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Another Tool in the Birth Bag: A Sociological History of "Gossip" in American Childbirth

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Another Tool in the Birth Bag: A Sociological History of “Gossip” in American Childbirth

Senior Project Submitted to
The Division of Social Studies
of Bard College

by
Theodora Stone

Annandale-on-Hudson, New York
May 2023

This project is dedicated to my mom, Sheila.

Acknowledgements

Thank you to my family and friends for indulging me.
And thank you, Dominique, for doing the same.

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"It is the tittle-tattle of life that makes the world go round, not the pearls of wisdom that fall from the lips of the Aristotles and the Einsteins."
Joseph Epstein, Gossip, Grooming, and the Evolution of Language

Introduction

My mom is a home birth midwife. And my childhood was, in large part, spent watching her talk to the women around her—fellow midwives, clients, friends, female relatives, moms, school administrators, dental hygienists. My mom was in constant communication with other women. I was young when I realized these exchanges were unlike those she shared with my dad. They were subtler, and somehow more loaded. Women delivered ambiguous yet meaningful glances and entertained annoyingly long conversations in parked cars. These were words and expressions that I could not follow (I was not intended to). But they appeared crucial to the functionality of a given day. I started this project confident that I wanted to think and write about gossip—to be an investigative advocate for talk, particularly for talk between women.

I quickly understood the insurmountable breadth of that ambition and sought to specify my curiosities further. My first thought was etymology… so much is in a word! I learned that "gossip" is a conjunction of the term "god-sib," or "godparent," and that the presence of a god-sib at the birth of their god child was paramount to early practices of childbirth.[1] How had the word for godparent journeyed so far from its original meaning to embody the blanket term for trash-talk? Why *that* word? I then thought of my mom, her propensity for talk, and her profession. She represents the original conception of the gossip— a woman whose presence is, in many ways, required at a birth. I considered the time I have spent in birthing spaces and thought about who typically inhabits them: women. And what do women do so well with one another, particularly in the absence of men? Talk. It is here that I see a relationship between conversation,

[1] Cortez, Rafaela. "The Scandalous Origins of Gossip." *Unbabel*, 13 October 2022, http://resources.unbabel.com/blog/origins-gossip.

knowledge democratization, and childbirth. I also see that women have historically been chastised for their propensity for talk.

At the dawn of the 20th century in the United States, virtually all documented childbirth took place in the home, was led by a midwife, and was attended by female relatives.[2] In 1940, that percentage had shrunk to only half of all births, and by 1969 home birth accounted for a mere one percent of all American births. Data from the turn of the century claims a steady maintenance of that number.[3] The average 21st century mother-to-be gives birth in a hospital bed and is attended in her labor by a surgeon. So, what happened? Where did all the midwives go? And how did this shift from home birth to hospital birth affect the women participating in it?

I argue that the transition from social practices of childbirth in the home to the medical framework used in contemporary times robbed women of the social tool of "gossip," which is useful in many arenas but particularly so in childbirth. My understanding of gossip is at once conventional—secret-sharing, storytelling, judgment-passing—and unusual—network-building, trust-instilling, lifesaving. In fact, I posit that these seemingly incongruent definitions cooperate and bolster one another to illustrate an honest depiction of "gossip" as something that connects women in their shared experience. Gossip is, then, the development and protection of community by means of conversational bonding, while remaining also the small exchanges between individuals on matters seemingly insignificant. In this way, it imbues everyday happenings with meaning. Within the context of birth, "gossip" manifests in the form of talk and presence—in questioning, truth-telling, listening, and in "being there." Childbirth can be dangerous, and my research shows that gossip, and the communication it facilitates, is an important mitigator and support for women therein. The acknowledgment of "gossip's" disappearance in the

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[2] Wertz, Dorothy C., and Richard W. Wertz. *Lying-in: A History of Childbirth in America*. Yale University Press, 1989, pp 2.
[3] Chervenak, Frank. "Home Birth." *Wikipedia*, https://en.wikipedia.org/wiki/Home_birth.

medicalization of birth presses a twofold question: What is gained and lost in the institutionalization of childbirth and resultant abandonment of "gossip?" Who gains and who loses?

In Early Modern England, a "gossip" was any one of a handful of women at the bedside of an expectant mother before, during, and after her labor—a midwife, a grandmother, a close friend. When English colonizers made their way to and throughout North America in the 17th century, their customs followed close behind. Among those was one very central to their marking their perceived territory— childbirth.[4] It is central to the development of a new world, of course, in that birth is the sole mechanism of population increase. What would henceforth become the pre-medicalization American way of birth was known by colonial settlers as social childbirth.[5] And so it went that the birthing space was comprised of a collection of women ranging from family to friends to midwives, all of whom shared in the collective and multi-level task that was aiding, comforting, and encouraging the mother-to-be in ways both physical and psychological. Friends and family acted primarily as emotional support, while Midwives played the dual role of physical and psychological aid to the mother to be.

When the cultural essence of childbirth changed from that of a social event into one of medical procedure, a once historically preserved practice capable of catalyzing conversation and bonding among women—by means of "gossip"— was lost, or at least pushed into the margins. Questions which ought to be posed about this transformation are who might have designed it and why might that have been? It is this questioning lens through which I aim my study of "gossip" and childbirth. I seek to uncover the effects of the medicalization of childbirth on the women involved and establish how the mainstream discontinuation of "gossip" in that space might have

[4] Cortez, Rafaela. "The Scandalous Origins of Gossip." *Unbabel*, 13 October 2022, http://resources.unbabel.com/blog/origins-gossip
[5] Wertz, Dorothy C., and Richard W. Wertz. *Lying-in: A History of Childbirth in America*. Yale University Press, 1989, pp 1.

aided in its transformation. I contend that conversation about birth supplies women with agency over their bodies, while its absence robs them of such control, and in doing so I aim to illustrate that this sort of talk can be considered generative gossip, given the historical denotation of the word as well as the functionality of the action.

In the Merriam Webster dictionary, gossip is defined as "rumor or report of an intimate nature; chatty talk; a person who habitually reveals personal or sensational facts about others." [6] Not unlike those of trash-talk or rumor-milling, descriptions and thoughts of gossip are typically imbued with negative connotations, thereby indicating that such behavior is inherently malicious or superficial. The above definition demonstrates the widely accepted relegation of gossip to the realm of frivolity. What is absent from this understanding is a recognition of the positive impact made by "gossip" across a historical landscape, particularly in the sphere of birthing practices.

This is a story about childbirth and what happened to the dominant cultural, social, and structural apparatuses therein. As a tool, "gossip" existed in times of social birthing, and these births, even in moments of fear or danger, were catalysts for networking and closeness among women.[7] Now that childbirth has been medicalized on a national scale, many American mothers and mothers-to-be exist within a system whose understanding of childbirth is one based in the judgment that the emotional experience of giving birth is less permanent or impactful than is the physical. This system also fails to recognize just how intertwined the mind and body are in the event of birth, with their ability to and likelihood of influencing one another.

American maternal mortality rates continue to climb, with more than a 10 percent increase between 2020 and 2021, and these deaths are often attributed to what are deemed

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[6]Merriam-Webster, Inc, editor. *The Merriam-Webster Dictionary*. Merriam-Webster, 2004.
[7]Wertz, Dorothy C., and Richard W. Wertz. *Lying-in: A History of Childbirth in America*. Yale University Press, 1989, pp 5.

