Birth Lost in Translation: Obstetric Violence and the Plight to Humanize Institutional Birth

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by

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ABSTRACT

My study investigates the contemporary global concept of obstetric violence. This concept originated in Venezuela in conjunction with the movement to humanize birth. At the same time, global public health initiatives to combat maternal mortality increased the number of facility-based births internationally with unintended consequences. I use content analysis of popular and peer-reviewed texts, podcasts, and in-depth interviews with birthing people and birth service providers to explore the ways various groups define, understand, and are using this term. I also investigate the ways autonomy and medical authority interact during institutional birth. My methods include illuminating cultural influences and focusing on the everyday behaviors and strategies that people utilize during hospital birth to propagate and resist violence in obstetrics in the U.S. and beyond. Assumptions of class and "belonging" intertwine with perinatal violence connected to discrimination based on race and indigeneity worldwide. Supremacist beliefs reproduced in the medical industrial complex prioritize babies, shut down the voices and agency of birthing people, and uphold institutional strategies that involve withholding information, unconsented procedures, and medical entrapment. These data indicate that centering reproductive and birth justice frameworks is especially important in moving towards a reimaging of birth as normal and birthing people as capable and competent both in and outside the hospital. Programs and policies modeled on existing community-based work are crucial to address issues of medical access and excess for pregnant and birthing people. These include promoting education and autonomy through outreach during pregnancy; implementing protocols of continuous care and consent during facility-based birth for effective communication at all levels; increasing accountability for providers/institutions related to rates of cesarean, induction, discrimination,
and mistreatment; creating linkages between providers/institutions and the communities they serve; and fostering a team-based atmosphere of supportive engagement among all stakeholders.

INDEX WORDS: obstetric violence, mistreatment in childbirth, disrespect and abuse in childbirth, traumatic birth, perinatal health, maternal mortality, medicalization of birth, obstetric racism
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DEDICATION

This dissertation is dedicated to my kids and to every parent (including my co-everything partner) doing their best in big and small ways every day. This is also dedicated to my sister Candice and Ruby Blow who supported me in imagining this chapter of my life (and learning).
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# TABLE OF CONTENTS

ACKNOWLEDGMENTS .................................................................................................................. V

LIST OF TABLES ........................................................................................................................ IX

LIST OF FIGURES ........................................................................................................................ X

LIST OF ABBREVIATIONS .......................................................................................................... XI

1  PREFACE AND INTRODUCTION ............................................................................................. 1

1.1  Background .......................................................................................................................... 4

1.2  Literature Review .................................................................................................................. 7

2  CONCEPTS AND METHODS .................................................................................................. 22

2.1  Concept Definitions and Language Use .............................................................................. 22

2.2  Methods and Sources: Content Analysis ........................................................................... 24

2.2.1  Data .................................................................................................................................. 25

2.3  Methods and Sources: Interviews ....................................................................................... 32

2.3.1  Data .................................................................................................................................. 32

2.4  Methodological Strategy and Theoretical Background ....................................................... 36

2.5  Analytic Approach ............................................................................................................... 40

3  OV: CHOICE WORDS AND LIVED EXPERIENCE AROUND THE WORLD ................................ 43

3.1  Defining OV: What is Obstetric Violence? ........................................................................... 43

3.2  Everyday Perspectives: Mistreatment and Abuse, OV and Traumatic Birth....................... 54

3.3  Most Common OV Reported .............................................................................................. 69
## LIST OF TABLES

Table 1 Texts and Media Included in Analysis ................................................................. 26
Table 2 BP Personal Characteristics .............................................................................. 32
Table 3 BP Birth Characteristics ..................................................................................... 33
Table 4 BSP Characteristics .......................................................................................... 33
LIST OF FIGURES

Figure 1 Frequency of Peer Review and Popular Texts by Time Period ........................................... 30
Figure 2 Frequency of Peer Reviewed Texts by Country ................................................................. 31
Figure 3 Frequency of Popular Texts by Country ............................................................................ 31
Figure 4 Most Common Forms of OV ......................................................................................... 70
Figure 5 Micro/Macro Context of OV ....................................................................................... 177
Figure 6 Translational Concept Map .......................................................................................... 240
Figure 7 Holistic Community Perinatal Care ............................................................................. 246
LIST OF ABBREVIATIONS

ACOG: American College of Obstetricians and Gynecologists
BIC: Birth Industrial Complex
BP: Birthing Parent / Birthing Person
BPOC: Birthing Parent of Color
BSP: Birth Service Provider
BWBJ: Black Woman Birthing Justice
CCB: Conversational Consent for Birth
GN: Global North
GS: Global South
HBHM: Healthy Mom, Healthy Baby
LTMS: Listening To Mothers Survey
MIC: Medical Industrial Complex
PWBO: Predominately White Birth Organizations
VBAC: Vaginal Birth After Cesarean
WHO: World Health Organization
1 Preface and Introduction

I began writing this dissertation in 2019 but my education about birth began in 2007. I am a parent to three kids, the first born via unplanned cesarean. I live in a state with limited options for birthing people (BPs) who, like me, wanted to birth vaginally after a cesarean (VBAC). This meant undertaking significant research from formal channels such as medical journals to understand the risks of this option and also from informal channels like online groups designed to educated people about patient rights. I learned a lot from that exploration and from pushing back against the medical status quo in my conservative state where only a few obstetricians support VBAC. Many of my friends and family didn’t understand why I cared so much about avoiding surgery and my original OB questioned my fitness for motherhood based on this decision. That experience compelled me to spend a lot of time sitting and listening to BPs who felt troubled or harmed by their hospital birth experiences. For six years I ran groups with first time moms and heard the themes around difficult births repeat week after week. Most recently, along with millions of other people, I watched mainstream media highlight the narratives of famous individuals who were mistreated during hospital birth as well as people who happened to capture their mistreatment on video. After my births, I began to seek out reports and studies of voices who are not often heard in birth culture and I carefully read those accounts too. I carry my story as well as the hundreds of other stories I’ve encountered along my path as I do this work.

I collected data for this project in 2020 in the midst of the initial days of the global COVID-19 pandemic -- an event that has changed society in every way, including the operation of the U.S. medical institution. Birthing people in the U.S. are currently fighting to have the basic right to bring birth companions into the hospital so they do not have to birth alone. On a larger scale, this health crisis has laid bare the vast inequity and inequality in the U.S. health
system and the ways that race, class, immigration status, gender, and many other social statuses are intertwined with structures that efficiently and effectively reproduce oppression. Moreover, this nation is embroiled in unrest in response to a string of murders of Black people by citizens and employees of the state. Finally, after the election of 2020, the U.S. is operating in political turmoil caused by a president who refuses to concede. None of these things are separate or stand alone. Each of these injustices exists within a larger structure that supports white supremacy in the U.S. upheld by neoliberalism and bound to malevolent capitalism. My day-to-day research and writing on obstetric violence (OV) are situated in this unique historical moment where people are dying, protesting, voting, teaching, and living together in ways that force us to reconsider what was ever “normal.” It is an especially fraught atmosphere in which to consider this violence against humankind -- when collective trauma in the U.S. is palpable on every front. I know that during my interviews and while transcribing them I heard and reheard this trauma echoed in the voices of the BPs and BSPs with whom I spoke. Further, I know my particular standpoint as an able-bodied middle class highly educated cis-het white woman affects how I interpret these data. I continuously ask myself whose story I’m telling? What might I be inattentive to in birthing people’s narratives? How can I make sure not to miss anything important? While white BPs also experience OV, Black and Brown birthing people are continually silenced and harmed within the medical institution in a targeted way.

Birth is ubiquitous yet extremely personal and it exists in this country predominately as an institutionalized life event. The story I’m writing is not new. To understand birth today it must be contextualized by nation, by health and economic system, by inequity and privilege, and by discrimination. The common thread that connects the data I am sifting through is the existence of institutionalized operations, the energy and outcomes these operations create, and the ways that
people (both BPs and BSPs) interact with the socially constructed demand to process bodies going through this particular physiological experience -- a process made more or less difficult, more or less harmful, and more or less human, based on social identity and status. My work is an investigation of how birth is entangled in this complicated historical moment. I use the concept of translation because it is a helpful analogy in illustrating my analysis. It is appropriate too as an acknowledgment that I cannot begin to accurately analyze every aspect of contemporary birth or fully understand the meaning of each individual experience. With this said, I submit the following sociological translation of one look at the multitude of voices imploring us to listen to their testimony about the complexity of birth and violence in institutions today.

My dissertation investigates the emergence of the contemporary concept of obstetric violence during childbirth (OV). The background and literature review provide information most important in understanding OV as a globalized concept and galvanizing topic today. My methods and data chapter includes details about how I established my analytical anchors and the theoretical underpinnings of the canvas I then fill in with data collected over 2 years. I write about these data compiled from content analysis and interviews collectively and describe my findings in four parts. Chapter three focuses on outlining the parameters of OV and efforts and challenges to defining it, individual interpretations of harm, and the most common forms of OV globally. Chapter four focuses on describing social hierarchies of the birth industrial complex (BIC) situated within the influences of medical authority, as well as institutional and individual strategies utilized within it. Chapter five details the concept of translation in this dissertation and how communication dysfunction in the BIC influences OV, and chapter six explores resistance and agency around the topic highlighting strategies to thrive found throughout these data. Writing this dissertation felt dire at some points and painfully redundant at others yet knowing
that the seeds for a complete reimaging are right here, and always have been, is hopeful. I write beside others who look towards dismantling a broken system and rebuilding as a means of creating right relationships with one another and a truly supportive institution for every birthing person.

1.1 Background

The term OV originated within a legal context in Venezuela in 2008 and criminalized violence against women during birth perpetuated by doctors and hospital staff. It is situated within the framework of a larger goal to eliminate violence against women in all aspects of social life and arose in conjunction with the Latin American based social movement to “humanize birth” in that region (Laako 2017). The humanize birth movement has influenced many US, UK (United Kingdom), and Australia (AU) based birth organizations and galvanized recent discussion around abuse during childbirth (Floyd 2007). I used content analysis to investigate the origins of this contemporary concept and its adoption in various contexts, including in popular and scholarly texts as well as online texts and audio interviews (podcasts). Through semi-structured interviews, I delved into individual’s experiences of violence in childbirth. I explored the perspectives and interpretations of both BPs and BSPs. The combined use of content analysis and interviews allowed me to contribute an understanding of the broader arch of the issue, as well as insights into how people grapple with violence during and after birth as part of a lived experience.

Undeniably, after birth people encounter a postpartum period that is severely under-supported practically, emotionally, and often medically in this country. This vacuum of support, coupled with the new responsibility for a tiny human life leaves most new parents little room to think about, let alone process, their birth experience. This is especially notable because the
statistics are clear that childbearing in this country is challenging for many. In the U.S. today, up to thirty percent of birthing people report psychological birth trauma and one out of six people report mistreatment during hospital births, a disproportionate number being Brown and Black folks (Soet, Brack, and Dillorio 2003; Vedam et al. 2019). Additionally, between fifty and eighty percent of birthing people report physical injury to themselves resulting from the experience (Butler 2017). The vast majority of people do not pursue litigation after assaultive events and may not even report mistreatment for various reasons, including feeling grateful to be alive, the general lack of support for new families, and cultural messages that suggest birth is inherently traumatic and urge people to quickly “move on.”

In recent years, popular and mainstream media outlets have highlighted abusive circumstances related to women’s health. With the explosion of social media accessibility, several stories depicting disturbing birth experiences went viral, circulating to thousands of viewers. The first is a video showing Kimberly Turbin, a Mexican American woman, actively protesting an episiotomy while she’s in the pushing stage of labor (YouTube 2014).1 The doctor proceeds to perform the procedure crudely and repetitively, against her wishes. Another is a snapshot of Caroline Malatesta, an extremely distressed white woman immediately after giving birth to her child. The Yahoo news story describes an ordeal that includes nurses forcefully preventing the baby from emerging from her body for several minutes until the obstetrician arrived; a decision that resulted in significant bodily harm to the mother (Greenfield 2015).2

In addition to these stories, victims recently lodged various legal cases against serial sexual predators in the medical field. In 2016, seventeen women sued the Columbia University

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1 An episiotomy is an incision into tissue around the vaginal opening used to aid obstetricians in speeding up the exit of babies from the birth canal.

2 Both women (Kimberly Turbin and Caroline Malatesta) were able to prove they sustained serious physical injuries due to their experiences and were successful in receiving monetary compensation through civil litigation.
and its related hospitals for covering up decades of sexual abuse by an obstetrician, Robert Hadden (Graham 2018). In that same year, over five hundred people accused, George Tyndall, a gynecologist at the University of Southern California, of various sexual abuses over tens of years (Cowan 2019). Finally, in 2018, hundreds of women testified against the former U.S. gymnastics organization physical trainer, Larry Nassar, resulting in a sentence of decades in prison for sexual abuse. Stories like these, and the broader #metoo movement, contribute to public awareness of wrongdoing within corroborating institutions and the U.S. medical system that until this point have remained normalized or enveloped in shame. Overall, events in recent years indicate that issues of ongoing institutional abuse endured in contemporary society are entering mainstream discourse and claiming some deserved attention.

While the existence of abuse and mistreatment in childbirth is well established, pressing concern around the state of maternal health worldwide is creating new frameworks for understanding the issue and implementing policies aimed to ameliorate the problem. The sociological study of the topic promises to illuminate crucial links between the micro and macro aspects involved. Further, it is critical to better understand the social factors of birth today as the most vulnerable pregnant and birthing individuals are in an extremely precarious position in the escalating maternal health crisis in the U.S. I devote the next section to placing birth within a socio-cultural context in the U.S. before delving into synthesizing the literature regarding violence that occurs around birth globally today.

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3 The doctor plead guilty but received no jail time.
4 George Tyndall was arrested in 2019 and charged with “29 counts of sexual penetration and sexual battery by fraud.”
1.2 Literature Review

The United States fails birthing people and infants miserably when compared to countries of similar economic wealth around the world. According to recent data, the U.S. ranks last among “developed” countries in maternal morbidity with a rate of 26.2 deaths in 100,000 live births (and rising) (Global Burden of Disease collaborators 2015). The second worst rating for a comparable high-income country is the UK at 9.2. As is the case with a plethora of health outcomes in the U.S., due to systemic racism and the political system of white supremacy, maternal mortality disproportionately and most dramatic affects black BPs. American Indian and Alaskan Native BPs are also more likely to die due to pregnancy related causes (Petersen et al. 2019). Data for Asian American and Hispanic categories of data are difficult to tease out due to the diversity of demographics within them but on average rates for both groups of BPs are similar to or better than white BPs (Moubarac 2013).

The crisis of the Black/white disparity in maternal health is increasingly hitting mainstream media. High-profile black celebrities Beyonce and Serena Williams both took their stories of complicated pregnancies and harrowing “near-miss” births public in 2018. Journalistic health reporters have picked up on these racial disparities as an intriguing (and profitable) story line and popular media outlets have continually broadcast the statistics in various forms. For example, a recent New York Times article emphasized the fact that regardless of socio-economic status and level of education, black women at a four-fold risk to die from pregnancy-related causes than white women (Villarosa 2018). Nash suggests this repetitive political-cultural

5 In 2017, the average rate of maternal mortality in the U.S. for black birthing individuals was 56.3 (MacDorman, Declerq, and Thoma 2017). This rate is four times higher than the rate of death for white women.
6 “Maternal near miss” is defined by WHO as “a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy” (Souza and Pattinson 2009).
framing of Black women in the perinatal health crisis has created a contemporary controlling image of a Black mother in peril (2019). Importantly, messages from birth advocacy organizations indicate the importance of explicitly naming *racism* and not race as the culprit for this disparity (blackmamasmatter.com). Moreover, in the U.S., in addition to white supremacy, market-driven health services, hyper-inequity, and misogyny within the institution of medicine greatly influence health service encounters.

In the U.S. birth shifted from home to hospitals in the late 1800s and the rate of hospital birth has remained remarkably high. For white women with means, this shift involved a transfer of power from women assisting women in birth through the midwifery model to white male physicians attending birth and “delivering” babies with medical instruments.7 While midwifery practice in hospitals in the U.S. has increased recently, home births are rare due to regulation and lobbying by organizations like the American Medical Association (AMA) that seeks to legally prohibit midwives from attending birth in people’s homes. There are 36 states where certified professional midwives (CPM)8 can legally attended home birth. In 14 states and 3 territories, including the U.S. Virgin Islands, Peurto Rico, and Guam, CPMs attending home births may be criminally prosecuted (pushformidwives.org 2021). Though recently increasing from just under 1% in 2004 to 1.36% in 2014, the home birth rate hovers around 1%, leaving the hospital rate at 99% where it has been since 1955 (cdc.gov 2014). Birth centers offer a kind of medical midpoint between hospital and home birth. There are 375 birth centers in the U.S. including many that specifically support BPOCs (National Academies of Sciences 2020). To be sure, the vast majority of births do not belong in a hospital but currently in the U.S. most take place there.

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7 A systematic campaign to shut down midwifery outside of hospitals was complete in 1960 with the termination of the “grand midwives,” African American midwives serving the black, brown, and poor during segregation in the south (Rothman 2016; Litt 2010).
8 Nurse Midwives have nursing degrees and primarily practice in hospitals.
While my interviews focus on the U.S. context, my study incorporates content and texts from around the globe and include areas where facility birth is much less common. It is important to point out the vast differences in resources and access that are represented in perinatal health globally and that influence reports of OV. In 2014, Romanzi called this landscape an “obscene maternal and neonatal apartheid” (p.837). The maternal mortality rates per 100,000 babies born in the areas of focus in this dissertation as of 2013 are as follows: Sub-Saharan Africa 550; The Caribbean 190; Southern Asia 190; Latin America 77; “Developed Regions” (Italy, Croatia, UK, US, AU) 17 (an average) (WHO 2014). I bring together global health policy, medical and social science studies, legal scholarship, as well as popular perspectives, to lay the groundwork for my dissertation on OV as an emerging legal concept from the Global South (GS) and its appropriation outside of the legal context in the U.S. and across the Global North (GN).

The Safe Motherhood Initiative was implemented by WHO in 1987 to address maternal and infant mortality across the world. WHO reinforced this initiative in 2000 with the release of its Millennium Development Goals, which call for increased access to medical treatment and trained birth attendants during childbirth for women across the globe. This resulted in overcrowded physical spaces and overworked BSPs in many areas (Grossman et al. 2001; Ith, Dawson, and Homer 2013; Jewkes, Abrahams, and Mvo 1998; Kruger and Schoombee 2010; Kumbani et al. 2012; Miller et al. 2003). Many BPs avoided facilities (hospitals or clinics) in light of these factors, and some blame this phenomenon for failed Millennium Development Goals in many countries (Bohren et al. 2015; Crissman et al. 2013).

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9 I use the term Global North and Global South throughout this paper to indicate the geographic area from which my data originates and to acknowledge the North/South divide in birth practices globally.
Reports of violence against laboring people in targeted regions of the maternal mortality improvement initiative (Bohren et al. 2014; Okafor, Ugwu, and Obi 2015) as well as other locations (Beck 2004; Menage 2003; Dietsch et al. 2010), led WHO to release a statement titled “The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth” in 2015. The report acknowledged that the dramatic increase in facility birth rates resulted in “disrespectful, abusive or neglectful treatment during childbirth,” and indicated action points for change based on a human rights framework that included BPs in the improvement process. The statement called for training medical staff in respectful practices, increased research into the accountability of health systems as well as support and funds from governments to research disrespect and abuse during childbirth (WHO 2015). WHO also rolled out the Mother and Baby-Friendly Hospital Initiative (MBFHI) in 2015, aligning with its new goals for improving the care and treatment of birthing people within hospitals and other facilities. This policy added new initiatives to the Baby-Friendly Hospital Initiatives (BFHI) established by WHO in 2000 to encourage and support breastfeeding. New global policies, like MBFHI as well as activism around medical abuses in birth, contributed to reframing some traumatic birth discourse into gendered violence and abuse discourse.

In the early 90s, psychology, nursing, and childbirth education researchers in the GN began to describe the phenomenon of traumatic birth within the medical literature as an experience of primarily white high-income women. Some sources state that 40% of new mothers will experience a traumatic birth, with up to 7% developing clinically diagnosable post-traumatic stress disorder (solaceformothers.org; pattch.org; Greenfield et al. 2016). By the early 2000s, new understandings of trauma, combined with an increased interest in maternal mental health, contributed to research focusing on the causes of trauma during childbirth. Studies in the GN
revealed that abuse in hospital births represented a significant underlying factor in psychological trauma endured as a result of birth (Thomson and Downe 2008; Wijma et al. 2007). Even so, medical researchers in high-income countries remained primarily interested in the psychological impact of the birth experience along with individual risk factors for traumatic birth.

In the literature, some defining risk factors for traumatic birth include previous traumatic experience; a history of sexual abuse; psychological distress due to “brusque or unsympathetic care”; an inability to obtain wanted interventions or enduring those which were unwanted; and extreme pain (Beck 2004; Beck 2009; Beck 2011; Greenfield 2016; Reed et al. 2017; Reynolds 1997). Little consensus existed among researchers on a sufficient definition for traumatic birth until a comprehensive concept analysis and literature review offered the following: “The emergence of a baby from its mother in a way that involves events or care that causes deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature” (Greenfield et al. 2016:257). It is unclear whether or not researchers agree on this exact definition, but Greenfield’s distinction between psychological trauma and physical trauma incurred during childbirth greatly expanded the bounds of what would be considered a traumatic birth in medical literature produced in the GN. The relationship between traumatic birth as a medicalized phenomenon and OV is largely unstudied, but the temporal proximity of the growing bodies of discourse and overlapping usage of the terms in various academic and popular sites is compelling.

While many researchers explored and expanded definitions of birth trauma, others attempted to create standardized terminology to describe and report occurrences of the mistreatment of BPs emerging primarily from the GS (Mexico, Latin America, the Caribbean, “developing” Asia, Africa, and the Middle East). Bowser and Hill (2010) conducted a
foundational landscape analysis in which they identify seven categories of abusive care during childbirth. These included: physical abuse (hitting, slapping, kicking), non-consented-to care, non-confidential care, undignified care, discrimination, neglect, and detention in facilities (due to inability to pay) (Bowser and Hill 2010). Freedman and colleagues used this model and contributed the idea that the categories interact within a three-tier conception including individual, structural, and policy levels (2014). Freedman and Kurk then expanded these categories contextually to recognize that experiences of OV vary culturally and geographically often due to constrained resources and stressed BSPs (2014).

Finally, the ongoing conversation in the literature to define violence during childbirth culminated in 2015 when Bohren and colleagues conducted a systematic global review of research on mistreatment during childbirth, using data from 65 studies across 34 countries of all income levels. Their results indicated 7 “typologies” of “the mistreatment of woman during childbirth”: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards, poor rapport between women and BSPs, and health system conditions and constraints (2015). In line with others (Fawcus 2016), the authors problematize the inconsistence of terminology across studies, including “obstetrical violence,” “disrespect and abuse,” and “dehumanized care”; and they argue for the adoption of “mistreatment of women during childbirth” as an all-encompassing and appropriate terminology (2015). Researchers seem to regard this comprehensive analysis and typology as sufficient and complete at this time, yet the use of many terms to refer to “mistreatment” during childbirth, including OV, persist.

In 2018, Beck conducted a secondary analysis of data on OV from high-income countries and the results were similar to those found in low and middle-income countries (Bohren 2014). “Failure to Meet Professional Standards of Care,” a category consisting of neglect, abandonment,
refusal to provide pain relief, lack of informed consent, and painful vaginal examinations, was the most reported form of mistreatment for high-income countries (Beck 2016). Connecting data on traumatic birth with emerging definitions of OV represents a turning point in the understanding of industrialized birth in the GN and opens channels for research and ideas across borders. One area that researchers in all areas of the world continue to consider is the impact of inequality on the experience of OV.

The impact of SES on health outcomes is well established historically, cross-culturally and internationally (Gazmararian, Adams, Pamuk 1996). Here, I focus on considerations of race, gender, and sex influencing OV throughout the literature. As reported in the introduction, racism is a determining factor in perinatal health outcomes in the U.S. today. A large national survey revealed that 24% of respondents experienced discrimination during their hospital stay and Black and Lantinx birthing parents were much more likely to report discrimination, citing race, language, or culture as the cause (Declercq 2013). As others have fully articulated, primarily white male actors built the white supremacist and patriarchal institution of medicine by experimenting on and appropriating black people’s bodies and the medical industrial complex (MIC) continues to operate according to racist and discriminatory practices (Roberts 1997, Washington 2006, Feagin 2014). Feminist anthropologist Dana-Ain Davis’ proposal to recognize and specify obstetric racism “as both an occurrence and analytic” is a crucial step in linking OV to disparities in the U.S. and elsewhere (2018:1). When considering race as a fundamental cause of disparities in maternal mortality in the U.S., the concept of obstetric racism is helpful in analyzing the process through which health inequities become embodied experience (Phelan and Link 2015).
Results from studies mainly conducted in the GS reveal that laboring people are more likely to be mistreated if they belong to indigenous, immigrant, racialized, or other groups of stigmatized social status (Janevic 2011; Human Rights Watch 2011; Hulton 2007; McMahon et al. 2014; Moyer et al. 2014). Smith-Oka constructs the concept of “corporeal microaggressions” as a mechanism through which OV reproduces “class and race-based explanations of otherness” within the context of facility birth in Mexico (2015). Additionally, Bohren and colleagues detail evidence that the stigma of advanced maternal age and various medical conditions also increase reports of discrimination and OV (2015). Of course, issues of gender inequality feature prominently in OV literature as well.

The Latin American birth movement is strongly rooted in the idea that OV is a form of gender violence (Sadler et al. 2106; Williams et al. 2018). The implementation of legal statutes defining OV comes from legislation passed in that region declaring, “the right for women to live free of violence” (ECLAC 2007). In the U.S., the connection between mistreatment during childbirth and gender violence has brought critique due to the overwhelming presence of women OB’s (Diaz-Tello 2016). Diaz-Tello explains this reduction of gender violence as manifesting from men against women, “misses an important understanding: an act of gender-based violence is not considered such because the perpetrator is a man, but rather because the victim is a woman” (2016). While micro-level processes are important, inequity in the larger structural aspects of the provision of health services and society at large come to bear in OV perpetuated under internalized gender norms (Diaz-Tello 2015; Fawcus 2016; Sadler et al. 2016; Castro and Savage 2017).10

10 It is important to note, mistreatment during birth around the globe is perpetrated by medical BSPs of all genders.
Sexual abuse during childbirth is reported in some data sets in the OV literature (Bohren et al. 2015), but Beck indicates that sexual assault was not noted by laboring people in high-income countries, although many described treatment that evoked feelings of being sexually assaulted and raped (2016). The polarizing term "birth-rape" entered the discourse of U.S. birth culture in the early 2000s and remains greatly debated. Various media campaigns based in the GN include individuals’ statements of personal experience with an intent to expose institutionalized violence (improvingbirth.org; humanizebirth.org). The language used by posters to these sites often describes their experiences in terms of sexual violence. These experiences frequently occur when medical procedures are performed insensitively, without positive consent, or when medical staff ignores laboring people’s active protests. Contemporary ideas of OV are rooted in the medicalization of childbirth, a topic that is often taken up by feminists.

Sociology as a discipline has shown little interest in researching childbirth per se (Oakley 2016). However, feminist informed critiques of state interference in reproduction (Roberts 1997; Flavin year 2009) and the medicalization/industrialization of birth do exist (Simonds et al. 2007; 2002; Rothman 2016). At times, feminists herald medical interventions in birth as a move toward equality, and at others brand them as a tool of oppression. For example, anesthesia via "twilight sleep" reigned from the 1930s to 1950s and was seen by some feminists as liberating (white) birthing people from the pain of labor, while the 70s saw an awakening and countermovement toward natural birth without medication. The fight to birth in a de-medicalized environment stemmed from that movement in the U.S. Rothman talks about the “strange community that was brought together in the home-birth movement” of the 70s -- referring to folks ranging in views from evangelical (anti-feminist) to radical feminist perspectives, but sharing a collective interest in birth outside the hospital at that time (2016:126). Despite highly energized pockets of activism
and an established cyber-community, home birth remains a marginalized option in the U.S. today.

There is longstanding tension among dominant feminists regarding the meaning and motivation behind the adoption or resistance of medical interventions in childbirth. Some cite empirical data on birth experiences that do not align with a sweeping feminist critique of medicalized birth (Fox and Worts 1999). Most recently, Rothman makes the case that birth became industrialized, much like the food industry, and that medicalization through interventions have dulled our collective “taste” for a birth experience free of modern modifications (2016). Johnson, writing on the north/south politic of birth maintains that reproductive medicalization is largely a “problem” for privileged women and is proposed primarily using a white middle-class feminist lens (2016). Adding additional nuance to the medicalization of birth debate, Miller and colleagues present the idea of “too little too late” (TLTL) versus “too much too soon” (TMTS) as it relates to OV and efforts to reduce maternal morbidity and mortality (2016). TLTL applies to the massive disparities pregnant and laboring people experience in accessing health services, while TMTS relates to OV due to unwanted or unwarranted medical procedures endured within birth facilities (2016). In line with the TMTS perspective, an abundance of evidence shows that rates of cesarean births and episiotomies reflect over-medicalization through unnecessary procedures that lead to violations of autonomy for laboring people (Salgado 2013; CDC 2016; Freyermuth, Munos, and Ochoa 2017; Zaami et al. 2019; Anorim et al. 2017). The pursuit of legal recourse due to incidences of mistreatment in childbirth is something that scholars in the U.S. are just beginning to discuss. Cultural and state-mandated norms of fetal protection and consent influence the path to legitimation for OV claims within the legal system in this country.
In conjunction with protocol that privileges infants’ health over that of mothers, laboring people also note lack of consent as a common aspect of medical professional’s mistreatment (Declercq et al. 2013). Borges notes that current legal standards for proving that procedures were non-consensual during birth are incredibly high (2018). This is partly due to the practice of all-encompassing consent forms that are completed during intake at many hospitals as well as case law that gives the state responsibility for maintaining the life of the fetus (Borges 2018). Reinforcing this institutionalized fetal protectionism is the precedent of malpractice suits and large settlements driven by the capitalist economy of the U.S. that give OB’s incentives to perform procedures defensively to avoid blame for negligence (Morris 2014; Borges 2015).

Additional barriers to establishing effective legal recourse for OV in the U.S. include the practicalities of unsupportive family policies and a lack of information about what constitutes mistreatment (Karuka 2018). Overall, while some legal scholars call for it (Borges 2018; Diaz-Tello 2015; Kukura 2018), it is unclear whether the U.S. will adopt an effective legal framework for OV. Social movements may be a determining factor in the success of such potential moves.

The GN quickly picked up on the growing consciousness and momentum -- extending from social movements in Latin American and the Caribbean -- to “humanize birth” and criminalize OV. Predominately white birth organizations (PWBO) like Improving Birth and Birth Monopoly began to adopt and appropriate the OV concept to build educational resources and to raise awareness (improvingbirth.org.; birthmonopoly.com; evidencebasedbirth.org). It is important to note that these contemporary predominately white birth organizations (PWBIs) focusing on childbirth began long after pioneering activist movements for reproductive justice lead by people of color and indigenous folks.

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11 These legal standards may become even more stringent as many states continue to pass increasingly restrictive abortion law in an attempt to push a constitutional review of Roe vs. Wade.
SisterSong Women of Color Reproductive Justice was founded in 1997 on ideals of reproductive justice for marginalized groups, centering queer communities and people of color (sistersong.net). The group arose from a committee of black feminists during an abortion rights conference and at the same time the National Latina Institute for Reproductive Health became established in the U.S. Critical race and health legal scholar Dorothy Roberts championed the inception of both organizations and the collective reproductive justice movement (2016). In the most recent edition of *Killing the Black Body*, Roberts links the Black Lives Matter movement to reproductive justice based on their common demand that “U.S. society begin to value black people’s humanity” (2016: xxi). In that vein, in 2013, Black Mamas Matter Alliance (BMMA) was established with a focus on racism in obstetrics and the maternal morbidity and mortality crisis for black women (blackmamasmatter.org).

OV activists and researchers often call on a human rights framework to invoke the need for “person-centered” or “woman-centered” care in childbirth as a right of *all* laboring people, yet there is a lack of agreement on how this concept is defined and how to effectively implement it (Great Britain Department of Health 1993; Molina 2016; Afulani 2018; Rubashkin, Warnock, and Diamond-Smith 2018). Tension exists in the U.S. between birth movements centering marginalized folks while focusing on reproductive and birth justice and those supporting dominant groups with birth “rights” goals. This tension is noted by Cristen Pascucci of the organization Birth Monopoly as reflecting a difference in the “sense of urgency” among groups (2019). In a recent podcast, Pascucci frames the problems of maternal health care today as a “spectrum” from maternal mortality (disproportionately impacting black women) to birth injury and PTSD and says, “we [birth advocates] should have a sense of urgency about all of it” (2019). Meanwhile BPs at the margins throughout the world continue to fight for reproductive and birth
justice in both organized and informal ways. My project will help to better describe this tension and uncover possible linkages for solidarity between movements in the U.S. as well as broader international movements to eliminate OV.

Several key points from this review drive my dissertation. First, the concept of OV represents an aspect of global medicalization that is crucial to understand due to far-reaching consequences for people’s lives and societies as a whole. Second, grappling with the framing of this topic by various stakeholders in the early stages of its emergence may benefit movements in building effective strategies for change. Third, U.S. sociological studies of violence in childbirth using an OV framework are acutely needed and foundational scholarship in the field of OV calls for a focus on both micro and macro-level influences (Savage and Castro 2017). The perspective of BSPs and laboring people are critical in understanding the link, between institutional abuse and individual interactions. While BP’s and BSPs’ narratives of abusive birth interactions exist in many countries (Asefa et al. 2018; Cardoso 2017; Dietsch 2010), they are sparse in the U.S. hospital context (Lyndon et al. 2017). To address these gaps in the literature, I conducted a qualitative mixed-methods study including content analysis of scholarly/popular texts related to OV and the web presence of birth non-governmental organizations (NGO’s), as well as semi-structured interviews with BPs and BSPs in the Atlanta area.

The research site of Atlanta provides a socio-political location rich with a racially diverse population and a complicated past (and present) related to birth. Historically, highly experienced Black midwives employed resistance strategies during their work with enslaved birthing people throughout the U.S. South. After legal slavery ended, the racist medical institution in the region continued to exploit the labor and expertise of grand-midwives\textsuperscript{12} for the duration of the Jim

\textsuperscript{12} grandmidwives is an updated term preferred over “granny” midwives.
Crow era of legal segregation. Today Atlanta has a thriving home birth community and birth center established through grassroots efforts in 2017. Notably, two nationally influential birth justice groups, SisterSong and BMMA, call the city home. At the same time, the cesarean section rate in the state is 34.2 (the 10th highest in the U.S), and in 2016 it ranked worst in the U.S. for maternal mortality across races\(^\text{13}\) (ACLU 2018; CDC 2016). Birth culture in Atlanta is representative of both the struggle of BPs to advocate for themselves and BSPs to provide care within an oppressive and dangerous system. This research locale provides a unique opportunity to give voice to diverse narratives within the larger story of the maternal health crisis in the U.S. today. I had two sets of research questions for this investigation. The first set relates to the content analysis portion of my study and the second to the interviews I conducted:

1) Who uses the term OV? How is it defined? What are the most common forms of OV? How is OV dependent on identity and social location? How is the term appropriated in the GN? What tensions exist among birth advocacy/activist groups? How are mainstream activist groups in the U.S. supporting the most marginalized birthing populations? How are feminism(s) showing up in movements?

2) How do BSPs and BPs in the U.S. context understand and interpret transgressions of medical authority and violence during institutional birth? How do they understand feminism(s) as related to birth? What specific strategies do individuals use to navigate contentious hospital birth? What institutional strategies contribute to OV in hospital birth? How might support and trust at the interactional level disrupt medical authority? And how does violence in the form of mistreatment in birth impact well-being?

\(^\text{13}\) White women in Georgia are twice as likely to die from pregnancy related complications than the national average and Black women in Georgia are six times more likely to die than white women in Georgia.
2 CONCEPTS AND METHODS

2.1 Concept Definitions and Language Use

*obstetric violence (OV)*

Obstetric violence (OV) is a multi-dimensional concept. Its origins are rooted in well-defined legal imperatives in the context of some South American nations. In 2015, The international public health literature operationalized this concept outside of its legal meaning with support by WHO to include various behaviors engaged in by BSPs and birth facilities around the world. Additionally, both mainstream and social justice-oriented birth activist groups in the U.S. use this term to describe a range of experiences birthing people have in this country today. While some researchers interested in OV have settled on usage of the term “mistreatment” as noted earlier, this word fails to address the level of direct action and material consequence in its meaning. I choose to use the term OV because it more accurately captures the visceral experience reported by birthing people and references theoretical constructs salient to my study.

*traumatic birth*

Traumatic birth is a medical concept that developed in the psychology, nursing, and childbirth education literature in the mid 1990s. Researchers utilized small samples of predominately middle-class white birthing people from high-income countries and qualitative methods to define traumatic birth. This definition evolved to include any birth that a birthing person subjectively identified as traumatic. In the last ten years, since the introduction of the concept of OV in international public health literature, researchers and other stake holders are discussing the concept of traumatic birth in conjunction with OV and increasingly studies incorporate larger and more diverse samples.
**birthing parent/people/women**

In this study I use the term birthing person/parent (BP) and birthing people/parents (BPs) as overreaching terms to reference individuals who give birth. These ungendered terms are intended to be inclusive and are appropriate in recognizing the full spectrum of folks who experience hospital birth. While I accept the tension in knowing that much OV is inflicted due to misogyny, and that the gendered treatment of birth underpins that reality, it is also important to use language that allows for human complexity and broadens the discussion of birth experiences in this dissertation. While many BPs self-identify as women, as do the BPs I interviewed, some do not. I do not assume the gender of individuals (at large) who birth in my writing. I choose to use BPs instead of birthing women to reference both my interviewees and BPs more generally. I do this for the sake of continuity and to indicate inclusion of my sample in the group of BPs globally who represent a range of gender identities and expressions -- who birth now and always have. Further, I use this language as a meaningful and consistent reminder of complications of gender and sex in birth and OV that warrant critical discussions about feminism(s) in movements of birth justice. Finally, I use expansive language with the understanding that there are moments in time and locales where strategic birth activism focused specifically on the oppression of women using gendered language is necessary and beneficial (Mohanty 2003).

**birth service provider**

It is common in pregnancy and birth healthcare to use the term “provider” only for OBs and Midwives as a hierarchical signifier. I use the term birth service provider (BSP) in this paper to identify any person providing services to BPs in the hospital setting during birth. This includes
any health (para)professional in the space: doulas, nurses, nurse techs, midwives, anesthesiologists, OB/Gyns, and neonatologists, etc. If I use the term “staff” I am usually indicating a broader scope that also includes administrative workers. I accept the tension that as birth service providers and hired supporters for BPs doulas are in a unique position in the BIC. While they may operate on the periphery of the MIC, I see issues of their professionalization and politicization as intertwined with the BIC and feel, at this time, the label is appropriate. When I need to clearly reference hospital-based medically trained BSPs specifically I use the label “hospital BSPs.”

2.2 Methods and Sources: Content Analysis

My methods for this study were immersive and sources came from a range of origins. In addition to interviews and texts from websites, blogs, newspapers, magazines, and peer-reviewed journals, I also listened to a multitude of podcast series focused on birth that exploded over the years I worked on this project. I watched documentaries and short films made by activists and advocates around the world available online too. Many of these podcasts and videos offered direct narratives from different groups of birthing people. I cite these sources throughout my work as both collaborative evidence and counterpoint that inform my analysis. The variation in data type helped me to triangulate my findings and enriched my understanding of the concepts at the heart of the study.

14 Today there is an emerging shift involving a subset of folks in doula roles who prefer the term “birth worker” or “perinatal healthcare worker.” Simultaneously there is a movement to center advocacy in doula work more explicitly.
2.2.1 Data

I gathered the bulk of data for the content analysis portion of my project through ProQuest searches of peer-reviewed and popular articles and Medline searches with full text available in any language. I then reviewed online blogs and podcasts of birth advocacy non-governmental organizations (NGOs) and searched Google for “obstetric violence.” I completed an initial search through ProQuest using the terms “obstetric violence” (N=210 scholarly and popular texts), “obstetrical violence” (N=21 scholarly and popular texts), and “birth rape” (N=115 scholarly and popular articles). This search confirmed my background and literature review temporally, with the concept beginning to appear in publications and online sources in 2008. As such, I conducted a content analysis using popular web-based texts and peer-reviewed literature from 2008 to the present. First, via ProQuest using 18 available databases, I performed two searches (1 for popular and 1 for peer-reviewed texts) using the terms “obstetric violence,” “abuse in childbirth,” mistreatment in childbirth,” and “birth-rape.” Then, I grouped articles into 3 sections, by 4-year increments, from 2008 to 2019. I also completed a search using the term “obstetric violence” using the Medline database as the topic is related to the institutions of medicine specifically. I cross checked the articles from Medline and ProQuest to confirm that I completed a comprehensive survey of the available texts. After getting familiar with the data and establishing high level themes, I chose 10 texts from each of the three time periods in both the popular and peer-reviewed sample to conduct line-by-line analysis (N=60). In addition to the ProQuest popular text search, I also searched for popular web-based articles with Google and chose 5 articles for line-by-line analysis (N=5). Table 1 lists all articles I analyzed, and any quoted media from my sample.
<table>
<thead>
<tr>
<th>Peer Review Texts</th>
<th>Popular Texts and Other Media</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pickles, Camilla. 2015. “Eliminating abusive 'care'.” SA Crime Quarterly; Pretoria. 54: 5-16.-PR3</td>
<td></td>
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<tr>
<td>Correio, Selma Villas Boas Teixeira; Carolline Fontes Campos de Souza Silva Correio, Leila Rangel da Silva Correio, Cristiane Rodrigues da Rocha Correio, Jessica</td>
<td>Articles</td>
</tr>
<tr>
<td>Lauer, Matt, and Natalie Morales. 2015. “So what Better Way to Face My Fear than to Face it Head Or Teeth on.” Today.-POP4</td>
<td></td>
</tr>
<tr>
<td>Meares, Michelle. “Some Home Truths on a Woman's Right to Choose.” The Daily Telegraph, April 06, 2012.-POP7</td>
<td></td>
</tr>
<tr>
<td>“Opinion: There is no such Thing as Birth Rape.” 2010. Parentdish [AOL - BLOG]-POP9</td>
<td></td>
</tr>
<tr>
<td>Freedman, Mia. “Comparing Birth to Violent Crime is so Offensive.” Sunday Telegraph, Apr 08, 2012.-POP10</td>
<td></td>
</tr>
<tr>
<td>Kelly, John, Christopher Schnaars, and Alison Young. “Hospitals blame moms when childbirth goes wrong. Secret data suggest it’s not that simple.” USA Today. Nov. 13, 2019-POP11</td>
<td></td>
</tr>
<tr>
<td>Seals Allers, Kimberly. “Obstetric violence is a real problem. Evelyn Yang’s experience is just one</td>
<td></td>
</tr>
</tbody>
</table>


Dzomeku, Veronica Millicent, Adwoa Bemah Boamah Mensah; Nakua, Emmanuel Kweku, Pascal Agbadi, Jody R. Lori et al. 2020. “‘I wouldn’t have hit you, but you would have killed your baby:’ exploring midwives’ perspectives on disrespect and abusive care in Ghana.” BMC Pregnancy and Childbirth. 20: 1-12. -PR12


eexample” The Washington Post. February 6, 2020.-POP12

Marquand, Sarrah L. "Don't Get Pushy, it's a Woman's Right to Choose." The Daily Telegraph, July 30, 2011.-POP13

Miley, Marissa. “Expectations: Brazil's Cesarean Section Problem: After a Young Mother is Forced to Deliver Via C-Section, Tensions Flare Over a Woman's Right to Choose how Her Child is Born.” GlobalPost, Apr 26, 2014.-POP14

Zadrozny, Brandy. “’New Mom Begged Doc: 'no, Don't Cut Me!': A Disturbing Video shows a Young Mother Pleading with Her Doctor Not to Perform a Forced Episiotomy--and Now She’s Suing for Assault and Battery.” The Daily Beast, June 05, 2015.-POP15


Blogs


Newman, Casey. 2018. “‘The baby is the candy and the mom is the wrapper.’ A call for humanized birth.” Improving Birth.-BG2


Pascucci, Cristen. 2015. “Pregnant Women Ask Court to Affirm Their Constitutional Rights. Hospital claims women lose right to refuse surgery when pregnant.” Improving Birth.-BG5
Dawes-Gay, Elizabeth. 2017. “Motto how the senate’s health care bill will seriously hurt black women.” Black Mamas Matter Alliance.-BG9

Podcasts

Pascucci, Cristen. 2019. “I’m not vulnerable more.” Katherine Dipaulo on alleged sexual assault during labor. Birth Allowed Radio, 32.-PC1
Pascucci, Cristen. 2018. “They wouldn’t let me call it assault because we need to protect the doctor.” Anonymous Nurse. Birth Allowed Radio, 24.-PC2
Dekker, Rebecca. 2020. “Finding the Right Provider and Birth in the Dominican Republic with Leiko Hidaka.” Evidence Based Birth Podcast.-PC3
Dekker, Rebecca. 2020. “Solutions for the Crisis in American Maternity Care with Jennie Josephs.” Evidence Based Birth Podcast.-PC4
Dekker, Rebecca. 2020. “Inclusion for Queer and Transparent Families with Danie Crofoot.” Evidence Based Birth Podcast.-PC5

References
Carneiro, Rosamaria. 2015. “‘Para chegar ao Bojador’, é preciso ir além da dor’: sofrimento no parto e suas potencialidades” / “To get to Bojador, it is necessary to go beyond pain’: suffering in childbirth and its potential.” Sexualidad, Salud y Sociedad/Sexuality, Health, and Society; Rio de Janeiro. 20: 91-112.-PR17
Murray de Lopez, Jenna. 2018. “‘When the scars begin to heal’: narratives of obstetric violence in Chiapas, Mexico.” International Journal of Health Governance. 23(1): 60-69.-PR18

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15 Refers to the historically significant discovery of a route around Cape Bojador - which is considered a dangerous stretch of sea - by a Portuguese Sailor in the early 1400’s.
16 Links included in reference section.
First, to document the entire census of articles, I created a graphic representation of the articles in each source from each period (Fig. 1). Then I noted organizing themes of the articles and tracked the frequency of themes in the texts. I examined the characteristics of the articles in my final sample and noted the country of origin (where data originated) for all articles. I created a map showing frequencies of the peer-reviewed (Fig. 2) and popular articles (Fig. 3) geographically. I also identified themes and connections between themes for all three time periods in the sample and compared and contrasted the peer-reviewed and popular articles' framing of OV and made note of any differences.

My NGO analysis included five popular birth organization websites: evidencebasedbirth.com, improvingbirth.org, birthmonopoly.org, blackmamasmatter.org, nationaladvocatesforpregnantwomen.org. I analyzed the organizations’ “home” and “about us” pages (N=10). Also, I searched the organizations’ blog posts for text and audio content related to OV and choose 5 articles or podcasts that met criteria to analyze (N=25) and 3 “toolkits.” I confined the search for scholarly works to peer-reviewed articles with full-text availability published in any language through the ProQuest Central database. Criteria for removal from the peer-reviewed sample for analysis included books and book reviews. One exception is a book

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17 The articles published in languages other than English were translated with online translation software through ProQuest or through Google Translate. Languages translated into English included Spanish, Portuguese, and French.
that provided especially relevant and timely interview data from the Black Women Birthing Justice research project. I excluded duplicates and articles that mentioned OV non-substantively. I confined the search for popular texts to newspapers, magazines, blogs, and podcasts. I retained articles reporting varying accounts of the same news events or that followed the same story over time.

![Figure 1 Frequency of Peer Review and Popular Texts by Time Period](image)

**Figure 1 Frequency of Peer Review and Popular Texts by Time Period**
Figure 2 Frequency of Peer Reviewed Texts by Country

Figure 3 Frequency of Popular Texts by Country
2.3 Methods and Sources: Interviews

2.3.1 Data

I collected interview data during 1.0 – 1.5 hour in-depth recorded semi-structured interviews with BSPs (N=8) and BPs (N=15). Table 2 shows the demographics and characteristics of BPs and Table 3 shows the demographics and characteristics of BSPs. Every person that I interviewed identified as a woman (N=23). All BPs were married except for one (N=14) and all were heterosexual (N=15). BP ages ranged from 30 – 40 years old. All BPs held some form of private health insurance coverage. I indicate in the tables and in my writing the personal and perceived race and ethnic identities self-reported by participants. I gave all participants a pseudonym to protect their identity and changed hospital names. I identify any doctors named by BPs or BSPs with a random letter.

<table>
<thead>
<tr>
<th>BP Name</th>
<th>Personal Race/Ethnic Identity</th>
<th>Perceived Race/Ethnic Identity</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daisy</td>
<td>white</td>
<td>white</td>
<td>Therapist</td>
</tr>
<tr>
<td>Amaya</td>
<td>white</td>
<td>white</td>
<td>F/T Parent</td>
</tr>
<tr>
<td>Naomi</td>
<td>white</td>
<td>white</td>
<td>Nuclear Engineer</td>
</tr>
<tr>
<td>Kelley</td>
<td>white</td>
<td>white</td>
<td>F/T Parent</td>
</tr>
<tr>
<td>Tabitha</td>
<td>white</td>
<td>white</td>
<td>Nurse</td>
</tr>
<tr>
<td>Emily</td>
<td>white</td>
<td>white</td>
<td>Health Insurance Administrator</td>
</tr>
<tr>
<td>Julia</td>
<td>Latina</td>
<td>Latina</td>
<td>Nurse</td>
</tr>
<tr>
<td>Sarah</td>
<td>white</td>
<td>white</td>
<td>Corporate Business</td>
</tr>
<tr>
<td>Kate</td>
<td>white</td>
<td>white</td>
<td>Advertising</td>
</tr>
<tr>
<td>Nia</td>
<td>Caucasian/African American</td>
<td>ambiguous</td>
<td>Preschool Teacher</td>
</tr>
<tr>
<td>Ava</td>
<td>Latina/Columbian</td>
<td>white</td>
<td>Professor/Entrepreneur</td>
</tr>
<tr>
<td>Claire</td>
<td>white</td>
<td>white</td>
<td>F/T Parent</td>
</tr>
<tr>
<td>Jasmine</td>
<td>Black</td>
<td>Black</td>
<td>College Administrator</td>
</tr>
<tr>
<td>Alexis</td>
<td>Asian</td>
<td>Asian</td>
<td>Public Health</td>
</tr>
</tbody>
</table>
Table 3 BP Birth Characteristics

<table>
<thead>
<tr>
<th>BP Name</th>
<th># of births</th>
<th>Birth of focus</th>
<th>Medical Complications</th>
<th>Induction</th>
<th>Mode of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daisy</td>
<td>1</td>
<td>1st</td>
<td>None</td>
<td>No</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Amaya</td>
<td>2</td>
<td>1st</td>
<td>None</td>
<td>Yes</td>
<td>Cesarean</td>
</tr>
<tr>
<td>Naomi</td>
<td>4</td>
<td>3rd</td>
<td>None</td>
<td>No</td>
<td>Cesarean</td>
</tr>
<tr>
<td>Kelley</td>
<td>1</td>
<td>1st</td>
<td>None</td>
<td>Yes</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Tabitha</td>
<td>3</td>
<td>1st</td>
<td>None</td>
<td>Yes</td>
<td>Cesarean</td>
</tr>
<tr>
<td>Emily</td>
<td>1</td>
<td>1st</td>
<td>High Blood Pressure</td>
<td>Yes</td>
<td>Cesarean</td>
</tr>
<tr>
<td>Julia</td>
<td>2</td>
<td>1st</td>
<td>None</td>
<td>Yes</td>
<td>Cesarean</td>
</tr>
<tr>
<td>Sarah</td>
<td>1</td>
<td>1st</td>
<td>Premature Labor</td>
<td>No</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Kate</td>
<td>4</td>
<td>3rd</td>
<td>None</td>
<td>No</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Nia</td>
<td>2</td>
<td>2nd</td>
<td>Suspected Cholestasis(^{18})</td>
<td>Yes</td>
<td>Cesarean</td>
</tr>
<tr>
<td>Ava</td>
<td>2</td>
<td>2nd</td>
<td>Premature Labor</td>
<td>No</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Claire</td>
<td>1</td>
<td>1st</td>
<td>Maternal Brain Tumor</td>
<td>No</td>
<td>Cesarean</td>
</tr>
<tr>
<td>Jasmine</td>
<td>2</td>
<td>2nd</td>
<td>Postpartum Hemorrhage</td>
<td>Yes</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Alexis</td>
<td>2</td>
<td>1st</td>
<td>Premature membrane rupture</td>
<td>Yes</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Taylor</td>
<td>1</td>
<td>1st</td>
<td>None</td>
<td>No</td>
<td>Cesarean</td>
</tr>
</tbody>
</table>

Table 4 BSP Characteristics

<table>
<thead>
<tr>
<th>BSP #</th>
<th>Profession</th>
<th>Personal Race/ethnic Identity</th>
<th>Perceived Race/ethnic Identity</th>
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</thead>
<tbody>
<tr>
<td>Allison</td>
<td>Doula</td>
<td>white</td>
<td>white</td>
</tr>
<tr>
<td>Violet</td>
<td>Midwife</td>
<td>white</td>
<td>white</td>
</tr>
<tr>
<td>Laura</td>
<td>Doula</td>
<td>white</td>
<td>white</td>
</tr>
<tr>
<td>Carla</td>
<td>Midwife</td>
<td>white</td>
<td>white</td>
</tr>
</tbody>
</table>

\(^{18}\) Cholestasis is a condition of the liver during pregnancy that causes extreme itching and can lead to the death of the fetus.
<table>
<thead>
<tr>
<th>Name</th>
<th>Occupation</th>
<th>Race</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isabel</td>
<td>Doula</td>
<td>white</td>
<td>white</td>
</tr>
<tr>
<td>Martha</td>
<td>OB/Gyn</td>
<td>white</td>
<td>white</td>
</tr>
<tr>
<td>Julia*</td>
<td>Nurse</td>
<td>Latina</td>
<td>Latina</td>
</tr>
<tr>
<td>Vanessa</td>
<td>Doula</td>
<td>Black</td>
<td>Black</td>
</tr>
</tbody>
</table>

*Julia participated in two separate interviews, one as a BP and one as a BSP

**Birthing People (BPs)**

I conducted semi-structured interviews that provided general background about the interviewee and the origin of their thoughts/beliefs about birth. Additionally, I included questions about the participants’ birth and immediate postpartum experience. I asked for the medical facts as participants understood them, as well as about their experience of the birth itself: their treatment during pregnancy, labor, and the immediate postpartum period. I asked participants to focus on the moments of the experience that held the most meaning for them, as this was an effective way to pull out and investigate the most contentious and troublesome parts of the experience. It also allowed participants to think about the most positive aspects of their birth. I posed questions about consent, autonomy, communication and decision making in the hospital, and transgressions of medical authority (See Appendix A – BP Interview Schedule). I asked several questions that explored the support system of the laboring individual and the interactions they had with BSPs during birth. I then asked how BPs thought their race, ethnicity, or any social identity/status might have impacted their treatment, how they would categorize their experience, and their thoughts on the terms “traumatic birth” and “OV”. Finally, I asked them to reflect on the meaning of feminism and birth and if they identified as feminists.
Birth Service Providers (BSPs)

I conducted semi-structured interviews that provide general background about the career history of the interviewee, their thoughts/beliefs about birth, as well as their understanding of their roles as a birth BSP. Additionally, I included questions that asked them to reflect on specific interactions with clients/patients. I also asked questions about consent, autonomy, communication and decision making, and transgressions of medical authority during hospital birth (See Appendix B for BSP interview schedule). Finally, I inquired about whether and what they knew about the terms “traumatic birth” and “obstetric violence” at the end of the interview (if not mentioned spontaneously earlier).

