Laboring Women, Coaching Men: Masculinity and Childbirth Education in the Contemporary United States

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Hospitals have adopted a rhetoric of family-centered maternity care, and one of the ways in which they show their commitment to it is through the integration of the husband-as-coach model of childbirth (the Bradley method) into delivery practices. I argue that this model's widespread popularity testifies less to the culture's endorsement of a woman-centered approach than to healthcare's appropriation of "natural" childbirth as a site for the production and reproduction of patriarchal and capitalist power.

Feminists have written extensively about the ways in which reproductive technologies turn the natural process of conception, pregnancy, and birth into disempowering experiences for women. Paradoxically, this medicalization of birth is taking place at the same time as hospitals are increasingly adopting a rhetoric of "natural" childbirth and family-centered maternity care. Medical institutions across the country are now sponsoring childbirth classes that draw on alternative models of childbirth (the Lamaze and Bradley methods) and encourage couples to become participants in "natural" childbirth rather than passive recipients of health care's drug-induced intervention. Yet, despite the time, resources, and energy that are spent representing "natural" childbirth as the ideal form of delivery, couple after couple enter the labor room determined to have a natural childbirth and leave it after having (begged for) an epidural. As Naomi Wolf points out, "what most parents-to-be don't realize until it is too late is how little effect on pain [natural childbirth techniques] are likely to have in a hospital setting: such . . . techniques were not designed for high-tech
hospitals that place time limits on labor and seek to speed up contractions" (2001, 88).

Works such as Wolf's latest book (Mis)conceptions (2001) elucidate the contextual reasons for the failure of the "natural" childbirth model in the institutional setting of the hospital. What they do not explain, however, is why the institution itself is not taken to task for the lack of success of the very model it so uniformly and warmly espouses. Since hospitals encourage "natural" childbirth and an extremely high percentage of couples give up on it during labor, why isn't the mainstream holding these institutions responsible for this high rate of failure? Instead of giving up trying to have a natural childbirth in the hospital setting, expectant mothers are increasingly giving up on natural childbirth tout court. Why aren't more couples turning away from hospital delivery, considering its disempowering effects? Indeed, the potential failures of the natural childbirth model outside the hospital setting is immediately used to discredit home birth and its proponents. Why is there such double standard?

I argue that what explains health care's lack of accountability for the waves of failure and disappointment couples experience when they attempt natural childbirth in an institutional environment is the deployment of masculinity through childbirth education. Childbirth classes have predominantly adopted the husband-as-coach model of childbirth as standard practice. They thus stage a hegemonic form of masculinity (the man as leader) that paradoxically founders when an inexperienced and poorly trained coach fails to live up to the expectations raised in childbirth class. It is unrealistic to think that a six-week course could possibly provide an expectant couple with the experience and competence needed to cope with the pains of labor. That the health care industry nonetheless continues to sponsor these classes suggests that far from being costly to the institution, the failure of the "natural" husband-coached model of childbirth might in fact be serving its purposes. By integrating men as coaches in the labor room, the responsibility for the failure of the natural childbirth model is shifted onto the couple, thus effectively obscuring the ways in which the highly clinical and profit-driven environment of the hospital is implicated in such a failure. Because power is rhetorically and performatively located in the husband's masculinity, it eclipses the power of institutionalized delivery as hospitals rush through birthing practices to save and make more money. As a result, what is a highly institutional relationship is displaced and personalized. In a striking reversal of the usual ruse of capitalism, health care's touchy-feely "feminist patriarchy" is thus substituting unpaid labor (the husband-coach) for (under)paid female labor (the doula or professional labor assistant), destabilizing in so doing norms of masculinity for its own purposes. This article examines the costs and implications of this reversal for the laboring woman.

Throughout this essay, I use my own experience as a template for my analysis of childbirth education. I do so not because my experience speaks for itself but
precisely because it failed to do so when I most needed to make sense of it. It is indeed only with hindsight that I could put it in its proper institutional and ideological context and explain my own conflicted feelings during the birthing process. I therefore appeal to experience not as incontrovertible and transparent evidence that foregoes scrutiny but as the very element that requires analysis in an investigation of childbirth education. Specifically, the anecdotal weight I bring to the paper seeks to illustrate the degree to which childbirth practices today personalize and obscure ideological discourses and their effects. It also serves to show the continuing relevance of the category of experience for feminist politics and philosophy, and to challenge the experience/theory opposition that continues to inform much of feminist inquiry in the twenty-first century. As Susan Bordo (1997) reminds us, "... discourses impinge on us as fleshly bodies, often in ways that cannot be determined from a study of representations alone. To make such determinations, we need to get down and dirty with the body at the level of its practices. ... Keeping track of the practical life of our bodies is important to keep us intellectually honest" (1997, 183–84).

In early spring 2000, several months before my due date, my husband and I enrolled in the childbirth class sponsored by the hospital in which I was slated to deliver. The course took place once a week from 7 p.m. to 9 p.m. and was six weeks long. There were five expectant couples in the class, all heterosexual, and except for one couple who dropped out after two weeks because of a scheduling conflict, we were all faithful attendees and conscientious students. My husband and I were extremely pleased that the partners of pregnant women were not only welcome but in fact encouraged and expected to attend and participate in the course and in childbirth. We would not have had it any other way, and it was a relief to know that we would not have to seek another source of “live” support and information when it came to preparing for childbirth together. Like most pregnant women, I could visualize sharing the experience of my child’s birth with no one but my partner. Neither he nor I believed that a female presence would or could provide better labor support by virtue of her gender or personal experience of motherhood. Years of activism in the feminist movement had disabused me of the belief that gender identity alone could provide the grounds for the kind of bonding and solidarity identity politics proclaimed. The only kind of closeness I now valued was based on choice and actions, not on biological or social destinies people happened to share by virtue of their gender. The kind of women-only ritual that childbirth education and childbirth itself had been in the context of the second wave represented the separatist feminism I had long disavowed, so I was all the more willing and eager to embrace the husband-as-coach method.