"avoidable" causes. The rate in the US is roughly triple that of its fellow wealthy nations.[8] An awareness of the fact that hospital birth in the United States does not provide better odds of survival across the board evokes questions about what the purpose of a broadly medicalized framework of birth is. It would seem that without the informational exchange provided by "gossip" among women and between care provider and patient, birth is, despite technological advancement, dangerous.

Literature review

This analysis of "gossip"— its presence and its function—in the birth space is informed by existing literature in several ways. In this section, I briefly present the secondary sources that define the field, and in the subsections below I elaborate on how each source relates or contributes to my argument. The assertion that gossip was once an active participant in childbirth requires historical groundwork in order to stand. A lot of that foundation has been laid by Richard and Dorothy Wertz' *Lying-In (1989)* in its account of American birthing ritual from social 17th century birth to entirely medicalized 20th century birth, highlighting the changes in personnel, practice, and outcome across that timeline. Jessica Mitford's *The American Way of Birth (1992)* focuses on the history of medicalization and its industrialization of childbirth in America, with added thought on the effects of that transition on women giving birth. Both works evidence the presence and absence of "gossip" across time in the birth space when it manifests as informational exchange between a mother and her team, in cultivations of experience-based knowledge, and in the women at the side of a mother in labor.

Moving away from chronological accounting and towards more theory-heavy work, Nancy Schrom Dye's writing on childbirth in her piece "A History of Childbirth in America" (1980*)*

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[8] Langmaid, Virginia. "Study of Wealthy Nations finds American Women Most Likely to Die of Preventable Causes, Pregnancy Complications." *CNN*, 5 April 2022, https://www.cnn.com/2022/04/05/health/us-women-health-care/index.html.

unpacks the potential reasoning behind medicalization as it relates to control and bolsters the argument that much of the changes made to American birth practices were about power rather than health. She articulates the role of knowledge in power allocation with the case study of the transition from midwife to doctor-led birth; by limiting the informational exchange between women in childbirth, men were able to assert control over its practice. Similarly, Peter Conrad explores the pervasiveness of medicalization on a broader scale in “Medicalization and Social Control” (1992) and provides insight into the profit-motivated origins of the medicalization movement. His work speaks to the motivations behind the medicalization of childbirth as largely profit-oriented and sheds new light on the devaluation of midwifery as a necessary step in consolidating the market of childbirth within medicine.

Colin Leys locates a thinking error on the subject of the American health care system in “Health, Healthcare, and Capitalism” (2010), as his research exposes the misidentification of that system as a world leader in innovation and care, when it is, in fact, only a leader in monetization. He breaks down the dynamic between capitalism, healthcare, and medicalization, exposing their triangularly symbiotic relationship as one only beneficial to its leaders. Hospitals, he argues, impose greater medical intervention as a means of money making. Like that of Peter Conrad, Leys’ work bolsters the profit-motivated perception of medialization that underpins my hypothesis.

Gossip theory plays a significant role in my articulation of the relationship between gossip and childbirth, as published works provide insight to my conception of a new, relatively unconventional definition of the word. With reference to sexual assault whistleblowing on college campuses, Mark Alfano and Brian Robinson unpack the social function of gossip within marginalized communities in “Gossip as a Burdened Virtue” (2017). They posit that talk can decay the line between the private and the public, effectively exposing harms that historically remain

hidden. Similarly, I assert that gossip in childbirth breaks down the walls built by the medical framework and allows for a safer process.

In her TedTalk, "The Sociology of Gossip" (2013), celebrity gossip columnist Elaine Lui asserts that gossip—national and provincial—is a tool capable of exposing the ethical convictions of a given society. Her understanding mirrors mine in its conception of gossip as norm instilling, while it diverges in its equating norm instilling with the shaming of otherness. This latter conviction is incongruent to my thinking of gossip because I think it is capable of validating otherness through informational exchange, by spreading awareness of how behaviors and circumstances deemed "other" are actually quite common. Similarly, Joseph Epstein confronts cultural ways of knowing in *Gossip: The Untrivial Pursuit (2011)*, wherein he questions society's refusal to understand gossip as a form of knowledge. His exploration of the curiosity inherent in gossiping speaks to the human desire for information and the ancestral roots of that curiosity. The sociological foundation for gossip laid out in Epstein's writing imbues it with epistemological value, as he posits that gossip is a meaningful way of knowing.

Robin Dunbar's *Grooming, Gossip, and the Evolution of Language* (1998) analyzes the social worlds of primates and humans alike and ultimately concludes that human gossip and primate grooming function in similar ways. As intimacy building tools, gossip and grooming serve the shared purpose of community fusion. At the dawn of the spoken word, inter-group grooming became relatively obsolete, and the verbal exchange of information assumed its role. These theorizations bolster the argument that gossip can be the glue of a given collective. Approaching from different angles, these thinkers meet on their recognition of gossip as a social force rather than a trivial pastime. It is my conviction that, given its connective power, gossip before, during, and after labor provides its participants with sentiments and realities of safety.

In advocating for the existence of gossip at the time of birth, it is especially useful to study the communities whose practices reflect that model. In their work, *When Survivors Give Birth (2004)*, Penny Simkin and Phyllis Klaus explore what it means to call on the social mores of old in the modern moment. Their work delineates a step-by-step manual for assisting in the labor of a mother-to-be with a history of sexual abuse; through question-asking, active listening, patience for the labor process, and the power of language, the guide provides an impressive illustration of what is possible when gossip is present in the birthing space. In contrast, but to similar ends, an article entitled "Here's What Med Students Actually Learn About Pregnancy—And What They Don't" (2018), Jenna Flannigan exposes holes in medical birth training and illustrates one doctor's journey towards a more holistic, gossip-infused understanding of birth, inspired by her birth own experience. The thoughts of these individuals, while varied in subject matter and stylistic presentation, contribute equally to my argument. They support the ideological welding of birth and gossip as having a shared history and a mutually beneficial function.

A historical foundation

In order to assert any meaningful ideas about or suggestions for the birthing space, a historical narrative of American childbirth is required. That story is twofold: there is, at once, the tale of social childbirth and that of medicalization. Pushing and pulling for centuries, the two systems evolved (or perhaps devolved) in opposition. Medicalization ultimately won the battle of predominance, rendering a once ubiquitous social paradigm a subculture. Dorothy and Richard Wertz' *Lying-In* (1989) documents this dual history as it shifts from the social model of colonial childbirth to the hospital-happy model of the 1980s. In addition to their already comprehensive account of childbirth practices across centuries, Wertz and Wertz accent their writing with

thoughtful tangents on some of the harder to identify, more nuanced elements of doctor and midwife-led births.

The two critique the American public's "love affair with technology," and argue that more technology does not necessarily mean better, more appropriate treatment. They assert that "few people would quarrel with an innovation designed to help a few women in extraordinary situations. The danger lies in the unwitting extension to all technologies designed to help a few."[9] The work of Wertz and Wertz supports my argument that, in so many cases, the most useful means of intervention in birth is the posing of a question– "What is your ideal birth plan?" "How are you feeling right now?" "Are you comfortable with _____". Without such verbal engagement between a laboring mother and her birthing team on the subject of her labor, she runs the risk of becoming emotionally and physically disassociated from the event all together.

