Obstetrical Rituals and Cultural Anomaly: Part II

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Full Text: (Part I of Dr. Davis-Floyd's article may be found in PPPJ Volume 4, Number 3, spring, 1990. Part II completes the article, including references for both parts. Editor) FOURTH CONCEPTUAL DILEMMA: HOW TO "FENCE IN" THE DANGERS ASSOCIATED WITH THE LIMINAL PERIOD IN BIRTH, WHILE AT THE SAME TIME ALLOWING CONTROLLED ACCESS TO THEIR REVITALIZING POWER A fundamental paradox presented by most initiatory rites of passage to the cultures which design them lies in their official recognition and indeed, publicizing, of officially non-existent transitional stages of being. The category systems of most cultures allow individuals to be either "here" or "there," but not in-between, for the existence of inbetween calls into question the absoluteness of "here" and "there".25 It is a well-documented feature of rites of passage that those in the liminal phase must be conceptually, as well as physically, isolated from the rest of society24-52-53 as their existence poses a threat to the entire category system of that society. Yet it is also well-documented that this very threat can be of tremendous benefit to society, for in the process of the symbolic inversion of a culture's category system lies the potential for the expansion, growth, and change of that category system, and thus of the culture itself. This bring us to the fourth conceptual dilemma presented to American society by birth: how to "fence in" the dangers associated with the liminal period in birth, while at the same time allowing controlled access to their revitalizing power. Roger Abrahams54 points out that a tremendous amount of energy is generated in the profound symbolic inversion of a culture's deepest beliefs which is characteristic of the liminal period in initiation rites. He states that while this energy may remain unfocused for the initiates, who often do not know exactly where they are nor exactly what is happening to them, it is focused and thus usable by the elders conducting the rite. Therefore, Abrahams suggests, initiatory rites of passage may be carried out as much for the benefit of these elders as for the initiates.54:12'39b Brigitte Jordan provides us with an excellent (and brief) example of the symbolic process through which the focusing of the energy generated by the birth process away from the mother and toward the medical personnel who attend her takes place: In hospital deliveries, responsibility and credit are clearly the physician's. This becomes visible in the handshake and "thank-you" that resident and intern (or intern and medical student) exchange after birth. "Good work" is a compliment to a physician by somebody qualified to judge, namely another physician. Typically, nobody thanks the woman. In the common view, she has been delivered rather than given birth.55 This interactional pattern of focusing the creative energy of birth onto the physician works to revitalize and perpetuate the medical system in its present form, and thus our core value system is perpetuated as well. Many women attempt to reclaim this revitalizing birth energy through subsequent, self-empowering births in the hospital and at home: I sat there. . . . and then I realized-Hey, I did it! I wanted to have the baby at home and I read the books to figure out how and then I really did it! It worked! I didn't have to go to the hospital at all; the doctors didn't touch me! Then I realized that if I could do that great thing, perhaps I could do other things as well.56 Women scholars in general need to consider the potential cultural significance of the re-focusing of the creative birth energy away from medical personnel and back onto the mother and her family through the rituals of home birth. FIFTH CONCEPTUAL DILEMMA: HOW TO ENCULTURATE A NON-CULTURAL BABY Although birth is certainly a passage for the baby from the womb to the world, it is not a rite of passage for the baby unless, as for the mother, specific cultural actions are taken to make it so. A fifth conceptual problem with which the birth process confronts our culture, and indeed every culture, is how to find an effective means of removing new members from the non-cultural realm of the womb and placing them in the cultural realm of society; in other words, how to enculturate a

