ADDRESSING THE DOULA PARADOX: AN ANALYSIS AND REIMAGINING OF A CHANGING ROLE IN REPRODUCTIVE JUSTICE

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ABSTRACT
The history of obstetrics and obstetric violence shows that, historically, midwifery has been just as safe, if not safer than in-hospital birth. Using Michel Foucault’s Discipline and Punish as a theoretical framework, we can see how hospitals, like most social institutions, function as disciplinary forces for social control. In this article, I analyze the hospital doula as an example of Foucault’s docile body to demonstrate how doulas act as reformists while indirectly furthering the medicalization of birth and the marginalization of the midwife within the institution through assigned subservience and cultural assimilation. In addition to textual analysis of other scholars’ work on birth and birthing in the US, I employ narrative theory and autoethnography of my several years’ experience as an in-hospital doula to reimagine the doula’s role and propose sustainable and practical solutions to obstetric violence and medicalization. I argue that doulas, as midwifery advocates, can assist in shifting the birthing paradigm from obstetrics to midwifery by dispelling myths about home birth and by informing clients about the safety of midwife-supported pregnancy and birth.

KEYWORDS
Doula, docile body, institution, medicalization, midwifery, obstetric violence.

THE DOULA: AN EXPANDING AND EVOLVING ROLE

The term “doula,” a Greek word for female slave, is now associated with a modern definition first coined in 1973 by author Dana Raphael and codified by Doulas of North America International (DONA), the world’s first and largest doula training organization. According to DONA (2020), a doula is defined as “a trained and experienced professional who provides continuous physical, emotional, and informational support to the mother before, during, and just after birth.” While there are various definitions of what a doula is and does, DONA’s definition describes the basic outline of a doula’s accepted role in Western medical circles. There are many people who hire doulas and still prefer (or require) a medicalized approach to their maternity care because they are comforted by the hospital setting or have technocratic or surgical births. However, in this paper I focus on those individuals who desire little to no intervention, who have uncomplicated pregnancies, and who actively wish to resist external control of their pregnant-birthing bodies. My goal is to provide an analysis of the systems involved in the control and domination of the reproductive body, specifically in the birth space, and to offer solutions for doulas who wish to reclaim birth from violent obstetrical structures and return control to the pregnant people themselves.

My findings build on the more recent turn in doula circles towards “radical” and “full-spectrum” care that covers all reproductive health choices, including abortion and adoption. This turn is rooted in the reproductive justice framework, which The Reproductive Justice Media Guide describes well:

The reproductive justice framework is rooted in the recognition of the histories of reproductive oppression and abuse in communities of color. This framework uses a model grounded in organizing women, girls, and gender non-conforming (GNC) people to change structural power inequalities. The central theme of the reproductive justice framework is a focus on naming and eliminating the control and exploitation of women’s bodies, sexuality, and reproduction as an effective strategy of controlling people, particularly women of color, trans and GNC

The histories of reproductive oppression and abuse in the United States date back to the beginning of the development of gynecology as a science, when enslaved black and brown women were forcefully subjected to medical experiments (DeGruy, 2015). With this in mind, we recognize the potential to heal deep ancestral trauma felt by many people today by de-medicalizing birth and revitalizing midwifery care.

My evidence overwhelmingly opposes medicalization and supports the reintegration of a social model of care. I find that through assigned subservience and cultural assimilation in the hospital setting, doulas act as reformists within the very patriarchal and capitalist structures they set out to dismantle; they even indirectly further the medicalization of birth and the marginalization of the midwife. This leads me to a hope of reimagining — I hope doulas will begin a realistic reimagining of our role in society. Let us begin to dismantle the medical model of birth altogether by reclaiming our bodily autonomy through the revitalization of midwifery care. To this end, may my paper function as a call to action.

METHODOLOGY: AUTO-ETHNOGRAPHY

Since modern doulas are a relatively new addition to the birth scene (1960s), they have been the topic of very minimal qualitative research. I add to this small literature by combining textual analysis, narrative theory, and autoethnography from my time as a practicing in-hospital doula. At nearly every birth I have attended since 2008, I have done my best to maintain written records of the events to provide accurate birth stories for my clients and for my own later reflection as a researcher. Sampling from these sources, I depict what I witnessed to be the average hospital birth experience for my clients and the pressure I felt to assimilate into hospital culture while also resisting it—what we call the doula paradox. Whilst using self-reflexive investigation to explore excerpts from my personal doula stories (with names changed for client privacy), I interweave my experiences with quotes from scholarly work and doula narratives to explore the larger cultural, political, and social contexts of doula work.