Birthing People (BPs)

I recruited individuals living in the Metro Atlanta/Decatur area who have given birth to a child in the past seven years for the study. Recruiting materials specified that I was looking for people who experienced a difficult hospital birth. Additionally, I contacted local birth professionals in the Atlanta/Decatur area and asked that they share the information about the research opportunity with their clients. I sampled purposefully to include birthing individuals who varied by race/ethnic identity. I initially recruited individuals who previously participated in a community group for first-time moms. I approached these potential participants via an email describing the study. A second recruiting avenue was through a parent listserv of the Centers for Disease Control (CDC) employees and their families and friends. This listserv includes thousands of folks from the Atlanta and surrounding metro area. I asked all potential participants to contact me for initial screening. I included participants with a range of experiences that included conflict or tension between BPs and BSPs/staff/hospital and I screened out those for
whom birth was psychologically troublesome primarily due to disappointment with the outcome (i.e., “I planned for a natural birth but ended up with a cesarean”) as well as those for whom conflict with the hospital or BSPs was minimal.

**Birth Service Providers (BSPs)**

I recruited BSPs in the Metro Atlanta/Decatur area for the study. Recruiting materials specified that I was looking for professionals with at least five years of experience in prenatal/antenatal/postnatal services. I initially recruited contacts known through my professional work in the community. I reached these potential participants through a personal email from me describing the study and a social media post.

### 2.4 Methodological Strategy and Theoretical Background

Using ideas from Dorothy Smith’s *Institutional Ethnography*, my project has a starting point of “actuality” and a methodology that acts as an “unfolding,” revealing the way “things are actually put together, of actual ongoing social organization” (Smith 1996). While I align less with Smith’s insistence on women’s standpoint as unifying, a commitment to my understanding of “sociology for people” includes a focus on the importance of the everyday of people’s lives as a foundation for inquiry (Smith 1996). Childbirth is not an everyday occurrence in individual lives, yet I propose that folks bring strategies as well as general expectations informed by their “everyday” social understandings, to the experience of birth in institutions. BSPs certainly operate in “everyday” ways to navigate their jobs and the institutions within which they work.

I investigate and analyze strategies of agency (and their constraints) during hospital birth to illuminate possible pathways for transformation and with the foundational idea that the structure
of the institution, as well as its operations and range of outcomes have purpose. Further, I work from a perspective that OV on some level exists as an element of this purpose. This argument requires me to refrain from simply observing the institution as a “functioning” objective body separate from people and to instead unpack the material world of the organization that is made of people’s actual “doings” in relationship to each another and to the institution (Smith 1996; Mullings 2006:6). Adopting a standpoint that allows a critical look at the BIC’s “actual” purpose and one that connects institutional operation directly to people, their work, and their relationship is fruitful because we are then unable to detach OV from both its structural and individual agents. Using this perspective, instances of excess death and suffering in the BIC are not unfortunate incidents of an otherwise well-functioning medical system but are evidence of specific practices that produce these very outcomes via a system that relies on human agents sanctioned by state authority to carry on. My combined analysis of existing content and original interviews sheds light on how organizational power is understood by, and interacts with, individuals during childbirth in hospitals today (Smith 1996).

In analyzing peoples’ understandings of OV globally, various frameworks of racism are important. The culture and ideology of racism varies by place and culture. In much of Latin America there is a tendency to attribute racism to a “class problem” that is only “skin deep” (Wade 1997; 2010:96). In all geographic contexts, indigenous and Black and Brown BPs face specific challenges in relationship to the health system and facility-based birth. Scholarship from South America and the Caribbean is especially informative in framing the locally-dependent ways that classism and racism intersect in the lives of indigenous and Black folks (Golash-Boza 2012: 25). I am also indebted to Kemberle´ Crenshaw’s concept of intersectionality and emphasize the idea that various and simultaneous identities have substantive consequences.
within institutions that can disadvantage or advantage individuals in multiple interactive ways (1991). In this project, extending abstracted intersectional theory to an embodied intersectionality is crucial. As Ahmed states, “violence is directed toward some bodies more than others” (2017:34). Naked and vulnerable bodies are subject to institutional procedures and processes in a literal and visceral way during childbirth.

I understand violence in this investigation as operating at the interactional level as well as fundamentally at the macro-level. To position this idea in relationship to OV, I use Galtung’s (1969) concept of structural violence as entrenched and normalized in everyday institutions and the idea pursued by Farmer (2006) that structural violence describes “social arrangements that put individuals and populations in harm’s way” (p.449). Further, theories of race and reproduction are also relevant in this investigation into hospital birth. Dorothy Roberts’s and Patricia Hill Collins’s descriptions of historic and ongoing controlling stereotypes of black mothers and the white supremacist elevation of white motherhood in the U.S. adds a layer to the theoretical lens of the current project (1989; 1997). To be clear, the existence of institutionalized racism, sexism, and heterosexism and the differential impact of these ideologies on laboring people is not in question. Learning more about the multiple ways violence occurs and is combatted and absorbed by those who experience it while giving birth is a goal of this study.

Contemporary theoretical contributions to the sociology of health are also important in this project. The medical industrial complex (MIC) as presented by Simonds (2017), is especially relevant in the exploration of birth experiences today. Considering the increasing reach of fetal and maternal medical recommendations, diagnostic testing, implantation devices (during labor and otherwise), and rate of surgical births, the description of medicalization as imbuing everyday culture and even understandings of self is highly applicable to pregnancy and birth in the U.S.
(Simonds 2017). Additionally, Feagin’s conception of systemic racism (2006) expressed in relationship to U.S. “health care” (Feagin and Bennefield 2013) emphasizes the historical roots and ongoing racist practices embedded in and perpetuated by the structure of the institution of medicine. It is vital in any study of U.S. medicine to acknowledge its white supremacist origins and understand the interest in maintaining white (male) dominance through a system of hierarchical power as foundational to the institution (Starr 1982; Washington 2007). In addition, the power of this medical structure depends on interconnected systems of racism and sexism embedded historically in U.S. society at large (Davis 1981).

The focus of WHO on maternal health has galvanized research and activism related to birth and OV around the globe. This action is parallel to and often extends from the globalized spread of feminist ideas and gender justice as well. These processes are apt to be understood using dynamic transnational feminist and gender inclusive perspective. The landscape of global health is more interdependent than ever before, and it is crucial to keep in mind the influence of worldwide initiatives and policies on birth culture and practices. In this investigation, I employ theories of globalization interpreted within a “feminism without borders” framework, as articulated by Chandra Mohanty (2003). This strategy for praxis and research emphasizes “political and ethical feminist solidarity” over surface assumptions of unity based on sex or gender (Mohanty 2003:3). As Johnson’s qualitative work on the North-South politics of birth illustrates, culture, race/ethnicity, and economics contextualize pregnant and birthing people’s desires and the accessibility of those desires within and between communities as well as countries (2014).

Further, I recognize the globalized medicalization of birth through international policy implemented by health systems has led to increased romanticizing of the “third world birth” by
the white middle class along with attempts to adopt similar practices (Johnson 2016:58). The western gaze of colonialization applies to the appropriation of the concept of OV in high-income countries by dominant white birth activism (using a patients-rights perspective), where mostly white middle class women can imagine themselves and their struggles as similar to that of “the third world woman” (Mohanty 1984:333). The tension between access and privilege within health systems, birth work, and in birth culture contributes not only to disparities in health outcomes, but it also shapes every BP’s ability to engage in birth with agency in the fullest sense.

2.5 Analytic Approach

Articles and web-based texts

I employed grounded theory strategies to identify emerging themes and the conceptual framing of OV from the data. Guided by prior research into the development of traumatic birth as a medicalized phenomenon, I entered the field of scholarly and popular texts to begin my study. In my first phase of data collecting and textual field work I sifted through texts and NGO sites until I reached saturation. Next, I combed through the texts and analyzed the data for commonalities, linkages, and differences (Strauss and Corbin 1998; Thomas 2006). In this stage, I made notes for each piece of text and then for each grouping of peer-reviewed and popular data as well as each website. Focusing on social/cultural considerations, I examined the framing and various definitions of the concept of OV in all sources. I examined the texts for common themes and differences, particularly authority-agency, medicalization, and potential paths toward birth justice. Additionally, I explored how various agents understand and use emerging concepts related to OV in discourse.
My project is guided by several principles of Grounded Theory Method (LaRossa 2005; Strauss and Corbin 1998). I employ the fundamental idea of emerging themes in the initial coding process of the articles. Using NVivo as an organizational tool, I used a line-by-line coding strategy and an initial open coding process for each text to contextualize the messages at the most substantive level (Glaser 1978). I made notes as I worked through my line-by-line analysis highlighting theoretical and material connections in the texts around the concept of OV. I began writing more detailed notes as an iterative process after line-by-line coding of peer-reviewed texts and ten interviews with BPs (N=7) and BSPs (N=3).

*Interviews*

I audio recorded the phone interviews with a recording app, and then uploaded them to Dropbox. I used a grounded theory strategy to code all interviews and began transcription after I completed three interviews. I used sonix.ai transcription for initial transcribing and then listened to the interviews at one quarter speed to clean up them up. For each interview, I made notes and memos after the transcription process regarding themes and commonalities in each of the cases. I also made note of medical terms and new concepts. I isolated themes within individual interviews and then analyzed them comparatively across interviews. I performed the second round of coding by group (BPs and BSPs). In this round, I identified the most salient themes, condensed overlapping codes, refined similar codes to create meaningful hierarchies when appropriate, and compared themes across groups. The interview data provided first and second-hand accounts of material experiences of hospital birth in Atlanta. Much of the testimony corroborated and enriched established themes from text analysis. In addition, interviews added
important reflections on the subjective and medical experience of navigating the BIC during a
difficult birth, and thoughts on conceptual terms from the literature.

A final note on analysis, in this research I recognize that I cannot compare one individual
experience of violence in obstetrics to another -- between or within country contexts. I also
acknowledge the vastly different environments and health stresses encountered by BPs as
meaningfully differentiating their experiences. I hold these differences in mind simultaneously in
this analysis knowing that there is no possible way to universally sort them.
3 OV: CHOICE WORDS AND LIVED EXPERIENCE AROUND THE WORLD

Texts from my content analysis came from 5 continents and 29 different countries. The bulk of peer-reviewed texts came from and focused on the GS (N=108). The GN (N=37) represented a smaller sample from primarily Europe (N=12) and the US (N=15). Twenty-eight sources in the content analysis contained themes of globalization. With the globalization of facility-based birth came the globalized effort to name and understand OV. Interested actors expanded the concept of “OV” from its legal origins in South America, rooted in a framework of gender-based violence and largely based on over-medicalization. In the past two decades, researchers set out to describe abuses and mistreatment in childbirth in various contexts and under the governance of a multitude of nation-states. Scholars, BPs, advocates, and other stakeholders around the issue sought to define and operationalize the phenomenon and its contours (N=43). Complexities of the concept contribute to the focus on politics of language around OV and my interviews provide insight into how this language fits or does not fit everyday understandings of contentious hospital birth in the U.S.

3.1 Defining OV: What is Obstetric Violence?

A bulk of texts focused on defining the concept of OV and its various elements. The urgency to define OV arose from a collective response to address reports of abuse precipitated by WHO initiatives to reduce maternal mortality. An initiative against OV, which the WHO labeled “disrespect and abuse” (D&A) began in 2015. Many authors highlighted this remarkable globalized effort (N=26):

Disrespect and abuse of women during labor and delivery has become an increasingly recognized phenomenon over the past decade. Global public health norms now explicitly condemn such practices, acknowledging them as both a
violation of a woman’s rights and also, instrumentally, as a deterrent to the use of life-saving facility-based labor and delivery services.... There is growing global commitment to addressing this challenge, which has been buttressed by policy statements from the World Health Organization, the Lancet and notably the White Ribbon Alliance’s 2011 facilitation of the Respectful Maternal Care Charter, a global consensus statement on a positive vision for respectful maternity care with a definition of disrespect and abuse and the corresponding rights. This Charter has been translated into eight languages and shared among providers, health managers, and advocates, and is anchored in United Nations and other international commitments signed by most national governments (Burrowes et al. 2017-PR1).

This example is illustrative of the multiple layers, mechanisms, and organizations contributing to the globalization of the concept of OV (referred to here as D&A); through research, the creation of “global health norms,” and institutionalized international policy response. The excerpt also shows a short list of the range of political alliances and organizations emerging in the last decade putting forward statements and policy recommendations in an attempt to address OV. While a plethora of interest in creating policy and standards in maternal service provision exists, it is unclear how critically groups are examining the issue and how effective they will be in changing practices to truly impact material experiences for BPs. Notably, only one article in this sample focused on analyzing global health networks around the issue and how they might work together best: “global health networks need tools to help them plan successful campaigns and evaluate the impact of their work, as well as to coordinate and reinforce each other’s efforts” (O’Conner McGowan and Jovilet 2019-PR2). Authors across sites with a stake in the conversation, used various language and many names to describe “OV” in texts and appropriated the concept of OV in contexts for their purposes.

While violence during pregnancy and birth has always existed, people around the world picked up and retooled the contemporary concept of OV beginning in the early 2000s in an unprecedented way. It is important to note that OV as it is originally defined constitutes the following violations as listed by Fernandez in a popular article:
The following acts implemented by health personnel are considered [OV]: 1) Untimely and ineffective attention of obstetric emergencies; 2) Forcing the woman to give birth in a supine position … 3) Impeding the early attachment of the child with his/her mother without a medical cause … 4) Altering the natural process of low-risk delivery by using acceleration techniques, without obtaining voluntary, expressed and informed consent of the woman; 5) Performing delivery via cesarean section … without obtaining voluntary, expressed, and informed consent from the woman (2013-POP1).

Much of the violence in this definition refers to specific issues of medicalization and patient rights covering poor quality of emergent care; lithotomy birth position\textsuperscript{19}; separating babies and BPs; and requiring informed consent for procedures to augment labor and cesareans. These core aspects of OV touch on the majority of experiences noted in middle and high-income countries and some are also common in low-income countries. Strikingly, studies from low-income contexts were much more likely than high and middle-income countries to report incidences of outright physical abuse like “hitting, slapping, and pinching.”

The expansive explication of OV globally included many projects of renaming and redefining. Pickle’s remarks on the “nascent global trend to act against OV:” “[T]he term is being used by a body of commentators and activists beyond Latin America to describe a list of inappropriate practices that constitute [OV]” (Pickles 2015-PR3). Authors often acknowledged the extension and appropriation of the term and the roots of the concept in Venezuelan law. Popular sources (N=9) and peer-reviewed texts (N=8) were equally likely to cite the origins of the concept, and many recognized the original framing of over-medicalization coming from the movement to humanize birth.

\textsuperscript{19} Lithotomy position involves lying on your back with legs bent at a 90-degree angle with the support of footrests attached to the bed or human support.
The meaning of terms and the movements they were connected to was important to scholars. Pickles hones-in on the difference between the purpose of the humanized birth movement and laws against OV:

According to Dixon, while the humanised birth movement primarily focused on changing medical protocols, the movement against OV identifies certain protocols as violence and “not just less-than-ideal practices carried out by unknowing but well-meaning providers” …. Furthermore, research … demonstrates that the term “obstetric violence” is being used to describe a wide range of inappropriate obstetric care, which spans basic verbal abuse to serious and intentional instances of physical assault (emphasis mine) (Pickles 2015-PR3).

As noted here, folks ascribed types of mistreatment to the term OV that were not outlined in its formation. Pickles also notes the distinction Dixon makes between resistance to over-medicalization by “well-meaning” providers and the emerging resistance to violence in birth ranging from “basic” verbal abuse to intentional physical assault. Making a case that OV can reach the legal standard reflected in this language is important to the contingent of people seeking to criminalize it in the U.S. and other countries with common law systems. Most legal scholars used the term “OV” while public health researchers most often used the term “mistreatment” or “disrespect and abuse” (D&A) to describe the same “range of inappropriate obstetric care” noted above. Public health scholars were less concerned with issues of over-medicalization as much of the data came from lower income countries where issues of strained resources and access demanded prioritization.

Scholars agreed that unequal distribution of power is crucial to keep at the forefront of any conversation about OV. The tension around meaning and power emerged when researchers attempted to measure and define instances of OV:

As the comparisons between observation and self-report below imply, these are essentially measuring two different -- but both relevant -- aspects of the social relationships that constitute health system dynamics, rather than being two
alternative ways to quantify one unified, sharply delineated thing called D&A (Freedman et al. 2018-PR4).

Importantly, Freedman and colleagues note that attempts to measure OV (here D&A) must be founded in the understanding that complicated “social relationships” are at play in the “health system dynamics” that contextualize OV. All perspectives and subjectivities are crucial to understand, especially in ways that illuminate relational pathways between BPs and BSPs and their importance in health outcomes and well-being. The usefulness in gathering data from various perspectives using different methodologies emerged in the texts as researchers wrangled with the broad usage of terms and the complexities teeming within any bureaucratic attempt to pin down OV. A researcher analyzing OV in the context of Ethiopia comments: “Poor clinical care, whether intentional or not, is not a phenomenon that fits neatly in the categories of abuse defined in the Respectful Maternity Care Charter” (Burrowes et al. 2017-PR1). Further, cultural and political variation presented a challenge to the global effort of accurately describing rates of occurrence. Public health researchers (N=6) found the failure of facility-based BSPs and BPs to recognize OV in violations of autonomy like “denial of birth accompaniment and lack of choice in birth positioning” problematic (Burrowes et al. 2017-PR1). Both popular and peer-reviewed texts nodded to the inconsistent quality of various stakeholder’s awareness of OV and the nuance necessary in attempts at definition.

Much of the data from early public health studies came from low-income countries. In time, a theme of identifying and understanding “OV” and “mistreatment” in middle and high-income countries surfaced. Data from PWBOs revealed a consistent and transparent effort to inform BPs in the U.S. about OV and advance a particular definition meant to broaden ideas of what constituted it. A popular birth blog invokes a human rights frame to emphasize that “violations and atrocities” are not just committed by “third world dictators.”
Believe it or not, human rights violations during pregnancy and childbirth are a huge issue in this country -- one of the wealthiest nations on earth…. You know those examples of mistreatment…. The yelling, being ignored, coercion, and having procedures done to you against your will? Those are all human rights violations and they happen every day in every hospital in this country (Newman 2019-BG1).

The author compares the U.S. to low-income countries run by “dictators” to “shock” readers into understanding that less direct abuses like coercion and consent (that likely happened to them) also fall under the umbrella of mistreatment. Similarly, another U.S. mainstream birth website informs visitors that “OV does not necessarily mean physical force” (birthmonopoly.org) and links OV to bodily autonomy and decision making. The blogger appeals to the acceptance of globalized authority stating that this conception is legitimized and called “disrespect and abuse” by the WHO. Attempts like these from PWBO to align with BPs globally speaks to the constant pull to center whiteness and represents a “western gaze” cast with desire to benefit from the current focus on perinatal health more broadly.

Most recently researchers from the U.S. joined in the growing movement to bring to light OV in high income countries. An author reports evidence from a 2013 U.S.-based study:

> Physical abuse was uncommon, but verbal abuse and failure to respond to requests for help were the most common types of reported mistreatment; rights to information and autonomy were apparently disregarded…. While the overall rates of mistreatment are lower in our US sample than recent studies report in low resource settings, they are still unacceptably high for a high resource country given a cultural emphasis on autonomy, gender equity, human rights, better working conditions for providers, and resources for training (Vedam et al. 2019-PR5).

Overlooking the history of the health system in the U.S., the authors point out the failure of this country to live up to perceptions of “exceptionalism” despite a plethora of resources. Overall, there is evidence that BPs in high-income countries do experience a range of OV and most urgently we know that BPs from marginalized groups are affected disproportionately.
With the push to contextualize OV in various settings, the politics of naming and accounting for OV came up in middle and high-income countries where the medicalization of birth is high for BPs with access. The terms used to describe contemporary understandings of OV created conversations about appropriateness, meaning, and usage as indicated by an author in a perinatal education journal who lists the various terms to describe “maltreatment” as “abusive behavior, negligence, ill-treatment, disrespect, and dehumanization.” The author mentions the term “OV” only to say that it “appears in articles of law” (Levesque et al. 2018-PR7). Scholars and popular contributors alike shared the hesitancy to use the term “OV” outside of the legal realm objecting to its directness and expanding range of use. For example, on the show *Good Morning America*, Kathie Lee Gifford relays a story about a Venezuelan medical student posting a selfie with a woman before the woman’s cesarean with the comment “Lady, I can deliver your baby, but first let me take a selfie.” This story was framed as “OV” by activists in that country, who began a petition to implore the hospital to sanction the medical student: “Kathie Lee Gifford: I don't know that violence is the right word. That's just incredibly rude…. And unethical (Lauer and Morales 2015-POP4).” Kathie pushes back against the language of violence in obstetrics and seeks to reframe the behavior as “unethical,” and “just” rude. The resistance to calling offensive acts perpetuated by medical personnel “violent” partly resides in an internalized value of prestige attributed to the profession of medicine. Minimizing degrading behaviors therefore upholds the integrity of the medical institution while attributing OV to isolated incidents of individuals making poor choices. As in other institutional settings, those with power are given the benefit of the doubt while the burden of proof lies with those objecting.

Unsurprisingly, the legitimacy of evidence brought by BPs was questioned when individuals and organizations used the term “OV” to describe birth experiences. For example, a
group of organizers attempted to establish the existence of such experiences within the Italian Health System (IHS) by bringing a document before the Italian Health Ministry in 2015. When the Ministry refused to acknowledge the group’s documentation of “OV” due to a lack of evidence, the birth advocates created Osservatorio sulla Violenca Ostetrica Italia (The Observatory of Obstetric Violence in Italy) to collect more. Government institutions in that country refused to assist in the collection of data, so the group eventually partnered with a private survey agency (Doxa) to interview birthing people. After publishing the results independently, the organization received scrutiny over its methods and motives. Professional groups and government officials framed its activities as “misunderstanding” and “mystification.”

A letter signed by objectors appeared in an Italian journal:

It is supposed that 424 women, who gave birth over a 14-year period, were interviewed by the Doxa but it is not clear how they were enrolled and/or selected…. These interviews were commissioned by Battisti, Skoko, Ravaldi, Ceriçco, who had prepared the questionnaires. The objective of the survey already emerges from the name identified to describe the phenomenon that combines the attribute “obstetric” to the word “violence,” determining a serious effect of social alarm as well as damaging the image of the [national health system] NHS and the reputation of the professionals working in this medical area (Scambia 2018-PR6).

The array of opponents within the “NHS” protested against the unscientific and relatively small sampling of participants for the report as well as the usage of the term “OV.” They focused on these issues (many they created) to justify invalidating the cases. The health system in Brazil also pushed back on the term “OV”:

In May, Brazil’s Ministry of Health issued a directive for the government to stop using the term “obstetric violence” in public data and guidelines that describe these situations. A backlash ensued, which pushed the ministry to concede that women are allowed to use the phrase to talk about the topic. It didn’t change how the government itself used the term, however (Bondioli 2019-POP3).

In the end, the Health Ministry “allows” Brazilian individuals to use the term “OV,” but the government does not accept it. Finally, when confronted with testimonies of OV collected in
Croatia, a popular author highlights the denial of the Croatian health minister: “[He] suggested the story was a figment of her imagination: “This is not how it’s done in Croatian hospitals. You can give me your medical records if you want and I’ll take a look” (Twigg 2019-POP5). This is an example of the way “experts” commonly let BPs know that they were simply confused about their birth if they had any complaints.

Language around OV showed local specificity. For instance, the term “birth rape” came up significantly in the popular texts for a limited time period (2010-2015) especially in the UK and AU where there is less governmental enforcement of specific language. BPs who used this term felt an extreme loss of control and experienced birth as particularly dehumanizing as corroborated by BSPs:

[N]urses frequently used phrases such as the “physician violated her,” “a perfect delivery turned violent,” “unnecessary roughness with her perineum,” “felt like an accomplice to a crime,” or even “I felt like I was watching a rape” (Fernandez 2013-POP1).

A BP quoted in a newspaper article provides her perspective of this kind of “unnecessary roughness” stating, “He was tugging and pulling my vagina in ways I could barely believe were happening.” Karalun defines this BPs description as “birth rape” due to the BP being “physically violated in this bodily area.” (Karalun 2019-POP6). Meares adds the elements of active dissent and physical restraint to the idea of what constitutes “birth rape,” saying, “Some people report being held down, procedures performed on their most intimate area without consent while screaming out ‘No.’” (Meares 2012-POP7). Lack of consent, active dissent, physical restraint, and physically “rough” and insensitive treatment by BSPs were key to understandings of birth as assaultive. There were two examples of BPs comparing their birth experiences in the hospital to past assaults. An excerpt from a letter written by Kimberly Turbin was quoted by Heyes-Klein in a popular article:
So, then after he yelled at me he cut my vagina 12 times…. A little cut turned into Dr. A’s horrific rage against me as a human being…. I wanted to cry so badly, and I was so horrified while he was cutting me. I could not believe after explaining that I was raped twice that I was going to experience Birth Rape under your care (Hayes-Klein 2014-POP8).

Hayes-Klein used this testimony to support the appropriateness of BPs comparing assault during birth to rape. Authors acknowledging similar claims by BPs argued for their validation by using BP’s own words and explicitly tying elements of physicality and lack of consent inherent in rape to OV in the medical setting. Goer quotes a BP with a history of sexual assault who recounts her traumatizing experience during labor. The BP had an epidural that limited her ability to “keep [her] legs up!” as the nurses and midwives implored:

They grabbed my hips and forcefully moved me around into the position they wanted me in, without asking. They just did it…. This forceful manipulation of me triggered a memory in me of being gang-raped at 15 years old…. [During the rape] He kept yelling “keep your legs up bitch!” and I couldn’t…. During my son’s birth the words the nurses and midwives yelled at me and the ways they manipulated my body was so similar, it was if the rape was happening all over again. It was terrifying (Goer 2010-PR8).

The embodied memories of “numb[ness]” and helplessness in both circumstances as well as similarities in messaging from BSPs contributed to the BP’s analogy of birth and rape. Using the testimony of a rape survivor and the gut-wrenching parallels drawn between that experience and birth, Goer provides an effective rebuttal to arguments by some in popular culture who assert that using the term birth rape lessens the experiences of rape victims. The number of authors validating the use of the “birth rape” term (N=6) in this sample was roughly equal to those critical of the term (N=5).

The usage of the term “birth rape” caused conflict and not surprisingly created a backlash among popular writers defending medicalized birth and BSPs. Critics were wholly offended by the reference to a sexual violation, regardless of the connection to power and loss of autonomy.
that the concept is meant to express. A particularly memorable critic assumes that BPs using the term were largely referring to “a birth that wasn’t exactly what a mother had in mind.” The idea that BPs were exaggerating their trauma was common: “[I]t is wrong to diminish the plight of survivors of sexual assault by calling it rape. Co-opting the language of one class of victims only serves to diminish any real trauma suffered by another” (Parentdish 2010-POP9). The author, who is “sorry, but babies come out of your vagina,” points to the egregiousness of BPs referring to over-medicalization as birth rape thereby minimizing the trauma of rape survivors.20 Detractors framed the usage of the term in the context of medicalized birth as both demeaning to women and sacrilege. The tension around who “deserves” to be called a victim also underpins policing the ways BPs can describe their experience in order to preserve the “sanctity” of the medical establishment. Similar to the reaction around the term “OV,” the term birth rape was often seen as a personal afront to medical professionals. Freedman, writing for an AU newspaper, claims using the term birth rape turns BSPs and the institution of medicine itself into “the enemy” and asks, “How have attempts to save the lives of mothers and babies become confused with violent crimes?” (Freedman 2012-POP10). The connection to criminal behavior made in this statement is noteworthy and is exactly what some scholars were interested in sorting out.

Scholars commenting on efforts to criminalize OV in countries outside of Latin America suggested that specific actions satisfied the requirements for OV if they qualified as assault by fulfilling a legal standard more stringent than that of malpractice. In regard to the Kimberly Turbin case, a U.S. lawyer explains that battery is “a pretty extreme characterization of a

20 In my sample I did not encounter evidence of BPs using the term birth rape in this way.
doctor’s actions,“ but may hold if other parameters are met -- such as lack of consent and restraint (Grant 2017-POP2). The intricacies of violence during birth and language that encompasses accurate meaning both in and out of the court room demands critical attention.

The conceptual layers of OV cross arenas of medicine, public health, law, and activism. Defining OV in a way that allows flexibility for various contexts and subjectivities is not without conflict. There is a lack of consensus across sites and actors about what constitutes OV and the data that is most lacking in consensus is that coming from birthing people themselves:

[O]ur partnership approach was aimed at clarifying the expression [OV] with a view to increasing recognition of the various manifestations widely reported by many women. However, there is still no consensus on this recognition, both in practice and research settings and among women…. The following question should be raised: are women comfortable with the terms “obstetric violence”? (Levesque et al. 2018-PR7).

In the next section I share findings from my interviews with BPs and BSPs on this topic.

3.2 Everyday Perspectives: Mistreatment and Abuse, OV and Traumatic Birth

mistreatment and abuse

After talking in-depth about their hospital birth, I asked BPs to reflect on how they would categorize their experience and whether they believed any part of it constituted mistreatment or abuse. Most BPs (N=8) immediately agreed that their hospital births did. For example, a midwife swept\(^\text{21}\) Tabitha’s membranes without prior knowledge or consent affirmed without hesitation that she considered an absence of consent to be abuse. BPs interviewed who specifically noted neglect as part of their births (N=3) had different thoughts on whether or not it qualified as mistreatment. Daisy had a precipitous birth and labored mostly in the waiting area and public

\(^\text{21}\) A painful procedure that is used to induce labor where the provider “sweeps” their finger between the amniotic sac and the uterus.
bathroom after staff at the front desk dismissed her and her partner. She states, “Yeah. [I was mistreated]. I will put it in the category of neglect.” Kate also experienced a lack of support due to the effects of a staff shortage during her hospital birth. She felt that a nurse disregarded her requests to labor in an effective manner and forced her into an epidural:

Kate: I would describe it as…. I mean, like a neglect. Yeah, it was definitely she was not listening to what I needed or my cues and she had very little concern for me as the patient…. So yeah, I mean, I would say that it was a mistreatment, you know?.... I felt like I kind of got corralled into something I didn't necessarily want.

Interestingly, for Kate, coercion to accept intervention falls into the overall category of neglect via neglecting her autonomy. Emily, the third BP who reported neglect quickly describes her experience as neglect yet is decisive that it is not mistreatment: “Neglect. I wouldn't say abuse or the other one [mistreatment]…. Not mistreatment. I think it was just overall apathy for what was going on with me.” Emily would not call the lack of concern from BSPs mistreatment precisely because it lacked action and intent even though their inattentiveness led to rising blood pressure and an emergency birth. The various perspectives on the concept of neglect and what qualifies as mistreatment or abuse from BPs points directly to findings from texts about the complexity of OV and the difficulty in capturing the frequency of its occurrence.

Adding to the depth of the concept, several BP explained their understanding of mistreatment by specifying the difference between physical and verbal -- or “psychological” -- abuse: Ava: “I would categorize the way that that nurse treated me in … as mistreatment. I would. The being unheard -- I think that's me being mistreated for sure. It's not physical, it’s verbal. Right? Like you don't need to be physically mistreated for it to be that.” BPs had strong recognition and consensus that not being heard was a form of mistreatment. Disrespectful or rude treatment defined by the attitude of hospital BSPs was less consistently categorized as mistreatment by interviewees:
Ava: I think that I had plenty of interactions that felt that it was just not appropriate behavior or that it was not…. What's the word I'm looking for? That they were insensitive to the scenario -- to the situation because I think that these are people that do this every single day in and out in and out.... They see hundreds of people.

BPs understood that the “everyday” doings of hospital BSPs were in conflict with their desires to be cared for in a personally connected way. After more thought on “violence” in birth Ava brings up a situation involving an unconcerned midwife and a very painful cervical exam:

Ava: [The midwife said], “Okay, I'm the midwife here and I'm going to check you”… and I said, “Okay fine.” Claudia, I had never experienced something that painful! She put in that speculum. I was yelling. It was horrible … she finished the exam and … I was bawling. And I was just like, “This was horrible” -- and she didn't acknowledge it…. The way that she acted was …[to] give me a pat on the back like, oh, I'm so sorry [sarcasm]. I would give her the stink-eye every time I saw her. I was like, I do not want to see you ever again woman.

The “insensitivity” that Ava speaks of is a prominent theme in reported cases of OV and it often co-exists with other more explicit behaviors by staff and hospital BSPs. The lack of BSP awareness or effort to acknowledge obvious physical and psychological suffering of BPs was an indication of clear mistreatment for many.

In contrast, Nia who experienced a cesarean with inadequate anesthesia and care that was brusque and unsupportive does not categorize any part of her birth experience as mistreatment: “I don't know if it [was] mistreatment ... I wouldn’t use the word mistreatment. The only thing I could say that was questionable was with my son’s circumcision. But other than that no.” Nia refers back to physical injury (a botched circumcision that became infected and required a revision) as an example of possible “mistreatment,” but does not consider her suffering due to insensitive providers as sufficient for the definition. Kelley also wrangles with the different parameters of physical and verbal mistreatment when considering her birth that began with a coercive induction:
Kelley: I wouldn’t say anything physical and it’s kind of a gray area to me as far as kind of fear-mongering -- if I would really say that was mistreatment or not?.... I don't think it was with bad intentions that they said it, but I also don't think it was the right way to do it … it was traumatic to me for sure, but I don't know if I would qualify it as mistreatment.

Kelley considers the medical objective of her BSPs when deciding whether she felt she was mistreated. For her, defining physical violations as mistreatment is clear but psychological mistreatment must meet standards that require intent as well as “long-term” duration. Of note, her trauma from hospital BSP coercion tactics is not sufficient for her to describe them as “mistreatment.” Yet, when I reframed the question as a “rights” issue and asked if she felt like her “patient rights” were ever violated, she confirmed they were.

Kelley: Yeah, because I wasn't informed. I wasn't informed about options, and to me that's a big part of patient rights … throughout the time I was in the hospital, I wasn't given any options until I asked for them or until I pushed back and said, “I don't want that.”

Kelley’s response was quick and confident when I asked this question. Sarah had stronger feelings about hospital BSPs coercing her during labor and did not need a “patient rights” framing to come to that understanding: “I would say [Dr. A] wagging her finger in [my partner’s] face was probably mistreatment …that felt like coercion. I mean, I think the whole [experience with pregnancy and labor] is abusive.” She then brings up interactions she had with hospital BSPs early in pregnancy when she suffered the loss of one of her twins:

Sarah: It was … dismissive of my feelings from the very beginning when I asked [Dr. B] to tell me whether or not I was carrying the B sack [twin] and they said it doesn't matter. That's emotional abuse. It does matter! I'm telling you it matters. Read the fucking ultrasound!

BSPs denied Sarah’s explicitly voiced desire to have complete information about her body because it was inconsequential to them. This direct refusal by BSPs to acknowledge Sarah’s bodily sovereignty or respond to her needs rose to the level of emotional abuse, for her,
regardless of intent. BPs’ emotional responses to their hospital births ranged from anger and sadness to resignation and justification. Importantly, every BP distinguished between their subjective feelings and the objective events of birth.

Some BPs I interviewed (N=7) considered the events of their medical birth encounters to fall under the larger umbrella of what is to be expected in hospital birth:

Julia: I don't think it was mistreatment. I think it's just that cascade of interventions. I think I just followed it to a tee…. I think there was no turning point once I basically got admitted, you know? It was just everybody doing their job…. Nobody was rude or mean to me everybody was very apologetic when I was in pain or whatever.

Julia implicates over-medicalization as an inescapable automated force that takes over once the hospital threshold is crossed. Interestingly, she internalizes this cascade as something she “followed” even though she described actively resisting interventions for much of her labor. Further, she takes into account the amicable attitude of hospital BSPs as a factor in excluding the experience from that of mistreatment. Taylor gave birth in the same facility without her partner present and experienced a precipitous birth and unnecessary cesarean under full anesthesia:

Taylor: I would just say [the BSPs] were more engaged in their plan than mine. I wouldn't say I don't want to say it was mistreatment because I can't say that in all honesty.

CT: Do you think that they were respectful of your rights as a patient?

Taylor: I think they did what they needed to do to protect themselves more so than what I wanted...would have wanted.

Even when I reframed the question with Taylor as one of patient rights to circumvent the issue of intent, she does not see the lack of engagement in supporting her autonomy as mistreatment but instead as justifiably (and expected) defensive and medically-centered practice. In this way, BPs often did not see coerced and forced medical procedures during birth as mistreatment because they were part of the hospital status quo. In order to warrant the label of mistreatment, BPs often understood experiences as needing to fulfill the requirement of ill intent or involve
malpractice/medical mistakes that led to physical damage. For instance, Claire, who was in a unique situation due to going through pregnancy and labor with a brain tumor, experienced brusque treatment and was separated from her baby without explanation:

Claire: It's really hard for me -- like if pressed -- to come up with an answer to that, you know? I mean again brain tumor or not...there are a lot of things that I...wish that the hospital had done differently, but I don't know that it's anything that I would be angry enough about to ever complain about since nothing went wrong health wise. It's like you can take a little bit of an emotional beating but had we taken any sort of a physical beating I would have raised issue with it.

Claire’s thoughts were definitely underscored by her medically complicated situation, but others shared the idea that if they “got out” of hospital birth alive and relatively healthy, they had nothing to complain about. Labelling their medical encounters with birth as “mistreatment” was seen as a complaint and indicated they were, on some level, “officially” charging the BSPs or hospital with some wrong-doing.

A shift change occurred during Alexis’ induction and she believes hospital BSPs changed the Pitocin plan at that point without her knowledge. The nursing staff denied her pleas to turn down the medication and she was instructed to “hold her baby in” for several minutes:

Alexis: I think mistreatment makes it sounds like a legal term -- a legal issue. I probably wouldn't.... It sounds like the beginning of a legal process.... No, because I wasn't given the wrong medication.... I can't even say that they gave me the wrong dose of anything.... [I]t's possible that [the BSPs] decided to make a different case, but they just didn't communicate it to me which I think is just poor care. I wouldn't say I got poor medical care because it wasn't like.... I wasn't injured or anything... I definitely felt like I was not valued as a person. I felt … traumatized.

It is important to consider that what remains unknown about Alexis’ story is what keeps her from feeling certain about whether she was mistreated. She later mentions that she hasn’t asked for her

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22 This physiologically impossible task is often given to BPs when they are in the transitional stage of labor but an MD is not available or the room is not prepared. A well-known case in the U.S. involved a similar situation that resulted in permanent injury to the BP and was one of the first cases of maternal birth injury successfully litigated (Nathan 2016).
medical records because she would rather not know: “I'm kind of scared to find out what's in there [laughs] to validate everything as true. So, I mean I'm kind of leaving it as…doubt.” With a rigidly legal conception about mistreatment, “not knowing” is a coping strategy that allows Alexis to maintain the narrative that what happened was a communications problem akin to poor customer service and not poor medical care. Again, when I frame the question in terms of patient rights, her answer is immediate and clear.

CT: Do you think that your rights as a patient were upheld by the medical team?
Alexis: No, I don't. [laughs] Because I should have been able to have a conversation. I should have been involved in my care. There’s something called patient-centered care like I'm supposed to get it....there’s all this research and all this talk about advocating for your care…provider communication. You know? Those are real things. [My patient rights were not respected.] Not at all!

Alexis easily assigns her experience to a patient rights violation. This differentiation between medical care and patient care was a strategy used by several BPs in the sample to understand their hospital birth and was discussed in texts as well. Pickles points out this nuance in the ways BPs understand their care during birth existing as an obstacle to addressing OV legally in South Africa:

Further, these common law crimes might not be seen as adequate mechanisms to remedy the distinct harms experienced at the hands of medical practitioners during pregnancy and birth. This might be the case because the harm is taking place in a medical “care” and life-giving context, and as long as a pregnant person and baby survive birth, medical care could be considered to have been sufficient (emphasis mine) (Pickles 2015-PR3).

Based on the evidence from BP interviews I would agree and add that contingent notions of what constitutes “harm” in the medical context are barriers to fully understanding the true extent of OV.

Overall, many BPs who initially rejected the terms “mistreatment” and “abuse” easily reframed their thinking on the handling of their care using the concept of patient rights. This
makes sense in the context of U.S. individualist culture and the BIC as a capitalist model with patients in the role of consumers. Ironically, this “patient rights” positioning adopted by BPs ends up protecting BSPs and institutions by separating medical services provision from its very subjects. It also allows BPs to compartmentalize their experiences and avoid dealing with troublesome aspects that would prompt accountability or action -- a potentially cumbersome and time-consuming task as there are few paths of recourse currently available. Of note, while some BPs considered violations of patient rights a client service issue as opposed to mistreatment or abuse, the global literature leans heavily on ideas of rights violations to define OV (as mistreatment and D&A). These findings suggest that researchers and advocates need to consider expanding the language used when gathering data from BPs on OV, particularly in high resource country contexts.

At the end of interviews, I asked BPs and BSPs if they knew the term “obstetric violence.” If they affirmed their awareness of the term, I asked them to give me their thoughts about it. Most interviewees had at least heard of the term and many BSPs gave examples of witnessing it. Their accounts included watching BSPs use force, failing to adequately inform birthing people about procedures, and performing procedures without consent. Allison succinctly and clearly describes what she considers OV: “I've seen a mother forcefully taken off her hands and knees and put on her back…. I know I've seen mothers be given an episiotomy when they didn't know it was happening and weren't asked permission and didn't need one.” Allison immediately connects the physicality of forced body position and lack of consent to OV and ticks off the facts that unnecessary episiotomies are performed when BPs are unaware. Violet also swiftly reports physical restraint as OV: “being held down on the OR table or being rolled back
for a C-section and you’re screaming.” BSPs (N=6) mentioned unnecessary, forced, or covert procedures including episiotomies, membrane “sweeps,” fundal massage, and cesareans:

Laura: I've seen the Midwife strip the mom's membranes and then tell her she did it after she did it….I had one doctor that … he pushed really hard on the mom to tighten her uterus and she was glad it happened but I was like....just it looked violent. I don't know I go back and forth on whether or not I felt like he was doing the right thing, or he could have just given her shot of the Pitocin in the thigh….I don't know how much birth experience you have as of late, but episiotomies are a thing of the past. Considering the fact that … [the doctor] just busted out with that mess like and the baby was like six pounds. It wasn't even like this monster kid -- and again, though, the mom is okay with it.

Laura lists instances of OV she has witnessed and observes the theme of blind acceptance by BPs of medical authority. This is an example of the way objective and subjective differences in OV came up for some BSPs in the moment. Additionally, immediately after birth, BPs with “healthy” outcomes often appear to be fully accepting of whatever and however medical procedures occurred. Julia and Carla both noted this theme in their thoughts about OV:

Julia: I'm pretty sure I have experienced [OV] when I'm attending some deliveries. I believe I have. I just think that maybe it’s too accepted among BSPs and even like women themselves for the sake of having, you know, a healthy baby.

The normalization of OV in obstetrics and an initial attitude of gratefulness on the part of BPs interact in cyclical ways to contribute to its proliferation. The coping strategy of gratitude used by BPs to survive the BIC psychologically intact is discussed in detail in Chapter 6.

Some participants made a connection to OV, largely in the context of unwanted, painful, and inappropriate touching, vaginal exams, and cervical checks (N=4). Sexual abuse during birth in the hospital came up only in a podcast series from a mainstream birth organization. The case involved a BP who experienced unwanted and unnecessary procedures which ended in sexual assault.

It was the middle of the night … [the BSP] came back into the room and said, “I need to check you.” I said, “I don’t think so. I was put on bedrest and I was told no
one was to check me. I didn't need it. My doctor just checked me.” He said, “I know. I need to check you anyway.” (Pascucci 2018-PC1).

The BP’s vulnerability was exploited at night when she was without her partner and made possible in part by the large number of BSPs involved in her treatment. The assailant, who turned out to be a medical student, proceeded to perform contraindicated and excessive membrane “sweeps” without the BPs consent and then assaulted her rectally and vaginally with his hands under the guise of a “rectal exam.” He ended the battery by masturbating beside her conspicuously behind a white paper gown (Pascucci 2018-PC1). This abhorrent violation took place during an anxious time for the BP who was in premature labor and hoping to extend her pregnancy as long as possible. She had to factor in her and her baby’s survival when enduring the shocking physical and sexual violence that occurred: “Had I angered him, it could have been a lot worse. But I still have a lot of guilt and shame and anger at myself for not stopping it, not doing something. But my body was frozen and in shock” (Pascucci 2018-PC1). The long-term suffering for the BP was understandably severe in this case and yet the BP has not been able to hold the perpetrator accountable to date. This was the only evidence of explicit sexual assault in the U.S. during hospital birth in my data, though the undue shame involved in incidents like these may suppress reports. Martha solely attributed sexual abuse to the term OV:

Martha: I’ve heard about it and I'm sure and it must happen, right? But I just find it so flabbergasting.... I mean probably one out of 40 times that I check a patient -- I don't have a chaperone … that's only because something crazy is happening and I can't get a nurse and I feel like someone needs to check. But the other 39 out of 40 times I always have a chaperone with me. I just don't know why that's not the universal policy.

While a universal policy, like Martha mentions may not prevent sexual predators from operating in medical institutions, awareness of such a policy may alert BPs to request a chaperone if not provided. Of note, though many people accept “checks” in labor as part of the necessary monitoring of labor and progressing Martha notes that these sometimes physically (and
psychologically) painful exams can lead to abuse and are largely unnecessary. She indicates evidence that cervical “checks” are risky and part of a misguided obstetric practice that should be obsolete and yet the protocol is so ingrained that BPs themselves “ask to be checked.”

The idea that intervention and monitoring improve birth outcomes regardless of evidence to justify it is deeply rooted. Carla brings up a more subtly violent situation when she considers the term OV when doctors attempted to force a BP into a cesarean preemptively due the prediction of a “10-pound baby.”

Carla: I mean things like that that I wouldn’t say were directly violent…. [But in labor the BP] is saying, “Maybe they’re right something’s wrong. I’m not able to birth this baby.” And it’s like do you actually think something’s wrong? Or have they just told you that you can’t do this for the last 3 weeks?

Carla notes that this kind of coercion and the matter-of-fact attitude of the OB is a kind of psychological violence that causes doubt for the BP and can lead to unnecessary surgery. The “big baby” narrative was pervasive across high income context as an unfounded reason for cesarean.

Several BPs commented on the impact of the term “obstetric violence” and felt that the straight-forward term is appropriate and serves to bring to light to the realities of hospital birth: Tabitha: “I don't think that [the terms OV and traumatic birth] are used often enough. You say OV and it’s like, What? What is that? How could that happen?... It sounds clinical and dry. Yeah! So, what do you want to call it?” Naomi: I think they're sort of jarring to most people … [people] hear those terms and they kind of brush up against them and think that this is some sort of over-reaction of what's normally supposed to happen.” Thus, normalization of medical authority and medical procedures in birth interfere when trying to describe the range of particular violence(s) that are commonly suffered during birth and are also unacceptable. We can see this struggle against institutionalized norms too when the concept of trauma during birth is unpacked.
Traumatic birth is now a somewhat mainstream concept in U.S. culture and has saturated birth culture. A popular piece puts forth the observation that “activists” (the ones mentioned are white women) are most concerned with bringing to light the emotional aspects of birth.

Childbirth activists provide a different perspective of this mistreatment of laboring women by health BSPs and make visible the emotional sequel of such care. Interestingly, abuse has been discussed almost solely by people who define themselves as childbirth activists, such as Susan Hodges (president of Citizens for Midwifery) or midwife and homebirth advocate Sheila Kitzinger (Fernandez 2013-POP1).

In this vein, trauma is often connected to mistreatment by PWBO:

If you haven’t experienced any of these subtle or not so subtle ways healthcare officials demean and dismiss pregnant and postpartum women, just look at social media. On Facebook, there are well over 40 birth trauma support groups with tens of thousands of women all over the world (Newman 2018-BG2).

BPs I interviewed learn about traumatic birth via various sites from social media and friends to their own support team. They talked about a growing definition of trauma, the difference in physical and emotional trauma, and a healthy outcome as an obstacle to justifying negative feelings.

Interestingly, while there is evidence that mainstream understanding of the scope of trauma is increasing and the bounds of what it covers in birth are expanding, some BPs I spoke with struggled with the label. Daisy, a therapist, distances her birth from “trauma” due to outside messaging that “allows us to dismiss people’s trauma sometimes” when the outcome of birth is positive and you have a healthy baby. As with considering the categorization of “mistreatment,” the physical condition of BP and baby featured prominently in the analysis of trauma for some BPs. Sarah contrasted her experience with her friend who had a hemorrhage and ended up in the ICU:

Sarah: I did have an unmedicated delivery, which is what I wanted. Did I have to hide in the bathroom so that I could achieve that? Yes, I did. So, it’s one of those
… it doesn't feel black and white. I didn't end up in ICU. I didn't have a hemorrhage…. Like that's a traumatic birth experience clearly. And this is like, “Oh they wanted you to get an epidural so you could be continuously monitored. You're going to call that traumatic?” I mean, I think yes.

It was apparent that BPs were comparing their births and their residual feelings about it to others close to them and at large. For BPs, psychological trauma without physical suffering or medical trauma was a grey area. Amaya: “[there’s a tendency] to not feel like what you experienced was traumatic enough” to label it traumatic if “everybody came home.”

On the other hand, many BPs and BSPs (N=7) were comfortable with the idea that birth trauma is clearly personal and subjective. Amaya, in particular, framed birth as particularly vulnerable and apt to produce trauma for BPs: “I think that there is intensity and the potential for trauma in all birth and what pushes it over the edge is, you know, very personal.” The personal aspect of trauma meant that it could exist with or without objectively traumatic medical events. For example, Naomi states, “I had a postpartum hemorrhage which on paper again should be traumatic, but no it was fine.” More than BPs, BSPs had a strong understanding and acceptance that trauma was ultimately subjective and that they had a part to play in preventing it to the extent such mediation was possible.

Julia: I think that a traumatic birth is whatever the mom says it is and that's really hard because … there [are] somethings that has to be done…. But I think that they can be done with grace. I think they could be done with empathy…. Then of course the most obvious ones like somebody, you know, grabs a baby because they’re in rush and ripping you to a fourth degree [tear] because … they had to go do something -- like that's very obvious or you know, like basic negligence.

Julia alludes to a line that can be crossed when the objective definition of trauma due to OV becomes “obvious” and results in physical injury. The ability and power for BSPs across specialty to mediate trauma is an important thread throughout this study. BSPs were clear that trauma was a common and pervasive aspect of birth to be considered and managed at all times.
and talked about challenges to mediating trauma due to its individualized nature and the unpredictability of birth.

The discussion of trauma from BSPs and BPs indicates the multilayered aspects of hospital birth and the complexity of potential trauma that exists. The idea that birth is a vulnerable life event regardless of circumstances is situated for BPs within the norms of hospital birth where the potential of medical trauma exists, due to both medical complications and medical interventions. Additionally, BPs embody their past physical, emotional, and sexual traumas as well as the possibility for trauma based on discrimination due to social stigma and identity. In discussions of birth trauma related to OV, holding space for all of these realities and being sensitive to the range of subjectivities is important. The impact of birth trauma on BPs whether physical or psychological and regardless of its origins is significant.

I asked BPs to talk about how their birth experience impacted the early days of parenthood. More than half of BPs (N=9) described their births as traumatic and about 80% of those (N=7) described significant negative consequences. Interestingly, regardless of preferred mode of birth no one I interviewed in this sample described feeling like a “failure.” 23 A Brazilian scholar reported this common feeling after difficult births especially in higher resource countries:

[W]omen felt shamed and humiliated by professionals, more than this, they felt let down by their own bodies. The women who underwent emergency caesarean sections spoke of a sense of failure, which took time to reconcile, and impacted upon them as maternal subjects (Correio et al. 2018-PR9).

BPs in my sample did not express these frequent themes but did express a range of strategies in understanding and addressing the mental health issues stemming from their birth experience, from “powering through” to seeking help through traditional (and less traditional) therapies.

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23 This indicated to me that my intake screening process was successful and that BPs I spoke with saw the conflict within the events of their birth problematic and not the outcome.
Many BPs sought out community online through social media: Emily: “I was completely disassociated from my daughter and did not connect with her. [I] started googling and joining Facebook groups and things like that…It was horrible. It was really bad.” For many BPs who experience difficult birth, the burden of anxiety and depression are framed as everyday annoyances added to many other daily challenges of having a newborn. For Nia the stress included an embodied feeling of anxiety: “I feel anxious every day all day long. I just feel like I can't shake it.” A traumatic birth experience made it that much harder for many BPs to recover physically and mentally from childbirth and many recounted the complicated reality of welcoming a new child and processing negative feelings about their births simultaneously.

The intense emotions and effects that lingered postpartum for BPs were varied and complicated among BPs and for each. Julia was “angry” in the early days postpartum and wanted “to disappear” and also felt great gratitude for her baby. Her mental state was made worse due to recovering from a long induction and an unplanned and unwanted cesarean: “I just feel like I was in a bit of a state of emotional pain, and I know everybody does go through it some of it to some extent, but I really feel like I was not all there.” BPs sometimes minimized their negative mental health states, as Julia downplays her undiagnosed postpartum depression here though she describes a moment in the early days postpartum as more traumatic later:

Julia: I just felt so bitter. I was just really upset about it and but I didn't really I mean I felt very emotional…. I was smiling in my face, but when I got in the shower, I cried for the longest time. It was a hard [starts crying] and even thinking about it now. And then just seeing that scar and realizing and I was so swollen … so you have to think about that too. I pushed. I was so swollen and everything hurt and I just… [T]hey [the nurses and Dr.] did that to me.