non-cultural baby. In our medieval past, before the mechanistic model of the universe had fragmented our religious worldview and displaced the Catholic religion as our society's conceptual foundation, the symbolic enculturation of new members of society was accomplished through the ritual of baptism. Today, we do it through the rituals of hospital birth. Our babies are baptized by inspection, testing, bathing, diapering, and wrapping in a technological process which extends even to the alteration of their internal physiology through the administration of a Vitamin K shot57 and antibiotic eye drops.58 Thus properly enculturated, the newborn is handed by the nurse to the mother to "bond" for a short amount of time-an enactment of the technological model's insistence that society gives the baby to the mother, instead of the other way around. And what society gives, society can take away. After the "bonding period," the nurse takes the baby from the mother to the nursery and places it in a plastic bassinet for a ritual four-hour period of separation, thereby enacting the tacit cultural stance that society has the right to take the baby from the mother because the baby utimately belongs to society.59 Of course, we have chosen to develop medical instead of religious rituals to fulfill the universal social need for symbolic enculturation of the newborn because we have taken ultimate responsibility for the human body, for the perpetuation of society, and for the performance of any necessary mediation between society and the supernatural that concerns the body, away from the churches and given it to our medical system.60 So medical procedures replace religious ones, fulfilling many of the same purposes and satisfying many of the same cultural and psychological needs. Moreover, while most cultures seem content to use their baptismal rituals simply to make the baby "human," we in our arrogance use our entire set of birth rituals to actually make it appear that our babies are cultural products. To quote one San Antonio obstetrician: It was what we all were 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. Another obstetrician expresses the prevailing cultural belief that only the combination of technology and skilled technicians can "deliver" those perfect products to society: My philosophy is using what I've been taught to use and what I've seen in my experience works, keeping in mind safety above all else, and not compromising safety for social reasons. If women put demands on me where I can't monitor the baby, or have an IV in them when they suddenly abrupt and go into shock, start hemorrhaging and go into shock before I can get an IV in-no, I can't live with that, I can't put myself-or wouldn't put them-in that kind of jeopardy. They can go to somebody else. There are guys out there that will do anything they ask, who make birth a social event. And I think they jeopardize the woman's safety and the baby's safety. SIXTH CONCEPTUAL DILEMMA: HOW TO MAKE BIRTH, A POWERFULLY FEMALE PHENOMENON, APPEAR TO SANCTION PATRIARCHY In medieval Europe, birth was an exclusively female phenomenon, but the baby was considered impure and unable to go to heaven until baptized by a male priest, who often had to wait in or near the house to be immediately available. For should the babe die, it could not go to heaven until it had been symbolically removed from the earthy impurities of the female realm. Thus the powerfully female phenomenon of birth was channelled, albeit after the fact, into sanctioning patriarchy after all. The ritual of baptism clearly delineated the high cultural value placed on the male realm, and the fundamental cultural devaluation of the female realm characteristic of medieval Europe. As is true of so many of our cultural institutions, modern obstetrics is grounded in the medieval Catholic Church's value-laden system of symbolic oppositions between right and left, male and female65-a belief system which held unadulterated conceptual hegemony over Western Europe for over 1000 years. If, as I and others argue,32'61-62 the basic thrust of our technology still is toward the right hand of maleness, then the birth process confronts American society with the same conceptual challenge faced by medieval society: how to make birth, a powerfully female phenomenon, appear to sanction patriarchy. For in spite of its technology and its cleavage to a patriarchal system of social life, our society's perpetuation still depends on women. The conceptual tension inherent in this paradox is also neatly dissolved by the rituals of hospital birth. These procedures not only make birth appear to be a mechanistic process by which a baby is produced, but also make the men who "manage" that process appear to be the producers. A future trend in obstetrics is the increasing