The hospital course we attended was an eclectic mix of various methods. Our childbirth instructor Diane soon identified herself as a Lamaze instructor while drawing on Bradley terminology since she foregrounded husband-assisted births
as an inherent part of natural birthing. In fact, she spent (too) much energy trying to put the men at ease, thanking them for their presence and highlighting the importance of their role during as well as before and after delivery. The Bradley Method was named after the man who designed it, Robert A. Bradley, an American obstetrician from Kansas. In 1965, Bradley published his book *Husband Coached Childbirth* in which he explained that women could give birth naturally and successfully by relying on the help of their husband trained as a coach and by following six principles. These were the need for darkness and solitude, the need for quiet, physical comfort during the first stage of labor, physical relaxation, controlled breathing, as well as closed eyes and the appearance of sleep. The Bradley method strongly echoes the Lamaze method, the most popular method of labor and delivery today, which first became known in 1959 with the publication of Marjorie Karmel's *Thank You, Dr. Lamaze*. Indeed, Lamaze too relies first and foremost on relaxation as a way of alleviating anxiety and minimizing pain during labor.

Upon joining the childbirth class, we naively assumed that the integration of the husband-as-coach model of childbirth into the standard care of pregnant women was based on the experience of a significant number of women who had deemed it the most effective kind of support during birth. If, as we were being taught in childbirth class, relaxation was what we should strive for during labor, it made sense that a loving spouse/partner who was absolutely committed to being his lover’s helper during labor would be a better source of support than a well-meaning but nonetheless intruding stranger. Furthermore, like many feminists of my generation, I thought that the patriarchal envelope in which my relationship to my husband was being packaged through childbirth education would not affect *our* experience of childbirth or the egalitarian relationship to which we were both committed. We could both read through and hence ignore the ways in which the husband-assisted model reinscribes hegemonic masculinity and the father’s status as head of the family within the feminine space of labor.

Needless to say, the very choice of “husband” rather than “partner” illustrates the heterosexism that has traditionally characterized the institution of motherhood and that continues to define hospitals’ cooptation of alternative childbirth education. In addition, the term “coach” to name the activity of the partner also reveals a lot about what kind of gender roles the parents are expected to play in the delivery room. Tellingly, when the supporting cast is someone other than the husband, they are designated as *doula* or *assistant* rather than as coach (Sears and Sears 1993, 23–24). In other words, when the support person is more likely to be female, her role is described as more passive and subordinate. By contrast, the role of coach is reserved to the male partner who is perceived not as taking orders but as giving instruction, training, and directing. The association of the term coach with sports is yet another way in
which the husband-as-coach model tries to ensure that the man’s conventional role as the site of authority is not threatened by his presence in the unknown and feminine space of labor. By indirectly framing labor as a sporting event, the language of coaching represents the woman’s sweaty and straining body as one whose activity and level of pain can and should be directed by her partner. It ultimately turns the alienating experience of labor into a familiar site where a masculinized form of power seeks to reassert itself through the figure of the husband. As a feminist involved with a feminist, I knew that my husband and I would not be perpetuating such conventional norms of masculinity and femininity. This was a script we knew not to follow. What we were not aware of, however, is the extent to which we remained mere pawns in a play even though the hierarchical gender structure underlying the husband-assisted method did come undone (and only marginally through conditions of our own making).

Indeed, what often unravels in the labor and delivery room is anything but the successful coaching scenario for which childbirth classes prepare expectant couples. The reality is in fact radically different from the scenarios depicted in childbirth education (whose worst cases, in retrospect, do not look bad at all). When our much awaited day finally arrived, for instance, my husband was extremely intimidated by the role of “expert” he was supposed to play and not surprisingly, he could only perform it as an amateur, that is, with a complete lack of self-confidence. He was as far from fulfilling the part of a directing coach as one could imagine. His desperate attempts to help were just the pathetic gestures of a person who felt completely out of his depth in the face of so much pain. I knew him too well not to read through the facade, through the periodic smile or nod with which he sought to appease me. Neither he nor I could focus or relax, nor could we go on automatic pilot and do the breathing exercises effectively when they were most needed. My pain was so upsetting to him that he would have done anything to put a stop to it. When I asked for an epidural, he immediately acquiesced even though his job was to guide me through natural childbirth. And when I was not given the epidural, his despair at finding out that it was too late clearly equaled mine. Despite the weekly classes we had attended and the copious readings we had done, neither of us were prepared for the amount of pain delivery entailed. It did not help that it had all been scripted ahead, classified, described, and explained, and that millions had experienced this before. It did not help that the nurses and medical staff around us had an all-knowing face. They were too busy attending to their duties and assumed an understandingly blasé attitude. The nurses have neither the time nor the energy to attend to and manage the expectant mother’s fluctuating emotions and needs. And after all, isn’t that the husband’s function anyway?

While the model of husband as coach is supposedly put into place to provide the laboring woman with continued support, it typically fails to provide the kind of expert guidance she needs to achieve relaxation and calm. One can then only
wonder why health care continues to sponsor a model of normative masculinity (the husband as coach, the man in charge) that founders again and again and fails to provide the kind of guiding and benevolent patriarchal direction it is supposed to represent. What function, then, can an ineffectual coach possibly play in labor? Why is there such institutional commitment to staging a gender performance that almost always results in gender trouble?

