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The Technocratic Birthing Model as Seen in Reality Television and Its Impact on Young Women Age 18-24

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**The Technocratic Birthing Model as
Seen in Reality Television Through the
Eyes of Young Women
Age 18-24**

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May 8th, 2011

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Abstract

In the Western ethnomedical tradition, childbirth follows the technocratic model, a concept developed by Davis-Floyd (1992). Within such a system, the woman's body produces a fetus, much like a machine produces a product, and is delivered unto society by the physician (mechanic) in the proper manner and time. This cultural conception of birth has led to a society in which maternal and child health has suffered, as many of the practices employed by a physician during a managed labor and delivery are not backed by evidence-based medicine. This thesis argues that reality television shows, specifically *A Baby Story* enable the continued cultural transmission of the technocratic model to young women. This study examines the conception of childbirth among young women (18-24) as well as the role of reality television in perpetuating the technocratic model.

Executive Summary

This thesis takes a multidimensional approach and seeks to address a complex social and physiological process: childbirth. The purpose of this project is to examine the technocratic model of childbirth as seen in the reality television series *A Baby Story* and its impact on young women of college age (18-24).

It is imperative to examine the way in which women give birth within our Western, medicalized system as well as the cultural messages women receive while giving birth. Anthropologist Robbie Davis-Floyd developed the critique of the technocratic model, which, at its core praises science and technology as the highest achievements of man (Davis-Floyd, 1992, p. 47). Under the technocratic birthing model, the woman's body is viewed as a machine that may break down or become inoperable at any time. Because of the fragility of women's bodies, physicians must actively manage childbirth. The idea of the body/machine began with the Enlightenment and led to the rise of obstetrics as a medical practice.

In the United States, we spend more money per capita on maternity-related costs yet have one of the highest maternal/neonatal mortality rates of industrialized nations. The technocratic model espouses ideals of scientific progress and empiricism; however, many of its practices have been shown to be ineffective in caring for laboring women. Why, then, does this system not adapt to promote more recently scientifically proven practices? This is a question raised by many authors, including Davis-Floyd (1992), Block (2007), and Goer (1995). The authors come to similar conclusions that the technocratic model is a cultural rite of passage that imparts ideas of the inferiority of women's bodies and the supremacy of technology.

In an effort to understand how the technocratic model is understood in real-life scenarios, I elected to review 51 episodes of the reality show on The Learning Channel (TLC). I chose this show because of its sensational nature, along with the fact that, according to the Listening to

Mother's II Report (2006), nearly 60% of pregnant women seek information on pregnancy and childbirth from reality-based shows. Of the 51 episodes, physicians attended 39 and 12 were attended by Certified Nurse-Midwives. Of the 39 physician attended births, a vast majority of the women experienced medical intervention as well as received verbal messages about the inadequacy of their bodies with language loaded to imply failure. For example, many women were told that they were not dilating "fast enough," that their labors had "stalled," or that they were "failing to progress." In these cases, the physicians would act to augment the labor to make it fit with the model of a consistent, technocratic birth.

Perhaps more significant is the fact that of the 39 physician births, 97% involved the laboring woman and/or her family expressing intense fear related to childbirth. I interpret this fear to be induced by both lack of knowledge about the birth process and the use of invasive medical procedures. These are the technocratic model's greatest tools in its self-perpetuation. By instituting fear of the natural childbirth process, physicians can easily take control of a situation and increase medical intervention. Because women are enculturated in the technocratic medical system, their fears are assuaged by the use of technology, thus creating a feedback loop that allows for the continuation of the model and its perpetuation by women themselves.

I decided to investigate the effects *A Baby Story* might have on young women, who are avid consumers of reality media. Due to the intense fear and highly technocratic births I witnessed in *A Baby Story*, I expected nearly all of the young women to espouse similar feelings regarding birth. Instead, what I found was incredible variance in opinion that ranged from full acceptance of a holistic model of birth to young women who fully accept and trust in the technocratic model. Most of the women expressed feelings that fell on a spectrum, some closer to a wholistic, natural view and some closer to technocracy. In general, the women were

indifferent to the procedures witnessed in *A Baby Story*. Of the eight women I interviewed or conducted a focus group with, many held moderate views on intervention and synthesized their opinions based on a combination of reality television, relative's or close friends' experiences and biology/health class.

This information was very different from the responses from even slightly older women interviewed for the *Listening to Mothers II* survey. It is significant that young women do not have a comprehensive understanding of what would constitute an uncomplicated, low intervention birth. From this data, I infer that young women, even those not preparing to start families, could benefit from more detailed education in pregnancy and birth. As evinced in *A Baby Story*, the women who were physician-attended were more fearful of their births. As most women will give birth with a physician (only 9% of births are midwife-attended in the U.S.), greater education may decrease their fears and increase their control of their birth process when they do begin families.

Part One: The Current State of Maternal Health in America and the Technocratic Model

The Rise of Technocratic Childbirth in Western Culture

For much of human history, women have given birth with the aid and care of a midwife. The definition of a midwife is hard to pinpoint, merely because midwives in their communities were often seen “as birth-attendants, as women workers, as active members of their communities, as ‘missionary’ and political figures and as defenders of their status” (Marland, 1994, p. 1). In the Middle Ages, the role of a midwife varied from women attending birth as neighborly bonding to women who took on the profession for most of their lives and earned a steady income. (Marland, 1994, p. 2). Some midwives, such as London’s Elizabeth Cellier, revolutionized the profession by setting up a college for midwives while she was battling religious, political and medical issues of the late 1600’s (Marland, 1994, p. 6). Throughout medieval Europe, different state and local laws regulated midwife certification and practice, illustrating diversity throughout the profession.

Highly significant is how midwives were viewed by the society they served in medieval Europe. Midwives were usually women well versed in herb-lore and the human body, and because of this, many women may have been feared by the Church and the upper classes. In medieval Europe the Church took no issue with male physicians for the upper classes, but it promoted the idea that midwives were performing the work of the Devil. In this double standard of care “the real issue was control: Male upper class healing under the auspices of the Church was acceptable, female healing as part of a peasant subculture was not. The Church saw its attack on peasant healers as an attack on magic, not medicine” (Ehrenreich and English, 1993). In fact,

most early medical schools included no instruction on pregnancy and birth, as they were not regarded as medical problems (Davis-Floyd, 1992, p. 29).

In the seventeenth and eighteenth centuries, however, midwives relied on their reputations to build a customer base through word of mouth (Marland, 1994, p. 6). Midwives' influence on the social sphere became evident when they were called upon to "administer emergency baptisms, report on illegitimate births, abortion and infanticide" (Marland, 1994, p. 7). This increased influence made the aristocracy nervous that lower- to middle-class women had gained too much power in the public arena. Slowly, municipal and medical authorities began to more strictly regulate these duties. "A midwife's morals, religiosity, and sometimes her skill were evaluated" by the male hierarchy of Europe, which led to the decline in midwives' autonomy in their profession (Lingo, 2004, p. 2).

Many midwives in the seventeenth and eighteenth century were caught up in larger social issues that were out of their control. Suddenly, they were "caught between the forces of tradition and change, religious morality and Enlightenment government" (Marland, 1994, p. 8). Enlightenment ideals swept through Europe, emphasizing science and rationality, while downplaying tradition and religious dogma. The Enlightenment also changed the way that midwives were viewed by the wider society as well as how they were allowed to practice. Isobel Grundy explores Sarah Stone's eighteenth-century article regarding the ignorance of midwives. Stone, a midwife herself, held advanced knowledge of anatomy and the birth process. Grundy first explains that with the advent of scientific discovery, "that which is replaced by scientific, objective knowledge is categorized as 'old wives' tales'; modes of knowledge possessed by women are downgraded as insufficiently logical or specialized" (Grundy, 1995, p. 128). "Men-

midwives,” who began practicing in the eighteenth century, propagated the dismissal of women’s knowledge as illegitimate and non-scientific.

Stone reprimands midwives in general, not just male ones, for their lack of knowledge concerning anatomy. Stone’s criticism, however, is aimed mostly at her male counterparts. She thinks it deplorable to berate female midwives, claiming to represent science and authority when they hold little knowledge of their own. Stone accuses these “young Gentlemen pretenders” of the same ignorance demonstrated by female midwives, but also of having no knowledge of the healthy female body. These men gain the knowledge of women’s bodies solely from dissection, not from education and practice on a living body. Stone’s criticism of the rising male midwife marks the beginning of the authoritarian stance of men, and later the medical profession, regarding childbirth.

Obstetrics and midwifery differ fundamentally in their origins. Midwifery arose as a social support system using empirical knowledge, while obstetrics developed from scientific discovery based in Greco-Roman philosophy (Lingo, 2004, p. 1). Increased study of anatomy and surgery began the practice of obstetrics in Europe in the sixteenth and seventeenth centuries. Through the eighteenth and nineteenth centuries, the emergence of obstetrics and the continuing practice of midwifery provided for the dissent and distrust of both parties towards one another. Although both fields have the same end goal – a good birth outcome, the practice of each field is distinctly different in that “obstetrics focuses on the problems and difficulties of pregnancy and labor; midwifery emphasizes the normalcy of pregnancy while acknowledging the vulnerability associated with the reproductive process.” (Lingo, 2004, p. 1). This led to a critical split between the philosophies of midwives and physicians. Those who practiced obstetrics, in the early days at

least, viewed pregnancy and birth as a dangerous process fraught with risks that could be “cured” through obstetrics.

Simply, practitioners of obstetrics looked for the easiest and most painless way to remove a fetus from the womb. In the nineteenth century, obstetricians developed and stressed the “machine” model of the body, which later gave rise to the technocratic model (Howell-White, 1999, p. 6). This model emphasized its “machine”-like qualities and deemphasized the experiential aspects of the human condition and what anthropologists now call the lived experience of the body and women’s authoritative knowledge of birth. French researchers went so far as to:

“Remove the emotional and spiritual associations of birth so that ‘they could then look intently at what determined the success or failure of birth’ and make this ‘their arena for further scientific study and medical art’” (Wertz and Wertz qtd. in Howell-White, 1999, p. 6)

To remove the experience of the woman from the equation was to deny the social impact a birth had on the community. Viewing birth in a strictly medical capacity degraded the power and significance of a birth, and by extension, the power and significance of the midwife, not to mention the mother.

Judith Pence Rooks examines the role of forceps in greater male control of birth and the rise of obstetrics. During the late eighteenth century, midwives often called surgeons and physicians to assist a difficult or complicated labor. Because of this practice, midwives and physicians were doomed to have disparate experiences with birth. A successful midwife may see hundreds, if not thousands of babies successfully born during her career, while a physician may see only “complications unrelieved by experience with normal deliveries” (Rooks, 1997). One

such surgeon was Peter Chamberlain, the inventor of forceps. His invention made it possible for a surgeon to remove a fetus from the birth canal during a labor that could have resulted in death for both woman and infant. Chamberlain kept his invention a family secret for more than one hundred years (Rooks, 1997). Due to this advantage, the Chamberlain family served the British royal family in the capacity as “man-midwives.” Following the lead of the Chamberlains, “other doctors bought their ‘secret’ tool or developed similar instruments on their own. Few midwives could afford to buy them and most physicians were not willing to teach a midwife how to use them (Rooks, 1997). Thus began the rift between assisted and natural birth and the hierarchical positioning of obstetrics and midwifery. The success of forceps delivery under dire conditions fit the medical interventionist model and soon after medical schools began including obstetrics as a specialty and obstetricians’ increased use of technological interventions pushed midwives to the sidelines of women’s health care in the industrialized west. Midwives remained important in less developed countries and rural or poor communities in the developed countries.

Unlike medicine, midwifery views birth as a natural process and experience for the woman that needs no “solving.” Midwifery arose as a social support system that emphasized the nature and necessity of birth. Women viewed childbirth as a natural event that, although potentially life threatening, was not a pathological process that needed medical intervention and remedy (Lingo, 2004, p. 5). In describing the diary of Martha Ballard, a late eighteenth-century midwife in Maine, Howell-White explains that Martha described birth in a fundamentally different way from her peers who practiced obstetrics. Instead of dilation, delivery of infant, and delivery of the afterbirth, Martha defines birth in ““social rather than biological terms each marked by the summons and arrival of attendants - -First the midwife, then the neighborhood circle of women, and finally the after-nurse”” (Howell-White, 1999, p. 5-6). This more wholistic

view of birth emphasizes the role of a midwife as a birth attendant, a teacher, and a woman who brings the female community together in support of the new mother.

The philosophy of midwifery is markedly different than obstetrics, but with the advent of maternity hospitals for poor women, the practice and predominance of obstetrics grew. These hospitals provided a boon for the obstetrical profession because they “ provided an endless supply of patients on whom males could practice birthing techniques for normal and abnormal deliveries” (Lingo, 2004, p. 4). The effect that these hospitals had was two-sided. On the one hand, the kind of education that the hospitals provided eradicated the ignorance that Sarah Stone wrote about. Famed and skilled surgeons and physicians set up lecture series and curriculum to educate these eager obstetricians. The teaching methods in maternal hospitals allowed for the hands-on learning that the male-midwives of Stone’s time lacked. However, it also provided education to an all-male provider clientele, perpetuating the removal of women from the birthing profession. In England and the United states “midwives were rarely regulated and essentially were excluded from the hospitals and proprietary schools that employed the new techniques, instruments, and obstetrical knowledge” (Lingo, 2004, p. 5). At the same time that midwives were losing their autonomy, women were losing an important social support. Without a midwife and community centered birth, the strong social ties that were held among women were diminished (Cook, 1994, p. 3).

With knowledge being spread, albeit not evenly, between obstetricians and midwives, what could cause a sudden shift from midwife-attended to hospital dominated birth? The general consensus is that the American Medical Association, in conjunction with elite medical professionals, began a campaign to eliminate midwifery. Such a cultural, and economic, shift, “supported the movement of childbirth into hospitals, led to the near demise of midwifery during

the first three decades of the twentieth century” (Rooks, 1997). Among the many reasons physicians pushed for hospital-based birth was the advent of “twilight sleep” in 1914. Because the drugs used to initiate twilight sleep (morphine and scopolamine) had dangerous potential side effects, they had to be used under the careful eye of a physician. Women, who could afford such practices, abandoned their home births and midwives in order to undergo this procedure. Women sought out doctors who performed “Twilight Sleep” to act as a symbol not only of their social class, but also as an example of the progress of modern medicine (Rooks, 1997). This process left women not only completely unaware of the birth, but also posed a serious risk to the fetus. Many children of mothers who had undergone anesthesia suffered from neonatal depression, which impairs lung functioning. Even with these risks and side effects, a “1997 report by British researcher Irvine Loudon found that hospital deliveries rose from 24 percent of all births in 1932 to over 54 percent in 1946” (Lingo, 2004, p. 7). With more than half of births taking place in hospitals by the mid-twentieth century, the medical community was well on its way to completely removing women from midwifery care.

This surge in hospital births led to a new generation of obstetricians, and with them, complicated obstetrical practices. It is important to make clear that these procedures were developed and performed in the name of scientific discovery, not necessarily for the well being of women and babies. These specific protocols and procedures were put in place in the United States, with European countries following suit. These practices included, but were not limited to:

Anesthesia, forceps delivery, shaving the pregnant woman’s pubic area, administering an enema and refusal of any food or drink for the woman prior to labor, episiotomy, lithotomic position for birth, and administering pitocin or other drugs to induce and control labor (Lingo, 2004, p. 8).

These complex, and mostly unnecessary procedures, are accompanied by IV injections, fetal monitors, and in rising numbers, caesarean sections. Especially disheartening is the practice of not allowing the laboring woman to consume food or drink. The reasoning behind not providing sustenance for the woman in labor is the possibility of an emergency caesarean section. However, only 1-3% of labors end in emergency c-sections due to life-threatening issues such as a prolapsed cord, placental separation, or sudden fetal distress (Akin, p. 1).

The emergence of these procedures and practitioners did not make birth safer, as one would think. Maternal mortality rates, in fact, rose dramatically. Infection proved to be the greatest cause of maternal mortality, even after germ theory and antiseptic practices were implemented. The use of forceps was especially dangerous due to lack of proper sanitation leading to high instances of septicemia. Statistically, a woman had no greater risk of dying in childbirth in 1863 than in 1934 (Lingo, 2004, p. 8). The increased rate of maternal mortality was attributed not only to sepsis, but also to the unnecessary practices listed above. It is especially evident that the fault lies with the intervention techniques because “when interference occurred, the death rate due to sepsis (infection) was 40 per 10,000 births, while the rate for spontaneous deliveries was 4 per 10,000” (Lingo, 2004, p. 9).