number of women who will be practicing this specialty; half of the students in many medical schools today are female. In 1986,69% of medical school graduates who said they would choose obstetrics were women, compared to 34% in 1982.63 Nevertheless, most female obstetricians practicing today went through medical training as a decided minority and so were often constrained to overcompensate for being female: Women in obstetrics are, as a group, more in philosophical agreement with their male medical colleagues than with female midwives. They are not even necessarily more polite to patients or more willing to accept the patient's having a more active role in her own care. This may be due to a number of factors: the selection process of medical schools; the socialization process during medical education; psychological factors related to the choice of obstetrics as a specialization; the stress inherent in obstetric residency programs; and the fact that women in medicine comprise a small minority.... they may feel that they have to outdo the dominant group-males-on male terms.64:139 Thus far these women have in general made no significant changes in the conduct of American birth. What differences the power of their increasing numbers will make remains to be tracked by students of the American way of birth. SEVENTH CONCEPTUAL DILEMMA: HOW TO REMOVE THE SEXUALITY FROM THE SEXUAL PROCESS OF BIRTH Of course, if babies are to be technologically instead of naturally produced, and if their production is going to sanction patriarchy instead of equality, then sexuality is going become an anomaly in relation to birth, which brings us to our seventh dilemma: how to remove the sexuality from the sexual process of birth. Women's sexuality has long been a problematic issue for Western society.66-67 In the Middle Ages, it was thought to be a devil-inspired seducer of righteous males.31 Today, sexuality remains a potent conceptual threat to the creative powers of technology, and female sexuality remains the chief reminder of that threat. As a number of physicians and medical anthropologists and sociologists have pointed out, our medical system has done a thorough job of convincing women of the defectiveness and dangers inherent in their specifically female functions.32,61,68-69,70,71,72,73-74,75 The hysterectomy, for example, is the most commonly performed unnecessary operation in the United States, with the radical mastectomy in second place.76 It has been a recurrent theme in American medicine that to remove a woman's sexual organs is to restore her body to full health and greater potential for productive life. Our society has developed no more effective teacher of this doctrine than obstetrical rituals. As Sheila Kitzinger77 stresses, birth is a normal female sexual function (the fact that I feel the need to reference an authority on this point itself speaks eloquently for the desexualization of birth in our times), as is evident in Lynda's description of her labor: Labor for me was a total turn-on. Yes, there was pain-a lot of pain, and the most effective relief for it was stimulation of my clitoris. Larry rubbed my breasts and my clitoris and kissed me deeply and passionately for hours until the baby came. And when he had to go out of the room, I masturbated myself until he came back. I had lots of orgasms. They seemed to flow with the contractions. Even when I was pushing I wanted clitoral stimulation. It was the sexiest birth ever! And I loved every minute of it. I was completely alive and alove-turned on in every cell of my body. I felt that the totality of Larry and me-the fullness of everything we were individually and together-was giving birth to our child. [Suzanne] Yet it is precisely female sexual functions which the technological model finds threatening and labels both "defective" and "tabu." So effective are hospital routines at masking the intense sexuality of birth that most women today are not even aware of birth's sexual nature. For example, stimulation of the laboring woman's breasts and clitoris has been proven to be extremely effective in strengthening labor, yet is utterly tabu in most hospitals, where the synthetic hormone pitocin is administered intravenously instead.78 The routine performance of the episiotomy is another excellent example of the desexualization of birth in the hospital: an effective alternative recommended by many midwives is perineal massage with warm olive oil, far too overtly sexual a procedure for most obstetricians. Through pitocin and episiotomies, sterile gowns and sheets, enemas and pubic shaves, anesthesia and orange antiseptic, the intense and potentially ecstatic sexuality of birth is consistently and effectively masked. Just how intense that ecstasy can be is evidenced by midwife Jeanine Parvati-Baker: I feel the baby come down. The sensation is ecstatic. I had prepared somewhat for this being as painful as my last delivery had been. Yet this time the pulse of birth feels