Julia describes the emotional work of managing two co-existing emotional truths. Part of Julia’s difficulty was accepting the unwanted events in light of her background as a nurse and her collegial relationships with the BSPs involved.
Overall, BP and BSP interviews showed a general awareness of contemporary concepts within hospital birth and a mix of ideas on what constitutes OV, abuse, or mistreatment. Some BPs easily connected their experiences to “mistreatment” or “abuse,” while others distanced their experience from these terms and instead framed their experiences as violations of patient rights. BPs clearly distinguished between emotional consequences of birth and the objective experience and put considerable thought into the ways they categorized it. Nurses, midwives, and doulas (N=6) supplied ample evidence of witnessing OV. Interestingly, the OB in the sample was the only BSP who indicated she had not witnessed “mistreatment” or “abuse.”

3.3 Most Common OV Reported

The findings across the data globally showed that much of reported OV fell into the categories of unnecessary or non-evidenced based medical interventions, “unethical” practices, and general poor care. The following is a good example of the common range of findings from low to high-resource contexts:

Broadly, researchers found [D&A] in maternal health care comes largely in the form of unnecessary medical interventions (e.g., routine episiotomies, moving to cesarean section too quickly, routine fundal pressure) and unethical practices (e.g., multiple vaginal examinations without indication, lack of anesthesia during routine episiotomies, physical and/or verbal abuse, lack of privacy or confidentiality (Sreenivas et al. 2015-PR10).

Evidence from the U.S. specifically showed that many BPs experienced less physical abuse and more verbal attacks, coercion, and withholding of support. Findings from a study from California with BPs of color are representative of many of the common violations:

Participants discussed sharing of personal information, violation of physical privacy and being “yelled at” by a physician. Half of the participants discussed being pressured or threatened, with the most common type of threat being, “if you do not comply or do this, your baby will die, or you will have a bad outcome” (Vedam et al. 2019-PR5).
BPs and BSPs I talked to described threats and coercion that referred to the death of the baby as particularly troublesome. I discuss this highly pervasive and disturbing theme in depth as a BSP and institutional strategy in Chapter 4. The forms of OV that came up most frequently and overlapped most in my content analysis and interviews were birth positions (N=18) and mobility (N=14), food and water restriction (N=11), lack of pain medication (N=25), negligence and poor quality of care (N=10), and lack of consent (N=18) (Fig.4).

![Figure 4 Most Common Forms of OV](image)

restricting basic autonomy: birth positions, mobility, eating and drinking

One of the most fundamental and common complaints reported by BPs in the literature and in interviews was related to lack of autonomy around laboring positions. This finding was clear across the globe and between different groups and demographics. BPs reported wanting to labor outside of the supine and lithotomy position and “resented feeling forced to deliver in undesirable or humiliating positions that rendered them passive” (Bohren et al. 2015-PR11). A midwife in Ghana narrates the conflict created by this desire:

She told me the baby is coming, so I told her to lie on the floor because if she stands, the baby can hit the floor…. But this lady didn’t do it but rather … she squatted …
in Ghana here, or in this hospital, the patient, you are supposed to lie on your back…. I told her to lie on the back. And she was like “no, this is what I want.” And I told her “you can’t do this to deliver, please, lie on your back.” So, I held her hand and I turned her to lie on her back, but this woman refused to open the thigh for me to even do the delivery (Dzomeku et al. 2020-PR12).

Importantly, regulation of body positioning and restricted mobility not only impede labor but are a form of embodied disempowerment. Leiko Hidaka, a doula based in the Dominican Republic, points out the faulty reasoning of an OB who restricts BP movement: “I have heard doctors say, ‘What? She wants to go to the toilet? No, no, no, no. Because she could give birth there.’ And I’m like, ‘I don’t think she’s not going to notice when the baby is coming out’” (Dekker 2020-PC3). Evidence of active rejection of BP embodied knowledge of moving during labor exists across country contexts for various reasons including obstetric norms, lack of training or understanding of physiological birth, as well as unsanitary hospital conditions. Across settings, there is evidence that conflict between BSP and BP over birth positions and freedom of movement can lead to OV in the form of both explicit physical and verbal abuse. A birth organization in the U.S. recounts the “landmark case” of Caroline Malatesta who won a large settlement:

At Ms. Malatesta’s birth, the hospital nurses forcibly turned her onto her back (she was in a hands-and-knees position) during the delivery and held the baby’s head in for 6 minutes until the doctor could arrive, causing a severe, lifelong, maternal nerve injury….The use of forcing women into the care provider’s preferred position has also been described as “obstetric violence” (Dekker 2018-BG3).

Dekker uses this case to educate readers that restricting movement constitutes OV. While BPs and BSPs brought up this basic lack of autonomy to choose a birthing position as problematic, only two BSPs in my sample considered it OV. Carla vividly recalls one BPs embodied knowing that was ignored in this regard:

Carla: This one woman was pushing for a long time, and she was on her back in a supine position and she said, “Can I get on my hands and knees?” And they’re like,
“No, no, no the baby's about to be born.” But then she couldn't effectively push…. She was really upset by that. Even afterward she's talked about -- “If they would have just let me do this. I could have effectively done it.”

Julia also recalled an inner perception, which she fought to have heard, that being on her back would not lead to successful vaginal birth.

I asked the doctor so many times. I said, “Okay if he's asynclitic24 can we just get me on my hands and knees? I know my legs are numb, but can you guys just help me get into other positions?” And they're like, “No just hold your hand behind your thighs and push.”

The friction between embodied knowing about birth positions and directives based on institutional protocol in opposition to them during both medicated and unmedicated births was common throughout texts and interviews.

There is evidence that the insistence to regulate BP’s bodies to particular positions in the U.S is driven by protocols and practices that mandate continuous or “intermittent” monitoring of the baby’s heart rate with the justification that it is necessary for the safety of the baby. This is noted in a popular article that quotes an OB’s “birth plan” that includes mandatory continuous monitoring: “This is the only way I can be sure that your baby is tolerating every contraction. Labor positions that hinder my ability to continuously monitor your baby's heart rate are not allowed” (Goer 2010-PR8). While EFM is widely used in middle and high-income countries to prevent fetal demise, its only established efficacy is that of leading to unnecessary outcomes (Sartwelle, Johnston, & Arda 2017). BPs (N=7) talked about the desire to move freely in labor, EFM, and the role they felt it played in their contentious births.

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24 An asynclitic presentation is when the baby’s head is tilted towards the shoulder, making progression through the birth canal more difficult.
The attachment to monitors and machines obviously hindered the ability of movement driven by BP physiology and this often began an incremental loss of autonomy for BPs. Julia felt like being mobile was one of the first sources of contention with hospital staff.

I'm like, okay, well I'm in the hospital I can't really walk around like I would at home and I'm kind of tied to this [IV pole]. So, I was like let me go rock in this chair -- because I was reading that can help...and they didn't have a birthing ball or anything and I got in this chair. A nurse comes in and says, “What are you doing?” [using a loud voice] and I said, “What do you mean? What's going on?” She's like, “You can't do that. You need to go back in bed”....I get back in bed … but ... very reluctantly...I'm like, “Are you sure?” She said, “Well this is what we have to do because of the Dr's orders...if you want to sit there, I can always call the Dr. and then we can monitor you wirelessly.”

BPs were often navigating hospital policy and various gatekeepers in attempts to exert basic forms of agency. Eventually Julia managed to get the wireless monitor ordered by nurses who did so “very begrudgingly.” When alternate monitoring devices were available, device preferences always required haggling with hospital staff and ultimately doctors made any decision to deter from continuous monitoring. When wireless monitoring is an option in facilities it may still have institutional rules attached that restrict its availability and mechanical issues that limit its use:

Alexis: [T]hey had one [wireless monitor] in the daytime but it wasn’t working It took them like two hours to get somebody in to get it to work and....It didn't work really well, even then and you couldn't walk very far....When the nurse left I would get up … I would literally be holding it because that thing does not stay and it has to be at a certain angle. So, I'm holding it and trying to walk and you know do my thing. Eventually the thing would slip and she’d come back … then it would slip again … going back and forth like that….At some point she was like, “I need you to lay in bed! I need you to stay in bed!”

Like Alexis several BPs found satisfying hospital requirements for monitoring, as regulated by nurses, while laboring in a way that felt comfortable impossible. Understandably, nurses expressed frustration at BP’s attempts to behave and move in expected and natural ways that conflicted with their own duties of surveillance. Beyond all of the difficulties with continuous
monitoring, the option of intermittent monitoring was also problematic. Allison: “you can be off of monitor for 40 minutes, but that’s … that’s bullshit. You know? Because you are finding your jam. Sometimes it takes 40 minutes to find your jam. You know in the shower, whatever, wherever, and then it’s, nope you gotta get back. So that’s just bullshit.” While intermittent monitoring is offered as a concession by hospitals to give laboring people more freedom, as Allison notes it’s fairly useless because of the disruption it causes in the labor process. Most importantly in the context of OV, fetal monitoring combined with restricting birth positions have the potential to create a cycle of unnecessary and unwanted interventions.

Taylor: I believe [the baby’s heart rate] had more to do with positioning -- like how I was positioned while I was going through the contractions. Where I … probably should have just been up kind of walking around and processing through -- versus laying on my back, you know?

Taylor ended up with a cesarean birth but later realized that her baby’s heart rate dropping -- which precipitated the call for surgery -- may have had to do with hospital BSPs restricting her movement during labor. Some BPs and BSPs questioned the legitimacy of physician decision for cesarean based solely on one fetal read out without trying different options to otherwise stabilize the baby. Forced monitoring and inaccurate assessments combined with restricted mobility separated BPs from their birth experience and inflicted the violence of unnecessary interventions and related risk. It makes sense that BP and BSP conflict often arose from these kinds of power struggles over simple, but incredibly influential forms of basic autonomy.

Though not evidence-based, many hospitals and OBs require fasting during labor to avoid the extremely minimal risk of aspiration under anesthesia, should an emergency cesarean occur later. Carla points out, that outside of the realm of medicalized labor, refusing to feed a

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25 The risk of aspiration during cesarean with full anesthesia was found to be .064% in a study of about 1,500 high-risk patients (Dindelli et al. 1991).
pregnant person is “abusive.” Julia came up against hospital fasting policies despite trying repeatedly to gain permission to eat: “I felt weak when I was pushing. I'm like, ‘Well no wonder all I've had is, you know saline and antibiotics.’” Of note, denying food and water during labor is part of the rationale for “starting an IV” for fluids that leads to the implementation of further intervention. The refusal of nourishment and the stark denial of BPs requests was deeply impactful for Amaya:

I had been given the ok by the doctor who was on overnight to have a little bit of breakfast and then the doctor who was on after that busted in the room … like, “Did she eat? She can’t eat!!” -- just like freaking out. I hadn’t been able to eat because I was so scared anyway, and that just felt really awful…. It was just so … just felt very … like they didn't actually care.

For Amaya, the reaction of the OB towards her basic desire to eat made her feel remarkably unsupported in an especially vulnerable moment. In addition to interview data, evidence from around the globe indicated that withholding food and drink is common: “I could not eat during the childbirth labor, but just drink water. Only after I gave birth to my child, they did give me a snack” (Correio et al. 2018-PR9). Overwhelmingly, BPs mentioned lack of mobility and Hospital BSPs refusing to allow food and water as primary sources of loss of autonomy. Evidence suggests that these restrictions resulting in losses of the most essential forms of autonomy during birth increase reports of mistreatment and OV.

*inadequate pain relief and poor “care”*

Throughout the data evidence of inadequate pain medication during facility-based birth surfaced in a range of circumstances. At times pain medication was inadequate or emergent situations made anesthesia impossible. At other times pain medication was withheld knowingly
until asked for and sometimes it was refused even when requested. A nurse recounts a common scenario:

“You're the one who didn't want an epidural, this is the price you pay” -- this is often when they refuse to give the patient adequate local anesthetic for laceration repair²⁶, despite the fact that the patient is crying out for it and I am standing there holding it out to them. I have seen this too many times to count. The physician's answer is often “I only have a few more stitches left” (Goer 2010-PR8).

Lack of adequate pain medication is used as revenge for a BP’s choice to labor unmedicated as well as the excuse of convenience during a vaginal repair. The false assumption that BPs who have worked through labor pain without medication do not require pain medication or are numb to procedures that cause other forms of pain is common:

Sarah: I had to have a wound cauterized with silver nitrate and she was like, “You can take it you had unmedicated labor.” I'm sorry having your vagina burned with silver nitrate is not the same thing as natural childbirth, like no. [It was] very like, “You can take it” [makes noise like cauterizing tool].

Sarah’s experience with a midwife who practiced according to this myth shows a lack of understanding about pain during birth and general negligence of her patient’s needs. The vengeful attitude of some BSPs towards the small percentage of BPs who labor unmedicated in the hospital is significant and concerning.

Another shockingly common situation involved BPs undergoing cesareans with failed or inadequate epidurals:

I have seen [multiple times in different hospitals] ...cesareans when a patient’s epidural becomes inadequate during surgery. Despite her crying out “Ouch, I can feel that, that feels sharp! That hurts!” she is ignored, told “No, it's just pressure,” “I'm not even doing anything that should hurt” ... or “I’m almost done” (Goer 2010-PR8).

²⁶ BPs commonly require repair using stitches for small to moderate internal and external lacerations that occur during vaginal birth.
Nia, who experienced a second cesarean describes what she felt as “not so much pain” but the feeling of intense physical sensations of surgery:

Nia: And I start screaming bloody murder because I tell you the first time [primary cesarean] I was so numb I didn't feel anything like you kind of feel a little tugging just barely you know? But I literally didn't feel a thing. And this time I kid you not I started crying and screaming I can feel everything … It felt like someone just ripped….my stomach was cut open and they just grabbed it and ripped it…. And I just was….It was horrible. I would never wish that on anyone…. I remember thinking during it -- this is hell.

The “show must go on” attitude of BSPs when BPs are struggling with pain management further aggravates the situation. Of the BPs interviewed, four of the nine who had epidurals spontaneously mentioned the anesthesiologist having trouble injecting it correctly or had incomplete pain relief from the procedure. It is clear that in facilities around the world BPs are suffering from painful procedures without adequate pain medication. In the U.S. and other high-income countries this is not due to availability or shortages but to false beliefs about pain and laboring people, the general attitude of medical convenience, and racism.

A recent study of almost 10,000 postpartum birthing individuals found that Black and Brown BPs are less likely to be listened to and treated for pain than white BPs (Badreldin, Grobin and Yee 2020). In line with current and historical disparities in treating racial and ethnic minorities for pain, evidence that race influences the treatment of pain during birth and immediately postpartum emerged in my interviews.

Isabel: I also had a client who her pain wasn't being taken seriously when she was asking to have more IV…. It took them so freaking long to come and bring her meds, but I literally went to the nurses’ station and was like, “Excuse me? Can we please get this medication for my client so that she can get some rest so that we can get this baby out?” So, I just feel like they were totally ignoring her and discounting her pain and they weren't believing her that her pain was what it was … to the point where I, as a white woman [and her doula], had to step in and be like, “Please listen to her and give her this medication that she's requested twice now.”
Not acknowledging BP pain is a “big offense” and important not only because every birthing person deserves humane treatment, but because the same beliefs and norms that underlie denying pain meds to Black BPs are at the root of egregious acts of medical neglect that can lead to death. Kelly and colleagues detail the negligent events (including minimizing pain) that lead to a Black BP dying a week postpartum:

Felicia West’s body started sending out warning signals. Her blood pressure spiked. She complained of a splitting headache. For three hours as she headed toward a stroke…. They gave her painkillers and an ice pack -- and they made her wait. Then, after a series of handoffs, a doctor in training finally was tapped to deal with West’s blood pressure. The doctor was in no hurry. “Ok, well it will be a while before I can see her because I have a lot of people before her.” Before dawn, West was dead (Kelly Schnaars and Young 2018-POP11).

In these events of obvious and willful neglect we also see an example of a lack of accountability and poor communication driven by discontinuous and too little attention at critical moments. In cases of Black and Brown BPs, racism complicates and amplifies these institutional problems.

Common in both texts and interviews, negligence and poor quality of care are dangerous forms of OV that represent the most direct link to maternal mortality. An Ethiopian study found both BSPs and BPs reported “sub-standard” clinical practice including “having poor follow up care, and being given improper medication” (Burrowes et al. 2017-PR1). Violet noted how difficult her time as a nurse at a hospital serving predominately low-income BPs of color was, due to the “crappy care” she witnessed at that facility, a quality of care that nurses then accepted as “normal.” Violet: “That breaks my heart. That's not good care. I shouldn't have to beg a provider to come to the bedside to please review this strip. You know? Please come do a C-section for this two out of eight BPP like please!!” Her experiences ranged from having to “beg” for MDs to provide medical care to her patients to urging MDs to refrain from performing procedures without consent and against their will:
Violet: I’ve seen some really like terrible care from [Dr. R] and from other BSPs that are just doing things without informed consent or people are…they’re rolling them back for emergency C-sections while [BPs] are screaming down the hall. “No, don't cut me. No, don't cut me” and it's like you literally can't do that.

To illustrate the utter lack of consent or respect for autonomy involved in the OV she’s witnessed Violet vividly describes the strength of resistance used by BPs in an attempt to salvage their agency.

During my interviews, several BPs described instances of poor medical care in the form of medical negligence. Jasmine, who experienced a postpartum hemorrhage, explains the unfolding of a critical moment when the on-call doctor was unable to perform a life-saving procedure in a timely manner:

Jasmine: [My partner and mother] were very mad about that. That was my mom's biggest thing was in the moment she said they were…my partner he was yelling at the doctor to do something and my mom was just like watching the blood. She said it was silence. She was like it was almost a dull silence in the room and nobody was doing anything but just watching it happen…at some point the [observing doctor] just pushed [the on-call doctor] to the side…and just started sewing as fast as she possibly could….Then the nurses started moving again, but at some point, they said it was literally…it was just still in the room. Everything had frozen as they just watched me bleed.

In this moment, Jasmine understands that her life was in the doctor’s hands who was “frozen” and if it had not been for the action of a different OB in the room, whom she knew from pregnancy appointments, she would have lost her life. Jasmine also mentions complete neglect during her pregnancy care:

Jasmine: So, I didn't have any care basically. It was no one checking stuff like that for me throughout my pregnancy…. It was just like okay, it’s time to do the diabetes test do the little test, as long as the baby's measuring fine, she's good to go. But I don't think anyone really read the chart that much. If they'd seen it, they may have seen that I do have a problem with anemia and I probably should have spoken up more about it.
The anemia may not have caused Jasmine’s hemorrhage, but it did make it more difficult to recover from afterward, as she required a blood transfusion. Notably, even when poor and negligent care was obvious, BPs often took some responsibility for it. Emily also received neglectful care during pregnancy that impacted her birth experience. She reported increasingly high blood pressure scores to her OB beginning at 27 weeks through the “patient portal” but never received a response and states, “I don’t know why I thought it was ok.” Emily ended up with pre-eclampsia at 36 weeks which required an induction that eventually resulted in a cesarean. Jasmine and Emily looked back on negligent care that began during pregnancy and rightly wondered whether proper attention from medical BSPs may have changed their outcomes. Both of these BP’s births turned into emergencies that would qualify as “near misses” (emergency events at the end of pregnancy and during birth) which are significantly more fatal for BPs of color. Writing for USA Today, Kelly, Schnaars, and Young speak to the common misattribution of poor outcomes to uncontrollable social factors: “West’s death -- along with several other deaths and close calls at Touro -- cannot be explained by demographics alone. The data, medical records and lawsuits suggest a complicated mix of misdiagnoses, delayed care and a failure to follow safety measures” (Kelly Schnaars and Young 2019-POP11). While hospitals serving lower resourced individuals lean on statistics for poorer outcomes in these populations as justification, it is clear that the deadly culprit of poor medical care in pregnancy and birth is one that is tightly entangled with classism and racism.

Both the peer and popular texts and interviews overlapped with evidence of poor quality of care and negligence around medication, involvement of trainees and students, and lack of basic hygienic care. Trainees and students involved in the care of BPs with and without their consent and knowledge was an issue that came up prominently in both texts and interviews. BPs
often felt uncomfortable with less skilled BSPs being part of their care team and their involvement was associated with poor quality of care in some cases. Authors from a study based on interviews with Ethiopian BPs state: “Women reported some providers were incompetent and negligent. Women also reported observing junior care BSPs being guided by senior care providers to perform certain procedure ... junior providers take longer time to perform tasks and [were] often left unsupervised by senior care providers” (Gebremichael et al. 2018-PR13). Beyond concerns about quality of care, complications of privacy and consent during labor also came up in teaching hospitals. This theme is discussed in detail in Chapter 5.

Finally, the issue of basic hygiene and its connection to monitoring blood loss came up in peer-reviewed texts primarily from lower-resource countries but a related theme was noted in one interview. An Ethiopian BP states, “Sometimes, they don’t change beds well” after naming other negligent acts (Burrowes et al. 2017-PR1). In many countries the policy of restricting birth companions means that, “After delivery, some women were left alone in their own blood, urine, and feces with no support from the health workers to clean up” (Bohren et al. 2015-PR11). This lack of attendance to basic necessities not only increases chances of complications from excess bleeding but dehumanizes BPs who are recovering from birth. Emily described a particularly vivid and meaningful memory from the recovery room:

Emily: When I came out of the C-section and [we] were still in that tiny, tiny, room ... it was the next day I think and they hadn't changed my pad or ... checked to see what my bleeding….I mean, I think they came in and checked but they didn't actually help clean me up at all. So, when my mom got there… she did it ... She cleaned me….I didn't think it was a big deal when she was doing that. But now I'm like isn't that kind of key to making sure the bleeding is normal? And helping someone feel like ... an actual person?

Poor quality of care and negligence represent discrete aspects of OV that lead to poor health outcomes for BPs and feelings of disregard. While this kind of violence is contextualized by
structural factors and health system economies, it is possible on some level in every facility regardless of available resources.

There are striking similarities of OV type in reports from facilities across the globe -- a fact which speaks to the overarching commonality of manifestations of violence in medical institutions. These similarities may help scientists and BPs to collaborate broadly in envisioning and implementing a less violent system of maternal health care while also providing adequate access to medical services. At the same time, there are important differences in structural and individual factors both internationally and within country contexts that must be addressed in site-specific ways. Detailing the BIC as a system both reflecting and reproducing social hierarchies is important in understanding the complexities of OV.
4 THE BIC: REPRODUCING HIERARCHIES AND OPPRESSION

In this chapter, I situate OV within the maternal health system, a system (particularly in the U.S.) that is built to regulate and process bodies for profit. The medical industrial complex (MIC) is well described and theoretically in line with the prison industrial complex as a site of white supremacist and capitalist convergence (Alexander 2012; Simonds 2016). I refer to the current maternal health system that exists within the MIC as the birth industrial complex (BIC) because of the drive to standardize pregnancy and birth through medical intervention in facilities that are efficient and “productive.” The global public health agenda is to save lives and the institutional aim is to take on that mandate in a cost-efficient way that produces income for specific stake holders. Even though around the world, the BIC systems and physical environments vary, the rationale and visions are similar. The BIC is comprised of the structural elements that interact with institutional culture creating a specific context for the experience of facility-based birth. Using Simonds’s concept of Hospital Land, an extended and detailed critical analysis of medicalization as a “warped amusement park,” you might say that the birth “adventure” is situated somewhere between the haunted mansion and “it’s a small world” (2017: 17). I argue throughout this chapter that the BIC and hospital systems reflect and reproduce social regimes particularly well through normalized everyday strategies that perpetuate selective violence during birth. In the intimate space of birth, vulnerability on multiple levels, is exploited by hospitals and BSPs in large and small ways that effectively uphold the status quo and normalize OV.
4.1 Categorizing Laboring Bodies: Race Class Gender Regimes

Hierarchical categories based on stereotypes were endemic in instances of OV across the globe. Historically, sexism and anti-black racism provided the means of establishing the foundation of all medical knowledge, but particularly that of obstetrics and gynecology (Washington 2007). These ideologies are still present in medical culture today and the practices based on them persist as a way to regulate people, their behavior, and to determine who is more or less “risky” and more or less “worthy” in the medical space. Throughout the texts and interviews stereotypical assumptions guided the treatment of pregnant and laboring people:

Violet: I think morbidly obese women get treated poorly. There's a stigma around that in the hospital, you know, and absolutely woman of color [are treated poorly]. Hispanic women especially if there’s a language barrier, low socioeconomic class, immigrant, Medicaid, all of it. All of it. If you’re not a well-educated high socioeconomic status white woman with your husband there and your doula there to advocate for you then…. I don't think all the time it's blatant, but I think it's just ... not acknowledging…. Like “I'm just going to hang this Pitocin….You know, not asking for consent (that's how drug errors happen). That sort of thing.

Violet’s remark typifies the idea that belonging to the dominant group in the U.S. (including being a socially acceptable size) establishes a certain “privileged” level of service from the institution and medical staff. This ascribed status elicits additional dialogue from staff and an effort to “acknowledge” patients and their rights to information and autonomy around medical treatment. Violet points directly to the tangible connections between discrimination, poor quality of care, and medical mistakes. In essence, categorizing of BPs by hospital BSPs serves to stratify the type and quality of services as well as the manner in which they are provided.

belonging, deserving, and blame in OV: race, citizenship, and class

Both global and local hierarchies influence the way the institution and hospital BSPs view and treat BPs entering facilities for birth. The role of cultural racism, anti-black racism, and
anti-indigenous racism in OV was pervasive across nations and population and racialization was often conceptually inseparable from gender, sex, class, and citizenship status. In geographic areas where indigenous populations or migrant and refugee populations existed and experienced stigmatization in society, stigmatization also existed in connection to these statuses in the birth space. In some African countries disease status was often noted as a factor:

[R]easons for neglect include punishment for being disobedient; avoidance of HIV positive women; a refusal to treat migrant, non-South African citizens or refugee patients; or that patients are perceived to be undeserving (such as the poor, single or unmarried patients, and black patients) (Pickles 2015-PR3).

Texts from the GS and the U.S. also showed tension around class, race, indigeneity, and migration as each status was entangled in explaining violence inflicted upon BPs during birth and disparate health outcomes. Less “deserving” BPs included a range of marginalized statuses dependent on locale. For example, indigenous midwives and BPs in Mexico are blamed by the upper classes for maternal mortality and preventing the racial “uplift” of the country due to traditional birth practices. A Mexican scholar notes that these are, “personal-mediated racist practices against indigenous women by the mestizo upper class in favor of the nation-state and its modernization” (Dorr and Dietz 2020-PR14). The politicization of medicalized birth practice as a nation-building project was apparent in various country contexts and various actors used the framing to reinforce boundaries of belonging and respectability. Blaming marginalized BPs for health disparities crossed borders.

In the U.S., BMMA noted that Black women are often blamed racial disparities: “We find the responses the hospitals have [about racial health disparities] are full of these dog whistles that are anti-black and anti-woman…. This statement is a perfect example of how black women feel entering this hospital: You’re poor, you’re uneducated, you’re fat” (Kelly Schnaars and Young 2019-POP11). Similarly, Jennie Josephs, founder of Commonsense Childbirth, the
first Black midwifery school in the U.S., speaks directly to obstetric racism and points to the “blame the woman approach” that continues to “condone” behavior that produces racially discriminatory outcomes:

That’s what it’s about. That’s the bottom line. It isn’t about well, something’s wrong with your physiology, something’s wrong with your genetic makeup. Oh my gosh, if you only ate right, you wouldn’t be in these dire straits. We know all of this is absolutely not the truth (Dekker 2020-PC4).

The theme of blame and personal responsibility directed towards victims of OV was pervasive across content and the gendered regimes of race, class, and citizenship often intersected. For example, a midwife from Ghana narrates the ways indigenous BPs are mistreated:

| to put it mildly, some of these petty traders are not exceptionally neat, not their fault but a lot are unkempt. So, when they are coming to labour, instead of taking a bath, shave, do the necessary little stuff that makes a woman presentable, she just picks a bag and presents herself to the ward. Sometimes, you open that bag and it is full of bed bugs. So, if you don’t hold yourself in check, you will get angry [and act unprofessionally] (Dzomeku et al. 2020-PR12).

Deviance from gendered expectations of the dominant class is anger provoking and thus leads to OV according to the midwife. A midwifery student from Ethiopia provides a similar account of abuse “especially if the patient is from a rural area” …. “because the patient is not clean” (Burrowes et al. 2017-PR1). In combination with “withholding treatment” and “threats of beatings,” a systematic review found BSPs blamed BPs and held them accountable for their own poor care (Bohren et al. 2015-PR11). The evidence overall indicates that blaming BPs for OV and for socially constructed differences in health outcomes crossed theoretical bounds of individualistic vs. collectivist culture as well as paradigms of social status.

The texts often compared public and private hospitals in countries across the globe that operate explicitly within economically (and therefore racially) segregated healthcare systems. For example, “Poorly educated and [B]lack women” in the public system of Brazil face issues of
access that “women who are better off and white” do not (Melo et al. 2014-PR15). Public and private hospitals differed in quality of care and in policy and protocol: Leiko: “All of the women in this [public] hospital that came in labor -- all of them had Pitocin…. If possible, they will break waters. And they don’t use epidurals in public hospitals here” (Dekker 2020-PC3). Leiko notes a common confluence of over-medicalization and under-medicalization confronted by BPs in the public hospital tier. In general, public hospitals across the globe tended to be the less desirable birth option for BPs.

In interviews and texts, the vulnerability of being or being perceived as poor and uneducated made people more like to be “taken advantage of” during birth:

Women face varying degrees of OV in most settings. But the worst is the treatment meted out in government hospitals to the poor and most vulnerable population…. It is made worse by a culture of impunity, where health providers know they will get away with it (Luz and Gico 2015-PR16).

This assessment by Luz and Gico is not out of line with the view of some BSPs I interviewed. Violet described exploitive and abusive behavior of an OBs as an accepted part of the institutional culture of Stratford, a hospital that serves significant population of BPs who are “self-pay.” Violet: “[The OB] is just very over-the-top. She goes from zero to a hundred…. She ended up losing her privileges at Stratford which takes an act of congress frankly because of just completely inappropriate behavior.” In my interview sample, BSPs most frequently implicated OV related to poor care in hospitals that served the most racially and economically diverse populations. These hospitals were also the least likely to punish OBs for violating standards of care. Julia connected the exploitation of poor immigrant BPs to a particularly cesarean happy and extremely insensitive OB, whom she tried to avoid, that continued to practice without sanction:

Julia: He is a very bad doctor and it almost feels to me … [substantial pause] ... So, the population of patients he brings in is very important because it feels to me like it's almost -- I have no evidence for this -- but it feels to me like maybe it’s
some sort of racism? Because he takes care of all these patients from a particular population who don't speak the language who don't have access to insurance or adequate healthcare. And so, they end up doing the self-pay eventually emergency Medicaid.

While Julia is hesitant to attribute the abuses she’s witnessed to racism, she is certain that the behavior of the OB is inappropriate and constitutes OV. She indicates his motivation may be financial saying, “so, you make a lot of money from [self-pay Medicaid].” Most BSPs interviewed and quoted from content made direct and clear connections between obstetric racism and OV.

The most overwhelmingly influential factor related to OV through discrimination was race, ethnicity, and indigeneity. At the same time there was abundant evidence from texts and interviews that a hierarchy operated through mutually reinforcing racialized and classed stereotypes during birth in the hospital. For many BPs, medicalization emphasized this type of discrimination: “Women felt that some biomedical models of maternity care disrespected cultural preferences and propagated racial stereotyping” (Carneiro 2015-PR17). Personal accounts from texts and interviews highlight the idea that race seemed to override all other social statuses and stereotyping drove much interaction between birthing parents of color (BPOC) and BSPs. A Hispanic BP says discrimination “put my life and my newborn’s life at risk:”

The doctor who refused to test me for an amniotic fluid leak and instead tested me for an STD test I had already received during the pregnancy. I believe his assumption that I was leaking something due to an STD rather than a pregnancy complication was due to race (Vedam et al. 2019-PR5).

Treatment based on racial stereotypes that included assumptions of socioeconomic status and sexuality was common. It is important to understand the medical outcomes for marginalized groups as connected to these direct institutional and individual racist norms and practice. Julia, a self-identified Latina, ended up having an unwanted c-section:
Julia: I'm a Latina young mom. I'm supposed to come in and just shoot this baby out -- that’s the general perspective -- and then I didn't. Or [BSPs assume] that Latina women are kind of meek or they are so thankful for everything you do and just kind of go with the flow. Whatever you want to do.

Julia advocated for herself throughout her birth and felt ongoing tension between the expectations of hospital BSPs, her desires, and her birthing reality. Julia’s response supported evidence that racism influences staff and BSPs expectations of BPs during birth and the ways that they seek or do not seek engagement, permission, and consent from laboring people.

BPOC interviewed expressed that their education, background, and insurance status was often not recognized which led to a general feeling that staff and BSPs misunderstood who they were as embodied race was understood to be the most salient factor in their treatment:

We are treated as less than and ignored. I was married, working and had insurance in a semi-private room, somehow a social worker still ended up in my room asking me if all of my kids had the same father. This is what they do and how they think of us (Newman 2019-BG1).

Alexis: Somehow, I seemed difficult by asking questions. And I don’t think if I were white, I don’t think they would have treated me that way. They wouldn't have thought that I was having doubts about giving my baby steroid shots [laughs]. You’re supposed to ask questions. Why would you get a shot without asking questions?

Alexis highlights the absurdity in the idea that white educated moms are respected for questioning medical protocol while BPOC face sanctions and assumptions about their parenting capabilities for the same behavior. Along with an awareness of misrecognition by hospital BSPs, Alexis detailed the emotional work of code switching in the hospital when advocating for herself and her baby: “like through all of this I was actually … how I’m talking to you now is pretty much how I talked to them. It was very articulate. I used the word concerned and you know, I was very very careful with my words.” Alexis spent significant energy attending to hospital BSP perceptions of her when she wanted to be able to get up and move around during labor to
increase her chances of vaginal delivery: “I used the word I'm concerned. I'm concerned is not threatening! It tells you that I'm concerned about something. I'm concerned about the weather, global warming, you know? I wasn't emotional. I was very measured in the way that I said it.” There was a clear mental and emotional toll for Alexis in attempting to come across as unintimidating by maintaining an image of a “respectable” and objective individual throughout labor. She later shares how hard this was for her:

Alexis: It was so awful. I felt like I [had to] advocate for myself … you know, how you do and say all the right things but none of that makes a difference? And I shouldn't have had to … in one of the hardest moments in my life … been so cognizant and so careful and so measured. I shouldn’t have had to have done that. It should have been easier.

Alexis chose to continue to advocate for herself with tools she acquired due to her personal background and career in health research though she knows it was wholly unfair. The energy required to use her everyday strategies to navigate the hospital and BSPs was energy she needed in this personally challenging moment. Like Alexis, many BPOC’s called out, and were highly cognizant, of the fact that they deserved recognition and support without having to fight for it especially during a vulnerable time like birth.

The complexities of race and class showed up when the highly educated BPs I interviewed tried to understand the root of discriminatory behavior by hospital BSPs:

Alexis: I'm not necessarily saying that the BSPs were racist or the reasons, they asked me this question, but I definitely got the impression that they may have thought I was a different person than I was. And I'll say my husband is black and I've always wondered if part of the reason…. But my husband is black and the family members that we had come were Black and so it's always kind of been at the back of my mind.27

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27 Alexis’ comment is in line with research that indicates non-Black BPs with Black partners experience higher levels of mistreatment (Vedam et al. 2018-PR5).
Jasmine was also left wondering how her racial identity may have played a role in her difficult hospital experience and especially the negligent treatment she received from a white OB. When reflecting, she explained the changing socio-economic demographics of at the hospital: “When I delivered my first son it was more like a private hospital and when I delivered my second son it was such a drastic difference. It was more like [names largely public serving urban hospital].”

Jasmine: I have a pretty good insurance … and I'm sure [the BSPs] don’t know that but they know I’m a working person and I have a pretty good job. So, I don't think they viewed me as someone who maybe was less than when it comes to finances … regarding race I just did not feel like she took me at all seriously or like I was an individual. I think she thought it was like another one of her rounds…. [Come to think of it] I don’t know if maybe the Dr. had been dealing with people who look like me, but did not have as much finances?

As indicated in many of the responses from BPOC, race and assumptions about socioeconomic status were highly intertwined. BPOCs revealed giving considerable thought to the ways that BSPs interpreted and misinterpreted them -- as people -- in the hospital setting. Jasmine makes a connection between BSP’s ineptness at communicating with her as an “individual,” and her race. This inability or unwillingness to recognize certain BPs as consequential that Jasmine describes is telling and aligns with findings throughout my study. Many BPs, like Jasmine, hypothesized a sense of BSP “callousness” that happens over time when “dealing” with lower-income and less educated BPs and a large patient load. Evidence from Violet indicates that discrimination based on race is moderated by class (displays of class membership). When talking about race, class, and gender she relayed an understanding of complexity within BSP/patient relationships:

Violet: some of [the instances of OV] were with young African American physicians. That they are the ones inflicting this violence, you know? And … why?… I think in a way too … the young African American woman [OB] would take beautiful care of higher socioeconomic status African American [BPs]. It was almost like this friendship -- my best friend I'm taking care of, you know? And then for lower socioeconomic women it was like this person I can take advantage of. It's very clear…. [I]t's easy to think like, oh, it’s the older white man….that’s not necessarily true.
Overall, interviews revealed the social dynamics of a culture of white supremacy permeating the hospital and medical space leaving individuals grappling with how racism and classism influence birth in the BIC.

Perceptions of race and racism had material consequences for BPs in this sample. Alexis’s premature baby was kept in the NICU after birth and the use of a special machine was necessary to get the ok for the baby to leave: “If I were a white person, they would have found the [piece of equipment]. [My baby] didn't have to be in there as long as she did but that also plays into the like the communication piece and how I'm read.” The medical institution and its actors “reading” BPs played a direct role in tangible outcomes. Carla retells an event after a home birth where a BP “lost a little too much blood” and led to a healthy newborn unnecessarily separated from its parents:

Carla: The ambulance came and they're fussing over the baby who is completely fine…. And we're like, “No, no, no. The mom. You need to focus on the mom.” But then they take the mom, and they insist on taking the baby….I get there and ….They’re giving the baby a bath they’re taking off the umbilical clamp and giving the baby a new one. They're doing all of these things to the baby! But this woman was not white, and I think that they were taking advantage of the situation and they were just completely disrespectful to the parents and the parent’s wishes.

This account presents more evidence of the ways that BPOC are more likely to be “taken advantage of” and is an example of the invasive reach of hospital authority that can occur even when birth happens outside the hospital. Additionally, this BP’s baby was kept in the hospital after the BP was discharged for another 24 hours because “They told her that they need to keep the baby for observation in case it develops jaundice!” According to BSP and BP accounts, being a BPOC presented a constant and significant challenge to recognition by the medical institution as a capable and worthy individual. It also resulted in increased medical management against BP’s desires often without cause.
BPs did not always have clarity on how their race influenced their birth experience.

Jasmine reflected on the possible causes of her life and death situation:

Jasmine: I don't know if it's two things…. Basically, it could have been a combination of [the white attending OB] is young and I remember the feeling when she walked in the door like she knew what she was doing. Like she knew everything. Like, “We're going to deliver this baby. Don't worry. I've done this…. I got this.” So, she came in very cocky and confident. So, I don't know … if it was this combination of she was young, and she over thought her ability? Or she was a white woman and I'm a black woman…. Like I said, I never saw her [the white attending OB] again. It wasn't like a, hey this is what went wrong. This is what happened. Nothing….. I feel like she knew she messed up too -- but she did not have it in her to face me after that. And that's to me…. I don't know if it was my color or her age or if she felt ashamed at that moment…. I'm just not sure which one it was but [my race] is a possibility.

Jasmine hones-in on the lack of connection with the white OB and her failure to provide closure around this incident as part of what lead her to believe the doctor’s actions and inactions were due to race/racism. It is possible that the “cockiness” the white OB exuded, the lack of personalized attention, and the shame that Jasmine attributes to age are all influenced by racism. Jasmine is inclined to an either/or framing on the topic, but I would argue all of these things she insightfully mentions are at play. Overall, the inability to connect with BPs based on race is a significant factor in poor clinical care. Taylor describes the facts of racial disparities in birth but says she did not feel “racially profiled” during her hospital experience that included an unnecessary cesarean birth under full anesthesia:

Taylor: I didn't feel like that but again the intent behind how a system works is…. A lot of times you don't feel its affects until after it's done…. If somebody asked me which hospital [to birth in], I would say Baston Hills -- if you want to have your child [laughs]. At Westwood I think they look for ways to put you on a table…. I don't think it's that their system is … it’s not all racially motivated. They may do more [cesareans] on Black women -- which there would probably be a level of racial reasoning there -- but it's just their culture. Because they’re the baby factory and they have the highest rate of cesareans … because you know a cesarean’s 30 minutes you're done you're done!
While Taylor acknowledges the systemic forces at play in her experience she does not commit to race as a significantly influential factor. The narrative of Westwood’s proclivity to over-medicalize writ large leads Taylor to assume this was the largest determining influence in her (mis)treatment. In light of these data, I argue that being Black and without a birthing partner present may have also played a significant role.

Carla recalls an incident where a Black BP sought repair for tearing after a home birth at the hospital and was clearly discriminated against:

Carla: [They said] “Oh, your midwife can't handle that?” [They] kind of mocked her midwife. So, then [the BP] is getting stitched up and they either didn't give her enough lidocaine or they didn’t wait for it to kick in…. She’s like, I was feeling it and I told them, and they dismissed it. They just didn't acknowledge it and continue to suture her up…. [Afterwards] they told her they didn’t have any numbing spray for her -- that they didn't have any ice packs -- like the things that hospitals are always stocked with! They told her that they were out of it…. They made some comment about her being on Medicaid and her husband was like, “We're not on Medicaid.”

Again, racist stereotypes and classism (in addition to racist medical beliefs about pain) are linked in this example of a Black BP who received discriminatory and blatantly poor care. The outright lies in this excerpt underline the enormous harm possible from BSPs acting on ingrained stereotypes. The disdain of the nurses towards home birth in combination with their deliberate neglect of the BP based on a presumption of insurance status highlight the dynamic intersections of violence during birth. This BP also recounted nurses continuously asking why she chose homebirth and she replied by stating the obvious: “Because this is how I would have been treated in labor!… I'm glad I chose to give birth at home … because of the way I'm being treated right now!” In addition to belittling the BP and her choices, the response by nurses illustrates the dominance of medical authority in cultural ideas of birth in the U.S. The theme of hospital avoidance due to mistreatment noted in largely lower-resource countries is also present in this
scenario. Of note, Julia and Taylor (both BPOC’s) chose home births after their difficult birth experiences.

While most BSPs (N=6) gave examples of witnessing mistreatment based on race, throughout interviews many BSPs and BPOC expressed reluctance to attribute (mis)treatment to race and racism and offered other possibilities:

Carla: I yell[ed] at nurses to come in the [triage] room because they just kind of ignored her a little bit…. I can't say that that was specifically race because it’s like all right, they could have been busy or not taking her very seriously…. Sometimes I just write that off as they’re just busy and she’s in triage. They don’t really care.

The bureaucracy and lack of sensitivity of the hospital environment made it difficult for some BPs and BSPs to connect poor treatment to race if there was not explicit discriminatory behavior or language involved. Some BSPs in this study also worked within the framing that obstetric racism and discrimination were the sole domain of white BSPs constraining their perspective of OV. Using a structural approach, we can see that even without individual actors, racial violence and discrimination are built into the BIC setting, dynamics, and policy through white-oriented decision making and administration (Feagin and Bennefield 2014).

Several white BSPs seemed aware of racism in medicine yet held limited perspective. For example, Martha supports her argument that “race is where it’s at” with this reflection:

Martha: The only time that I know what kind of health insurance my patient has is when I’m going to tie your tubes…. If you have Medicaid you have to have signed this sterilization form at least three days before I tie your tubes or else Medicaid won't pay for it, which is a holdover from the days when we used to inappropriately sterilize people -- but now it’s working in the opposite way. So that people with Medicaid are not able to get the sterilization that they desire. Which is crazy…. Otherwise, I have no idea if the hospital gets reimbursed. I don't know at what rate and it doesn't matter to me.

While the intent of this response is to express the fact that the insurance status of patients is unknown to hospital BSPs, as we saw in an earlier excerpt, not knowing Medicaid status does
not preclude them from making assumptions based on perceived race. Martha then describes a Medicaid requirement that brings insurance status to light. Interestingly, she suggests that this is an outdated rule that is no longer needed. While the rule may have unintended negative consequences, the literature tells us that the topic of forced sterilization is more complex than these remarks suggest and that this form of state sanctioned OV is not a relic of history.

Evidence from Mexico and Canada document birth control forced on mostly indigenous BPs:

They force us to sign the declaration of consent that we want the IUD. If you can’t sign it yourself, the husband has to. I mean that’s a crime. They force you, although you should have the control over your body….That’s why many women don’t want to go to the hospital for delivery or don’t want to have a doctor take care of them (Dorr and Dietz 2020-PR14).

Similarly, unconsented sterilization and forced sterilization are still active practices in the criminal “justice” system (Flavin 2009), and in immigration detention centers in the U.S. as recently as 2020 (Moore 2020). The lack of understanding of the reach of OV in all of its forms limits BSP and the medical institution’s ability to fully acknowledge contemporary manifestations of racism associated with OV and address them.

Finally, the concept of racial microaggressions came up when Martha reflected on the difficulty of communicating about racism in the hospital amongst colleagues:

Martha: I have certainly had experiences where I felt like a patient was being treated differently because of their race and, it’s really hard. I try to be an ally and I try to help the staff member kind of see it at least from my perspective, but it’s hard. I think we all have implicit ways [of being racist] in our vocabulary. Like you might be more likely to describe a white patient as being “lovely” than a black patient and little unconscious things that we do.

Part of what is “hard” seems to be the ways that this everyday racism is viewed as unattached to intention. Martha describes just one off-hand example of a myriad of microaggressions embedded in medical culture. Pointing out that these are “little unconscious things” displays her awareness of the existence of racial bias and discrimination while at the same time minimizing
its cumulative harm. Microaggressions in the medical environment may be written off as slips of
the tongue but they reveal deep-seated beliefs and are linked to attitudes and norms that impact
care and maternal health outcomes (Slaughter-Acey et al. 2019; Freeman and Stewart 2018). Our
embodied race carries history and imbues interactions with meaning and dynamics of power
regardless of our consciousness or intention. Describing a patient as “lovely” amongst colleagues
rather than describing them as “difficult” contributes to material benefits for BPs in the form of
attention and quality of care. Thus, behaviors from BSPs associated with implicit language
serves to categorize BPs in hospitals in particular ways and contributes to OV.

I asked all participants to reflect on their race and their experience with birth in the
hospital. In this section, I include the responses from mostly white and white appearing BPs
which indicated a range of knowledge about the current maternal mortality crisis, racism in
medicine, and the concept of race discrimination and privilege. Amaya applies the white racial
frame (Feagin 2013) as she describes her class and race privilege as rendering her “neutral” in
the hospital setting.

Amaya: I would say that there was not probably any marked difference or you
know, like that it had much of an influence because you know, I do have the
privilege of being a middle-class white woman, and I think that’s generally just
kind of… I get to be neutral in that way.

Though expressing some understanding of racism in other responses, Amaya sees whiteness as a
default that didn’t impact her experience one way or another in the hospital. On the other hand,
Claire expressed that “unfortunately” everyday race privilege is at play “no matter what you’re
doing … whether you are getting gas or you’re having a baby in the hospital.” White BPs had
some guilt and discomfort when answering this question. For example, the question of race
prompts Sarah to bring up her partner’s race/ethnicity as well as her child’s: “I mean I bet people
of color have a shittier experience than I [did] … I don't know that. My son is a quarter Japanese,
but he looks white. People think he's white.” Even BPs like Sarah, who did not explicitly respond with knowledge of racial disparities and racism in birth, knew that it surely occurred.

Emily and Tabitha -- who both worked in healthcare -- described a stronger connection between their race and their care. They also expressed an awareness of racial discrimination in birth and disparities in outcomes:

Tabitha: [B]eing white definitely helped me. I tore and bled for quite some time and it wasn’t until the blood pressure machine was doing 47 over 36 that people came in and started really paying attention to my husband who was like, “This thing is going off. This thing is going off! This thing is going off!!”… People paid attention finally and I don't know that that would have happened had I been a woman of color. I’m afraid that people would have written off my husband if he had been a man of color.

Jasmine’s description of hearing her partner’s desperate pleas while BSPs neglected to respond to her during a similar situation involving a hemorrhage corroborates Tabitha’s impression:

Jasmine: I heard my partner screaming…. Screaming at the top of his lungs and I, you know, I was out of it. I knew he was stressing but I didn't know exactly what was happening … I didn't know I was bleeding out….From [my partner’s] point of view, the [OB] just sat there and she kind of breathes in and doesn’t move and that’s the point when… I guess hearing him in the background was real sad… He’s like, “Please save her! Do something!!” and then nothing. The doctor [wasn’t doing anything].

Jasmine emotionally recalls this especially meaningful moment with her partner and describes a result that is in direct contrast to Tabitha’s account. A feeling of disconnect, and not being able to communicate or elicit a response from hospital BSPs and staff was common throughout texts and interviews for BPOCs and often was encountered in high stakes situations. The two different scenarios give us a glimpse into the ways that racism may influence important relationship dynamics during crucial moments in hospital birth when BSPs have to act confidently and quickly to provide appropriate care.
White appearing BPs who identified otherwise had nuanced feelings about race and their experiences. Nia identified as “Caucasian and African-American:”

Nia: I'm only a quarter. My mom is half black. From an outside perspective I’m probably seen as Caucasian…. People always ask me what I am…But I would never say I identify as Black primarily although I do mark two or more races…. African-American women die every day from stuff like that. So, no. I don't want to say mine had anything to do with that.

Though noting her race as ambiguous to others Nia distances her multiracial identity from her experience bringing up that boundary especially due to racial disparities in maternal mortality. Ava, talks in depth about the privilege she assumes she received, during her extended stay of hospitalized bed rest, due to this perception of her racial/ethnic identity:

Ava: I'm Colombian. I was raised in Colombia. That's how I identify. I feel very connected to Colombian culture. I speak Spanish. I teach Spanish. I'm raising [my child] bilingually blah blah blah, but I'm white passing. So, my family is a mix of indigenous and Spanish. I'm more white -- even though I'm not white. I'm considered white passing…. I mean I have to say yes because it would be tone deaf for me to say no…. But the history and what everything suggests -- what life suggests -- is that the fact that I’m white passing the fact that I have a white husband…. It's probably very likely -- a hundred percent -- it influences how I'm treated in a hospital setting. So, I would want to believe that because of the [Black and Hispanic] community that they’re serving that they would treat everybody equally but I'm going to make the assumption that they don’t … that the way that doctors probably connected with me and would sit on the little couch in my room maybe wasn't the same way that they would connect with other people.

Ava details the many ways she feels connected to her Columbian (and indigenous) identity while at the same time she is highly aware of her treatment as “white” during interactions with the everyday world. Of significance, she highlights the micro-affection of white doctors’ comfort with her allowing them to relax and interact in uninhibited ways. Again, this sense of ease and comfortable connection described through behavior and communication style is what several BPOCs felt was missing or disjointed in their care with white hospital BSPs.
As class and race surfaced continuously as interdependent systems, it is important to note that white and white-appearing BPs often attributed their ability to self-advocate and communicate effectively with BSPs to their education, knowledge base, and general plethora of resources: Ava: “I'm lucky because I have the education. I have the background. I know who I am…. I have that privilege but there are many people that don't. So, I can speak up for myself and be like, “No, fuck you!” Maybe [some] people are not going to do that.” White and white appearing BPs also mentioned that their personalities played into the way they were able to communicate and advocate (or not) in the hospital setting: Sarah: “I don't shy away from confrontation. I also am not the type of person that's just gonna scream at a waiter, you know for forgetting my side of parmesan cheese. I'll try to have a hard but productive conversation with you.” Similarly, Kelley iterates the ways in which she was very comfortable advocating for herself and attributes that to “knowledge,” “confidence,” and “resources” without an analysis of race privilege. She does acknowledge that there are people who may not be “perceived as educated” but does not attribute that perception to race or another factor. Most BPs had an awareness of the ways that BSPs perceived them and consciously attempted to manage these perceptions. In addition to race and education, size was a social status with both material consequences for provision of medical services and perceptions of BPs.

The status of “plus-size” or “fat” emerged from the data as a contested identity in the hospital during birth in popular texts and interviews specifically in the U.S. context. Isabel and Laura both expressed frustration when noting that “plus-size” clients are “bullied” and pressured into medical interventions more readily due to perceived risk. The medical stigma of being fat and pregnant negatively influenced the BPs confidence and potentially added undue stress to normal pregnancies and labor. Laura describes the dubiousness of OBs considering fat pregnant
folks “risky” by saying “my air quotes -- overweight diagnosed clients.” In practice this medical stigma is powerful:

Laura: OBs tend to put them through a more fine-tooth comb … everything is more extreme …. [A BP during labor] said, “I told you that they didn't believe I could do it” because she was obese and eventually at the end the baby had one decel – one - and [the OB] was like, “You know, you're not really dilating and your baby's heart rate's in danger now. I just feel like we need to c-section you.”

The medical framing of pregnancy as a state of peril catapults obese BPs into a “high-risk category” that receives extensive scrutiny from doctors already poised to interfere (Simonds 2007). Rothman notes, “Even if a woman does have all the healthy characteristics medicine can ask for, she still won’t be called healthy, or even normal” (Simonds 2007:30). In this case, Laura was upset by the OBs swift move to cesarean and believed the BP was manipulated and coerced.

Isabel observed a similar kind of undermining approach used by hospital BSPs with her client:

Isabel: That woman she was definitely absolutely -- had fat…. So, the doctors were bullying her about her weight and telling her that she wasn’t going to be able to birth such a big baby. They kept calling her baby big too because her body is big…. She was always feeling very upset about the weight and them talking about her weight … and suggesting that her being fat was putting the whole pregnancy at risk when otherwise … she didn't smoke she ate very healthy. She goes on walks with her wife every single day -- but the fat phobia I think that that definitely affected her care.