THEORY: FOUCALDIAN LENS ON DOULA CARE

From Michel Foucault’s Discipline and Punish, we understand that hospitals function as a disciplinary force for social control, like most social institutions. I argue that the doula is restricted to a role of subservience within the institution and is forced to assimilate and comply with prevailing medicalized systems to remain tolerated by the obstetrician—an embodied form of institution. While the doula may act as an embodied form of protest by inserting herself into the institutional domain with the intention to reform it (or oppose its interference in the birthing event altogether), she is often reduced to docility since she must operate within the confines of institutional rules and regulations in order to maintain her presence in the hospital space.

Applying Foucault’s concept of the docile body to an analysis of the hospital doula’s place in the socio-medical hierarchy, we begin to see the doula as an embodiment of pathologized protest (Foucault, 1975). Such “pathologies of female protest,” Bordo (1993, p. 324) explains, “function, paradoxically, as if in collusion with the cultural conditions that produce them, reproducing rather than transforming precisely that which is being protested.” In the doula paradox, most doulas seek to defend and protect physiologic birth in American society while simultaneously reinforcing institutional discipline of the body. Thus, a pressing imperative in reproductive justice work is that we recognize the doula’s existence at the intersection of feminist dissent and maintenance of the established order. The technocratic domination of the reproductive-birthing body is so normalized that pregnant people only indirectly challenge structural violence and obstetric threats to their autonomy, biology, and psychology by hiring a doula. I argue that in their role as docile protestors, hospital doulas can only mitigate, not eradicate, this obstetric violence; this role should be a temporary tactic to resolve the doula paradox, achieve better birth outcomes, and transition to widespread midwifery care.
The institutionalization of obstetric violence: technocracy, commodification, and patriarchal professionalism in medicine

Beginning in the late 1800s and early 1900s, the establishment of for-profit hospitals and the accompanying institutionalization and specialization capitalized on physicians’ higher status and their perceived medical authority—in comparison to at-home, female healers (Feldhusen, 2000). At this time only men were trained as obstetricians, as women were understood to be “emotionally and intellectually incapable of learning and applying new obstetric methods” (Litoff, 1982).

In 1915, Dr. Joseph DeLee, later known as “the father of modern obstetrics,” described childbirth as a pathological process in need of intervention. DeLee insinuated that midwives were uneducated and dangerous and that all women must birth in the hospital, which fed into racist propaganda that defamed midwives and their patients (mostly women of lower socioeconomic status, women of color, and immigrant women). DeLee claimed that midwives lowered the “dignity of obstetric art and science” due to their community and cultural ties (referring to the more humanistic and holistic approach of what we now call the social model of care—in contrast to the medical model) (Leavitt, 2015; Wagner 1994).

DeLee’s work as a part of the patriarchal and commodified medical industry laid the foundation for the sexist framework from which obstetrics operates to this day: the competent-physician-versus-incompetent-midwife belief system. Midwives have been barred from policymaking in maternal health care, making midwifery laws inconsistent and incomplete. This reinforces socioeconomic barriers not only for pregnant people desiring midwifery services but also for potential students seeking midwifery education. This system silences centuries of midwives’ accumulated birthing knowledge and leaves parents as passive non-agents in the birthing process. Essentially, obstetricians deliver the baby to the parent rather than the parent being the active birther of the baby (Wagner, 2001). Just a few years after DeLee denounced midwifery and determinedly promoted hospital birth, 30 to 50 percent of births began taking place within the hospital by 1960 (Feldhusen, 2000). Within just a few generations of medicalized birth, “women had given up almost all power over procreation to licensed professionals and state bureaucracy” (Institute for Anarchist Studies 2010).

Lauren Plante’s essay on the rise of cesarean surgery in the International Journal of Feminist Approaches to Bioethics (2009) describes how hospital births tend to have a dehumanizing “factory” feel. Gestation and parturition are viewed as mechanistic and linear processes; normality is defined as a strict timeline and specific sequence of events, any deviation from which is seen as abnormal rather than a variation of normal. As Plante points out, moving toward a more humanistic or holistic approach is not currently supported by the existing paradigm since capitalism is at the root of the commercialization of this physiological function. People wish for autonomy; yet parents are treated as units of production in the commodification of childbirth. Hospital administrations expect predictability, patient care pathways, and in-patient patterns. If we continue to normalize this approach to childbirth, Plante warns we will be stuck in it for a very long time.

The drive for convenience and monetary gain—along with the fear of liability and malpractice suits, not prognosis certainty (ACOG, 2012)—pushes an interventionist agenda in the modern technocratic medical system. Most routine intervention in labor and birth is unnecessary; many doctors and patients are unaware that intervention is truly harmful and obstructs a normal physiological process that often unfolds organically when left to its own timeline. These problems are particularly acute in the American maternity care system, which is the costliest in the world yet alarmingly and harmfully inefficient. For example, in the United States a routine vaginal birth and a surgical delivery costs an average of $8,775 and $11,525 respectively. California performs the most expensive cesareans in the country at a whopping $42,530 in Los Angeles (Mangan, 2016).