wonderful! I am building up to the birth climax after nine months of pleasurable foreplay. With one push the babe is in the canal. The next push brings him down, down into that space just before orgasm when we women know how God must have felt creating this planet. The water supports my birth outlet. I feel connected to the mainland, to my source. These midwife hands know just what to do to support the now crowning head, coming so fast. How glad I am for all those years of orgasms! Slow orgasms, fast ones, those which build and subside and peak again and again. That practice aids my baby's gentle emergence so that he doesn't spurt out too quickly. He comes, as do I.79 EIGHTH CONCEPTUAL DILEMMA: HOW TO GET WOMEN, IN A CULTURE WHICH PAYS INCREASING LIP SERVICE TO THE IDEAL OF EQUALITY, TO ACCEPT A BELIEF SYSTEM THAT DENIGRATES THEM. The eight and final conceptual dilemma with which birth confronts American society constitutes a potential cultural bombshell: how to get women, in a culture which pays increasing lip service to the ideal of equality, to accept a belief system which denigrates them. As Richard Bauman once said, "folklore is about the politics of culture." For me personally, the decoding of the symbolic messages hidden behind the scientific guise of hospital routines has led to a chilling reminder of the twin political threats presented to women by our technological model of reality. On the one hand, this model deprives women of their innate uniqueness and power as birth-givers. On the other, it perpetuates our cultural belief in women's innate physiological inferiority. And yet, because of the potential for conceptual egalitarianism inherent in technology, this model does contain certain conceptual advantages for women which, in the early part of this century, proved alluring enough for many women themselves to actively work for the cultural adoption of this model of birth. The birth process in American culture is and always has been a matrix of gender differentiation. In the 1800s, when most women gave birth at home, motherhood was the central defining feature of womanhood, and women's appropriate domain was the home. Early feminists eagerly sought technological hospital birth, in the hope that it would constitute a positive step toward true equality of the sexes through removing the cultural stereotypes of women as weak and dependent slaves to nature. Many of these early feminists went to great lengths to achieve anesthetized hospital births.69:150-154,75:171-195 However, of course, instead of leading to equality, in its blanket categorization of the female body as an inherently defective machine, the technological model both reflects and perpetuates our profound cultural belief in the innate inferiority of women to the men who more perfectly mirror our cultural image of the properly functioning machine. Thus our society is presented with the dilemma of how to get women to accept a belief system based on the machine, as this system entails the principle of the male as the physically and intellectually more perfect member of the species no less profoundly than did the belief system of the medieval Catholic Church upon which it was founded. This socialization is accomplished for American society by the rituals of hospital birth, as through these rituals, the full cultural force of the belief and value system on which our society is based is brought to bear on birthing women. Through techniques like electronic fetal monitoring, the use of pitocin to speed labor, and the common demand that the birthing process conform to hospital timetables, birthing women are graphically shown that their bodies are defective machines dependent on technological tools and on other, more perfect machines to give birth. While not all women internalize and accept this belief system, many do: It seemed as though my uterus had suddenly tired! When the nurses in attendance noted a contraction building on the recorder, they instructed me to begin pushing, not waiting for the urge to push, so that by the time the urge pervaded, I invariably had no strength remaining, but was left gasping, dizzy and diaphoretic. The vertigo so alarmed me that I became reluctant to push for any length of time, for fear that I would pass out. I felt suddenly depressed by the fact that labor, which had progressed so uneventfully up to this point, had now become unproductive. [Merry] In Merry's statement, we can observe her internalization of the message that her machine was defective. She does not say, "The nurses had me pushing too soon, but "My uterus had suddenly tired," and "Labor had now become unproductive." After planning for a natural childbirth, Elizabeth gave birth to her first child by Cesarean section, although there was no sort of fetal or maternal distress: By the time the doctor finally got there and said we needed a C-section, we knew that he was right. I had been in labor for 24 hours, had