In her influential books Gender Trouble (1990) and Bodies that Matter (1993), Judith Butler advocates a cultural politics that works to expose the constructedness of gender identity. Gender, she argues, is a performance, a show we repeatedly put on (through dress codes, behaviors, etc.) and that “congeals over time to produce the appearance of substance, of a natural sort of being” (1990, 33). Nevertheless, the very repetition on which the naturalization of gender identity depends also opens up the potential for performative subversion. Indeed, repetition always introduces the possibility of failed repetition, and secondly, full conformity to these norms is ultimately impossible. The system itself guarantees, in other words, its own subversion. Unlike Michel Foucault, who tends to regard such processes of resignification as a ruse of power (1978), Butler is more willing to investigate their albeit contingent destabilizing force, hence her much contested celebration of drag in Gender Trouble. For Butler, “in imitating gender, drag implicitly reveals the imitative structure of gender itself—as well as its contingency” (1990, 137).

Ironically, the repetitive staging of heterosexual structures of gender and power in the husband-as-coach model of childbirth can also be seen as an instance of subversion guaranteed by the systemic level, since over and over again, the coach is unable to live up to the norms of controlling masculinity reinscribed by the system. While drag highlights the unexpected identifications and sexual practices that reveal the arbitrariness of conventional gender distinctions, the model of “natural” childbirth sponsored by hospitals today exposes the constructedness of gender even as it stages it in conventional and heterosexist terms. Through childbirth education, men and women are taught a script on how to perform their proper masculine and feminine roles within the heterosexual matrix of the labor room. That roles which would not have to be taught were they indeed “natural” have to be assigned and learned reveals how unnatural “natural” childbirth actually is. When the couple then fails to convincingly act out the script of “natural” childbirth, the performativity of gender is further exposed. The coach is feminized as his inexperience and incompetence render him passive, while the laboring woman’s anger feminizes her. Far from working to subvert institutional practices, however, this denaturalizing of gender categories through the feminizing of the coach does in fact function as a ruse of power. The performativity of gender thus highlighted is not a byproduct of a system otherwise invested in maintaining the sex binary so much as a crucial aspect of the system’s own deployment of the gender script.
The couple's inability to carry out the assigned script in the labor room, in other words, ultimately serves the ends of the birthing industry even as it threatens the naturalness of gender.

The laboring partners are indeed so busy sorting out their ambivalent position in relation to each other, their gender roles, and the birthing experience that they are unable to recognize that their contradictory feelings have less to do with the personalities involved than with the environment in which they find themselves. The alienating effects of the hospital setting themselves are obscured by the vicissitudes of the husband-assisted model. What this scenario effectively obfuscates is the parade of nurses, residents, and medical students with whom the expectant woman has to interact during labor, as well as the highly stressful and medicalized context of birth in which she is operating. I, for one, was so focused on the ramifications of the coaching partnership and my husband's ineffectualness that much more disturbing issues hardly fazed me: since my partner was to be my continuing source of support throughout labor, I did not think twice about the fact that the only member of the medical staff I knew and trusted personally in this whole process, namely my OB/GYN, would not appear until the very last stage of delivery; neither did I express any uneasiness when a medical student came in to ask questions I had already answered; or when a second one tried to pass as a doctor (while her shocking inability to make sense of the discrepancies in heartbeat picked up by the electronic monitoring device made us extremely anxious); I was too discombobulated by my husband's own confusion to object to the resident who came to examine me before her shift ended and whose replacement insisted on engaging me in intellectual conversations about English literature even as he was examining me vaginally again; I did not say anything when the labor nurse whom I liked but whose shift ended just as my contractions were picking up was replaced by a nurse who did not take my pain seriously because my contractions were still irregular ("It is your first child; you have at least twelve more hours to go"). As it happens, my contractions never became regular, so that the crowning of the baby's head literally took the medical staff by surprise. The nurse had to pull a doctor out of surgery to deliver the baby because there was not enough time for the OB/GYN on call to make it to the hospital.10

My way of coming to terms with my feelings of powerlessness was through anger. Faced with a busy and hence indifferent medical staff, I resented my husband's frightened and hesitant ways. I distinctly remember his attempts at relaxing me, at rubbing my hands, and the glares I directed at him any time he persisted in touching me. I kept shaking my head from side to side, and he kept turning to the nurse with beseeching eyes. When the contraction subsided, we were both so shaken by what had just transpired that we could hardly concentrate on what was coming next. In fact, the more my husband tried to help me refocus, the more irritated I got. I knew he was uncomfortable, I could
feel his despair and confusion, and that too made me impatient. The feeling was overwhelming and inexplicable, all the more so since he was desperately trying to comfort and help me through my ordeal.

Fortunately for both of us, labor was unusually short for a first delivery, and the bad vibes gave way to joy and relief at the sight of our healthy and vigorous son. I would probably never have revisited the issue had I not heard similar testimonies from other happily married couples. These women too were overcome by anger, resenting either the emotional distance their partner assumed to perform the role of coach or the ways in which his sense of powerlessness reflected their own. Some of them also spent most of their delivery worrying about their partner's feelings of inadequacy and fright instead of focusing on their own needs. In keeping with common lore, these women believed that their often explosive resentment during childbirth was just a psychological side-effect of "natural" childbirth or an inevitable extension of a male-female dynamic à la Camille Paglia (1992). Like models that, eager to celebrate gender subversion, examine it in isolation from other categories of power, this understanding of women's anger in childbirth solely in relation to the male/female dynamic ignores the larger institutional background against which this relationship plays itself out. It assumes that men and women are already constituted as sexual subjects prior to their entry into the arena of social relations. By contrast, I argue that the institutional context cannot be examined after the fact as if it exists outside the relation of women with men. While it is true that at a psychological level, resentment allows the laboring woman to cope with her feelings of disempowerment, these feelings do not ultimately result from, so much as get displaced onto, her partner's inexperience. They derive from the stressful setting in which natural childbirth techniques are in fact almost automatically destined to fail.

