of her second child in Pensacola, Florida, 1956

"I was turned off to the whole hospital thing, but I went on the recommendation of a friend and because it was cheap. You saw so many different doctors, and the whole thing was very impersonal. I didn't know anything, and I believed the doctors knew everything. I didn't want any medication,

by Elizabeth Fishel