Obstetric violence is an institutional and state-sanctioned type of violence against women,
trans, and nonbinary people that occurs during all stages of pregnancy, childbirth, and postpartum in both public and private medical spheres. Financial exploitation, contrived interventionism, and technocratic dehumanization are all elements of obstetric violence. Obstetric violence is a grave violation of human rights to equality, integrity, health, freedom from discrimination, access to information, and reproductive autonomy. This form of institutional violence is responsible for a rise in maternal and infant health complications, severe psychological distress, trauma, and an increase in maternal morbidity and mortality. While not limited to the United States, obstetric violence is deeply intertwined in our systems of oppression and dominance. It is important to note that even if an individual obstetrician may not hold misogynistic or patriarchal beliefs themselves, the system in which they practice is a direct manifestation of that reality and can only be addressed through and by systemic change. Liberating doulas from their paradoxical position as hindered reformers and unwitting reinforcers of the medical order is only one step toward that vision.

THE DOULA PARADOX: AN AUTOETHNOGRAPHY

“The body,” as anthropologist Mary Douglas has argued, “is a powerful symbolic form, a surface on which the central rules, hierarchies, and even metaphysical commitments of a culture are inscribed and thus reinforced through the concrete language of the body” (Bordo 2004, p. 165). The following autoethnographic account is an example of how the rules and hierarchies of the hospital are promptly imposed on the pregnant body through the symbolic action of removing external identifiers (clothing) and replacing them with a commercial hospital gown.

The interventions begin as soon as we set foot inside the hospital room. My client is told to change out of their own clothing and into a hospital gown, a powerful symbol of smudging out their identity with an institutional imprint. Some clients have mentioned the gown makes them feel small, like a number. Some have said it feels dehumanizing. Many doulas, myself included, suggest bringing an item or two of clothing the person can wear during labor, like a favorite pair of socks or a warm scarf that smells like home; this helps to subtly humanize the experience. However, I would often ask myself, what if they just stayed home and birthed with a midwife? Only then would humanization be all-encompassing; it would be the foundation, the very fabric of the birth experience. In the hospital, the routine is highly predictable. The hospital gown goes on. An IV catheter is placed. Food and drink are restricted. Various monitors are attached to the pregnant body. The focus then shifts from parent to fetus. Once the monitors begin chirping, the attention shifts from biology to technology. This is generally when the individual’s agency is lost. What is found on those monitors is what dictates the ebb and flow of their experience. I have seen instances where where nurses failed to look at the parent altogether — they simply walk in, consult the screen to check contraction frequency and fetal heart rate, then leave the room. This is when the doula’s role is significant. She does not watch the monitors; she watches the laboring person. She becomes interwoven with their experience, with her environment, both internal and external. Doulas are professionals at riding the waves of labor, intuitively navigating birth and institution simultaneously.

“Our conscious politics, social commitments, strivings for change may be undermines and betrayed by the life of our bodies—not the craving instinctual body imagined by Plato, Augustine, and Freud, but what Foucault calls the docile body, regulated by the norms of cultural life” (Bordo 1993, p. 165). The following example of society’s undermining of our body’s instinct involves a client who, during her prenatal appointments with me, spoke of refusing induction and her intuitive ability to trust her body’s birthing instincts. She was very adamant about not wanting an unnecessary induction; yet as soon as her obstetrician suggested it, she complied without further discussion of her concerns or questions.

Melissa, according to her dates, is 38 weeks. During her prenatal appointment with her doctor, she agreed to a labor induction the following morning using misoprostol, also known as Cytotec. The induction was not medically indicated, but a mere suggestion by her doctor. She called after her appointment to ask what I thought. I spoke carefully, “Well, ultimately it’s your decision, but I can send a few studies that have been done. Did your
“…doctor cover the risks and side effects?” She cleared her throat, “Not really, no. He was in a hurry.” I said, “Ok, I will email pertinent information as soon as I get home tonight.”

“Adhering to the rules the clinics impose, and balancing that with wanting to provide empathetic care, gives rise to a lot of gray areas. This is possibly the hardest thing to navigate as a doula” (Mahoney and Mitchell 2016, p. 129). Continuing with the previous doula narrative, we begin to understand where doulas must navigate immense challenges at the intersection of bureaucracy and social care. Laboring people are denied food and water and instead are offered ice chips or popsicles. Laboring while hungry only serves to create more challenges for parent and fetus. As a doula, I understand there is no medical indication for fasting during labor – yet how do you suggest a client eat if hungry against hospital policy?