By incorporating alternative models of childbirth into their delivery practices, hospitals ensure that the responsibility for the failure of "natural" childbirth gets shifted onto the couple's shoulders. Childbirth education trains the laboring partners to think of the coach as the source of comfort and support, so much so that they then automatically attribute her disempowerment and inability to relax during labor to the coach's poor skills. When the responsibility for making labor woman-centered is thus shifted, it is the man and the woman's relationship that is at stake rather than the clients' relationship to the hospital. By foregrounding the traditional structure of masculinity and femininity that governs the domestic sphere, the sponsored husband-assisted method thus privatizes what is primarily an institutional relationship. The expectant couple who, through childbirth education, was given the illusion of autonomy in decision-making simply internalize their incompetence as personal failure. It must be their fault if labor becomes so overwhelming that they cannot take charge of it. They should have paid closer attention in childbirth class, meditated
more, or they should have honed the relaxation techniques by longer practice. Never mind that nothing in the high-tech and high-traffic delivery room is conducive to relaxation. Never mind that neither the laboring woman nor her coach could possibly feel like participants in the context of the aggressive labor and birth management style that continues to characterize hospitals today. Never mind that “[i]n the United States, . . . it has become increasingly clear that what parents learn in childbirth classes does not prepare them adequately to deal with the highly medicalized environment and crisis atmosphere in the hospital” (Kitzinger 1995, 88).

Childbirth classes teach the laboring woman “to see her proper role in childbirth as providing a prompt, docile response to a series of medical interventions and instructions, and guided her husband or partner to comply as well” (Wolf 2001, 94). In fact, the coach’s inexperience turns the hospital’s way of delivering babies into a most welcome and reassuring intervention, while inversely, the hospital’s high-tech methods highlight the neophyte’s incompetence. The interpersonal conflicts that ensue between the partners as a result of unfulfilled and unrealistic expectations raised in childbirth class further contribute to giving the hospital an aura of neutrality and competent mastery. Despite its alienating effects, the institution is left off the hook because it becomes the backdrop against which the male/female dynamic is acted out. It simply assumes the role of a neutral arbitrating force ready to intervene when, for instance, the husband fails to perform his role. That this scenario perpetuates itself no matter how many couples find the model flawed has a lot to do, I suspect, with the participants’ unwillingness to draw attention to what might be perceived as the coaching partner’s incompetence.

Thus, what is ironic about health care’s apparent reliance on a patriarchal form of power is that whether the model of hegemonic masculinity it propounds lives up to its norms (which it mostly fails to do) or not, is insignificant to the success of corporate profit-making. That hegemonic masculinity may be destabilized in the unfamiliar realm of labor does not ultimately hamper the effectivity of its ideological function for capitalist gain. Economic interests in this context are dependent not on the maintenance of a gendered hierarchy but on the deployment of masculinity tout court. As long as the focus remains on the performance of the partner (where it indeed cannot help but remain), hospital procedures assume an aura of neutrality, and the capitalistic venture of the birth industry in the United States can continue, veiled and unhindered.

The deployment of hegemonic masculinity by a profit-driven health care system thus requires a consideration of the imbrication of both capitalism and patriarchy in our analyses of childbirth practices in the United States. It is a two-pronged dynamic that immediately evokes a feminist dual-systems theory. Throughout its history, socialist feminism has attended to the intersection of patriarchy and capitalism by looking first at how patriarchal relations help
preserve and reproduce the social relations of capitalism and alternatively, at how capitalist interests play a role in constructions of gender (by maintaining, for instance, a low-paid female workforce in industries or by consolidating the dominant modes of femininity and masculinity). Both approaches are important insofar as they bring an economic perspective to bear on gender relations, but they are also problematic because they almost automatically approach capitalism and patriarchy as two systems neatly overlaid on top of one another. Socialist feminists have too often assumed that capitalism is either necessarily invested in reproducing traditional patriarchal relations or dependent on hegemonic norms of masculinity and femininity that reproduce, for instance, the binaries of male/female, active/passive, mind/body, culture/nature, etc. Economic motives are thus seen as determining gender structures that are invariable and predictably hierarchical (whereby the right side of these binaries is always subordinated to the left side). By contrast, institutionally-sponsored “natural” childbirth reveals the ways in which late capitalism has long learned to deploy postmodern forms of gender fragmentation and instability in its relentless race for profit. As childbirth reveals, gender-bending practices are as effective a tool for minimizing cost and liability exposures as are conventional gender roles.

In effect, her partner’s presence gives the expectant woman the illusion of adequate support, in the form of one whose ineffectiveness she will retroactively be less likely to question, anxious as she often is to avoid highlighting his incompetence or hurting his feelings. Indeed, as second-wave feminists were keen to point out, “[w]hat we bring to childbirth is nothing else than our entire socialization as women” (Rich 1976, 178), and it is unrealistic to assume that “the mother [will] easily come to childbirth a changed woman after a few classes in natural childbirth or a heavy dose of Women’s Liberation” (Arms 1975, 22). Just as my intense resentment during childbirth cannot ultimately be made sense of without accounting for an investment in normative masculinity (he failed to be the man in charge), the laboring woman’s unwillingness to draw attention to the model’s failure (and hence to her partner’s incompetence) also implies a reenactment of conventional gender roles as she often worries less about herself than about her spouse. She feels guilty about her inexplicable anger instead of focusing on her own needs and body.

Women’s sense of alienation from their own bodies during childbirth is no new phenomenon. Childbirth has historically been an experience in which women have “felt out of control, at the mercy of biology, fate, or chance” (Rich 1976, 178). Feminists have written at length about how this disempowerment exponentially increased when obstetrics transformed from a female into a male province with the growth of an elite medical profession. As Suzanne Arms (1975) points out, one of the major differences between the midwives and obstetricians traditionally has been that midwives respond to labor pains by assisting the laboring woman and reassuring her that this is indeed supposed
to happen, while the obstetrician's impulse is to intervene, stop the pain, and do it for her. In this scenario, the husband-coach, who is often too stressed and inexperienced to provide the direction and advocacy he was barely trained to give, is only too happy to step back and let the nurses and doctors do it for him. As a result, "mothers and babies are delivered from each other in a mechanical maneuver performed by professionals" (Reid 1997, 18). This medicalized delivery takes place at the hospital, a space that was decisive in associating childbirth with the male medical establishment. As the site of birth, the hospital is all the more problematic because it links birth to disease. In its antiseptic and clinical setting, labor necessarily becomes something to be gotten through rather than a process of which the laboring woman can or even would want to take charge: "From being subjects of the birth experience, active agents, the primary participants in the event—active together, laboring together, mothers and babies have been reduced to objects of medical treatment, incapacitated into passive recipients of 'care,' to which the women at most give their 'consent'" (Reid 1997, 18).