been on pitocin for four of those hours, and had only dilated to four centimeters. It was clear to me by then that I would never be able to give birth by myself. My body just wasn't going to be able to do it. The Cesarean seemed the only logical choice. What had changed during Elizabeth's hospital labor was not the condition of the baby but her own perceptions of her abilities to give birth. Merry's and Elizabeth's experiences are representative of the frequent didactic success which obstetrical rituals achieve. In contrast, Teresa and Debbie will represent for us here the also frequent failures of obstetrical rituals to succeed in their didactic and socializing goals. These women actively rejected the technological model as it was transmitted to them through obstetrical rituals, and so were empowered as individuals and as women by their hospital birth experiences: Giving birth... . was really satisfying.... I felt incredibly powerful and absolutely delighted. I felt that I knew exactly what was happening, that I was, you know, that it was really a neat kind of letting go, that being totally in control kind of feeling ... extremely positive and incredibly powerful. My perception of it was that I was in charge and these other people were my assistants. That was the way I really saw it. The doctor would say "Don't push," and I would say, "I am not pushing right now," as if it were my idea not to push right now. And when he told me to push, I would say, "No, I am waiting for the contraction," and then when it came I would push. [Teresa] After I stood up to the obstetrician during my hospital birth, I started realizing that I could talk to a doctor like a person and not have to sit down and just listen and not say anything back.... So it changed me because I started having more confidence as far as getting what I want.... I am not intimidated any more.... it gave me more confidence about expressing what I know. When you're lying there flat on your back, and somebody is pointing their finger in your face, and screaming and yelling at you that you're going to kill your baby [because you won't have a Cesarean that you know you don't need], still to make a decision and not give in.... and be perfectly happy and sure of yourself that it is the right thing to do, it definitely carries over into other areas. [Debbie] The internalization of the technological view of their bodies as inherently defective machines (and of the inherent superiority of science, technology, and the patriarchal institutions which control and disseminate them) was avoided by 25% of the women in my study who, like Teresa and Debbie, actively rejected whatever they perceived as technological or institutional attempts at control of their hospital births. On the other hand, Merry's and Elizabeth's internalization of this model represent the experiences of the majority (63%) of the women in my study.80 Given our cross-cultural history of accepting belief systems that denigrate us, the level of our compliance with a belief system that will keep us forever on the left hand of health should come as no surprise. To claim back our biology demands a greater commitment to the conceptual notion of Woman than most of us are willing to make. To let machines give birth instead of women, or to turn birthing women into machines allows us to ground our sense of social identity and security in the dominant belief system of our society-always a comforting place in which to take refuge from the unknown. The problem is, of course, that our continuing complicity in this system will solidify it perhaps beyond redemption. CONCLUSION As we have seen, any society's ability to perpetuate itself depends greatly on its ability to offer the participants in the belief system on which it is based a variety of ways to mediate those conceptual oppositions which constantly threaten to tear it apart-or at least to appear to reconcile them. It usually does not matter whether the oppositions are really reconciled, as long they are handled well enough for most believers to be able to act in the face of whatever contradictions linger on-an increasingly critical role these days, as our technology has made giving birth a choice for most American women. So as long as obstetrics appears to resolve the conceptual dilemmas presented by birth to American society, then women can find the courage to choose to have babies in spite of the natural risk perceived to be inherent in the birth process, and doctors can find the courage to attend them. While the technological model remains dominant, few women will have the courage to choose to give birth or to attend birthing women without the conceptual resolution provided by obstetrical rituals. Those few who do make such a choice find it essential to completely reinterpret birth, under a different paradigm, as fundamentally safe. The paradigm of birth espoused by those women who choose to give birth at home has as its foundation a view of the female body as normal and healthy in its own right, and of the birth attendant's role as "guardian of