Many instances have been documented of disregard for the woman’s well being and recovery following the use of intermediary practices. In her book “Pushed,” Jennifer Block outlines how an obstetrician typically would handle a nineteenth century birth. Joseph Lee, a highly renowned obstetrician, spoke to the American Gynecological Association, of which he was president, and instructed his colleagues in how to conduct a normal birth:

administer morphine and scopolamine, then ether, then cut an episiotomy, extract the infant with forceps, sew up the incision, and give

more morphine/scopolamine to prolong the narcosis for many hours postpartum, and to abolish the memory of the labor as much as possible”

(Block, 2007, p. 21-22).

This philosophy, now known as active management, took all possible control over the birth out of the woman’s hands and placed it in those of her much more knowledgeable physician.

One debate that exemplifies the difference between midwife and physician care is that of how to deal with the perineum, the stretch of skin and muscle between the vagina and anus.

Midwives traditionally have women walk about, squat and sit to give birth, which protects the perineum from tearing. Also instrumental in preventing a painful and possibly infected tear is the practice of a gentle birth. Only in the nineteenth century did obstetrics invent a “purple faced” pushing process, in which a nurse would count to ten while the woman strained to expel the fetus from her womb. This violent labor technique could cause debilitating tears of the perineum and was then thought inevitable by physicians. By the 1950’s it was estimated that 50 to 100% of women experienced episiotomies (the cutting of the perineum) in hospitals (Block, 2007, p. 30).

The main objective in performing episiotomies was to progress labor to an acceptable rate for the attending physician. Bertha Van Hoosen writes that it is the duty of the obstetrician to decide “the time that the baby shall come, and the depth that the mother shall be laid open to hurry the birth” (quoted in Block, 2007, p. 29). These procedures were done to prevent further damage, yet if obstetricians simply let women deliver without time constraints, “normally every perineum will properly distend to allow the exit of the child, leaving all tissues intact” (Block, 2007, p. 28).

With these fundamental differences in practice and philosophy, midwifery and obstetrics were at an impasse. Whose place was it to decide what role an attendant had at a birth when there was now a choice between a hands-off and a total control approach? Block argues that the

change had to come first from the physicians themselves. By the mid-twentieth century, physicians were beginning to debate the issue, and the active management philosophy was becoming a minority thought. A more preventative, precaution-based philosophy, expectant management, arose, which stressed the importance of quality care and the most ideal conditions throughout labor, no matter how long it proved to be (Block 2007, p. 22).

Current Statistics and the State of Maternal Health in the United States

Although medical and midwifery philosophies concerning birth differ dramatically, women, especially in America, Canada and England are monitored and managed from conception through delivery. Jennifer Block outlines a common, modern maternity ward, equipped with fetal monitors, IV drips, electrodes to monitor dilation and contractions, and more nurses than could ever be needed. In fact, one would think that with this intense micromanagement of birth, America would have the best standard of care and the lowest maternal mortality rates in the world. However, even though 99% of American women give birth in hospitals, America has a higher maternal mortality rate than most other developed nations (Block, 2007, p. XIV). According to the World Health Organization, the U.S. ranks second to last among 33 other industrialized countries, and 30th with nations overall (Block, 2007, p. XIV). Technology is not the underlying factor, considering babies born prematurely in the U.S. have a greater chance of survival than anywhere else.

Countries that fare the best in maternal mortality, such as Sweden, Denmark and the Netherlands, follow a radically different program of care. Not only does the U.S. suffer from an epidemic of uninsured women and children, and the rates of those uninsured almost always follows racial and socioeconomic lines. In the Netherlands, however, midwives attend a vast majority of women for the duration of their labor, while obstetricians only attend high-risk births.

Also, 20 to 30% of births take place at home, and most of those have no medical intervention (Block, 2007, p. XV). In comparison, hospitals in the New York metropolitan area report a cesarean rate of 30-45%. Block explains that physicians', as well as women's, approach to birth in Scandinavia is fundamentally different than in the U.S. It is perfectly normal to allow natural physiological events to take place and for labor to progress on its own time. Scandinavian women often get up, move about, and choose a birthing position that is most comfortable for them. In America, however, women still overwhelmingly give birth lying down, fighting against gravity instead of working with it (Block, 2007, p. XIV).

Block and many modern physicians are now wondering whether "... American women [are] less able to give birth naturally than their Scandinavian counterparts?" (Block, 2007, p. XV). What processes have lead American women to give birth so differently than European women, even if statistics show that the American way of birth is not the best way? Reports actually show that when a woman enters a hospital to give birth, the idea of choice is merely an illusion. Even women who are deemed "low risk" often receive surgical intervention and have just as high a rate of infant mortality (Block, 2007, p. XII). This is not surprising though, because many hospitals mandate all of the attachments, such as IVs, fetal monitors, etc., as well as pressure women into making decisions in their (the hospital's) best interests.

Physicians and insurance companies have an unprecedented amount of decision power when it comes to how, when, and where a woman gives birth. Doctors make many of the decisions in the treatment of a patient because of risk of malpractice lawsuits. The British Columbia Reproductive Care Program's Vaginal Birth Assistance Guide carefully and coldly warns doctors "If a newborn is damaged and forceps have been used, then such use could feature prominently if litigation should ensue" (Obstetric Guide 14, 2001, p. 1). This warning is bolded

on page one of the document, highlighting the possibility of litigation as a key concern to physicians. Currently, London is shouldering £2.6 billion (\$5.9 billion U.S.) in malpractice fees related to childbirth (Obstetric Guide 14, 2001). Most of these cases were concerning issues of too little intervention or intervention that came too late. The authors remark that court cases are rarely filed because a woman felt unnecessary procedures have been preformed. Even if such a case goes to court, it would usually not yield much monetary compensation. Doctors, then, feel pressure to act boldly and preemptively, in the event that something should go wrong.

Unfortunately, a woman is four times more likely to die after having a cesarean section than after giving birth vaginally (Block, 2007, p. XV). Ironically, it seems as if physicians place women's safety at risk in order to ensure not a safe, but litigation-free, birth.

Insurance companies, on the other hand, are making it increasingly harder for women to choose options other than hospital birth. Even though the World Health Organization states that "midwives are the most appropriate primary health care provider to be assigned to the care of normal birth" insurance companies, through their policies, determine otherwise (qtd. in Block, 2007, p. XVII). Insurance companies, in recent years, have been able to lobby for their agendas and determine how America's healthcare system functions. Women must pay out of pocket (often \$2000 or more) to have a doula, a woman who supports a laboring mother emotionally and physically, with them in the hospital, and only nine states offer Medicaid reimbursement for doulas (Midwives Alliance of North America). Birthing centers, although they do exist, are few and far between, expensive, and in some states, illegal (Block, 2007, p. XVIII). Many birthing centers are failing due to skyrocketing malpractice insurance costs while many hospitals have disbanded certified nurse-midwife programs. Currently eleven states, including Alabama, Illinois, Indiana, and Maryland prohibit certified professional midwives from attending births

(CPMs are midwives who do not hold a nursing degree), and three others, including Connecticut, have not expressly outlawed CPMs, but they are not legally regulated (Midwives Alliance of North America).

The most recent data from the Centers for Disease Control offers some startling statistics on the state of maternal and child health in America. First, the percentage of women seeking prenatal care in the first trimester of pregnancy decreased. There had been a steady rise in the utilization of prenatal care from 1990 to 2003, but following 2003 those rates have stagnated. Alarmingly, nearly 22.5 percent of births in 2006 were induced, a 50% increase since 1990 (Centers for Disease Control, 2009, p. 2). The CDC notes that induction rates have increased for all gestational ages, including pregnancies that are characterized as pre-term. Along with rising induction rates, the United States has also reached a record-high cesarean rate of 31.1 percent of all births. In fact, “rates for primary cesareans were up, and vaginal births after previous cesarean (VBAC) were down” in 2006 (Centers for Disease Control, 2009, p. 2). This means that more women are having cesareans for their first deliveries and more women are also having repeat cesareans.

According to Amnesty International’s 2010 report, “Deadly Delivery: The Maternal Health Crisis in the U.S.A.” the United States spends more on hospitalization for pregnancy and childbirth than any other area of medicine, yet “women in the USA have a greater lifetime risk of dying in pregnancy related conditions than 40 other countries” (2010, p. 1). Furthermore, more than 17.5 million women, nearly a third of all women who give birth, suffer from a pregnancy-related complication that has ill-effects on their health. Amnesty’s lengthy report details how race, class, ethnicity, and immigration status of women in the United States contributes to inequity in maternal health care, and by extension, maternal mortality. African-American women

are nearly four times more likely to die of a pregnancy-related complication than white women, regardless of economic status. (Amnesty International, 2010, p. 1).

Currently, only six states (Florida, Illinois, Massachusetts, New York, Pennsylvania, and Washington) require that maternal mortality be reported to federal institutions (2010, p. 4).

Because of this stipulation, officials concede that national maternal mortality rates may be double the number reported, which is currently 13.3 deaths per 100,000 live births (2010, p. 3).

Amnesty notes that the American health care system compounds the problem of women being able to access affordable and quality maternal health care:

Although women in “active labor” cannot legally be turned away from a hospital regardless of their ability to pay, they may later be billed for thousands of dollars for medical care. Half of all births are covered by private insurance. However, policies that exclude coverage for maternal care are not uncommon and pregnant women may also find that they cannot get private health insurance because pregnancy is regarded as a “pre-existing condition”. Some 42 percent of births are covered by a government-funded program for limited categories of people on low incomes –Medicaid. However, complicated bureaucratic requirements mean that women eligible for public assistance often experience significant delays in receiving prenatal care” (2010, p. 5).

At the current moment in United States health care, quality maternal health care is a privilege reserved only for those who can afford it. On the one hand, the United States seems to have a paradoxical dichotomy of maternal care: those who cannot afford quality care because of race, class, or ethnicity, suffer from lack of access, while at the same time many of those women suffer from too much medical intervention when they do secure health care. A 2009 study

released by Kaiser Permanente indicated that African American women faced a significantly higher risk of primary c-sections and inductions, and the CDC has indicated, in its 2010 report that Black women's c-section rate has increased from 22% in 1996 to 34% in 2007 (2010: 17). As Black women's c-section rates rise to the national average, we can see a backwards health inequity. By increasing the incidence of major surgery for black women, risks associated with such a procedure also rise.

Even though 99.1 % of all births taking place in hospitals, and of those, 90% are overseen by physicians, American women continue to search for health care that is on par with other industrial nations. Through the process of medicalization, the birthing process has become more dangerous for women in the United States as we continue to fall further and further behind examples set by Sweden, Denmark, and other industrialized nations. In order to understand the implications of such a system, and more importantly, how to change it, we must not only examine modern childbirth patterns from a medical and statistical perspective, but also examine the way in which women think of birth, their birth experiences, and what young women expect out of birth.

The Technocratic Model of Childbirth

Health care decisions are not made in a vacuum, therefore it is crucial to examine the arena of American women's cognition and education in relation to the tendency to pathologize and standardize pregnancy and childbirth. In her study "Birth as an American Rite of Passage" Robbie E. Davis-Floyd conducted interviews with 100 women regarding their expectations prior to childbirth and their experiences following their births. Davis-Floyd opens her ethnography by stating, in concurrence with national statistics, most women are "subjected to a series of obstetrical interventions so standard that they are difficult to avoid in most hospitals, under the care of most obstetricians" (1992, p. 3). Davis-Floyd's study is imperative to understanding how women conceptualize childbirth and how women make informed choices because of her specific research population. In studying middle-class white women, who had the financial means to see a private obstetrician and, purportedly, had more options, Davis-Floyd explains that these women could exercise greater agency over their bodies and births than marginalized populations (1992, p. 4). This, Davis-Floyd notes, would allow her to address the issue that "given the possibility of individual, informed choice, why is the pregnancy/childbirth experience ritualized in such consistent and uniform ways...across the country?" (1992, p. 4).

In answer to her question, Davis-Floyd examines what she calls the "technocratic" model of birth and pregnancy that is espoused in the medically-dominated American birth. This concept revolves around the idea that the fetus develops "mechanically and involuntarily inside the woman's body, that the doctor is in charge of the baby's proper development and growth, and that the doctor will deliver (produce) the baby at the time of birth" (1992, p. 28). Through this process the pregnant woman will seek advice, confirmation, and reassurance from her chosen medical professional. In fact, Sheila Kitzinger, an anthropologist and childbirth educator,

explains that “in any society, the way a woman gives birth and the kind of care given to her point as sharply as an arrowhead to the key values in the culture” (1980, p. 115). In American society, those core values, as expounded by the medical establishment, are control, standardization, and use of technology as means of expressing societal progress. In a society in which mechanization of the human body is part of the dominant cultural narrative, physicians function as a means to transmit this message. It is no accident that “doctors themselves must undergo an eight-year-long initiatory rite of passage, a process of socialization so lengthy and thorough that at its end they will become not only physicians but the representatives of American society” (Davis-Floyd, 1992, p. 46). During this time, physicians are fully socialized to impart a system in which the doctor is in control while the ideal patient will comply, obey, and experience medical intervention as normal and necessary.

It is essential to investigate the modern American medical system as an ethnomedical system in order to understand the cultural proceedings revolving around pregnancy and birth. We must not forget that in such a system, as in any other, the technologies we embrace are both encapsulated by that system and formative of our worldview (1992, p. 47). The technocratic model began with the “body as machine” model formulated by Enlightenment-era philosophers such as Descartes and Bacon. Our medical system often views the human body as a machine, like a car that can be repaired by the mechanic, the doctor. The doctor is a highly trained, hands-on repairer of the human body, but it is important to recognize that under the technocratic model, women’s bodies are not equal to men’s bodies. Those same men who established the machine model of the body also established that the male body was the prototype of this machine and that the female body was “abnormal, inherently defective, and dangerously under the influence of nature, which due to its unpredictability and its occasional monstrosities, was itself regarded as

inherently defective and in need of constant manipulation by man” (Davis-Floyd, 1992, p. 51). In such a system, in which women’s bodies are inherently dangerous, ready to self-destruct at any given moment, it is no surprise many women do not trust their bodies to give birth.

As translators of cultural messages, physicians play a large role in shaping how a woman experiences her birth and how she views her body’s capability to give birth. Davis-Floyd explains that a male obstetrician she interviewed insisted that he had been taught to produce a perfect product: a healthy baby, no matter the means used to achieve such a product. The physician admitted:

“It was what we were all trained to always go after—the perfect baby. That’s what we were trained to produce. The quality of the mother’s experience—we rarely thought about that. Everything we did was to get that perfect baby”

(1992, p. 57).

This assertion shows the true value placed upon such an assembly-line system. In fact, such comments show that physicians treat fetuses as separate entities from the woman who carries them. The woman’s body produces a separate human being, beginning from the moment of its conception. The fetus can be treated by a physician as a being that has different interests and medical needs. Such a separation devalues the wishes of the woman, and many laboring women are coaxed into interventions “for the baby.”

In further explicating the cultural nature of physicians’ practices and rituals surrounding birth, Davis-Floyd explains that much of the ritual performed by physicians is for their own physical and psychological comfort. In order to work within a technocratic medical model, physicians must deny the powerful and uncontrollable nature of the birth process. To do this, medical personnel practice rituals to “define and categorize the events of labor and birth that

confront them and [be able to] act confidently in terms of those definitions to impose cultural order on inchoate nature” (1992, p. 64). Physicians work upon the assumption that as long as a labor is augmented and controlled, it is no longer a dangerous, unpredictable, natural event. Such a dichotomy allows obstetricians to impart this philosophy to their students as well as their patients, allowing them to purport a sense of control, which also functions to comfort those individuals who have been enculturated into the biomedical ethnomedical system.