And indeed, unless the expectant woman and her partner educate themselves about the choices they have during labor and delivery and make specific requests, they will most likely not be offered any of these options at the hospital. Instead, the nurses and physicians follow a routine whose main raison d'être is expediency and whose modification they rarely welcome. In childbirth class, couples are encouraged to put their requests down in writing if they want the hospital routine to be changed. They have to let the staff know, for instance, if they want to gaze into their baby's eyes before his or her vision gets blurred by the antibiotic ointment that is immediately administered after birth (Sears and Sears 1993, 45, 55). The mother has to explicitly decline having an episiotomy, which is otherwise automatically performed to "facilitate" delivery.15

When we went to the hospital to deliver, we had a birth plan and were both determined to be participants in rather than mere observers of the birthing experience. Unwilling to take risks, we chose the hospital over home birth. We actually believed that we would be able to combine the best of both worlds, that is, enjoy the safety of the technological world of the hospital while preserving the kind of intimacy and nurture associated with home birth. We thought that with my husband's continued support throughout labor, we could create a safe haven of intimacy in which our active participation in childbirth would transcend the alienating aspects of my environment. I had convinced myself that the very fact of being a laboring mother in an invisible assembly line of other expectant women would only help us create a parallel universe that would be meaningful to the soon-to-be three of us. The nurses and doctors would do their job and my husband and I ours. We would make the requests we had come prepared to make and ask, for instance, to be left alone with the baby after birth. We would periodically unplug the electronic fetal monitoring device (EFM)
which keeps women flat in bed to avoid disturbing the monitor tracings, and
simply walk around and put into practice the physiologic positioning we had
been taught in childbirth class. Like a flâneur who succeeds in being alone in
the midst of a crowd, we would manage to preserve a self-contained familial unit
in the midst of the institutionalized turmoil of the delivery room. Like many
other women of my generation, I thought that because I was an enlightened and
educated person who had assimilated feminism's lessons, I was somehow less
likely to be affected by the structures of power that surrounded me. I believed
that my enlightenment in fact allowed me some measure of distance and control
vis-à-vis potentially disempowering situations. I had knowingly chosen a more
impersonal and clinical setting for delivery, and I was determined not to let the
environment in which I was to give birth have any bearing on my relationship
to the birthing experience or to my husband. Their script, I thought, would
not affect ours.

Little did I know, however, how meaningless our script would become in
the context of labor and hospital practices. It was not that the medical staff
was unwilling to accommodate our wishes but that our wishes quickly sounded
hollow and trivial in the institutionalized context of the hospital where only
systematic procedures appear reasonable and acceptable. Faced with insufferable
labor pains and blasé nurses, we were quickly overwhelmed and the pseudo-
authority with which my husband was laden as coach only highlighted our
feelings of disempowerment. In fact, we felt like asynchronous hippies every
time we made a request that deviated from standard practices.\(^6\) I could not help
but feel guilty when I unplugged the fetal monitoring device to move around, so
much so that eventually even going to the bathroom felt like a dereliction of my
duty as a mother. By the end of the day, we were more invested than the nurses
on call in following and interpreting the needle's movement on the monitor.
After the birth, we were allowed to spend two hours with our son in the delivery
room before he was taken away to the nursery, but that was only because the
delivery that was slated to follow mine had been postponed. The room was not
going to be needed right away, so I was not rushed into a recovery room after
birth. We had of course been made aware that we had the "choice" (provided
we could afford it) to opt for a single room should we wish to keep the baby by
our bedside during the hospital stay. Considering our financial situation, we
chose not to take advantage of the "rooming-in" option. So for the following
two days, I made endless trips to the nursery to fetch my son and nurse him. My
request that he be exclusively breastfed did not stop well-meaning maternity
nurses from bottle-feeding him while he was in the nursery.\(^7\)

In light of such experiences, the medical institution's openness to the
husband-as-coach method can hardly be read as a sign of protofeminist con-
sciousness. Far from representing an increased sensitivity to women's needs
or to egalitarian family structures, what accounts for this smooth corporate
endorsement of the Bradley method is the fact that it is the least likely to affect the delivery routines and time pressures under which hospitals operate today. Husbands who are bound to be intimidated by their wife's excruciating pain during labor are more likely to defer to the authority of medical experts in the delivery room. They become as invested as the professional staff in having the birthing process be over as soon as possible, and they contribute to a climate that sacrifices the mother's autonomy and authority by giving the birth experience away to technology, anesthesiologists, and nurseries. In an environment that by its very nature defines birth as illness and labor pains as symptoms of a disease, the expectant couple is in fact often relieved to see the process taken out of their hands. The birth experience thus becomes anything but an occasion for the expectant woman and her partner to have responsibility and control over the basic life event that the birth of a family represents.