The next morning, I’m at Melissa’s side as a small dose of misoprostol is inserted vaginally and placed against her cervix. I’m not sure what to expect with this drug, I have only read stories about Cytotec being a dangerous drug with increased risk of uterine rupture, fluid embolisms, and fetal demise. I try not to think of these things as I massage Melissa’s swollen ankles. As we wait for the contractions to start, we joke and laugh with her husband Marcus who is unusually talkative. The excitement in the room is palpable and a loud growl erupts from Melissa’s stomach. “I only had time for peanut butter toast and some watermelon this morning. I’m starving!” Marcus turns to me, “She can’t eat now, can she?”

“[Doulas] wish we could make it easier for women. But that road leads to madness; we can’t lubricate the system more than we already do. There are no heroes in bureaucracy” (Mahoney and Mitchell 2016, p. 107).

I answer, “Well, hospital policy says no. For most women, midwives generally encourage eating whenever you feel hungry. Your body is working hard, it only makes sense to nourish it, right?” They both nod in agreement. I remind them, “But again, hospital policy.”

“[The woman] is invited to be an agent of her own care in the web of bureaucracy” (Mahoney and Mitchell 2016, p. 104). Many clients over the years have attempted to reclaim their autonomy in the birth space only to be reprimanded by hospital staff.

Melissa shrugs. Marcus pulls a bag of Goldfish crackers from Melissa’s labor bag and just as he’s handing it to her, the nurse walks in to check progress. “Oh no, no! She should not be eating!” They both turn to look at me. I smile and acknowledge nurse’s authoritative language; I tell her Melissa is hungry and ask what she’s allowed to eat, knowing that many L&D units either have popsicles or broth to offer. “She can have a popsicle. I have red or orange flavored.” Marcus jokes, “Red is a flavor?” The nurse doesn’t laugh, but Melissa does, “I’ll take orange.” The nurse checks the monitors. Melissa asks Marcus to pass the water bottle. Just as he leans toward her, the nurse chimes in again. “No fluids either. I will bring a cup of ice with your popsicle.” Melissa sighs deeply and looks at me. I catch the first glimpse of defeat in her eyes, so I attempt to shift the mood by reaching for my doula bag for a box of essential oils. The first contraction starts, and she breathes through it beautifully. “What’s your favorite scent?” She smiles, “Do you have lavender?” I pull a bottle of lavender essential oil from my bag. As the nurse turns to leave, I can’t help but think of how a popsicle, essentially food coloring and sugar water, will affect Melissa’s blood sugar levels. She briefly mentioned her reactive hypoglycemia in a prenatal meeting with me and I worry food restriction will negatively impact her labor, affecting her strength and her mood. Again, I push these thoughts to the back of my mind and massage a drop of lavender into my hands. “Ohhh, that smells nice.” Melissa sighs and rests her hand in mine. Marcus turns the TV on; it’s football season.

“The human connection most doulas seek comes with a price—being exposed to what the underbelly of pregnancy and reproductive health care truly looks like in this country. Many suffer the loss of personal agency as decisions that should be private become politically and bureaucratically charged” (Mahoney and Mitchell 2016, p. xxi).

The moment Christina introduces me as her doula, the mood in the room shifts. The nurse shoots daggers with her eyes in my direction. I feel small
for a moment but remember this is familiar territory for me now. I smile and try to make peace, “It’s nice to meet you. Thank you so much for all the work you do for parents and babies.” She doesn’t respond or even acknowledge she’s heard me and instead turns to look at Christina’s charts. This is going to be a long night, I think to myself.

“Part of doula work—especially in the way we define it—is attempting to change systems by working within them. It means that we have to push back against the injustices we see in our clinical spaces by being lovers, not fighters. It also means that change can be frustratingly slow, as you are now operating at the microlevel. Doula work is able to bridge activism with individual care by helping pregnant people have empowered healthcare experiences and helping ensure that those experiences are voiced to society at large” (Mahoney and Mitchell 2016, p. 125).

Christina is now in active labor. Things are moving along smoothly, but not fast enough for the nurse; she suggests labor augmentation using Pitocin. Christina has music playing quietly on a boombox she brought from home and tells the nurse she wants to walk to get things moving. She wants to move, to dance, “to get free,” she says. We both laugh. The nurse clears her throat loudly and we both look at her expectantly, waiting for her to speak, but she just continues staring at the monitors. Christina looks back at me and silently mouths, “what the hell?” I stand and walk to the hospital bed, “Wanna do a few laps around the L&D floor?” Before Christina could answer, the nurse says, “You need to stay in this room.” Christina looks at me with frustration.

“We were warned at our birth doula training that there would be some antagonism between doulas and hospital staff when we started. Many hospitals don’t have supportive policies to facilitate a client-centered labor. Instead, birth is often treated as inherently high-risk, and it can be frustrating or even heartbreaking for the doula to witness” (Mahoney and Mitchell 2016, p. 49).