In the film “The Business of Being Born,” the filmmakers interviewed a number of doctors concerning home birth in particular. Most of them repeated metaphors for birth that are consistent with the technocratic model. One obstetrician noted, “Giving birth at home with a midwife or somebody is like saying, ‘when you ride in my car, you don’t have to wear a seatbelt.’” Here, a woman’s body is being directly related to a vehicle, which could unexpectedly crash at any moment. Throughout the film, the OB/GYNs often resorted to using metaphors, many of which included machinery, rather than statistics, to dissuade women from the safety of homebirth. In fact, Davis-Floyd shows that the “body as metaphor for automobile” is not an isolated or rare comparison. In a 1926 issue of *The Century Illustrated Magazine* a physician explains if your car broke down on a country road and you couldn’t fix it, you would take it to the closest garage, where “trained mechanics and their necessary tools are. It’s the same with the hospital...If anything goes wrong, I have all known aids to meet your emergency” (Davis-Floyd, 1992, p. 52). This common metaphor is used in a near religious way. It is repeated multiple times in textbooks, media, and common culture. Through this repetition, women cannot see themselves in control of their bodies and their births, which is the end goal of the technocratic model.

For the technocratic system to function, hospital culture must remove a woman’s sense of her own control over her labor, and by extension, decrease her confidence in her ability to

actively give birth. It is clear that the system under which the United States functions is not concerned with evidence-based medicine. The use of many, if not all, common interventions (c-section, rupturing the membranes, analgesic pain relief, electronic fetal monitoring, etc.) show increased risk for both woman and baby. The biomedical obstetric practice is aware of these statistics, yet obstetricians continue to intervene in normal, low-risk births. This unequivocally shows that the preservation of the cultural methods employed by the technocratic system is essential to the continuation of obstetrics as a medical field as well as the Western cultural importance of technology supreme to nature. Women who are enculturated to have little faith in their body's capabilities inevitably face substantial fear during their childbirth experience. I will argue that fear and lack of real agency in the hospital setting, are the driving force behind the technocratic model, which alienates women from having an empowering birthing experience as well as perpetuates a maternal and child public health crisis.

Part Two: Pregnancy and Childbirth Portrayed in Reality

Television

Television Media and Mass Culture

Although one of the reasons I chose to document reality television shows depicting birth is the fact that many young women and young mothers watch such shows, another imperative reason is the relationship mass media has on the shaping of American culture. Experts in media studies argue that mass media has led to a “mass society” where social norms and realities are defined by media communications. In his 1979 paper, Denis McQuail explains the complex nature of the effect of mass media on individuals’ behavior. At the same time, media presents a “consistent picture of the social world which may lead the audience to adopt this version of reality, a reality of ‘facts’ and of norms, values and expectations. On the other hand, there is a continuing and selective interaction between self and the media which plays a part in shaping the individual’s own behavior and self-concept” (1979, p. 13-14). An individual’s interaction with mass media is complicated and multifaceted. Media is created with the intention of being marketed to both the masses and also to a group of self-selecting individuals who will find value in particular programming.

“A Baby Story,” is marketed mainly to white, heterosexual women of childbearing age, as these are the stories that are most often emphasized. According to the Listening to Mothers survey, two thirds of women watch reality based birthing shows, and a third of those women watch “A Baby Story.” Therefore, it can safely be extrapolated that this group of individuals is the target audience for such programs. McQuail’s paper reaffirms that there are surprisingly few diversified themes and images presented in the media, and it is these few selected images that come to cultivate the culture and consciousness that “form new bases for collective thought and

action quickly” (1979, p. 20). This condensing of cultural ideas has been referred to as a “global village” in which culture can be reproduced and standardized. In a 1982 study, researchers found evidence that media was viewed similarly by both uneducated and higher educated individuals, signifying a possible “cultural leveling” and the beginnings of a homogenized culture (Neuman, 1982, p. 486).

It is imperative to acknowledge that the standardization of the portrayal of birth may have far-reaching effects on how women conceptualize and expect to give birth. In fact, such a homogenization of birth in media has enormous implications for the technocratic birthing model. In a system that values the standardization and routinization of birth controlled by the physician, reality television shows further promote and perpetuate the normalcy of a technocratic birth.

Methods for Data Collection and Reasoning

In the modern world, the television and popular media are powerful enculturation tools. In order to examine how young women think about birth, it is essential to understand the means by which they are generally educated about birth. Although little research has been done with non-pregnant women concerning childbirth education, *Listening to Mothers II*, a national report by a non-profit organization, Childbirth Connection, reports that 68% of respondents of their survey had watched a reality-based television program about birth. The *Listening to Mothers II* (2006) survey included 1,572 respondents selected to reproduce a representative sample of the women who gave birth in the U.S. in 2006. In this sample, two-thirds of the women engaged in consumption of mass media related to birth, indicating that regardless of race, ethnicity, class, age and education, a majority of these women were consuming programming that primarily portrays white, wealthy, heterosexual birthing women as the norm. In fact, *A Baby Story* (The Learning Channel) was the most watched show of the five mentioned by the respondents (The

others included *Birth Day*, *Babies Special Delivery*, *Maternity Ward*, and *Bringing Home Baby*). Nearly 47% of women who had watched reality birth shows had watched *A Baby Story* and 32% of all women surveyed had seen the show (2006, p. 36). In fact, when asked how the women felt about the shows, 51% responded that it helped them “understand what it would be like to give birth” (2006, p. 36). First time mothers, 32% also noted that the shows made them more worried about giving birth. Also of note is that only a quarter of respondents (25%) indicated that they had taken childbirth education classes. With a much higher percentage of women watching reality-based birth shows than experiencing childbirth education, many women’s expectations of birth are only taken from such shows. Furthermore, these are important statistics in that a slight majority of women see the shows as providing a realistic portrayal of what birth is like, and for many of the women, it increases fear for their own birth experience.

Because there has been so little research done regarding reality birth shows, I took many methodological cues from the one study I found by Morris and McInerney (2010). In accordance with their data collection recommendations, recording shows in a snapshot of time will give researchers a more realistic view of what women will actually see in their daily viewing habits. The networks air episodes that occur in no particular order, and may have originally aired years apart from the episode that plays right before or after it. Therefore, “analyzing a season of shows (i.e., shows that aired for the first time during a given year)...does not capture what women are watching on television” (2010, p. 2). In order to fully analyze the cultural message women receive when watching *A Baby Story* I decided to follow this recommendation and I recorded 51 episodes of *A Baby Story* over the course of thirteen days (Monday through Friday) on The Learning Channel (TLC). These episodes were recorded from October 11th, 2010 through October 27th, 2010. While watching these episodes, I constructed a spreadsheet (summarized in

table Fig. 1) with the last name of the family featured and ten common birth interventions. I also recorded where the birth took place (hospital, birth center, or home) and whether a physician, certified nurse midwife, or certified professional midwife attended the birth.

The interventions I chose to document were cesarean section, episiotomy, use of pitocin (synthetic oxytocin), constant fetal monitoring, epidural analgesia, lithotomy birthing position, coached pushing, documentation of informed consent, induction of labor, and rupturing of the membranes. It is important to note here that many of these interventions could have been used in the birth for a specific case but not documented in the television version of the birth. This may explain the lower than average numbers of episiotomies shown in the series.

Along with recording common interventions, I also took notes on how the woman's birth experience was portrayed, her care provider's attitude toward birth, and the level of fear the woman seemed to be experiencing. In order to examine the high rates of intervention, it is equally important to discuss the decision-making processes and the attitudes of both the woman and her family toward birth, but also those of her doctor, midwife, and nurses.

Interventions Documented in *A Baby Story* (Fig. 1)

Intervention	Number of times used by Physicians	Percentage of physician attended births	Number of times used by Midwives	Percentage of midwife attended births	Overall usage	Total percentage
Electronic Fetal Monitoring	36	92%	5	41%	41	80%
Epidural	33	84%	2	16%	35	68%
Cesarean	17	33%	0	0%	17	33%
Pitocin	14	36%	1	8%	15	29%
Induction	10	25%	1	8%	11	21%
Membrane Rupture	11	28%	4	33%	15	29%
Coached Pushing*	20	91%	4	33%	24	70%
Lithotomy Position*	21	95%	7	58%	28	82%
Episiotomy	1	3%	0	0%	1	2%

*Both the coached pushing and lithotomy position statistics are counted out of 34 total vaginal births

A Baby Story: An Introduction

According to The Learning Channel (TLC) website, *A Baby Story* offers viewers a chance to watch

“an intimate and emotional journey by profiling couples' experiences from the final weeks of pregnancy through the first weeks of a new life. Go inside the delivery room for a voyeuristic peek at the drama of labor and the sheer joy and relief of the unforgettable birth moment. Share in the experience and all the

emotions parents feel when they first greet their newborn.”

The show has been on the air since 1998 and 735 episodes of 20 minutes each have been produced and are available to watch several times a day. The show is typically run on the network two to four times daily. An average episode of *A Baby Story* begins with the couple introducing themselves, often this includes footage from the baby shower and/or wedding pictures. The couple is most often a white, heterosexual (married), upper-middle class family. There has been effort in recent years to include more diversity in the couples being featured, as the older episodes (demarcated by different theme music and beginning sequence) showed almost all white families. Of the newer episodes, there were three episodes in which the families were Black/African-American, one in which an Asian-American family was featured, and one episode in which a mixed-race couple was featured (Asian-American woman, white man).

The couples are selected by their proximity to four major metropolises: New York, Miami, Dallas, and Chicago. Furthermore, couples nominate themselves by submitting an e-mail to the television network. In this e-mail, prospective couples are encouraged to list their due dates, doctor and delivery hospital. Because the couple is instructed to provide information on their doctor and delivering hospital, it is evident that the network is seeking to document hospital births that are supervised by a physician, the normative American birth.

Of the 51 episodes I watched, 50 occurred in hospitals. One birth took place in a birthing center. None of the episodes featured a home birth. Thirty-nine of the 51 births (76%) were attended by a physician (M.D.), 12 births (24%) were attended by Certified Nurse-Midwives, and no births were attended by a Certified Professional Midwife, Licensed Midwife, or Doctor of Osteopathy (D.O.).

Results: Documenting Intervention

Constant External Fetal Monitoring

According to the *Listening to Mothers* survey, 94% of women experienced constant fetal monitoring during their labor (*Listening to Mothers II*, 2006, p. 31). About a quarter of women experienced both external fetal monitoring (a belt worn around the abdomen) as well as internal fetal monitoring (use of an electrode placed on the fetus' skull). I only recorded external fetal monitoring for a few reasons. First, the external fetal monitors can be easily seen, and are thus easier to document. Second, the only way to document an internal fetal monitor is if the woman or her doctor talks about it during the episode. Because the episodes are only twenty minutes long it seemed unlikely that every woman who experienced internal fetal monitoring would talk about it or that this would make it into the final cut for the episode. Approximately 80% of women featured in *A Baby Story* (n=51) experienced constant external fetal monitoring. However, of the 39 physician-attended births, 36 of those births (92%) featured constant fetal monitoring while only five of the twelve (41%) midwife-attended births did.

According to Brackbill et al., the results of four studies in which women were assigned randomly to external electronic fetal monitoring and manual (Doppler) monitoring, “cesarean rates ranged between 63% and 314% higher for electronically monitored women than manually monitored women” (1984, p. 10). Furthermore, the authors note that there was no difference in the neonatal death rate for electronically and manually monitored fetuses. These cumbersome machines appear not to actually improve outcomes, and rather confine a woman to a bed for the duration of her labor, and as the authors also noted, helped ease the physician's own nerves and impatience (1984, p. 10).

Epidural analgesia

As far as epidural analgesia is concerned, it was by far the most popular pain relief method for both the women in *A Baby Story* and also those who participated in the *Listening to Mothers II* report. In the report, 76% of women indicated they had had an epidural as pain relief. Overall, 68% of *A Baby Story* women had an epidural for pain relief. Again, the physician/midwife split is striking: 84% of physicians' clients had epidurals for pain relief compared to only 16% (two of the twelve) of midwives' clients. Brackbill et al. discussed the use of pain relieving medications in labor, explaining that studies of women and babies who have received drugs during labor

have repeatedly and consistently demonstrated the sort of adverse effects that are associated with central nervous system damage: impaired sensory and motor responses...[most frequently these changes] include respiratory depression, general sluggishness and fatigue, extremes of muscular tone (limpness or rigidity), skin discoloration (blue instead of pink)...jaundice, abnormal EEG and sleep/alertness patterns" (1984, p. 17-18).

None of these possible complications were discussed with the laboring women in the episodes watched, and most of the women welcomed relief from the pain. Furthermore, there were a few episodes in which women experienced severe spinal headache, chronic back pain, and infection at the epidural site. Few women (under the care of a physician) were shown using non-medical pain relief (i.e., massage, birthing ball, shower or birthing tub). Neither were they offered these alternatives to an epidural in the episodes viewed.

Cesarean Section

According to the Centers for Disease Control's 2010 Report on Vital Statistics for 2006,

the cesarean birth rate rose again to an all-time high of 32.3% of all births (2009, p. 3). In the *Listening to Mothers II* study, the reported c-section rate was 32%, right on track with the national average. In *A Baby Story*, 33% of women gave birth via cesarean, all of them with physician-attended births. In 1970 the c-section rate was about 5% of all births, which is what the World Health Organization insists is a healthy c-section rate for an industrialized, generally healthy, country. Since then, it has increased nearly ever year to nearly one in three women giving birth by cesarean. Davis-Floyd explains that this gap in physiological need and the actual numbers is a symptom of the technocratic medical culture. The routinization of cesarean birth reinforces the physician as the mechanic operating on a malfunctioning machine (the woman's body). Davis-Floyd calls "delivery from above" the "most extreme manifestation of the cultural attempt to use birth to demonstrate the superiority and control of Male over Female, Technology over Nature" (1992, p. 130). One particularly disturbing passage indicates that by performing a c-section, the obstetrician himself is giving birth: "I felt a sense of excitement and of power and of personal accomplishment that is not present in the vaginal birth. This is the time the obstetrician truly delivers the baby; in a vaginal birth, it is the mother" (Harrison, 1982 in Davis-Floyd, 1992, p. 130). In a culture where nearly one third of women are "delivered from above" the mechanical model can more easily become the normal view of childbirth. As long as the cesarean rate remains this high, and rising, obstetricians will continue to enculturate medical students with the assumption that c-sections are normal and safer deliveries. To note, however, there are extreme cases in which a cesarean section is medically necessary and a life saving procedure. Moreover, not only does cesarean section fully remove the woman's participation from her own birth, it does so without improving neonatal or maternal health outcomes. In fact, quite the opposite has happened, and in the United States, a woman's risk of death following an

unnecessary c-section is three times that of a woman who has delivered vaginally. (Amnesty International, 2010, p. 9).

Episiotomy

Throughout the course of the 51 episodes, I witnessed only one episiotomy. None of the doctors or midwives discussed the procedure with their clients either prior to or following the births. This is an oddly low statistic for which there could be many reasons. First, the episiotomy shown in the *Baby Altero* episode was not discussed, nor did the doctor inform the woman she was going to perform one. It was by sheer observation and luck that I happened to catch this one and knew what I was witnessing. I assume that there were many more episiotomies that were cut from footage, seeing as 25% of women responding to the *Listening to Mothers II* survey indicated that they experienced an episiotomy (2006, p. 33). In fact, in the 1950's and 1960's, episiotomy was used routinely, and in 1979, the first year for which national data was available, 65.1% of all women were cut (Block, 2007, p. 30). Research since that time has shown that episiotomies cause undue harm and make the risk for third- and fourth-degree tearing nine times more likely (2007, p. 30). One of the hazards of collecting data from a television show is that editors do not always show everything that has occurred in reality. In fact, it is not surprising that I did not see more episiotomies, as the camera often only captures the birth from a side angle or focuses on the woman's face during the second stage of labor (pushing and delivery of the baby). Therefore, it is entirely possible that many episiotomies were performed, but did not make the final cut because episiotomy involves the cutting of a woman's perineum, a body region that cannot be shown on television.

Davis-Floyd views the episiotomy as not only an unnecessary surgical procedure, but as part of the technocratic ritual system. She explains that through episiotomy, "physicians, as

society's representatives, can deconstruct the vagina (and, by extension, its representations), then reconstruct it in accord with our cultural belief and value system" (1992, p. 129). Many physicians erroneously believe that a straight line is easier to repair than a jagged tear. Yet again, here is an instance in which male physicians have declared themselves better able to manage a woman's body than nature's design for labor and delivery. In fact, Davis-Floyd argues that the mere shape of the tear/incision is indicative of American culture's preference for technology over nature. The creation of the straight line in a woman's naturally curvaceous body is the ultimate ritual marking (1992, p. 129). With the use of episiotomy the labia itself, the literal life-giving flesh, can be mutilated by a physician to reflect the superiority of streamlined technology.