Against the fact of high rates of Cesarean labor in 1980s hospital birth, the writers hone in on language as a noteworthy reflection of a woman's thinking on birth. Production, they argue, is "the dominant metaphor" therein. [10] The doctors leading these births speak about the labor process as if it were performed by a mechanical apparatus—noting and remedying its "failings" accordingly. Wertz and Wertz comment on the language of the participating women and doctors, and how it relates to this body-as-machine thinking. Phrases like "the contractions came" and "labor stopped progressing" demonstrate the use of passive voice and effectively remove the mother's agency from her own labor. By infusing their narrative history of birth with seemingly minute details about the experience, Wertz and Wertz speak to the delicate nature of the event. They evidence its precariousness beyond the physical risk factor—while critiquing the medical obsession with perceived risk—and emphasize the meaning held by small moments in birth—

[9] Wertz, Dorothy C., and Richard W. Wertz. *Lying-in: A History of Childbirth in America*. Yale University Press, 1989, pp 273.
[10] Wertz, Dorothy C., and Richard W. Wertz. *Lying-in: A History of Childbirth in America*. Yale University Press, 1989, pp 274.

many of them verbal—and their impact on the mother. It is here that they locate gossip in childbirth.

Jessica Mitford's *The American Way of Birth* (1992) focuses its efforts on the financial and political significance of the medicalization of birth. She extracts from "standard" medical procedure the mechanisms through which hospitals and doctors are able to produce more babies and effectively feed an industry. It is worth noting that most of these practices directly contradict a gossip-infused birth paradigm. Mitford presents her reader with the event of a Cesarean birth which is perhaps the most absolute model of medical birth. She critiques its pervasiveness as something profit and convenience driven rather than exclusively safety focused.

In their article "Why the C-Section Rate Is So High" (2019), Emily Oster and Spencer McClelland articulate the suspicions felt by many, that cesarean births provide doctors and hospitals significant profit—being that they are a form of surgery—and that they are also scheduled according to the doctor's convenience. The rate of cesareans in private hospitals is double that in municipal hospitals, and salaried doctors are significantly less likely to perform cesareans than are privately practicing doctors, who collect their income on a per-birth basis.[11]

These cited methods used in medical childbirth highlight the impatience inherent in its structure. Patience in the event of birth is a manifestation of gossip, as it suggests a confidence in the woman giving birth and, in many cases, reflects her team's knowledge of what does and does not require medical intervention. Moreover, a patient birth practice is not profit-minded but, rather, mother-focused.

The medicalization of American childbirth

[11] Flannigan, Jenna. "Here's What Med Students Actually Learn About Pregnancy — And What They Don't." *Romper*, 8 May 2018, https://www.romper.com/p/heres-what-med-students-actually-learn-about-pregnancy-what-they-dont-8535440.

While medical "advancements" in birth can be documented as far back as the 16th and17th centuries, it wasn't until the 19th century that medical professionals came to intervene in the practice on the larger, industrialized scale. In a moment of threatening maternal and infant mortality rates, medical intervention meant development of a safer means of birth for American women. It also meant a departure from the sociality once intrinsic to the event. On average across the 19th century between 500 and 1,000 mothers died for every 100,000 births performed.[12] In 2021, the Center for Disease Control reports a rate of 32.9 maternal deaths per 100,000 births performed.[13] This is, of course, an undeniable evolution in a positive direction. It is, for this reason, important to recognize the improvements provided by certain elements of the medicalization of childbirth. And while the incorporation of—at times, lifesaving—intervention in the birthing space should be lauded, it is equally important to dig into the motivation to develop any once-social event into an industry.

Across a body of work, Peter Conrad's writing on the subject of medicalization defines it as a process whereby events and problems once widely recognized as non-medical become recognized as inherently medical and are treated accordingly. In an article entitled "Medicalization and Control" (1979), Conrad speaks to the increase in control over individuals and social institutions imposed by the event of medicalization. He asserts that, while the transformation of so many once-stigmatized conditions—alcoholism, mental illness, etc.—from reflections of character into indications of physiological or biological makeup in need of care presents a societal benefit, the penetration of undue intervention into normal life experiences is problematic. It is through this lens that my analysis of the medicalization of childbirth might be viewed.

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[12] Roser, Max, and Hannah Ritchie. "Interactive charts on Maternal Mortality." *Our World in Data*, 2021, https://ourworldindata.org/maternal-mortality.

[13] Hoyert, Donna. "Maternal Mortality Rates in the United States, 2021." *Centers for Disease Control and Prevention*, 16 March 2023, https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

Conrad's understanding elicits a questioning of the reduction of the role of midwives and other non-medical birth attendants. Without the personalization, dialogue, patience, intuition, and continuity of care—all of which fall under the umbrella of "gossip"— provided by midwives during pregnancy, medicalized birth can introduce a new kind of threat to an expectant mother and her baby. An overreliance by medical personnel on interventions like episiotomy, cesarean section, and induction of labor can lead to unnecessary complications and higher medical expenses. Hospitals and medical providers have financial incentives to perform these procedures, as they are more expensive than natural childbirth. With this knowledge Conrad asserts his belief that (over) medicalization is more profit driven than it is informed by a patient's wellbeing. I take this to suggest that the same process, when applied to the realm of childbirth, is also about profit and often to the detriment of maternal and infant health. Conrad's thinking on the process of medicalization as an economical investment for those leading it relates to my argument in its illumination of the non-patient-centered motives of medicalization which, in the case of childbirth, affect women.

In her work, *A History of Childbirth (1980)*, Nancy Schrom-Dye argues that the medicalization of childbirth has been an active catalyst in women's loss of control over their own bodies. By transforming the American model of birth from one guided by the collective knowledge of women into an event led by the thinking and control of male doctors, medicalization effectively removed women from the cultural conversation about birth. Most interventions, she says, are enacted more so to minimize perceived risk and to control the process than they are to care for the health and emotional wellbeing of a mother and her baby. Dye notes the transfer of control—from women to men—over women's bodies in birth, and credits this shift to the absence of informational exchange during birth paired with the masculine desire to control that which belongs to the

feminine. While woman-OBGYNs are the norm today, that was not the case at the moment of medicalization and, moreover, these women are still doctors who play by doctor rules– rules set by men at the dawn of the industry.

Following a temporal delineation of that shift, she presents her reader with a platter of questions for consideration:

> The major theme underlying this chronology is that of control: who has determined where birth has taken place and how has it been handled? Who has had access to knowledge about the birth process—male professional medical practitioners, female midwives, parturient women themselves? [14]

Dye's confrontation of control in birth is twofold. First, she considers the psychological effects of professionalization, arguing that the presence of the omniscient male doctor in charge of the progress of a birth indicates to his female patient that he is more qualified than she to harbor information about her and her baby, and that he will withhold information at his discretion. Second, Dye notes the patriarchal roots of a system in which men control the experience of women.