“Actually,” Christina says, quoting something she’d heard me say in a previous prenatal meeting, “walking helps things along. The movement helps get baby in a good position and helps stimulate the cervix.” I nod encouragingly. Without looking in our direction the nurse responds, “Don’t believe everything your doula says.” Christina opens her mouth to reply just as a contraction starts. Her breathing is now shallow and sharp, she’s vocalizing much more with this one than she did with any of the previous ones. I immediately realize it’s due to the tension the nurse is creating in the room. We breathe through the contraction together. As it ends, Christina asks if I can get ice chips. After returning to the room with a cup of fresh ice, the nurse is no longer in the room, but Christina is now in the middle of a contraction, her face wet with tears. I wait for the contraction to subside before acknowledging her tears, “what’s on your mind, mama?”

“The line of professionalism gets a little blurry, but so does the hierarchy that comes from a pseudo-therapeutic relationship. We’ve become very human to one another, all at once” (Mahoney and Mitchell 2016, p. 112).

“Will you bring me a wet washcloth? I don’t want her to see me like this,” she says softly, wiping her nose. “Of course. What happened while I was gone?” She looks at her hands on her belly, “I asked if we could just go for a short walk and she said walking won’t help, that I need to stay in bed. And then she said—” Christina let out a sob, shaking, the sound of defeat in her breath. I reach out to touch her arm. “It’s ok to feel overwhelmed. What she said wasn’t right. There’s plenty of evidence that walking helps.” She takes a deep breath and wipes her eyes with the wet cloth. She has hiccups from crying and we both laugh. “She said… I’ll want the epidural soon anyway. That it’s silly not to want it.” Christina’s breath catches in her throat as she speaks. I remind her to take a deep, grounding breath.

“You learn to read the energy in the room, the tone of her voice, the body language of those who come through the revolving hospital room door. You are to be a calming presence. [The doula] is both inured to and disoriented by this strange chaotic place—the tension between eminence and the nothingness, anticipation and the dire urgency” (Mahoney and Mitchell 2016, p. 85).

“I just don’t know if I can do this without an epidural now. I thought I could, but she makes me feel… I don’t know what to expect,” her voice
uncharacteristically weak. I hand her the cup of ice.

“Listen. You are so strong. Think of how strong you
and your baby are. You have overcome tremendous
odds already. You can do it; you’ve been doing it. You
have been preparing yourself for this for months.
As for the nurse, I’ll take care of that. Maybe she’s
having a bad day and I can try to lighten her mood.”

Another contraction comes. She breathes. I walk
over to the boombox and put on her favorite song,
then I turn the music up a few notches. Christina
lets out a deep sigh and smiled with relief. “Thank
you. I can’t imagine doing this without you.” I have
some great pep talks up my sleeve for Christina, and
an important peace-talk to have with the nurse in
the hallway, away from Christina’s worried ears.

“[Women who have given birth in the hospitals]
recount incident after incident of loneliness,
fear, frustration, humiliation, loss, and a deep
and guilt-ridden belief that they have missed
the most profound experience of their lives.
Evidence supports what many women have
felt for generations: that where and under
what conditions a woman gives birth greatly
affects the course of her labor, the normalcy
of her delivery, the health of her baby, and
the lifelong relationship with mother and
child. Childbirth is one of the most profound,
personal experiences a woman can have” (Arms
1975, p. xiv).

Jessica and I have spent some time during our
prenatal appointments together reviewing different
techniques to cope with pain. She marks on her
birth plan that she’d like to use upright positions,
walking, lunges, and that she would like to give
birth in a squatting position. She doesn’t like the
idea of being reclined in stirrups, she says it seems
disempowering.

“Plan to labor at home for as long as possible—
this is the key to reducing the risk of extra
medical interventions, as many doulas can
attest” (Mahoney and Mitchell 2016, p. 165).

The day comes. Jessica calls me at 11pm from their
tiny mountain home to say she’s in labor and
that she’s managed to breathe through intense
contractions for six or more hours now. Ryan gets
on the phone to tell me she puked in a box of his
favorite records, then laughs. They tell me they’re
making the trek down the mountain and that it’s
about a 45-minute drive from where they live to the
hospital. I tell them I’ll meet them there and that
Jessica did an amazing job laboring at home for as
long as she did.

“Doulas learn how to manage her body language,
when to step in and help, when to back off, the
timing of the procedure, and the culture of the
room” (Mahoney and Mitchell 2016, p. 94).