The forceful feminist critiques of institutionalized childbirth need to be extended to account for the incorporation of the husband-as-coach into the feminized space of labor and for its radical (mis)appropriation of the male-female dynamic during delivery. Far from providing the kind of advocacy and support the laboring woman needs, the husband-as-coach model only ensures that the role of supporting cast not be filled by a doula or professional labor assistant who might, from the medical profession's perspective, interfere, slow down, or challenge the high-tech processes hospitals follow today. Indeed, by virtue of their experience and practice, doulas are less likely to be intimidated by the physicians and nurses' authority or by their client's labor pains. Their primary concern is to make sure that the laboring woman's emotional and physical needs are met so that she can approach the birth experience with the right frame of mind. They know that slowing down labor and delivery is part and parcel of the relaxation techniques hospitals advocate in theory but not in practice. Where the husband-coach hesitates and defers, doula's inform and advocate. Where the husband-coach might control, doula's provide encouragement and guidance. They assist instead of directing, and empower instead of taking over. In fact, studies have shown that when a doula is present to guide the couple and model supportive behaviors, fathers tend to offer more adequate support to their partners as well (Simkin 1999, 22).

Effective continued labor support has been shown to lower cesarean rates, requests for epidurals, and maternity care costs in general (Kennell et al. 1991, 2197; Simkin 1999, 23). By virtue of their training and experience, doulas are necessarily more likely to provide effective labor support than the husband-as-coach model promoted by the Bradley method and facilitated by hospitals today. Nevertheless, medical institutions have remained invested in the husband-as-coach model, downloading the costs incurred by bad support onto other entities such as the parents and child. Their rational calculation of costs and potential liability lies at the very inception of the ambivalent forms gendered authority
takes in the delivery room. Masculinity is deployed so that health care can be produced at minimum cost. This imbrication of patriarchy and capitalism is particularly evident when the exclusion of a supporting cast who would interfere with the doctor's absolute power is paradoxically combined with the absence of doctors (who only briefly appear at the end of labor). 18

Although the contradictory deployment of masculinity in delivery practices enhances capitalist profit by disempowering women, this is not to say that we should advocate a blind endorsement of the doula or professional labor assistant as an alternative model. Indeed, some formulations of this alternative childbirth model are as likely to maintain unequal power relations as health care's cooptation of the Bradley method. William Sears—otherwise known as Dr. Bill Sears—and his wife Martha Sears are, respectively, a pediatrician and a nurse whose books on childbirth and childrearing are bound to be recommended to expectant couples at one point or another during pregnancy. The Baby Book (Sears and Sears 1993) in particular, a book that emphasizes the importance for both mother and father of sharing the nurturing role in childrearing practices, has become the contemporary Bible of pregnancy and baby care. Sears and Sears firmly discourage men from being the primary source of support to their expectant partner during labor and delivery. 19 In fact, they identify the coaching husband as a thing of the 1980s. This role, they claim, was no doubt an improvement on the previous era when fathers were banished from the clinical and sterile hospital environment where birth occurred. It is nonetheless not a role, they argue, that compares to the kind of "division of labor" that should characterize the twenty-first century's approach to delivery. In the more relaxed, intimate, and humane environment of the contemporary birthing room, "the pressure is off father to perform as coach" (Sears and Sears 1993, 20). The supporting cast is instead the professional labor support person, or PLA (professional labor assistant), someone the couple has previously met and trusts, and who is trained to assist labor. The PLA is, as it were, a personal trainer whose job is to make sure that labor is progressing comfortably and efficiently. She attends to all of the laboring women's mental and physical needs and "helps the mother move through labor in harmony with her body" (1993, 23). She serves as a liaison between the medical staff and the laboring couple.

The Searse's suggestion that the expectant couple hire a PLA for delivery is problematic, however, insofar as it ultimately promotes a separate-spheres ideology that says more about their preconceptions about gender difference than about women's needs in labor. The Searse themselves hired a labor support assistant for the birth of their last four babies, and according to Dr. Bill, "she and Martha spoke a woman-to-woman, mother-to-mother language of labor that [he] did not understand but [has] grown to respect" (1993, 23). In other words, men are from Mars and women from Venus, and they are inherently so rather than through circumstance or social intervention. For the Searse, gender differences
should be accepted as dictates of nature rather than interrogated as effects of power. The mother bonds with her child because she cannot help but do so: "the biological signals of the baby trigger a biological response in the mother. . . . [B]ecause she is there and physically attuned to baby, [mother] immediately picks up and feeds her infant . . . her milk-ejection reflex functions smoothly, and mother and infant are in biological harmony" (1993, 49).

In The Baby Book, differences between men and women are grounded in biology, and these differences are what, we are led to believe, ultimately makes the PLA a better labor support than the male partner: "The labor support person does not replace the father; rather she frees him up to do what a man does best—love his wife. Men seldom relate empathetically to the emotional and physical challenges of the laboring woman. It is usually better for the father to leave the technical matters to a labor support person while he embraces his wife, rubs her back, walks with her, gives her ice chips and fluids, and guards against commotion" (1993, 23). The term "empathetically" is significant because it implies that the PLA should not only necessarily be a woman but that she should herself have undergone the pains of labor before becoming a certified PLA. This privileging of biology embodies a mystique of birth hardly generalizable when it comes to women's relation to the experience. Many women who have had children would not relate empathetically to another woman's laboring needs or pain. They might not in fact have related to their own. In foregrounding empathy, the Searses also undermine the importance of expertise and training in the making of a good PLA, thus contributing to a climate that does not adequately remunerate doulas for their work. Indeed, it is difficult to value the activity as work if all that goes into providing adequate labor support is empathy based on biology.

Furthermore, while I certainly agree that what "a man" should do during delivery is love "his wife" [sic], Dr. Sears's investment in preserving clear demarcations between the husband's and the PLA's roles also says more about his own investment in safeguarding a dominant notion of masculinity than about the laboring woman's best interests. Indeed, it is quite unrealistic to imagine that the roles of two people striving to attend to the woman's emotional and physical needs during delivery will not overlap. If the husband is to love his wife and support her emotionally, then what part of the emotional support is he to leave to the PLA? What are the "emotional challenges" that, according to Sears, require professional intervention and not the loving spouse's? And how would he know the difference? Similarly, need the PLA restrain herself so as not to step on the man's loving toes? The Searses postulate a "division of labor" during delivery, but the working out of the details of such a scenario reveals the vacuousness of attempts at demarcating these roles. For instance, they delegate to the PLA the role of liaison between the couple and everyone else, while charging the husband with the responsibility to guard against commotion.
How are these two responsibilities to be kept distinct? And most importantly, why should they be? Is helping the laboring woman breathe by modeling the breathing techniques merely a technical matter? Should the husband refrain from joining in? And what if, after all, both the doula and the husband overlap in their supporting roles? What would be so bad about duplicating efforts in the service of a laboring woman?