The collective works of Peter Conrad and Nancy Schrom-Dye evidence the dynamic relationship between medicalization, childbirth, and control. Both authors speak to the profiting potential presented by the medicalization of an event that is, in many cases, non-medical in nature. The advancement yielded by medicine in the realm of birth is the development of life-saving equipment and intervention and its use at times when it is so needed. That said, the standardization of childbirth as a medical event—to the point that any given labor be transported to an operating room should it take "too long"— has affected the average mother negatively. In abandoning gossip—the conversational element of birth that was once inherent to its practice, medical personnel have robbed their laboring patients of physiological protection, feelings of safety, and control over their own bodies.

[14]Schrom Dye, Nancy. "A History of Childbirth in America." *The University of Chicago Press*, vol. 6, no. 1, 1980, pp3.

The relationship between capitalism, healthcare, and childbirth

While there is no section dedicated to the intertwinement of capitalism, healthcare, and childbirth beyond what is written below, it is important to incorporate the following literature into this review, because of the theoretical underpinning it has provided throughout this project.

Evidenced above is the not-so-earnest incorporation of childbirth into the medical industry and brought to light are the more political incentives and implications of that transition—among them, profit. Within a capitalist economy, like that of the United States, healthcare is a purchasable commodity. According to this system, healthcare providers, insurance companies, and pharmaceutical companies all function on the drive for profit. The medicalization of childbirth (and other historically non-medical events) gained significant traction in the 19th century, the very same time that industrial capitalism did as well.[15] Against the landscape of a country's budding for-profit mentality, medical professionals were eager to expand the range of their services and institutionalize an industry around their work.

In an exploration of the changes undergone by the American and European medical systems, Colin Leys' "Health, Healthcare and Capitalism" (2010), asserts that the capitalist assault on healthcare can be felt on most every level. He explains that the industry as a whole delivers substantial amounts of wealth to privately-owned pharmaceutical companies, while simultaneously abusing particular portions of its clientele on a historic and systematic scale. He writes that the present focus of said systems is one of money-making. A primary contributor to this conclusion is his understanding of the "therapeutic revolution" of the twentieth century, which, he claims, "gave rise to the dramatic growth of a science-based pharmaceutical industry, to be joined later by the closely related biotechnology industry." He argues that such forms of capital

[15] Weinberg, Meyer, and Percival Roberts. "A Short History of American Capitalism: CAPITALISM DOMINANT, 1865-1920." *newhistory.org*, 2002, https://newhistory.org/CH07.htm.

"exercise massive economic and political power and are closely linked politically with the also powerful private health insurance and healthcare provider industries, especially in the US."[16] The effects of a capitalist assault on the healthcare industry are felt on a national scale, and very strongly in the realm of birth.

For the purposes of my exploration into the medicalization journey of American childbirth, I think it important to emphasize not only the impact that the transformation of this system has on its participants, but also to analyze the larger inequalities that it reflects. While the "therapeutic revolution" most glaringly benefits pharmaceutical companies and medical executives, the medicalization of childbirth began, in part, as a reaction to the interests of a handful of male doctors who recognized what was, in the pre-medicalization era, an untapped piece of profitable real estate.

The medical revolution of birth did not transpire in a vacuum, and as such might be better analyzed as a reflection of the capitalist society under which it functions. The medicalization of childbirth deprived its participants of the skills and knowledge provided by midwifery and erased the feminine autonomy historically present in birth. Also present within hospitals and among medical professionals is a profit motive, one evidenced by the imposition of expensive medical technology. Under a capitalist birth model, mothers of all risk-levels are pushed into unnecessary intervention and away from the natural processes, resulting for women in increased medical bills and potentially negative health outcomes and for hospitals in greater profit and heightened control. It is in this way that the medicalization of childbirth capitalist designs. The increased control over women's professional and bodily autonomies imposed by the medicalization of birth robs them of the value of gossip, and the profit potential in its industrialization promotes a capitalist agenda.

The value of gossip

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[16]Leys, Colin. "Health Healthcare and Capitalism." *The Socialist Register*, 2010, pp 12.

In attempting a revision of the contemporary conception of gossip, existing theory on the benefit of gossip throughout history provides a strong foundation. Given its pervasiveness, gossip—talk about mutual experiences, values, or individuals—is something people of all societies seemingly feel the need to do. Since the dawn of spoken word, humans have been talking with and about one another. Results from a 1997 study on conversational behavior indicate that the average person spends about 60 percent of their time exchanging social information, or that which concerns personal relationships and experiences.[17] The goings on in our communities comprise so much of our lives. Beyond gossip's ability to provide its participants with connection and topics of conversation, there is evidence to suggest that insight into the happenings of a community can prove useful in matters untrivial. A fifteen-year-long study on the social response to the AIDS crisis in Malawi led sociologist Susan Watkins to the conclusion that gossip on the matter of who is and is not infected with a disease can be lifesaving. Her research on informal conversation about AIDS and the informational exchange therein was ultimately coined the "gossip-as-data" approach, a form of research which considers small, seemingly insignificant exchanges valuable.[18] In this instance, gossip in the community alerted its members to a threat—AIDS—and effectively decreased the spread of a dangerous disease. The practice of gossip maintained a community's cohesion while also keeping infection levels at bay.

In their piece "Gossip as a Burdened Virtue?" (2017), Alfano and Robinson explore gossip through a similar lens, likening it to the well-meaning tattletale in moments of insidious social threat. They argue that,

> In the context of oppression, certain traits become virtues for people in systematically disempowered situations, which can be used in the

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[17] Dunbar, Robin, and et al. "Human Conversational Behavior." *Human Nature*, vol. 8, no. 3, 1997, https://pubmed.ncbi.nlm.nih.gov/26196965/.
[18] Watkins, Susan. "Gossip as Data – IAPHS – Interdisciplinary Association for Population Health Science." *IAPHS*, 2017, https://iaphs.org/gossip-as-data/.

> pursuit of flourishing in the context of oppression and as a means of helping others who are similarly disadvantaged.

Here, gossip is considered an oppressed group's rejection of the system of their oppression. Alfano and Robinson access another version of gossip, in which its role is to oust the "wrongdoers," which is another way of cultivating community by bringing people together towards a shared cause. They focus on the far-reaching impact of the movement for transparency around sexual assault on college campuses during the 2010s and in this context liken gossip to whistleblowing—the thing that allows for the revelation of the once-private into the public sphere. This conception of gossip supports my framing of the phenomenon in its presentation of gossip as a social good for the marginalized. My focus, however, is on what gossip can do for the victims of said marginalization in terms of solidarity and community building. I see the role of gossip in the realm of sexual assault as a tool capable of inspiring open communication and think with Alfano and Robinson in recognizing that open communication as something capable of outing and punishing its perpetrators. Their understanding of gossip as a thing which, when exercised correctly, inspires the protection and safety of its users aligns with mine.

Despite the cultural relegation of gossip to a frivolous realm, thinkers like Alfano and Robinson are able to extract, with a historically informed perspective, the protective and connective value that gossip holds. In her TedTalk, "Gossip as Knowledge" (2013), Elaine Lui highlights those protective and connective values. She argues that the transfer of information to and about others provides its participants with insight into their social worlds. She gives examples of this exchange by calling on ancient depictions of gossip about the social and political movements of Egyptian pharaohs and queens as illustrated in hieroglyphics. In doing so, she illuminates a long history of gossip and its use among non-royals as a means of holding their rulers accountable. She focuses, then, on celebrity gossip magazines, arguing that we share "our

moralistic views on marriage and fidelity and social expectations of females in relationships," often imposing them upon people in the spotlight, when the reality is: "the way we gossip tells us more about us than about the celebrities." This cultural practice is refracted through our own biases and sheds light on larger social values and belief systems. Female celebrities act as sacrificial lambs in the sense that their mistakes are broadcasted and unpacked by the masses. In this way, gossip provides guidelines, particularly for women, on how to make informed decisions in order to protect themselves from the scrutiny of public opinion.