nature's processes"641138 and as the woman's nurturer and guide: Pushing can be a delicate process of balancing the energy with your body when the baby's head starts coming out.. . . That is when a woman may tear from pushing too hard and not being relaxed. Marimikel, the midwife, was very helpful in her support at this time. She would gently say, "That's good, that's good, now rest," guiding me carefully. Finally the top of Mela's head was out and I could reach down and touch her. This was such a blessing to feel her, to realize the complete circle of contact. She was outside of me, yet still in. I was aware of my energy becoming even more focused. I felt her whole head coming out. Imagine something thirteen and a half inches in circumference coming out of you! I knew my body was made to do this and it was: I didn't tear. It was another minute until another expansion came. I pushed down again, and she was completely born. What a miracle! This complete being came right out of me: toes, fingers, hands, spirit, body, energy and beauty.81 Simple as this may sound, the adoption of such a paradigm by society-at-large would entail a complete shift in our core value and belief system. Such a shift is indeed the aim of a diverse coalition of home-birthers, home-schoolers, feminists, childbirth activists, organic farmers, environmentalists, spiritualists, and most of those involved in the wholistic health movement, including increasing numbers of medical doctors.3,60,76,82-83-84 All these groups seek to invert our core value system, eliminating patriarchy, and placing science, technology and institutions at the service of nature, individuals, and families, instead of the other way around. Their active attempts at this extreme of social subversion are often greeted with extremes of resistance from those groups culturally charged with representing the dominant society. Thus obstetricians across the country often seek to eliminate lay midwives, medical doctors to eliminate chiropractors and homeopaths, corporations to harass environmentalists, and the courts to punish those who wish to educate their children at home. Even within the medical profession itself, physicians who espouse and attempt to act upon alternative belief systems are often either actively persecuted or dismissed as "radicals" by their colleagues. Said one such physician: One of the teachers most respected by the residents here is so respected because he can do a Cesarean in twelve minutes. His complication rate is horrendous because you can't help but butcher the woman when your emphasis is speed, but the residents don't seem to notice that. No residents scrub in on my deliveries because I don't do much, don't use the machines, so they think they have nothing to learn from me-they don't want to know about truly normal birth. As an anthropologist I can see that our present birthing system has meaning and a purpose within its cultural context which it serves well, but as a human and a woman I can see that there are other meanings, other purposes which would be better served. The anomalies resolved by obstetrical rituals under the technological model could also be resolved, perhaps even more successfully, by the replacement of that model with one which honors both the birth process and the female body. In the current challenges to the conceptual hegemony of the technological model, we are seeing our core value system questioned in ways that may eventually result in significant social reform. References REFERENCE NOTES 1. Hazzell, L.D. Commonsense Childbirth. Berkeley Medallion Books, New York, 1976 (1969). 2. Arms, S. Immaculate Deception. Bantam Books, New York, 1979 (1975). 3. Harrison, M. A Woman in Residence. Random House, New York, 1982. 4. Cohen, N. and Estner, L. Silent Knife. Bergin and Garvey Publishers, South Hadley, MA. 1983. 5. Peterson, G. and Mehl, L. Pregnancy as Healing: A Holistic Philosophy for Pre-Natal Care, Vols. 1, 2. Mindbody Press, Berkeley, 1984. 6. Goldsmith, J. Childbirth Wisdom. Congdon and Weed, New York, 1984. 7. Caldeyro-Barcia, JR., Supine called the worst position for labor and delivery. Family Practice News 5:11, 1975. 8. Banta, H.D. and Thacker, S.B. Costs and Benefits of Electronic Fetal Monitoring: A Review of the Literature. U.S. Dept. of Health, Education, and Welfare, National Center for Health Services Research, DHEW Pub. No. (PHS)79-3245, Washington, D.C.: U.S. Government Printing Office, 1979. 9. Tew, M. The Place of Birth and Perinatal Mortality. Journal of the Royal College of General Practitioners, 35, Pp. 390-394, Aug. 1985. 10. Stewart, D. and Stewart, L., eds. Safe Alternatives in Childbirth. National Association of Parents and Professionals for Safe Alternatives in Childbirth, Marble Hill, MO, 1976. 11. Stewart, D. And Stewart, L., eds. 21st Century Obstetrics Now! Vols. 1, 2. National Association of Parents and Professionals for Safe Alternatives