Pitocin (Synthetic Oxytocin)

Pitocin is a form of synthetic oxytocin, the hormone responsible for stimulating uterine contractions. In the 51 episodes viewed, 29% visibly used or talked about using pitocin as a means of progressing labor. Among deliveries that were attended by doctors, that proportion was 36%. One certified nurse midwife used pitocin as a means of augmenting labor (8%). As with episiotomy, it is possible that there were other instances in which pitocin was used but its use was not shown explicitly or talked about by physician or client in the final cut. In the *Listening to Mothers II* report, overall, 50% of respondents indicated that pitocin had been used to either speed up or induce their labors (2006, p. 33).

Pitocin is a powerful drug, and it is apparent that it is not used discriminatingly if roughly a third to half of all women experience its use to augment their labors. Jennifer Block explains the dangers that are inherent in the use of synthetic oxytocin:

with an epidural deadening the body's natural pain threshold, staff can keep upping the dose, which can lead to contractions that fire like a machine gun or

that last for minutes, during which time the fetus is oxygen-deprived. This is called hyperstimulation. It is not uncommon and would be considered a trauma—beyond what is normal. In half of these cases of hyperstimulation, the fetal heart rate drops below normal...If it stays there, it's fetal distress” (2007, p. 137).

In such a scenario, pitocin can lead to a chain reaction of interventions. In sum, as is explained in *The Business of Being Born*, a woman may come to a hospital in early labor, her contractions are not as strong or as fast as the physician would like, so he places her on a pitocin drip. The pitocin makes contractions unbearable and the woman asks for an epidural. If given in early labor the epidural can slow labor and more pitocin is given. The pitocin evokes hyperstimulation, as explained above, and the woman must have an emergency c-section due to fetal distress. Such a “snowball” effect can happen rapidly and the risks associated with pitocin are well documented. The risk for tetanic contractions that can result in uterine rupture is increased along with fetal bradycardia (decreased fetal heart rate decelerations) (Davis-Floyd, 1992, p. 97).

As with pitocin, induction of labor and the rupture of membranes are used to send messages to the laboring woman about the biomedical time-table and its importance. Michelle Harrison, author of *Woman in Residence* writes that hospitals routinely use “Friedman’s chart of labor” which indicated how a woman’s labor should progress, and “each woman’s chart has a blank graph of hours and of centimeters of cervical dilation which we must record approximately hourly in order to evaluate the shape of her labor curve. When a woman’s labor is off the ‘proper’ curve, she is subjected to intervention in several possible forms” (Harrison 1982: 121). Friedman’s chart has been described by the National Institutes of Health (NIH) as an arbitrary measure of natural labor and that “the concept that slow progress constitutes abnormal progress

permeates current obstetrical thinking, and although less easily documented, may also conceptualize the patient's expectations" (Weiner and Strauss, 1997, p. 173). Pitocin not only serves to speed up a woman's labor, but it sends a powerful message that the woman's body is not complying with medically appropriate and pre-determined timelines.

Induction of Labor and Rupture of the Amniotic Sac

The induction of labor functions to send a similar message as the use of pitocin implies: women's bodies do not conform to expected and acceptable timelines. In *A Baby Story* 21% of labors were induced, with a 25% induction rate for physicians and an 8% induction rate for midwives. According to the *Listening to Mothers II* survey, four out of ten women reported their care provider wanted to induce their labor. Overall, 34% of women reported having their labors induced with an 84% success rate (2006, p. 29).

An increase in inductions has occurred for a number of reasons, from women being uncomfortable to physician' vacation plans. According to the *Listening to Mothers* survey, one quarter of inductions were conducted because of physician concern with the woman being "over-due," another 19% indicated that an induction was done because the woman wanted her pregnancy to end, and 17% indicated that the physician had concerns about the size of the fetus. Overall, 35% of the women cited non-medical reasons for being induced. Many women may be anxious to end their pregnancies due to the arbitrary concept of a "due date." The approximated "due date" is defined by the first day of a woman's last period. A woman's pregnancy is then constructed around a standardized time table constructed by the physician. If a woman's "due date" comes and goes with no visible signs of impending labor, "she will grow increasingly more anxious with each passing day in which she does not conform to standardized expectations" (Davis-Floyd, 1992, p. 28-29).

One of the common ways that labor is induced is by artificial rupture of the membranes of the amniotic sac, which rupture naturally in a normal birth due to pressure from contractions. This procedure was used often by both physicians and midwives in *A Baby Story* with an overall rate of 29% of the 51 births. Physician attended births had an overall rate of 28%, while midwife attended births had a rate of 33%, exactly one third of the births. Although many physicians and midwives widely use amniotomy (rupturing of the membranes) there are many physiological risks. These risks include serious infection and cord prolapse. Furthermore, the amniotic sac acts as a cushion during contractions, and many women reported feeling more pain during contractions following the rupture of their membranes (*Listening to Mothers* 2006: 29).

Coached Pushing and the Lithotomy Position

Coached pushing and the lithotomy position are two of the most widespread “interventions” documented in *A Baby Story*. I defined coached pushing as any time a doctor, nurse, or midwife either counted to ten while the woman pushed or told her to stop pushing. The lithotomy position had two main forms: the woman completely flat on her back with her legs in stirrups or slightly elevated with a pillow behind her back. For births that did not end in cesarean, I witnessed coached pushing in 70% of the episodes. With physicians, women were coached 90% of the time while women who delivered with midwives were coached 33% of the time.

The lithotomy position was used by far the most frequently of any “intervention.” Overall, 82% of women who had vaginal births pushed on their backs. For physician-attended births that number jumped to 95%, while still over half of women (58%) who delivered with midwives pushed in the lithotomy position.

In regard to both the lithotomy position and coached pushing, an excerpt from *William’s Obstetrics* highlights the inability of a woman to push her baby out on her own:

“In most cases, bearing-down efforts are reflex and spontaneous in the second stage of labor, but occasionally the patient does not employ her expulsive forces to good advantage and coaching is desirable...Instructions should then be given the patient to take a deep breath as soon as the next uterine contraction begins and, with her breath held, to exert downward pressure exactly as though she were straining at stool...The effort should be as long and sustained as possible, since grunts and short endeavors are of little avail” (Helman, Pritchard, and Wynn, 1971, p. 407).

While there are many concerning statements in the passage above, first is the assertion that a woman’s pushing is not something she is actively in control of, unless she is doing it poorly. Her pushing is described as “reflex” and “spontaneous,” completely devaluing her involvement. Secondly, the textbook instructs physicians to coach their patients if they are pushing badly. This seems a logical contradiction; if a woman’s pushing is reflexive, how can she be coached to push “better”?

With regard to the lithotomy position, there is no question in *Williams* that the woman will be on her back. There is almost no instruction to the obstetrician who reads the text, but several pictures of women laying flat on their backs, legs up in stirrups, and fully draped so only the labia shows dot the pages on management of the second stage of labor. However, there is almost no worse way to give birth than on one’s back for a multitude of reasons. Among other issues, the most severe seem to be the full weight of the woman’s body is placed on her tailbone causing the compression of major blood vessels, weaker, less frequent contractions, as well as working against gravity while pushing (Davis-Floyd, 1992, p. 122). Evidence-based studies have shown that the lithotomy position is ineffective for the laboring woman, yet physicians continue

to favor it. For the physician, the lithotomy position is at once convenient and culturally significant. In another obstetric textbook, the authors describe the lithotomy position as “the ideal position for the attendant to deal with any complications that may arise” (quoted in Davis-Floyd, 1992, p. 122). Not only does this quote imply the pathological nature physicians seek in birth, but it also places the physician at the focus of the delivery. In the lithotomy position, the physician is in the seat of power while the woman lies helpless and immobilized on her back. The technocratic model is easily observed in the lithotomy position. The physician is conducting his orchestra and will soon deliver his product, the baby, through the use of technology and science.

A Note on Informed Consent

While I was documenting the aforementioned interventions, I was also documenting examples of informed consent between doctor/midwife and patient before such interventions were implemented. Because any signing of papers and explaining of risks could have easily been cut from footage, there is no way for me to tell if informed consent was obtained for every procedure. However, there were very few cases in which doctors or anesthesiologists were shown informing their patients of the risks of c-section, episiotomy, or epidural. The audience, therefore, can infer that none of these procedures hold inherent risk and that they are necessary and desired parts of a normal labor and delivery.

Analysis of Content: Common Themes of *A Baby Story*

“When the anesthesiologist arrived, I actually felt a glimpse of happiness, knowing that my pain was going to end as soon as he started the epidural. When I couldn’t feel the contractions any more, it was wonderful.”

-Baby Mazzerella

“After the epidural I felt like I was walking on a cloud of rainbows. I was like, ‘Whoohoo!’ This is great!”

-Baby Poku

“If there weren’t epidurals, I couldn’t have gotten through it. I don’t think I could have handled it...without it.”

-Baby Tlustachowski

“When I got the epidural all the pain went away in two seconds. Now I felt like I could actually go through labor.”

-Baby Grecia

Sixty-eight percent of the women featured in the 51 episodes of *A Baby Story* used epidural analgesia as pain management. A recurring theme surrounding the epidural was the fact that once the epidural was given, the women could continue on as if they were not in labor. They could lay back, sleep, and continue contracting without ever knowing it. Furthermore, not only did women love the pain-free feeling of labor, but many insinuated that labor is simply unachievable without the epidural. For example, in the episode *Baby Grecia* the woman describes her labor as “someone’s pounding [her] stomach with a sledgehammer every three minutes.” Commonly, women would be shown writhing in pain, the camera would pan to nervous husbands and friends and then cut to a commercial. Upon the return of the show, the woman would be shown post-epidural smiling, chatting with friends and family, or watching television. Labor following an epidural is often commonly called “heaven,” “pain-free” and “wonderful.”

This sequence is witnessed in the *Baby Mazzerella* episode quite clearly. At the start of the episode, the laboring woman is shown in pain, screaming and rolling around on the bed. The narrator announces, “Can husband Tony keep her calm until help arrives?” while the woman is begging, “Where is he [anesthesiologist]?” The concept of not being able to labor without an epidural speaks volumes to the influence of the technocratic system. Women’s bodies, in this model, are unable to stand the pain of labor without intervention. Here, the show itself names the medical professional, and the epidural he is about to deliver as “help.” Furthermore, the

narration insinuates that the correct action is for the husband to keep the woman calm. In this scenario, the only people who are in control of the situation are the men surrounding the laboring woman. The women in *A Baby Story* often thank the anesthesiologist and smile and laugh now that they are pain-free. As the *Baby Grecia* episode and many others attest, women believe themselves incapable of laboring without an epidural.

On the flip side, any woman who decides to have a natural birth is continually set up to fail by the show's narration. In one midwife-attended birth, the narration introducing the episode *Baby Cooper*, asked the question of a woman who planned for a drug-free delivery, "Can she do it, or will she surrender to the pain?" With such a statement, the show is setting up the audience for one of two scenarios: that they will watch this woman suffer for this "out of the ordinary" birth or they will watch her fail and succumb to the pain. Either way, the show's creators portray natural birth as something fool hardy and unnecessary. In the episode *Baby Cardona* the woman plans a natural birth but eventually asks for an epidural. Both before and after commercial breaks the narrator's voice repeatedly asked, "Is her epidural-free birth on the line?" More attention is paid to the decision and drama surrounding the scrapping of a natural birth plan than the actual birth. Once the decision had been made, the show rapidly wrapped up and suddenly the couple was telling the camera about their post-birth life. The dichotomy between the screaming woman laboring naturally and the peaceful, joking woman relaxing through her labor is so strong that the viewer is left with a very clear picture of the "right" way to give birth.

"Dr. Hux broke my water just to get things moving. I guess the pitocin was working but...I guess he just really wanted to get that head down and get my cervix open a little more"

-Baby Fitzgerald

"My induction was taking way too long"

-Baby D'Angelo

“Her contractions will become more effective, stronger and more frequent [with the pitocin]”

-Physician, Baby D’Angelo

“I wanted to have a natural childbirth...My water broke at home, and I didn’t know what to do. My body never went into labor and I ended up having to be induced and with the induction the contractions were really strong...and I ended up having to have an epidural.”

-Baby Petrokansky

“You’re exactly the same, about three to four [centimeters dilated]. What that means is that you really haven’t made any progress. You’ve been contracting adequately, every two to three minutes. We gave you some more pitocin, and you’re exactly the same. What’s probably going to be the best right now for you and for the baby is to deliver by c-section. I think we’ve given you more than enough time.”

-Physician, Baby DiJoseph

“She’s been on the pit [pitocin] for about two hours now, so I’m going to go in and check her. Hopefully she’s progressed so I can rupture her membranes and we can get this show on the road.”

-Physician, Baby Gilbert

The language of “failure” whether it be of a woman’s body, failure to progress, or failure to adhere to pre-determined timelines is very common throughout *A Baby Story*. Most of the time, physicians treat all of these ailments with the drug pitocin. Pitocin, as a synthetic version of oxytocin, increases the intensity and frequency of a woman’s contractions. Often, this drug is used to make contractions “more effective.” This is troubling language; should a physician tell a woman that he will give her a drug to make her uterus “more effective”? This sends the message that the woman’s uterus, working normally, is not effective. Moreover, one of the most commonly used phrases when a woman’s labor had stalled was “failed to progress.” Here, the message is blatantly clear. The woman’s body has failed at labor and is now in dire need of medical intervention. The woman featured in *Baby Petrokansky* explains that her body “never went into labor” following the spontaneous rupture of her membranes, leading her to seek out medical intervention. Through this intervention, she “failed” at having the natural childbirth she

had planned because she was in extreme pain. She does not frame the incident as a situation in which she was pressured into interventions before she was ready. She explains clearly to the viewers: her body failed her and then she failed to withstand the pain.

The description of failure on the part of the woman's body is so pervasive that many of the doctors, as well as the women, begin to use language that makes it seem as if the doctor is the person in labor. The woman explains, in *Baby DiJoseph* that the doctor "really wanted to get that head down and get [her] cervix open a little more." At this point, the woman is explaining her labor in terms of the doctor's control over her body. The woman's sense of failure is palpable, as she explains before she has a c-section: "I really thought breaking my water and all that was going to have me go the right way...the normal way. But now I'm scared." For *Baby DiJoseph*, and many others, clear time tables were constructed and should the women not labor along such predetermined guidelines, the language was clear: the labor "failed to progress." Following such a diagnosis, medical intervention was deemed necessary and life saving for woman and baby.

"I'm kind of nervous. I haven't had an ultrasound since week 20 and I want to know what's going on in there"

-Baby Kilpatrick

"There was always a big question mark every time we went to the doctor's office, like maybe this would be it."

-Baby Wayne

"Am I having contractions?"

-Baby Wayne

"She [mother of woman] asked me if my water broke, if I was having a bloody show, and I don't know. I don't know anything about that"

-Baby Neglia

"This pregnancy has been very overwhelming. My body is not my own. It's all for the baby"

-Baby DiJoseph

"I just needed to get to the hospital. I felt a lot more comfortable there,

and there someone was going to help me out...at the hospital someone knows what's going on."

-Husband, Baby Poythress

In accordance with the technocratic model, the physician must be the reigning authority on the woman's body and labor. In order for this to occur, two things must happen for the pregnant/laboring woman: first, she must be made to feel completely dissociated from her body's processes. As a result of this dissociation, she will defer to her physician as the authoritative figure regarding her labor. One of the greatest gifts to the technocratic system is epidural analgesia. In the episode *Baby Wayne*, along with many others, the women often ask their partners, physicians, and nurses when their bodies are experiencing contractions. With full epidurals, which 84% of women delivering with physicians experienced, the woman's body from her waist down is completely numb. Therefore, the physician must rely upon electronic devices, such as internal and external fetal monitors to interpret the woman's labor, which he must then describe to her. Such a dissociated state, on the part of the woman, puts the physician in a position where he, and his technology, can be the authority of the labor (Davis-Floyd, 1992, p. 102). Davis-Floyd comments that "such reliance on machines assures that the question of who knows what is really going on, as well as what is best for the woman and her baby, will be neatly resolved in favor of those who have access to the more valued technologically obtained information" (1992, p. 109).