In *Gossip: The Untrivial Pursuit (2011)* Joseph Epstein argues for a new understanding of gossip—naming it "an act of social intimacy." His work articulates gossip's ability to act as a navigation device on new social terrain. By discussing and exposing oneself to realities different from one's own experiences, one can prepare for the otherwise intimidating or taboo experiences that they themselves might face in the future. In the event of a woman's first pregnancy, being told by the women around her about their own experiences or those of other women in their community can quell the nerves of the primigravid (first time) mother. Take, for example, something like morning sickness: without conversation among women about what it's like to be pregnant, regular vomiting in the first months of pregnancy would undoubtedly frighten an expectant mother. Similarly, pain in labor is capable of stalling labor *if* the laboring mother is surprised by it, because it may inspire in her the fear that something is wrong and signal to her body that it should stop doing the painful thing. However, if she is informed by the women around her, she will be anticipating the pain, and, though possibly still alarmed, will be endowed with confidence in her knowledge that women before her have pushed through the same experience. Moreover, there is a physiological explanation for certain kinds of pain and their severity in birth.

Ina May Gaskin's *Spiritual Midwifery (2002)* notes that "a woman who is the center of positive attention, feeling grateful, amused, loved, and appreciated, has a higher level of the class of neurohormones called endorphins [which] actually block the perception of pain."[19] Significant to the midwife's role, Gaskin writes, is the regular dispensing of love and attention onto the laboring mother so as to keep her endorphins high (as well as encouraging others in the room to follow suit). She writes that humor is a huge help in keeping spirits high, acknowledging this is "a much easier task when you and she know each other well."[19] Gaskin speaks to the power held in a preexisting relationship and its influence on the progress of labor—to how gossip (as a closeness born of patience and conversation and as words of encouragement) can provide pain relief in certain cases.

In his book *Grooming, Gossip, and the Evolution of Language (1996),* British anthropologist and evolutionary psychologist Robin Dunbar speaks about the connective tissue built by talk and likens human gossip to primate grooming—both, he argues, foster community cohesion. He sees the informational exchange as a catalyst for the social bonding of individuals. By establishing and upholding social norms, gossip can effectively promote, within a given community, a culture of cooperation and trust. Among primates, grooming practices signal social hierarchies and establish closeness within a group. Like grooming, Dunbar writes that "gossiping is a social activity that allows us to display selective interest in other individuals, strengthening relationships."[20] Dunbar asserts that, at some moment in lingual evolution, humans traded grooming practices for gossip. Gossip and grooming alike provide their communities with value by developing social connections and fostering feelings of closeness. Gossip provides the same benefits in childbirth.

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[19]Gaskin, Ina May. *Spiritual Midwifery*. Book Publishing Company, 2002, pp 47.
[20]Dunbar, Robin Ian MacDonald. *Grooming, Gossip, and The Evolution of Language*. Harvard University Press, 1998, pp 68.

Midwifery as community oriented

Central to the thinking that conversation is vital in childbirth is evidence of its effective use. Argued here is the notion that information exchange allows for a safer experience in birth, one that is particularly true in the case that an expectant mother has a history of sexual trauma. In their book *When Survivors Give Birth (2004)*, Simkin and Klaus explore the existence and potential impact of sexual abuse on mothers and mothers-to-be and, in doing so, they outline a manual of sorts for midwives. They present their reader with the idea that sexual trauma and birth can become intertwined. In many cases, they posit, the trauma of childhood sexual abuse can be reenacted in the prenatal experience, during labor, and throughout the post-partum period. The guide includes instruction for midwives in instances of prolonged labor, resistance, or inability to tolerate medical procedures, and in otherwise difficult-to-navigate scenarios which result from sexual abuse. In the preface of their book, Simkin and Klaus write that phenomenon they illustrate can be exhibited in the unpredictability of labor, the relationships between the physical pain of giving birth and that of assault, and the anxiety induced in the new mother as she considers caring for another being when she feels, in many ways, like a child herself. They articulate the dynamic between the vulnerability of the laboring body and the invasiveness of the care provided by figures of authority with whom a mother-to-be has no rapport.

I take the philosophical and scientific work of Simkin and Klaus to be supportive of my theory that communication with an expectant or new mother is paramount to a safe and fruitful birthing process before, during, and after labor. Beyond their substantiation of the importance of discourse in the birthing space, the writers argue that allopathy in childbirth in the 20th century came to monopolize the field, and, in the process, effectively pathologized the collective American perspective on childbirth. With this change in understanding came excessive, oftentimes

unnecessary intervention in labor and the ensuant establishment of a multi-billion-dollar industry of birth.

What contemporary medical teachings about birth lack is a large emphasis on non-dire births as well as a comprehensive education on non-medical, interpersonal communication. In her piece "Here's What Med Students Learn About Birth–And What They Don't" (2018) Jenna Flannigan interviews Canadian physician Dr. Brenna Velker, who speaks about the reality of medical birth training. Velker admits, "because there is so much for us to learn in medical school, we don't really learn a lot about the normal stuff, about how to manage the things that are not super dangerous."[21] Instead of focusing medical teachings exclusively on worst case scenarios, Velker argues, there should be a balanced emphasis on conversation as well as "normal," safe labor. Following the premature birth of her own twins, Velker struggled with the feeling that she was not caring properly for her babies. Her independent research led her to a newfound thinking on the importance of breast milk for the nutritional and emotional wellbeing of the newborns—a fact not mentioned during her medical education or her birthing experience. "What we learned about breastfeeding in medical school was, 'Here is the breast. Here are the different parts of it. This is the hormone that causes it to happen. The end.' which is basically nothing."[21]

It was the wealth of information provided by the anecdotal evidence on mommy blog forums as well as the personal assistance of a doula which allowed Velker to deepen her understanding of nursing. Her own recognition of an absence of talk (gossip) in her professional and personal lives inspired a quest for just that. She is but one example of the many women who seek out gossip in spaces where there seems to be none. Dr. Velker asserts that her own experience with motherhood has altered her patient care practices in that she has become an advocate for

[21]Flannigan, Jenna. "Here's What Med Students Actually Learn About Pregnancy — And What They Don't." *Romper*, 8 May 2018, https://www.romper.com/p/heres-what-med-students-actually-learn-about-pregnancy-what-they-dont-8535440.

question asking— in particular, she urges her patients to push their obstetricians for the "why" of any given procedure or intervention. In the past, a typical nugget of advice from her to an expectant mother might be "Do whatever your OB says because they know what they're doing." Today, Velker says she is more likely to tell a patient "your body kind of knows what it's supposed to do, and you always have the right to say, 'I think I'd rather try something else.'"