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In the lithotomy position, the woman lies on her back on a narrow delivery table with her feet up in stirrups and her buttocks at the table's edge. Use of the lithotomy position tends to make pushing the baby out more difficult and injurious than necessary, as this position 1.) focuses most of the woman's body weight squarely on her tailbone, forcing it forward and thereby narrowing the pelvic outlet, which both increases the length of labor and makes delivery more difficult8S:8; 2.) "compresses major blood vessels, interfering with circulation and decreasing blood pressure, which in turn lowers oxygen supply to the fetus"16:13; 3.) "increases the need for episiotomy [and the likelihood of tears] because of disproportionate tension on the pelvic floor and stretching of the perineal tissue"16113; 4.) "because the baby's passage through the birth canal must work against gravity, forceps extraction is more frequently required and physical injuries to the baby are more numerous."16113 19. An episiotomy is a surgical incision of the vagina to widen the birth outlet: The doctor has a sincere belief that an episiotomy protects the fetal skull and brain, shortens the second stage of labor and thus reduces the chance of minimal brain damage from hypoxia [oxygen deprivation]. . .. prevents later prolapse of the uterus, and also protects against third degree tears of the perineum."17112 That birth without episiotomy will result in prolapse of the uterus, or in weakened support of the bladder for excessively stretched muscles has never been proven, nor has the assumption that it will protect the fetus from damage.3:98 However, in a scientifically controlled study of the outcomes of planned home vs. planned hospital birth, in which the couples participating were matched for age, risk factors, and socioeconomic status,86 there were nine times as many episiotomies (supposed to prevent tearing) in the hospital group and nine times as many severe third- and fourth-degree) tears in the hospital group. Explains Michelle Harrison: Think of the episiotomy this way: If you hold a piece of cloth at two corners and attempt to tear it by pulling at the two ends, it will rarely rip. However, if a small cut is made in the center, then pulling at the ends easily rips the cloth. Doing an episiotomy is analogous, and sometimes results in tears that extend into the rectum. Physicians argue that this "clean" tear is more easily repaired than the ragged one that occurs when a woman tears without a cut. My experience has been that the small tears that sometimes occur without episiotomy are easy to stitch and less bothersome to the woman. Episiotomies, once repaired, are often debilitating and are the source of much pain in the post-partum period.3:97 20. In 1970 the national Cesarean section rate was around 4%. By 1986 it had jumped to 24.1%, according to the most recent statistics available from the National Bureau of Vital Statistics, Washington, D.C. This dramatic increase in the number of Cesareans performed in the United States has produced no subsequent improvement in infant or maternal mortality rates. 21. These interviews have been conducted between 1981 and 1988 in Austin, Texas, San Antonio, Texas, Chattanooga, Tennessee, and elsewhere in the United States. The majority of people interviewed were middle-class, mainstream American citizens, as I was seeking to understand the processes at work in childbirth as it is experienced, not by any particular minority, but by the majority of American women. Quotations from these interviews will be used throughout this article. A more detailed discussion of this research appears in 22. 22. Davis-Floyd, R.E. Birth as an American Rite of Passage. Ph.D. dissertation, Department of Anthropology/Folklore, University of Texas at Austin. University Microfilms Publication No. 86-18448, 1986. 23. Davis-Floyd, R.E. The Technological Model of Birth. 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treatment of choice. [87, p. 153] 48. Fiske, S. Pigskin Review: An American Initiation. In The Nacirema: Readings on American Culture (Edited by Spradley, J.R. and Rynkiewich, M.), Pp. 55-68. Little, Brown and Co., New York, 1975. 