I walk into the labor room; Jessica is moaning
loudly. Ryan is leaning over her, rubbing her back.
The contraction subsides and Ryan turns to greet
me. “She’s getting the epidural. Things are moving
really fast and she wants relief.” I look to Jessica.
“Oh,” I kneel to meet her gaze. “Jessica, I hear you’ve
asked for the epidural and I know that’s something
you wanted to avoid. Now that I’m here, are you
sure you don’t want to try some other things first?”
She’s shaking, “I’m sure. It’s too much.” I stand
to help her up, “Ok, let’s get you comfortable.” The
contractions are coming on strong and fast. She’s
very vocal as we wait for the anesthesiologist. Ryan
and I are asked to leave the room while the epidural
is placed. We return once it’s done. Jessica looks
exhausted and relieved. I pull the curtain closed and
joke, “I hear you puked in a box of Ryan’s favorite
records?” We all laugh. “Well, maybe he won’t leave
it on the living room floor next time.” We all laugh
again. Within two hours Jessica is complete and
ready to push. The epidural has changed the game
plan and she’s no longer able to push in a squatting
position, so I suggest adjusting the bed so she’s
sitting more upright. The nurse stops us, “Jessica,
you’ll have to lay on your back for this. It’s the safest
position for baby.”

“The pathologies of female protest function,
paradoxically, as if in collusion with the cultural
conditions that produce them, reproducing
rather than transforming precisely that which
is being protested” (Bordo 1993, p. 324).

Jessica responds, “But we decided—” Her voice trails
off and she looks to me. I turn to the nurse to say,
“The supine position narrows the pelvic outlet, it’s
counterproductive. Her birth plan states the reasons
why she’s chosen to birth in a better position.” The
nurse becomes suddenly rigid, her back straight
and her voice shrill, “A BETTER position?” She
then turns to Jessica and Ryan. “Flat on your back
OPENS the pelvis, NOT the other way around!” I
feel my face burn red. I know this nurse is wrong,
but as a doula, I know I must bite my tongue and
and swallow my protest.

"Female pathology reveals itself here as an extremely interesting social formation through which one source of potential for resistance and rebellion is pressed into the service of maintaining the established order" (Bordo 2003, p. 177).

A butter knife could cut the tension in the room. I blame myself. I take it as another dose of humility as a doula. I should not have spoken directly to the nurse and I should have used softer language. This is what it feels like to be a new doula not yet understanding the politics of the birth room. I sit down in the chair across the room feeling defeated. Jessica lays back. The nurse claps her hands, "I'll let the doctor know you're complete and when I get back, we can start pushing!"

"The doula finds that she must make herself very small, very physically unobtrusive in order to stay out of the way" (Mahoney and Mitchell 2016, p. 86).

On her way out, the nurse glances at me condescendingly. I shrink. It's a feeling I know I'll become very familiar with as a doula. As the door closes, Ryan kisses Jessica's forehead just before she says, "Jasmine, don't worry. We know she's full of shit." Ryan laughs. I fake a smile as a lump settles in my throat. I blink back tears and take a sip of cold coffee. It's at this moment I realize Jessica and I are both expected to be compliant and quiet in the hospital room, despite her wants and her needs as the laboring person.

"The muteness of hysterics and the return to the level of pure, primary bodily expressivity have been interpreted, as we have seen, as rejecting the symbolic order of the patriarchy and recovering a lost world of semiotic, maternal value. But at the same time, of course, muteness is the condition of the silent, uncomplaining woman—an ideal of patriarchal culture. Protesting the stifling of the female voice through one’s own voicelessness" (Jaggar and Bordo 1989, p. 21).

The concept of the docile body is illustrated clearly throughout these autoethnographic accounts and can be applied to both the birthing woman and the doula. However, when we look at the doula's role in particular, we see how she is confined to a small space inside the birth room, rendering her almost invisible. The doula is only allowed to attend to the mother’s emotional and physical needs, not to challenge harmful obstetric practices. During births, the manifestation of the docile body is observable within nearly every labor in the hospital setting.

THE DOULA PARADOX: REFORM OR REVOLT

In her ethnography of doulas, sociologist Bari Meltzer Norman concludes that doulas are largely "apolitical" and "passive," and that "in trying to make quiet waves, doulas ultimately help along the current medicalized system of birth" (Norman 2007, p. 280). Monica Basile then poses an important question in her PhD dissertation, Reproductive justice and childbirth reform: "to what extent are doulas capable of creating institutional change in order to improve birth experiences and outcomes?" (Basile, 2012). I have heard countless new clients cite feelings of disillusionment or a defective, deadened, and fragmented sense of self after routinely medicalized first births as their reasoning for hiring me for subsequent births. In an effort to use doulas as a wedge between their bodies and the hospital institution, many clients assign hard-to-fulfill and problematic roles to their doulas: buffer, protector, even savior.

As proponents of "humanized" care, doulas profess values that align with their clients’ wishes to separate themselves from the institution. The tenants of humanized birth include: "putting the woman giving birth in the center and in control so that she and not the doctors or anyone else makes all the decisions about what will happen; understanding that the focus of maternity services is community-based primary care, not hospital-based tertiary care — midwives, nurses and doctors [must] all work together in harmony as equals—[and basing] maternity services on good scientific evidence including evidence-based use of technology and drugs" (Wagner, 2001).