A fixation on the size of fetuses (though irrelevant) combined with “fat phobia” and the continued regulation of weight gain in pregnancy by medical authority (forever conflated with hypertension since the 60s) creates challenges for “plus-sized” BPs during pregnancy and birth (Simonds 2007). Beyond the medical stigma of fat, fat discrimination at large existed:

Naomi: I think being plus-size really does factor into it. I think people when they see me they're sort of like surprised at what I do for a living as a nuclear engineer, you know?.... I think there's definitely some factor of you know, presenting as a fat person that really decreases my credibility and respect.
Medicalized fat stigma and societal associations of fat with classist tropes leads to prejudice and biased practice by BSPs in birth. Naomi goes on to describe difficulties around the lack of accommodations for “plus size” laboring people and how that impacted her experience with monitors that did not fit causing “a lot of unnecessary freaking out.” BSPs also spoke about how size stigma played into the built environment of the institution as size excluded BP from certain options and restricted choice of laboring place: Isabel: “[Plus-size BPs] also can't have a water birth. So that's like an actual thing. They can't do. If you have a certain BMI, you can't have a water birth.”

Martha: Size is totally an issue. It's really hard in medicine because frankly as a surgeon I cannot do surgery on someone of a certain size if we don't have the equipment to do so…. We transfer patients above a certain BMI out to other hospitals because of their BMI -- because we don't have the capacity to do a C-section if they need one or because our beds, they can't accommodate their BMI and that's terrible.

Martha goes on to describe her own internalized biases around size.

Martha: [at a different hospital] We get transfers in because of size -- which is really awkward…. It sucks. And yeah, I'm sure that I ask more about diabetes and hypertension history in someone who’s overweight. I'm sure that I do those things. And I'm sure that my heart sinks a little bit when I walk into a room and my next section is a BMI 48.

Martha implies a dynamic that knowingly harms BPs who come into the hospital specifically to accommodate their size and acknowledges issues of prejudice towards BPs as par for the course. Of note, Martha was the only BSP who acknowledged and directly reflected on her own bias and its influence on treatment and did so most directly around size and race. Throughout my investigation, interviewees responses and texts provided evidence of the intertwined state of sexism, genderism, racism, and classism in material experiences of OV with racism being most
influential. In addition to social status and identity within the BIC, birth culture at large was influential in the way BPs and BSPs understood OV and birth in the hospital.

4.2 Birth Culture, Race, Class, and Feminism: “There’s a huge divide.”

Values, beliefs, attitudes, and particular behaviors related to birth culture emerged prominently in texts and interviews. A birth culture focused on problems of over-medicalization arose most commonly in texts and videos originating in Brazil and the U.S. (N=29). While conceptions of race and racism vary between these two nations, the birth cultures of the U.S. and Brazil share an understanding of birth as a feminist issue and there is some evidence that the relative dominant groups are becoming increasingly aware of intersecting oppressions acting therein.

Activists in Brazil and the U.S. used documentaries and social media campaigns to raise awareness of OV through individual testimony. Some of these documentaries were highly produced and others were recorded on phones and pieced together in amateur fashion. There was a tendency for films centering white and upper-class people to focus on OV as an issue of over-medicalization while those centering BPOC highlighted issues of morbidity and mortality. For example, a professionally produced Brazilian movie with multiple installments on Netflix *The Birth Reborn* (2013) stands in stark contrast to *A Dor Reprimida: Violência Obstétrica e Mulheres Negras* (2017), a movie that highlights the poor outcomes for Black women in public hospital systems. In *The Birth Reborn* (2013), a white upper class appearing woman is filmed

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28 While other forms of discrimination like heterosexism and ableism did not come up in this analysis specifically. They are most definitely influential in the BIC and contributory to OV.
talking about how important and essential the experience of vaginal birth is while lounging in her plush home complete with indoor/outdoor gardens and pools in the background. When the shot shifts to a midwife standing in a rural landscape, the privilege of rejecting medicalization and classist stereotypes is further emphasized. She describes how “country folk” are able to approach birth simply without the “burden” of over-thinking that “modern” women bear. In contrast, A Dor Reprimida: violência obstétrica e mulheres Negras (2017) presents Black BPs detailing experiences of abuse and mistreatment in facility births with minimal production offering gritty visuals, poor sound quality, and direct camera shots. These examples represent important differences in analytical framing of OV in birth by country, race, and material experience. As no social group is a monolith, neither is the experience of OV universal or equalizing.

Class was also at play in cultural mandates to research and become educated before birth as a way to avoid over-medicalization. This was a prominent theme for most interviewees and education often came in the form of media consumption. Laura speaks to patterns she observes in BPs with induction and a popular film comes up:

Laura: It’s hard because some of the moms try to go without the epidural first because their first-time moms and the Pitocin just seems too much. And then they get the epidural and then it's just this like, you know, you've seen the movie -- you’ve seen that the birth -- it's just goes downhill from there.

In responding to what she finds most difficult to manage in hospital birth, Laura brings up inductions and refers to the scene from a ubiquitous film in U.S. birth culture, The Business of Being Born (2008). Central in the film is the shot of a long list of patients and rooms in an obstetric ward written on a white board with “pit30” by their each of their names. This cultural classic details the over-medicalization of birth, the impact of interventions, and the phenomenon

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30 Pitocin is a synthetic version of oxytocin, the hormone that causes contractions. It is used commonly in the hospital setting to begin or augment (“speed up”) labor.
often referred to as “a cascade of interventions” ending in cesarean. Many BPs in texts and interviews (N=7) spontaneously mentioned this movie and the concept of being swept away by medicalization in the hospital as resonating with their own experience. The movie, featuring mostly white BPs, is a highly influential educational tool that shapes beliefs about birth in the hospital and leads to many expressing the desire to avoid unnecessary interventions.

Daisy: I [feared that] I was going to kind of you know end up in this, you know…. I think I watched the Business of Being Born and that kind of made me not want … that made me think about what I wanted…. [I was afraid] of losing control … like all of a sudden you’re in the operating room or something.

Naomi, who went on to have a home birth after three cesareans, comments on the widespread influential nature of the film calling it “the gateway drug to out of hospital birth.” Taylor also remarks on the powerful influence of the film in processing her forced cesarean as an issue of over-medicalization: “Especially after I watched The Business of Being Born -- It just became very apparent that it was more about you know not allowing the woman to have the full process of it.” The “business” of medicalized birth was exposed in the movie through the depiction of overuse and abuse of interventions and procedures for profit. The messaging that hospitals are unjustly pushing interventions for economic reasons resonated with BPs in this sample of educated lower-middle to upper class women. The Business of Being Born (2008) was the only movie BPs mentioned as influential in their thinking and planning for birth. In contrast, a more recent short film produced by Fusion TV on the state of birth in the hospital called Death by Delivery (2018) centers a race-critical perspective of the issue in the U.S. using footage from interviews of BPOC across the country discussing discrimination, poor quality of care, lack of access, and racial disparities in maternal mortality. It seems, the divide of interests along racial lines in birth culture is reflected in both the difference in framing, and popular awareness of the issues.
BSPs mentioned issues of race and racism in birth culture mostly when I asked white BSPs (N=8) about the concept of “cultural competency” and their practices (How do you understand the idea of cultural competency? Can you tell me how this is reflected in your practice?). Interviewees spoke to the role of race in their fields and detailed navigating interactions with patients as well as with colleagues. At times they discussed their experiences with an understanding of the larger context of historical racism and racial health disparities.

There was a tendency for BSPs to understand issues of race using a black/white binary. Podcast and texts also revealed this racial paradigm common in the U.S. An exception was Vanessa, a Black “elder” doula, who noted,

Vanessa: Here in Georgia it’s very black -- white. I’m like, “Well there’s more than just black and white people how about that?” It just gets on my nerves the race thing here is just so crazy.... It’s all about black white and then you know I hear a doula say, “Oh I had a white client!” I’m like, “What are you talking about? She’s your client.”

In addition to the problematic framing of people into Black or white racial categories within birth work locally, in Vanessa’s view, the race of her clients was not a significant or worthy topic of professional discussion. This perspective is remarkable in that it leans into an anti-racist view that wholly individualizes clients without giving weight to their racial identity as a factor of that relationship. This perspective is in alignment with Vanessa’s holistic and non-discriminatory practice philosophy more broadly.

On the other hand, white BSPs often struggled with issues around client “choice” and their own inter-racial intelligence, competency, and comfort:

Violet: I had a [Black] family at their first visit ask, “So, do you even ever take care of Black women?” Her husband just kind of flat out said that and I was like, “I'm so glad you asked. Yes, absolutely. Please ask anything you're not going to offend me”.... I was able to say, this is our preterm birth rate for both for all of our women, but especially for African-American women....I think that helped. But I do
sometimes feel like, you know, truly at the end of the day -- I'm a white woman talking to a Black woman or husband about their care.

While Violet attempts to gain trust by using outcomes and macro-level evidence to allay the patient’s concerns about race in regard to their medical relationship, she believes and is somewhat resigned to a sense that the micro-level experience is disconnected in a meaningful way for her Black BPs. Several white doulas I spoke with justified serving mainly white BPs due to word-of-mouth marketing, and because of the general racial/ethnic segregation of the metro area where participants worked and lived. A recognition often thinly veiled as “just the way it is.” Vanessa observes an outcome she notices when doulas use implicit discriminatory client selection practices like only working in certain hospitals, “there’s the whole thing of …doulas overshooting the actual client. And then they get only certain types of clients as a result…” In her assessment client homogeny comes from these kinds of direct but seemingly innocuous choices. Isabel manifested a different framing for her practices of client selection. In her account there is a tension between having an inclusive practice and supporting the work of doulas of color:

Isabel: I personally love and I'm totally willing to support Black and Brown women. But also, I think that Black moms deserve Black doulas and there are so many good Black doulas. My partner [back-up doula] for two years was a Black woman and a yoga teacher, and sometimes [I would say] Jasmine is a better fit for the intimate care part because she has lived your experience….So, I think that it's just my awareness of….connecting Black and Brown folks with Black and Brown birth workers. I'm not saying I won't do it. I'll absolutely do it and I have done it. But again, if I'm not the best person for them I have no problem admitting that I'm not.

Isabel expresses a hesitancy in competency when considering working with Black clients. Interestingly, she doesn’t detail how she knows when “she’s not the best choice” for black clients soliciting her care. While there is an authentic desire to do what’s “best” for BPs there also
seems to be a tendency for white birth workers to avoid racial discomfort and personal growth using various justifications to keep themselves in their comfort zone.

Carla, in particular, noted wanting to work with a diverse group of BPs. She references the “huge divide” among Black and white midwives regarding views on certification and professionalization that is “very complicated” as well as the desire for racially concordant care by BPs that impacted this goal for her. Carla: “[T]here are women who specifically choose black midwives and that’s fine.” The politicization and oppression of midwifery as a practice in conjunction with historic and continued racism within dominant organizations creates complex racial dynamics for midwives and BPs. A BP from the Black Women Birthing Justice (BWBJ) project recounts how she sought out an African-American midwife for her birth after an unplanned hospital cesarean:

Lauren: I didn’t know where to look. I actually put “African-American midwife” in the Google, and when I called the midwives I called, I asked, I got surprised answer like you need to be birthed by an African American? Okay, I’m not trying to be rude, but I’m just wondering, do you know any? I got the name of one African-American ob-gyn, who was so busy she couldn’t even talk to me. She has famous clients or something. So that experience was “Okay, I don’t need – I’ve been there, I had Dr. Hollywood, he was a white guy, but you know, I don’t need the black female version please. (Oparah 2018:51).

Importantly, in this excerpt Lauren indicates her preference not only for an African-American BSP but also the midwifery model of care. The percentage of Black midwives is low due to historical exclusion, but their expertise is increasingly sought after as awareness of the benefits of the midwifery model of care specifically for Black BPs is increasing (Yoder and Hardy 2018). There is also a substantial body of research on the positive effects of racial concordance in medicine and particularly in maternal health that is informing BP choice and the interactions between BSPs and BPs (Greenwood et al. 2020; Takeshita et al. 2020).
BSPs and BPs mentioned a lack of Black and brown professional representation in the BIC. A statement Vanessa makes on the segregated aspect of birth culture in the GA illustrates one of the many ways racism hinders career development for BSPs of color: “It’s so rigid and fake when it’s not. The GA birth network -- they’re crap. They’re nice for white women. Women of color will get on there and, ‘Well I tried to connect buy nobody would really connect.’” Vanessa calls out the popular on and offline platform meant to support and “connect” birth professionals throughout the state as practically useless for BSPs of color. The importance of diversifying the field was important for others too:

Julia: We need more people that look like us whoever we are -- you know, Black, Asian, whatever…. I’m so happy when I see a Latina nurse because I’m Latina, you know?... Because that’s a huge population -- percentage [of BPs] at this institution and I think it’s just so unfair that they wouldn't want to attract more Latina nurses or nurses who speak Spanish…. I think especially the L&D world needs to do better with that.

Julia pointed to structural bias in medical education as a challenge for diverse BSPs and as a factor in the lack of representation. She makes a personal connection to the micro level benefits of race/ethnic concordance and perinatal health. While some white BSPs understood the lack of POC representation in the medical field to be problematic they expressed uncertainty in how to support change. Violet expresses the desire to bring a full-time midwife of color on board with her group but alludes to this desire being frustrated in some way. “I really want to serve women of color … we have one midwife, that's Indian…. but we have not had a full-time midwife that's a woman of color despite really trying…we really want that.” While she feels it is important, Violet does not provide further reflection on why the group may not be able to accomplish the goal of retaining a midwife of color.

Vexing moves for meaningful representation is the burden that tokenism creates for (mostly women) BSPs of color in a majority white field. Martha mentioned a friend, a Black
woman OB, who felt the overwhelming pressure of having no room to fail. Julia speaks to the practical burden on POC staff: “Some L&D nurses will look at me and be like ‘Oh yes, I’m so glad you’re here for my delivery because she speaks Spanish. This is great.’ I do have to continually remind them -- I am not a licensed interpreter. That is not my role.” The durable lack of representation and the burden of under-representation created a tension many BPs and BSPs expressed around race and the medical profession. It is well documented that increasing representation -- as well as support and equity -- for medical BSPs of color should be part of a multipronged effort to address race and ethnic disparities in health outcomes. (Smedley 2003).

Not all people who give birth in hospitals identify as women, but the medicalization of birth and its politicization are soundly gendered. To gauge feminist ideology and its influence on understanding the birth experience, I asked BPs to reflect on their connection to feminism as well as how it informs their ideas about birth. Most BPs expressed some alignment with feminism but many with qualification. A fewer number of BPs brought in intersectional thinking regarding race and class though most reflections remained gender essentialist with responses expressed an understanding of “fundamental differences” between men and women and the idea that “a man is never going to be able to experience childbirth.”

Julia and Sarah drew on explicitly gender-centric ideas about the construction of medicine and the BIC as a project of the patriarchy in their responses. While Julia describes her feminist beliefs as “not super hardcore” she had a lot to say about gender and midwifery:

Julia: I hate this thing like it’s us vs. them -- but a lot of the dr.’s are male, but all of the midwives are women.... First of all, I don’t think it’s natural. Like when did man being an OBGyn make sense?... And that you know, the midwife movement was just always put down. Like what more would you want? It’s women treating women. Women know what women have and how they feel.
Sarah, like Julia framed childbirth as “natural” for women as an argument against its paternalistic medicalization and capitalization:

Sarah: [W]e have been here on the planet for thousands of years and to our knowledge there has not been a man who birthed a single baby. So, we were meant to do this. There’s nothing wrong about birth. It’s totally natural. I think that where it gets tricky is the systems that have been put in place to quote “save lives” were predominantly constructed by men and they exist within a capitalistic system, which is really driven by the dollar. So, things have been systemically put in place to remove a woman’s intuition from herself to make her doubt her ability to naturally birth a baby or even to say I want the drugs now and mean it. You know? Like now is when she wants the drugs!

Sarah picks up on the pathologizing, disempowering, capitalist loop in the BIC and, though she emphasizes the medicalization of birth as problematic, comes back to feminism being about autonomy. Overall, a gender-centered everyday feminist thought was pervasive in most responses.

Some BPs distanced themselves from feminism and others were unsure about the relationship between feminism and the childbirth experience:

Claire: I would never go wear one of the pink pussy hats or whatever anything like that. I don't think that’s socially appropriate. But do I believe in equality on every level absolutely and my parents brought me up in a way to treat everyone equally absolutely.

Claire leans on a general ideology of equality passed down from her parents akin to color blind racism and uses wearing a “pink pussy hat” (made popular by the March for Women in 2016) as a boundary to indicate her conservative thinking on the topic. Ava was the only BP who brought up distancing herself from feminism due to racism: “that’s a really complicated term because you know, when we speak about feminism, it’s usually under white feminism. So, I'm very aware about the concepts and how problematic they are.” Hesitancy to label oneself a feminist came up for Kate as well but for different reasons. She indicates not being a “joiner” and evokes an individualist ideology as justification saying, “I always joke the only thing I’m committed to are
my husband and my children.” Kate then concedes that women are devalued in general and reflects on her previous teen birth:

Kate: I recognize…. [significant pause] … [sighs]…I do recognize that women are often devalued in that position of not knowing what’s best for them. And since I experienced that in my first birth at such a young age, I think it created an impression in me to know that I have to be my own advocate and that I have to have a voice for myself. And I have to speak louder than they speak.

The theme of not being heard was significant throughout this study and it came up several times when BPs reflected on feminism and childbirth.

Nia had an awareness that BSP gender did not guarantee that they refrained from “muting” BPs. Nia: “[My OB] thought that he knew what was best for me -- even tried telling me what he would tell his wife and stuff like that…. And it’s not always males … there’s women who do it to women.” Nia in particular expressed the critical understanding that paternalism lies in the field of medicine and is not necessarily tied to the gender of the individual OB. Finally, multiple BPs detailed a narrative of unfolding understandings of feminism and also presented a more actively developing intersectional understanding. Kelley gets closer to a gender and class-oriented feminist approach when talking about “access” for “women and people who identify as women or female or however to have the rights they need to have…. The medical system should give people the same information, opportunities, and ability to understand and advocate for themselves and I don’t think it does.” Alexis relates to feminism but suggests it is not a helpful frame for understanding birth:

Alexis: [I]t’s part of a system. You are born into a system and you’re part of the system and you have to work to not be part of the system. So, it's not just me on a personal level it is part of how our country runs. How the world runs…I don’t think [issues related to birth] are so much [about] feminism. I think it’s human rights. I think it’s you know, it’s for everybody.
Alexis extends the framework of issues around birth to encompass human rights and conveys a sense that while equality should be a basic goal -- “Yeah, sexism shouldn’t exist. Smash the patriarchy and all that”-- what is more important is the freedom for women “to be -- to be as they are … to be safe.” This freedom is what is missing from the BIC in Alexis’ account and is what should be focused on.

The BPs with whom I spoke all identified as heterosexual cis-women and did not attribute gender or heterosexual privilege to their experiences. BSPs did not recall or describe mistreatment based on gender non-conformity or sexuality. Overall, the data gathered from interviews showed a constrained understanding of gender and its relationship to birth for BPs. While responses reflect a range of engagement with feminism that may or may not be accurate for BPs at large, the responses do give some measure of the gender-centered position of feminism in mainstream culture. The lack of inclusion of transgender issues in responses is telling. Two decades ago, in 2002, in an essay titled “Deconstructing Trans,” Riki Wilchins asked:

Where is feminism today? Why has transgenderism remained the source of long-running tensions within feminist ranks? Genderqueerness would seem to be a natural avenue for feminism to contest Woman’s equation with nurturance, femininity and reproduction: in short to trouble the project of Man. Yet feminists have been loath to take that avenue, in no small part because queering Woman threatens the very category on which feminism depends…It may take a generation of young women to take queerness to its natural feminist conclusions - women for whom such queerness is not a threat but a new kind of feminist freedom (p.57-58).

Thinking about transmen in the context of birth adds further opportunity to contest the boundaries of gender as it relates to childbirth and parenting. The responses from BPs here suggest everyday interpretations of feminism have not pushed the boundaries to “a new kind of feminist freedom.” I would argue that 20 years later, we might accept the limits of traditional feminism(s) in resisting gendered oppression in birth. It seems analytically and materially more
useful to engage in an expansive feminism represented in the realm of queer theory to understand OV (Sullivan 2003; Monaghan and McCann 2020) although it is also imperative to provide an explicitly race critical analysis; something with which queer theory has struggled (Johnson 2001). Inevitably, the contested site of birth will continue to be a place where gender and sex are undeniably messy and visceral; a site that complicates identity and one that invites conversation between feminist and queer theorists alike.

One of the most telling pieces of popular discourse to enter birth culture recently years is a letter written by a group calling themselves “women-centered midwifery” (WCM) (and signed by “the mother of midwifery” Ina May Gaskin) to The Midwifery Association of North America (MANA). The letter was in response to revisions in MANA’s “core competencies” that implemented inclusive language for BPs “i.e., pregnant/birthing person” instead of “woman” (WCM 2015). The extremely transphobic letter suggested that these revisions were “contributing to the cultural erasure of women’s wisdom that the physiological power encoded in our female bodies.” I am not sure how using inclusive language “erases” women but perhaps it puts a squeeze on the essentialized oppression to which some feel entitled. The letter reads as a fear-based power grab and clutching of binary thinking that benefits the type of “patriarchal oppression” from which the group claims to seek “liberation.” Further, significant evidence in texts suggests that issues related to non-binary and trans people and birth are part of the contemporary conversation of OV:

Dani: I think one of the biggest struggles that my community faces, in terms of trans people and non-binary people especially or even masculine women or butch women face, is there’s a lot of transphobia for sure … can feel very disheartening because you have people who are supposed to be respecting the autonomy and the choices and the existence of somebody else…. It can be violent in a way. Not that it can be, it is. [Transphobia] is a form of violence against trans people and non-binary people to not respect who they are and not respect where they’re coming
from and saying all kinds of things like misgendering them, or ‘Well, they’re not really a man,’ or this, that, and the other. The list goes on (Dekker 2020-PC5).

Notably (and possibly in response to MANA’s move) a range of approaches expanding gendered language around birth on birth advocacy websites and some incidences of broadening language in peer-reviewed and popular texts existed. Four of the five websites I examined included statements that articulated the organization’s stance on an expanded understanding of gender in relationship to their advocacy. Three used the terms “birthing people” and “pregnant people.” BMMA detailed who they believed fell under their conception of “mamas”: “We recognize, celebrate, and support Black mamas – those who care for and mother our families and communities -- whether they are trans, cis, or gender non-conforming.”

Evidence Based Birth (EBB) speaks directly to the choice of language around gender on their materials and information presented on their platform citing “national health care initiatives” as a motivating factor. They indicate a “hope” that their language, using “women” and degendered terms as well is received as “balanced and inclusive.” The founder of EBB, Rebecca Dekker includes significant reflection on gender and birth and seeks to highlight folks in the birth community who do not identify as cisgender.

[O]ne thing that I’ve noticed is even in some really conservative parts of the country, the South … when I say, “birthing person,” nobody gets offended…. Although we do get emails, I’d say about every other week or so, from people who are extremely angry … for even using any kind of gender-inclusive language. They say that we’re trying to get rid of the word woman (Dekker 2020-PC5).

It remains to be seen, how much this cultural shift outside the hospital translates into the culture of facility birth.

Martha talked at length about frustrations around the lack of awareness of the basic difference in sex and gender in obstetrics: “I hate it when people call the baby’s sex the gender.” She recalled addressing the subject with a superior: “[The doctor] said something about how we
can determine the baby's gender based on this test and not this test…. I said, Doctor W. you mean sex. She looked at me and she was like ‘What?!’” While Martha’s reflection on gender in the OB specialty suggests some flexibility and new understanding (at least on her part), she is clearly frustrated with the lack of awareness and education about sex and gender in the profession at large noting bringing up the conversation is often “like talking to a wall.” Over three years of engaging in careful study of birth culture I have witnessed some change. On social media, images of transmen in labor and birth have moved from getting banned on Instagram31 to being shared widely in the birth community through various nationally recognized birth organizations. The visibility of transmasculine birthing people on social media (@dannythetransdad, @alionsfear, @kaydenxofficial), a call for gender inclusive midwifery (Reis 2020), and scholarship investigating transgender issues in the OBGyn field are hopeful signs towards shifting the “social taboo against the pregnant man” and the possibility of a more inclusive birth environment to come for everyone (Toze 2018:194).

4.3 Medical Authority in the BIC

The globalization of facility-based birth warrants a perspective that critically considers colonizing influences. A Mexican scholar highlights the influence of colonialism on the current health system: “We discussed enduring colonialism, which emphasizes the continuity and persistence of asymmetrical power relations in health care due to health disparities by race, gender, culture, and ethnicity” (Dorr and Dietz 2020-PR14). The authors indicate that understanding institutional racism in Mexico against indigenous birthing people as rooted in colonialism is crucial in that context.

31 Some photos are still banned if nipples of pregnant transmen are shown.
To dismantle these types of vicious circles of institutional discrimination, personal stigmatization, and victimized internalization between nonindigenous public health professionals and indigenous patients, the whole institutional system of health care must recognize the institutional racism, that is, colonially rooted means of perceiving, classifying, and simplifying indigenous “otherness” (Dorr and Dietz 2020-PR14).

I argue that OV and discrimination in the BIC across the globe arises from and is reproduced by a similar process of categorizing and designating “otherness.” In this way, medical authority in the BIC is uniquely situated to operate as a tool of white supremacy to regulate who “belongs” and receives benefits (like quality care) from societal membership. As a site of racialization, producer of health disparities, and population control, the particular ways that authority is wielded in the BIC is important. At the basis of the medical takeover of birth is the disconnection of BPs from their own bodies and an emphasis on the safety of the baby. In the contemporary context, this often means asserting authority through coerced procedures like inductions to prevent things from “going wrong.” Fetal protectionism, paternalism, and resulting practices in the BIC like “dead baby” threats, and a reliance and trust in machines are evidence of ways that aspects of medical authority work together to create an environment that fosters OV. At the same time, the evidence here suggests that BPs are not “blindly following” medical authority in many cases but actively pushing back on this authority with differing levels of success.

*fetal prioritization: Are you a mother? or a murderer?*

When thinking about the BIC as a system with a unique culture that processes BPs and babies through childbirth, a core value of “protecting” the baby in conjunction with the belief that pregnancy.birth is essential (as is motherhood) for women arises. In addition, the BIC assumes that every desire of every pregnant person culminates in, and should be fulfilled by, a baby who arrives alive. In contrast, various aspects of reproduction and sexuality come up when speaking
to BPs and analyzing texts about hospital birth and OV that complicate this reductive assumption. During interviews, BPs’ thoughts and personal reflections on a wider range of reproductive experience including pregnancy loss, stillbirth, infertility, abortion, and sex drive emerged. Also present were BP’s internal and external expectations of “motherhood” and what it means to be a “mother” in relationship to childbirth. Pregnancy and birth do not occur in a vacuum or under perfect circumstances but co-exist with all kinds of common health and life struggles. BPs are people who birth multiple babies and who may also choose to end unwanted pregnancies at different times and for different reasons. BPs are people who lose wanted pregnancies and may give birth to babies who are not born alive or live only moments. BPs carry babies under stressful circumstances, babies who come too early or too late, and some who are born during a time of a BP’s own precarious health.

In my sample, BPs volunteered that they had abortions (N=3) and lost previous pregnancies (N=2). Some struggled with infertility (N=3), and pregnancy complications like premature membrane rupture and labor (N=3). One BP was pregnant when she found out she had a brain tumor and had to undergo necessary treatment while pregnant. I also spoke with a BP who had a planned stillborn birth in the hospital and had a very difficult time in that setting due to protocols administered by BSPs that did not consider her unique situation. For example, her husband had to wear a name tag when he left the room that said something to the effect of, “I’m a new Dad!”32. Moreover, circumstances of BPs provided a range of perspectives of birth as complex and fraught with a range of emotions. This messiness is in juxtaposition to social expectations of a monolithic “motherhood.”

32 BP did not share her full story, but it is important to extend the scope of hospital birth to these situations.
The socially mandated role of the “good mother” is used as a means of control and is reinforced in the BIC today. BPs make sense of birth in the context of external and internal pressures as well as their own life stories. Like many other situations in society, if a BP’s experience is outside the range of expected “normalcy,” it is often marginalized. This ostracism of particular experiences of BPs is foundationally supported by fetal protectionism. As Seals-Allers states: “The focus has been on the fetus at the expense of and exclusion of the mother. It's another way of isolating the mother, whose body is also very relevant” (Seals-Allers 2020-POP12). The prioritizing of fetuses dovetails nicely with cultural beliefs that good mothers are wholly self-sacrificing. Thus, the “good mother” archetype for BPs further emphasizes their isolation and disconnection.

The racialized construction of motherhood also influences the treatment of BPs in the BIC. A conversation about the cultural context of what it means “to be a good mother” in the texts showed how these values and beliefs serve to regulate BPs interpretation of OV:

Local ideas and beliefs over what one must endure to become a “good mother” contribute to how acts of [OV] are treated and interpreted by professionals, the community and the individual alike. The ways in which women interpret violence in relation to the wider context of their everyday lives have significant implications (Murray de Lopez 2018-PR18).

While geographical contexts differed, across the texts popular commentators and hospital BSPs interpreted BP attempts to shift the focus to themselves as a personality flaw linked to social circumstances. In the case of low-income countries, patients not “listening” to medical authority was connected to a perception of lack of education and linked to selfishness as expressed by a midwife who assumes: “[BPs] may not even care for their own baby at this stage; they just want to save their own lives” (Burrowes et al. 2017-PR1). Interestingly, in higher-income contexts, refusing medical advice and not being compliant is often seen as a trait of an “informed” BP, yet
education and access does not mean that BPs will be successful in asserting agency. Leiko discusses this issue in the Dominican Republic:

You would think that a woman who has access to a private hospital, because she has probably more income, is a more educated woman who can make better choices and who is able to choose a care provider that will more or less be on the same page as she is. But amazingly, that’s not the case. We see many women who think they will have a vaginal birth, who think they are being taken care of by somebody who supports their choices. And somehow around week 35, 36, 37, something comes up. And the moment that a mom is told you’re putting your baby’s life at risk, that’s it. She’s not going to argue. She is going to accept usually whatever the doctor tells her (Dekker 2020-PC3).

The pressure to be a “good mother” along with the personal desire to keep babies safe subdues conversations that would resist medical authority for many BPs today. Further, not only does the medicalization of motherhood prescribe the idea that listening to doctors is what “good mothers” do, it is what good citizens -- who are responsible and morally upstanding -- do.

Evidence both in texts and interviews showed that religion plays a key role in how hospital BSPs interact with BPs in matters of authority. BSPs used religious values of essentialized motherhood to minimize BPs emotional states and feelings in the moment:

[The anesthesiologist] crouched in front of my face and told me that I was not in control. God was in control. Didn’t I care about my baby? It wasn’t about me anymore. I should dry my tears because today was the joyful day my baby would be born (Mathis 2016-BG4).

Interestingly, the BSP in this excerpt feels it necessary to lean on religion and notions of an all-powerful God to “remind” the BP that they did not have control in the BIC33. The tension between the dogma of the medical institution over birth and the strategy of invoking religion to discipline and regulate BP’s experience is telling. Ava, was on bed rest in the hospital to stop premature labor with a second pregnancy when she encountered religious messaging:

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33 Interestingly, more than one BP interviewed noted an anesthesiologist featuring prominently in their experience. This highlights the need for training and awareness of OV for anyone who comes in contact with BPs.
Ava: [the BSP said] “Oh, but if you make it to 28 weeks it'll be such a blessing for the baby.” And I turned around and said, “What?”…. it was also implying this religious element of the situation being a blessing…. I afterwards spoke with the doctor and I said, “Coming from a Jewish family, somebody that you know, actually I don't believe necessarily in a God. She's implying that maybe what I'm doing as a mother is not correct. Right? That I should put my own suffering and feelings aside in order to just submit to this.”

Ava was clear that invoking religion, specifically Christianity, in this setting was not acceptable to her. She continued to talk about how, in other interactions, she felt some OBs did not acknowledge her “as an individual” or were dismissive of the “turmoil” that extended weeks of bedrest caused for her:

Ava: It felt that they were just asking about the survival of this child when me myself physically the person that is actually mentally and physically there and present is struggling and … I felt a lot of guilt around that because I was breaking and I didn't have space for that and I just couldn't because that made me a bad person [starts crying]. It made me a bad person and it made me a bad mother that I would be -- That felt selfish.... It was really really difficult because for them it seemed like, “Oh, of course yeah, [you’ll make it to] 32 weeks.”… There was… almost these assumptions, like of course she’s here for her child and she’s a mom and she wants this baby and I was like, well, it’s more complex than that. Of course, I want this baby but my emotions and my anger and frustration and sadness can also coexist with that feeling of wanting a child.

Tones of pro-life discourse tinge Ava’s testimony as she describes the reduction of herself as a whole person in the BIC, to a mother (a vessel) who “of course” is giving everything over to prolonging the pregnancy for her fetus who is not yet “present.” This pressure conflicted with a range of feelings that made her feel like a “bad person” and particularly “a bad mother” for having any thoughts of her own well-being. Ava felt the religious elements of this tactic acutely, not necessarily knowing its pervasiveness in the hospital birth context. The multi-purpose use of religiosity by hospital BSPs to uphold the doctrine of medicine as the ultimate canon resonated with “good mother” compliance strategies.
Overall, the pressure to be a “good mother” exists in societies at large and is continually echoed in the BIC often through the dramatic query, “Don’t you care about your baby?” levied at BPs when they attempt to exert agency or express negative emotions during labor:

BWBJ: Linda: They’ll say, “Well don’t you care about your baby?”… No, I was gonna have her down at the 7-eleven, but I came up here instead. You know, it is just so incredible the things they will say to people. And they will pull the dead baby [card] out quicker than you can blow your nose. You know it’s like [imitating a nurse or ob-gyn], “Well, you CAN do what you want. Yeah you can NOT have the monitor on, but you know people have done that and then their babies are dead and then what will you do?”… once they say the dead baby to you, that’s it, because you’re not going to be the martyr. (Oparah et al. 2018:112).

Not only does this rhetorical question allow hospital BSPs to have the final say by creating a medically moral stance, but it is also an obvious attempt to inject fear and uncertainty into the situation for BPs. Beyond these consequences this ridiculous question also creates a binary where compliance is the only option unless, of course, BPs want to kill their babies. So, are you a murderer? or are you a mother? they ask. The “good mother” or murderer narrative has immense power in the BIC; so much so that for a BP to express an explicit wish to prioritize their own life over their child’s is taboo. While the “good mother” mandate is not new, its sacrificial implication is particularly important in reports of OV today due to the precarious state of maternal health today. When asked if she had a birth plan, Sarah responded that her plan was “not to die and that made people really uncomfortable:”

Sarah: When I told them like -- and I love my son. I'm very glad he's here. But I would say no, no my plan is for ME not to die… I didn't want to die. I mean, I would prefer for him to also live [Laughs].... That goes without saying.

Thus, in response to the question, “Don’t you care about your baby?” As Sarah states, “that goes without saying” and she planned to survive too; being a white BP with insurance, the odds were in her favor.
It is worth noting that some aspects of prioritizing babies in the immediate postpartum, like the push to keep BPs and babies together, have simultaneously improved for things for BPs. Many talked about wanting and planning to be connected to their baby in the immediate postpartum period and showed an awareness of this institutionalized practice due to global public health initiatives (N=6). “Baby-friendly” hospital status in the U.S. means interventions are delayed during the “golden hour” so that parents and newborns can meet each other without interruption. Allison describes this phenomenon as well received even the less progressive hospitals (which she avoids). “Allison: I know there’s this big push internationally or nationally for [BFHI status] to happen and a lot of hoops to jump through in order to achieve that and by achieving it you can put in on your website.” Allison points to the market driven goal for hospitals to achieve the BFHI status and interviews indicate that this marketing works. In practice, if babies are delivered vaginally, protocols related to this status do seem largely beneficial to BPs and babies. Julia and Claire experienced cesarean births that prevented them from this kind of immediate contact. Claire: “I thought everybody was on the same page about skin to skin when the baby comes out and it turns out they're not? …. I had the delusion of thinking that the hospital would make it like a warmer kind of atmosphere.” Claire’s account reveals the expectation of most BPs to connect immediately with their newborn. Though it is not always common practice after surgical birth, some OBs offer cesareans which include this small but important moment for parents. Naomi recalls her cesarean as a “kind of a cool experience” with a “really good doctor [who] does a great family centered cesarean.”

*the paternal paradox: cesareans, the state, and the “hero” OB*
Practices of OBs like alternative cesareans and hospital policy often collide. OBs who break institutional norms in the U.S., from an untraditional approach to cesarean birth to the types of vaginal birth they support, can receive harsh sanctions. A doula speaks to her knowledge of tension between hospital policy and OBs who “want to do something different.”

Allison: You know Dr. L is an example … he got penalized for allowing a woman to birth -- I think she's was having twins or maybe even triplets and it was his practice to allow that and his belief that it was safe. And it was done safely... The parents were thrilled but he was released as a BSP from that hospital.

While institutions may penalize MDs who break protocol, BSPs who act as gatekeepers for particular modes of birth are often positioned by BPs, who are happy with their birth outcomes, as “heroes” in birth culture and spread the word within information networks.

In addition to state regulations that determine where birth is “legally” attended by BSPs, ever-narrowing hospital and BSP policies that mandate who can birth without surgery contribute to the phenomenon of “cult-hero” status for OBs who resist medical norms and support vaginal birth. Primary cesareans are common, and policies vary across institutions and OBs as to whether VBAC is “tolerated” or supported. Each cesarean creates increased risks for potential medical conditions with future pregnancies including placenta accreta which has quadrupled since 1980 from 1 in 1,250 pregnancies to 1 in 272 (National Accreta Foundation 2020). Placenta accreta is linked to a 60% chance of maternal morbidity and a 7% mortality rate (Kandil et al. 2019; Belfort 2010). Many BPs are never informed of the iatrogenic risks of cesarean or the consequences and challenges the major surgery poses for future pregnancies.

In light of the numbers of cesarean birth, its high stakes risks, and connection to OV, it is important to understand what is driving primary cesareans and who is requesting them. Two of

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34 This is a condition where the placenta is embedded too deeply in the uterus and makes it difficult to detach after delivery often causing severe blood loss and requiring a hysterectomy.
the four main reasons given for primary cesareans include issues with positioning and fetal monitoring (which is often inaccurate) that indicate an issue with the fetus, accounting for about 40% of them (ACOG 2014). Further, according to the Listening to Mothers survey only about 30% of repeat cesareans are decided on by the BP and 1% of BPs request a primary cesarean (2013). More recently, ACOG cites primary cesarean requests by BP at 2.5% (2019). In pop culture, some social media writers have called out celebrities (e.g., Victoria Beckham, Britney Spears) as “too posh to push” and others have defended their choice for surgical birth without medical necessity (Marquand 2011-POP13).

Growing awareness of the risks of cesarean and its connection to maternal mortality is putting pressure on a system that opts for surgical birth too often. Beyond an extraordinarily high cesarean rate and restrictive regulations for subsequent vaginal birth, there are other presentations of pregnancy that are highly restricted. For example, about 7% of all pregnancies are breech at term and only about 4% of those birth vaginally. Twins occur in about 4% of all pregnancies, and only about 25% of twin births are birthed vaginally (Rosenstein et al. 2013):

[O]ver half (56%) the women who wanted VBAC were denied that option, and a 2009 survey of 2,850 U.S. hospitals revealed that half of the hospitals had an outright or de facto ban against VBAC, the latter meaning the hospital had no official policy against VBAC, but no obstetrician would allow one. Vaginal breech birth and vaginal twin birth are almost impossible to obtain. Refusing vaginal birth forces women to agree to surgery or forgo medical care (Goer 2010-PR8).

Goer details a definition of obstetric abuse in the U.S. context which includes the inability to refuse birth via cesarean due to “official policy” and sometimes simply to the lack of OBs willing to support vaginal birth in certain instances. This excerpt makes clear that despite the desire of BPs, increasing restrictions have shut down modes and means of vaginal birth. As is the case with abortions (Yanow 2013), fewer and fewer OBs are able/willing to provide care for regulated birth situations and procedures like those discussed above.
The contested state of affairs around vaginal birth creates the conditions for what I call the “paternal paradox” in the BIC. A confluence of factors, including particular geographic areas where few (if any) skilled BSPs are available to attend “complicated” but common presentations for vaginal birth in the hospital (i.e., previous cesarean, over 40 weeks, anything but vertex baby positioning, twins, advanced maternal age), create incredible demand. BPs with the means to travel often research birth groups online to find OBs and midwives who are willing to support them. Faced with limited options, BPs may be investing in paternalism of a different persuasion in order to attempt this mode of delivery. A midwife discusses her perspective of this scenario:

Violet: It breaks my heart too because they're trying so hard to get good care, to improve their outcomes as women, and make good decisions for them and their family and yet I feel like they’re being duped. I feel like [they’re] being manipulated and, in a way, given a bait-and-switch, and taken advantage of you know? Truly…. [Dr.M] even flat out said … something to the effect of basically women care more about their birth experience and a vaginal birth than the actual baby. And it's like -- that is so not true.

Interestingly, Dr. M’s comments (as relayed by the Violet’s colleague) turns the tables on the idea of prioritizing baby and takes this value/belief in the opposite direction. The BSP’s assumption that vaginal birth is what all women want -- at all costs -- is an example of this flipside of paternalism in medicalized birth which Violet calls out using the term “bait and switch.” A well-known, and extreme critic of “natural birth,” Amy Tuteur of the Skeptical OB blog, goes further as reported in a popular local paper, “[Tuteur said] that obstetrics may be paternalistic, but the natural birth movement has become a vehicle for some doctors who develop a cult following and engender their own brand of paternalism” (Hart 2018). This conversation around particular “hero” OBs in the media is evidence of a rubber band effect resulting from highly restrictive birth practices that create a landscape of extremes in birth culture.

Allison: It could be insurance I do think a lot of [the conflict between BSPs and hospitals] is hinged on litigation and I can't blame them I mean the American public
has put themselves in a corner with this by suing every time something goes wrong instead of accepting responsibility for themselves.

Evidence corroborates Allison’s thought and suggests that the high rates of litigation for OBs is part of their defensive and over-medicalized practice. In the extremely paternalistic framework of hospital birth, the “responsibility” of OBs and midwives for outcomes are therefore enormous -- this very factor reinforces attitudes and practices that further suppress autonomy. Excessive litigation hinges on the acceptance of paternalistic medical practice and lack of shared decision making and responsibility.

*embodied knowledge overruled*

The theme of medical authority over of a sense of embodied reality for BPs was clear in my investigation (N=25). A general assumption exists that information from medical authorities is more reliable than that offered by BPs during birth. Naomi refers to the “millennia of misogyny” contributing to the idea that women “don’t have the capacity to understand what’s happening to their bodies.” The authority to dismiss embodied knowledge of BPs serves as the foundation for hospital BSPs to carry out their own agenda using various recurrent tactics. Despite pressure from her family to comply, Kelly Turbin begged the OB to let her “try” pushing without an episiotomy: ‘No! Why? Why can't we try?’ The doctor’s voice is authoritative now, even angry, as he responds: …. ‘Listen, I am the expert here. You can go home and do it. You go to Kentucky’ (Hayes-Klein 2014-POP8). Clearly birth experts belong in the hospital according to the doctor and “uneducated” BPs who want to remain in control of their own bodies don’t. Grant, a lawyer, discusses the “tendency to defer to a doctor as the expert” in these cases due to the belief that “[Episiotomy] is a doctor’s decision, not a woman’s decision” so “What is this woman
complaining about?” (Grant 2017-POP2). I noted this insistence of OB authority to overrule
embodied knowing and BP bodily autonomy in interviews with less verbal force.

Nia had two troubling situations with BSPs who denied her embodied knowing. The first
occurred at a visit concerning her cesarean incision:

Nia: [The OB is] pretty much just telling me that everything's fine but that it makes
sense that I'm concerned because I've never seen or dealt with this before, but they
see it all the time....But pretty much just didn't acknowledge the fact that I'm in
pain.... It hurt so bad. It's oozing green stuff and blood and it smells weird....She's
like, “If you just give it time” and I said, “I'm sorry, but it's been three weeks”... I
literally could not walk. Every time I moved it hurt. She said, “You already had [a
cesarean]. So, it just makes sense. It's probably the nerves.” And I said, “It's not the
nerves!”

The doubling down on “normalcy” in the face of complaints of discomfort and pain by BSPs
created a disconnect for BPs who struggled with physical and emotional recovery from birth.

Hospital BSPs repeatedly responded to BPs asking to be seen and validated by telling BPs that
they misunderstood the situation or didn’t know as much as hospital BSPs did about their bodies.

Nia also recounted a feverish episode just after cesarean birth:

Nia: I was freezing and then all sudden like in a split second I was sweating and I
was hot...I'd say, “Can you take off these blankets?” And they would barely take
off one and ... no one was listening to me ... They're saying, “That's normal, the
drugs, blah blah blah.” And I'm sweating -- like take this shit...and no one's doing
it!... And my temperature was spiking.... I said, “.... I need you to pour water on
me.” And they say, “Oh we can't do that!” They put the air as far down as it could
go and I was still sweating.... I was trying to get them to sit me up and they're like ...
“'You can't do that yet!” I was like “Don't touch me” ... and no one was
listening! They finally took my temperature, and it went from 100 to a 103.... I'm
like no one's fucking listening to me. You know? Like I know my body and I'm
telling you!

As detailed here, not being heard during times of discomfort and staff ignoring or not prioritizing
embodied knowledge often created escalating situations of distress for BPs. Further, the
restrictions the BIC places on autonomy combined with an inflexible system of standardized
treatment is upsetting by many BPs reports. This combination of influences is often seen during the pushing stage of labor.

The second stage of labor involves the BP moving the baby through voluntary or involuntary “pushes” out of the birth canal. A sort of vague instruction to “bear down” is often combined with coaching and counting and made more difficult by a supine position. In the case of BPs laboring without epidurals, many will experience the urge to push as less controllable if at all. There is varied evidence on the effectiveness of “coached pushing” and a range of experiences of pushing exists for BPs: Daisy: “it was very disorienting to have multiple messages plus my own -- my body's own messaging -- which is like -- You push now! You push now!” Jasmine also vividly remembers the pushing stage of labor without an epidural and the conflict she had with the OB who was instructing her to push against her embodied knowledge. Jasmine compares this birth to her first labor with an OB who instructed her to follow her body’s cues for pushing. She feels like the command from the OB to push when she did not feel the urge may have contributed to the hemorrhage that occurred:

Jasmine: she told me [to push] and I remember my body stopped…. She kept telling me to keep pushing and I remember telling her, “I don't have to. I don't have to.” And she's like, “You have to push. You have to.” So, I said “Fine.” So, I forced a push … and he came out….I'm like, okay, and then I started to see stars. I mean, they laid him on my chest at one moment and I saw him but then I remember I told the nurse that I can't hold him…. I kept thinking to myself, I don't think this girl knows what she's doing. That had crossed my mind when she was yelling at me to push and I'm telling her I don't… I shouldn't [push].

Many BPs drew on past experience when trying to put the medical story into context and make sense of what happened. BPs with more birth experience expressed knowing BSPs were soundly incorrect on certain points. The authority of the medical professionals to dictate when a BP is “ready” to push and the conflict it creates also existed in peer review texts from various countries:
I was examined and told my labour is at early stage ... at that point my baby was on the way out but I was restricted to stay in my left side.... I told my care provider I am urged to push down and requested for help.... he said I just examined you (you are not yet ready) and ignored me and continued playing with his mobile phone ... the urge to push down was irresistible, I then turned on my back by myself and gave birth ... then the care provider tried to assist, my child was not crying immediately ... I think it was suffocated for long as the provider ignored my call (and delayed the process)...luckily my baby survived but I was not happy with the care” (Gebremichael et al. 2018-PR13).

There was a tendency as noted here to attach BSP denial of BPs embodied knowledge to medical issues that subsequently unfolded. The disconnection the Ethiopian BP describes between hospital BSPs and the realities of labor as felt and expressed distinctly by BPs was common from texts across the world and in interviews:

Alexis: The contractions were non-stop and I couldn't handle it and they said to keep the baby in and I was trying but I really -- the baby should have come out. I was in a horrible, awful position trying to keep the baby in when I shouldn't have had to and the Pitocin was still coming… that was a really awful part…. And they said, “If you feel a lot of pressure, don’t push.”

Alexis details staff failing to assist her when she knew she was ready for the pushing stage of labor. Hospital BSPs directed her to attempt to do the opposite of what her body was physiologically signaling for her to do if they were not in the room. Alexis relayed the excruciating feeling, during several minutes of trying to hold the baby in against the forces of her body (augmented by Pitocin), during that time.

Further contributing to BP’s struggle to have their embodied knowledge valued was the BIC reliance and prioritization of universal standards and machines. For example, “specialists” informed Julia that her baby was intrauterine growth restricted (IUGR)\(^\text{35}\) and she needed to be induced:

Julia: I'm not a particularly tall person…. I’m 5 feet at most…. I'm not supposed to have this big, huge baby…. I always go back to that and I'll tell you why because every anniversary of his birthday or every time I think about the way my daughter

\(^{35}\) IUGR is a term for babies who are not measuring as expected for gestational age.
was born [at home] I'm so tempted to write this letter to [Specialist’s office] and just tell them how wrong they were and how wrong the technology is and how they were not very patient centered and they didn't listen to me.

Julia’s baby was born weighing 7lbs 2 oz after a forced induction that led to an unwanted cesarean. She describes “rage” and “kicks” herself for not avoiding or refusing an induction based on the machine reading of her baby’s size -- which she felt was to be expected and was incorrect anyway. Specific moments when BPs resigned themselves to medical authority directly against their self-judgment stood out for them in meaningful ways. Ava talks about a scenario that occurred during her 6-week long hospitalized bedrest for premature labor:

Ava: I'm bleeding. I'm having contractions. Something is happening…. [The nurse] comes and I'm like “Can you see the contractions on the monitor? I know I'm not crazy!” … all day I've been hearing “We can't see them,” “They're not coming up.” And I'm personally keeping track of them on my fucking phone. This is ridiculous! I'm keeping track of my own contractions with my phone because the machine doesn't pick up on them…. I'm telling you…. Something is going on … I'm like “Hey, have you picked up on them?” I need validation. “No Mrs. G I am not picking up on them.” And [the nurse] kind of rolling her eyes at me. And I'm like, “No. I'm not crazy!”

Hospital BSP’s invalidation of BP knowledge through machines was obviously frustrating.

Ava’s story is also a good example of how feeling unheard combined with an exasperated attitude on the part of BSPs created a more intense experience for BPs in this sample. In contrast to the over reliance on machines, Sarah provided an example where staff refused to use readily available technology:

Sarah: I was bleeding. So, I went to the ER and the twin was gone from the ultrasound. I had to beg the OB who was attending … to read the ultrasound and tell me if she saw the B sack…. And [the OB] said, “What does it matter if it's there or not? We're going to just treat you like you're a singleton parent.” She said, “From our point of view it doesn't change the course of care.” That just totally misses what was going on with me! You know? I had just lost the baby. I want to know if the baby. If the fucking embryo -- was still floating around in my uterus!

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36 Sonograms have an error range of about 5% in estimating baby’s weight overall (Milner and Arezina 2018) and this increases to 15% in the last trimester (Castro-Vasquez and Taboada 2020). Babies weigh 7.5 lbs. on average at birth with 5.5 -- 10lbs considered in the “normal” range.
For Sarah, losing one of her twins was of course deeply personal. The handling of the situation with her BSPs and their unwillingness to understand her perspective and give her the evidence she sought and needed for closure was damaging. Unfortunately, throughout texts and BP interviews taking time to connect BPs with their bodies during medical appointments, procedures, and birth was not common. I did not find any evidence of the use of machines to support or enhance BP’s knowing.

*medical entrapment in the BIC: induction, epidurals, and cesareans*

The increasing practice of inducing labor (often precipitated by information from machines) is a good example of the active role the BIC plays in the detachment of BPs from their bodies and birth:

Carla: [A]ll of my aunts, they always were induced. They were always told when they would give birth and that their bodies just didn't know how to go into labor. … just this very managed thing which growing up you’re like oh the doctor told you when your expiration date is and if you don't have the baby then they make you have a baby … but I was just like, why are doctors just telling women what to do? …. [T]hey were never encouraged throughout pregnancy or even in birth that their bodies know what to do or they know what to do.

The use of induction for a range of normal presentations in pregnancy is pervasive across these data. While the physical impact of inductions can be extremely negative, Carla also brings up the idea that medicalizing the start of labor embeds insecurity into parents from the beginning. The act of forcibly beginning birth is one of the most compelling illustrations of medical authority in the BIC today. Induction of labor is a commonly used intervention around the world (Marconi 2019) and was an important theme mostly coming up in interview data and popular texts. Over 50% of BPs in my sample experienced induction of labor (N=8) with over half ending in cesarean births (N=5). Data from 2016 shows that the national average for inductions is about
25%, and the state average where my BPs gave birth at about 24% (NCHS 2014). Inductions in the U.S. more than doubled from 1990 to 2010 from 9.6% to 23.8 percent. Rates of induction declined for several years in the U.S. but then inched back up to 24.5% by 2016; the most recent year with data (DHHS 2018). Rates in the UK also increased from 1 in 5 births in 2008 to almost 1 in 3 in 2018 (NHS 2018).³⁷

The means of induction (starting from zero) and augmentation (intensifying/increasing contractions after labor begins spontaneously) range from natural processes like having sex and nipple stimulation to more invasive forms like amniotomy (breaking amniotic sac or “waters”) and a Foley bulb for forced cervical dilation. Medicinal augmentation often comes in the form of Cervadil, a drug that is meant to “soften and ripen” the cervix, and Pitocin which stimulates and intensifies contractions. The physical and chemical manipulation of inducing labor amounts to forcing a relationship between a BP’s body and labor that is more intense yet slower progressing than physiological labor. The entire induction process lasted from 2 to 5 days for most induced BPs in my sample (N=6), and once started there was no option for BPs to leave the hospital or end the undertaking. As Tabitha states: “[Induction] was the roller coaster ride of slowness that I couldn’t get off of.”

Inducing labor and augmenting labor with Pitocin can be violent for bodies that are not ready for birth. As BPs in texts corroborate:

“It was like being tortured because I was … screaming … begging, really, really begging for [the Syntocinon³⁸] drip to be turned off”; “[I] don't feel I gave birth and had a baby on that day. I just felt I went into a room and was just assaulted”; and ‘It was violent and brutal” (Goer 2010-PR8).

³⁷ I attempted to find statistics from other countries online but was unable to locate that information.
³⁸ Name of synthetic oxytocin used in AU
Theresa from the BWBJ research project agrees: “By this time, they had tried to give me an epidural and it didn’t take. And so, I’m like literally in hell. Lucifer is looking me in the eye. It was so painful” (Oparah et al. 2018:121). Despite its intense effects for both BPs and their fetuses, the use and abuse of Pitocin is widespread (Ventolini and Neiger 2004). “Inappropriate medical treatment, such as the practice of administering Pitocin until the baby goes into distress (and cesarean surgery is called for), is also clearly abusive, although few women are aware that this is deliberate mistreatment” (Fernandez 2013-POP1). This abusive medical practice coined “pit to distress” indicates the goal of administering the drug until “hyperstimulation” of the uterus is reached:

The exposure to risk associated with oxytocin use is a classic cascade. Oxytocin use may lead to hyperstimulation of the uterus. Hyperstimulation of the uterus may lead to uteroplacental insufficiency, impairing fetal oxygenation. Decreased fetal oxygenation may lead to fetal metabolic acidosis and myocardial depression. Ironically, when some practitioners detect this pattern, they may give more oxytocin to accelerate labor or “pit through.” (Tillett 2011).