In the episodes *Baby Kilpatrick* and *Baby Poythress*, both the women and their partners turn to technology both to seek confirmation of safety and well-being. The woman in *Baby Kilpatrick* had not had a sonogram since her twentieth week of pregnancy, and thus sought confirmation from her physician regarding not only the fetus' health, but also "to know what's going on in there." The phrasing she uses is highly significant; sonograms do indicate fetal health

that cannot be known by the woman, but her statement indicates that a sonogram will tell her about the events that are occurring in her own body. Furthermore, the husband in *Baby Poythress* indicates that although his wife wishes to labor at home as long as possible and that she is doing well so far, that the authority on her well-being and progress will occur at the hospital. A similar event occurred during the episode *Baby Wayne*. The woman and her partner seek information from her doctor during their visits. The woman does not see herself as the authority on when her labor begins, but instead wonders, “maybe this will be it [the beginning of labor]” every time she visits her doctor. In these scenarios, the woman’s subjective experience regarding her labor holds less authority than the objective, scientific information that a physician in the hospital could offer.

“Let’s get you that epidural.”

-Doctor

“I’m still on the fence about the epidural”

-Woman, to cameras after doctor leaves the room

“She’s about six centimeters dilated and she’s requesting an epidural”

-Doctor, on the phone to anesthesiologist

-Baby Nazario-Hilbert

“Give me a hook [to nurse]...I’m going to break your water, ok?”

-Physician, Baby Nazario-Hilbert

“What we’re looking for is if there’s adequate labor, and we know it’s happening because we have the monitor, but are we making adequate progress? The answer is no. At this point the course of action would be to change plans and go ahead with the c-section”

-Physician

“Well....we never even considered c-section...but whatever’s best. At this point it’s all about the baby.”

-Woman

“Well, she’s decided to go ahead with the c-section”

-Physician, to cameras outside the room

“When they told me I had to get the c-section, I was nervous and scared, but I guess I had no choice”

-Woman, later to the cameras (Baby Seetoo)

The above quotations detail two episodes, among many, in which physicians had either made decisions regarding the labor of a woman without her knowledge or instances in which the physician assumed he was offered an option when the women perceived it as a command. During both of the above episodes neither woman protested or questioned the doctor's decisions before accepting interventions they did not want. This is a powerful indicator of the differential power relationship between patient and doctor in the technocratic system. Much like birth as a rite of passage for women, obstetricians undergo an eight-year rite of passage in which they are indoctrinated with the cultural traditions and practices of obstetrics (Davis-Floyd, 1992, p. 254). Throughout this process, "initiates" follow Turner's classic chain of events during an initiation rite: separation, liminality, and aggregation (1979). Through these phases, the initiates will emerge from their training divorced from their original ideas regarding medical practice and they will now "be structured in accordance with the technocratic and scientific values of the dominant medical system" (Davis-Floyd, 1992, p. 257).

Physicians in training are taught by instructors using language regarding obstetric procedures such as "performed," "done," and "acted." Through the use of this language, obstetric procedures, cognitively, become the only viable option for the student. This way, student-obstetricians begin to see birth as an actively managed event, and in fact, an event that they will someday manage. In the mind of the student, there is no question as to the necessity of routine management and intervention (Davis-Floyd, 1992, p. 259). Routinization of medical intervention contributes to the homogenization of hospital births, of which the physician is in complete control.

The authority with which the physicians of *A Baby Story* make decisions about their patients' care, with or without their complete consent, is a result of their near-decade long

initiation into obstetrics. First, the physicians speak of the birth in communal terms by using pronouns such as “we” when the woman is the only person giving birth. This cognitive association shows the extent to which the physician sees himself as an active part of the woman’s labor. The physician involved in the episode *Baby Seetoo* uses this language deliberately and repetitively. Not only do physicians use the language of “we” to describe the woman’s labor, but in this instance it appears as if his usage of the word “we” relates to the technocratic system as a whole. He insists, “we are looking for...adequate labor and we know it’s happening because we have the monitor.” The physician views the woman’s labor as a process managed by “them” (i.e.: the hospital, monitors, doctors, nurses). Therefore it is easy for him to recommend a cesarean in a way that, on a conscious level, he believes is a choice, but due to his initiation process and world view as an obstetrician, the woman is not presented with a choice. The disconnect is evident in the way the physician and the woman speak separately about the decision to move forward with a cesarean. While the physician indicates that the woman has chosen to have a c-section, the woman is very scared and feels that she has been commanded to undergo surgery.

Even more striking are physicians who have made a decision and act upon it without asking the woman’s consent or wishes. This behavior was evident when a physician asked a nurse for an amniohook (used to rupture the amniotic sac), then told the woman he was going to break her waters. There was also only one episiotomy conducted (that could be seen, at least) in all 51 episodes. The physician cut the perineum quickly without a word to the woman about what she was doing or if the woman consented. Such instances give us insight into the world-view and rituals of obstetricians. Under the technocratic model, the physician is the mechanic for the woman’s body and must make sure that it runs correctly and in accordance with proper time constraints. When asked their role in a birth, many obstetricians gave similar answers to the

following quotation, from Davis-Floyd's study: "I sort of see my role at birth this way: I am the captain of the team, and the mother and the father and the nurses—they are all players. If somebody is going to call the shots, it's going to be me" (1992, p. 268). Obstetricians have been trained to be the "captain" of birth, and thus see their role as the decider, and even the "deliverer" themselves. The most important aspect of technocratic birth is homogeneity and constant control. In order for a birth to progress in this way, the physician must be indoctrinated with these messages during his initiation and conduct birth in an authoritarian manner.

In order for women to continue using the services of the technocratic system, physicians and the medical community must constantly barrage the woman with exaggerated, or even incorrect, scientific information. Davis-Floyd explains the obstetricians in her study seemed "consistently to take seriously research that validated their standard practices or expanded their technological repertoire, while explaining away research results that challenged those practices or the basic philosophy that underlies them" (1992, p. 262). Obstetricians tend to practice this way in order to continue to validate their ritual procedures, even if it undermines maternal and child health. The misguided information is introduced to women to create a sense that without the technocratic system, birth is dangerous and unpredictable. To build confidence in the effectiveness and necessity of obstetricians, hospitals, and invasive technology, women and their families must be told a constant stream of technocratic "facts." Such facts are seen often in *A Baby Story*, and are repeated to an even wider audience. They include, but are not limited to:

"She's 38 weeks, which is plenty...plenty of gestation"
-RN, Baby Robinson

"She's at 37 weeks, there's not going to be any harm in bringing the baby out a little early"
-Physician, Baby Rishko

"After having the first c-section, there was the option of having

a vaginal birth, but it's very dangerous, there are a lot of risks.”
-Partner of woman, Baby Meyer

“They had given her the pitocin at that point, because her water had broken and we had to get the baby out as quickly as possible.”
-Partner of woman, Baby Tlustachowski

“Dana was kind of torn as to when to ask for the epidural. She was concerned that it would slow her labor, and Dr. Hux actually told her that it wasn't so.”
-Partner of woman, Baby Fitzgerald

“We're going to break your water as soon as possible because that will get you going”
-Physician, Baby Szymanowicz

“I generally don't let my patients go longer than 41 weeks [gestation].
-Physician, Baby Gilbert

Some of the most frequently repeated information that can be refuted by empirical studies is the belief that delivering a baby early will not cause harm and that vaginal birth following a cesarean (VBAC) is dangerous and should be avoided. According to the March of Dimes, estimation of due dates can be off by two weeks, therefore, the woman who was induced at 38 weeks could actually be 36 weeks, which would make her baby a late term preemie. Risks associated with late term prematurity include breathing and feeding problems, jaundice, and trouble regulating body temperature. Several babies on *A Baby Story* had to spend time in the NICU because of early delivery and the resulting breathing problems. One story in particular, *Baby Kilpatrick*, featured a woman who was delivered at 37 weeks due to low amniotic fluid. Following the cesarean, the baby suffered from sleep apnea related to an immature brainstem. Overall, five babies (10%) were admitted to the NICU due to breathing problems associated with early delivery.

A widely held belief by both physicians and clients on *A Baby Story A* is that a repeat cesarean is a safer option than a vaginal birth after a cesarean (VBAC). In fact, Henci Goer,

author of *Obstetric Myths Versus Research Realities* points out that the common misconception of “once a c-section always a c-section” is not corroborated by empirical studies. This myth arose from the danger of a trial of labor associated with a vertical uterine scar (rarely seen any more) that could lead to catastrophic uterine rupture. However, in the 1970’s, physicians switched from a vertical incision to a low, transverse incision. Goer points out that “study after study has shown, it [the uterine scar from a previous cesarean] rarely gives way, and when it does, the separation is usually like opening a zipper: neat, bloodless, and benign” (1995, p. 41). The rate for uterine rupture is roughly 0.3% and nearly 70% of women who are allowed a trial of labor after a cesarean successfully complete a vaginal birth. These statistics are often ignored by the physicians of *A Baby Story* as well as other studies that indicate the risks of elective cesarean. In fact, the risks of placenta accretia (where the placenta grows into the muscular wall of the uterus) and placenta previa (where the placenta covers the cervical opening) increase significantly with the number of cesareans (1995, p. 46). These are two of the most serious complications of pregnancy that can result in maternal or perinatal death and often require a hysterectomy (1995, p. 46-47).

The above quote by the husband in the episode *Baby Tlustachowski* and the physician in *Baby Szymanowicz* in reference to the rupture of a laboring woman’s membranes exhibit another common obstetric myth. It is widely believed that once the amniotic sac has ruptured the woman must deliver in 24 hours because of the risk of infection as well as the idea that induced rupture of the membranes will speed up labor. Intervening in a labor lasting longer than the prescribed amount of time following amniotic membrane rupture arose following a slew of studies conducted in the 1960’s. These studies indicated that a neonate had a high chance for infection if not delivered before the 24-hour mark (1995, p. 205). However, Goer points out that as long as

physicians and nurses only perform pelvic exams when necessary and generally try to keep fingers and monitoring devices out of the woman's vagina, her chances for infection are, indeed, lower even if she is allowed to labor for more than 24 hours after her water breaks (1995, p. 206).

In regards to the practice of amniotomy, or artificial rupture of the amniotic sac, Rosen and Piesner in a 1987 study wrote, "The status of the membranes has but a small effect on the length of labor... We conclude that a routine clinical practice of rupturing membranes in the presence of normal labor progress adds little to labor management and should be questioned" (quoted in Goer, 1995, p. 239). Further, research has shown that the amniotic fluid acts to equalize hydrostatic pressure, therefore intact membranes work to protect fetal-placental circulation and help to distribute pressure more evenly on the fetal skull as it descends into the birth canal (1995, p. 240). Often amniotomy is performed in order to place an internal fetal monitor on the scalp of the fetus's head. Authors of several studies have concluded that while amniotomy may speed labor by one to two hours, there is no physiological benefit to the procedure (Goer, 1995, p. 240). In the case of *A Baby Story*, amniotomy was often used as a method to "speed up" labor, which is indicative of the pervasive technocratic culture. Should the time frame not match with expected progress, the woman's labor is actively managed in order to force her body to fit the expected time schedule set by the physician and the hospital.

Physicians in *A Baby Story* frequently use interventions that are not backed by science, leading to a philosophical quandary. If obstetrics is, at its core, the scientific study and management of the pathology of pregnancy and childbirth, why do its practices so often stand at odds with empirical, scientific evidence? In 1993 an anthropological study found "...a pervasive assumption, shared by medical practitioners and their clients alike, that [obstetric] practices

are...scientifically grounded. On examination, the evidence on which his conviction is based is sometimes non-existent, and if it does exist, is frequently far from clear-cut” (Goer, 1995, p. 349). Goer also cites Robbie Davis-Floyd’s characterization of the technocratic model of birth that views a woman’s body as a defective machine as one reason for such a dissonance between scientific knowledge and obstetric practice.

Elizabeth Janeway, a sociologist, also explores the idea that under the Western social system, relationships are assigned as roles of reciprocal pairs. In such a system, the “principal player expects the proper response from the other players. If one of them misses a cue, confusion and distress result. If the lapse is relatively minor, the usual reaction is to laugh it off. Thus a woman who does not want an epidural may be portrayed as misguided, or perhaps selfish...If the departure is more serious, shaming may be the tactic. Thus a woman who refuses electronic monitoring may be told she is taking an irresponsible chance with her baby” (quoted in Goer, 1995, p. 354).

This sociological premise may explain why so few women offer dissenting opinions to their physicians, even when they have made their wishes known to their families minutes before. Furthermore, in Western society, the physician holds respect and power through his position, thus the woman is not the principal player in Janeway’s theory; the physician is. Therefore, the physician, acting upon his technocratic training, will have decided the best course of action in managing a labor and will expect the culturally appropriate responses from his patients. In such a setup, the culturally correct response to a physician’s decision is approval and affirmation of the doctor’s wishes, and consequently, affirmation of the technocratic worldview.

A Case Study in Fully Technocratic Birth: *Baby Carter-Woods*

Of the 51 episodes, none was a better example of what a fully technocratic birth looks like than *Baby Carter-Woods*. In this episode Kathy Carter-Woods prepared for her third scheduled c-section. In the introduction to the episode, the narrator tells us that “Kathy Carter-Woods may look happy, but inside, she’s a nervous wreck...how will this mom handle the panic of a painful c-section?” Before the footage even begins rolling, the producers of *A Baby Story* have introduced very powerful words and emotions into the viewers’ minds. Such narration insinuates that it is not only normal to be a “nervous wreck” but that “panic” and “pain” are to be expected. Further into the episode, Carter-Woods speaks to the cameras and explains that this is her “third pregnancy, third c-section... I feel like I know what I’m doing, like, it’s no big deal...I just feel like I don’t have to do that much.” Here, the woman admits that she is not an active agent in her birth, which recalls Davis-Floyd’s interviews with physicians in which they revealed at the thought of “delivering from above.” Carter-Woods is the perfect patient for the fully technocratic physician; she has wholly accepted the power of the physician and her powerlessness in her own birth-giving.

The quotation that is most indicative of Carter-Woods's feelings towards birth is when she is talking to her physician before her c-section: “I’m ready for my baby-ectomy! Isn’t that what it’s called when they remove something, an –ectomy? So I’m ready for my baby-ectomy.” In this instance, Carter-Woods has adapted a common medical term associated with the removal of an unnecessary or diseased organ, e.g., the removal of an inflamed appendix is called an appendectomy. In fact, medical dictionaries define the suffix “ectomy” as to “surgically remove or excise” (<http://www.jklcompany.com/e.html>). By assigning the suffix –ectomy to her labor, Carter-Woods has effectively removed herself from the labor and delivery process entirely.

One would assume that because Carter-Woods has such trust in the medical system that she has had positive experiences with her previous technocratic births. In fact, quite the opposite is true. In her second c-section she experienced an uneven epidural, in which she would be numb in some areas but not in others. Quickly following the epidural the fetus went into distress and she was rushed into the operating room. Due to the uneven spinal, Carter-Woods explains that “as soon as they cut me, I felt it. I couldn’t stop screaming. I just felt like I was going to die.” Following such an experience, Carter-Woods did not reject the technocratic model, but instead further embraced it. Indeed, for the cesarean featured in the episode, she requested that the anesthesiologist put her under general anesthesia. In a typical cesarean, the woman is administered a spinal block (epidural) so that she remains awake and alert while the section is being performed, albeit separated from seeing the procedure by surgical drapes. By requesting general anesthesia, Carter-Woods became a technocratic dream patient: she will not even be conscious or talking while her baby is “delivered from above,” and therefore will have no input to the delivery process and the procedures performed on her body.

In fact, her reasons for choosing general anesthesia derive more from her fear of technocracy than her love for it. She was so scarred (literally and mentally) by her last experience that she sees no escape from the terror induced by a c-section than to be unconscious. Carter-Woods has a very nuanced experience with the technocratic system: she is at once terrified and comforted by its rituals as noted by her comments before her surgery: “I wasn’t nervous, but now I am, now they’re doing medical stuff to me. I feel like it’s going to be ok, no matter what though.” The woman and her family are nervous regarding the cesarean, but have an overall sense that things will be alright in the end. This is one of the greatest tools physicians use to perpetuate the technocratic system: the concept that technology saves lives in all

circumstances and the patient must let the operators of the body-machine control the situation so that lives can be saved. In fact, Carter-Woods' socialization into the technocratic system is so complete that in order to escape the scenario of her last very painful birth, she sees more technological intervention as her only option.

The Language of Fear and Its Purpose in Perpetuating the Technocratic Model

"I'm afraid, I'm afraid I'm doing something I shouldn't be doing."