While it is true that the Searses do assign a nurturing role to men throughout their book, they never do so at the risk of challenging gender distinctions. Even when they assign a quality usually associated with femininity to men, they ensure that nurturing does not constitute a threat to dominant masculinity. Throughout the book, they reaffirm a Victorian ideology of separate spheres that reinscribes male authority (disguised as benevolent detachment) and female subordination (disguised as instinctual motherhood). That women's reproductive function and bodily differences provide the foundation of gender difference is so taken for granted that even male forays into feminine roles cannot challenge the binary opposition that underpins the Searses's conception of gender. The male/female and mind/body dualisms are left intact as fathers learn their nurturing role from scratch, while mothers only have to listen to their built-in response mechanism to cater to baby's needs: "A father's nurturant responses are a little less automatic and a little slower to unfold than a mother's" (Sears and Sears 1993, 44).

As Chris Weedon explains, "The effect of privileging certain ideas of difference—for example women's natural and intrinsic mothering nature—has been to limit women's value, whatever their individual circumstances, to discourses of motherhood with which most women did not fully or even partly identify" (1999, 12). Childbirth education needs to move beyond the normative dualisms that maintain existing social relations if the structural power relations that govern women's lives are to change. This is not to say, as my analysis of institutionalized childbirth education demonstrates, that the subversion of gender roles will automatically contribute to empowering women. As the corporate cooptation of the Bradley method in today's delivery practices reveals, whether the model of hegemonic masculinity that health care propounds lives up to its norms or flounders is insignificant to the success of corporate profit-making. Its presence is all that is required to contribute to capitalist gain.

Since the 1980s, hospitals have done much to adopt the rhetoric of family-centered maternity care. In fact, as Celeste Phillips points out, "[f]or a hospital to admit that family-centered maternity care is not a priority is to commit economic suicide" (1999, 11). The incorporation of what was once considered an alternative model of childbirth into delivery practices is part of an institutional effort to give the appearance of being woman-centered. But as this article has shown, even changes that first appear as a concession to a proto-feminist agenda can be and are often appropriated as tools for capitalist profit-making. The
institutional control over women's bodies is paradoxically consolidated even as HMOs are sponsoring a model of "natural" childbirth they claim will reempower the laboring woman. Through childbirth education, the health care industry deploys norms of masculinity that contribute to their profit-driven practices while simultaneously obscuring them. A transformative feminist analysis of childbirth must therefore necessarily attend to the political economy of patriarchy if it is to contribute to a feminist struggle for transformative change. It needs to emphasize a perspective on social relations that does not merely link capital's drive to accumulate to the construction or consolidation of sexual difference but that also accounts for the ways in which the destabilization of gender may also serve the health care industry's profiteering ends. It also needs to discuss labor and childbirth in relation to both femininity and masculinity. Indeed, while feminist analyses such as Wolf's in her recent book (2001) focus on the facts and figures surrounding the conveyor-belt philosophy of maternity wards, I have sought to add an important personal dimension to the story, namely the impact of birthing on the couple rather than exclusively on mother and child. Before both mother and father can experience the birthing process as empowered participants rather than as passive objects, hospitals will have to abide by the values of the natural childbirth rhetoric they have coopted. That would entail employing adequately remunerated professional support personnel in a truly relaxing setting.

Notes

I would like to thank Amanda Anderson, Carrie Tirado-Bramen, Jim Holstun, Jane Morse, Lonny Morse, Joanna Tinker, and the anonymous reviewers at Hypatia for their invaluable comments on an earlier draft of this paper.

1. See Mary O'Brien's The Politics of Reproduction (1981), Barbara Duden's Disembodying Women (1993) and Emily Martin's The Woman in the Body (1987) for a radical critique of the disempowerment of pregnant women in the face of medical and state expertise about fetuses, monitoring, health and hygiene. According to Michelle Stanworth, "New reproductive technologies are the vehicle that will turn men's illusions of reproductive power into a reality. By manipulating eggs and embryos, scientists will determine the sort of children who are born—will make themselves the fathers of humankind. By removing eggs and embryos from some women and implanting them in others, medical practitioners will gain control over motherhood itself" (1997, 483–84).

2. I am well aware of the history of hospitalized childbirth, which was instigated in the hope that it would reduce morbidity and mortality. However, while hospitals have a part to play in the care of women with serious medical conditions and women who develop a problem during labor, it is safe to say that "the supporters of hospital births have never been able to produce a single valid statistic which shows that hos-
pital birth is safer for all women than home births” (Beech 2000, 1). In fact, Marjorie Tew’s (1986) work on birth outcomes in Britain and the Netherlands shows that in all risk groups, hospital birth produces higher mortality rates. According to Tew, one of the reasons some studies show the mortality rate at home to be higher is because they include women who had unplanned home birth and often no prenatal care. Even when taking unplanned transfers to the hospital into account, Tew concludes that home birth is safer than hospital birth (see Tew 1986 and 1990 and Tew and Damstra-Wijmenga 1991). Rona Campbell and Alison McFarlane (1986), and Keith Howe (1988) similarly demonstrate that there is no evidence to suggest that hospital birth is safer for women than home birth, and that in fact, the perinatal morbidity rate (PMR) may be higher in hospitals. Mark Durand (1992) and Ole Olsen (1997) determined that there were no significant differences regarding PMR between planned homebirth and planned hospital birth. Both studies deemed homebirth to be a safe alternative to hospital delivery and one that leads to fewer interventions (also see Johanson, Newburn, and Macfarlane 2002; Lothian 1995; and Wickham 1999).