After increasing malpractice suits, in 2013 officials added Pitocin to the US “Hazardous Drug List” and introduced standardized protocols (Oláh and Steer 2015). According to the LTMS III 41% of labors are induced in the U.S. and 63% of those include the use of Pitocin (2013).

BPs I interviewed endured inductions for various reasons including concern about IUGR and amniotic fluid levels (N=3), pregnancy complication of the BP (N=3), and elective after 40 weeks (N=2). Inductions are often performed when BP’s pregnancies extend beyond 40 weeks with cut-offs determined at the discretion of the Midwife or OB.

I certainly felt pressured to induce during my first pregnancy. Even during my second, I had the cutoff time of 41 weeks because that’s all they’ll “let you go to.” Never was there a discussion why or how care could change once I hit 41 weeks (Newman 2018-BG2).
Along with BSP common practice, as with other interventions, the specific culture at the hospital often influences the path that unfolds for inductions. Laura speaks to the high rate of inductions that end in cesarean at a particular hospital: “I have some that go well, but the inductions at Westwood every single one of them has turned into a C-section.”

BPs expressed a range of understanding about induction before it occurred from excitement to dread. Kelley was “excited” before realizing that going home “wasn’t actually an option.” “I kind of had this thinking. I’m like, oh we’ll go check me out to be like things are fine, you know?” Some BPs recounted personal knowledge as well as “horror stories” about induction passed down from others that caused them to worry about what their own experiences would be like. Nia recalled hearing that the use of a “Foley bulb” was “more painful than birth itself.” After her induction she concludes, “So, they were right about that.”

Finally, it is worth noting that sleep came up in relationship to inductions for BPs who had especially long labors. The inability to sleep, and for several BPs not eating or sleeping made labor especially grueling: Kelley: “I was so confused by what was happening because I had been asleep and suddenly there were people in the room, and they were like doing things without telling me stuff.” For BPs, being alert and aware enough to try to attain information and to be involved in decision making was especially difficult during the induction process. Julia who also had a long induction (over 5 days) also talks about staff “doing things when you’re sleeping.” Julia: “I would just kind of wake up in a daze and say yeah, that’s okay whatever you need to do.” It is clear that the process of induction can leave BP uniquely vulnerable to loss of autonomy. Moreover, out of the BPs I spoke with who were not induced due to medical complications (N=5), three experienced significant outside pressure or coercion to comply. The
compulsion to be induced was an additional control exerted by the BIC that often confused BPs who later questioned whether they could have avoided it all together.

Birth culture often points to the “cascade of interventions” as an amorphous process detached from anyone’s intention or motivation “sweeping” BPs through procedures during hospital birth. This “cascade” is usually referring to a group of interventive practices (i.e. starting an I.V., breaking waters, adding Pitocin for a “slow” or “stalled” labor, getting an epidural) often precipitated by induction, that lead to situations like immobility, “unsuccessful” pushing, and ultimately ending up with a cesarean. I argue it is more useful to tell a different story about this phenomenon; a story where institutional agents act with intent committing a form of medical entrapment. For instance, BPs and BSPs spoke about BPs going to regular appointments which gradually turned into situations that they could not have anticipated, were not prepared for, and about which they were not given enough information to participate in decision making. These appointments set the stage for BPs to make forced decisions under stress that greatly impacted the trajectory of their birth. Without prompting Isabel told a detailed story of a client she thought of immediately when she agreed to participate in this study:

Isabel: she was still nine days away from her due date…. She was going in for a regular weekly appointment. They are telling her how good he looks -- the baby looks -- and how healthy everything is, and everything is great. And they’re having this really great positive interaction … then the nurse or technician leaves and another one comes in … then the language starts to change, and the experience starts to change. And they start telling her like “Oh, well, you know your water is looking a little low and you’re here right now. So, you can just go across the street to the hospital to have it checked out and go ahead … they’ll probably induce you and you could leave here with the baby tomorrow.”

In this case, hospital BSPs instill fear in the BP by focusing on and emphasizing nominal or usual risk. For instance, though 91% of OBs believe that isolate oligohydramnios (low fluid) in an otherwise healthy pregnancy requires induction of labor (Schwartz, Sweeting, and Young
2012), research shows that poor outcomes are no more likely in these situations than in general and induction in these cases increases the risk for cesarean (Locatelli et al. 2003; Manzanares 2007). Isabel called what unfolded an “abusive” situation:

Isabel: the staff becomes really serious with her and they’re like “Well, if you go home tonight, you could come back tomorrow with a stillborn baby.”… She starts crying and she’s just like, you know, how did it go from everything is great…to ultimately you need to be induced today? And if you don’t do it today, you’re going to come back with a stillborn, baby?…. she was so stressed out … thinking that her baby is going to die because she didn’t do the right thing because she didn’t take advice from the experts or whatever … she was very very upset after the C-section because she totally felt like she had been had…. One thing she said when I visited her was just like, “Why did I do this to myself?”

This story brings together the element of a quick shift in BSP mood and framing of the pregnancy, the confusion that shift causes in the moment, and the internalized blame for medicalization BPs often feel after making a decision under duress. “Fear-mongering” around babies dying if BPs did not comply with interventions was particularly salient around inductions.

Once BPs agree to induction, they are likely to be administered Pitocin and need an epidural for pain relief (due to artificially strong contractions) which results in less mobility and increases the chances of sub-optimal positioning of babies as well as increasing the risk of fetal heartrate inconsistences. Isabel felt conflicted about not being able to prevent negative outcomes for their clients around induction: Isabel: “It’s this really sad feeling of I hate to say I told you so, but I told you so…. But when things start to head that way in a birth, I immediately know, I always know exactly how it’s going to end.” The predetermined force connected to induction that Isabel describes relates to the medical entrapment that is operating under the guise of a chain of interventions that simply can’t be stopped. The interconnected nature of interventions means that once BSPs begin inducing labor, it is inevitable that they will utilize many other interventions. When BPs are induced, BSPs may jump to cesarean when they believe it is highly
likely or it is simply convenient (for them). Even when BPs are not induced, epidurals are often strongly suggested because having an epidural in place makes it much easier to transition to cesarean birth quickly as the anesthesia can be adjusted to completely numb BPs from the waist down.

BSPs also suggest epidurals to allow BPs to labor in a supine position when continuous monitoring via wireless monitor is obstructed for some reason. For example, Sarah could not use the wireless fetal monitor because of a policy that disallowed its use in premature labor. She describes questioning why her team, which purported to be supportive of unmedicated birth, pressured her to get an epidural instead of coming up with a creative solution for her to stay mobile and labor most effectively. Sarah: “I remember climbing into bed and thinking if I had gotten the epidural, I would be getting a C-section.” Sarah’s remark reflects the power struggle many BPs felt against the ever-looming cesarean and the will to listen to themselves over pressure from BPs. A final excerpt on entrapment comes from the BWBJ project and focuses on Megan who experienced pressure to agree to Pitocin after her dilation slowed around 6cm:

So, they came in and said, you’re going have to have this baby, we’re going to have to help with some intervention….they couldn’t do the monitor anymore and they had to do the rod thing that twists into the baby’s skull (internal fetal monitor). All of these fucking things! It was one thing after another….it came down to, either we are going to give you some Pitocin or you are going to have to have this epidural. It was like, ‘Or something’….They started the Pitocin and that baby laughed. That did not do it. I didn’t dilate anymore. But now the interventions have started. Now, because I’ve had the Pitocin and my body is doing something but the baby is not moving, now we’ve got to do this, and we’ve got to do that….So, I ended up getting an epidural. (Oparah et al. 2018:122).

The pressure to add Pitocin (that was not effective) lead to Megan agreeing to an epidural she didn’t want and eventually an unplanned and unwanted cesarean. In this case, entrapment occurs under the monitor the baby mandate supported by vague “dead baby” threats and Megan states, “It was somewhere around here I lost my voice.” Whether or not epidurals do increase the risk of
cesarean is unclear though many have sought to answer this question and sort out the evidence (Goer 2015). The variable of commitment to vaginal birth by attendants and hospital BSPs seems to be a significant, but understudied, influence on these outcomes as well (Follette et al. 2015; McClung 2019). A tool that further enables the process of entrapment is urgency (performed or real) and the construction of emergencies during birth.

A sense of an urgency is commonly invoked by BSPs and institutions to justify the assertion of total medical authority. A conversation about emergencies and authority came up in both popular and peer-reviewed texts as well as BP interviews (N=17). A peer-reviewed critique of an Italian public study and report on OV provides insight into notions of power involved in medical urgency during birth:

"Statements of OV submitted by the interviewers such as "force a woman to undergo an unnecessary caesarean delivery" or "practice an episiotomy with no warning," do not take into account the power-duty of the professionals to co-decide, guide women's choices, act urgently, even without consent, to avoid serious danger to the person’s life or integrity (Burrowes et al. 2017-PR1)."

The author considers acting “even without consent” during emergencies as a practice that would necessarily lie outside the realm of OV. A popular article quotes an anonymous Swedish OB working in India with the same perspective:

"Due to a lack of economic resources and therefore time constriction, “there are a lot of procedures being done without consent,” he said. “Vaginal cutting is very common due to fast labors; medicines are given to make it quicker. This is not discussed with the patient, but all countries make medical decisions in acute situations,” he said (Yerepouni Daily News 2019)."

The doctor suggests that overruling patient consent in India is justified by its commonality in “all countries.” Further, disregarding BP consent is supported by structural scarcities in that context that shorten time allowed for labor. In the U.S. a popular birth organization questioned the legality of this kind of loophole hospitals and doctors use to force cesarean: “A New York
hospital … said in papers filed last week that women are not entitled to due process in childbirth, asserting that if doctors call an ‘emergency,’ a court order is not needed for a doctor to force a woman to have surgery” (Pascucci 2015-BG5). This claim is further explored by scholar Murray de Lopez studying the power construction of emergency during hospital birth: “Framed within the medical lexicon of emergency (evoking the drama of life or death) acts of violence become rationalised by both perpetrators and victims as a means to an end” (Murray de Lopez 2018-PR18). The realm of birth is high stakes for BPs with relatively little experience and this tension, juxtaposed against the “everyday conditions of emergency in the hospital environment,” creates an atmosphere where medical violence becomes both expected and accepted.

In line with a constructivist perspective, evidence from interviews and texts indicates that BPs questioned medical situations labeled emergencies by hospital BSPs:

Nia: With [first baby] and stuff and the emergency c-section -- which now I don't know now if it was an emergency? You know reflecting back on it and talking to people…. I was in the operating room for about an hour before it even happened. So, it's like was that an emergency or wasn't it?

With time and reflection, Nia questions whether her primary c-section called an “emergency” actually reflected the medical reality. BPs often noted that in the midst of “discussions” of consent around cesareans (often involving “dead baby” threats), hospital BSPs simultaneously got them ready for the surgery -- making it clear BP input held little weight if any. The appearance of a lax atmosphere also contributed to the debate over what was labelled an “emergency” for BPs:

The operating room was ready, and the team was scrubbed, but no one was in a hurry … a sneaking terror crept into my mind. Was this really an emergency? Having gone through 9 cm of unmedicated labor, they decided to extract my baby, for no medical reason... 3 months later, when I was finally able to negotiate getting my daughter’s heart rate strip…I saw the truth. My daughter’s life was never in danger (Conrad 2019-BG6).
Regrettably, this scenario is not uncommon throughout these data. In my interviews, Taylor describes a similar situation in which she was laboring unmedicated and without a labor partner (though her uncle was present). A staff member took her uncle out of the room and convinced him that he needed to get her to sign a consent form for a cesarean “just in case” it became necessary though there was no indication at the time:

Taylor: So, once I signed the paper, they went into C-section mode. The nurse came in to kind of get my IV and everything started…. Then I was basically on a stretcher and whisked off to the emergency room. And so it immediately became not like this is in case we have to do this [perform a cesarean] but it was like we are doing this right now.

Soon after Taylor arrived in the operating room under the auspices of an emergency due to fetal distress, she realized there was a miscommunication about the fetal heart tones. There was no discussion of other options and she was swiftly put under full anesthesia for a cesarean. In this scenario we see the process of entrapment aided by urgency as BSPs and staff secure a signature for consent of surgical birth and the course of action quickly and permanently changed in spite of counterfactual evidence.

A final scenario that called into question the true state of a BP’s medical status involved Kelley. She explains how OBs expressed varying levels of concern in her case and recommended induction for a “change” in amniotic fluid levels at 40 weeks:

Kelley: Once we got there, they check my cervical dilation -- still not at all dilated. Not at all. No ripening. Baby was not ready to come out, so we did … the least intense cervical ripener and dilator. Did that again on Tuesday because there were still no changes. Wednesday morning -- and so this is like different doctors every day -- and nobody's checked my fluid levels. Nobody once we’re at the hospital actually seems concerned about anything!... There are monitors on -- but nobody has said anything about, oh the baby's in distress … nothing! It’s just fine. I'm like, well what the hell?

39 I believe the BP meant she was taken to the OR urgently not the “emergency room.”
Clearly Kelley’s BSPs were not as concerned as they indicated because no one checked on the baby or the “fluid levels” that presented the need for induction in the first place. She is left pondering why she is there when the baby is clearly not ready and BSPs have completely changed their tone. Situations like these gave BPs the impression that what was constructed and conveyed as an emergency was not an urgent medical situation at all. Thus, making them question the difficult procedures they endured full stop.

I present the idea of “medical entrapment” to trouble the prominent idea in birth culture of an objective “cascade of interventions.” Evidence throughout these data show that individual agents acting under institutional governance entrap BPs in ways that lead to their loss of autonomy in birth. A final theme that emerged around induction -- “Since you are already here” -- is a justification used by agents of medical authority to initiate institutional engagement in managing birth or intensify that engagement based solely on the physical presence of the pregnant person in an MD’s office or institutional space. The “since you are already here” theme emerged predominantly in interviews and supported the act of medical entrapment.

Attempts to hold BPs in medical facilities after a routine appointment is not uncommon and occurs with active pressure to induce labor usually based on information provided by sonogram. OBs sent three BPs in this sample for inductions after a sonogram at a regularly scheduled appointment. Isabel quoted an OB as saying, “Well, I’m here and you’re here and we could just get this started right now.” The push to artificially begin birth in the BIC is powerful and the explicit use of this strategy gives us insight into the everyday ways medical convenience overrides BP autonomy. The medical institution’s role in birth is not to support or standby but as Isabel suggests: “no matter where you are on your time-line … [They say] ‘Well you’re here so we can go ahead and get you hooked up on your IV … get the ball rolling … to move this right
along.” As is the case in many social situations, once a boundary or threshold is crossed, it is much easier to continue on the same path than to change course: Tabitha: “18 hours in I was like, can I just please turn this off and I can just go home for a little while? because my body is not ready. I'm not ready. I remember thinking that … but you know what that is so silly. We're so far in let's just go.” Many BPs interviewed (N=5) who experienced long inductions (> 24 hrs.) mentioned their bodies not being ready and having thoughts of wanting to leave, yet once the process is started inductions are rarely paused or stopped.

The “since you are already here” justification came up largely around inductions, but it was also particularly salient for Taylor:

[T]o get to the table … and hear the head surgeon say, “So why are we here? I don’t see…. You know there really isn't any … there wasn't enough stress [on baby] for me to actually be there. Really it became well because we were already there. It was more like well because we're here let's just go ahead and do it versus you hope that somebody would say well it doesn't… [the baby] seems fine. Let's wait and see… next thing I knew the mask was over my face and then I woke up with a baby.

Instead of slowing down and regrouping after realizing the baby was not in danger, the medical team proceeded with the most extreme action possible. In the end, Taylor endured an unwarranted cesarean in an unconscious state with her uncle looking on from the observation area above.

While OV of this kind is perpetrated by individuals it is important to illuminate the institutional and concrete elements that support and propagate it. There is a reality of getting “caught” in the medical system in the BIC and this is not a happenstance or a rare occurrence. The particular ideological and cultural aspects of birth complicate entanglement with medicine for BPs and can mean over and under treatment, hyper-surveillance and neglect all in one encounter. There is a physicality to OV related to the structures and spaces that normalize protocol and policies that in any other specialty of medicine would not be tolerated. “Since you
are already here” gives us a glimpse into the magnitude of the pull of that system and the motivation of the BIC to process BPs through birth on institutional terms using highly questionable but *common* practice. Each aspect of medical authority presented here is further upheld and reproduced by ideological and everyday strategies that sustain and ensure the survival of the BIC.

### 4.4 Ideological and Everyday Strategies to Preserve the Status Quo (BIC Survival)

As with all cultures, there are ideologies that the BIC and the folks working in it, must embrace to maintain the existing state of affairs and its survival. I explore these ideologies and strategies with the understanding that paternalism and fetal prioritization, more specifically, are the foundation for them. In this section especially, I employ a methodological strategy of “a sociology for the people” (Smith 1996). I lay out findings and work through an analysis that seeks to elucidate the ways that the everyday workings of the medical institution create both the climate and the material contingencies required for OV.

*doing what’s best, the end justifies the means, healthy mom -- healthy baby*

Ironically, despite the consistent prioritizing of babies the idea that hospital staff and BSPs prioritized BPs best interests emerged. Both popular and peer-reviewed texts in the U.S. spoke specifically about the precedent of law related to OV and the way that the “doctor knows best” idea pervades the space of pregnant and laboring people uniquely. It is important to note that while legal precedence grants all patients the right to decline medical procedures, in practice this right for pregnant and laboring people is often thwarted by medical (and state) authority: “It’s a symptom of how deeply ingrained the idea is that the doctor wouldn’t do anything to harm
you” (Grant 2017-POP2). U.S. commenters commonly framed the dismissal of claims of OV as part of the larger oppression of women and a disregard of informed consent rights:

“While U.S. laws state unpermitted touching even for medical procedures as battery, no provision has been made in regards to pregnant women. Despite several lawsuits filed against physicians, most rule in their favor keeping the fact that “physicians know best” as paramount …” (Newman 2018-BG2).

Popular texts continually highlighted discrepancies in application of law that led to a failure of the system to incorporate and protect pregnant and laboring people using this ideology to bolster defendants’ arguments.

A theme that existed in parallel and often intertwined with “doing what’s best” was the “end justifies the means.” A common belief, when applied in this context, means whatever happens in labor and whatever treatment vetted out is justified by a positive (live) outcome. This belief is noted by a peer-reviewed article analyzing data from 34 countries.

Nurse-midwives justified their mistreatment of women by claiming that they were attempting to ensure safe outcomes for mothers and babies, and excused the perpetration of physical abuse as a “necessity” to ensure compliance and safe birth outcomes, believing that they were “forced by circumstance” (Bohren 2015 et al.-PR11).

Particularly in middle and low-income countries, staff shortages, and economic and other resource constraints were underlying factors in justifying mistreatment in exchange for maternal and fetal outcomes. Evidence from Ghana shows that midwives normalize physical abuse as an effective everyday tool in making sure babies live:

*Midwife 1*: I have [hit] on several occasions but when I finish and the baby come(s) out, [Laughing], [I say] Madam, I am sorry for hitting you, I wouldn’t have hit you but you would have killed your baby. *Midwife 3*: Oh, it happens all the time. The hitting, it is an everyday occurrence...even you, they will insult you when you come here (Dzomeku et al. 2020-PR12).

The midwife emphasizes the normality of the institutionalized violence (especially “hitting” BPs to open their legs during labor) and its justification as a tool used without bias regarding
individual social status. While data from the U.S. did not present justification for explicit
physical or verbal abuse, BPs I interviewed did justify coercive tactics to comply with
interventions strongly suggested by hospital staff:

Kate: I justify when I look back that it was the right decision because [baby] was
turned and it may you know, she could have gotten caught or stuck in the birthing
canal if we had gone a different route. So, I justify it to myself but…. I felt corralled
like I said. And so, I will justify to myself like, okay well it worked out … and
maybe that was a godsend to some degree, but I still felt like I wasn't valued.

Kate ended up with an unwanted epidural that caused complications during labor and postpartum
but rationalizes the decision because in the end, her baby arrived safely. The ideologies discussed
in this section are so effective for the BIC because they include beliefs that appear to support the
overall goal of healthy birth outcomes while at the same time undermining BP autonomy and
upholding medical authority.

In the 90s and early 2000s, in line with WHO plans for improving maternal and infant
outcomes, government and private organizations funded and developed to support national
public health initiatives began using the tag line “healthy mom, healthy baby” (HMHB). This
also became a catch phrase used in middle and high-income countries amongst birthing
individuals and in birth culture. The mantra became particularly useful in shutting down
complaints about birth experiences in the BIC if mom and baby came out relatively unscathed.
Evidence from this study illustrates that the irrefutable truth embedded in the phrase is what
makes HMHB so polarizing and effective in quelling critiques of treatment in the BIC. I argue
that people giving birth, much like those in this sample, desire their own health and that of their
babies to be good. I also argue that most would also like to feel heard, seen, and respected during
hospital birth. The HMHB ideology is commonly employed and lodged at individuals who
express a desire for this both/and outcome.
BPs who are able to voice concern about this topic are often those who have combined privilege (i.e., economic, race, sex, gender, ability). For example, popular U.S. blogs focused on emphasizing the damage of emotional pain and the way the quip of HMHB minimizes that experience: “Women who have been screamed at, ignored, and subjected to unwanted procedures and exams during pregnancy and birth, who are experiencing depression, anxiety, and PTSD -- only to be told, ‘but you have a healthy baby, so what’s the problem?’” (Newman 2018-BG2). This blog excerpt is also representative of researchers and activists in birth culture making links between mistreatment in birth and postpartum mood disorders. Pickle’s frames the work of Spanish activists against OV as helping to “conceptualize the malaise many women feel after childbirth” due to physical experiences of abusive, dehumanizing, or violent ‘care’ … despite surviving birth and having a live born child” (Pickles 2015-PR3). The HMHB global mantra contributes to the gaslighting that many authors and researchers describe and is explained by one popular blog as beginning with “lies” within hospital culture about cesareans that radiate out into the larger community.

That moms should just be grateful they and their babies are alive, because some women and babies aren’t…. I look at my c-section scar. I see one experience, replicated by the thousands all across the United States, where women are regularly coerced and forced into unnecessary c-sections with fraudulent information, threats of the death of their baby, and then supported with refrains from friends and family admonishing women that “at least they have a healthy baby” (Conrad 2019-BG6). Again, there is an emphasis on over-medicalization in the form of unwanted and unnecessary c-sections from this U.S. source as is more common in high-income countries and heard more often from dominant birth culture.

A question of legitimacy exists around birth trauma or OV that does not result in significant physical harm beyond expected iatrogenic effects. Evidence shows that this quandary is further supported by HMHB ideology in governmental and judicial practice. Miley relays a
statement by a Brazilian official in regard to a highly publicized court ordered cesarean that occurred in direct violation of Brazil’s “penal code” which grants BPs full autonomy in birth: “But in the end ... Adelir was healthy, and delivered a healthy baby girl” (Miley 2014-POP15).

Similarly, in the U.S., Kimberly Turbin was initially told: “The problem is, you don't have any damages. Your baby is fine, and you are alive” (Hayes-Klein 2014-POP8). Another U.S. author notes this legal hurdle: “It is not uncommon for lawyers to be reluctant to pursue a maternity case as they see that the woman has survived, and so has the baby, so what is the problem?” (Bondioli 2019-POP3). Popular articles heralded the Turbin case as especially pivotal due to the fact that the birthing parent and baby survived the ordeal, and yet the case was seen as worthy of litigation.

It is important to note that while the popular texts I studied sometimes framed BPs as dramatizing mistreatment in birth as shown in the first excerpt below, the BPs I spoke with expressed a more down to earth understanding of their experience and described feeling conflicted because they and their babies did survive:

When human life is at stake, certain niceties risk being overlooked. Surgeons can be aloof. Nurses become too busy for small talk. Dreams of a carefully orchestrated birth plan are soon left in shreds. Yet none of this is ultimately important. It's only the outcome that matters -- a healthy mother and a healthy baby (Marquand 2012-POP16).

In contrast to this depiction of BPs lacking an appreciation of the medical care they received, Claire describes processing her experience almost exactly as the author mentioned but still felt “anger” at how her medical team treated her during hospital birth:

Claire: I guess [my biggest hope was] for everyone to come out healthy...[In the end] I didn't feel like I should complain about anything because I got a healthy baby out of it. You know? So, then I was like, so maybe the doctors were focused on their jobs. Maybe they were rude to me. Maybe, people weren't as warm as they should have been or didn't give me as much explanation as they should have but they knew what they were doing, and they got her out healthy. So, maybe I should
just cut them some slack kind of thing. I try to be a little more empathetic toward the people that -- even though I was angry with them for how they handled things -- they also gave me exactly what I wanted. So, it's kind of a double-edged sword.

Instead of the entitled and somewhat irrational version of BPs presented by some, Claire articulates the medical aspects of her birth experience as both gratitude inducing and worthy of critique. Further, Marquand uses hyperbole to describe BPs expecting birth to be a “carefree party” complete with “a lullaby-playing orchestra” and “cheer-squad” when “the chief objective of the birth itself isn't to have a good time -- it's to maximise the health and safety of a mother and her newborn child” (Marquand 2012-POP16). Again, when I spoke to BPs, they repeated the idea that they hoped and were happy for their health and their baby’s. When asked about birth plans, no one mentioned anything specific about the birthing environment, but BPs did express hoping for general health.

Alexis: I wanted to be alive and I wanted a healthy baby … that was my greatest. I knew I was going to be in pain. You know that was inevitable, So yeah, I wanted to live -- [laughs] wanted my baby to live [laughs]. That was basically it.

When asked about how they felt about their experience BPs again brought up their appreciation of the “healthy” outcome while examining the experience more critically. Emily: “I mean the outcome's great because I'm alive, my baby's alive, but the experience could have been different.” Tabitha: “Yeah. That didn't go like I planned but ‘you have a healthy baby.’ [sarcasm] Yes! Yep.” Tabitha uses sarcasm and self-deprecation to emphasize the dissonance she feels around the “healthy baby” mantra when applied to experiences like hers, a long grueling induction with less-than-optimal support that ended in a cesarean birth.

Overall, BPs, regardless of circumstance, are pressed to get rid of negative feelings about birth in the hospital in light of birthing a baby born alive and surviving themselves. In my sample, many BPs expressed distress after their difficult birth experience i.e., postpartum
depression, anxiety and insomnia (N=8). While my numbers are too small to analyze this phenomenon based on race, it is worth stating that the Black BPs I spoke with did not describe significant emotional distress after their objectively traumatic experiences. We do know that on average Black BPs are more likely to experience postpartum mental health issues but are less likely to seek treatment (Kozhimannil et al. 2011). Additionally, I argue that for some white and white appearing BPs who identify as women and are accustom to race privilege which provides physical and emotional protection for white women in institutions and everyday life, the reality of OV is jarring (Collins 1989). Racial identity and the existential dissonance created by OV and mistreatment during birth may play a role in the difficulty of integrating the birth experience for white and privileged birthing parents.

There is privilege in expecting the freedom to create one’s own narrative inside the institutional space; in essence entitlement to two complementary strands of a birth story -- the medical and the personal. Kate: “I feel like my birth story got taken away from me. I feel like it’s not really my story. It was a story someone created … a narrative that was created for me through somebody else’s choices and actions.” For Kate, “my birth story” is one that integrates, in an acceptable way, the individual experience and the medical narrative into a congruent sense of self. I would argue that what underpins the ability of BPs like Kate to lay claim to that unique process is profound. Overall, the HBHM belief serves to silence many BPs when their experiences are less than ideal and regardless of the individual response to a difficult birth, this ideology can minimize the importance of a holistic view of health for all BPs.

strategies to disempower BPs: lying and coercion
Findings from this study detail the everyday institutional and BSP strategies used to disempower BP during hospital birth. Strategic behaviors include a range of coercive tactics normalized through routine use and facility protocols that emphasize time management and medical convenience. Various themes related to coercion came up throughout texts and interviews; coercion connected to tension between hospital administration/policy and OBs, coercion around interventions, and nuances in the nature of coercion. Pickles notes Mexican law related to coercion and OV in the state of Veracruz: “[OV] includes coercive practices such as “bullying and psychological or offensive pressure”, which inhibit women's free decision-making about motherhood…. On the face of it, maternal preference may appear to remove the presence of obstetric violence, but it is now well established that coercive tactics by hospital BSPs are regularly employed in order to sway pregnant people into accepting certain procedures or processes over others (Pickles 2015-PR3). The “offensive pressure” utilized by hospital BSPs to force BPs to comply is found throughout these data and in varying extremes. Again, one of the most common threats used in coercion for compliance is about babies dying. Carla details a situation of home birth transfer for breech presentation:

Carla: this mom was totally compliant -- totally fine. She was fine with having a c-section…. And the nurse … was like, “Oh we don't do vaginal breech births here because the last vaginal breech birth I attended the baby died.” And it was just like, “How is that what they -- what!? Where is your bedside manner?” We weren't being difficult … Why is that acceptable to say right now?... Then [the BP] just starts to naturally have the urge to push….And it’s like here’s this woman now who’s not trying to deliver this baby vaginally … uncontrollably pushing and you're terrifying her because you just said breech babies die!

This example also shows us that beyond direct coercion in the moment, the use of dead baby talk by BSPs also exists as a constant reminder of the power dynamic in the BIC and the lack of control BPs have within it (and with birth in general). This ever-accessible life and death framing makes coercion by BSPs to comply with procedures especially effective.
Evidence of outright lying as part of coercion is especially troubling. Laura recalled a situation where a BSP lied about the numeric progression of dilation.

Laura: The doctor came in and was like, “I'm going to check you. Oh, well, you’re a six or seven. I'm going to come back in an hour and see what's going on.” Doctor comes back and says “you’re like a four.... I just don't think you're progressing.” And the mom said, “Well, I was a seven!” and [the OB] is like, “No, no, you never were seven … you’ve been stuck at a four remember?” And I was like -- wait what? And so, the doctor left, and I said to the mom, “Please tell me that you're picking up on this math?… I need you to tell me you heard that.”... You literally out of your mouth said, “She’s a seven” but then just said “No, you’ve never been a seven!!”

This scenario was particularly meaningful to Laura because eventually her client had what she considered an unwarranted cesarean. Pickles also included this specific tactic in discussing the definition of coercion: “Coercive practices that are identified as [OV] include … lying to women about the progression of labour in order to encourage cesarean section delivery” (Pickles 2015-PR3). Lying about the “progression” of labor is particularly effective when the institution’s or BSPs time limits on vaginal labor are pressed.

The politics between hospital agents and BSP practice around liability was implicated in coercion specifically for Naomi and Kelley. Naomi vividly recalls this aspect of her hospital birth. She had two previous cesareans and traveled out of state to secure the care of a particular OB who was open to VBA2C:

Naomi: We got a call on the phone in the room from [Dr. P] and he … essentially told me that the anesthesiologists on staff don’t like that I've refused an IV and if I don’t agree to get an IV, it will jeopardize all future VBACs at that hospital. I remember trying to process this information while I was in the middle of labor and I remember asking, “What if I don't do that?” … he just reiterated, “Well … it could jeopardize all future VBACs.”

While the framing the OB uses is likely honest and accurate, it uses Naomi’s advocacy and strong commitment to VBACs (the very reason she is there) against her. After labor stalling and

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40 The risk for uterine rupture during labor after cesarean increases with each cesarean. Many OB’s who support VBACs limit their support to VBA1C.
Hospital BSPs pressuring her for hours to consent to a cesarean, Naomi finally agreed. At that point, the anesthesiologist was having a hard time placing her epidural effectively and the OB uses the tactic again:

Naomi: [Dr. P] said, “It's not going to work. So well, we’re gonna put you under general anesthesia now.”... [He] told me that if I did not consent to the general anesthesia that he could not be my doctor anymore and that I would have to go home … thinking back on it I know that that's coercion and I know that that's illegal. They can’t send a woman home at eight centimeters that is not what would have happened. But in my mind that was the option I was being presented with.... I was about to say, “Okay. Well, I guess I'm going to go home. I'm going to drive home three hours and hopefully just have my baby like on the side of the road.”

Naomi was in the OR alone but was able to refuse general anesthesia in part because, soon after this conversation, a final epidural attempt was successful. What made the full anesthesia a clear boundary for her in spite of the coercion was her understanding that the cesarean was not an emergency, nor medically warranted. Next, she considered what was behind the OB’s actions:

Naomi: “I’m pretty analytical and so I feel sort of matter of fact about it ... once the birth happened I sort of could see the strings that were being pulled.... I felt like this was coercion and manipulation and it’s not fair.” Naomi felt she was “thrown under the bus” by Dr. P., who had an ongoing conflict with the hospital over the kinds of autonomy he supported for BPs, and “sort of like a pawn in a bigger story that was going on.” The politics between BSPs and the hospitals they worked in was also revealed to Kelley and used coercively: “the doctor had said … they’d had several incidents where people didn’t [come in] and they had bad outcomes. So, I get where they're coming from a liability standpoint. I get where they’re coming from.” Even though Kelley expressed an understanding of the BSP motive, she questioned the approach: “I got really scared which isn't how I feel like they wanted to come across. I don't know but it really, it really shook me.”
Coercion was particularly salient in interviews around the use of epidurals with various institutional tactics playing into this coercion. The following excerpts are examples of two on opposite ends of the spectrum. The first describes a subtle kind of coercion and psychological manipulation:

Julia: [The nurse] would say things like, “Oh I know, you're just one of those that if you get the epidural and have a c-section you’ll blame it on the epidural.” And she would say things like...in a nice tone...like, “No, I understand”… I would say she kind of nudged me.... I felt like she was saying you’re not strong enough. Just get the epidural and you'll get some rest.

Julia emphasizes the subtlety of the nurse’s tactic but describes distinctly feeling that it undermined her capabilities. On the other hand, Sarah recounts the OB physically and verbally intimidating her husband in an attempt to get her to consent to an epidural:

Sarah: [Dr. A] said that to my husband, “You don't care about the life of your baby”...[she] had her finger in his face…. “You need to think about the life of your baby, the life of your son.... You need to get her to get in the bed!” You know, get the epidural and get into bed.

Creatively, the OB attempts to coerce the BP through her husband using the “Don’t you care about your baby?” retort. Others have cited (Hall, Tomkinson & Tomkinson 2011) this threat as commonly used in non-emergent situations to “mobilize fear of death to push non-compliant women to stay in bed with an external monitor on...” (Oparah 2018:113). For BPs desiring labor without medication in this sample, there was a unique tension around epidurals. The procedure limited BP mobility and their ability to labor freely in exchange for giving hospital BSPs more control over unfolding events.

Throughout these data, folks from marginalized groups (particularly Black and indigenous BPs) were at higher risk for receiving coercion and threats from hospital BSPs. In line with others’ findings, these groups were also at increased risk for threats with consequences that involved state sanctions (Flavin 2009; Morris and Robinson 2017): “[M]y original ob/gyn
practice was rude and insulting to me and said that I risked having child protective services being called if I refused antibiotics due to being GBS positive” (Vedam et al. 2019-PR5). The regulation and manipulation of health service payments that flow into facilities is a form of coercion at the macro level. An indigenous BP from Oklahoma speaks to this: “[I was] forced to be in a hospital because of having Medicaid which led to many interventions and being bullied/talked down to until I agreed. This pregnancy we saved up for a midwife so I can have a home birth (Vedam et al. 2019-PR5).” As noted earlier, each state in the U.S. controls where (and with whom) BPs can birth “legally” and is highly influential in regulating the procedures and health services covered by insurance. The constraints of health insurance plans that only pay for hospital services and do not cover out of hospital births leave vulnerable BPs with fewer resources to support a safe birth environment. As in the global literature, mistreatment is a reason that marginalized BPs in the U.S. avoid hospital birth.

Zadrozny references an informal survey of 2000 BSPs notes that the institutional practice of providing inadequate time and space for discussion of interventions during birth is common as well as outright disregard of BPs:

63 percent of maternity support workers either “occasionally” or “often” witness a provider “engage in procedures without giving the woman a choice or time to consider,” and 17 percent report that BSPs go through with procedures even when they are explicitly against the wishes of a laboring woman (Zadrozny 2015-POP17).

A particular type of coercion I call “don’t ask -- just tell” corroborates these findings and emerged mostly in my interviews around induction. This strategy is an important finding which showed that the tactic of coercion expressed nuance depending on individual level factors. Julia, who works in healthcare, describes this strategy:

Julia: I kind of see how they speak differently to everybody. You know, some people they’re like, “Are you okay with this?” And then with other people they’re
like, “Hey, we're going to do this.” So, I felt like I was the latter -- like we're going to do ... this is what we're doing. I wasn't given much of a choice.

As a Latina, Julia puts herself into the category of “other people” who are simply told what will happen.

When considering the “don't ask -- just tell” theme it is worthwhile to bring in conceptions from scholars that outline the socially reinforced categorization of particular groups that negates their human-ness. This negation, with both structural and individual level factors, eliminates the responsibility of society to recognize or engage at all with these groups. Michelle Alexander elaborates this idea as it is seen through the creation of a caste of formerly incarcerated Black men via the prison industrial complex (2012). Marc Lamont Hill utilizes the lens of history, culture, and politics using events of police brutality and environmental racism, to argue that society has cast poor and Black folks into the category of “nobody” (2017). He describes a socially-constructed category that effectively erases humanity and yields certain lives disposable by those with power through moral justification. Similarly, Brittany Cooper explicates the idea of “space takers” versus “history makers” in her Ted Talk “The Racial Politics of Time” (2019). In the context of racialized gentrification, Cooper references the ways that particular groups do or do not warrant acknowledgement and consideration as autonomous people writing their own futures. Applying these concepts to the BIC, if you are nobody or merely a space taker (i.e., Indigenous, Black, Brown, and poor) then medical authorities do not have to engage as if you are someone, somebody, some human with needs and rights. Moreover, rights are not granted but must be “fought for” by those who are educated enough to know they have them, feel entitled to them, and are comfortable enough in the BIC setting to demand them:

Julia: I feel like my autonomy was kind of taken away from me. I guess as soon as I kind of walked in and in order to get [them back] I would have had to fight really hard. Like I see some of these women now -- they come and they’re like, “No IV.
No this. No that.” And I kind of wish I had done that but … walking in -- those rights -- it's like you kind of have to earn them back. I know they're posted everywhere. I know they're in your admissions packet -- patient rights and this and that -- but realistically I don't think I had much autonomy, you know?

Julia discerns between the bureaucracy of “rights” on signs and paperwork and the process of negotiating her autonomy materially with the hospital (which should fulfill the duty of translating those rights into action). This kind of ongoing responsibility of advocating for oneself in the BIC is complicated by social identity. “Don’t ask -- just tell” is a strategy used most frequently according to Julia when BPs are recognized as “other people” (i.e., people of color, not English speaking, poor) and supports a caste system interacting with facility hierarchies upheld through racialized medicalization and more specifically obstetric racism.

A final type of coercion that emerged from the data is what I originally termed “persistent asking” and then a midwife later labeled “aggressive suggesting”. As the authors of the BWBJ project point out:

In a situation where a pregnant individual initially makes it clear that they do not want a specific intervention that hospital staff believe is the best course of action, there are a number of possible outcomes. The medical professional may offer their expert opinion, and accept if their recommendation is rejected. They may also insist upon an intervention in a way that wears down the pregnant individual’s ability to continue to refuse (Oparah et al. 2018:123).

The latter type of communication is what I’m referring to here and was frequent in high-income settings. A popular article refers to the kind of high-pressure sales-type approach hospital staff can apply when discussing interventions: “The nurse soon ‘gave her best pitch for Pitocin,’ a drug Alli had specified not wanting to take during labor” (Karalun 2019-POP6). Behind much of the pressure to comply with suggestions for interventions was BSP intent to manipulate or “manage” the course of birth into cesarean. Allison describes a common example along these lines:
Allison: [The OB] put doubt in her mind and kept asking to break her water over and over again, you know, I think if we break your water this baby will come down and so forth and so on and I got a nuance from the nurse that [big sigh].... I got a feeling from something the nurse said that he was really heading towards a cesarean no matter what. Sure enough, after about the third time, he talked her into getting her water broken and the baby came down asynclitic and she pushed … for maybe two hours…. Sure enough he called a cesarean she cried her eyes out.

Hospital BSP’s withdrawing of support for vaginal birth unless it happened quickly and “calling” cesareans significantly impacted doulas and BPs. BSPs employed persistent-asking in combination with threats of fetal demise in some cases. This dual tactic was successful because it wore down and undermined BPs by creating insecurity, uncertainty, and a sense that acquiescing might lead to the outcome BPs desired.

Epidurals, again, were a common source of contention and subject of this type of coercion. The evidence suggests institutions and hospital BSPs “push” this intervention for pain relief in significant ways:

Isabel: There was a midwife…. that was totally epidural happy. She just was like, “Well, let’s just do it. Let’s just give them out!”.... And that was disturbing to me seeing her kind of … she's like, “I'm the midwife” but she’s in there pushing all these drugs on people. Literally aggressively suggesting that they need to do these things.

Isabel is partly at odds with a BSP claiming the midwifery profession yet peddling the most extreme form of pain relief as standard. Sarah validates this observation recounting her interaction with hospital BSPs around an epidural: “ [I asked] how far along do you have to be to where you can't get the epidural? And I was basically asking like how far do I have to get for them to stop asking me to get this fucking epidural?” Sarah remarked on the favorable response of hospital BSPs when they mistakenly thought that her question indicated agreement to submit to the procedure after hours of them relentlessly and combatively suggesting it. Kate talks about
her experience with “aggressive suggesting” and an epidural when she is denied her preferred options of pain relief:

Kate: I felt trapped like I was up against the wall …. The resource she was really offering me was the epidural that we had to order … she had to order it now. She had to walk out of the room and order it now -- otherwise I wouldn't be able to get it so I couldn't wait. And I was like “Well my doctor said I could wait” … and she's like, “Well, we'll have to call him too…. If I were you, I'd just go ahead and order the epidural”…She's like, “Okay. So, did you want me to call the anesthesiologist then?” And I was like, “Just call them. Yes, just call them.”

Kate feels “trapped” by her pain on one hand and the nurses relentless and sole offer for pain relief that she doesn’t want on the other. She also illiterates structural elements of the situation saying she was “up against a wall” due to the hierarchical protocol that requires approval from a doctor. A shortage of nurses to contact doctors meant additional time was needed -- yet in short supply. In this way, the element of time and gatekeeping become part of the everyday coercion strategy that justifies itself -- “You have to order it now.” Hospitals use the burden of time it takes to gain approval for patient desires or to activate interventions as tools of persuasion at the expense of laboring people. This “business as usual” element of hospital culture validates practices that prioritize this kind of order and routine over individual needs of BPs.

*business as usual, disconnection, and objectification*

Individual strategies of objectification and disconnection to disempower BPs are connected to the larger culture of “business as usual” in the hospital environment. Several BSPs and BPs discussed the fact that the hospital was primarily a business in their responses:

Isabel: Yeah, so when you first get to the hospital you and then you're immediately on their time and they want to get you in and they want to get you out because you might get that bed turned so that they can be more money and that's just saying that it's a business at the end of the day.
Similarly, Jasmine describes feeling, from the beginning of her pregnancy, that the rotating aspect of providers lead to them *processing* her instead of caring for her: “So it was like everyone was just checking the balances off their forms and calling it a day.” Allison recounts a story that gives some insight into an OB’s beliefs about his role in the business of hospital birth: “[The BP had] No risks. No problems. No heart tone issues, and was laboring and progressing, and [the OB] came in and did an exam and he goes, ‘Well your five centimeters. If you don’t have a baby in three hours that I’m just not doing my job’.” This attitude was normalized by many BPs who exhibited a neoliberal informed kind of acceptance of the hospital as a place of business (even though most are “not for profit”). Further, whatever status quo best supported that business made sense and was expected.

The rigid bureaucracy of hospitals as businesses contrasts with the flux state of birth and creates a sense of tone deafness on the part of the institution. This comes up for BPs when navigating both the structural and interpersonal hospital space. Kate talked about the disconnection during her initial contact in the hospital with a temporary nurse unfamiliar with the unit: “she’s trying to figure out the machine … I’m just standing there just waiting and I’m laboring with a pole attached to me.” Throughout interviews, the reliance on onerous machines, created a distraction for hospital BSPs from connecting with the BP’s present situation:

Kate: [The nurse says] “I need you to go ahead and make a decision on this”…. She’s turned back around at this point. She's not looking at me anymore…. She's barely engaged me as it was…. She’s turned back around to machine. She's trying to get the paper to come out. She’s messed up the paper.

Kate’s description of trying to make meaningful decisions while the nurse is “fumbling with machines” speaks to the dissonance between the attention of the institution and staff on everyday workings and BPs’ material needs. Daisy recounts a similarly disconnected experience:
Daisy: When I checked in at the hospital and I was on all fours in the administrative check-in room -- they asked for my social security [number]…. I couldn't say it all in one period of time because I was having such an intense contraction. And then from there they sent me to the waiting room. They didn't check my blood pressure. They didn't monitor the baby. They just sent me out. Right after that I saw my Midwife who had lunch in her hand and … she was like, [uses a happy bright tone] “I'll see you soon!” and she went back into the Women’s Center, beyond the waiting area with her lunch….So then I went on to spend another hour and a half [in the waiting room and bathroom] in this just escalating state.

Daisy mentions she is “on all fours” a visual that coveys to those familiar with birth that labor is intensifying. She wonders how no one she came in contact with understood her situation to be worthy of admittance. Daisy’s sense of being “lost” in plain sight resonates with Freedman and colleague’s description of the contrast between feelings of belonging and comfort that staff feel in hospital spaces and those of patients who find it “uncomfortable and alienating:” “Multiple ways in which facilities are spatially organised and routinely function intensify that difference and help convert it into a power dynamic that emboldens BSPs and belittles or silences patients” (Freedman et al. 2018-PR4). The waiting area of the hospital layout in the scenario Daisy describes -- walled off with a window and staff tending it -- lends itself to reinforcing a strict boundary and endowing staff with the power to decide when BPs are allowed to be “admitted” to the working hospital space.

Objectification supports the “business as usual” perspective and amplifies the risk of OV. Across article types and interviews objectification emerged significantly (N=19): “Women reported feeling stripped of their dignity during childbirth due to the health workers’ objectification of their bodies. Women felt that they were ‘processed technically’ and did not receive humanized or compassionate care” (Bohren et al. 2015-PR11). BPs from various country contexts speak to being dehumanized during facility birth. BPs expressed feeling like an “inanimate object,” “a lump of meant,” or “a slab on the table” (Fernandez 2013-POP1). Popular
texts revealed detailed analogies comparing the BP to an everyday container like a “ketchup bottle,” “paper towel tube,” or a candy “wrapper.” For Laura, whether it is verbal or physical disrespect, objectification is key to the OV she witnesses: “[M]eaning I’m going to touch your body in a way that I see fit or I’m going to lie to you as I see fit.” Hospital BSP entitlement in the perinatal space upheld by the ideologies previously described create commonly cited behaviors tied to objectification.

In lacking respect for the human being that inhabits the body, hospital staff and BSPs objectify laboring people as a matter of course. The routinized character of birth in hospitals is reflected in some BSPs attitudes: “After a long and painful induction, ... he [doctor] sat on the couch and complained that watching [the laboring woman] push her dead baby out [antepartum demise at 36 weeks] was ‘like watching paint dry,’ and left to see patients in the office” (Goer 2010-PR8). The doctor’s actions and statement make clear that, in his opinion, supporting a BP with her stillbirth is as worthwhile as staring at a wall. Significant in these data is the more implicit objectification exemplified by hospital BSPs talking over BPs in the OR -- as if hanging out around the office water cooler: “I remember the staff chatting over me about their lives; I felt invisible” (Murray De Lopez 2018-PR18). Reports like this one are strikingly frequent and similar, indicating that small talk in the OR during cesareans can feel extremely demeaning to BPs. For Nia this was compounded by the carelessness of the anesthesiologist.

Nia: some of the [medicine] kept getting in my eye and stuff was just shooting out everywhere. He looked at me and just kind of left it and my husband had to wipe it away [laughs]. So, then we get in the operating room and it went downhill from there… I could feel absolutely everything and then on top of that him and whoever he was working with … they're talking about golf?!
The stark contrast of meaning between the BPs important life experience and casual talk of sports or chit-chat between co-workers often made whatever difficulties BPs were having with unplanned cesarean birth worse.

The common practice of referring to laboring people as the number that represents how “open” their cervix is measuring, e.g., “you’re a four” is an example of everyday embodied objectification. Labeling BPs by this number is not only misrepresentative of what is actually happening in labor but is mentally defeating. This practice reinforced physical violations that came up in the form of direct manipulation of the BP’s body in careless, unthoughtful and at times deceitful ways. The use of fingers and hands to manipulate the cervix or perineum in an effort to “speed up” birth for no medical reason by midwives and OBs was pervasive. Sometimes BSPs took advantage of the numbing effect of an epidural:

After the physical assault the OB then lies to the BP suggesting a non-evidence based, and unwarranted intervention for her next pregnancy. Similarly, a podcast reveals a report from an anonymous nurse about an OB who routinely performs “manual episiotomies.” The nurse describes her first time witnessing this “procedure” and watching him tear a BP’s perineum “like a piece of paper.” The BSP then goes on to insert a finger in the BP’s rectum saying, “I’m just checking to see if baby tore you all the way through.” It became clear that this was common practice for the OB as nurses had a name for it, “the [Doctor’s name] maneuver.” (Pascucci...
BSPs I interviewed also recounted witnessing unnecessary and physically invasive clinical practices by OBs with little regard for the BP’s wishes, concerns, or well-being.

Violet: [Dr. C] will manually dilate her cervix without consent. And then [Dr. N will] put spoons forceps on your baby and pull them out from zero station without having any conversation about the risks of doing that. Then he'll have, you know, a third or fourth degree [tear] he'll repair but then you know in several cases they've shown up in the ER with stool coming out of the vagina because it wasn’t repaired properly.

Violet emphasizes the unconsented aspect of practices to augment vaginal birth she has witnessed performed without informing the BP about the possible risks of injury and harm. The effects of maternal birth injury due to vaginal delivery are less discussed but important to conversations of OV.

Objectification was also presented through arguably less violent but substantially violating and devaluing gestures. Allison recounts the way an OB would speak over the BP’s body as if he were working under the hood of a car: “[the OB said] ‘I'm going to let you push for a little while longer’ and he would look at me with his hand up her vagina saying, ‘Sometimes these babies just don't fit’ and I'm thinking well that's because you intervened.’” Allison mimics the casually dismissive tone of the OB and indicates his fault in the current situation due to breaking the BPs water. This, along with the entitlement of the physical gesture and inaccurate “man-splaining” of birth, contributes to the objectification of the laboring person. Objectification is also at play in a remarkable way for Julia:

Julia: I mean the whole thing was terrible but when I got to 3 centimeters … they were like, “Hey, let's put a cook foley bulb so we can get you also like physically dilating.” So, they call in the doctor on call and I of course I know him too! I see him all the time on the floor and I'm like got my lady bits out and he's got his hand in me. I'm like, “I fucking know him!” I work with him. And my husband is next to me and I'm like, there's another man with his hand inside of my vagina. So, [the OB is] says, “[Your cervix] is really posterior. I can't reach all the way there.” And says, “Let’s give her some morphine.” And then they were like, “Oh we can't get it … let's get the midwife with the long fingers in here.” And then she tried and like
I'm on my back almost doing somersault backwards because my knees are so far up against my ears.

Julia recounts the embarrassment she feels on multiple levels while hospital BSPs work on, maneuver, manipulate, and talk about her body over her head during an unsuccessful attempt to place an induction device. Julia states, “I was obviously not ready to labor.” The visual of the unusual position of her body and multiple people in the room (one of whom is a colleague) while she is extremely vulnerable is telling of the prioritizing of the institution’s determination at the cost of the BP’s dignity.

Facilities often failed to uphold BP’s expectations of privacy during labor. Daisy shared an excerpt from a letter she wrote to the hospital after her birth:

Daisy: I became delirious with pain and went to the public bathroom where I sat backwards on the public toilet and continue to labor. I was terrified and confused as to why I was not being seen or attended to. Multiple hospital visitors walked into the bathroom while I was there. I was embarrassed to learn later that people outside could hear my labor sounds and were worried for me.

Of course, BPs expressed a desire for basic privacy in the hospital birth environment. Laboring in a “public” bathroom in the waiting room conflicted with every expectation Daisy had about hospital birth in the U.S. where most BPs are given a private or semi-private room if available. In country contexts where space is limited expectations of privacy are lower but still exist. A BP describes breaches of confidentiality by BSPs in Ghana who will “call the patient by their disease:”

Some people [health workers] won’t even ask for your concern when they are going to give you an injection, she won’t even ensure privacy, just turn your buttocks this way Madam, and then she injects you...Well, these can cause the patient to be so stigmatized beyond being human (Dzomeku et al. 2020-PR12).
The objectification of BPs through manipulation of their bodies, referring to them as a number or condition, and general disregard for personal privacy and dignity results too often in feelings of dehumanization.

Disconnection and stonewalling are behaviors connected to objectification that further support “the business as usual” culture and maintain the status quo. BPs across texts and interviews pointed to this barrier to respectful and satisfactory care. Jasmine describes meeting the OB on call for the first time during her birth saying, “it was all business and I was fine with that but when all this went down -- she froze and disappeared and never came back.” Jasmine specifically remembers the disengaged behavior of the on-call OB during her birth which required an emergent procedure by another OB to stop a hemorrhage:

Jasmine: [The on-call OB] really didn't interact much with me. It was just like, “Hey”-- came in shook my hand -- “Ok, so we're going to start the [Pitocin] at this time.” I’m thinking I guess I'll see you in a minute [but] [the on-call OB] walks out and then the next time I see her is when she is coming back to deliver.... [My mom and partner] said [the observing OB] literally just moved [the on-call OB] out the way, flipped a bucket over, sat on it and started sewing as fast as she could.... [The on-call OB] disappeared after that. I've never seen that woman after that!... I went back and looked even on my son’s birth certificate it says [the observing OB] the doctor that saved me … because I did go back to see if I could find who that woman was [on-call OB] and I didn't hear anything.

Jasmine noted multiple times in our interview that the on-call OB disappeared after she failed to render emergency care. BPs often attempt to retrace medical events and identify personnel through their hospital records but many times they are unsuccessful. Importantly, Jasmine felt that her race played a role in the disconnection and complete disengagement of the on-call OB who did not take the time to check on her after the event.