Although 99% of birth in America take place in hospitals (Basile 2012), it is estimated that only 20% of women require some form of intervention in the birth of one child and
and may not require similar care in subsequent pregnancies; this means that “at least 90 percent of all birthing mothers can have normal, spontaneous births and have healthy babies” (Wagner, 2001, p. 56). Midwives are undoubtedly the safest birth attendant for low-risk birth according to American perinatologist and perinatal epidemiologist Marsden Wagner, Director of the University of Copenhagen-UCLA Health Research Center and Director of Women’s and Children’s Health for the World Health Organization (Wagner, 2001).

Birth is social by nature, which is why emotional support greatly improves birth outcomes. Since birth was historically supported by an informal and intuitive social model of the midwife, the home was the original and most appropriate place for it to take place, much like any other normal biological process. Birth requires privacy, much like sex and orgasm. In her TEDx Talk, childbirth expert Kate Dimpfl shares, “what gets the baby in gets the baby out.” This is common knowledge amongst the midwifery community, and it is essential in understanding the physiology of birth; according to Dimpfl, “The hormones in birth and sex are identical.” Thus, both sex and birth require similar environments for the smoothest experience to occur. The sexual nature of birth is best expressed in a space where safety and privacy are key. For many people, this translates to birthing at home. A World Health Organization (WHO) publication states:

> “It is important to remember that it has never been scientifically proven that the hospital is a safer place than the home for a woman who has had an uncomplicated pregnancy to have her baby. Studies of planned home birth in developed countries with women who have had uncomplicated pregnancies have shown morbidity and mortality rates for the mother and baby equal to or better than hospital birth statistics for women with uncomplicated pregnancies.”
> (WHO 1985, p. 86-87)

Moreover, most postpartum trauma, including postnatal post-traumatic stress disorder (PTSD), can be prevented with appropriate social care and – even more easily – by choosing to birth outside an institutional setting. According to The Birth Trauma Association, the leading cause for birth trauma is the type of delivery. The factors include labor induction, feelings of loss of control, high levels of medical intervention, cesarean section, impersonal treatment, being ignored or neglected, conflict with hospital staff, lack of information and/or explanation of procedures, lack of privacy and dignity, iatrogenic harm to infant, and poor postpartum care. While a few of these factors are caused by technological intervention, many are undoubtedly due to lack of social support.

However, unnecessary interventions are inevitable in the hospital even with the watchful eye of a doula. In my research I observed various tactics used by doulas who sought to better inform individuals on the range of normal labor and birth experiences while simultaneously reinforcing the cultural normalcy of hospital birth for uncomplicated pregnancies. Doulas use catchphrases like “informed birth” or “empowered birth,” which are merely half-truths since we often fail to mention the option of birthing at home – which drastically reduces the risk of unnecessary intervention. This silence implicitly normalizes medical birth. The reason for this silence is likely a lack of accessibility for many people: legislation and regulation create barriers and hinder affordability. It is one thing if a client chooses hospital birth because they desire pain medication and are comforted by technology; it is another to have a client who wishes to avoid medicalization altogether yet is left unaware of alternative options. Why is it that we encourage clients to plan an ideal anti-interventionist vision of their birth only to sit back and watch silently as they intentionally hire a trained surgeon whose pathologized view of the body will naturally lead to active management and intervention? As we all know, once a patient steps inside the hospital room it is no longer up to them what happens to their body. As activist and doula Mary Mahoney shares, “the truth is, once your client is at the hospital, whatever part of the spectrum of pregnancy care she’s there for, you have to work within the system that’s in place” (Mahoney and Mitchell 2016, p. 45).

When we consider American misconceptions
about birth as outlined by Suzanne Arms in Immaculate Deception, what role do doulas play in the reclamation of bodily autonomy? Is the role revolutionary or reformist? Do doulas seek to liberate or perpetuate the limitations of our freedoms? How do doulas participate in and perpetuate gender-based oppression in the medical industrial complex? From my own research, it is clear that the doula has become an appendage of the medical institution to provide the emotional support it fails to give; this led me to the idea of doula as reformist, not revolutionary change agent. The doula’s role as a change agent is limited by the medical system and by the encroachment of capitalism as doula care becomes increasingly commodified.

Many doulas with more politicized agendas claim the role is certainly open to continued evolution; it remains fluid, existing on a spectrum with vast variations in philosophy and praxis. This means they believe doulas are indeed radical change agents, the “birth justice wing” of the reproductive justice movement (Mahoney and Mitchell 2016). However, we still cannot ignore the fact that such wide variations in philosophy limit the potential for a cohesive movement with a shared end goal, thus leaving violent and oppressive structures unchallenged and reducing doula work to micro-level advocacy. In fact, I would argue that midwives are doing far more radical birth justice work by operating outside the confines of the medical establishment. The doula’s role is relatively new while the midwife’s role is as old as time and facilitates holistic birthing conditions with elements of social support not possible in institutional settings.