3. I use the term masculinity to refer to the authority society invests in males through gender roles.

4. See Joan Scott’s important essay “Experience” for a critique of the use of “experience” as an unproblematized category in positivist feminist politics. According to Scott, “[t]he project of making experience visible precludes critical examination of the workings of the ideological system itself, its categories of representation (homosexual/heterosexual, man/woman, black/white as fixed immutable identities), its premises about what these categories mean and how they operate, its notions of subjects, origin and cause” (1992, 25). In other words, using women’s experience as the source of explanation rather than as what requires analysis often entrenches the very categories whose origins and effects we should be questioning.

5. See Karen Wallace’s “Focal Point on Childbirth Education: The Bradley Method” (2000) for a fuller description of the method’s components and history.

6. There is a clear distinction between Bradley and Lamaze: the former involves “natural breathing” rather than controlled breathing, for instance. Lamaze is also more flexible for medical interventions and therefore more appreciated in the hospital setting. For a historical account of the childbirth movement since the 1920s, see Celeste Phillips’s “Family Centered Maternity Care: Past, Present, Future” (1999), Doris Haire’s “Focal Point on Childbirth Education: A History of Childbirth Education” (1999) and Richard Wertz and Dorothy C. Wertz’s book Lying In (1989).

7. Bradley, a product of the conservative fifties, was very heterosexist in his conception of the birthing team, and the institutional appropriation of the Bradley rhetoric perpetuates this heterosexism. In the alternative birthing scene, however, Bradley has changed with the times: there is no assumption, for instance, that the coach will be one’s husband or partner. The course is a ten- to twelve- week marathon where the couple spends more time lying on blankets side by side working on pain exercises than listening to lectures. The exercises involve touching, massaging. The coach is taught to be entirely focused on the needs of the laboring woman, and the assumption is that s/he will be as exhausted as the mother by the end of the birth. This new and improved Bradley method is still a very fringe movement that most health insurances do not cover (personal communication).
8. As Wolf points out, one of the things childbirth class does not explain effectively is "the pain of childbirth and what to do about it other than breathe helplessly in its grips and take major drugs simply to cut off sensation" (2001, 91). She also draws attention to the fact that the educational birth videos shown in childbirth classes represent passive and emotionally detached births where no one yells, grunts, or pants and where no one is stroked or kissed during labor.

9. The quotation marks I have used throughout the paper to qualify "natural" are meant to emphasize the fact that hospitals appropriate the term but do not adhere to the drug-free, vaginal delivery it implies. The myth of a "natural" childbirth in the hospital setting is then maintained, I argue, through the yoking of the practice with a gendered division of labor (pun intended). Because the supposedly "natural" model of childbirth hospitals have endorsed is based on traditional gender roles, the understanding of gender as a resistant variety of natural difference constructs the illusion of naturalness even as delivery is medicalized.

10. See Sara Wickham (1999) about the lack of continuity of care in hospital birth and the low levels of (sometimes very junior) medical staff (1999, 16).

11. Besides the nine friends and acquaintances whose stories reflected my own, I also found further evidence about the gap between what men are prepared for and the reality of childbirth in much of the literature about birth. Lesley Barclay, Jenny Donovan, and Ann Genovese (1996), Linda Berry (1988), Jenny Donovan (1995), Martin Johnson (2002), Penny Simkin (1999), Suzanne Steinberg, Lawrence Kruckman, and Stephanie Steinberg (2000), Katri Vahvilainen-Julkunen and Anja Liukkonen (1998) report that men find the experience anxiety-producing and fail as a result to provide effective labor support to their partner. In (Mis)conceptions (2001), Wolf also documents instances of what has now entered the common lore about delivery, namely women's anger directed at their partner (2001, 90).

12. See Deana Midmer's article "Does family-centered maternity care empower women?" (1992) for a description of this management style and its effects.


15. This procedure is performed on 80 to 90 percent of first-time mothers during delivery (Bruce 2001, 54; Davis-Floyd, 1998, 15; Sears and Sears 1993, 27; Wolf 2001, 172). According to Sheila Kitzinger, "it is the only surgery likely to be performed without her consent on the body of a healthy woman in Western society" (1995, 1) even though there is no evidence to suggest that babies arrive healthier because they emerged faster due to an episiotomy (Wolf 2001, 173). For other routine procedures that occur without the laboring couple's consent, see Wolf (2001, 146).

16. For other examples of the institution taking over, oblivious to the laboring woman's wishes or concerns, see Wolf (2001, 147–49).

17. As Sears and Sears point out in The Baby Book, "kind nurses will often 'spare' the mother a feeding and go ahead and feed baby a bottle during the night" (1993, 48).

18. Until economic motives override patriarchal allegiances and the costs incurred as a result of poor labor practices are shown to be significantly higher than the costs of hiring adequate support for the laboring woman, this current state of things will not
change. Only then will the doula become a staple of childbirth education and replace the misguided role husbands are now playing during labor. For this to happen, however, doulas would have to be renumerated in an adequate manner. Today, they still receive no third party reimbursement and are underpaid for their work.

19. The Searses' expertise is based on years of parenting experience (they have raised eight children, some of whom were adopted) and on thousands of hours of counseling pregnant couples and confused parents during twenty years of pediatric practice. They are probably the most well-known proponents of "attachment parenting" today, a style of parenting that consists of connecting with the baby as soon, as unconditionally, and as thoroughly as possible. The major components of attachment parenting are responding to the baby's cues, breastfeeding (on demand), wearing the baby (slings are highly recommended), and sleeping with the child.

20. The formulation "a man" and "his wife," with its evocation of conventional marriage vows, says a lot about the Searses' gender allegiances as well.

References