Disconnection in the hospital by staff and BSPs is a tool for their survival as it allows them to compartmentalize and perform their work in a high-pressure environment. This strategy is juxtaposed against the often-emotional process of birth for BPs and further contributes to their
disempowerment in the hospital setting. Instances of crying by BPs existed throughout the data in interviews (N=13) and texts (N=7) and was often met with emotional stonewalling from hospital BSPs: Alexis: “And then so [the nurse] eventually left the room and I’m bawling and bawling. She comes back. She doesn’t say anything [laughing] about me crying.” Inadequate BSP reactions to crying include ignoring the social cue completely, commanding people to “stop crying,” and name calling (i.e., “crybaby”). Clearly, navigating a high patient volume and intense patient emotional states requires emotional labor that many hospital BSPs and staff are not equipped or willing to undertake.

*maintaining the medical hierarchy: complacency, playing nice, and bullying*

The various ideologies that underpin medical authority during hospital birth and the strategies that reinforce it depend on the existence of an internal hierarchy within the BIC. Throughout texts and interviews researchers and participants (N=23) made connections between these institutionalized hierarchies and OV. Goer highlights how the nature of hierarchy promotes abuse which flows down from the top: “Because authoritarian social systems allow some individuals unrestrained dominance over others, mistreatment and abuse are likely to follow” (Goer 2010-PR8). The stratified structure in health systems permeated geographical contexts as the medical chain of command in hospitals is in keeping with existing societal and local hierarchies. Hierarchies in the BIC create order, acceptance, and proliferation of the everyday violence vetted out during facility birth. These laddered systems of power vary by institutional organization and are contextualized based on the specific structure of any given health system.

Hierarchies around hospital protocols often frustrated midwives and nurses. Evidence from Ghana indicated the midwives’ frustration at the lack of support from physician colleagues
to allow BPs to birth in effective positions (Dzomeku et al. 2020-PR12). Another midwife is constrained by hospital polices that provide different levels of comfort for BPs based on ability to pay: “the hospital protocol is asking you to maybe let the person lie on the floor … you have no option than to do what you’ve been asked to do” (Dzomeku et al. 2020-PR12). Leiko described the implicit understanding that it is the doctor and not hospital policy that is penultimate during facility birth in the Dominican Republic (Dekker 2020-PC3). Across texts and interviews, evidence corroborated the idea that doctors had the power and ability to act independently of hospital policy.

Of course, the hierarchy in hospital birth is connected to social regimes operating at the societal level. The social stratum that BPs and BSPs inhabit and navigate in everyday life are brought with them into the hospital where they then encounter the additional forces of the institutionalized medical hierarchy. An article from Tanzania evokes the need to understand the workings of this ongoing organizational power in order to address OV: “They need to examine the ways in which hierarchies of power that permeate health systems and the marginalising, demeaning practices that go with those hierarchies are internalised, naturalised and/or normalised by patients and providers alike” (Freedman et al. 2018-PR4). The evidence in this study shows internalized hierarchies reproduce normalized practices that buttress power through “complacency” and “playing nice” as well as outright “bullying.”

Violet recalls her shock as a new nurse in response to abuses she saw taking place: “I turned to my charge nurse … I said, ‘You've got to stop this! This is not okay.’ No one's listening to me … she did nothing. She was our charge nurse of like 30 40 years. She did nothing.” Violet emphasized the absolute inaction and “complicity” of her superior attributing it to normalization of OV. She later reflected on how administration addressed these issues: “If anything, I felt like
it was more the inaction… and lack of support that just like complacency of what was allowed to go on.” Julia backs up this idea of willful administrative ignorance of the issue:

Julia: We report [the offending OB] to charge nurses. We report him to the anonymous line -- this and that -- but yeah, nothing nothing happens! And I sense [the other nurses] frustration and I've listened…. [I]'s not just one or two nurses. It's everybody -- and it was so weird because I'm like, nobody likes him on postpartum, nobody likes on L&D…. What is what's going on? It can't just be coincidence. I believe in 1 coincidence but not 50 or 100 or 1000.

Julia emphasizes the continuous nature of the offenses that go unsanctioned despite a consensus from staff that, in sheer number alone, seems to objectively legitimize the complaints. BPs also experienced this attitudinal strategy from administration around reporting OV to staff immediately postpartum. Naomi: “[S]omeone came by [the hospital room] to do a customer satisfaction survey sort of deal…. So, I basically, told them in short order what had happened and that it was completely unacceptable…. It was just sort of like, ok. Sorry to hear that.” A popular article detailing the Turbin case, reflects a similar situation: “A representative from the hospital came to her room the next day to ask if she was ok and Turbin said she wasn’t. According to Turbin, the woman handed her a pamphlet about post-partum issues… and that was it” (Grant 2017-POP2). In this way, normalcy of OV combined with a “business as usual” frame enables it to continue unfettered. Further, due to inadequate options for recourse, and a lack of transparency on the part of hospitals, BP feedback is of little concern to the institution.

“Playing nice” was an additional passive tactic that emerged from interviews. This strategy maintains the institutional hierarchy and status quo by providing surface level acquiescence to patient desires and accommodation of their feelings. Amaya talks about the nursing staff initially “throwing [her] some bones” during the early stages of induction by letting her “walk the halls.” As the medical management of her labor intensified, staff was increasingly less receptive to the BP’s requests including informing her of the dose and timing of drug
administration. Amaya recalls the resolving of tension between herself and staff saying that “things felt lighter” when the decision for surgical birth was made: Amaya: “[O]nce I was in the OR it become less of like a -- ‘This what's going to happen’ and more of like a -- ‘Oh how are you feeling?’ [fake nice voice] You know -- that kind of thing.” Amaya noted the relief of BSPs once the unknowing and unpredictability of vaginal birth was behind them. The attitude of “niceness” often came across as misplaced and ingenuine to BPs. Ava describes her BSPs reaction when she came into the hospital in premature labor: “She was checking to me to see if it was amniotic fluid or not…. She came back and said, ‘I'm so sorry it is amniotic fluid.’ And that's when everything kind of started with the why are you being so nice to me?” In Ava’s case, hospital BSPs implemented “nice-ness” in lieu of offering information and to avoid open communication and difficult conversations about the BP’s medical condition. The strategies of “complacency” and “playing nice” emerged as power plays couched in passive behaviors to both pacify BPs and avoid conflict.

On the other hand, “professional” bullying is an aggressive tactic to maintain the traditional power dynamic among BSPs made worse by structural inadequacies: “Deleterious intra-/interprofessional dynamics such as bullying and gender-/class-based discrimination among health care personnel are also prevalent in Mexico” (Sreenivas et al. 2015-PR10). Violet corroborates the stress of poor infrastructure and bullying:

Violet: [I]t became a very difficult job to have to continue to go back to day after day … management issues were a big big issue. There was a lot of bullying we were constantly short-staffed which then led to safety concerns. At the end of the day, you know really just not feeling like you were able to give the care to your patient that … she deserved and should have gotten.
Evidence existed in texts and interviews pointing to OBs bullying and threatening nurses mostly around resisting unnecessary interventions. Goer notes OB’s “use of power to trap nurses in no win positions.” A nurse states:

A female obstetrician on our unit is notorious for ‘punishing’ the nurse for failing to push Pitocin hard enough to get patients delivered by the end of the work-day, by taking the patient back for a Cesarean. She then tells the nurse “Have it your way, but it's your fault she ended up with a section” (Goer 2010-PR8).

This evidence suggests entrapment on a professional level is also occurring around induction/augmentation and cesarean. Julia describes the discretionary power of “calling” a cesarean that OBs wield:

Julia: I later learned that the doctor who did my section is actually one of the least patient doctors -- like she's very quick to cut… So, at that point even the nurses … weren't trying to I guess rock the boat either, you know?... I remember looking at [the nurses] kind of like almost begging them like please!... But the doctor’s in the background already like hey, can we get a type and screen? Can you get the OR ready? And they are already trying to follow their doctor's orders.

Despite Julia’s pleas with the nurses to delay the surgery, she knows that their status prevents them from doing so. The decision made by the team (without her) and lead by the OB is unyielding. Keeping staff “in their place” and creating an appearance of a unified mindset (that of the OBs) in the presence of BPs was also noted by Allison when a nurse was called outside the room to speak with the OB:

Allison: she rolled her eyes like oh my God, what did I do? ...And when she came back in the room the Dad said, “So I guess you still have a job because you're still here” kind of jokingly and she goes “Yeah,” she kind of rolled her eyes and said, “They all just have their own little way of doing things” and kind of sighed. And then her whole -- like she had been so enthusiastic with his mother. “Oh, my birth yesterday was natural and you're doing a great job and you're going to be able to do this!” and her demeanor changed after that. She became less invested in the pushing... So, my suspicion is that he told her look we're doing a cesarean so just wrap your head around that.
Doulas and nurses offered insight into the behind-the-scenes communications and power dynamics during labor and delivery. “Buy in” for vaginal births was an issue many BSPs noted as challenging.

The hierarchy in the BIC is similar to that in all areas of medicine but is unique in that it also includes non-medically trained doulas or traditional birth attendants (TBAs) depending on country context. Evidence shows that these BSPs have the least power within the hierarchy during birth in most facilities, though their acceptance in the birthing space varies based on OB/midwife attitude. Leiko suggests the tension between doctors and doulas is “a little bit of … maybe an ego thing.” Sahara, a participant in the BWBJ project, supports this idea stating:

“I had been talking to my doctor about a doula. She’s like, “You don’t need a doula.” And then she’s like, “I don’t even really like doulas.” She was very honest about it. She said, in her experience, they are pushy. And she was like … “they try to get you to have the opposite of whatever your doctor wants you to have or they start arguing with the doctor.” (Oparah 2018:83).

The information that doulas and TBAs provide to BPs changes the power dynamic putting OBs in a less totalitarian position. In an attempt to maintain this power doulas and TBAs are framed as outside actors and not considered “part of the care team.” For example, Ibanez-Cuevas and colleagues note the cultural knowledge and practices of TBAs in Mexican facilities are not accepted and thus the TBAs experience “exclusion” and constraints to their full practice (Ibanez-Cuevas et al. 2015-PR20). Doulas throughout interviews also voiced feeling excluded and understood their subordinate place in the hierarchy:

Laura: they don't acknowledge your existence where if you speak you can catch the eye roll. I always tell people if you're going to these hospitals like Westwood or Sullivan, you don't have to make a big fuss about the fact I’m the doula because they will treat me differently. I'm not birth team member at that point. I'm their opposition. And I'm the one who's supposedly going to get in the way and play with the monitors [laughs] so I just suggest you say [your friend] is coming.
Laura recognizes cues of contempt if she speaks up and suggests BPs employ the subversive tactic of not revealing her doula role to avoid defensive actions. Allison recounts receiving sanctions by a midwife for “overstep[ing] her boundaries”: “I've had my hand slapped. I had one midwife who … refused to work with me…. We ultimately you know, were able to come to a … peaceful understanding if you will … it just puts you in your place and reminds you that you're really nothing in their eyes.” Several local doulas mentioned that speaking up in hospital birth and engaging with staff and BSPs can result in getting “kicked out” of the room. Most doulas I interviewed reflected the understanding that they are “no one in the hospital” and continuously emphasized that they are solely there to support the client in engaging with the medical team

Maintaining the institutionalized hierarchy of professionals in the BIC is integral to its survival. The status quo as evidenced throughout texts and interviews includes implicit and explicit practices of violence normalized by various ideologies and supported by both passive and overtly aggressive behaviors by staff and OBs. The entrenched nature of the medical hierarchical system is a reproduction of societal hierarchies and a reflection of the way that the MIC trains medical professionals. When asked why she thinks OBs practice in the authoritative way that they do Leiko states:

I would start with trauma and fear. I think it is similar in the United States, the way that when you’re doing your residency you’re treated basically as something less than a human. And come on, when you’re done with that and you’re finally on OB-GYN, you’ve got four years of baggage of being mistreated, and on top of that, four years of not seeing a normal birth, at least in the DR (Dekker 2020-PC3).

The hierarchical white supremacist culture that OBs as surgeons, and all medical students are trained to “fit” into professionally devalues connection and empathy. Simultaneously, the

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41 There is one exception to this approach from interviews and I designate an entire section to this particular doula’s philosophy, perspective, and professional strategies in Chapter 6. I also challenge this approach with information from other content sources in Chapter 6.
authority of medicalized birth becomes the dominant framing for both OBs and medically trained midwives (Jones and Okun 2001; Wagner 2006). Mistreatment in medical training and its resulting mental health effects on students is a longstanding issue in the U.S. (Richman et al. 1992) that is continuing to be addressed in a collective way by the medical institution along with academic hospitals responsible for training MDs (Karp and Levine 2018).

The extensive reach and power of medical authority to determine when and how BPs birth is well documented (Rothman 2016; Simonds et al. 2007; Washington 2006). Various health organizations like the WHO have supported increasing the scope of this authority in birth in recent decades with little attention to the quality of that increased engagement. These data show that forced interventions (inductions, augmentation, epidurals, excessive monitoring, and cesareans) continue at rates that are detrimental to BPs. As such, evidence indicates that the will of hospital BSPs and institutions to determine when and how birth occurs -- through medical entrapment -- is expanding at the expense of BP autonomy. Further, the BIC actively categorizes BPs based on social identity and status. OV disproportionately impacts BPs of color around the world who must navigate the white-oriented BIC as “others” (Feagin and Bennefield 2014). Everyone who gives birth in a hospital does the work of making sense of their experience in retrospect, especially if it was difficult. BPOC interviewed in this study had the additional work of interpreting the perception of their identity as an influencing factor in their treatment both medically and personally. Obstetric racism in the BIC is a direct and indirect contributing factor to OV and perinatal health outcomes. Therefore, it is crucial to incorporate racism into definitions and theoretical frameworks used to understand OV.
5 THE BIC: LOST IN TRANSLATION

I use the title “Lost in Translation” for the whole of my project because poor translation at many levels is the crux of OV. Further, the four dynamic aspects of the meaning of translation apply in this work: 1) to change from one spoken language to another; 2) to change in form or condition; 3) to explain in terms that are easily understood; 4) to bear or carry from one place to another (Mariam-Webster.com). I define poor translation during hospital birth as a lack of recognition of BPs (as fully human and birth as non-pathological) in combination with inadequate and harmful communication that is rooted in relational ineptitude and results in the injurious and callous application of medical services. The site of translation between current health systems and historical and contemporary oppression is where BPs become unrecognizable (as whole people or people at all) to institutions. In this study of hospital birth, the themes of a loss of the right to self-determination, and lack of recognition of self by others emerged consistently. To illustrate these connected motifs, I use translation as a heuristic to highlight the possibility for failed or successful communication. I also use this idea to conceptualize the complex and particular opportunities and obstacles to successful translation that BPs encounter when they cross the threshold of the hospital or other facility to give birth. Individual agents in facility-based birth are acting within multiple nested cultural forces as well as state and institutional structures complicating recognition and transparent communication (Fig.5). The act of translation happens at each juncture and through each layer, with multiple actors involved in the possibility of being seen (and heard) in the BIC -- or being lost. Incredibly, on top of this complexity, BPs and babies enter as one and leave as two -- a most unique translation in and of itself.
The interactions between micro and macro level influences during birth are significant in ways that other experiences in the hospital setting are not. Any time we enter the hospital, we face the process of recognition by the institution and our treatment is influenced by that assessment. This recognition process is high stakes during the highly intimate experience of birth and can render BPs particularly vulnerable in medical facilities. Peer-reviewed texts across continents and country contexts made connections between micro and macro drivers of OV. Freedman and colleagues use anthropology data from Cameroon to elucidate the way macro level constraints “translate” materially and the “altercations with users [that] arise” from that process:

[W]hen BSPs work in “unsuitable spaces that lack basic equipment and supplies … [it] engenders a permanent uncertainty,” making it impossible to follow rules and procedures that were designed for an idealised, well-stocked setting. Instead, to manage this uncertainty, health workers need to mobilise considerable intellectual resources to constantly anticipate needs and demands and to “translate” the resources they do have into improvised responses (Freedman et al. 2018-PR4).

The authors illuminate the effort and energy involved in “this demanding and continuous process” of everyday translational work performed by humans and compounded by minimal resources. Texts like these represent the larger understanding and consensus that the issue of OV is complex and complicated by various and simultaneous influences across all levels of social analysis. With this perspective I discuss communication dysfunction in the BIC and the drivers of this dysfunction.
5.1 Communication Dysfunction in the Birth Industrial Complex

Even when BPs and BSPs share a language in common with the health institution, they still have to manage the challenge of understanding medical terms and concepts. When a language barrier is introduced, these existing issues are often intensified and aggravated by racism and classism. Indigenous BPs in Mexico (and elsewhere) face severe translational issues compounded by racism that put them at risk in the facility setting: “I can’t talk to the nurses because I can’t speak Spanish. God forgive me for not having been to school” (Dorr and Dietz 2020-PR14). Even when opportunities for translation are available ingrained BSP attitudes can maintain barriers: “[the doctor] doesn’t want any [interpreter] help. He does everything alone. But he doesn’t understand the local dialect. He speaks only Spanish. Who knows how he does it, and then he becomes also aggressive. No wonder, people don’t want to be treated by him” (Dorr and Dietz 2020-PR14). Further complicating adequate translation is the idea that even if one has
basic knowledge of language it may not be sufficient in medical spaces because “communication inside medical facilities is emotionally and substantively demanding” (Dorr and Dietz 2020-PR14).

In Ethiopia class differences are influential in the issue of translation as BPs and facility-based BSPs note: “[D]ifficulties [arise] due to the patient and provider not sharing the same language, vocabulary, or concepts, and BSPs having to care for rural, poorly educated women who might not be familiar with health facilities” (Burrowes et al. 2017-PR1). Feelings of discomfort and humiliation stemming from racism/classism are part of the broader issue of poor translation of medical information that leads to OV worldwide. Researchers focusing on indigenous BPs in the Chiapas Highlands of Mexico implicate such “linguistic barriers” that create an atmosphere of fear and distrust for BPs (Ibanez-Cuevas et al. 2015-PR20).

Translation problems are significant for migrant BPs in all settings. In the U.S. context, Julia spoke to her background translating in medical spaces for her family and particularly during birth for her mother when she was just six: “I was the one to learn English, so I had to translate for my mom when she went to appointments…. I was in the delivery room kind of translating.” Julia’s background is called upon in her everyday work at Westwood hospital:

Julia: I'm there to kind of help coach [Hispanic BPs]. I try to be that voice for them. I'll do kind of that interpretation, but I will in -- with my own words and in our language. I’ll cheer them on and then when baby is out, you know, just kind of keep it going. “You did so good!”

Though she is not officially a hospital interpreter Julia provides authentic “interpretation” of encouragement for Spanish speaking BPs during birth through translational work with a more genuine feel than the typical options her hospital offers BPs: “[T]hey have three ways to get a translator. One is the in person … Then we have iPads … and then we have the phone…. They do have many ways to get access. So, I always stress that too. To ask for them.” While there are
various ways to receive translation services at the hospital, they must be requested by BPs.

Additionally, the in-person option is constrained by weekday office hours (which birth does not ascribe to) and translators who are general hospital interpreters and not trained specifically in the labor and delivery context. Improving traditional language translation services may be an area of hospital focus that could result in significant improvement for BP’s birth experience. The only other BP I interviewed who brought up issues of language was also bilingual.

Ava: [W]hat if you have an individual that doesn't think the way that I think?... Somebody that doesn't know how to communicate. Somebody that doesn't speak the language…. You have all these other scenarios where if you're not vocalizing and communicating -- like what the hell is going to get lost?

Ava points to aspects of self as well as language barriers that contribute to communication gaps during hospital birth implicating the range of important effects that may be neglected in the process. The large number of people involved, with whom BPs had little or no relationship, intensified the difficulties of communicating and translating the medical experience.

Data across countries showed evidence that OV was influenced by the sheer number of individuals involved in facility-based birth and the uneven attention they provided. When asked who was with her in the delivery room, Daisy describes the inner and outer state of confusion and flux of people: “Um it’s hard to say [laughs]…. you know, it’s like looking through a vortex.” BPs talked about a marked feeling of being both overwhelmed and underwhelmed by attention during hospital birth -- an aspect of the experience related to both structural issues and the unplanned nature of birth. Kate: “[The nurse] has no interest in me … [it] was more about just getting her stuff done so she could get out ... like you walked in it looked like a war zone. Nobody's anywhere … the room I got had just been cleaned out.” Kate connects the attitude of the nurse and lack of individualized care she encountered to a staff shortage making the analogy to a “war-torn” environment. In contrast, an Ethiopian BP describes their experience:
There is a shortage of beds. No waiting area, we just roam around the facility. I went in the evening and met a lady midwife who evaluated me only once overnight and she didn’t reappear. I delivered in the morning and was assisted by the morning provider. She was called after part of the baby was delivered by itself; she didn’t care for me much (Burrowes et al. 2017-PR1).

In this case, the “care” is not just disjointed but non-existent. The disconnect in provision of medical services and general attention for BPs was reinforced by the number of people “floating” in and out of the birth experience. A lack or excess of attention in the hospital also depended on time of day as well as shift cycles. An Ethiopian article notes this contrast: “At night women often experienced neglect. On the other hand, women who delivered during daytime complained about having too many trainees around them during daytime and more violation of privacy” (Gebremichael et al. 2018-PR13).

BPs around the world had strong feelings about the involvement of trainees in their births. A student shed light on complaints about excessive numbers of students in Ethiopian facilities:

Midwifery student: It [verbal abuse] happened in Debre Markos Hospital. We students were many in number, and clients got ashamed to be free in front of us [to permit vaginal exams], and did not comply with the orders given by BSPs…. BSPs will be in a rush and will shout at the clients (Burrowes 2017-PR1).

The presence of large numbers of people invading (and violating) the intimate space of birth was one of the most difficult issues for some BPs. In another example, an indigenous BP in Mexico explains: “It was lovely to have a child, but the process of having all these people touch you. That was horrible and it wasn’t even just one doctor it must have been about seven different people putting their hands inside me […] they were all male doctors … they were all really mean” (Murray de Lopez 2018-PR18). In the U.S. context, Aja from the BWBJ project recounts dealing with the intrusion of hospital BSPs during her birth:
The whole time it was like, “No. No. Why are you touching me? What is your name? Could you introduce yourself before you start feeling me up? Can you tell me what you’re doing? Why are you touching my machine? What are you putting in my veins? Can you tell me what you’re doing? No. No I don’t want that. No. I don’t want that. Okay. Why are there six people in this room, and four of you are discussing Grey’s Anatomy, two of you are arguing with me about what I should be doing, why are you in here? Can you just get out?”(Oparah 2018:68)

Again, the presence (and actions) of multiple people was experienced as an invasion and interruption that created tension and contributed to breaches of trust, confusion, and conflict. BP interview accounts also indicated lapses in confidentiality and transparency when it came to trainee involvement in birth:

Alexis: First thing I had is a medical student. I did not know she was a medical student. She did not come in and announce herself as a medical student. That was the first thing that I thought was wrong…. I did not know who I was talking to. It was not a time for me to be teaching somebody -- and I know I'm in a teaching hospital -- but a medical student? I was having a pre-term birth it was not the time … when I found out who she was I was really angry.

Alexis had strong feelings about the medical student involved in her care particularly because the student was not forthcoming about her identity from the beginning and Alexis felt that this incident set the tone for the rest of birth. Interestingly, many BPs defended the “idea” of teaching hospitals but pointed out their discomfort around receiving care from trainees:

Kelley: I had clearly written … that I did not want Med students around…. Nobody paid attention to that. Even when they came into the room they didn't ask me if it was okay for them to be there. I constantly had to be like, “Please no Med students” or “I'm okay with them observing but I don't want them doing stuff”… I got really frustrated really quickly … especially when it was a group of like six or seven med students just poured into the room as I was pushing and I was just like, “Out!” And the dr.'s like, “Well I'm the dr.” I'm like, that's fine and I [want the] med students out. And she's like, “You're not okay with Med students?” I said, “No….do you see what state I'm in right now? I'm the one who has to do this?” You should have asked.

Kelley’s narrative and others indicate that even when a request is made by BPs to restrict medical student engagement, their wishes may not be upheld. The type of self-advocacy Kelley
describes engaging in requires both energy from the BP (that they may not be able to expend) and recognition by the medical team. The invasion of BP intimate space by entitled strangers was noted by many as Kelley mentions not meeting the doctor “at all before she was sitting down between my feet.” She also detailed feelings about her preference for OBs and not “trainees” to perform procedures. The issue of trainee negligence came up in popular texts significantly in relationship to maternal mortality in the U.S:

The trainee doctors started to deliver the baby’s head, but they couldn’t get it out. “There was a lot of yanking. The whole table was rocking,” she said….After delivery, the OB/GYN fellow discovered Jenny Nedopak’s uterus had ruptured, court records say. Only then … did the trainee doctors call their LSU professors to help perform a hysterectomy to stop the bleeding…. The Nedopak’s lawsuit says that “extensive uterine damage occurred due to aggressive and inexperienced delivery maneuvers by the residents” (Kelly Schnaars and Young 2019-POP11).

Evidence showed a call for increased scrutiny of policies and training programs at teaching hospitals across the U.S. to identify practices that increase the prevalence of OV. Beyond the influence of trainees and students on the birth experience for BPs in the sample, the effect of “on-call” policies in large hospitals and OB/Gyn practices played a role.

Issues with on-call doctors came up in both interviews and popular texts. The phenomenon of “on-call” policies was a frustrating obstacle for communication, consistency of care, and general relationship and rapport (N=8). The inability to communicate with desired on-call OBs and midwives during birth and afterward was frustrating for BPs. Jasmine was particularly disturbed by the on-call policy at the hospital where she delivered that prevented the OB whom she knew from providing care even though she was present.

Jasmine: [My OB] was already in the room originally. So, I just assumed she was the one delivering. And then the other - the young woman came in and that's when I looked and I was like, who is this?? And she's like, “I'm on-call. I'm delivering your child.” I was very confused, but I was like ok I'll just go with the flow. But I was like my doctor is in the room so why does that other person need to be there? That's what I just did not understand. Why does she have to be there at all?….. So,
what [my previous OB] explained to me was that … the policy they have where whoever is on call is the first to deliver.

Without explicit explanation of the issue, Jasmine is left to conjecture that the on-call OB “wanted money for [her] delivery.” Jasmine highlights the hospital policy that in her understanding “has nothing to do with the care of me.” She reiterates that she “feels in [her] heart” that her experience would have “gone differently -- or how it was resolved” if it were not for this policy. The role of institutional policy as a constraint in birth and potential contributing factor in OV was a common theme throughout the data (N=29).

The restriction of companions compounded the issue of inconsistent and meaningful attentiveness in many countries outside of the GN. Even when BPs had birthing companions, like Kelley, they often felt alone: “We were kind of just left alone in the room for a lot of [labor] and I wasn't expecting that…. [My doula’s] like well they’re watching you on the monitor.” Hospital culture and structure does not provide human support or encouragement for birth (especially vaginal birth) but focuses on machines (that don’t work well), production, and outcome with little concern for BP engagement. Highly surveilled throughout labor by machines and an extremely alert nurse, Alexis found herself in need of attention at the end of labor and had to “[try] really hard not to have a baby.” Reflecting on this Alexis says, “Nobody was available. When I think I was ready to give birth nobody was available.” In many examples like this one the tension of “too many people” yet a lack of meaningful regard was compounded by poor communication between BPs and hospital BSPs at all levels.

*miscommunication, lack of information, lack of consent, and not being heard*

The lack of control for BP over who provides care, the constant flux of personnel and intermittent quality of their attendance, created gulfs of understanding and general confusion.
Poor communication within the BIC amongst BSPs and staff lead to misunderstandings and subsequently poor quality of care:

[The BSPs] hurt us psychologically. They came and did vaginal examinations repeatedly as simple as anything but it is a big trauma to us... I tried to [stop] repeated vaginal examinations...only to receive an insult...“shut up” you conceived for your own...they were not also well organized and often did not communicate well to one another...so the same examination is done repeatedly unnecessarily (Gebremichael et al. 2018-PR13).

The medical trauma inflicted on Ethiopian BPs by BSPs is compounded by verbal abuse and miscommunication that leads to unnecessary procedures, and distrust between BP and staff. In a U.S. based example, the plan that Alexis made with her OB about Pitocin was changed without her knowledge but because he was off duty and the nurse “never showed up again” she had no recourse. In addition, Alexis reported a troubling situation when she asked for information about an intervention to protect her premature baby and subsequently agreed to it. She recounts feeling unseen and confused as multiple MDs come and ask her about the shot she already received even after she requested to speak to a neonatologist for a very different reason:

Alexis: There’s all this fear, like is my baby going to be fine. Is she fully developed? Is she going to die?....I don't know. So, I asked to speak to [a Neonotologist]. She comes in and asks me about the shot! I had already gotten a shot two doctors ago! So, I interrupted her because she was getting ready to leave. I was like, “I already had the shot I actually asked if I could just speak to you because I don’t know anything about having a preterm baby”.... I had to ask her to give me information about this baby that I was going to have early because she apparently was coming in for a shot.

Stories of miscommunication often presented opportunities for resolution but the themes of “too many people” and “business as usual” thwarted their repair. While dealing with managing BSP perceptions of her as a BPOC, Alexis stresses concern about the immediate future for her baby and has to ask for more information about what to expect. Adding insult to this situation, the hospital is not only offering no proactive information about her premature child to support her --
they are also assuming that she is refusing an intervention to benefit her unborn baby. Alexis attributes her treatment and misrecognition by the hospital in part to racism as previously discussed.

The “withholding of critical information” by the BIC is a global phenomenon in birth that makes it difficult to reach the threshold of informed consent from BPs. Lack of information is a particularly concerning theme that impacts communication and made it difficult for BPs to understand their physiological and medical condition, as well as to be active in their own care (N=32).

Women commonly described communication issues with health workers that left women feeling “in the dark” about their care. Health workers actively dismissed women's concerns and anxieties regarding potential complications or impending delivery. When faced with labor complications, women believed that adequate explanations from health workers were imperative to fully comprehend the situation, but these explanations were often rushed, if provided at all (Bohren et al. 2015-PR11).

Texts and interviews contained much evidence that important medical, and sometimes practical information, was inadequately presented to BPs during birth if presented at all. Many BPs interviewed remarked that hospital BSPs failed to inform them about their options, physiological states, medical status, or provide explanations even when asked. In many cases BPs felt hospital BSPs withheld information and remarked on how they wrangled with hospital BSPs for it in the moment. For example, Kate recounts a point where she attempted to confirm why she was having issues with blood pressure during her birth:

Kate: I'm pretty sure [the nurse] dosed me a third time with the blood pressure medicine and she said, “Wow, she must have given you a lot of epidural medicine” and I was like, “Is that what it is?” She's like, “Yeah…” … she said it under her breath. I don't think I was supposed to hear.

The explanation for Kate’s low blood pressure was not intended for her to hear but merely slipped out. BP narratives revealed it was common for BPs to seek and find out bits of
information surreptitiously. On the other hand, Claire directly and persistently asked for information that never materialized:

Claire: I asked, “Why haven't you laid her on me? I need skin on skin now”…. And they yelled at me at first. “Oh, no, we're not doing that. You're not allowed to do that! Nobody told us we were going to do that.” And I was like, “What do you mean nobody told you?”…. They didn't really give me a reason that’s why I didn't understand…. I thought it was standard. I didn't have to tell you that I wanted to hold my baby when it came out of my body!... It was very odd…. I've never really been able to figure out why I had to fight so hard to get them to give her to me.

Claire assumed she would have immediate contact with her baby and describes considerable thought in trying to “rationalize” what happened. BPs often ruminated on why specific incidents occurred when confronted with a lack of information from hospital BSPs and staff. This was especially true in births with emergent events. Jasmine describes a chaotic situation during birth, and she struggles to understand what caused her hemorrhage:

[R]ight when she kept telling me to push [I thought] like -- ahhh this was a bad decision -- that was the moment where I knew what I should have been doing but I just did [what the OB said] anyway. And I think back like was that the reason? Because there’s no one who really explained why I bled out.

BPs missed considerable and meaningful pieces of information both during birth and immediately postpartum. Ava recounts what happened when her water breaks prematurely at 24 weeks:

Ava: [N]obody would talk to me directly … nobody would tell me -- “I’m so sorry that it's amniotic fluid because this means that you might lose the baby.” Nobody told me that ever! Nobody. Nobody. I had to -- within that high-stress moment of me trying to understand what the hell was going on…. I didn't understand…. Like is this baby going to die? Is it not going to die?....It came to the point I actually had to tell one of the high-risk dr.’s, “I don’t need any southern hospitality or any of this bullshit. You need to talk to me.” … if you don’t tell me things how am I going to make an educated decision? This is my body. This is the baby that I’m carrying and if I don’t have information what the hell am I going to do?
BPs repeatedly expressed the desire to know the status as well as the risks of their medical situation and to receive that information in a straight-forward fashion. The frustration Ava has with an institutional strategy to placate and withhold is clear. Emily corroborates this idea:

Emily: I’m a very scientific person. I think that medicine has a place everywhere and I don’t discredit anything doctors do but I also think that informed consent is - I didn't feel like that was going on in my situation. I wasn't given a pros and cons of the interventions that were happening to me…. I really wasn't given the full scope of what my diagnosis was [or] why I was there. They never once said, you know, “Here's where your pre-eclampsia is on the severity level.” No one ever had that conversation with me…. No one ever even told me, “This magnesium we're giving you is to prevent seizures.” They just said, “This will bring your blood pressure down.” But there's other medications they can give you to just bring your blood pressure down. They're giving that to you so you don’t have seizures. So, you basically don't die.

Emily highlights the point that BPs are capable people who deserve to know what BSP’s medical assessments are and what procedures and interventions mean for them. BPs I talked to always wanted to know the full scope of their own and their baby’s conditions and wanted their questions answered honestly in real time. The theme of needing “more” support, information, engagement, and validation ran throughout these data. Claire: “I needed more interaction or help of answers or something. I just need more, you know?”

Most disturbingly, the lack of information in the BIC according to texts and interviews often lead to situations where BPs endured procedures unknowingly:

Violet: I literally had to say the physician. She is not giving consent. You do not have consent. Like let me be very clear you do not have consent…. At least twice that I can think of definitely breaking water without … telling anyone what they're doing … putting internal monitors\(^\text{42}\) on … without telling them at all what they're doing, starting pit [Pitocin] without telling them what they're doing. Definitely I think it's a much more complicated. [OV] is not as like blatantly obvious [as] what people are talking about.

\(^\text{42}\) Internal fetal monitoring requires hospital BSPs to insert a small screw into the scalp of the fetus to pick up heart tones.
Interestingly, Violet frames the less “blatantly obvious” OV in terms of BSPs “not telling [emphasis mine] anyone what they’re doing.” This issue persisted across the globe and even when consent was obtained, it was often in a cursory manner. For example, a BP notes “the health worker only went through the motions of obtaining consent” (Bohren et al. 2015-PR11).

In particular, BPs and BSPs spoke about lack of consent and information around the artificial breaking of the amniotic sac or amniotomy, also known as “breaking water.” This procedure, that Listening to Mothers III (2013) reports is performed in 31% of vaginal births in the U.S. with the belief that it will “speed up” labor, is not backed by definitive evidence and can increase the risks of cord prolapse, and infection (Saaid 2014) and poor positioning of babies. Institutions have varying (and arbitrary) policies on how many hours labor can continue once the membranes are ruptured. Many BPs, like Emily, don’t understand the consequences: “I had no idea that once someone breaks your water you have 24 hours to deliver.” Julia emphasized that breaking her water was “just kind of a statement” the doctor on call made without providing information on “pros or cons” -- “they just did it.” Laura noted seeing this procedure performed deceptively without consent: “I'm sure there’s occasionally that being checked the water breaks, but when it’s -- there’s just this energy that’s like oh, your water broke! [feigned shocked voice] and I'm like, hmmmmm.” Aja, a participant in the BWBJ project, describes a similar situation:

Aja: Then one of the doctors stuck her hand in my vagina for a so-called cervical check and while she was in there she grabbed my bag of waters, pinched and twisted and it broke and fluid came gushing out and she said, “Oh I’m so sorry, that was an accident!” And I said, “Really, you don’t think I could feel your hand in my body?... And I said, “I don’t want that doctor to touch me again.” And they were like, “Oh, you know, she says it was an accident.’ And I was like, “No, I don’t care.” (Oparah et al. 2018:121).

Tabitha recalls her reaction when her membranes are “swept” without her knowledge or consent:

Tabitha: That was the biggest one because it really felt like [the midwife] walked in the room was like, let me check you...here you go... bye and left and like there
was no can you help me process what just happened. What did you just do to me? [the nurse said] “Oh, I just checked you I didn't do anything.” Are you kidding me? “You are never touching me again.”

In this case Tabitha’s midwife uses the strategy of lying after the fact. Of course, BPs voice broken trust after hospital BSPs take blatant advantage of the vulnerability of their bodies during “checks” to push their own agenda. The frequency of these remarkably parallel scenarios indicates the institutionalized nature of this particular strategy of medical entrapment.

The lack of information and misinformation given to BPs about cesarean is an important theme to discuss, not only because rates in high-income countries for this major surgery range from 30-80% (with a worldwide rate of 21%), but because risks for future pregnancies and maternal mortality increase with each cesarean birth (Boerma 2018):

[W]omen were asked to agree or disagree with four statements on cesarean surgery’s adverse effects. Three-quarters of the respondents on every question were either not sure how to respond or responded incorrectly. Women who had cesareans were no more likely to know the right answer than women who did not have cesareans (Goer 2010-PR8).

Leiko speaks directly to the problematic lack of understanding BPs have of the procedure in the Dominican Republic, where cesarean rates hover around 60% -- one of the highest globally.

[You have the women who are like, okay, I’m going to have a C-section because it’s painless… I mean, it is painless during the surgery, but nobody tells them what happens after that. Nobody asks them, “Are you going to have more children? Do you know how this could affect you?” They don’t have this information. And you run into a bunch of people who will go like, “Oh, I had a first C-section and then I have had two miscarriages at 8 weeks, 10 weeks.” And I’m like, “Technically, it’s not a miscarriage, but okay. I get it.” And they don’t relate that to the possibility that the C-section scar may be affecting the pregnancy. They were not told these things. (Dekker 2020-PC3).

The dominance of cesarean birth in the hospital and the risks it can cause for future pregnancies ties it to other forms of reproductive justice. Julia refers to an OB who works with an immigrant population and his adherence to the “once a section always a section” industry motto. She also

43 Injury from vaginal birth and lack of information is also important though it came up less.
indicates her concern about him using an outdated version of Cesarean incision known to cause a higher risk of uterine rupture with future pregnancies\(^{44}\) and that this “only adds to his cycle.”

Lack of information, lack of consent, and the combined lack of informed consent each contribute substantially to OV during hospital birth and poor quality of care.

\textit{not being heard and provider attitude}

“Not being heard” was one of the most robust themes in these data and indication of communication dysfunction. BPs throughout texts and interviews reported being shut down, silenced, and generally ignored (N=38). Peer-reviewed texts across countries included these themes as noted by Pickles:

\[ \text{Calls for assistance are left unanswered either because of resource shortages or intentional staff conduct (watching television, sleeping, talking, having tea or a meal); patients deliver without knowledge of what to expect and at times on their own; and questions about complications, procedures, labour progress and general care are left unanswered (Pickles 2015-PRI3).} \]

Interviews also revealed many BPs felt ignored and unsupported when asking for help during pregnancy, birth, and postpartum.

Emily: So, I have emails in a patient portal to my OB telling them that I had high blood pressure readings…. I think [the OB] answered my email one time…. [T]hen the next time I reached out and told her about the new readings I had gotten she just didn't reply.

First time moms, like Emily, in this sample sometimes attributed their poor treatment or lack of attention from medical BSPs to perceptions of them being “neurotic” or “crazy” due to their primiparity status. Daisy’s husband attempted to solicit help from the check-in desk twice while she was laboring in the bathroom: “one of the two times the person completely ignored him….\(^{44}\)

\(^{44}\) A vertical incision from the belly button to the top of pelvis is more likely to rupture than the more contemporary horizontal incision just above the pelvis.
He said hello. She did not look up. He stood there for like two minutes at the window and then left.” Feeling unseen by hospital BSPs in critical moments was particularly upsetting:

   Ava: I'm bawling and … nobody's listening to me. Nobody's paying attention. I'm telling them I'm having these contractions … nobody has come to see me … nobody was listening to me and I knew that something was happening … it was happening fast and I needed something and someone to be there and to take action … I just felt so helpless.

The failure to respond to BPs along with nonchalant attitudes from BSP significantly contributed to distrust and feelings that no one cared. Violet expressed her feelings of frustration and anger when BPs are actively and loudly voicing themselves to no avail: “I'm not an angry [type] person at all, but that gets me so enraged. You know that she's screaming, and no one is listening. What more can she do?” Violet’s comment highlights the vulnerability of BPs, for whom their voice or that of others is often the only advocacy tool available to them in the moment.

I previously discussed inadequate pain medication as one of the most common forms of OV and its connection to race. Pain is also one of the situations in which BPs are shut down most commonly:

   I have seen ... Cesareans when a patient's epidural becomes inadequate during surgery. Despite her crying out “Ouch, I can feel that, that feels sharp! That hurts!” she is ignored, told “No, it's just pressure, I'm not even doing anything that should hurt” ...or “I'm almost done” (Goer 2010-PR8).

Reports of the continuous denial of BP pain despite BPs voicing their complaints during surgery is extremely troubling. Additionally, evidence showed that not only are invasive maneuvers common practice for OBs and nurses to perform without BP knowledge during the pushing stage -- but these practices also caused intense pain over and above that expected in labor:

   First the doc does an exam-says there's a [cervical] lip... . Next thing I know, the nurse has her hand in there, holding the cervix while mom is screaming, “Get out, OUCH, get out, THAT HURTS”-I look the nurse in the eye, tell her AT LEAST 10 times, “She ASKED you to stop- she does NOT consent to this.” So now, she's pushing..., but this DAMN doctor, kept trying to stretch [the vaginal opening] with his flipping fingers-and she kept
screaming how bad it hurt. I kept saying to him OVER AND OVER, “Can you PLEASE stop?!?! The only time she screams is when YOU DO THAT” (Goer 2010-PR8).

While perineal “massage” during the pushing stage is a common practice meant to prevent tearing, in this excerpt, the nurse and BSP are invading areas of the BPs body (cervix and vaginal opening) that do not need to be touched, much less “stretched” manually, during birth. Adding to the severity of the violation, the BSPs ignore the direct calls from the BP to cease the assault.

Texts and interviews showed a plethora of examples of the influence of professional attitudes and frame of mind on BPs during labor and birth. BSP attitude and tone influenced and moderated communication and relationship during hospital birth from accounts around the world:

Women were positive about professionals who were supportive, friendly, polite, and who stayed close for their needs. Women even preferred professionals who did nothing but spoke to them with encouraging words and showed sympathy. On the contrary, women expressed hatred for those who were cruel, not compassionate and showed unfriendly facial expressions (Gebremichael et al. 2018-PR13).

BPs and BSPs I talked to often described negative BSP attitudes and the general atmosphere using the adjective “cold.” Claire: “It was super sterile … and I expected the doctor to you know, introduce herself and maybe talk to me a little more like I was a human and not hide on the other side of the sheet and yell at me when I cried or ask questions. It was very cold.” Other excerpts depict significantly similar accounts of the roughness of some hospital BSPs: Daisy: “The doctor who came in and did my stitches was not helpful. She was very brusque and not gentle.” This tendency towards “roughness” is heightened for marginalized BPs when combined with discriminatory aggression: “Indigenous woman who gave birth in Texas: The doctor who performed my c-section was hateful, rude, rough and threatening” (Vedam et al. 2019-PR5). Julia speaks about the differences she and other nurses observe in BSP attitude in the hospital:
Julia: Because there are doctors and midwives that will they will do the coaching, they'll talk to them, they'll be so sweet, they'll stay there they'll help clean up the patient. I mean, they'll really be involved, and you can tell that those patients feel loved. But you just don't see that with this particular Dr. His bedside manner just everything … But it does -- it leaves me just shaken. It does take a while for me to kind of just recover from… It makes me angry … because God it's just it's so wrong. It's really wrong.

Julia describes the distinct and real emotional toll witnessing abuse takes on BSPs. The prevalence of OV in a BP population with social vulnerabilities compounds the moral objection that she feels towards this specific OB.

Beyond an attitude devoid of warmth, the impression that health professionals, especially nurses, were “annoyed” with BPs was a common theme (N=10). A peer-reviewed article using data from 34 countries concludes: “women felt like a “burden” or a “nuisance” or that they were “bothering” the health workers or “putting them out” (Bohren et al. 2015-PR11). Many BPs I interviewed had vivid memories and thoughts about specific nurses and staff that exemplified this disposition:

Alexis: the nurse did not give a shit. She did not give a shit that the other doctor agreed to something and it wasn't happening…. She looked so annoyed that she had to come in every single time [the fetal monitor slipped] and there was nothing wrong with the baby….She just kept coming in….and I get that the baby was early…they probably see the worst but when you’re in that moment you’re like, “What the fuck?” She was not kind….I think she was young….I don't know if she had kids, but she just was not warm….my contractions had stopped so we were just standing there waiting and … the woman rolls her eyes. Rolls her eyes! She was the worst. She was really the worst.

Overall, BPs had strong feelings about BSP’s attitudes, and these interactions influenced their evaluations of birth. Several BPs, like Alexis, brought up the age of hospital BSPs and their parental status as potential explanations for their lack of empathy. No one I speak with referred to BSP attitude as their sole contention with the birth experience, but many BPs brought it up as a contributing factor.
5.2 Transitions: Getting Lost in the Birth Industrial Complex

BP accounts and texts incorporated evidence that the contextual element of transition via changes in medical status and momentum, as well as shifts in mood and personnel are linked to OV. As discussed, BPs are doing the work of integrating their experiential and embodied understanding of birth into the unfamiliar medical narrative playing out in the hospital in real time. All of the elements described to this point are at play in complicating that work.

Many BPs I interviewed spent ample time talking about feelings of confusion during their births:

Nia: [the midwife] was going to call the OB. The OB would come, and he was going to try one more time [to birth vaginally] and then if not, we’d go do the cesarean. Well, then it got all blurry because then the nurses kept coming in and were unhooking me and stuff and I wasn’t sure what was going on. I was like, “I thought we were?” And they were like, “Oh no when he gets here you just going straight back.” So, there was a lot of confusion about that….that was really stressful because I'm like, “Wait do I get one more shot? Or are we going straight on?”

Nia indicates her lack of control and the disconnect between the nurse’s behavior and her understanding of what was happening. This moment is especially meaningful because it meant the end of Nia’s chance for vaginal birth, an opportunity that took considerable effort to pursue. Moving BPs, often in an immobilized state, from the delivery room to the OR for a cesarean was a moment that come up throughout the texts and interviews as anxiety provoking and one for which BPs lacked preparation. Nia: “I started panicking because I wasn't really mentally prepared [for a cesarean]…. And then just like the looks of everyone just seemed really bummed…. because my birth team was amazing…. But then everything changed once the OB got there -- even though they said he was this great guy.” Nia works through the disappointment of the transition and the general interruption in the make-up of her birth team. When hospital BSPs and plans change, a dearth of information and communication creates confusion and there
is increased risk for BPs to lose autonomy and engagement in the process. Evidence suggests an increased risk of mistreatment when vaginal birth requires instrumental assistance or results in cesarean (Vedam et al. 2019-PR5). Hospital staff and BSPs disconnect from the plan to birth vaginally more quickly than BPs who are immersed in the embodied act of labor. Physically moving BPs from one place to another, in the case of cesareans after a long course of labor, is only one small part of the transition for BPs that also includes mentally changing expectations, grappling with disappointment, and accepting the new course; sometimes all in the span of a few minutes.

The inability of BPs to be active in the events that were unfolding due to protocol, “too many people,” medication, pain, and other physiological states created a void of confusion: Jasmine: “I'm just waking up [from passing out]. I'm like, What's going on? I didn't quite know….I was out of it…. I couldn't do anything but just lay there…. then they left - everyone left out the room at one point and I remember just lying there thinking -- What happened?” It takes time and adequate information to process what is happening during transitions, two elements that are not always readily available in the hospital. Sometimes BSPs stepped in to serve as translators who interpret medical information and relay it to BPs in the moment -- often quickly with a simple gesture. Jasmine describes a nurse communicating the rapidly progressing medical events in her birth after hemorrhaging and offering support when anesthesia wasn’t possible: “I come back and a nurse is whispering in my ear and she told me.... She said, ‘We don't have time to give you anesthesia so just hold my hand.’” Interviews provided evidence that BSPs helped BPs ground their experience through support and information. This practice helped alleviate confusion and often created a positive shift in the overall tone of the birth.
BSP shift changes significantly impacted unfolding events and created new interpersonal challenges in texts and interviews. Martha indicates it’s one of her greatest challenges: “When shifts change and people change my plan that makes me mad. Or when I’m the one that has to come in and change the plan. That’s hard.” Shift changes compounded the existing problems of disjointed care and communicating with busy hospital BSPs as BPs had to work up to them through the chain of command. An additional common circumstance related to shift changes is the possibility of the trajectory of birth changing due to varying BSP practices and protocol. Transitions of care that change outcomes are common and these changes can be seen as both positive and negative. Carla describes how vaginal birth was successful in part because an on-call doctor was not able to access the BPs file where her regular doctor had indicated his recommendation for a cesarean due to a “big” baby. The BP was far enough along (nine cm dilated) at the shift change, when her regular OB came back on duty, to “push out a posterior 9-pound 6-ounce baby” despite his order for cesarean. The power of a shift change is in the potential for a new set of plans, a different approach, and thus a different interpretation and translation of the medical narrative. Vanessa, summed it up when asked about her experience interacting with BSPs in the hospital and how that influences birth. She laughed and said, “It’s all about the shift change.” Alexis believes this is true and also unfair.

Alexis: if [your birth is] at … a hospital system where you have people rotating in and out -- your birth is going to vary. And I think that's really unfortunate. I don't think it should vary by who you get like by chance…. I think for a life coming into the world you should get more than that…. I think it's really unfortunate that those people -- in that moment of time -- have that much power over this experience.

Alexis’ thoughts indicate that the human connection lottery operated by the BIC inevitably falls short of providing consistent quality care for BPs. The challenge of the inconsistency of quality
of care during shift changes is something that researchers continue to address (Ruhomauly et al. 2019). These data call for research into this transition during childbirth more specifically.

Being lost in translation during birth in the hospital involves multiple strands of communication dysfunction emerging from a confluence of micro and macro factors during birth that impact BP agency and sense of self. Across the globe language barriers thwart effective communication inside the BIC and these barriers are not necessarily broken down by surface level approaches. Beyond language, the translation of the medical narrative from staff and BSPs to BPs is often poorly executed if attempted at all. A lack of straight-forward information and recognition by the institution and its agents contribute to unconsented procedures and generally poor treatment. The structure and policies of teaching hospitals, as well as the on-call strategy utilized by large OB practices contributes to discontinuous care, miscommunication, and breaches of privacy. Finally, transitions in the BIC are unique and destabilizing events that add a layer of confusion to birth in facilities for BPs and should be given special focus.
6  FIGHTING FOR BIRTH: INDIVIDUALS AND COLLECTIVES

Throughout my study, acts of agency and resistance emerged prominently in narratives of contentious hospital birth in texts and interviews (N=54). Using a method of inquiry into the “actualities” of people’s doings as they navigate institutional realities provided for a good viewpoint to describe agency related to OV (Smith 1996). BPs questioned their experiences, actively sought to engage others in strategies for resistance during birth and applied (or intended to apply) their newly gained experiential knowledge afterwards in specific ways to support other BPs and to address systemic problems in the BIC.

Previously, I noted the ways globalization has contributed to the propagation of OV and to the mobilization of scientists and others to understand it. As scholars note, globalization also creates networks of resistance (Mullings 2004; Mohanty 2003). The politics of OV and birth, both at the national and personal levels, surfaced contemporaneously. Located within individual understandings of parenthood, social politics, and the relationship of personal health to the health system at large, the reasoning and motivation behind survival strategies and resistance varied. Most importantly, abundant data that elaborates on various frameworks for change appeared. When analyzing these globally-emerging approaches, the roots of the historic work of marginalized communities within birth and its links to activism around perinatal health today are clear. These justice-based approaches hold the most promising pathway for transformative change through a reimagining and repurposing of institutional birth and ultimately an end to OV as commonplace within it.

6.1 Birthing People Resist In and Outside of the Hospital

BPs resist dominant paradigms for birth in meaningful and bountiful ways as individuals and collectives continue to push back on state and institutionalized practices that intervene in
reproduction and birth. Strategies used during facility-based birth are reflective of BP’s everyday strategies. Murray de Lopez highlights resistance in studies of OV:

“It is important to think about what can be learnt from how women interpret and experience acts of [OV]….The narratives also reveal ways in which women employ tactics (silence, avoidance, opportune decision-making) that they often use in other aspects of their lives to deal with everyday forms of oppression and violence (2018-PR18).

BPs bring their internal strategies of survival as well as concrete knowledge of life into the BIC. The “everyday forms of oppression and violence” that BPs face vary at multiple and intersecting locations of identity and geospatial reality. With this understanding, part of explaining the institutional relations of the BIC includes illuminating various “cracks” in the usual workings of facility-based birth that provide opportunities for action to move beyond the status quo.

**overt and covert resistance**

BPs actively resisted procedures, plans, and protocols during birth by vocalizing their dissent and directly objecting. Texts and BSP interviews showed much evidence of BPs saying no to specific procedures like episiotomy: “No, don’t cut me!” (Hayes-Klein 2014-POP8). BPs also mentioned learning in real time from their birth experiences. Kelley, after an exhausting day of induction, recognized she needed to position herself to resist:

Kelley: [T]hey came in and slapped oxygen on me and started the glucose drip and I'm like, “What's going on?”….After that I was like no I'm not just saying yes to [any]thing anymore. So, that kind of helped in that way….I was like, okay, I'm gonna start questioning and saying, “Ok well, why are you doing this?”

After waking up confused and getting an oxygen mask brusquely applied without her consent, Kelley realized she needed to act on her own behalf during interactions with the medical staff in order to preserve any semblance of autonomy. She then upped the level of attention and energy
she devoted to communicating with her hospital BSPs so that she could insert *herself* into her
“care.”