-Woman, Baby Mazzerella

"I have huge trepidation and fear that this might not go well. [Our daughter] has spoken to me and she has said, 'I'm really afraid for my mommy and daddy.' I don't think she has a real grasp of what could go on, but there is still that fear of what its going to be until that baby gets here."

-Husband, Baby George

"But when a routine doctor's visit turns into a major scare, all hell breaks loose. Will Joanne be able to regain her composure?"

-Narrator, introducing episode Baby Kilpatrick

"I was scared, I was shocked, I was crying"

-Woman, Baby Kilpatrick

"It's normal to be anxious, it's normal to be concerned."

-Physician, Baby Kilpatrick

"The worst part is being strapped down to the boards. Both legs, both arms. That's really the most stressful part for me."

-Woman, Baby Clearwater

"During the surgery...I wanted to cry so much. I didn't like the tugging and the pulling. I was very scared."

-Woman, Baby Jenkins

"Knowing I was going in for a scheduled c-section made me really scared. I just got more and more anxious as it got closer. And now I'm scared. I'm scared to death. I just have had so much time to think and prepare for how scary it is."

-Woman

"How are you feeling about having a c-section today?"

-RN

“I’m scared. I’m scared out of my mind”

-Woman

“That’s normal. Everyone that comes in is scared. That’s normal.”

-RN

-Baby Tesar

“Labor and delivery is the scariest thing for me. People try to reassure you and say, women have been having babies for thousands of years, but there’s thousands of different stories...[it’s] just so scary because it’s so unknown. You don’t know what’s going to happen.”

-Woman, Baby Poku

“The sheer fear of surgery leaves this mom at the brink of a melt-down”

-Narrator, introducing episode Baby Meyer

“I was panicking...Having been through it [cesarean section] before doesn’t alleviate the fear of going through surgery”

-Woman, Baby Meyer

“I’m afraid to give birth, I’m not going to lie. I’m terrified...I’m really nervous about the pain and the unknown.”

-Woman, Baby Gonzalez

“I’ve been so scared of the epidural since the moment I found out I was pregnant. I’m terrified that it’s going to hurt so bad, or I’m going to move, or do something the doctor doesn’t want me to do, and hurt myself...I just want to get to the end”

-Woman, Baby Coles

“If I was going to have a panic attack, it would have been right then. The walk to the OR was like the walk down death row...I have never been so scared in my entire life. I didn’t know what I was supposed to be feeling and what I wasn’t. It was very scary.”

-Woman, Baby Coles

“When they rolled me into the OR I was overwhelmingly scared.”

-Woman, Baby DiJoseph

“When they told me I had to get the c-section, I was nervous and scared, but I guess I had no choice. I was just unprepared.”

-Woman, Baby Seetoo

Of all the themes presented in *A Baby Story* fear was the most common emotion displayed both by pregnant and laboring women and their families. Of the 51 episodes, 38 (74%)

used words related to fear to describe pregnancy, labor, and delivery. These words included not only “fear” or “scared” but “afraid,” “nervous,” “trepidation,” “fearful,” “concerned,” “anxious,” “stressful,” “nerve-wracking,” “panicking,” “terror,” “freaking out,” “chaos,” “terrifying,” and “horror.” Of the 12 midwife attended births, none of these words was used to describe a birthing experience, except for one woman who referenced a previous labor attended by a physician. Of the physician-attended episodes, 37 of the 39 (95%) women attributed these words to some aspect of their labor, though most often it was a reference to pain, the use of pitocin, the placing of an epidural, or the prospect of surgery.

In analyzing the language content on *A Baby Story* along with the interventions that women undergo, it is clear that physicians use fear as a mechanism to perpetuate the technocratic model of care. Much of the fear displayed by women in the above quotations relates to fear regarding cesarean section and anesthesia. If women are so very afraid before and during this procedure, the question arises, why don't women refuse c-section and other interventions that cause them fear? The answer can be found in the physicians who induce uncertainty about the birth process itself as well as doubting a woman's ability to safely give birth without the earlier labor, such as constant electronic fetal monitoring, pitocin, and amniotomy. The phenomenon of cascading medical interventions is part of the technocratic birth system that ultimately removes the mother's (referenced as the woman's) influence from the birthing process. Pitocin, amniotomy, and induction send a clear message that a woman's body is not conforming to the correct time scale (Davis-Floyd, 1995, p. 98). The technocratic birth system enculturates the woman, and this process involves two distinct events. The mother/woman begins to see her body as a failing machine and comes to believe that a physician, the practitioner of the technocratic model, will make her body function properly and produce the goal – a healthy baby.

This complex process can be seen in the analysis of the two kinds of responses women have to medical intervention: acquiescence to the doctor's wishes and active participation in a technocratic birth. It is instructive that many of the women who are fearful of cesarean section undergo the procedure because they believe they must do so because they have had a previous cesarean or because they have been told the fetus is in distress, too big, or overdue. The mother featured in *Baby Meyers* displays this feeling: she has been through a c-section before and fears her second one, but must undergo the procedure for the health of her and her baby. In *Baby Coles* the mother shows similar fear of entering the operating room, comparing the walk to the OR to the walk down death row before execution. Many women tie their fear to the unknown nature of childbirth. In fact, in not a single episode did prospective parents speak of childbirth education classes or preparation. In order to escalate the normalcy of such fear, and continue to undermine a woman's confidence, physicians and nurses often tell their patients that being scared is normal. It is intuitive to think that a physician or nurse would not want their client to be scared, but in fact, fear is the technocratic model's best tool. There is no better way to convince a woman, quickly and efficiently, of her body's defectiveness than by keeping her ignorant of and, by extension, scared of the physiological process of birth (Davis-Floyd, 1992, p. 53). And the trump card played is always the physician's superior knowledge of the childbirth process and his/her ability to captain the team to a positive end.

Physicians use the well being of the baby as a motivator to get women to agree to technological interventions. One of the major components of the technocratic system is the focus on the product of the woman body/machine: the perfect baby. Such a focus on "the production of the 'perfect baby' is a fairly recent development, a direct result of the combination of the technocratic emphasis on the baby-as-product with the new technologies available to assess fetal

quality” (1992, p. 57). In the instance of *Baby Seetoo*, not only is the woman pushed into a cesarean she does not want, she tells her family that she and her husband “never even considered c-section...but whatever’s best. At this point it’s all about the baby.” She then relays feelings of fear for the procedure. In this situation, the physician used the social set-up of reciprocal pairs, as described by Janeway, to create the end result he desired. The physician, as the key player, expects a certain response from his patient, the other player. Should she depart from the response desired, the physician can use shame or fear as a tactic to make the scenario resolve the way he desires (Goer, 1995, p. 354). Women like those in *Baby Seetoo* do not resist interventions because they have been made to believe that if they do not accept them they will put their baby in jeopardy.

However, there are some women who seek out the technocratic model but when the time comes they fear its procedures. Davis-Floyd refers to such women as those who fully accept the technocratic model. It appears these women have been more deeply enculturated into the technocratic model, as they actively pursue high-tech interventions instead of marginally resisting them. Davis-Floyd’s subjects, as well as the women in *A Baby Story*, “did not usually constitute a conscious belief in the mechanicity of their bodies or of the labor process, but rather took the form of unquestioning acceptance of the value and validity of the medical definition and management of their births” (1992, p. 189). Many of these women, as well as the general public, hold the belief that before obstetricians attended women’s births the maternal and neonatal mortality rates were much higher (Goer, 1995, p. 357). In fact, many women endure their pregnancies “waiting for the other shoe to drop” or fearing the “many unknowns” and the “mysterious nature of childbirth”. Few physicians are portrayed talking to their patients about the physiological process of birth. Rather, it is reduced to talk of adequate (or not) contractions,

dilation, and pushing. By keeping women uninformed of what a normal, physiological birth might look like, many of the women in *A Baby Story* quoted above readily accept technocratic interventions as necessary or even desired. In these instances, women place their full trust in the technocratic model.

Furthermore, many women discuss being “scared out of their minds” or even “scared to death” at the prospect of labor and delivery and physicians and nurses step in, in at least two separate episodes, to reassure their patients that their fear is a normal part of the process. When one works within a system that normalizes fear, the practitioner may easily step and act as the person in charge of the birth. Physicians then reduce the fear of their patients by implementing technology and a rational time-centered model of the birth process. In fact, Davis-Floyd describes women who display full espousal of the technocratic model as women who view labor and birth as “bewildering and frightening and wish for their labors to be made as reassuringly mechanical as possible” (1992, p. 190).

Davis-Floyd identified 9% of the women in her study as fully accepting of the technocratic model and another 9% who completely rejected their own biology in favor of the technocratic model’s rituals. In *A Baby Story* nearly all (95%) of the women seen by physicians made comments that implied their full acceptance of the technocratic model or their denial of their own body’s natural biological birthing capabilities. Because of the format of *A Baby Story* it was difficult to pinpoint where some of the mother's opinions lay on this issue, as not all women discussed their feelings about birth and only expressed fear. Others were very clear about their full rejection of natural childbirth. In fact, the mother featured in *Baby Kilpatrick*, regarding her scheduled c-section said: “I can tell you, I don’t feel cheated. I don’t feel like I need to experience contractions. I’m kind of glad about it.” However, she also experienced severe fear

and distress while undergoing her cesarean. Davis-Floyd expertly explains why women like Kilpatrick experience intense fear when they expect the technocratic system to belay any anxiety:

“hospital procedures are not specifically designed to serve as vehicles of concern and reassurance to birthing women, and often they do not...they usually have no cognitive matrix in terms of which they can interpret their experiences, no breathing rituals, no ‘labor support person’ to mediate for them between cognition and chaos. They expect that hospital procedures will serve that function for them, will reassure them and make them feel safe. But the technocratic model on which these procedures are based, especially in its extreme traditional form, does not acknowledge the mother’s cognitive need for an intelligible framework within which to interpret her experience, nor the psychological devastation that can result from living through such an intense experience in the total absence of such a framework.” (1992, p. 191).

Of those women who had physician attended births, only two had trained support persons (doulas) available to interpret their experience and advocate for their wishes. Interestingly enough, these were the two births attended by physicians in which the women did not exhibit fear of their births.

In order to further remove women from positions of power, and to increase their fear, during birth, laboring women are addressed either very positively or negatively while in the pushing stage of labor. Five women were addressed, during coached pushing, as “good girl” by either the physician or nurses. This infantilization was offered as a reward for following the instructions of the physician. Sometimes, however, the women were demeaned because they did not follow technocratic procedures during the final stage of the birth. During the pushing phase

of *Baby Tlustachowski* the woman was very vocal while she pushed. The physician responded to this by insisting, “deep breaths, no noise, nice deep breaths.” While the woman pushed, the physician spoke to her very harshly and continued to say that the woman was not going to push effectively as long as she made noise. In episode *Baby Arcell* the attending physician insisted “this should be the last contraction you have to push really hard, come on, hun, come on, harder, now!” When the woman had to push for more than that one contraction, the physician became frustrated and told the woman she was not pushing effectively and she must follow his instructions exactly or the baby could be hurt. In the final moments, the physician is nearly ready to deliver his perfect product unto the world through the use of science and technology. Throughout vaginal deliveries, the phase of pushing was the most controlled by physicians, as well as the space where women were most verbally punished or rewarded for complying with the technocratic system.

All of the tactics discussed above serve a distinct purpose: to instill mystery and complication into the birth process by keeping women uninformed of what is being done to them. Many of the women who expressed a lack of knowledge also tied this feeling into their fear of their births. When women fear their births, and especially the pain associated with birth, a great majority of them turned to medical intervention. In this way, physicians continue to implement the technocratic model under the guise that women are "choosing" the interventions offered rather than being forced or co-opted into them. Mothers who were fearful of birth also hesitated to deny technological intervention, since it was presented in such a way that it was not perceived as a choice but the "only" course to a healthy baby.

While only 18% of the women in Davis-Floyd's study espoused the technocratic model or rejected their biology, 95% of the women in *A Baby Story* who delivered with physicians and

73% of the women overall express opinions of fully accepting technocracy. It is significant that the women featured in *A Baby Story* and the women interviewed by Davis-Floyd are represented very differently in their proportions. It can be inferred that the producers of *A Baby Story* and the network, TLC, look for a very specific kind of story to tell, and it seems as if the story they privilege above all others is the supremacy of the technocratic model of birth.

Part Three: The Impact of *A Baby Story* on Young Women

Reality-Based Birth as Seen Through the Eyes of College-Aged Women, aged 18-24

Methods and Reasoning

For the final prong of this project, I elected to interview young women who are familiar with the show *A Baby Story* and gauge the level to which they have been impacted and educated by reality-based birth stories. There have been few studies regarding reality birthing shows, and even fewer, if any, which reference young women's ideas about childbirth. The two extant studies relevant to my work include Morris and McInerny's sociological study of a number of birth-related shows and the Listening to Mothers II survey, which interviewed women who had recently had children. The Morris and McInerny study did not address the impact of reality-based television's messages on its viewership and the *Listening to Mothers II* survey only interviewed women who had had children. This study seeks to investigate the impact one specific, long-running show has had on young women during a narrow window of their reproductive lives: at the point at which they have just become adults and are not yet looking to start families.

My goal was to assess the extent to which young women are educated about the physiological aspects of birth, where they receive such information as well as how they view childbirth. It was also my aim to examine how much of the content of *A Baby Story* young women absorb and how this may affect the decisions they make if and when they have children of their own. Of the women surveyed for the *Listening to Mothers II* report, 68% of women reported watching a reality-based birth show, with *A Baby Story* being the most prevalent show watched. Furthermore, a slight majority (51%) of women interviewed responded that the show helped them to understand what it would be like to give birth, and 32% of first time mothers

reported that the shows increased their anxiety regarding their pending births (2006, p. 24). It is evident that based on these numbers, a majority of birthing women are watching shows like *A Baby Story* and taking in the messages that shows such as this one impart.

Based on this research, I decided to interview young women age 18-24 to determine what, if any, impact *A Baby Story* would have on their ideas surrounding birth. I also wanted to see if young women were viewing *A Baby Story* with the same intentions, as well as hearing the same message that birthing women get from the show. In order to do this, I sent a preliminary e-mail to the campus listserv looking for participants. My specifications for inclusion in the study were:

- 1) You must be a woman between the ages of 18-24
- 2) You must not have given birth, either vaginally or by cesarean section
- 3) You must have seen *A Baby Story* within the past three months.

I received many positive inquiries and decided to host a focus group with a small number of women as well as conduct a few informal, one-on-one interviews. My focus group consisted of five young women and took place on February 11th 2011. Between February 5th and February 18th I interviewed an additional three young women in a one-on-one setting.

Before the focus group started, I showed one of the few clips I could find online that had *A Baby Story* footage to refresh their memories regarding the show. The clip featured came from the episode *Baby Armstrong*. The clip's epithet reads: "The Armstrong's are disappointed to find out they will need a c-section, but are delighted by the birth of their new son." The clip can be found at: <http://tlc.discovery.com/videos/a-baby-story-baby-armstrong.html>. The woman's story featured in this episode is typical of those that are common on the show: she is attended by a physician in a hospital, she has multiple interventions, and following the physician's

recommendation to have a cesarean to do lack of progress in labor and fetal heart deceleration, a c-section is performed. The woman notes that she is disappointed not to have had a vaginal birth, but asserts that in the end she will be healthy and the baby will be healthy and that is all that matters.

I entered the focus group, as well as the interviews, with specific guiding questions, which included:

-Describe the process of birth, start to finish

-How did you learn this information?

-Imagine you are giving birth. How would you want it to be? What are some of the emotions you associate with birth?

-Do you think reality-based television shows portray birth accurately? Where else have you seen real footage of birth, or been to a live birth, if any? If you have what was that experience like?

-Describe a typical episode of “A Baby Story”

-Do you have a favorite episode? Why is it your favorite?

-What is most memorable about the show?

-Who is in charge of the birth during “A Baby Story”? Who is making the decisions?

-Have you ever seen a midwife on “A Baby Story”? What was that like? Do you think the experience would be different than having a baby with a doctor?