Velker's story is one in which a medical professional's own birthing experience changes her understanding of what it means to assist in birth. Her quest for knowledge about her own body, beyond her medical training and OBGYN's advice, inspired her focus on dialogue between patient and care provider. Flannigan's conversation with Velker speaks to the relationship between birth and gossip—without using the word "gossip"— in its advocation for conversation in the birth space. She effectively articulates the relationship between question asking and the safety of a given birth.

Simkin, Klaus, and Velker speak to the significance of community in childbirth and, particularly, how that community can be developed by means of conversation. In Velker's case, her independent journey to find open informational exchange brought her to the work of a handful of mommy blogs and a doula. She was able to find the kind of talk she was looking for—but only once she stepped outside of her own medical training. The writing of Simkin and Klaus also speaks to the oftentimes necessary retreat from medical thinking in order to attain safety.

Methodology

What I aim to uncover in this study is what links women to gossip, what links gossip to birth, and what these relationships say about how American culture has historically understood women. In particular, I seek to explore gossip as a beneficial actor in women's experiences of birthing. In weighing my methodological options, my choice to explore the historical significance

of gossip rather than conduct interviews on the issue was twofold. The first book I read on the subject was Wertz and Wertz *Lying-In (1989)*, a comprehensive history of American childbirth. I was immediately struck by the evidence that gossip was an active participant in birth—evidence that dated back to the colonial period, and it only felt appropriate to give voice to that story. The other half of my decision is a result of the historical nature of the project itself. If the connection between gossip and childbirth is, to my thinking, in the etymology of the word "gossip"— as having once referred to the women in attendance at birth—then it makes sense that my study begins there, in colonial America, at the bedside of a laboring mother.

Thus, I began by outlining a history of childbirth from colonial practices through medicalization, with my narration focused on the presence and absence of community and communication among women as it has been documented across this timeline. My study centers its analysis on selections from four types of birth stories: the first, from diary of a colonial midwife in Maine;[22] the second, a collection of letters from new mothers to a Dr. Grantly Dick-Read, in recollection of their hospital births in the immediate aftermath of World War II; [23] the third, an assemblage of accounts of controversial midwifery practices of the late 20th century as delivered through Ina May Gaskin's birthing manifesta;[24] and last, an account of contemporary birth practice collected by a journalist looking to illustrate a more accurate depiction of hospital birth in modern times.[25]

I read through these resources—Martha Ballard's diary, letters to Dr. Reed, online forums, and publications—on high alert for the presence of certain vocabulary: words like

[22] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991.
[23] Thomas, Mary, editor. *Post-War Mothers: Childbirth Letters to Grantly Dick-Read, 1946-1956*. University of Rochester Press, 1997.
[24] Gaskin, Ina May. *Birth Matters: A Midwife's Manifesta*. Seven Stories Press, 2011.
[25] Burns, Annie. "'A scene from a horror movie': 9 mothers speak out about alleged mistreatment during childbirth." *CBC*, 7 November 2016, https://www.cbc.ca/news/health/hospital-mistreatment-stories-1.3834899.

"community," "fear," "together," "understood," "communicate," and "listen" stood out to me as intimations of the phenomenon for which I searched. In addition, I read through the written work of those widely recognized in the midwifery community, as it was important to me that I develop a firm grasp on what the study of midwifery instills in its students.

Focusing my efforts on Ina May Gaskin's *Birth Matters: A Midwife's Manifesta (2011)* in tandem with her *Spiritual Midwifery (2002)*, I extrapolated much about childbirth as it is seen through the eyes of a midwife. These books emphasize pre and post labor care, and they insist that both are equally as influential in the experience of giving birth. They focus their efforts on communication and connection between themselves, their clients, and their clients' communities. This gave me a stronger grip on what I should be looking for in earlier documentations of childbirth. It is important that I locate the aspects of social childbirth which contemporary mothers and midwives want to replicate and how, exactly, they do so.

I look to outline a history of childbirth from early midwifery to medicalization and thereafter, while focusing on the existence or nonexistence of community and communication as they manifest in gossip. I draw on my selected birth stories with a focus on the discrepancies between the practices of medical and non-medical professionals. In particular I consider the conversational patterns (if any) of doctors, family members, and midwives, and their effects on patients. I look for situations in which gossip provides solutions or a set of guidelines in moments of fear. Gossip plays a significant role in these moments in its cultivation of the birth space as one of talk, which inspires a practice of honesty and teaches its participants that truth sharing can be lifegiving, when so many have learned to regard it as life-threatening.

This project feels relevant to the present moment because of the still rising maternal mortality rates in the United States. When considering the truth that maternity and newborn care

provide state and commercial insurers with their largest payouts, at upwards of 50 billion dollars a year, it is important to ask: what accounts for such costs, if not better odds of survival?[26] Tales of the colonial midwife's practices and social capital; letters from the counterculture of natural birth in the mid-twentieth century; and contemporary accounts of hospital and natural births alike—each story assumes a unique position in my attempt to paint an accurate picture of the practices and experiences of the people giving and aiding in birth before, during, and after the medicalization of childbirth in the United States. I think gossip can be a force for good in this expensive and potentially dangerous experience for women and their babies.

Historical context

"What if the medical establishment that purports to be saving women from the specter of pain and danger is instead ejecting them from the seat of their power?" [27]
Ani DiFranco, Foreword, Birth Matters: A Midwife's Manifesta

At once a biological fact, a cultural marker, and a social event, childbirth encompasses much of what it is to be human. Naturally, then, a society's birthing practice—where it happens, who is enlisted to lead it, and how the laboring mother is treated—is telling of that society's values. It is for this reason that the shift from 1900 to 2000 away from midwife-led homebirth and toward physician-led hospital birth is worthy of investigation. The landscape, actors, and significance of American childbirth have been evolving since the establishment of colonial settlement in North America and because birth acts as a cultural marker, it is an effective way to track the unfolding identity and ideals of a new nation. This study begins its journey, then, in the 17th century English settlement of what is now the United States, a temporal positioning which

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[26] Rosenthal, Elisabeth. "American Way of Birth, Costliest in the World (Published 2013)." *The New York Times*, 30 June 2013, https://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html.
[27]Gaskin, Ina May. *Birth Matters: A Midwife's Manifesta*. Seven Stories Press, 2011, pp 7.

provides useful contrast to the contemporary moment; it is also a time during which the blueprints for an industry of medicalization may have been drawn up.

Initially, frontier women called upon an inherited European framework of social childbirth, whereby women delivered women inside their homes.[28] As the nation gained footing on the global stage, however, shifts in the collective cultural identity took place—and it was important that they function to further the American economy. One such shift meant that childbirth, a community event with little monetary significance guided by the wits of women, transformed into a highly billable medical procedure controlled by men.