The physical restraint of BPs made it easier for hospital BSPs to override acts of BP
resistance: “I had just said ‘no’ and he did it anyway. He said, ‘just stay still!’”
(birthmonopoly.org). The ability of BSPs to perform procedures without consent was partly
enabled by the lithotomy position of BPs -- common in hospital birth and widely contended by
BPs for decades. Naomi recalls the moments after she decided to elect for a cesarean to end
contentious hours of labor. She repeated “I do not consent” to demands that she go under full
anesthesia for the birth. She knew that for some women this “happens anyways without their
consent”:

Naomi: I remember being thankful that I was not lying down at that point … because I really believe that if I had been lying down … they just would have put the mask over me and that would have been the end of it. But the fact that I was sitting up and that there were enough other people in the room to hear me saying, “I do not consent.” I feel like that really factored into the fact that my consent was respected.

While Naomi believes both the position of her body and the number of witnesses played into her
ability to resist successfully, Violet speaks to a coercive situation that turned out differently:
“I've seen five people holding a woman down with her legs back on an OR table because the
heart tones are down. The doctors are pulling with a vacuum [and] the woman [is] screaming,
“Stop! Get out! Stop!” And [the BP is] literally so strong she's moving the locked OR table
across the room against all of these people.” Clearly, the BPs position on an OR table and the
restraint of multiple BSPs prevented her from fulfilling her succinctly expressed desires. In
comparison to Naomi’s story, despite the BPs massive display of objection, the hospital BSPs
did not break from their activities of “extraction” or respect her active and forceful dissent.
“Steamrolling” BPs meant that no matter what feedback the medical team was receiving from them -- procedures continued. Violet: “I was like, “Hold on stop … give her a second!”’ But none of that was being listened to … because truly I felt like if you literally just give her five seconds to say. ‘This is what's going on I really need to do this.’ I think she would have [taken a] deep breath. [And said] ‘Okay - let's do this.’” BSPs repeatedly described the solution of connection with BPs in moments like these for “time outs” to interrupt the chain of procedural action and allow BPs to regroup and rejoin. Martha points out that there is always time to make a connection with BPs even in emergent situations, “I sit down on the edge of the bed and talk to BPs about what is going on and usually they come around--even in an emergency you can take one minute to do that.”

Extremely poor quality of “care” is inherent in disregarding and ignoring actively protesting BPs. As Vedam and colleagues found (2019-PR5), this kind of OV was more common for BPOC in my study. In many cases, BP autonomy is at extreme risk if the BP is not a certain “somebody” no matter how loudly they or others protest on their behalf. A significant proportion of BPs experiencing OV are not people who “slipped through the cracks.” These are people who, while in labor, may be screaming, pleading, or physically resisting with all of their strength. These are also people who may finally give up the struggle to be heard or simply chose not to “fight” due to pure exhaustion or as an intentional strategy to survive.

Beyond overt strategies for resistance, the data show many covert tactics BPs and doulas use to circumvent institutional power and maintain autonomy. BPs used less obvious subversive tactics both in initial responses to mistreatment and after direct tactics failed. An Ethiopian BP describes one such strategy:
Since I was in pain, I told her [the midwife] to save me. She shouted at me and then I didn’t talk to her even when I was in pain. I refused to comply with her orders after that. When she asked me to push more, I didn’t assist her (Burrowes et al. 2017-PR1).

BPs used whatever resources they had to push back on poor treatment in ways that would thwart their medical team’s approach or make things harder for hospital BSPs in general:

Sarah: The [fetal monitor] bands were making me feel claustrophobic and the nurse said, “Oh we have these wireless ones.” And I was like, “Great, I want those.” And then they said, “Never mind [because of premature labor].” And that’s when I said, “Well [let’s] just get the epidural going.” But I am apparently a bitch because I knew when I asked for that, I was just buying myself time. Like you won't let me use the wireless monitor? Ha ha. I'll do it to you too.

Sarah was attempting to birth without medication and knew that it would take a substantial amount of time for the epidural that her team was aggressively suggesting she receive to arrive. She uses the false request after hospital BSPs reneged on allowing the wireless monitor with the ulterior motive to “buy” more time to labor without interruption and also as payback for her medical team’s lack of support. Subversive strategies by BPs allowed for a modicum of agency in situations involving interpersonal conflict and institutional restraints. In circumstances where BPs felt unseen and unheard; creative tactics helped them regain a sense of integrity if not actual power.

Evidence of BSPs, particularly nurses and doulas engaging in covert acts was also plentiful. Two examples came up for BPs in the postpartum period. Nia had trouble breastfeeding and was delighted when a lactation specialist provided a solution outside of standard protocol: “I don't know if I'm supposed to say this but [laughs]-- when we left out she gave us a big container of donor’s milk and put it on ice and told us to hide it and we smuggled it out.” Breastmilk is a precious resource and the nurses’ willingness to help Nia obtain it led to her ability to eventually breastfeed her child in the way she had hoped she could. Alexis also had help from a nurse who eventually “hijacked” a piece of equipment necessary to ensure her baby
could come home sooner (8 days), rather than later (possibly weeks). The most consistent covert tactic enacted by doulas was to support BPs in avoiding medical engagement in birth as long as possible.

Doulas and BPs both mentioned the advice to strategically avoid appointments for induction (for non-emergent reasons) and the hospital in general during labor: Vanessa: “I always get my clients there about 6/7 centimeters on average -- if they're a hospital birth -- and try to get them there at 9/10 in general [laughs]. I want them not to have to be there that long.” Beyond avoidance, once at the hospital doulas described strategies that helped them support BPs outside the radar of institutional surveillance. Allison outlines her strategy for communicating inconspicuously with BPs when she thinks hospital BSP’s suggestions are “out of line.”

Allison: I might say, “Would you guys like some time to pray about this or talk about this? We could all leave the room.” And then I leave the room too…. Sometimes I'll text … and say something like, “I would ask more questions about this” or “Remember what we said about breaking the waters.” Some subversive way of communicating to them that [lets them know] they can wait or ask for pause here.

Subterfuge with cell phones allowed Allison to keep in contact with her clients without appearing to be “influencing them.” Depending on hospital culture, at times doulas had to manage the stereotype of their profession as generally oppositional to the biomedical birth model and OBs while finding ways to help BPs secure autonomy.

Many doulas in this sample and at large (particularly those working with mostly white affluent BPs) work strictly under the traditional philosophy that they speak only to their client and never directly to hospital BSPs. In many cases doulas acknowledged the threat of getting “kicked out of the room” factored into decisions about speaking up for clients. Laura described a

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45 There is a recent shift in parts of mainstream birth culture towards empowering doulas to act as advocates in a more engaged way. I discuss this more in a subsequent section.
situation where an OB, known for his “blacklist,” was not listening to a BP about pain during pushing:

Laura: The fact that she's complaining about one leg hurting -- I don't want her to push through it and rip a ligament or bruise her tailbone or something. So, I'm like “Hey guys, let's just take a small break.” I said [to the Dr.], “Can you give me a minute?” [then to the BP] “Can you explain to me what's going on with your leg?” And [the OB] was not thrilled … But at the same time, I was like, “you need to be heard and he's completely steamrolling you.” So [the BP] … shifts her hips and she says, “Okay, better.”

Laura thought preventing an injury was worth the risk of angering the BP and proceeded to use a reset to connect the BP and BSP with what was physically happening in the moment allowing for adjustments and shared decisions. Doulas often felt that the rigid hierarchy of BSPs prevented them from questioning protocol without the perception of antagonism. Laura also described feigning ignorance and a peer relationship with a BP which allowed her to question the “automatic” cesarean policy 18 hours post-breaking of the waters posed by a nurse.

Simply questioning mandates presented as “policy” was a strategy that acknowledged the interaction between institutional power and provider/employee agency. A U.S. nurse describes: “There are certain policies to be followed and it's the doctor's decision (Goer 2010-PR8).” While the OB sits atop the hierarchy, nurses also play a substantial role in gatekeeping around particular hospital “policies”:

Kelley: I was really nervous about having somebody put something in my spine. I was very grateful that they let [my husband] stay in the room…because I basically [had] been told, “No, no, no, no” [about everything else]. I asked the nurse, “Do you think they will [let my husband stay]?” She's like, “They might. Just ask.”

Midwives and OBs have the explicit power to act independently of institutional policy and in many cases, BPs were able to negotiate the circumstances they desired successfully and directly. Further, doctors and midwives had the ability to pause the chain of events and help BPs gather information, reset, and mutually decide how to proceed. This power is one reason that BPs seek
out particular providers; and simultaneously, it is also a power that breaks down in large practices with complicated call schedules.

**networks of information: facility and provider choice**

These data show that BPs go out of their way to find specific OBs and midwives to support particular circumstances of pregnancy and birth, based on reputation of practice, or to maintain a relationship with a BSP who was supportive in the past. For the majority of BPs, insurance constrains where they can birth as well as the midwives and OBs who can provide services. When deciding amongst options, BPs use various networks to gather information that is important to them. An author points out that in Ethiopia “women ‘shopped’ for care, going out of their way to attend facilities known for providing quality care” (Burrowes et al. 2017-PR1). A BP in that study explains that health workers relay information to the villages about which facilities are best, and that BPs will undertake considerable inconvenience to travel to them (Burrowes et al. 2017-PR1).

Doulas in my sample (N=4) had different views on calling out particular hospital practices and bringing them to the attention of potential clients. Two doulas had a personal policy of exclusively attending births at favored hospitals to avoid this tension. Isabel: “I just weed myself out at the very beginning to say, ‘I’m not good for you.” Laura also provided insight into her strategy for client “match:”

Laura: If you want this type of doula care or you're wanting this type of birth I will not support you at that hospital because they don't match and you're going to cry and you're going to be sad. Now if you're like my sister who wants a scheduled induction and her nails done and eyelash extensions and she's okay with the C-section -- sure, let's do it. But you cannot go there with a very particular birth plan.
Laura offers the stereotype of a BP who cares more about her appearance and convenience than a “very particular birth” -- which in this example seems to mean vaginal birth. Someone who would opt for a fully medicalized hospital option is the only kind of person she believes she could support at the offending hospital. Vanessa offers a contrasting perspective:

Vanessa: Some people who are looking for a doula [ask] ‘Well where do you? Do you not? What hospitals do you birth at?’ I'm like, “Wherever my client goes??” … My clients are across the spectrum. I don't discriminate. I mean whatever -- it’s whoever becomes my client. Right? If you want *firm direct support* [laughs].

Though many doulas indicated being “full spectrum,” meaning they support BPs through any reproductive event (i.e., infertility, live birth, abortion, miscarriage, stillbirth), Vanessa used the contemporary extension of the idea of “full spectrum” in birth work to include complete acceptance of any client regardless of identity, birth desire, or birth location. She uses her practice philosophy as the only barometer of fit and is confident working with anyone in any hospital. The notoriety of hospitals and providers as “doula-friendly” as well as their general standing regarding interventions factored into most doulas willingness to take on certain clients. This is a concerning finding as BPs do not always have flexibility and need support most in the very hospitals doulas in this sample tended to avoid.

BPs use word of mouth to share information about the realities of BSP practices and attitudes. Sarah: “I've just told other women, ‘Don't go there.’ I've also said that this is fucking terrible that that's the most supportive practice of natural [unmedicated] birth that delivers at Johnston--like if this is the best there is, we've got a problem.” In texts and interviews, it was clear that switching OBs during pregnancy is a common practice for BPs with the means to do so, if it becomes apparent that their desires for birth (e.g., VBAC or avoiding induction) have little chance of realization. BPs searched for OBs and midwives through research, taking various classes for pregnant people, and through online groups like ICAN and informal Facebook pages:
Nia: I didn't know that most doctors weren't VBAC friendly until I joined that Facebook group... [the OB] kept putting me off. I would ask him about it [and he’d say] “We'll talk about it next time, next time.” Then finally I came in with all my books and I had all these questions. He's like, “I'm going to be honest our place of work usually doesn't do those. I can think about it but it's probably gonna be no”….And I was like, yeah, that's not the answer I want. So, I actually transferred doctors.

OBs are often unwilling to state up front that they don’t support VBACs because their lack of support goes against published guidelines from professional organizations and public health entities which indicate VBAC is not only safe but preferable over scheduled repeat cesarean. The result is a situation where OBs placate BPs’ requests and queries with “we’ll see” until a reason arises that they can exploit to schedule a cesarean or they are forced to answer directly. Evidence in the texts and interviews showed that some BPs are willing to switch BSPs at any point in their pregnancies if they feel uncomfortable or unsure about how the practice will support them.

6.2 Ideological Strategies to Survive the BIC

In addition to behavioral strategies for survival, the interviews and texts presented common ideological strategies for BPs during and after birth. For BPs with contentious births there was a self-discerned limit of effort, and when it was reached many described being “out of fight.” At times BPs interviewed and in texts also expressed the idea of “going with the flow.” Both of these strategies served BPs as modes of boundary-making that supported their sense of self-efficacy. Two additional strategies emerged that BPs employed after a contentious birth and offered comfort and clarity: “gratitude” and “moving on.” These strategies allowed BPs to focus on their new family and related responsibilities while healing and persisted through integrated life narratives.
BPs in my sample described strategies that allowed them to maintain a semblance of inner control in the moment and when used upon reflection, the strategies aided in understanding the larger factors influencing their birth’s unfolding while allowing them to let go of undue personal responsibility. At the end of a long birth with lots of wrangling over particular practices, interventions, or modes of birth BPs often “chose” to give in. “[S]ome [BPs] indicated that they agreed to procedures such as epidural analgesia and vacuum extractions in an attempt to end the trauma they were experiencing” (Fernandez 2013-POP1). Motives for these strategies included preserving a sense of coherence and physical and emotional energy. Many BPs understood that, without external support, their attempts for agency during birth would be fruitless:

Naomi: I had no more support and the OBs were recommending a C-section because they thought [the] baby was going to be big…. So, eventually I was just out of fight and I agreed to a C-section….There was no distress there was no medical reason whatsoever. I was just out of fight and so I had a completely unnecessary C-section at 43 weeks.

Naomi reads the writing on the wall when even her family was “freaking out” about her above average length of pregnancy and “failed” induction of labor. While some used this strategy when giving up on fighting for a labor and birth that deviated from medical norms, long labors also required BPs to assess their ability and resources to continue to use valuable energy to resist. For example, at the end of a long, induced labor, Amaya “decides” to agree to a cesarean. After soliciting her OB’s opinion on the likelihood of cesarean, the OB confirms ‘I’m thinking yes.’ Amaya then circumvents the inevitable “call for cesarean” from her doctor by calling it herself. Taking power back in “deciding” to switch paths for birth was a way for BPs to maintain a sense of personal sovereignty.

“Going with the flow” occurred when BPs faced unwanted events that they knew they could not control and came up particularly around interpersonal exchanges. As Jasmine reflected,
“But you know in hindsight you just-- you got someone going at you. You just go with the flow.”

“Going with the flow” meant BPs made a decision to refrain from using energy to engage in acts of resistance and framed their decision making as “accepting” what was:

BWBJ: Nadia: I didn’t want to put myself under more stress and be confrontational with people who were trying to help me, you know. I felt like I didn’t really have a voice throughout the process. You just go with it. You accept things for what they are. There’s no point arguing (Oparah et al. 2018).

It is important to note that “going with the flow” as a way to avoid conflict and as a survival strategy is distinct from what some BPs describe as easily submitting to medical authority during birth as a tendency of their conflict-avoidant personality. In my study, particular BPs (often socially privileged) had more success “arguing” than others. It is necessary to take into account the internal resources and ability of BPs to spend them during and after birth, particularly those most marginalized.

Both texts and interviews revealed the practical strategy of “moving on” for survival after a contentious birth. In the context of life as a new parent embracing the full notion of “moving on” as a means of gaining clarity makes sense and aligns with an emerging sense of purpose and focus on baby. Seals-Allers notes this tactic: “[I]f the mother and baby are both reasonably healthy, most women would rather try to put the traumatic experience behind them as they focus on parenthood” (Seals-Allers 2020-POP12). At the same time, issues with baby’s health may also bring up this strategy. For instance, with her child in the NICU, Ava compartmentalizes her birth experience so that she can fully engage in this unexpected development:

Ava: I didn't follow up because it probably didn't matter at that point. [My baby] was in the NICU. It didn't matter. I moved on. I was like that's done. I'm moving on. I've said what I had to say, and I don't care at this point because my focus is somewhere else.

BPs only have so much energy and ability to “care” about what happened during birth. While some acknowledge OV as problematic and then move on, others feel immense gratitude.
The theme of gratitude come up in interesting ways for BPs and was observed in some cases as problematic by doulas and nurses. China Tolliver, a former doula and now podcaster who produces stories about indigenous, Black, and brown BPs, explains BP responses after birth involving OV:

China: Afterwards, they’re either -- two things happen. One they’re like, “Oh my gosh my Dr. totally saved me.” Right? So, it’s like this victim/savior thing. “I had an emergency c-section and they saved me and by baby’s life because it was so in danger” -- Where I’m thinking they threw you in front of the train and snatched you from it. Or the other one is like, “What the fuck just happened” where they’re totally in shock (Renee 2018-PC6).

China describes the story line of gratitude pushed by unquestioned belief in medicine and alludes to the entrapment of BPs through interventions that then require cesarean as the final resolution. It is significant that China contrasts these initial responses she observes. Birth can be a complex medical and personal event that takes time to understand. Some BPs will maintain their initial feelings about their experience but, for others, these early sentiments will change over time. For example, Nia eventually described parts of her birth as “really dark and scary,” “painful,” and “troublesome:”

Nia: I didn't feel that way right away. I actually felt very happy about my birth experience and very excited. It took me be being home to reflect on it a little deeper before I realized that it wasn't what I thought it was. I think I was just like so happy for [baby] to be here.

BPs are often happy to meet their babies after months of pregnancy and feel a flood of emotions including relief -- questioning the experience may come later. Still, many BPs buy in to the medical story provided by hospital BSPs and believe whatever procedures they endured during the birth process saved their (or their baby’s) life. Several doulas I interviewed, who believed hospital BSPs “hoodwinked” BPs, reported this false-consciousness on the part of BPs. Like China, Laura found it difficult to understand how her client was at peace after she was pressured into a cesarean by her OB using deception:
Laura: [The BP said] “I mean I had to have a C-section, Laura, because my baby's heart was decel-ing and I saved his life.” And I was like, “Okay.” [The BP said], “Oh it was a miracle. I just can't even believe that doctor saved me.” And I was like, “What is happening?” But okay sure. Sure. You play that story out however you want and I'm here if you want to talk about anything else.

Remarkably the BP co-signs on to “saving” the life of her baby by agreeing to cesarean. Julia describes a similar situation complicated by the immigrant status of the patients of an OB with a reputation for committing OV: “A lot of these patients always rave about [Dr.P]. They are like, ‘Wow, thank you so much you did you did great for me.’ But they don't know, you know? They just don't know.” Disturbingly, in this case, gratitude for access to medical services is conflated with an unwarranted appreciation for an OB who is not acting in good faith.

Finally, some BPs expressed gratitude grounded more concretely in actual medical events. Gratitude for life for Jasmine was emphasized by her emerging understanding of postpartum hemorrhage and hearing testimony at an event from the husband of a BP who did not survive and went through “the exact same stuff”: “I'm glad to God. I'm so thankful … that close to death and it's something [that] freaks you out but it makes you appreciate so much that you're here….And I'm so grateful.” It makes sense that overwhelming gratitude follows experiences of near death in the BIC. Narratives of gratitude are complicated by historical cultural messaging that birth is inherently dangerous and contemporary realities of the dangers of the BIC, particularly for poor Black and Blown BPs. Due to intense struggles and an awakening to institutional power during hospital birth, the experience of OV often serves to politicize BPs on various levels. The material experience can bring awareness to the disempowerment strategies employed by the BIC and illuminate connections between personal experience and broader group issues.
6.3 Birth is Political and political

Janks describes and conceptualizes the importance of multiple levels of political struggle using politics with a lower case ‘p’ to refer to the “everyday” intra and interpersonal politics of life and Politics with a capital ‘P’ referring to governmental power, treaties, and various forms of international engagement (2012:151). Using these ideas, reproduction and birth exist within a highly contested tangle of power. The micro-level and meso-level politics of birth were evident in these data along with the macro-politics of governmental and nationalistic themes embedded in global health rhetoric and policy declarations. The biopolitics of birth operating at all levels can be seen in this study best by using world-systems analysis (Wallerstein 2004), and intersectional approaches to health (Mullings 2005; Mullings 2006), with an understanding of the globalization of white supremacy (Christian 2019).

Intersectional frameworks in health help us to focus on the:

- processes through which multiple social inequalities of race, gender, social class and other dimensions of difference are simultaneously generated maintained and challenged at the institutional and individual levels, shaping the health of societies, communities, and individuals (Mullings 2006: 24-25).

Situating OV in the BIC as part of a larger process of health determined by social inequalities, world systems analysis helps us to see that OV is woven into a global apparatus that prioritizes the endless accumulation of capital (Wallerstein 2004). This capitalist value becomes a self-evident “truth” and justification of the collateral damage of human dignity and life. In relationship to health systems, markets driven by international economies foster public health programs that prioritize positivist measures of health and determine pregnancy and birth practices as well as the overall culture of perinatal “care.” Neoliberal economic reforms in the ‘80s (deregulation and privatization) lead by political leaders in the Western world commodified health in general, and in the process ignored important aspects of perinatal health that were not
the most “cost effective” to address or measure (Farmer et al. 2013). A path was set to prioritize baby’s lives over BPs through popular support of the United Nation’s Children’s Fund’s “child survival revolution” campaign with highly specified interventional programs. Funding of these programs by the World Bank deterred from their traditional practice of broad investment in health systems (Basilico et al. 2013). These economic and political shifts set the stage for further deterioration of care and choice for pregnant and birthing people around the world.

On top of political, economic, and cultural shifts around health in recent decades we can overlay a complex system of local nuance and rationales of racialization influenced by the dominant racial/racist structure and “order” of the Global North (Bonilla-Silva 2001; Mullings 2005; Christian 2019). Christian’s conceptualization of the “world system of global white supremacy” describes the way transnational racialization, a process dependent on national history and global positioning interacts, through racist structure and ideology, on nation dependent “racial social systems” like the state, discourses, and institutions (Christian 2018:173). Mulling’s assertion that “patrolling the boundaries of gender and the national body” has produced “the more extreme forms of racism” can be situated in this formulation in relation to the BIC today (2005:676). I argue that the current state of perinatal “health” services provision is an extended part of the historical “racist project” focusing on Black women and reproduction (Mullings 2005:676) with implications for Brown and indigenous BPs worldwide as well. In a neoliberal capitalist world system with deliberate and consequential hierarchies, the BIC acts as a conduit between racist structures and racist ideologies using OV as a form of policing, at a critical life moment, the boundaries that determine where BPs (and their children) rank on the societal ladder. National and international responses to OV reflect the influence of these complex global structures.
In addition to the WHO’s proclamation against OV, the legitimacy of addressing OV was established in part through recognition by internationally cooperating and governed bodies. Texts from various countries pointed to “internationally adopted human rights standards and principles” (Bohren et al. 2015-PR11) and the United Nations’ definition of violence against women (VAW). These international declarations are foundational in understanding OV as a global issue that should concern nation states. Several texts also mentioned that in 2015 the UN and the African Commission on Human and People’s Rights drafted a statement “calling on states to address ‘acts of obstetric and institutional violence’” (Murray de Lopez 2018-PR18).

While it is unclear how governments are holding themselves accountable, there is evidence of political leaders using the emotionally evocative concept in an attempt to stoke national pride. Maduro uses OV as a case in point to help describe the project of “revolution” and nation-building as connected to feminist ideals during economic and infrastructure collapse:

20 years ago, it was normal to be born in Venezuela in the midst of obstetric violence. And it was hard for us to even imagine that at the moment of birth, not only the health of the newborn is important, but also the health and rights of the mother and her family. But the revolution changed and it became feminist. And among all of us, we decided to remove sexist violence from our health system and empower women through the national human birth programme….Our [democracy]….It is a democracy of the people. A democracy that is also Latin American, African and indigenous. Because in Venezuela, we have a rite and a foundational myth (Maduro 2018-POP18).

Maduro juxtaposes Venezuela’s ever-evolving “revolutionary project” of democracy against “class-based” and elitist democracy as seen in countries where “fair is what suits a few.” Writing during a time of political and economic upheaval with extreme negative impacts on maternal health (maternal mortality increased 65%), he argues that the implementation of the “human birth program” speaks to a true democracy, the success of which is reflected in the framing of OV as a thing of the past. In countries with national health systems and free “universal”
coverage, a focus on perinatal health (real or perceived) can be held up as a beacon of national honor and governmental allegiance to its citizens.

In mostly popular texts, authors reported state interest in signaling dedication to fighting OV as a women’s and human rights issue. In Brazil, a newspaper reporter writes on the response to the story of a BP, who planned a VBAC. “Armed police” forced the BP (Adelir) out of her home through medical mandates applied by a court order and, once at the hospital, BSPs anesthetized her and performed a cesarean without consent. “[T]he Brazilian government issued a statement sympathizing with Adelir and reiterating the country's commitment to ‘humane and safe obstetric care’” (Miley 2014-POP15). This glaring inconsistency between national decrees and practices that directly defy them existed in several examples. Burrowes and colleagues listed all of the most common forms of OV in Ethiopia stating:

Nonetheless, Ethiopia has enshrined promotion of women’s rights and status in its constitution and subsequent national policies, and has supported the core UN resolutions and other international agreements that acknowledge the rights of childbearing women to respectful maternity care (Burrowes et al. 2017-PR1).

The Ethiopian national stance as mere political optics is further suggested when the author brings up the disconnect between the existence of policy and the usefulness of policy, “However, individuals are unlikely to know about, much less use any mechanisms to address rights violations.” The gap between statements of dedication to “respectful maternity care” by governments and the material experience of BPs during birth is deepened by the lack of operationalized modes to address OV and coordination of means for BPs to report it when it occurs. Whether genuine desire and will exists on the part of nation-states who are pledging (on an international stage) to devote serious effort to anti-OV work is unclear.

The personal was political in a poignant way for BPs who were also politicians by profession. For example, the writer of a Croatian newspaper article quotes a member of
parliament in that country, Nincevic-Lesandric, who made public her personal experience with “medieval treatment” after a miscarriage. After that, a movement of BPs (around 400) testifying about their experiences of OV in that country went viral with the hashtag #breakthesilence (Twigg 2019-POP5). A popular article also details the experience of U.S. representative Thierry of Texas, who had a medical emergency after heart complications from an epidural: “[T]he experience has given Thierry a unique perspective in tackling the racial discrepancies being found in Texas' maternal mortality rate” (Brinlee 2017-BG8). Experiencing a range of OV galvanized BPs to better understand the medical circumstances around their cases and often lead to gaining knowledge of systemic issues in reproductive health.

Jasmine’s birth experience “brought out the activist” in her and she extensively researched Black BPs and hemorrhage. I include her testimony (at length) because she let me know that one of the reasons she spoke with me was specifically to increase the awareness of this issue:

I realized…it all comes down to your doctor. That's all it boils down to and [in my case] if she was capable of saving me cool, but if not, then I just would have died and been a statistic…. I guess it made me want to know more about what was going on and it broadened my understanding of this is a bigger situation…. And right now, hospitals have the option, doctors have an option, to use [a hemorrhage kit]. But if there was legislation to make it mandatory that they have to use it … or they can be sued for malpractice if someone ends up dying…. Something like that could change millions of lives because now the doctor is going to think twice, you know, they're going to make sure, they do everything to save that patient…. If I can help in any way … bring light to the situation then I'm going to do it.

I was unable to find the specific legislation Jasmine was working to support but the Institute for Healthcare Improvement (IHI) does offer a “bundle”46 in conjunction with the Alliance for Innovation in Maternal Health (AIM) to address obstetric hemorrhage in hospitals; a

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46 Bundles are a set of best practices and supported by evidence and put forth by the IHI to address specific issues in medical systems and improve outcomes through automatic protocols (ihi.org 2020).
complication that increased significantly between 1990 and 2014 (CDC 2014). A recent study conducted in a local teaching hospital showed positive results in preventing severe hemorrhage by implementing such a bundle using an institutionally comprehensive and collaborative strategy (Joseph et al. 2020). This plan included an iterative process of training and developing a protocol that specified elements of hemorrhage carts and indicated calling for one at a “stage 1 concern” as indicated by quantitative\(^47\) blood loss measurement and changes in vitals. Of note, considering evidence from this study, the data are mixed on whether induction increases the risk of blood loss, but Joseph’s and colleagues include it as one of the elements in the “medium risk” category (Joseph et al. 2020). Interventions like this are evidence that improvements in institutionalized care are possible with sustained focus and a fully integrative approach.

In texts and interviews, all kinds of BPs become more uniquely aware of birth rights and justice issues and many took on personal initiatives to advocate for others based on their insights. For some the event served as a site of politicization and new awareness of gender oppression:

Nia: I guess I just didn't realize this before that people don't trust women and their bodies to be able to make the right decisions for themselves … It really sucks, you know, I [didn’t] really think about it much before…. I didn't think it was an issue, until I started having kids my own and people are trying to tell me what to do.

The political and personal varied for BPs who were still integrating their birth narratives into their life stories and doing the work of processing the personal through a broader lens. Many BPs incorporated this new knowledge and either refocused their occupations or took on activism in addition to current careers. The influence of personal experience in birth advocacy and activism cannot be understated. This significant factor is driven by ever increasing digital modes to connect and share information and personal stories in unprecedented ways.

\(^{47}\) It was not until 2019 that ACOG began recommending objective measurements of blood loss over “visual” estimations in attempts to address the “54-93% of maternal hemorrhage that may be preventable.”
The web-based digital data in this study offer insight into the ways activism around OV is continuing in some circles and developing in others. The vast availability of information and perspectives enriched conversations happening in social media networks and also highlighted polarizing viewpoints. Evidence showed various modalities of digital activism across the globe (N=20) that brought light to incidents of OV through both individual sharing and formal and informal collection. The websites I studied offer a good representation of the ways folks are framing perinatal health problems and challenging the system.

Findings from the website analysis showed differing frameworks based on organization mission but in general reflected a birth justice orientation or a birth rights orientation. Using a civil rights framing, BMMA focuses on changing policy and the NAPW focuses on defending and filing lawsuits on the behalf of the most vulnerable populations of pregnant people. On the other hand, Birth Monopoly, Improving Birth, and Evidence Based Birth all took a consumerist frame approach.

I analyzed “toolkits” offered by three of the websites studied. Improving Birth provided a short packet of information designed to help BPs after a difficult birth to file a “grievance.” This included what documents to write, what information to include, and where to send them. While PWBOs honed in on individuals and individual rights, the two organizations I studied that centered marginalized groups and birth justice highlighted societal inequity and collective approaches. BMMA presented a comprehensive resource in collaboration with the Center for Reproductive Rights, titled “Advancing the Human Right to Safe and Respectful Maternal Health Care” (2018). This guide had multiple chapters on topics highlighting access, quality, and accountability. The elements of advancement included structural issues like non-discrimination
in access supported by economic, food, and housing justice as well cultural competency for hospital BSPs and respect for “women’s decision making power and bodily autonomy.” Talking points for advocates were an important part of the BMMA toolkit.

Advocacy was also the focal point of the toolkit created by NAPW called “Birth Rights: A resource for everyday people to defend human rights during labor and birth.” (https://advocatesforpregnantwomen.org/wp-content/uploads/2020/05/BIRTH-RIGHTS-A-resource-for-everyday-people-to-defend-human-rights-during-labor-and-birth.pdf). The specification of everyday people invokes a justice orientation and this toolkit narrowly focuses on providing material strategies for BPs both during a “violation,” and coping afterwards. Strategies like asking questions, asking for more information, and “repeatedly asserting that more time is needed” in the moment stood out in corroboration of findings from my interviews that indicated BPs often lack crucial information and that interrupting the flow of events and asking for pause supported their agency (NAPW 2020:28). Direct tactics to resist “steamrolling” included saying, “Does anyone else hear me saying this? I am saying stop. I am saying no” (NAPW 2020:27). In line with findings in this study, the organization also promoted trauma reduction strategies for those accompanying BPs, such as connection via eye contact, physical touch, and verbally expressing “I’m with you. I see what’s happening” (NAPW 2020:27). The everyday strategies and grounding ideas put forth by NAPW resonated with the real needs expressed by BPs in texts and interviews who felt lost and unseen in the birth process.

Finally, of important theoretical note, the NAPW toolkit provided a conceptual chart in a section titled, “Moving Toward Social Justice.” This chart condensed many of the themes in these data around developing OV activism and birth justice and it is worth unpacking this information. The chart separated three approaches to address the problem of OV. First the chart
lists a *perinatal health care* perspective framing of the problem as a “delivery issue” with access as the solution and improving maternal mortality as the goal (NAPW 2020:54). This lens, informed by structural functionalist thought, is one that the WHO prematurely adopted in the 90s and early 2000s when rolling out initiatives to increase facility birth globally. Second the chart lists a *perinatal rights* viewpoint that sees the issue as one of “protecting rights.” This point of view seems to align with that of PWBOs informed by second wave feminism and a subject-oriented human rights approach centering the individualistic goal of autonomy and choice. Theoretically we see symbolic interactionism in this framing that would stress individual meaning in birth culture and align with the importance of the BPs birth “story.” Traumatic birth as a solely psychological result due to disappointment around medicalized birth may be an issue understood best using this lens. Lastly the chart situates birth justice as an approach that sees the perinatal health problem as one of “structural inequality” with the goal of righting societal inequity through challenging “stratification” of people through law and policy. This view engages a social justice human rights approach as well as critical race and intersectional perspective to contextualize the problem and connect it to larger societal processes. I argue that for birth culture at large to “move toward birth justice” as laid out by NAPW, empathy as well as a holistic understanding of everyday people (and their everyday lives) is required to tackle broader systemic issues. Additionally, I would ask, can we combine all three approaches? Can highly accessible perinatal healthcare recognize and protect rights to autonomy while seeking to right broader social inequities? This seems like a reasonable comprehensive goal and including web-based strategies for addressing OV and disparities in perinatal health with it in mind hold promise.
Evidence in this study shows myriad ways the internet offers educational capabilities in both formal and informal settings. Using online education courses designed for hospital BSPs to combat OV was a successful and scalable model. Further, one of the most powerful initiatives that digital networks in birth culture can leverage is the centering of marginalized groups. Isabel: “We live in the age of information technology and everything is literally at your fingertips….You can learn really quick!” Dani A self-identified queer doula also underscores this idea:

Even if you don’t necessarily know an educator in your area, there are plenty of people on the internet who do this work, myself included. I talk very openly about trans and non-binary issues on my social media….There’s a lot of queer and trans people who are really doing solid work and having these conversations that you can just follow us online and learn from us that way (Dekker 2020-PC5).

In a world bursting with people detailing their life and work, ignorance about any aspect of birth experience can be remedied. Following social media accounts is a simple way all BSPs and BPs can educate themselves on their own time⁴⁸.

Beyond a platform for education, internet tools also allowed for the mobilization of everyday BPs around the world to document and bring attention to the issue of OV. I found a varied genre of international documentary films and videos available online highlighting various aspects of OV, the issue of birth rights, and access to perinatal health services. The internet also facilitated global activities of collecting names for petitions and testimony of OV. In the U.S., the Birth Monopoly website has a map that pinpoints incidents of OV reported by BPs and BSPs. There are various versions of the Observatory of Obstetric Violence, a grassroots platform for data collection, in Spain, Italy, France, Columbia, Argentina, and Chile. The hashtags #breakthesilence, a “viral consumer-social media campaign” started by the organization

⁴⁸ Signing up for paid subscriptions to additional content like newsletters or workshops and videos helps sustain these folks and their contributions to birth work and birth culture.
Improving Birth in the U.S. (2014), and #bastatacere (originating in Italy) are used by BPs around the world to share individual experiences with OV. Awareness campaigns are part of first steps to establish the existence of OV as well as its depth and breadth across the globe outside of public health and academia.

The internet allowed “outsiders within” a broad audience to validate their shock at what they endured or witnessed. Nagarajan provides an excerpt from a doctor’s blog:

“...in an Indian government hospital giving birth to a child is not a unit less than suffering third degree torture in jails. Pregnant women are beaten like anything and, worst of all, the doctors feel it's justified. .... Unreasonable use of [drugs] to speed up the labour and unwanted episiotomies…with accompanying fundal pressure manoeuvres (which are contraindicated) leave you baffled,” (Nagarajan 2015-POP19).

Taking the personal public serves to de-normalize institutional violence. While the extent of OV in this account is extreme the culture shock described by Patel is similar to that reported by BPs and BSPs across texts and interviews. For Kimberly Turbin, the internet served as a way to reach a virtual sounding board when she questioned whether her anger about the forced episiotomy she endured was justified. Though her family insisted that “episiotomies were a standard part of giving birth and she had nothing to complain about,” Kimberly wasn’t convinced and posted the video of her assault:

“A lot of the responses said, ‘Oh my God, that’s horrible’, like they knew something was wrong with the situation. I felt very validated. People were making it seem like I was making a big deal out of nothing, but I knew I wasn’t crazy or whiny” (Grant 2017-POP2).

The framing of BPs as “whining” about abuses in childbirth is common and possible due to the privilege of access to medical care in many contexts, the prestige assigned to medical professionals, and the proclivity to dismiss complaints of women in general. The internet
allowed Turbin to share a materially abusive experience that was also clear to tens of thousands who viewed the video and commented on her ordeal with words of support.

The ability of BPs and BSPs to share their opinions and experiences on social media lead to pleas from some OBs and cultural observers to stop what they assessed as an attack on medicine and hospital BSPs themselves. Polarizing views on social media of course create the most traffic and are driven by algorithms out of the control of posters. Conversations about home birth provided the most extreme commentary between those supporting choice and autonomy in birth and those supporting the biomedical perspective. Both texts and interviews showed that BPs and BSPs who felt comfortable with homebirth (particularly in the U.S. and AU) often received anecdotal stories of fetal and maternal death to justify hospital authority. Martha gives an example of this kind of story as justification for her concern about the current “cultural myth” that planned home birth is relatively safe:

[The BP] ended up going into labor at 44 weeks at home and her baby died…. she wrote this beautiful blog about kind of who she had been before her baby and then who she was after her baby and how her perspectives on birth had just changed so much because of that experience.

Martha uses the blogger’s self-reflection and tragic loss to myth bust. In a common narrative of medical redemption by home birth loss, the BP notes the impact of the life-changing event and its influence in bringing her to understand how “dangerous” birth can be. Martha then shared a story about a BP she knows in her personal life who had a medically-complicated home birth “and she ended up almost dying at home in her bathtub with a fourth-degree laceration and a massive postpartum hemorrhage.” She describes the framing of autonomy in birth culture as a “symbol of womanhood” so powerful that it overrides people’s understanding of birth as life-threatening and needing medical management.
As we work to disentangle the life event of birth from medicine -- while supporting access to good health and medical services when needed worldwide -- we can also work on making hospital/facility encounters less violent. Further we should support equitable choices for all BPs in birthplace and provider. Romanzi speaks to the wariness (and sometimes refusal) on the part of BPs forced into facility birth by global health policies embedded in “Western” medicine and suggests, “Euro-American strategists hoping to improve outcomes by restricting home birth have lessons to learn from African data” (2014). The OB, with experience in Tanzania and Somalia, proposes meeting BPs where they are and “embracing homebirth” through mobilizing community based medical access everywhere. In the “Euro-American” context this would include “creating cooperative midwifery, obstetric, and pediatric professional guidelines for home birth” as part of “global obstetric guidelines that eliminate the stratification between wealthy and poor countries” (Romanzi 2014).

It is important to note here that birth centers are a tested and trusted alternative to hospital birth. They need access to hospitals and OBs but require less medical equipment and funding to get started. The ability to provide more individualized care is an asset when accommodating birth customs globally and grounding access in a community care model. Ibanez-Cuevas and colleagues suggest an initiative that mobilizes the “local indigenous community…in order to create a physical space [for birth outside the hospital] to improve health care and patient satisfaction” (2015-PR20). In the Caribbean, an organization called “New Life Birth Centers” seeks to jumpstart community-based care with the birth center model as well: “They open it up. They get it running. They train people so that the center can stay in the community and be run by the community” (Dekker 2020-PC3). The ability of birth centers to form, survive, and thrive depends on regulations that vary by state. In addition to the positioning of birth centers by some
in the BIC as competition for hospital maternity dollars, birth centers receive lower payments for the same services as hospitals making their financial health a constant concern and potential barrier to their existence. (Kozhimannil 2019). Policies that support the proliferation and support of birth centers worldwide and the integration of home birth into the perinatal health system could go far in alleviating many forms of OV.

### 6.4 Frameworks for Changing the BIC

An abundance of frameworks for change existed in these data as folks on all sides of the issue put forward ideas for action that would transform/translate health services provision for BPs into health care. Models often included more than one approach, emphasized collaborative care and the understanding that addressing OV in birth was part of a human rights agenda to be addressed at multiple levels of society. Evidence-based backed strategies (N=6), a focus on access and quality (N=6), patient-centered care (N=4) that includes cultural humility (N=7) and shared decision making (N=6) made up the range of frameworks invoked to tackle the problem of OV. The need for team-work (N=26) and a human rights perspective (N=34) underpinned all of the paths for change.

*evidence-based medicine, quality and access, patient-centered care, shared decision making*

The evidenced based movement in medicine came in response to decades of “expert” driven practice that had little if no scientific evidence to back it. While taken up in clinical practice and public health research, critics of the general evidenced-based approach emphasize the need for sensitivity to individual circumstances and remind proponents that even empirical data is not bias-free (Cohen and Hersh 2004). Taking these critiques into account, the integration
of evidenced-based approaches is particularly important in addressing OV because childbirth is an area where conventional practice norms, even in the face of evidence of clear harm, are ingrained. Price pushes evidence-based instead of dogmatic practice:

As the nation begins to address the [maternal health] crisis and best practice recommendations emerge, it is important that we put our collective biases and long-standing beliefs aside and respond to the emerging evidence with a commitment to rapid improvement. Birth philosophies are a touchy subject with everyone believing their way is best….The sooner we identify best practices that prevent maternal deaths, the better (Price 2019-BG7).

The loaded phrase, “a touchy subject” is somewhat unclear but the fervor with which aspects of birth are debated throughout birth culture bears out the blogger’s statement. As such, beyond clinical relevancy, evidence-based approaches are helpful in both grounding conversations about best practices in scientific research and challenging the culture of obstetrics.

The tension between expanding access to medical services for BPs globally, and increased instances of OV is seen through approaches that underline the need for access and quality of medical service provision. The brutality and discriminatory practices exposed when countries took up projects to expand medical services to BPs who historically birthed outside of hospitals was a shock to many. The “violent and rude” mistreatment of BPs, particularly the young and poor, included “hitting, slapping, and pinching” in Kenya:

While [The United States Agency for International Development (USAID)] praises efforts to improve the facilities … by the government [of Kenya], and increased investment by private individuals, it suggests that the ‘soft tissues’ during labour and delivery, which can be described as “a vulnerable moment” during the birthing needs to be documented (Kariuki 2015-POP20).

While the official attempts to acknowledge the role of people and relationship during facility birth as “soft tissues,” I argue the core issues of humanity in birth -- preservation of dignity and life -- are much harder and stronger than described. Interestingly, while this is an example of a
paternalistic U.S. response to OV in another country, I am not aware of any direct response to OV in this country.

In the U.S., issues of access to medical services for BPs are closely tied to historical inequity, and disparities in perinatal health are inseparable from conversations about OV. The chair of the steering committee for BMMA remarks on a bill in the U.S. that would mean the loss of insurance for millions, including many poor BPs. She gives economic and health statistics for Black women and concludes: “We know that we need greater access to care not less” (Dawes Gay 2017-BG9). The lack of Medicaid expansion in twelve states in the U.S. since 2014 adds to the dire situation of access for poor folks, among whom Black and Brown BPs are disproportionately represented (KFF 2020). It is not a coincidence that 8 of these 12 states are in the South. Sexism, racism, colonialism, and white supremacy pervade medical systems across the globe and lead to OV.

In light of systemic oppression in medicalized birth, and in line with what feminist health activists have called for over decades (Davis 2007), researchers aiming to alleviate OV suggest service provision that is woman-centered/patient-centered/people-centered. For instance, in 2017, the WHO set standards to evaluate moves to expand health services “to the extent they are safe, effective, timely, efficient, equitable, and people-centered” [emphasis mine] (Vedam et al. 2019-PR5). Part of this “centering” included bringing BPs into the decision-making process during birth. Listening to BPs to find out what is most important to them in birth is an approach with potential in all geographic and health system contexts:

[O]nly the individual woman knows what components of cultural background and context are relevant and important to her healthcare encounter... the cornerstones of cultural humility and humanized childbirth are ... recognition of the belief continuum in childbirth care, communication with empathy regardless of disparities or cultural biases, and empowerment of women through shared decision making (Sreenivas et al. 2015-PR10).
The data shown here supports the framing of cultural humility as part of patient-centered care and as key to shared decision making (SDM) as a process between BPs and hospital BSPs. Evidence in and outside of academia that these terms are used loosely is a material challenge. Rupert Sherwood, The president of the AU college of Obstetrics and Gynecology states that reforms supported by that group, “were a step in the right direction of collaborative care” and that “It comes down to that buzz phrase of `women-centred care' -- keep the woman and her family at the centre of your attention when you're deciding what to do” (Byrnes 2012-POP21). Notably, Sherwood intends to focus on “the woman and her family” when he is making decisions. Taking “patient-centered care” from a “buzz phrase” to a useful model, of which SDM is an integral part, is critical in terms of its successful application.

The broadly defined practice of SDM focuses on supporting autonomy and “well-being” through two-way communication. Importantly SDM, first articulated in 1982, expanded and contextualized the bureaucratic process of medical “informed consent” (Childress and Childress 2020). “Ethically valid consent is a process of SDM based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form that details the risks of particular treatments” (President’s Commission of Ethics 1982). SDM came up in this study as a formal approach, a strategy midwives I interviewed engaged in as an inherent philosophy of practice, and one that doulas supported BPs in engaging with along with their midwives and OBs: Violet: “at the end of the day [the BP and their family] truly truly are the ones that have to be comfortable with the decisions [they] make and any kind of repercussions from that.” A theme of autonomy and the responsibility that comes with it arose around SDM in practice:

Leiko: Usually, the women I work with are the women who, first of all, understand that their birth does not depend on anybody. You don’t put your life in somebody
else’s hands. You just invite somebody else to provide support, if needed. It’s quite different (Dekker 2020-PC3).

This shift in thinking, outlined by Leiko and emphasized by me in this dissertation, is helpful in detaching outcomes from particular BSPs. It is also useful in addressing the paternal paradox wherein BPs hand over all decision-making power to a BSP without question simply because the BSP supports a broader range of options for vaginal birth. Instead as Leiko states, the goal of SDM is an acknowledgement of BP power and an open and mutual relationship that allows for partnership with hospital BSPs in the birth process.

Of course, SDM was reported by BPs as appreciated and meaningful:

Nia: It was—everything was my decision. They would tell me…we can't do Cervadil you could do the Pitocin… but it's up to you. If I wanted to be checked it was up to me….They made me feel really empowered because like I said, they never pushed anything. They gave me suggestions or told me what they [thought] that I should do next and they talked to me the whole time... And they told us why everything needed to be done and what this would do versus that.

Evidence in these data are clear that SDM and informed consent are always possible. Zethof offered specific action points for engaging in SDM even in emergencies: “Information should be provided without use of medical terminology, adjusted to the language and understanding of the woman. [Information about cesarean] is preferentially given during pregnancy or, if during labour, between contractions” (Zethof 2020-PR21). Tangible and concrete steps contextualized with an understanding of birth exist to support effective translation of medical situations allowing for SDM and ultimately informed decision making by BPs. Further, evidence aligning with the repetitive underlying theme of “teamwork,” clearly show that BPs and BSPs benefit from addressing issues of OV cooperatively and collaboratively.

human rights and legal pathways: possibilities and challenges
Stakeholders at all levels drew on a human rights frame translated from the “humanize birth” movement, human rights law (and courts), and national constitutions. Many authors pointed to the Universal Declaration of Human Rights (1948) to underscore violations in birth:

“Article 3: Everyone has the right to life, liberty and security of person. Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Bondioli 2019-POP3).” Even scholars who questioned the omnipotence of the human rights framework recognized its foundational role in mobilizing change in birth:

[Human rights helped to redefine maternal mortality as a public health imperative, as a fundamentally social and political challenge that reflects deep social fractures and institutional frailties…Human rights tools have been particularly effective in highlighting the long-simmering issue of poor interpersonal treatment of women during childbirth in facilities (Freedman et al. 2018-PR4).]

Evidence shows that the specifics of “social fractures” and “institutional frailties” that influence both maternal mortality and OV during facility birth are culturally, economically, and geographically contingent. Government and national attention were differentially located in relationship to both of these issues and engagement with HRBA depended on the particulars of societal inequalities and inequities. For instance, in India where physical abuses in birth are common and maternal mortality is high, an author stresses the right of human survival:

Though the violation of reproductive rights is not yet considered a human rights issue in India…the National Human Rights Commission (NHRC) has…issued notices to the state government….An indication of just how bad things are is the fact that a judgment from the Madhya Pradesh High Court had to state the obvious -- “a woman's right to survive pregnancy and childbirth is a fundamental right” (Nagarajan 2015-POP19).

On the other hand, in the U.S., writers commonly framed human rights plights as connected to “healthcare rights” and their suppression by capitalism:

Pregnant women giving birth at the hospital are people too and are entitled to the same fundamental healthcare rights as anyone else. In fact, no patient has a greater need for a secure right to informed consent than today's maternity care consumer.
When obstetric medicine is known to have variable standards of care without a solid evidence basis, and doctors confess that the skyrocketing cesarean section rate is largely driven by profit, convenience, and perverse liability incentives, every birthing woman needs to be able to say “no” (Hayes-Klein 2014-POP8).

Many authors and advocates in the U.S. cast BPs as “consumers” using a subjects/rights-based human rights framework to position them as primarily people whose transactional rights are ignored and exploited for profit. Stressing the core difference between a movement that is against the over-medicalization of birth and a movement that prioritizes human rights in birth, Leiko Hidaka states, “this is not about being pro birth. I say this is about being pro women, pro person, pro human” (Dekker 2020-PC3).

Striking similarities exist in the use of legal mandates in countries where out of hospital birth options are limited. There is ample evidence in these data that BPs (and some BSPs) around the world are arrested for attempting home birth as well as for refusing cesareans and inductions. Hospitals and affiliated BSPs use judicial sanctions to force BPs into hospitals, detain them, and force them to undergo unwanted procedures. In the U.S., Child Protective Service’s use of the refusal of cesarean as “evidence of neglect or abuse” is not uncommon, and state involvement in the U.S. for cases like these disproportionately impact immigrants, poor BPs, and BPOCs (Morris and Robinson 2017; Julian et al. 2020).

Midwife and U.S. law student Alexa Richardson is working on an argument to achieve “affirmative consent in childbirth as a legal standard” (Milano 2020). Based on three months of research in Guatemala, Richardson suggests that the OV that she witnessed (BSPs calling BPs “ugly” and “dirty,” vaginal exams by up to 12 medical students, and forced cesareans) is “not that different from what is happening in the U.S. -- the difference is in degree not substance” (Milano 2020). While there is connection between conceptual elements involved in OV across the globe, I argue this comment reveals a false equivalency of the issue lacking a critical lens as
well as contextualization of the problem. Legal efforts to address OV in the U.S. are important but currently seem obscured by a limited perspective missing comprehensive understanding of its complexity and historical roots.

Some authors illuminated the tension between individual and institutional responsibility: “obstetric violence legislation mainly focuses on individual wrongdoers and not the structural violence that facilitates systematic human rights violations within the realms of obstetric care” (Pickles 2015-PR3). Many authors shared the understanding that legal pathways are only one part of the response to OV, and not an all-encompassing solution:

Consequently, any statutory crime developed in response to obstetric violence should be adequately linked to broader efforts that specifically denounce the appropriation of pregnant people's bodies by individuals, civil society groups, the judiciary and the state (Sreenivas et al. 2015-PR10).

Authors repeatedly insisted on the connection between OV and institutional abuse beyond individual violations. Though this seems elementary, Sandhya, an Indian doctor interviewed for an online newspaper regards the idea that abuse may be related to genderism and sexism as somewhat novel:

In [BSP] training, there is no sensitizing about gender or imparting of soft skills such as how to engage with patients….The terms of abuse used against pregnant women are shockingly similar across the world. It could be something to do with how we view reproduction and women (Nagarajan 2015-POP19).

Again, labeling respectful interactional capabilities as “soft skills” seems inappropriate considering they are meant to tackle gender-related abuses that are so strong and durable they hold true throughout the world. Overall, for many scholars and BSPs across disciplines, a continuous theme for fighting OV included the priority of a “shift in power relations” and shared “accountability on an individual and collective level” (Sreenivas et al. 2015-PR10).
Congruent thinking existed on the principles of humanized childbirth from folks across conversations which include decision making for BPs, centering their needs, and deconstruction of the hierarchical systems of the BIC. While these principles are uncontested, the essential question standing between them and effective translation still exists, Who is seen as human in society today? The answer to this fundamental question determines not only who has access to quality health services but also who has the ability to receive those services respectfully. Jennie Josephs describes the thinking of hospital BSPs and the obstacles to the recognition of the humanity of BPOCs:

The main way of [BSP] thinking and being -- implicitly or explicitly -- is, this is a problem…. I’m going to be put out. This person, because of who she looks like she might be, I’m going to judge her and assume that I’m going to have to work hard or do different, better, something, and I don’t want to do. I don’t have to. I’m not even getting paid enough. All of these things get in the middle of just being able to relate to a fellow human being and provide care (Dekker 2020-PC4).

BSP’s readiness to access tropes of “difficult” patients and negative assumptions about the health interaction based on appearance is clear in Josephs’ account. Racism and discrimination are substantial barriers to the project of humanizing birth. As Dorr and Dietz lowlight, “Regarding human rights, the neglect of racism and other discriminations are a considerable omission” (Dorr and Dietz 2020-PR14). More than a “considerable omission” -- in line with others (BMMA and NWAP) who juxtapose the plight of birth rights against a society of systemic racism -- I argue that a human-rights-based approach that does not acknowledge racism and discrimination is not useful for attacking OV anywhere on the planet. Clearly, a global reproductive justice framework is called for in terms of understanding the scope of the issue as well as supporting effective solutions for OV.

Beyond strengthening civil rights for all marginalized groups in the U.S. generally, one pathway that might be fruitful in combatting OV is the reinforcing of existing civil rights-based
legislation in the context of health and enacting healthcare anti-discrimination law. Though Title IV of the 1964 Civil Rights Act would seem to provide protection from discrimination in health systems, the same problems that prevent the act’s application within other institutions -- the legal precedent that requires individual intent and the lack of political will to litigate and enforce it -- hinder its usefulness for OV (Randall 2006). In 2014, a renewed focus on hospital compliance with title IV was initiated by the department of justice enforcement in 2014 (Chandra, Frakes, and Malani 2017), but results from that initiative are not available. Most recently, the Maternal Care Access and Reducing Emergencies act (Maternal CARE act) was introduced in 2019. This act grants federal funds for implicit bias training for hospital BSPs and at home pregnancy care for the highest risk populations. While groundbreaking, the legislation’s emphasis on implicit bias, a relatively mainstream and accepted concept, conveniently neutralizes intent and removes the concept of racism from discussions of racism. Needless to say, while the bill is helpful on some level in terms of improving access, it is not clear whether and how judicial and legislative action can help eliminate other forms of OV.  