49. Cafferata, J. The Marines: An Initiation into Manhood. In Rites (Edited by Cafferata, J.), Pp. 234-239. McGraw Hill, New York, 1975. 50. Carver, C. The Deliverers: A Woman Doctor's Reflections on Medical Socialization. In Childbirth: Alternatives to Medical Control (Edited by Shelly Romalis.) Pp. 122-149. Austin: University of Texas Press, 1981. 51. Konner, M. Becoming a Doctor: A Journey of Initiation in Medical School. Viking, New York, 1987. 52. Chappie, E. and Coon, C. Principles of Anthropology. Holt, Rinehart and Winston, New York, 1942. 53. Turner, V. The Ritual Process: Structure and Anti-Structure. Aldine, Chicago, 1969. 54. Abrahams, R.D. Ritual for Fun and Profit (or The Ends and Outs of Celebration). Paper delivered at the Burg Wartenstein Symposium No. 59, on "Ritual: Reconciliation in Change," Wenner-Gren Foundation for Anthropological Research, New York, 1973. 55. Jordan, B. Birth in Four Cultures: A Cross-Cultural Investigation of Childbirth in Yucatan, Holland Sweden and the United States, p. 50. Eden Press, Montreal, Canada, 1980. 56. Ashford, J.I., Ed. Birth Stories: The Experience Remembered, p. 80. The Crossing Press, Trumansburg, New York, 1984. 57. Vitamin K is routinely injected into all newborn babies. The rationale for this is that newborns are born without Vitamin K in their systems, because they have "inadequate intestinal flora." Lack of Vitamin K can lead to hemorrhage in the newborn after several days.[45:186) However, breastfeeding the baby will quickly establish adequate intestinal flora without the need for Vitamin K or the pain of an unnecessary shot. Too early injection of Vitamin K in newborns has been implicated as a possible cause of neonatal jaundice. 58. Silver nitrate or an antibiotic substitute is placed in the eyes of almost every hospital-born baby in the United States to prevent the development of blindness in case the mother should have gonorrhea. Its administration, or that of a substitute, is required under state law in all 50 states, on the theory that it is impossible to know which ones need it and which ones do not. Silver nitrate binds with the membranes of the baby's eyes, causing redness, irritation, swelling, and blurred vision in the first few days of her life, thus interfering with visual learning and adjustment to the new environment. 59. More dramatic examples of society's claim to ultimate ownership of the baby are provided by Irwin and Jordan in their recent article "Knowledge, Practice, and Power: Court-Ordered Cesarean sections" [Medical Anthropology Quarterly 1, 3, Pp. 319-332]. The authors document and analyze various recent cases in which a pregnant mother was forced or nearly forced to have a Cesarean against her will, on the grounds that the state had the baby's best interests in mind, while the mother did not. In one case, in Denver, Colorado, attorneys and a judge were called into labor room of an obese woman who was refusing a Cesarean which had been ordered by her obstetrician on the basis of meconium staining in the amniotic fluid and signs of fetal distress as read by both external and internal monitors. Declaring the fetus "dependent and neglected," the judge pronounced the baby a ward of the state until birth and ordered the Cesarean, which was performed against the mother's will. The baby was born healthy, which surprised the physicians, but the mother suffered from delayed healing of her incision. 60. Mendelsohn, R. Confessions of a Medical Heretic. Warner Brothers, New York, 1979. 61. Corea, G. The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs. Harper and Row, New York, 1985. 62. Arditti, R., Klein, R.D., and Minden, S., eds. Test-Tube Women: What Future for Motherhood? Pandora Press, Boston, 1985. 63. Wall Street Journal p. 1. Obstetrics and Gynecology. 26 January, 1987. 64. Lichtmann, R. Medical Models and Midwifery: The Cultural Experience of Birth. In Childbirth in America: Anthropological Perspectives, (Edited by Michaelson, K.L.), Pp. 130-141. Bergin and Garvey Publishers, South Hadley, MA 1988. 65. Davis-Floyd, R.E. Right and Left, Male and Female: Childbirth and the Power of Symbolic Oppositions. Paper delivered at the Annual Meetings of the American Folklore Society, San Antonio, Texas, 1981. 66. Freud, S. The Basic Writings of Sigmund Modern Library, New York, 1938. 67. Jones, A.R. "Writing the Body": Towards an Understanding of L'ECriture Feminine. In The New Feminist Criticism: Essays in Women, Literature and Theory (Edited by Showalter, E.). New York, Pantheon Books. 68. Ehrenreich, B., and English, D. Complaints and Disorders: The Sexual Politics of Sickness. The Feminist Press, SUNY College, Old Westbury, NY, 1973.

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