The focus group was diverse, in both opinion and ethnicity. There was a range of opinion regarding birth that encompassed ideas from an aspiring midwife to a young woman who indicated she would want general anesthesia should she have a cesarean section. Of the eight women in the study, one was Eastern European immigrant, four were white, one was black

woman, one was Hispanic, and one was Southeast Asian, Each of the participants has been given a pseudonym to protect her identity. It is also imperative to note that all interviews were transcribed verbatim in order to capture the exact words the participants used to describe the birthing process. In her study of women's ideas about menstruation, birth, and menopause, Emily Martin shows how women's use of either active or passive verbs in describing bodily processes can tell us how they think about their bodies. Therefore, it was imperative that I transcribe my participants' words thoroughly and accurately so that such an assessment could be made.

Moreover, it is difficult to assign each young woman into a category of "wholistic" "technocratic" or "middle range." There are simply no easy boxes to define either the young women's feelings regarding birth or how to assess where on the scale such opinions would fall. In this section, I will use the term wholistic, to describe sentiments that indicate that the young woman believes that the female body is normal and that birth is a natural event that a woman actively does. In the holistic model it is the woman, not the physician, who will deliver the baby by listening to her body's innate knowledge, and the role of birthing attendants is to encourage and support the family unit (Davis-Floyd, 1992, p. 156-57). I assessed the participants based on a number of characteristics in their statements. First, I looked closely at how the young women want their future birthing experiences to be. I feel that this is a more accurate descriptor of her feelings related to a wholistic or technocratic model. Secondly, I examined how much fear played a role in the emotions these young women associate with birth, as well as the perceived trust in the medical system.

In reading the transcripts of the interviews, I have compared the number of times a young woman used language that would indicate that her statements supported either the technocratic or holistic models. Kris was the only participant whose comments fell squarely on the side of the

wholistic model (her ratio was 0 technocratic to 13 wholistic statements). Three participants fell more towards the middle. Tera had a 5:13 ratio, Tammy fell more in the middle with a 5:7 ratio. Barb fell squarely in the middle with exactly 6 comments supporting technocracy and 6 comments supporting wholistic methods. Carol and Ashley's scores begin to mark the middle-technocratic range with 8:3 and 9:2 respectively. Diane was relatively quiet during the focus group, but all 5 of her comments fell strongly in favor of technocracy. On the farthest end, Holly showed near full acceptance and trust in the technocratic model with a ratio of 18:3.

Themes of the Interviews/Focus Group

Participants describing the birthing process, from start to finish:

A woman needs to be dilated a certain amount of centimeters. I think its 8... I'm not sure. She has to be fully dilated. And then she can either start having a natural birth or, sometimes it takes some time to get a woman to be fully dilated so they may start her on pitocin to increase the contractions...and then she's ready to go and...I don't know, it takes a couple hours. And then the baby goes down from the uterus into the birthing canal and then it comes out...and then there it is!

-Tera

Ok, so like, always in the TV show, they'd be somewhere and the water breaks and then everyone's freaking out, so they go to the hospital and the doctors and the nurses all check them out, see how far she's dilated. And then they hook them up to machines and stuff, to monitor the baby and then it's like, labor begins...when she's enough centimeters, now they have to push, because it's time for the baby to come out, and they have to get him out before there's complications or he could get injured. And so they do that, and they push, and there's counting. I'm not really sure what the counting is, but they do that, and then the baby's born

-Holly

One of the first things I asked my participants to do was to describe the birthing process. My aim was to gauge not only the young woman's physiological knowledge of birth, but also to analyze the ways in which young women talk about birth and how that may be indicative of how they think about their bodies and birth as a whole. Emily Martin, in her work *The Woman in the Body* interviews women of all ages in relation to gynecological exams, menstruation, and birth.

She explains that she is interested in how women construct their concept of “self” as well as to examine “the fragmented and alienated condition in which women are alleged to exist” (Martin, 2001, p. 71). The fragmentation that Martin references is prevalent in the technocratic model of the body and can often be seen in *A Baby Story*. In the episode *Baby DiJoseph*, the woman proclaims that her body is not her own, that it is “all for the baby.” Furthermore, with the use of epidural analgesia, the woman’s labor process, quite literally, becomes separate from her mind. Her body labors but her mind does not perceive the contractions. Martin explains that many women in her study who underwent epidural analgesia felt as if their bodies were objects to be manipulated by their physicians (2001, p. 84). Martin also discusses, in relation to menstruation, that many women see this process as something that happens to them, not something they actively do, for example, they refer to cramps as something a woman “gets” or menstruation is something a woman “has,” for example a woman “has her period,” implying that she does not actively menstruate (2001, p. 71).

Both of the young women quoted above display a degree of fragmentation that Martin discusses. I wanted to look at how young women see women’s bodies giving birth, as either something active or passive. Both Tera and Holly explain labor using similar verb tenses. To Tera, the baby “goes down” the birth canal. For Holly “they” have to push. It is unclear, in Holly’s case if she is referring only to the woman only and using a colloquial “they,” or if she is referring to “they” as the doctors and nurses, as well as the woman. However, in the previous sentence she explains that “they hook them up to machines...and when she’s enough centimeters, they have to push.” It is of note that Holly says “when she’s enough centimeters, *they* have to push,” as if it is the doctors and nurses who are involved and actively pushing.

Physiologically, Holly, Tera, and the other women tell a similar story in their lack of details. Neither of the women mention that it is the cervix that needs to be dilated or that the fetus passes through the vagina. “She” must be dilated is as specific as many of my participants were able to explain. Furthermore, nearly all the women mentioned the drug pitocin at some point in their interview. This drug is featured prominently on *A Baby Story*, and when asked, all attributed their knowledge of the drug to watching *A Baby Story*.

Where Participants Learn about the Birthing Process

Some of it from health class, but I never really paid attention...some it, actually, from *A Baby Story*, or what my mom has told me.

-Carol

I started watching *A Baby Story* when I was really little, so I probably learned a lot of that stuff when I was little, but now my family tells me stuff, and I know someone who just had a baby at home and she had a midwife, and now I’m in a lot of parenting classes [for my major] and we’re learning the actual biology of it.

-Tammy

Shows, like the TLC one [*A Baby Story*] and class, like biology class. I think it’s a combination of information and also from, like, other people’s experiences.

-Tera

I don’t know, just from, like, taking AP Bio [Advanced Placement Biology] I know my teacher was telling me that by nature, being pregnant is high risk and then even worse is if you have twins, and that’s even more high risk. Just, like, a lot of people think that this [giving birth] isn’t something risky, like everyone goes through it.

-Diane

Like the women interviewed for the *Listening to Mothers II* survey, all of the women in my study have compiled their knowledge of childbirth from many sources. Whereas more first-time pregnant women in the survey rated books, their friends, and the internet as their best sources for information, respectively, the other mothers in this study seemed to gather information from different sources after they have had their first child (*Listening to Mothers II*,

2006: 23). In my study, for the most part, the young women have gained their knowledge from three sources: reality television, biology or health education classes, and parental or other relatives' stories and experiences. This is to be expected, as the women in the Listening to Mothers survey were seeking information for their own impending birth in the very near future. The young women I interviewed, however, did not indicate that their motivation for watching *A Baby Story* was educational in nature. During the focus group, the women agreed that their focus was on the story of the couple as well as the baby once it was born; any education regarding childbirth was incidental.

Emotions Associated with Birth

I know a lot of stress...a lot of stress going into birth just 'cause it's like a scary thing just going into it. Like, you don't know...I don't know personally, but I suspect that it's a scary thing just going into it.

-Carol

In the beginning, like through the whole pregnancy you're really anxious, you don't really know what's going on, like what's going to happen, there's so many fears that are involved with it. And then when it comes down to the day and your water breaks, I'm sure there's so much more anxiety then because its like, everything you've been working up towards, it's there. And definitely the husband would be feeling guilty, at least I hope, during the whole pain aspect of it. Really, just anxiety is the biggest thing. Then following the birth complete joy, because it's done, you're happy and everything's fine. So it's worth it.

-Holly

I'm going to be totally honest, I'm freaked out about the whole thing, regardless of how it happens. I don't know, it's just something that I'm fearful of. I don't do well with pain or any of that stuff.

-Ashley

As of now, it looks like a really exciting process. But I know when it's happening it can be a really emotional time.

-Tera

Regardless of whether they embrace a more wholistic or more technocratic model of birth, all of the women expressed fear of the pain associated with childbirth. This fear and the

motivations behind it, however, varied between the women who expressed differing ideas regarding holistic versus technocratic birth. Holly expressed the most technocratic sentiments regarding birth by stating that the husband should feel guilty for causing his wife pain during birth, as well as referring to birth as something that is “worth it” and the greatest joy comes because it is done. Holly does not specifically want to go through the birthing process, but sees it as a trade-off: one must go through this pain in order to get a baby.

Ashley and Carol simply offer sheer terror of the pain. The three women, Holly, Carol, and Ashley, fall closer to the technocratic model in their opinions about childbirth, and express very technocratic views in regards to pain. Davis-Floyd explains that the Western medical system is continually “engaged in demonstrating the high negative value we place on pain. Perhaps we devalue pain so much because it, like birth, reminds us of our human weakness---our naturalness, our dependence on nature. Machines don’t feel pain, so if we are going to be like them, neither should we” (1992, p. 102). Not only do these young women think that pain is bad, they also say that they have “low pain tolerance” and wouldn’t be able to “handle” a natural birth. Such ideas are indicative of internalized feelings of the inadequacy of one’s own ability to birth without the aid of technology.

How Young Women Envision Their Births

I would want to have a baby in my house. Maybe in the bathtub. I want to be a midwife, so I would probably want another midwife present, but hopefully I’ll kind of be my own midwife.

-Kris

I don’t want the epidural for myself or the baby, because you can paralyze a woman. I know it doesn’t happen often, but it’s a risk, so I’m not looking forward to that. And I heard it sometimes makes your baby kinda high, and that’s why they’re like, a different color when they come out. So for myself I want something more natural. I think women’s bodies were made for this, and before all this technology they could do it.

-Tera

I don't know, I have it in my mind that this whole pregnancy thing and giving birth isn't going to bother me, like, I have said that I want to do it the natural way, well when I say natural, I mean no epidural, and come out regularly but I don't want a c-section. Because that's scary. That scares me.

-Barb

I think I want to be in a hospital for sure. I was actually talking about that with my boyfriend...but I would want to have a baby in a hospital because I wouldn't want to feel all the pain, but I also wouldn't want a c-section because I also think it's an accomplishment to have gone through the birth process.

-Tammy

I have never thought of doing an at-home birth. I thought that was like, "Oh my goodness" and then my cousin did it and her kids are great, and that looks like such a good idea, but then again I want to be a nurse, and I know that I can put my trust in the hands of those people [doctors and nurses] because I know I can trust them, with their expertise and things like that. But I definitely want to do a natural birth and things like that you know, within a hospital setting.

-Holly

Ok, so I'm definitely gonna be in a hospital 'cause I have like, zero pain tolerance. I get a prick on my finger and start freaking out. I'm gonna be drugged up as much as I can physically possibly be.

-Carol

I've heard that giving birth is one of the most painful things you'll ever experience as a woman, so that's scary, and I was thinking about how lots of people get spinal taps, and that's a scary thing to me, that doesn't seem safe to me. I think it is like... fear of the unknown....but when you're going through labor, you're like, give me everything [drugs]!

-Diane

The order of the quotes above represents the spectrum that these young women show in their attitudes regarding birth. Kris is a young woman who has witnessed births outside of *Baby Story* and also wants to be a practitioner of the wholistic model. Tera wants to give birth in a free-standing birthing center and possibly have a water birth. Tera also expresses that "women's bodies were made for this," and has full confidence in her body's ability to give birth. Barb insists that she is not scared of birth, but is scared of the possibility of technocratic

intervention. Moving toward the more technocratic end of the scale, Tammy wants to be in a hospital and espoused views that it is safer there, but also believes it an accomplishment to have gone through the birth process. Holly, on the other hand wants to be a nurse and fully embraces physician's expertise, but still aims to have a natural birth. Holly is very informed about birth and holds very technocratic views on birth, which I will discuss later.

Carol and Diane represent full acceptance of the technocratic model and wish to have their births emulate this model. Carol sees birth as terrifying and painful and expects she will actively seek out epidural analgesia. Diane, as seen in an earlier quote, has been taught, and accepts that pregnancy, in and of itself, is a high-risk endeavor. In her introduction to the technocratic and mechanistic model of the body, Davis-Floyd explains that in such a model, the male body acted as the prototypical model and the female body was regarded as "abnormal, inherently defective, and dangerously under the influence of nature" (1992, p. 51). Furthermore, it is no surprise that Diane holds technocratic views regarding her future childbirth if she has been taught that pregnancy is an inherently dangerous state for the female body.

Opinion on Birth From Others' Experiences

I thought it was American doctors [who decided the labor was taking too long], they rush you to your due date. My cousin gave birth here and it was on her due date, and she was really going by everything the doctor was saying because it was her first baby, and she was really nervous. My mother and aunt were trying to tell her, like, it's ok if the baby goes past a couple days but she only listened to her doctor, and her doctor, literally the next day, had her come in, started her on everything to speed up her process, and I thought that put the baby in distress. And originally she wanted a vaginal birth but after like, oh my God, she was in there forever...they had to do a cesarean because the baby was in distress....If they had waited a few more days the baby would have been ready, naturally. Started the process by itself. So yeah, I think doctors are a little too quick to determine, let's get the baby out....they could have given the baby a couple more days. I mean they say after a week if the baby doesn't start coming then consult your doctor, but really? After one day? Give me a break."

-Tera

My uncle is a police officer, and he had to help this woman deliver a baby on the side of the highway, and he didn't really know that much, but he had to help her and he had to cut the umbilical cord on the side of the road with the knife in his pocket. Like, if you don't make it to the hospital on time, you can resort to other means.
-Ashley

Very few of the women in the study had actually seen a baby born outside of the context of reality television or biology class. Kris, the proponent of the wholistic model had witnessed two, but only two young women shared specific stories about other women's births that they had heard about from others. I also asked participants if they knew their own birth story, but none could give very clear details. If they did know, they usually knew the time, the hospital, and whether they were delivered vaginally or via cesarean.

Two young women, however, Tera and Ashley, shared stories that directly shaped their views on birth. Tera, whose views fall toward acceptance of a more wholistic model relayed the story of her cousin's highly technocratic birth. Tera shows, in the quotation above, that she sees the physician's practices as the cause of the baby's distress as well as the need for her cousin's cesarean. This participant sees herself as outside the technocratic system and therefore, can view it critically. Tera emphasizes, when talking about her own future birth experience that she believes women's bodies are fully capable of natural birth. She also speaks to the issue of trusting one's doctor versus trusting your body's own natural process. While discussing her cousin's induction, she touches upon one of the core features of the technocratic model: the concept of time. Birth is the "process that reproduces society...and must be culturally shaped to occur within a specific amount of time, just as must the production of any factory good" (Davis-Floyd, 1992, p. 98). In her cousin's case, Tera saw a technocratically controlled birth and disagreed with the general tenets of such a system. She also explains that her mother and her aunt disagreed with the physician's decision. While many young women look to reality television and

health classes to construct their views of birth, it is evident that familial opinions and stories intensely impact how young women view birth.

Ashley has a different experience with a family member's story about a birth. In this instance, her uncle, a policeman, helped a woman deliver without any training or emergency medical support. Ashley shared this story in the context of a focus group and shared very technocratic viewpoints regarding pain relief and her own experiences with *A Baby Story*. In fact, her story regarding how she wants her future birth to go is not included because she insisted she didn't want to know about her own birth or had ever really thought about her own birth experience. While other women were sharing their experiences, Ashley jumped in with this story, and it seems as if she is actively examining her thoughts as she tells it. She says that if one doesn't make it to the hospital, one can "resort to other means." Here, she is beginning to think about birth from an out-of-hospital standpoint. She continues to express some moderately technocratic views, but in this short story, she shows that she thinks that there may be more than one way to birth.

The Role of the Woman and the Doctor, as Seen in A Baby Story

When asked about the role of the woman in *A Baby Story*:

I think she's just there to carry the baby....and they're there to bring it out.

-Kris

Yeah, definitely more passive, because you ARE the patient and it's...you're in a fragile situation as it is, you're...there's not really a whole lot you can do. It's just one of those things where you have to go with the flow. Most of the time the woman's focus is on the baby, and if the doctor says this is best for the baby, they say, "Ok, well I might as well go ahead and do it."