On levels spiritual and physical, the midwife has been an ever-relevant character. Dealing in matters of birth, sex, sickness, and death, she is a steward of all things meaningful. She is also a keeper of knowledge. It is, perhaps, for precisely this reason that midwifery has been historically challenged by the dominant social structure for and under which it functions. Early publications of English midwifery guides emphasize the importance of the aspiring midwife's avoidance of gossip. The male writers of these instructive works were not bashful in their convictions. In his manual, *The Midwife Rightly Instructed (1736)*, surgeon Thomas Dawkes writes "the woman midwives … are bold and indulge their tongues in immodest and lascivious speeches."[29] Dawkes was not the only one to express such a sentiment. A few decades later, Dr. William Buchan writes of his own contempt for social childbirth, arguing that the gathering of women at a birth "hurt the patient with their noise: and often, by their untimely and impertinent advice, do much mischief."[30] The word mischief assigns a level frivolity to the relationships between a woman and her gossip. That which is "noise" or "impertinent advice" to Buchan

[28]Wertz, Dorothy C., and Richard W. Wertz. *Lying-in: A History of Childbirth in America*. Yale University Press, 1989, 3.
[29]Dawkes, Thomas. *The Midwife Rightly Instructed*. 1736.
[30]Buchan, William. *Domestic Medicine*. 1789.

might to a laboring mother be emotional support or ease-inducing informational divulgence shared by someone with a similar experience under her belt. Conversation among women during birth represented to both doctors a trivial, time-consuming nuisance.

The 18th century was the dawn of the medicalization of birth, a process dependent on the successful shift in consciousness of a population of childbearing women on the subject of what qualifies a desirable birthing experience. Safety is what most, if not all, women were after, so it was up to doctors to convince women that their methods were safer than those of traditional midwifery.

It this way, the idea that women might be useful in the birthing space endangered the medical model. Moreover, the fear of informational exchange among women has always threatened their male counterparts, and it is the pairing of midwives' knowledge and the successful execution of its exchange which has rendered them equal parts social threat and functional necessity. The story of American childbirth and its progressive abandonment of midwifery exposes a patriarchal society's centuries-long attempt to penetrate this province of women, quell the sociality therein, and capitalize on its monetizing potential.

English-born women living in Colonial America followed their own long-standing traditions of social childbirth, which they had inherited from their mother country. For the extent of her pregnancy, during her labor, and often for the weeks that followed, an expectant mother's immediate world became her friends, her relatives, and her midwife. She chose the space in which she desired to labor and who she wanted to be present when the time came.[31] Towards the end of her pregnancy, cooking, cleaning, and providing emotional support to her family became nearly impossible, if not potentially fatal. Social childbirth allowed for a period of "lying-in,"

[31] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991, pp 180.

during which a woman's contemporaries assumed her daily tasks as their own. At a time when a woman's primary role was to care for her children and her husband, the actual birth of a child was, in some ways, a time of respite during which she could submerge herself in the comfort that was the knowledge and assistance of her female community.[32]

The practical utility of social childbirth extends beyond shared chore-duty. Because the women surrounding an expectant mother ranged from her own little sister to the town wise-woman, age became obsolete in some senses and meaningful exchanges happened between all parties. Gossip presented itself when older women shared with the mother-to-be their experiences in childbirth, quelling not only her anxieties about the birth at hand but also those of the imagined future deliveries of the youngest woman in the room. The gossip leading up to and during the birthing process provided the psychological protection of feeling that one is not alone, while simultaneously strengthening one's odds of physical wellbeing due to the presence of more information. Birth was, in this way, a natural part of a woman's life; as much as it was a fear inspiring task, it was also something to look forward to, because it held the promise of a newly forged trust and closeness among women of all ages in a community. And it grounded the mother-to-be in the reality of what she might be met with in labor but bolstered the intimidation of that experience with a confidence provided by the histories of the women at her side.[33]

Colonial childbirth practice marked the official employment of the midwife. In Old English, "midwife" translates as *mid (with) wif (woman)*— "with woman."[34] In many instances, her primary task was just this— to be present at the birth of a child. The most useful tools in her birth bag were her presence and her wealth of experience. The number of births she attended

[32] Schrom Dye, Nancy. "A History of Childbirth in America." *The University of Chicago Press*, vol. 6, no. 1, 1980.
[33] Wertz, Dorothy C., and Richard W. Wertz. *Lying-in: A History of Childbirth in America*. Yale University Press, 1989, pp 8.
[34] "Oxford Languages and Google - English | Oxford Languages." *Oxford Languages*, https://languages.oup.com/google-dictionary-en/.

might serve alone as comfort enough to a primigravid mother. Moreover, in England, whose practices were a primary influence on colonial birth culture, a midwife's title was not one earned through schooling or licensing but, rather, given to her by another midwife. It was common practice that a woman be enlisted or encouraged by a midwife to attend births at her side, and over time, having adequately studied and participated in the births, earn the title of midwife. In this way, the library of birth knowledge was not exclusive to any one group of women but, instead, was a shared resource among all women—in effect, midwives self-selected according to whether or not they saw themselves fit to be "with woman."[35]

In her book *A Midwife's Tale (1990)*, Laurel Thatcher Elrich analyzes the diary of Martha Ballard, a midwife working in Maine during the transition between the colonial period and the Victorian era. Elrich presents the roles of a varied handful of women present at a colonial-era birth— she introduces the tasks of a servant, a neighbor, and a healer. Her emphasis in delineating the roles of these women is in their potential interchangeability. A female servant was capable of acting the role of the neighbor, checking in on an expectant mother, the healer could, if need be, clean a woman's home in the event that she was unfit to do so herself, and the neighbor was qualified to tend to her friend's needs in labor, bar any major complication. Finally, it was the midwife whose work encompassed the responsibilities of all three roles, rendering her most fit for the job of childbirth, an event which blurs the lines between the social, the spiritual, and the medical.

Elrich writes of this time, "the social construction of healing allowed the free flow of information from one level to another" and "the social base of female medicine is apparent in the

[35] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 199, pp 17.

very casualness of the entry."[36] Gossip spread the word that a woman was capable of the job, though the field was not exclusive to the steadiest hand or the most obedient student; it also called in women with the gift of communication—those capable of speaking clearly, honestly, and with grace in times of crisis—recognizing them as uniquely capable in the birthing space.

In contrast, the institutional basis for masculine medicine is evidenced by the largely anti-social approach therein. After the mid 1700s, American men began to return to the colonies following the completion of their medical training in Europe. What they brought home with them was a particular set of skills related to birth, which were presently inaccessible to their female counterparts. It is important to note that while men were perhaps better trained in dealing with abnormal birth, their general understanding of birth and pregnancy was largely deficient, [37] due to a lack of foundational knowledge on the subject. Historically, this sort of groundwork would have been covered during one's participation in social childbirth – an education often provided to a female midwife since childhood. However, on this, the eve of a significant shift in the then arguably insignificant American medical world, men were quick to capitalize on an untapped industry, as they were presented with was an opportunity to validate the American system of medicine at large. Luckily for these men, the fear of death-by-childbirth inspired many women to seek out the attendance of a well-educated male doctor at their births.[38]

The first wave of European-educated American doctors coincided with the solidification of the European Scientific Revolution, which yielded, in large part, a technocratic model of medicine, under which the human body is regarded as machine and receives medical attention

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[36] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 199, pp 18.

[37] Aliabadi, Thaïs. "Very Old Spoiler Alert! Before 1875, Science Had No Idea ..." *Thais Aliabadi, MD*, 29 June 2017, https://www.draliabadi.com/womens-health-blog/very-old-spoiler-alert-before-1875-science-had-no-idea-where-babies-come-from/.

[38] Farber, Michelle. "The Technocratic Birthing Model as Seen in Reality Television and Its Impact on Young Women Age 18-24." *UConn Library*, 8 May 2011, https://opencommons.uconn.edu/srhonors_theses/187/.

accordingly. The technocratic model of birth perpetuates the understanding of the female body—particularly the pregnant female body—as a piece of broken machinery. It is through this lens that American doctors were "treating" birth. That is, they were tending to it as if it were a disease in need of treatment.