Small parts of this problem are being acknowledged in the ongoing cultural shift towards increased use of doulas. A New York Times article published in April of 2018, New York to Expand Doulas to Reduce Childbirth Deaths, describes a plan for a series of initiatives (including Medicaid coverage for doula support) aimed at addressing maternal mortality in New York, where the mortality rate for black mothers is alarmingly high. The announcement created an uproar in the NYC doula community and beyond; some celebrated it, while others (myself included) expressed deep criticism and skepticism. The widespread acceptance and push for standardization of doula support in the medical setting takes focus away from midwifery revitalization and systematically assimilates doula care into the standard medical model. It is no surprise that leading childbirth experts continue to urge against this. If our allegiance as doulas lies with families and community rather than with medical institutions and industries, then we should support the establishment of accessible midwifery education in every state, fund midwifery campaigns, and encourage insurance companies to cover traditional midwifery care.

CONCLUSION

I have since decided to step away from hospital doula work. The very last birth I attended in 2018 was marked by deep trauma and overwhelming defeatism. I will never forget the sound of the woman’s sobs as she shook, gripping my hands, repeating her fear of cesarean over and over; the obstetrician stood over her, insensitively and smugly saying “it’s not your fault you were born with this body.” I was filled with rage as I thought, how dare she. How dare this doctor, a fellow woman, tell this woman her body is broken. I knew the baby hadn’t been born yet because she’d labored hard for 24 hours with no food. Her maternal exhaustion was clearly caused by the institution’s denial of nourishment in addition to the Pitocin drip continuously forcing her uterus to contract without rest. Her body was not broken. She was caught in a broken system. Her body was not broken. She was caught in a broken system. She was denied sustenance in labor only to be told it was her fault for not sustaining; this not an uncommon occurrence. I suppressed my own grief to soothe her, comfort her, and remind her of her strength. After she was wheeled to the OR, I decided I could no longer bear witness to these routine systemic abuses.

I hope this paper and my own narratives serve as arguments for the liberation of the artistic impulse in birth work— a re-imaging of the doula’s role as midwifery advocate, as defiant protester, and as radical change agent. The doula, much like the midwife, guides and supports people. But unlike the midwife, the doula must operate within the confines of the obstetric system—as a kind of Foucault’s docile body. The doula’s position in the hospital space speaks to the symptomatic
invisibility she experiences at the very bottom of the institutional hierarchy. Her role is undeniably beneficial in terms of risk and intervention reduction, but her role is also undeniably restricted by policy and politics. The conventional doula’s role is indeed a form of pathological protest — a metaphorical band-aid (emotional support) for a rampant systemic infection (obstetric violence and the medicalization of birth).

I do not dismiss the fact that doulas are on the frontlines of reproductive justice work but urge a reprioritization of midwifery revitalization. If we are to shift away from technocratic culture into a more humanistic one, we need far more midwives to meet such a demand. Thus, a focus on accessible and affordable midwifery education is imperative. Doulas can easily support midwifery by dispelling myths about home birth and by sharing information about the safety and benefits of midwifery care. If a client says she wants to avoid medicalization, doulas should be prepared to discuss options for care-providers, as many times clients are unaware of local midwives or birth centers in their state. If a client decides on midwifery support, the support of a doula at home is still just as beneficial as it is in the hospital—not to mention it can relieve the midwife of some of her social duties so that she may be more attentive to the more clinical duties.

Each individual and their collective life experience is unique. As doulas, we always support informed decision-making, whether that includes an elective surgical delivery at the hands of a skilled obstetrician or a freebirth wherein the act of resistance is full rejection of all assistance other than the birther’s own instinctive hands. Neither is wrong nor right, as long as basic dignity and respect is practiced and intact. This is what reproductive justice is all about — total liberation and autonomy. In Jessica Gonzalez-Rojas’ and Kierra Johnson’s words, “reproductive justice is not a label—it’s a mission. It describes our collective vision: a world where all people have the social, political, and economic power and resources to make healthy decisions about gender, bodies, sexuality, reproduction, and families for themselves and their communities.”

In closing, Foucault’s Discipline and Punish reminds us of the primacy of practice over belief. It is simply not enough for us, as doulas, to believe in the safety and normalcy of physiologic birth; we must also learn the principles of feminist praxis and remain constant in our advocacy. It is simply not enough for us to be well-intentioned; we must also embody our knowledge. Our actions must be in alignment with our visions. We must resist docility. We must socialize birth by de-medicalizing it while assisting midwives in the revitalization of their art, for these actions are paramount to creating a culture of health equity and optimal care.

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