50 In reimagining the BIC, it is important to keep in mind critiques addressed at the reform of other oppressive systems like the prison industrial complex. Michelle Alexander emphasizes that paths of reform must also “contribute to building a movement to dismantle the system,” along with advocacy that “upsets the prevailing public consensus that supports the…system” (2012:224). Similarly, a text critiquing human-rights-based approaches and legal pathways to  

49 Protects people from discrimination on the basis of race, color, or national origin by institutions, organizations, and programs that receive federal funds.  
50 Some states like CA have had success in passing helpful perinatal health legislation but its anti-OV effectiveness is not known.  
51 At the time of writing, the Black Maternal Momnibus Act is making its way through the U.S. house; a promising bill that includes funds for “social determinants of health,” community-based care, and internal departments to handle complaints of mistreatment (2020).
address OV asserts that they are lacking when considering the transformative work -- beyond bureaucratic means -- that needs to be accomplished at both the micro and macro levels:

[To]o truly transform the relationship between women and providers, HRBAs will need to go beyond articulation, dissemination and even legal enforcement of formal norms of respectful maternity care…true transformation …cannot be compelled by the operation of law. It will also have to be built from the ground up through creative efforts to challenge settled patterns of behaviour and deeply entrenched health system structures that marginalise and abuse (Freedman et al. 2018-PR4).

There is understandable doubt about the transformational power of law without cultural change. Just as individual behaviors will not change based solely on institutional texts that declare they do so, announcing policy changes without effective means of implementation will not yield results. Ibanez-Cuevas, writing about TBAs in Mexican hospitals, illustrates this point:

[Current policies only go so far as to promote the restructuring of labor and delivery care for women, but without identifying pathways or processes for actually changing the practices that over-medicalize labor and delivery services in health institutions (Ibanez-Cuevas et al. 2015-PR20).]

Surface solutions to assuage issues of over-medicalization, like simply inserting BSPs with non-biomedical perspectives into hospitals, will not help, given the current medical hierarchy that pervades the BIC. A health scholar pinpoints this problem with inadequate interventions that lack necessary translation:

The typical HRBA asserts that health systems are by and for the people. …But the global health literature rarely acknowledges how profoundly different this conception of the health facility is from the actual, hierarchical way that facilities have historically functioned….The answer is likely to require not just a stock intervention, such as a patient charter or a maternal death review, but also very careful, sustained attention to the workings of power that must be persistently confronted during implementation (Freedman et al. 2018-PR4).

The strength and staying power of the status quo in the BIC is monumental but not insurmountable. As noted above and in this study, disempowering influences can potentially be
overturned with intentional scrutiny of BIC mechanics and better understanding the everyday ways people maintain and resist them.

In line with Goodale’s view of the globalization of human rights, I argue that, in order to apply HRBAs in ways that effectively combat OV in birth, human rights must be translated (and operationalized) locally with an understanding of pertinent power dynamics (Freedman et al. 2018-PR4). I would add to this perspective the basic understanding that birth is not pathological, and that all pregnant and laboring BPs are whole, worthy, and fully capable individuals. When looking for best practices to address OV, the answers will be found by seeing BPs and their desires/customs as important and listening to them. Even seemingly simple interventions to increase facility accessibility and quality of care can have a powerful impact:

The incorporation of traditional birth customs such as providing a coffee ceremony and porridge (genfo) to women…was mentioned by almost all patients as an example of quality care, and frequently cited as a factor in women choosing a health facility for delivery … provision of customary birth ceremonies was not mentioned by any of the providers or students as an aspect of quality care (Burrowes et al. 2017-PR1). The disconnect between facility-based BSPs and BPs on what “quality care” entails -- what it looks like, feels like, tastes like -- calls for a lens of embodiment incorporated into a human rights framework. Freedman and colleagues state: “a HRBA must be grounded in actual practical norms that can be identified empirically and its message must be vernacularised into a discourse that can connect effectively to the fears, hopes and aspirations of both women and providers” (2018-PR4). As many scholars indicate, we must move to more fully articulate what the range of human rights in facility and hospital birth looks like and what modes of being it inhabits.

I suggest human rights in birth includes full bodily autonomy and respect as well as individual and cultural autonomy and respect (e.g., freedom to exercise meaningful customs/behaviors and express beliefs in a safe environment of the BP’s choosing). It not only
encompasses the right to shared medical decision making between hospital BSPs and BPs (with complete information regarding options and the BP’s medical status), but also requires institutions to provide such treatment with compassion through sensitive and individualized care. To create a system that recognizes each BP as themselves and as human in all of these ways means that we have to completely transform the BIC. It is helpful to think of institutions as human made and operated when doing this transformative work toward the realization of human rights within perinatal health systems.

In thinking critically about human-rights-based approaches and OV, two elements are especially important. The first is the idea put forth by Buchanan that institutions are massively influential in people’s lives and are not objective or static structures (2013). When we understand that humans can change institutions, we can then see human rights as morally compelling the struggle to attain positive justice through them as opposed to merely attempting to prevent institutional harm (Buchanan 1996). Secondly, without acknowledging broader ideals of justice, it is easy for performative acts of human rights commitment to replace substantive efforts. As Nelson Mandela articulates in a UN address in 1998, the situations of health inequities around the globe are not “forces of nature,” but the “consequence of decisions which men and women take or refuse to take, all of whom will not hesitate to pledge their devoted support for the Universal Declaration of Human Rights” (Mandela.gov.za 1998). In this vein, it is of the utmost importance to converge the two frameworks of human rights, 1) individual/subject based, and 2) social justice based, when creating a birthing environment free from OV (Suri et al. 2013). This convergence of effort and understanding creates an immediate existential crisis for the institution of medicine, for the BIC, and for individual facilities. As Jennie Josephs details, while the fight for choice in birth (subject-based human rights) has
overlooked BPs who lack access and recognition (social justice-based human rights), neither movement can be realized fully within the current system:

Jennie: But even in the dominant culture communities, things are so messed up that we have to have these movements for women to learn about power and birth. We have to have these movements to push physiological birth. This is how upside down this is. And while we’re staying with our movements, and our push towards empowered birth, and evidence based, and all of these things, we still left behind the people who also need the same information, support, and encouragement to break the system wide open, burn it down, as far as I’m concerned because it’s lethal (Dekker 2020-PC4).

Can predominately white-led colonialist-thinking institutions burn themselves down? Can white patriarchal supremacy be dismantled within in the BIC and can we rebuild something that serves the interests of BPs and their families? The answer must simply be yes. Moreover, all “dominant culture communities” need to find ongoing ways to step aside, stand beside, and support both their peers and larger organizations centering marginalized folks in the fight for reproductive and birth justice.

With the help of emergent strategy as put forth by adrienne marie brown, the unwieldy task of transformation we are presented with is possible when we see the infinite ways small actions create waves of social movement (2018:82). The elements of the BIC work together right now in ways that reproduce all forms of oppression through OV. Undoubtedly, some areas of the BIC need to be clipped, burned, while others can be repurposed, retooled, and nurtured to interact in utterly transformed ways. Conceptually, emergent strategy tells us that we have all we need to recreate a more just birth environment and that we don’t have to know exactly how things will turn out before we start making changes that uplift people (brown 2018:111-112). It only requires mutually taking steps towards what we know works. This strategy moves us forward with some hope when we engage “the ‘resisting imagination’, the power to imagine the world differently” (Freedman et al. 2018-PR4).
6.5 Strategies to Thrive: Reimagining the BIC

The world has responded to OV with an array of interventions seeing to promote the effective translation of medical care in institutional birth. Overall, policy changes with BP input and clear mechanisms for implementation, as well as communication skills and ethics training that emphasize building rapport and critical thinking show the most promise. Of note, authors stressed the importance of educating BPs about birth, patient rights, and processes to report OV across country context and hospital system resource levels. Overwhelmingly community-based interventions at every level stood out as most worthwhile.

effective translation

*Effective translation* is the process that transforms perinatal health service provision into health*care* through human connection. Using the everyday strategies of BSPs and BPs and considering creative interventions around the globe, we can reimagine and restructure the BIC through this holistic approach. This means of change is based on recognition (birth is not pathological and every BP is fully human with specific needs and decision making capability); it is supported by empathetic and equitable communication (e.g. shared decision making and other forms of conversational consent); and it continually seeks paths for improvement -- offering direct applications through positive action (e.g. moves to large-scale community-based models, choice of birth place, policies that support open communication, transparency, and accountability) (Fig.6).
While it is clear that better communication, empathy, and anti-racist praxis are called for in the plight for humanized birth, the actual ways that people might interact with each other to achieve these goals needs illuminating. Connecting humans effectively requires a two-way pathway that is materially accessible. These data provide evidence of challenges in applying anti-OV policy and interventions to complex real situations in hospital birth. In 2019, ACOG launched a campaign called “Are You Listening? Every Mom Every Time” to fight maternal mortality due to neglect. It includes “racial bias training” and buttons sold through their website that state, “I’m listening. Every mom. Every time” (ACOG). While the attempt to connect their campaign to the real world is laudable, the communication process described by my participants sounds a lot more active. Instead of just listening they provide ongoing information and ask many questions from various angles with curiosity. Thus, when trying to better understand effective translation during birth especially in the hospital setting, it is important to articulate the theme I call *conversational consent for birth* (CCB).
Similar to informed consent and SDM but specified for birth and grounded in continuity, the ongoing and transparent dialogue of CCB acts as a bridge between the BSP and the BP. There are 7 elements of CCB: 1) it begins with an understanding that the BSP and BP are working together; 2) it is forward thinking (in an attempt to smooth transitions); 3) it is fact based rather than fear based; 4) it assumes the capability of the BP to understand their medical status and the risks and benefits associated with any interventions and participate in decision making; 5) it never assumes consent; 6) it requires recognition of patient feedback and real time adjustments and finally; 7) it centers the importance of the integration of the BP’s personal and medical experience in the moment. Carla talks about the way she uses CCB to discuss high blood pressure, a common and potentially life-threatening complication of pregnancy:

Carla: You can kind of see problems starting to creep up before they become emergencies and so… having this conversation of like “I noticed this is happening. Here are some suggestions for how to manage it”… and oftentimes, I'll send them research articles. “Here's what's normal. Here's what is not. And here's the reason we need to prevent this.” It's not-- this could be the outcome…. Obviously I'm not going to try to do something to scare a mom when her blood pressure’s already through the roof.

In this excerpt, Carla anticipates and hopes to prevent a complication by providing and trusting the BP with thorough information. Carla also takes into account the way any intervention to address an issue of concern might impact the BP and worsen their condition. In another example, Violet describes the way she approached conversational consent as a nurse during birth:

Violet: [I might say], “Hey, you're Group B strep positive; has anyone explained what this means?” And sometimes they say, “No, I didn't know I had to have antibiotics in labor.” [I say]… “This is the reason why…are you comfortable with that? Do you have any questions about that? You know just because I'm giving you this information and you don't say no--that doesn't imply consent.” Or… “Your doctor has ordered magnesium for you and this is why. This is what you can expect… What are your thoughts?” Just really walking them through it because I think so often things just happen to people and it's not always taken-- that moment to explain--this is what's going on… really taking that moment.
Instead of assuming the BP’s knowledge, Violet uses CCB to confirm the BP’s understanding of a particular medical status and provides information. Instead of moving ahead with general protocol using the “don’t ask just tell strategy,” she informs the BP that the power of consent is ultimately theirs. The “walking through it” Violet describes connects the BP’s personal and medical status in real time and is also extremely beneficial for BPs after the fact because it allows them to retrace the events of birth without wondering what happened and why.

During birth Violet also uses the CCB approach as a midwife to avoid unexpected transitions: “[I’ll say] ‘This is what I'm seeing. This is what I'm concerned about’ or you know ‘This is what I'm watching closely and if XYZ happens then this is what my next steps are.’” Giving BPs space and time to make decisions is an important aspect of optimally supporting CCB. Even if it is “just a minute,” the act of breaking the flow of medical events and regrouping is important for BPs to process scenarios as they unfold. As other BSPs and researchers have noted even in emergencies where previously unwanted interventions are required, there is time to connect with BPs: Violet: “even in an emergency situation…locking eyes with that person and say[ing], you know say[ing] their name and this is what's going on.” There are a range of effective techniques and modes of body language to promote personal connection. As in this example, it can be as simple as eye-contact and saying the BP’s name.

CCB is the responsibility of BSPs and the hospital and eliminates the tension BPs experience in asserting autonomy during birth. While it requires a shift in work and effort for hospital BSPs, moving the weight off of BPs to claim their autonomy has the potential to materially enhance the experience for both BPs and BSPs. While CCB alone will not overturn the white patriarchy of medicine, I unpack and operationalize it to emphasize that these behaviors do not necessarily come “naturally” and do not amount to “soft skills” or “just being
kind.” All BSPs can learn how to communicate more effectively. The application of this hard work takes an attention to nuanced differences in people and the application of medical care (if needed). It takes a cultivated intelligence and continuous professional and personal study. It requires effort and is extremely valuable. CCB is a communication framework grounded in empathy, concern, and authentic connection. Sreenivas highlights the global literature that overwhelmingly points to the desire by BPs for “empathetic support by providers, not just medical management” (Sreenivas et al. 2015-PR10). CCB is a strategy that details behaviors that anyone can learn and can serve as a foundation to transform the BSP/BP relationship to one supporting autonomy with empathy.

One distinct intervention in texts related to addressing OV through pathways of institutional culture included “mentorship and on-the-job role-modeling by identified champions within the facility” (Vedam et al. 2019-PR5). We know that empathy is a learned skill. Learning to interact supportively with patients, through hands-on mentoring, is one crucial piece of a complete anti-OV program. “Champions” emerged in these data in stories that included important moments where relationally skilled BSPs took the time to engage in meaningful ways:

Kelley: [Dr. M] was the first person I felt like actually listened after being there for two days. He didn't know what was going on, but he was willing to listen and have the conversation…. And I’m like, why couldn't any of the other doctors I saw before have that conversation? He listened. He actually listened and gave us the options. And he didn't gloss over anything…[Dr. M] called after [baby] was born to check. He wasn't even the one who delivered the baby and he called to see how we were doing and everything and I was like thank you [starts to cry].

Not only was Kelley appreciative of feeling heard and supported by the straightforward manner of conversation in the moment, but the OB authenticated the connection by looping back to check on her. This is a behavior that may not come naturally for hospital BSPs but can be taught and woven into their practice culture. The “kindness” of hospital BSPs making space for BP’s
full humanity stood out and was noted by several BPs who became emotional when recalling small moments within their often long and challenging births when they felt like someone cared.

BSPs also provided validation and support in the wake of problematic birth experiences (N=3). Jasmine sought out and went back to see her longtime OB:

Jasmine: He explained to me what went wrong--what they did wrong and he apologized of course…but it's not his fault…He explained that I had hemorrhaged and that there was a kit that [the OB] probably used to save me and that the first [OB] had access to it, but probably freaked out or didn't want to use it or didn't know how to use it - one or the either. He looked at the notes and he was like, ‘Oh my God! This sounds like a horrible delivery!’ That's the first thing he said to me. I was like - it was.

Though not in attendance at Jasmine’s birth, the OB was able to walk her through the events of her birth with empathy, and she was able to have a conversation that initiated her processing the medical facts of the ordeal of which she was never apprised. The ability to have conversations with BSPs who listened was important in the immediate postpartum for many BPs. Medical BSPs who were able to genuinely connect to BPs had tremendous positive influence going outside of their roles as “medical managers” to tether the personal and medical experience for BPs providing information and validation with compassion. The ability to use empathy as part of perinatal health practice is an integral part of an anti-OV movement. We should use any avenue available to enhance, reward, and center empathetic care in all perinatal health encounters.

I recognize that BSPs who are paid the least (the majority of whom identify as women) often end up doing the most intense and all-encompassing material work driven by applying empathetic care standards. I argue that this inequity is at times compounded by the essentializing of comprehensive empathetic care:

It takes a very engaged, vital and caring mind to assimilate the multifarious impressions and information provided by a pregnant, birthing or nursing mother. It is unique to every mother. It is distinct at every visit. The everchanging and increasing pieces of information take a thousand eyes and a vocational as opposed
to a professional heart to assess and midwife. Attaining the vital signs is the easiest part (MorningStar 2016-POP22).

MorningStar casts midwifery work as possible only with a “vocational” heart, invoking ideas of a spiritual or pious undertaking. The attachment of empathy and empathetic care to a “calling” rather than a “profession” positions midwifery outside the realm of the everyday and in some ways lesson the responsibility for other BSPs to practice with this philosophy. We should expect (and support the means to provide) a health system that offers holistic care including creative and dynamic approaches from the range of BSPs in birth facilities. We also need to recognize the value of the bridge building and connection work many BSPs are already doing. We must address the work conditions and structural issues that inhibit it, enhance factors that support it, and find ways to better compensate those who excel at it. Doula work in particular is a current site of political upheaval and transformation filled with tensions around praxis, practice approaches, and professionalization (Nash 2019). The role doulas/perinatal health workers/birth workers will play in emerging systems of perinatal health is unknown, but their potential influence (and exploitation) is worth continued study. Right now, many folks are reimagining the scope of BSP roles in ways that will support anti-OV practice as well as BP health and well-being.

Holistic community care is pro-human care

There are many terms called upon in this research to indicate a care philosophy that centers the BPs’ needs and concerns and ultimate health and well-being (i.e., respectful maternity care, patient centered care, woman centered care). Additionally, scholars consider cultural humility and cultural competency to be important aspects of these broader concepts. Cultural competency is the most widely adopted concept in health and medicine to refer to “behaviors,
attitudes and policies” that ensure individuals or institutions effectively and appropriately engage in diverse settings through understanding and respect of all cultures (Greene-Moton and Minkler 2020:142). Cultural humility as put forth by Tervalon and Murray-Garcia in 1998 stresses the quality of ongoing critical thought, “self-evaluation,” and learning necessary to developing “mutually beneficial and non-paternalistic partnerships with communities” (p.117). I argue that what is fundamental in the application of these complementary concepts is a continuous personal and professional anti-racist/sexist/genderist/ableist/etc. practice supported by personal and professional education and growth. As such all of these concepts (cultural competency/humility, patient-centered care, respectful maternity care) can be combined into one and referred to as “pro-human” (Hidaka with Dekker 2020-PC3). Further, it is critical to understand that pro-human care (as defined here) is inherent in the model of holistic community care put forward by folks doing this actual work (Fig.7). I provide specific knowledge and frameworks for best practices towards making this model standard from women of color at the end of this section.

**Figure 7 Holistic Community Perinatal Care**

As in many other areas of health, the beneficial qualities of community-based care are apparent in these data regarding anti-OV strategies. Community-based care consistently showed
its critical role in the success of programs to ensure people’s access and positive outcomes.

Wilson-Mitchell and colleagues stress that, “…increased access to high quality care will not necessarily improve outcomes without community engagement” (Wilson-Mitchell 2018-PR22).

These data show that successful programs linked health communities with the larger community and also rose from the ground up through community-building and development. Further, as noted by Julian and colleagues, community models are uniquely situated to take on inequity in health systems directly:

[C]ommunity-informed models of perinatal and reproductive health (PRH) acknowledge historical and contemporary harm in PRH service provision and create opportunities for focusing on structural benchmarks and mechanisms for advancing equity in health systems innovations (2020:2).

The effectiveness of community engagement at all interventive levels was significant from improving facility interactions through relationship to researching and developing interventions for health systems. Community based health service provision is obviously not a groundbreaking concept but a real collaborative effort to apply it widely to birth would be. Community has particular meaning for oppressed social groups wherein durable and resilient community relationships are an essential part of surviving and thriving. The skill of community organizing and mobilizing perfected by Black and Brown women in the U.S. and beyond stands out as a hallmark of reproductive justice work:

Too often, Black women are not recognized for the work they are doing to improve the health and well-being of our communities. We celebrate Black women’s ingenuity and resourcefulness. We acknowledge Black women’s traditional, cultural, and historical contributions to maternal health and birthing practices (blackmamasmatter.org).

Acknowledgement of the historical importance and invaluable knowledge of Black, Brown, and indigenous people around the world is a necessary part of fully embracing any contemporary iteration of community-based care for perinatal health.
Community care is embedded in a pro-human approach. There is a growing consensus that intersectional understandings of identity and social location are required for any BSP to be able to provide optimal care. Sabia Wade, a black queer doula and developer of the Birth Advocacy Doula Training (BADT) speaks to this awareness:

Sabia: I feel like advocacy and what [BPs] expect from advocacy looks different depending on who they are, their income level, their race, their gender, their sexual identity. All the different things contribute to advocacy, but it looks different depending on the person’s lens (Pascucci 2020-PC7).

There is also a conversation acknowledging the divide between doula approaches in predominantly white communities supported by traditional organizations that do not directly question hospital BSPs, and the necessarily more directive type of advocacy taking place in Black and marginalized birth work communities. As China states, “My job is not to make a doctor comfortable. My job is to support my client” (Renee 2018-PC6). A contingent of cross-racial/ethnic doulas are beginning to detail and articulate the value of doula work in the perinatal health crisis and anti-OV efforts. An important piece of this shift in doula work is moving it towards full spectrum practice as the norm and fully “standing in its power” to advocate, and help all BPs self-advocate, successfully (https://www.maternalinstinctsdoula.net/keepingyourpower-for-families.html).

Anti-racism practice is inherent in the application of holistic community care. A comprehensive system of community care that allows BPs access, continuity, and connection as fully human, is in direct opposition to models of compartmentalized white supremacist capitalist health service provision that dominate the globe. Working toward a retooled system based on reproductive/birth justice grounded in relationships requires a wide lens of community and a commitment to interdisciplinary, inter-professional, inter-cultural, inter-resource, and inter-identity alliances for all involved. In the U.S., racism remains one of the most salient influencing
factors in perinatal health and a point of contention within birth culture and communities. Like most organizations and institutions who responded in some way to the social unrest of the Summer of 2020, it is accepted and expected that PWBO acknowledge racialized disparities and obstetric racism in birth. It will be important to use this growing awareness and interest convergence to focus resources and energy on folks of color doing community-based and justice-oriented work. How can PWBO pivot and follow Black and marginalized activists and providers already working in communities? During this study, there were instances of sporadic “take over days” on social media where owners of mainstream (predominantly white-led) Instagram accounts handed them over to educators/influencers of color in the space. How can we make these “takeovers” more permanent? Can we take advantage of this existential crisis in birth culture and move towards trust and repair among folks with different perspectives? Can mainstream birth movements move support of Black, Brown, queer, and poor BPs from a “birth justice” tab on their website to the center of their advocacy? This would require eliminating some deeply-ingrained habits of white supremacy culture including perfectionism, power hoarding, and the right to comfort. Reciprocally, disavowing these things is also necessary in the much larger project of creating equitable perinatal health care.

accountability in the BIC

Medical dogma indoctrination starting with medical education pedagogy creates a dangerous situation where future doctors internalize the supremacy of medical intervention and their knowledge and abilities to implement it. This socialization to intervene is further reinforced by the threat of malpractice suites and the rising cost of liability insurance (especially for OBs). A body of research demonstrates that when hospitals and MDs admit mistakes through
“Communication and Resolution Programs (CRP),” they experience less -- not more -- legal action\(^{52}\) (LaCraw et al. 2018). If we are asking the BIC to transform into a place that recognizes BPs as fully human we must require this recognition extend to hospital BSPs as well. Shifting medical education and hospital cultures that uphold the MD “God complex” to one of human accountability is part of dismantling white supremacy in the BIC. Acknowledging mistakes and learning from them is key to this goal: “A non-punitive environment for healthcare workers, including physicians, supports open dialogue and process improvement” (Price 2019-BG7).

Taking a hard look at the toxicity of medical dogma in the BIC will benefit everyone involved.

Accountability programs that make hospital statistics regarding interventions available to the public are intriguing. A “mother-friendly accreditation program” is suggested by Improving Birth: “Imagine if, in just a couple of clicks, you could find a provider and hospital in your area that you knew with confidence had a healthy cesarean rate, low intervention rate and a high success rate of vaginal birth after cesarean?” (improvingbirth.org). The accessibility of simple statistics is a step toward empowering BP autonomy. Kimberly Seals-Allers, a Black writer and activist, is going further with this idea and applying it to track OV in hospitals. Her forthcoming app “Irth (as in Birth but we dropped the B for bias),” is a yelp-style review platform allows BPs to review hospitals and affiliated BSPs. It will also compile data from BPs’ descriptions of obstetric racism and report red flag issues to hospitals and the general public. In line with others (Chandra, Frakes, and Malani 2017), Seals-Allers calls attention to the importance of taking a proactive view that values listening and acting on the experiences of BPs over describing outcomes: “We can’t simply measure or fix this issue from the grave. This is ridiculous, right? I have a lot of respect for maternal mortality review boards … but we need to get on the front of

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\(^{52}\) LaCraw and colleagues found a 66\% average reduction in legal liability claims over a 12-year period for a hospital system where MDs held their own insurance and participated in a CRP (2018).
this issue and not wait for another Black woman to die before we start analyzing what happened” (Dekker 2021-PC8). There is a consensus on the need for a focus on direct improvements and applied research to address OV:

Jennie: Any and everywhere that you can see structural, racist, classist, sexist behaviors, and policies, procedures, ways of being, all of those show you exactly why we have what we have. So, it’s disingenuous to run around throwing our hands up. “We don’t we don’t know. We need to do some more research.” No, we don’t. We really don’t. Yes, it wouldn’t hurt to do some really useful research, and then act on that evidence. But we’re not interested in acting on the evidence. We’re interested in spending the money to maintain the getting off so we can have another run of conferences, and papers, and publishing, and blah-blah-blah (Dekker 2020-PC4).

Ignoring the obvious roots of OV and disparities in the BIC is indicative of the durability of white supremacist culture within all institutions and the self-interest of many invested in them. Working in and outside of traditional pathways for research and policy development are important in pushing past tokenism in interventions and change agendas.

Institutionalized obstetric racism must be addressed in conjunction with any moves toward personal accountability and racism training for hospital BSPs. Powerful organizations in obstetric and perinatal health in the U.S. need to reckon with their own hierarchical administrative structures that perpetuate racism and sexism. As evidenced recently, Timoria McQueen Saba, a Black woman courted by ACOG and invited to join its Patient Safety Council, is now suing the organization because they rescinded the offer after she expressed concern about a council member’s racist comments (Wise 2020). Talking about race and racism at every level is crucial in reimagining the BIC. A recent study called attention to the ways medical students receive inaccurate and incomplete teachings on race and racism that directly perpetuate myths of biological difference and racial stereotypes while promoting biased practice (Julian et al. 2020). Dr. Mimi Niles, midwife and researcher, elaborates:
I don't need my students to rattle off that Black women are three to four times more likely to die from a childbirth complication.... But I want my students … to ask the deeper questions. I want them to be asking. Why is this? What in the structures of care, what in the evaluations and the assessments of people's wellness and illness, what kind of racist ideologies have we built into these things? (Horton 2020-PC9).

Scholars in texts also emphasized moving beyond concrete facts about marginalized BPs to a more critical understanding of how to best care for them and understand the link between the BPs experience and larger societal issues. Efforts to improve treatment of BPs at the interactional level and to address structural racism within medical education, training, and professionalization are equally important and will pave the way for authentic engagement with the community and is a step towards large-scale holistic community care.

The overall reimaged system of perinatal healthcare is one that focuses on pro-human communication and a collaborative approach. It would offer fully accessible perinatal care by midwives (with a midwifery philosophy and training in physiological birth) as the standard. It would offer choice of birthplace and use medicine as a tool -- not a framework. Thus, we must seek the establishment of a less-hierarchical relationship between all BSPs. For example, evidence shows a simple intervention like a white board in every labor and delivery room (with all BSP names, BP birth preferences -- edited in real time, and questions) helps facilitate teamwork and communication while supporting informed consent, improving patient satisfaction, and may reduce cesareans (Pimentel et al. 2018; McClung 2019). Both simple and more complex solutions to dysfunction in the BIC exist and are working.

In closing, I present three perspectives on holistic community care. These three BSPs are working within the system that currently exists with pro-human tactics. Their cumulative knowledge and experiential-based formulations of solutions to the problem of OV and obstetric racism shine through these data. They are each doing work in their own sites guided by unique
expertise yet with a common thread of connection through determined and direct momentum. These individual yet synergistic actions promote the transformation of the BIC and its production of OV to an institution of care that is just for all BPs. I see the ongoing individual and collective practices described in the following section as a mutual interdependent movement with the potential to upend the BIC. As brown articulates: “Eventually, transformative practices that begin small will demand new societal structures” (brown 2018:203).

Jennie Josephs -- midwifery and community perinatal care

In addition to the first Black founded and accredited midwifery school (Commonsense Childbirth), Jennie Josephs has established an approach to community perinatal care called the JJway\textsuperscript{53}. When Josephs began midwifery work in the U.S. as a transplant from the UK, she imagined growing a practice to support Black and Brown women in home birth. After realizing that the BPs she sought most to support were often not interested in home birth and felt safer in hospitals, she pivoted to offering a platform of community perinatal care coordinated primarily with hospitals in early 2000. Six important principals make up this holistic community program:

1) Self-Reliance “the mother\textsuperscript{54} participates as an equal partner” BPs also receive a “prenatal passport card” where all of their labs, notes, and any communications are kept digitally, 2) Easy Access is guaranteed financially—no BP is turned away, and relationally – every BP is greeted warmly upon entering, the plan states, “this immediate connection is simple but critical,” 3) Team Approach “from the receptionist to the office manager,” the full staff (medical and non-medical) discusses each client and BPs receive education, information, and support from the

\textsuperscript{53} Jennie Josephs acknowledges this name was applied off hand and wasn’t intended to be permanent –but it stuck.  
\textsuperscript{54} The org’s 2018 Maternal Justice Report includes a section about moving towards changing their gendered language.
entire team, 4) Connection Creation “prenatal bonding” is promoted for the entire family and support system, 5) Gap Management identifies and bridges any resource deficiencies or barriers, and finally 6) Education is ongoing through formal and informal channels and is individualized in “message and delivery” (https://commonsensechildbirth.org/jjway/). These principles typify holistic community care based on connection.

In addition to the JJway, Jennie Joseph’s Commonsense Childbirth organization (and midwifery school) is also the home of the developing National Perinatal Task Force (NPTF): “Guided by fierce love for our families and communities, the NPTF seeks to dismantle the braid of oppression impacting communities of color. We recognize strength and abundance in the breadth of our intersectional collective in order to harness the limitless power of our lived experiences” (https://perinataltaskforce.com). The NPTF developed a program of “Perinatal Safe Spots” to highlight various efficacious models of community care and establish a “national network of movement-building bodies” (Cole, Rojas, and Josephs 2018:6). NPTF engages the Maternal Justice Model put forth by midwife Paula X Rojas, and models the framework’s approach to support systemic change. In a 2018 report detailing the task force’s creation, the team’s overall recommendations to foster improved perinatal health included public funds allocation for community-based programs; “wrap-around” services for BPs; a shift in organizational focus from “cultural competency” to that of “structural competency” as well as increased energy and resources aimed at righting “social inequities” on a wider scale (Cole, Rojas, and Josephs 2018:7). These recommendations reflect the concerns of scholars throughout this study that OV cannot be eliminated without mounting serious campaigns to alleviate issues at both a structural and societal level. In this way, the JJway and the National Perinatal Task
force are situated squarely in the larger project of dismantling white supremacy and neoliberal practice in the BIC.

A key to the JJway includes the seamlessness offered between midwifery prenatal care outside of hospitals and OB care and birth in hospitals. For BPs who want to birth in a hospital, the team creates a bridge of support through partnership with hospital BSPs. Josephs had to overcome significant challenges in creating these connections due to negative stereotypes about her patient population held by BSPs in the hospital setting:

Jennie: I’ve made a big effort to really be in relationship with the hospitalist, with the residents, with the charge nurses. I ate so much humble pie, I could choke. Just meeting, and greeting, and listening to all the … fear, and the drama. And understanding their perspective, even though it didn’t make sense to me, it was real to them. (Dekker 2020-PC4).

Josephs’ humility in her interactions with hospital BSPs and flexibility in her approach exemplifies pro-human care. Meeting BPs and BSPs where they are she moves forward with a single-minded agenda to provide holistic and respectful care to all BPs despite harmful entrenched beliefs that pervade the BIC. This particular expertise is what is also needed in broad scope to integrate home birth into the larger system of perinatal health.

Vanessa -- holistic method for perinatal assistants

Vanessa identifies as an “elder doula” as well as a therapist and researcher who mentors and trains perinatal assistants (doulas) in her unique method. Her guiding principles include taking on any client as long as they are looking for firm direct support. This support is holistic in that it considers the whole person and the whole couple (or family team). The trauma informed care she provides initially lays the groundwork for helping BPs to stay connected to themselves
and others during birth. This kind of relationship focused approach means that she has few BPs who experience psychologically traumatic births:

Vanessa: and you have a way in which to take your client through a journey on their birth. And helping them prepare for developing relationships in real time themselves.

Similar to the JJway, Vanessa’s method focuses on connection and relational alignment at every level. This embodied focus has physiological benefits for birth by encouraging the release of oxytocin with the intention to keep labor moving. Vanessa’s embodied focus is targeted to keep the BP in alignment and keeping the oxytocin flowing: “Oxytocin will come in and make you whole [laughs].” The trauma-informed method Vanessa uses is also beneficial for the doula as it creates initial and ongoing boundaries while providing a sharp focus on the work that needs to be done within the birthing “unit.” It is the responsibility of the BP and her partner/family to stay in alignment with each other and the doula’s role to keep an eye on any breaks in relationship: “It's the relationship that you have with [your] partner with yourself…. the relationship the birth team has with each other or not. And then your relationship with the hospital or not--you have to be able to as a doula observe all of that and make relationship in real time all the time.” The ongoing dynamic nature of this holistic method is congruent with CCB in that it continually joins the BP to others during birth and could be supported by “white board” interventions (Veronica 2018). It also holds the BP responsible for creating these connections themselves when possible. Vanessa encourages BPs to ask their providers at least three questions before birth and if feasible she accompanies them to the visit to “observe the communication dynamics.” Vanessa does not avoid any MD or hospital so her approach must be straightforward and confident. This method is resilient, loving, and meets BPs wherever they are.
While many doulas noted the fear of “getting kicked out of the room,” that was not a concern for Vanessa: “You cannot be this person fighting against -- because then you're taking away the voice of your client. And so that's the part like you have the radical doula, the fighting-for-this doula, but you cannot overshoot your client.” The inherent and consistent core of this method is the centering of the BP in relationship with all birth team members. Instead of “fighting” for a certain desire, the doula’s role is to facilitate connection moment to moment with hospital BSPs and BPs so that BPs wishes (which we know are often at the discretion of hospital staff and BSPs to fulfill) have the best odds of realization. Concurring with Vanessa’s thought of “overshooting the patient” Martha described situations where “[doulas] somehow make themselves more important.” I note this relational observation by Martha as direct evidence supporting Vanessa’s method. Importantly, while Martha asserted that a doula’s role is to “facilitate a plan that is comfortable for all involved,” Vanessa’s unique method leans into facilitating alignment and comfort around the BP and their plan, which is centered at all times. This difference is critical in successfully advocating for BPs through this holistic method. For example, Vanessa describes a situation where the BP begins feeling uncomfortable with a nurse and expresses that she wants a different one because “she’s not helpful”:

Vanessa: So, what I do is try to make ways for communication to go smoother so that the clients wishes are observed. I'm like “Hiii -- how's it going?” [to the nurse] I'll ask whatever question but then I say, “Did we look at the birth plan because, if not, they have one here.” [nurse speaking] “Oh yeah. I looked at the birth plan.” I'm like “Oh ok! Which parts of that can we go over and make sure it's ok right now?”…. [nurse speaking] “Ok. All right. Well, let me see.” And I say, “Well if you can just go over what works or not... Some hospitals are better at it than others.”… It gives [the BP] a rejoinder that [the nurse] cares about communicating with the patient. That she cares about her wishes. So that changed the energy there. [The nurse said] “Ooh. Ok. I'll do that when I come back.” …. I told my client, oh I think she just hadn't read your birth plan yet, but I think she was just irritated that there was a doula.
Vanessa positively engages the nurse and does not let her dismiss the birth plan of her client. She doubles down on faith in humans to connect and hospital BSPs to care. Even when other BSPs are “irritated” with her presence as a doula she is direct, firm, and is able to coax even resistant medical BSPs into communication that ultimately serves her client. She does not conform to traditional expectations of doulas in hospitals who are restricted by norms that forbid directly speaking to staff and doctors. This frees her to support BPs fully and changes the dynamic in the labor and delivery room considerably. I would argue this method plays a role in the fact that despite a twenty-year career in birth work, she is the only doula who reported witnessing little to no OV or mistreatment.

**Julia -- reimagining L&D nursing**

Julia, like the other BSPs featured in this section, shows strong commitment to advocacy through relationship building. Her perspective as a Latina mother and first-generation immigrant to the U.S. informed her understanding of how the BIC could better serve people. Julia describes her job as “a clinical intervention really.” Her nursing role is to attend to the baby just after birth until the BP and infant are taken to their postpartum room. She helps with the “bonding experience” between BP and baby including skin to skin and breastfeeding and answers any questions. The clinical benefit is that babies have fewer issues with regulating temperature and blood sugar. While her job requirements are to focus on the baby, she talks about the ways she advocates for BPs and supports their health and well-being in the process.

Julia: If I notice anything off or [the postpartum nurses] are not really, you know, providing that education or if the patient has constantly said, “I'm just really dizzy. I feel like I'm tired.” I will go and I will say, “Listen if you are ever unsure about what you're feeling I need you to press your call light, or I need you to tell your nurse, or when you go upstairs don't be afraid to look for any personnel that is trained for breastfeeding help.”
As Julia outlines, an additional area of anti-OV programming in which nurses are in the position to excel is staying alert to BPs’ needs immediately postpartum. BPs are often understandably overwhelmed shortly after birth and may not know which symptoms are concerning or when or how to ask for help. Julia normalizes attention of the hospital staff for BPs after a baby arrives (particularly for her first time and Spanish speaking BPs), and also reminds them to let a nurse or someone know if they are not feeling well. This kind of advocacy may seem insignificant, but securing support and information in the immediate hours postpartum may be crucial in preventing serious and life-threatening complications.

The elements of the job Julia describes that focuses on connecting babies and BPs to best clinical practices after birth for the baby’s benefit, largely overlaps with common desires of BPs. It would make sense to expand her job description (and pay) to focus on the BP during this time as well. The role could include education of BPs on all of the resources available to them in the hospital for support, encouraging utilization of free services and nurse’s assistance (as Julia is already doing), as well as providing a check list for postpartum symptoms to watch for vs. what is expected. This nursing role could take on the work required to monitor immediate blood loss through quantitative means as opposed to visual assessment (ACOG 2019). Additionally, training interpreters specifically to work in the labor and delivery setting can improve the experience for diverse language speaking BPs (Maher, Crawford-Car, & Niedigh 2012).

Julia actively seeks to engage and mentor anyone, and particularly Latinas, who show interest in nursing. In doing so she is working towards building a collaborative community of diverse birth professionals beyond the Black/white binary. Julia also expands on the idea of cultural competence in nursing culture and its limitations:

Julia: I think it's underestimated. Like [people think] anybody who went to nursing school and took a cultural nursing class can just go out there and be culturally
appropriate. I think they think that's just what happens—but it's not. You gotta have a little bit of background…I think that nurses…should really be going to conferences or volunteering in low-income or in communities where it's mainly Hispanic or Asian population.

Julia sees the incomparable value of her multi-cultural experience in her nursing work. She would prefer colleagues to be direct and inquire more about the large Hispanic population of BPs at her hospital and seek real world education instead of believing stereotypes passed down from nursing preceptors who did “their training twenty years ago.” Implementing community-based outreach programs that expose BSPs to the people they serve, possibly through education or other forms of relationship building, would help towards this end.

Overall, the methods and ideas presented by Jennie, Vanessa, and Julia share an interest in linkages at all levels and in the particular recognition of BPs as their fully human selves worthy of individual consideration and effort. I argue that this authentic interest, often driving midwifery practice, is care and the action of moving toward it might be called love (hooks 1999). In each of the previous examples we can also see the energy of emergent strategy, utilized by these BSPs on behalf of BPs, that focuses on the power of transformative relationships to advance repair and wholeness in the BIC in both big and small ways (brown 2018). Leading change and dismantling oppressive systems in the BIC with love-based advocacy, as many are already doing, is an anti-racist, pro-human, and community-building practice. BPs across the globe deserve nothing less.
6 CONCLUSION AND LIMITATIONS

In conclusion, the guiding strategy of this project involved uncovering the ongoing workings of the BIC to reveal dynamics of power as encountered by laboring people in hospitals. My study is limited by its small interview sample size and specifically the lack of OB informants. It is also limited due to the selection bias for BSPs who knew the study was about difficult hospital births. It is possible that some medical BSPs feel threatened by this topic or are simply not interested or concerned. As such, it is important to better understand the perspective of BSPs for whom OV is accepted, internalized, or not viewed as problematic. To gain this specific information a more targeted recruitment strategy and set of interview questions is needed. I am also limited by time in this dissertation as a wealth of information exists in many pockets of the landscape I uncovered that could be more extensively excavated and analyzed. The strengths of my study include the combination of content analysis and semi-structured interviews as well as use of popular and academic sources. The dynamic aspects of my data allowed me to observe and analyze connections across sites and sources in distinctive ways important to understanding OV as a global concept. Using content from across the world available digitally broadened my analysis of OV while talking to individuals locally gave insight into the highly contextualized nature of the concept. The combination of textual analysis and in-depth interviews allowed me to unearth connections between discursive and personal accounts of OV in hospital birth. It also permitted me to analyze relationships of authority vs. agency with an eye towards birth justice. I conducted this study with the understanding that the terrain of birth across the world, from preferences to outcomes, is tangled and vexed in many ways. The norms of birth practices around the world are situated within and dependent upon economies and governments that issue sanctions and regulate individuals’ access to various reproductive options and services.
Additionally, the interaction of global and local stratifications of class, race/color, gender, sexuality, ability, and citizenship status influence the structural barriers faced and unearned privileges afforded to individuals within health service systems. In other words, people experience birth universally, but it is not a universal experience.

Obstetric violence is part of the organized violence inherent to colonialism upheld by beliefs of medical supremacy. As such, birth is an incredibly important site for embedding and fulfilling goals of a flexible but (so far) permanent racial hierarchy (connected to class, sex, gender, ability, etc.) (Omi and Winant 2015; Christian 2019). At the same time, this site is energized with unique knowledge, opportunities for agency, and the unbroken will to push back against seemingly immovable systems. Given these data, the history of perinatal health, and the consensus that structurally-focused and community-based anti-OV interventions are necessary, a widely-utilized reproductive/birth justice framework is imperative for this work. What remains to be seen is whether or not dominant birth organizations, activist groups, and political leaders can leverage resources and follow the lead of reproductive and birth justice advocates globally. This shift in advocacy, from the goal of everyone having “human rights” in childbirth, to one supporting the humanity of every birthing person first and foremost is nuanced but important and does not mean one is sacrificed for the other. It does require the prioritization of seeing birth as normal and all people as fully human and deserving of health when making demands for childbirth rights.

In light of the current push for reckoning within institutions, this study contributes a unique look at hospital birth and the ways that contemporary violence in obstetrics is understood and may be challenged. I hope that future research will focus on the perspective of MDs and OBs in the BIC as well as all professionals who are leading successful community-based perinatal health
programs. Illuminating the material ways that over and under-medicalization during pregnancy and birth can be addressed while interrupting the status quo is crucially important. We need to implement policy that gives BPs choice in birthplace and provider while supporting ongoing BP autonomy and understanding during pregnancy and birth. Every policy should include explicit actions/standards for hospital BSPs and must be evaluated in an ongoing manner. Additionally, we should prioritize research in the U.S. that highlights the ways that particular models of government funding through Medicaid serve to perpetuate OV and incentivize the exploitation of BPs. Generally, my findings contribute to research on the MIC that indicate the routinized aspects of medical service provision and associated problems for patients related to participating in, deciphering, and meaningfully integrating the medical narrative need serious attention. An emphasis on holistic patient care, medicine as a tool for overall health, and conversational consent could improve all clinical practice. Most importantly my study adds to an ever-growing body of work from social scientists around the world seeking to better understand and improve the plight of birthing people today. We should seek ways to build and sustain collaborative global networks of researchers and practitioners who work to support BPs around the world in improving perinatal health at all levels. I recognize the galvanizing force of work in and outside of the academy by queer people of color who are dedicated to improving birth in the U.S. I hope the findings of this project will benefit those already working tirelessly toward dismantling systems of violence within institutions and building something new that works better for each of us. Finally, any work supporting reproductive life with an aim to improve the quality of choices therein for everyone must incorporate an awareness of a complicated and rich reality. This reality is available all around us (Birth Justice Resources - Appendix D).
Reimagining and transforming the BIC can begin in the medical training complex with teaching empathy, along with courses about racism, sexism, genderism, heterosexism, ageism, and ableism in medicine. Because birth is a unique life event often thrust onto a medical stage, when that situation occurs, it calls for particularly intentional medical translation by BSPs. OBs, nurses, anesthesiologists, and anyone coming in contact with BPs in the hospital should be required to complete education including communications skills and ethics trainings that focus specifically on obstetric violence. In addition, practical tools like evidence-based bundles for common medical complications and whiteboards that enhance communication and BP autonomy should be widely implemented. Language interpreters with specific perinatal health and labor training should be required for hospitals serving non-English speaking populations. We can also pay BSPs for the emotional labor involved in the recognition of all BPs and their individualized compassionate care by adding these specifications as line items to their job descriptions. Finally, we can support and compensate BIC workers with ongoing counseling and wellness benefits based on their suggestions and needs.

While developing intentionally pro-human birth policy aimed at structural issues we can simultaneously employ the use of anti-OV techniques and interventions that focus on relationship to enhance physiological birth and ground the personal experience for BPs. At each step of reimagining, it is crucial that we listen to birth workers from Black, Brown, indigenous, and queer communities. The burden of implementing strategies to thrive in the BIC should not be unfairly placed on the very people who are the most vulnerable in this system (Pascucci 2020-PC7). I am hopeful the cross-racial/ethnic collaborative work beginning in the birth world will grow and that transnational movements will also continue to develop.
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APPENDICES

Appendix A

Semi-Structured Interview: BPs

Thank you for taking the time to speak with me. I’m going to get started by asking some questions about your background and life experience up to this point. Then we’ll talk about your experience with hospital birth.

1) Background/childhood:

- Where did you grow up?
- How would you describe your childhood in general?

2) Background/current:

- Where do you live and what brought you to ATL?
- Can you tell me a little bit about your family life now? How many pregnancies? Kids?

3) Parenting:

- Tell me about how you became a parent.

4) Pregnancy experience:

Please describe any and all pregnancy experiences that you would like to share. We will end with the experience that lead to the birth that compelled you to participate in this study (if more than one please detail all that apply).
• Can you tell me a little bit about how you became pregnant?

• Was it relatively easy? If no, what was most challenging?

• How was being pregnant for you? What kind of support did you have?

• Did you have any complications or difficulties?

5) Birth beliefs/thoughts:

• What did you think or believe about birth when you were a child? Where did these thoughts or beliefs come from? Family? Friends? Religion/Spirituality? Other? Do share similar opinions and beliefs about birth with your friends and family?

• How do you think these things impacted you?

• How did you prepare for the birth/s of your child (ren)?

• Did you have a birth plan? How did you come to that plan? Was there anything specific that you were especially concerned about happening or not happening? (Golden Hour? Immediate Breastfeeding?) Did you visit the birth center or hospital in advance?

• Did your plans, opinions, or beliefs about birth differ from your family/friends?

• What were your fears about birth? Hopes?

6) Birth experience big picture:

I'm going to ask some questions about your birth experience now. Please answer these questions while thinking about the birth that compelled you to participate in this study.

• How would you describe your birth experience with (name) overall?

• Can you give me a nutshell version of what happened?
• About how long was labor?
• Who was with you?
• Are there any particular moments you remember vividly or go back to often?

7) Birth experience medical:
• Any complications during labor for you or baby? Immediately postpartum?
• What kind of decisions came up during labor? Medical, personal, otherwise?
• What about immediately after the birth? Medical, personal, otherwise?

8) Birth experience subjective:
• When you look back on it, what was the most difficult part of the birth process for you?
• How did you feel about the experience immediately afterwards? How about now?
• Has anything you believed about birth or early parenthood before you had a child changed?

9) Birth experience autonomy/authority:
• Can you talk about your ability to be active in your own care when you were in the hospital? How active were you able to be in what was happening?
• If you felt unheard or shut down, tell me more about that. Why do you think that was?
• How do you feel about the way your desires and wants were respected? Or not?
• How do you feel about the way your needs taken care of? Or not?

10) Birth experience support dynamics:
• How supported did you feel during your birth?
• Who offered the most support? Provider, staff, personal team? What were the ways you felt most supported? Who was least supportive? Provider, staff, personal team?
• Can you remember a specific time/moment you felt least supported? Most supported?
• If you had a birth plan (written or verbally expressed), how do you feel it was regarded by staff, your provider, or personal support team?
• How did your personal support (team?) interact with the hospital staff? How about with your provider?

11) Birth experience transgressions/violence:

• Were there any troubling incidences with the doctor/midwife or hospital staff throughout labor or immediately afterward? (Validation)
• Can you tell me more about what happened? What did you say or do next?....What happened then?....
• Where there any points of contention during your hospital experience? What happened? Did you report it? Why or why not? How was it resolved?
• Have you heard the term traumatic birth? Obstetric violence? If yes, where and how did you learn of it? What are your thoughts on the concept(s)?

12) Birth experience consequences:

• How do you think your birth experience impacted your early days of parenthood?
• How might it still influence you today?
• Did your birth experience help you learn anything about yourself?
(If negative thought/belief – validate – and provide alternative idea focusing on the fact that many people feel this way and point to structures and systemic reasons for their experience.)

13) Wrap-up:

- Considering everything you know about birth and new parenthood, if there was one thing you could tell people before they had their first baby that might help them prepare for the experience (birth or otherwise) what would that be?
- Do you have any thoughts, ideas, or theories about any part of birth, parenting or family life that you think are especially important?
- Would you consider yourself a feminist? If yes or no - What does that mean to you? Do you think this influences your perspective on childbirth or your personal experience of birth.
- Is there anything I didn’t ask that I should have asked, or anything you want to add that we didn’t talk about?

Appendix B

*Semi-Structured Interview: Providers*

Thank you for taking the time to speak with me. I’m going to get started by asking some questions about your background and life experience up to this point. Then we’ll talk about your experience as a provider with birth.

1) Personal Background:

- Where did you grow up?
- How would you describe your childhood in general?
• What did you think or believe about birth when you were a child? Where did these thoughts or beliefs come from? Family? Friends?

• How do you think these things impact the way you practice?

2) Career Background:

• What lead you into your current career? How long have you been practicing?

• Can you tell me a little bit about your current practice? Where is it located? What population do you serve? Has this changed over time? How so? And Why?

3) Current Practice:

• Did you always want to be a ______? Yes or no- Can you tell me more about that?

• How well do you think your training prepared you for what you do now?

• How would you describe your practice philosophy?

• What do you find to be the best thing about being a doctor/nurse/doula/midwife?

• What about the most challenging?

• What is a typical week in your practice like?

6) Birth experience big picture:

• How has working with birthing people either confirmed or changed the way your think about birth?

• What is your biggest fear regarding your practice?

• What about your greatest hope?

7) Birth experience medical communication:

• How do you handle communicating regarding interventions/complications during labor and immediately postpartum?
• How do you handle decision making during the birth process?
• In what ways do you practice cooperative decision making?
• How do you understand the idea of cultural competency? Can you tell me how this is reflected in your practice?

8) Birth experience autonomy/authority:
• What is your take on birth plans?
• How do you support your patients’ autonomy?
• What does “patient-directed care” mean to you?
• Most providers (doctors/midwives/etc) do not care for birthing people in isolations. Describe how patient expectations, hospital policies, and other external factors interact with your care during birth.
• Do you ever encounter conflicts between patient expectations and hospital policies (your own practice)? How do you manage this when it comes up?

9) Birth support dynamics:
• How would you describe your relationship with the hospital staff? Can you talk a little bit about that dynamic? How does it change in various circumstances?
• How about with your patients’ personal support (teams)?
• Have you experienced conflict during your career with hospital policy? staff? doulas? birthing individuals? What happened? How was it resolved?

10) Birth experience subjective:
• What is the most difficult part of the birth process for you as a provider, in general?
• Has there ever been a birth or births that you found particularly difficult? If yes –
  Can you describe that/them to me?
• How did you feel about the experience immediately? How about now?

11) Birth experience consequences:
• Have you encountered the idea of traumatic birth in your practice? With patients?
  Personally?
• Do you have any support in processing difficult experiences on the job? Please
describe those.
• How do those experiences influence you in your work? Everyday life?

12) Wrap-up:
• Considering everything you know about birth and new parenthood, if there was one
  thing you could tell people before they had their first baby that might help them
  prepare for the experience (birth or otherwise) what would that be?
• Do you have any thoughts, ideas, or theories about any part of birth or early parenting
  that you think are especially important?
• Is there anything I didn’t ask that I should have asked, or anything you want to add
  that we didn’t talk about?

Appendix C

Initial Screening Questions

1) Can you tell me a little bit about what was most troubling for you about your experience
   with hospital birth?

2) Would you feel comfortable discussing your experience in a group format with other
   people who also had difficult hospital birth experiences?
*If screened out, I will send resources that may be helpful for additional support.

Appendix D

Birth Justice Resources

Practitioners/Educators/Activists

@iamjenniejoseph
@drnicolerankins
@chinatoliver
@theblackdoula
@mamatotovillage
@cornerstone.birthwork
@kaydenxofficial
@kulunturjc
@empoweredbirth project

Advocacy Organizations and Training

www.globalforceforhealing.org
http://www.sparkrj.org
https://www.nationaladvocatesforpregnantwomen.org
https://birtherightsbar.org
https://blackmamasmatter.org
https://www.badoulatrainings.org
https://www.elephantcircle.net/our-model
https://www.ancientsongdoulaservices.com
https://transfertility.co/about

Videos

LGBTQ people and fertility

https://lgbtqpn.ca/library/scenes-from-a-fertility-clinic/?doing_wp_cron=1441587387.7621450424194335937500