-Barb

I think depending on how strong the woman is or how passive the woman is that will decide the doctor's role. My cousin, she was really passive and let the doctor have full rein over her birthing process, where I know if it was my mother or my aunt,

they would have waited a couple days and then if the baby really wasn't coming, then I'm sure they would have consulted their doctor. But some doctors are very "in your face" and they're like, "this is what you need to do" and some women will actually listen to them because they're scared at that point and they don't want to cause any harm to their baby. But sometimes the doctor is so focused on one way, that I think it can lead to problems in the delivery process, actually.

-Tera

I don't think anyone's in charge. I mean, the doctor is definitely saying, "Ok," and checking the progress and seeing if the mother is ready for, you know, induced vaginal birth or if its not going well they go for a c-section. And they show the mom a lot and ask her feelings like, "I'm just sitting here bored. I'm not dilated all the way yet. Just sitting. Sitting here waiting!" So I guess if you're gonna put someone in charge it might be, like, the doctors? I guess? But I don't see a power struggle in the birthing room. I guess it's all for the baby's safety, I guess, and for the mom's safety as well.

-Carol

I feel like a lot of times, they've [the woman and her doctor] talked before about what they want to do and then when it comes down to the day you have to completely rely on the doctor. Like, if they don't think this is going to be a good decision, then they have to make sure that the decision's changed. They are looking out for the health of the mom and baby.

-Holly

Each of the above quotations speaks to the role of physicians and women in *A Baby Story* and how those roles are perceived by each of the participants. Each quotation offers insight into how women who hold differing views on technocratic birth also hold different views on the roles of those involved in the birthing process.

Kris, who aims to be a practitioner of the wholistic model, sees a distinct power relationship between women and physicians. The way she phrases her sentence, "she is there to carry the baby" and the physician is present "to bring it out," shows that this young woman not only sees one of the main tenets of the technocratic model, but by wanting to practice as a midwife, is critical of such a scenario. She references what Davis-Floyd calls the "baby as product" portion of the technocratic model. Within the final birthing stages, the physician is the one actively delivering a perfect product unto society (1992, p. 57). Kris' words also imply the

passive nature of the woman's experience and the active role the physician takes in a birth in *A Baby Story*. Furthermore, while Kris is able to see the power and decision-making differential that is portrayed on the show, those who offer full embrace of the technocratic system do not.

For women like Holly and Carol, the physician is in charge of the birthing scene, and rightfully so. Both of these young women show that they fall in line with the technocratic model's focus on the baby as the product of the labor as well as the physician being the one to deliver it. Carol speaks of a woman's labor in *A Baby Story* as boring, and the woman is just "waiting." In this scenario, Carol does not see the woman as an active participant in this process. It is the physician who must decide whether the woman will have a vaginal birth or a c-section. Furthermore, Carol shows some cognitive dissonance in her statement; the physician is the one making the decisions, yet there is no differential in power between the woman and the doctor. This is a curious statement, but Davis-Floyd addresses the role of the physician to women who reject their biology in favor of technology, which, to an extent, Carol also espouses. The statement by Barb is one of the instances in which she expresses feelings closer to the technocratic ideals. She sees that women are in a "delicate" situation, and must, therefore, place full trust in their physician's decisions. Davis-Floyd indicates that women who believe that the physician will take care of the birthing decisions rely "on their physicians as they would on any professional in his or her area of expertise, expecting them to make reasoned decisions about their own needs and those of the baby during labor and birth, and they expected to be fully informed about the reasoning" (1992, p. 197). For women like Carol and Holly, there is not a power differential because they believe that physicians will act in the best interest of the baby and the woman as any professional would act in the best interest of his or her clients.

For women like Tera, who falls in the middle-wholistic area, the role of the woman and doctor is seen as more variable than for those on either end of the wholistic/technocratic spectrum. Tera incorporates her cousin's passive experience into her feelings about the physicians on *A Baby Story* and believes that a woman is fully capable of making her wishes known to a doctor who may be "in your face" regarding going about birth a certain way. Tera never uses the term "technocratic" but she does use words like "the usual way" and the "mechanical" way in reference to some birth stories she has seen on *A Baby Story*. She, like Kris, is able to see herself outside the technocratic model, and thus can see its motives. For example, she insists that some physicians may actually cause harm to a baby because they are set on conducting birth in a certain way. Tera is able to see one of the logical fallacies of the technocratic system that Davis-Floyd aims to address. One of her overarching research questions addresses the query: why do physicians perform procedures that may actually cause harm to woman and baby? The answer, as well as the motivation behind the technocratic model is to degrade and downplay the importance of the natural world and the power of female bodies while elevating science and technology (1992, p. 62).

***A Baby Story* Reinforces the Wholistic or the Technocratic Model**

Before [watching *A Baby Story*] I didn't really know the logistics of all the stuff that goes on and stuff like that. They go through going to the doctor visits, and the stages of labor and you can see them in action and you kind of know what you're getting into more. You knew you went to the hospital to have a baby, but with the show you can see the different kinds of complications that happen, and if you're worried about something happening you can see how it turns out, and even if there's something that happens during the process that's really scary they go back a few months later and see the mom is fine and the baby is totally fine. So like, while it might seem like, super anxiety level during that one aspect of it, like,

afterwards it generally turns out alright.

-Holly

When discussing the use of pitocin in *A Baby Story*:

It's so popular now...it speeds up the birth. [They use it] to get you out of the hospital sooner...so that they can get more people in. I don't know, I watched *The Business of Being Born*, I don't know if anyone else has seen that. I'm biased from watching that. Just about insurance and doctors and them just wanting them to be in and out of the hospital faster.

-Kris

If we're concerned about how realistic the show is in terms of things going wrong, what if you're at home and you need surgery but you don't have time to make it to the hospital? The thought that you could die is kind of scary. I would definitely want to be in a hospital, from watching the show.

-Diane

Finally, although it can be difficult to determine what impact *A Baby Story* has had on young women, as most build their model of childbirth from piecing together many sources, one of the major conclusions this data leads to is that *A Baby Story* has the largest effect on those who either fully embrace a technocratic model of birth or on those who embrace the wholistic model of care.

Both Holly and Diane's comments regarding birth fell heaviest on the side of supporting technocratic birth, and both of them seem to be the ones most impacted by *A Baby Story*. Of all of the participants, they are the only two who expressly indicated that *A Baby Story* had an effect on their cognition in regards to birth as well as their future plans. One of the most interesting aspects of this is that it appears that these young women, whether holding technocratic, "middle of the road" or fully wholistic views, seem to have already formed them from outside sources, and that those on either end of the spectrum use *A Baby Story* as a cultural reinforcement of their own views. For Holly and Diane, *A Baby Story* further increases their confidence and trust in the technocratic model.

Holly looks to the show as a tool to help her better understand what she can expect when she "undergoes" her birth. She can be given a more precise time line on birth's linear progression

as well as feel as though technocracy can take a frightening situation and place it under control. Holly looks to the technocracy featured in *A Baby Story* as reassuring and fear reducing. She states that within the show one can see a fearful situation that may feature complications turn out all right in the end. Holly sees birth like the 18% of women in Davis-Floyd's study who espouse full acceptance of the technocratic model, and thinks of birth as terrifying experience while also expressing "unquestioning acceptance of the value and validity of the medical definition and management of their births," (1992, p. 189-90). In fact, many of the women who fall into this category for Davis-Floyd are medical professionals. Therefore it is not surprising, that as a future nurse, Holly looks to the medicalized model as valid and desirable. For Holly, the purpose of this show is to provide her with a better understanding of what can go wrong in birth and how the technocratic system will help see her through it when she seeks out its services.

Diane has a slightly different experience with *A Baby Story*; while she looks to the show to reinforce her opinions that hospitals are the safest place, she has also gathered her experiences from a science teacher who instructed her that pregnancy is inherently risky, further reinforcing the Western idea that female bodies are, by nature, defective. Although the level of intervention and complications portrayed in the show were discussed earlier as moderate to high, *A Baby Story* is seen by Diane as an unrealistic snapshot of how birth actually happens. For her, the fact that everything generally "works out" for the woman and her baby is unrealistic in the sense that she believes pregnancy and birth have more complications and may need more interventions than are shown. Her last statement, "I would definitely want to be at the hospital, from watching the show," indicates that the impact of *A Baby Story* is that it reinforces her notions that birth is inherently an unsafe event that can be made safer through hospitals, physicians, and medical intervention.

On the other end of the spectrum, Kris, who fully accepts the wholistic model, sees the technocratic system displayed in *A Baby Story* as a reinforcement of her own opposing model of childbirth. She indicates that she sees the use of an intervention, such as pitocin, as not for the good of the baby and woman, but as a tool that is used by the technocratic system in order to push more patients through the hospital. Kris, like Tera and others who fall closer to opinions supportive of the wholistic model, see themselves as outside the technocratic system and recognize some of the logical, and public health contradictions that are employed by this model in order for its own self-perpetuation. Kris sees *A Baby Story* as a tool for her to strengthen her drive to become a practitioner of the wholistic model and, thus, has a vastly different experience with the show than many of her peers.

What, then of the women who hold more moderate views on birth? It is unclear, at this point and time whether *A Baby Story* has had a significant effect on women who hold positions that are in between the wholistic and technocratic extremes. As one can see in the text of the interviews, the most memorable things about *A Baby Story* for many of the participants are the couple's relationships and the babies themselves. The conclusion that I draw from this is that the young women who hold intermediate views on childbirth watch *A Baby Story* more for entertainment than to be educated about true birthing experiences. This trend is indicative that most women in the age group that I surveyed, 18-24, for the most part, are not yet married let alone actively planning their families, and thus they are not critically thinking about their intended birth experiences in relation to the births they see featured in reality television.

Discussion, Conclusions, and Limitations

While conducting this study, it became evident that there is a very limited amount of research, either quantitative or qualitative, that addresses the rituals concerning childbirth in America. In fact, very few studies address the role of reality television's impact on our own understanding of reality, let alone television media that deals with childbirth. This analysis would not have been possible without the seminal work, *Birth as an American Rite of Passage* by Robbie Davis-Floyd, as well as the studies done by Emily Martin, Morris and McInerney, and the *Listening to Mothers II* survey.

While I only examined 51 episodes of *A Baby Story* I believe the data are representative of the show overall. Although these women were giving birth in various states, hospitals and with different physicians, many of their births looked nearly identical. With near universal external electronic fetal monitoring (92% with physician attended births), the use of epidural analgesia (84% with physicians), and delivering in the lithotomy position (95% with physicians), it is evident that there is strong cultural support for routine births in American hospitals. However, it is not only the physicians that have been enculturated into a technocratic system. As seen in the student interviews, women, from a very young reproductive age, may already hold strong technocratic views enculturated during long-term routine health care within the biomedical system, and may thus seek birthing experiences that match the technocratic ideal.

One of the limitations of examining *A Baby Story* in the way I have done is that, as a single student researcher, the amount of data I was able to watch and discuss was relatively small and cannot be generalized to all of *A Baby Story*. Of the 735 episodes that exist to date, 51 episodes reflect only 7% of the material that is available for research. Furthermore, in the collection and analysis of qualitative data, the researcher is the tool. Therefore, in order to construct a more accurate picture, more research on this topic is needed.

In regards to the study done with young women and their feelings related to childbirth, it was honestly surprising that as avid consumers of media that reinforces fear and highly technocratized births, many women still held moderate or even moderately holistic views on birth. This may be due to a number of factors, and in order to make a more informed analysis on young women's ideas regarding childbirth, more data must be collected on how women are educated about birth and which of these sources has the greatest impact on how they form their model of pregnancy and birth. This study may serve as a pilot study for a much larger investigation into young women's views, but because such a small sample was taken, it is nearly impossible, if not irresponsible, to generalize the above analysis to a larger population.

What can be taken away from this study, however, is that the media we create can be used as a powerful reinforcement of views we already hold, not the other way around. Obviously more research must be done in this arena, but the results I have gathered were startling to me on many levels. First, I had expected young women to only view pregnancy and birth in a negative fashion because of the messages I had analyzed in *A Baby Story*. I also expected most of the education young women had received to come from such reality shows. In fact, many women shared positive expectations about birth and *A Baby Story*, overall, as well as an understanding that reality media is only a piece of their understanding of childbirth. While I was expecting all of the women to have been deeply influenced by *A Baby Story*, I found that the only ones who indicated such sentiments, at least consciously, were women who had very steadfast beliefs at one end of the spectrum or the other. They indicated that it was not *A Baby Story* that was formative of such opinions, but that the show served as a reinforcement mechanism; solidifying what they already hold as truth. In fact, many of the women intermediate on the continuum between holistic and technocratic birth gave opinions regarding birth that seemed to ebb and

flow with the conversation, and I believe that as these women grow older and possibly plan families of their own, their views may change or solidify in different ways. Some of these women may stay “middle of the road” and some may sway more toward a technocratic or wholistic model depending on other cultural influences, which may or may not be dependent on reality television. In future research it would be fruitful to contextualize pregnancy models of young women in the broader context of their orientation to the broader medical system in the United States, which includes not only biomedicine but also complementary and alternative medical systems (CAM). The broader struggle between ideologies underlying biomedicine and CAM seem to be reflected in these women's views about pregnancy and birth.

Works Cited

Akin, W. *Cesarean fact sheet*. Retrieved from <http://www.childbirth.org>

- Amnesty International. (2010). *Deadly delivery: the maternal health care crisis in the USA*. Retrieved from <http://www.amnesty.org/en/library/info/AMR51/019/2010/en>
- Block, J. (2007). *Pushed: the painful truth about childbirth and modern maternity care*. Cambridge, Mass: Da Capo Lifelong.
- Brackbill, Y, Rice, J, & Young, D. (1984). *Birth trap: the legal low down on high-tech obstetrics*. St. Louis: C.V. Mosby.
- Centers for Disease Control. (2009). *Births: final data for 2006*. National Vital Statistics Reports, 57(7).
- Cook, M. (1994). *Social support in midwifery practice and research*. Hunter Valley Midwives Association Journal, 2.
- Ehrenreich, B. (1993). *Witches, midwives, & nurses: a history of women healers*. New York City: Feminist Press at the City University of New York.
- Epstein, A (Director). (2008). *The business of being born* [DVD].
- Floyd, R. (2003). *Birth as an American rite of passage*. Berkeley: University of California Press.
- Goer, H. (1995). *Obstetric myths versus research realities: a guide to medical literature*. Westport, Conn: Bergin & Garvey.
- Grundy, I. (Ed.). (1995). *Sarah stone: enlightenment midwife*. London: Radopi.
- Harrison, M. (1993). *A woman in residence*. New York: Fawcett Crest.
- Hellman, L, Pritchard, J, & Wynn, R. (1971). *William's obstetrics: 14th edition*. New York: Appleton-Century-Crofts.
- Kitzinger, S. (2003). *The new pregnancy & childbirth : choices and challenges*. London: Dorling Kindersley.
- Lingo, A. (2004). *Obstetrics and midwifery*. Encyclopedia of Children and Childhood in History and Society.
- Listening to mothers ii: report of the second national u.s. survey of women's childbearing experiences*. (2006). Retrieved from <http://www.childbirthconnection.org/listeningtomothers>
- Marland, H. Ed.(1993). *The art of midwifery early modern midwives in europe*. London: Routledge.
- Martin, E. (2001). *The woman in the body: a cultural analysis of reproduction*. Boston: Beacon Press.

McQuail, D. (Ed.). (1979). *The influence and effect of mass media*.

Morris, T, & McInerney, K. (2010). *Media representations of pregnancy and childbirth: an analysis of reality television programs in the united states*. *Birth*, 37(2), 134-140.

Neuman, W.R. (1982). *Television and american culture:the mass medium and the pluralist audience*. *The Public Opinion Quarterly*, 46(4), 471-487.

Obstetric guide 14: assisted vaginal birth: the use of forceps or vacuum extractor. (2001). British Columbia Reproductive Care Program.

Rooks, J. (1997). *Midwifery and childbirth in America*. Philadelphia: Temple University Press.

TLC, (2011). *A baby story: about the show*. Retrieved from <http://tlc.discovery.com/guides/family/tlc-baby-block/a-baby-story/a-baby-story.html>

Turner, V. (Ed.). (1979). *Betwixt and between: the liminal period in rites de passage*. New York: Harper and Row.

Weiner, C, & Strauss, A. (1997). *Where medicine fails*. New Brunswick, NJ: Transaction.

White, S. (1999). *Birth alternatives: how women select childbirth care*. Westport, Ct: Greenwood Press.