Among several advancements in childbirth at the beginning of this shift was the invention and introduction of the forceps. The tool was invented by Peter Chamberlen in the early seventeenth century, but it was not shared with the public until nearly a century later. In early days, before the reveal of the forceps, Dr. Chamberlen's labor practice was such that he would blindfold the expectant mother while retrieving the tool and use it only under a linen sheet to hide its presence from her, and maintain modesty.[39] His early model consisted of "two enlarged spoons with handles that could be inserted separately into the birth canal and then joined and locked together so that the spoons cupped the baby's head to draw it out." [40]A revolutionary tool, the forceps were also capable of killing the mother or the child if used incorrectly or in a hasty fashion. Beyond clumsy usage, much contention surrounded the question of when, exactly, such intervention was appropriate. In large part, the issue lay in the fact that there were no trials done on the equipment. To this day it is not unusual that medical research efforts underfund studies focused on the female body. Forceps are no exception to this rule, and the choice of whether and how to use them was left up to the physician holding the tool.

Elizabeth Nihell, an eighteenth-century midwife, was vocal and adamant about her opposition to forceps as much as to the man-midwives who used them. She argued firmly, after having given them a try, that forceps were "at once insignificant and dangerous substitutes for

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[39] Campbell, Olivia. "Why Male Midwives Concealed the Obstetric Forceps." *JSTOR Daily*, 2018. *https://daily.jstor.org/why-male-midwives-concealed-the-obstetric-forceps/*.

[40] Wertz, Richard W., and Dorothy C. Wertz. *Lying-in: A History of Childbirth in America*. Free Press, 1990, pp 198.

[ones] own hands."[41] The general understanding here, and among many female midwives of the time, was that forceps did for man-midwives what patient hands did for female midwives—just faster, and with less thought. Because forceps were so uncommon among female midwives, for reasons manifold—potential legal restrictions, gendered medical inclinations, lack of physical strength—it is impossible to know whether the evolution of the tool might have been smoother and less harmful had the more intuitive and less urgent practices of female midwives been guiding it.

Had the forceps been introduced into the realm of childbirth in the hands of female midwives, whose knowledge of the female body surpassed their male counterparts' by default, and whose bodies had stake in the matter of the tool's use, their impact might have been a profoundly positive one. Instead, Chamberlen's early use of the forceps would serve as a metaphorical foreshadowing for what was to become of the reality of childbirth in the years to follow—a woman blindfolded on a table, being operated on by a man lacking the sight of his own hands. Forceps, blindfolds, and the boundary of the linen sheet are physical manifestations of the non-communication of this era. They represent the abandonment of transparency, conversation, and connection in labor—they are tools whose use and effect are actively anti-gossip.

In the greater history of childbirth, the Victorian era marks a notable intertwinement of motherhood and shame.[42] The technocratic model of birth, whose popularity grew throughout the eighteenth and nineteenth centuries alongside that of man-midwives, highlights the need for privacy in birth, and emphasizes it as a medical event between doctor and patient. The shifted

[41] Nihell, Elizabeth. *A Treatise on the Art of Midwifery: Setting Forth Various Abuses Therein, Especially As to the Practice with Instruments (Classic Reprint)*. Forgotten Books, 2017.
[42] "Victorian Values in a New Age." *US History Online Textbook*, https://www.ushistory.org/us/39d.asp.

meaning of birth away from that of a mechanism capable of building social, connective tissue between women and toward that of an illness in need of treatment had psychological effects on those partaking in the event. Pregnancy as a diagnosis informed the perceptions of the women receiving it and inspired feelings of urgency to get better. As evidenced by the writing of Elizabeth Nihell, one element of male-controlled birth is speed. Quickness was not central to a social understanding of childbirth, as such an event was, in some ways, meant to be a lengthy, involved celebration of life and community.

Martha Ballard's 18th century accounts of the pre-labor waiting period and the post-labor festivities give insight into this paradigm: "the Ladies who assisted took supper after all our matters were completed." It was not exceptional, but customary, that following a birth, "the women" cooked, ate, and drank together before spending the night in the new mother's home.[43] Martha accounts for moments of reciprocated care as well, noting her own naps by the fire, and expressing gratitude for the kindness shown to her when she eventually tired or ached. A midwife like Martha, whose decades of experience and market monopoly granted her a level of authority in the birthing space, was also just one in a group of women sharing in the mutual experience of life-giving. She was at once a friend and a professional in a unique moment during which two such identities were not only coexistent but interdependent. Martha Ballard straddled the social and medicinal worlds, and, in so doing, revealed that the throughline therein was childbirth. In stark contrast, the industrialization of childbirth worked to emphasize the quantity of delivery over the quality, effectively draining childbirth of its social significance.

Because American society operated according to Victorian ethics for much of the nineteenth century, and because childbirth's all-encompassing symbolism makes it a lightning

[43] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991, pp 98.

rod for the cultural values of a given time, the principles that dominated the Victorian era provide a clear idea of what it meant to give birth at the time. In particular, modesty and innocence were expected of Victorian women. In near-direct opposition to social childbirth, a woman or a mother's ability to practice silence and exhibit sexlessness were crucial to her value.[44] In this way, pregnancy was a complicated experience, in particular for first time mothers, in that the very act required for conception was, at once, sinful and biologically necessary. While motherhood was understood to be a woman's pride and purpose, her participation in earning that title was likely a source of shame. Pregnant women often stayed indoors, sometimes even concealing the event of their pregnancy from their husband until it became impossible to do so. The period of pregnancy was, at this time, referred to as "confinement." It was during her confinement that an expectant mother would retreat to her home, in the hopes of emerging a better woman, well-suited to care for her child. [45]

The Victorian era marks the birth of an American culture whose mothers-to-be hid themselves away until they might rejoin society with a baby on their hip and no discussion of where it came from. It was during this time that women halted open conversation related to their experiences in pregnancy, deserting gossip to satisfy the watchful eye of a society obsessed with purity. As much of history indicates, public disdain for something typically does little to eliminate the actual thing. Rather, it prompts the erasure of that thing from public conversation. In this way, Victorian women never ceased to be curious about and concerned with the goings on of their own bodies—bodies, they were taught, had a high likelihood of failing while giving birth, but were not taught what made birth dangerous—and they began to look beyond public

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[44] "Nineteenth-Century Moms Faced Familiar Issues - Racing Nellie Bly." *Racing Nellie Bly*, 8 May 2022, https://racingnelliebly.com/trailblazers/nineteenth-century-moms-faced-familiar-issues/.
[45] Mitford, Jessica. *The American way of birth*. Dutton, 1993.

conversation and towards their doctors for informational comfort. What was once a surplus of information provided to and by women became a scarce resource divvied out by male doctors to their paying patients.[46]

Under the nineteenth century's reign of purity, medical practice on female patients suffered. Some male obstetricians took to separating themselves from their patients with cloth, so as to blind themselves from the body they were operating on. Others insisted that the women labor only on their sides, so as to avoid eye contact between patient and practitioner. This sort of anti-exposure approach only limited the degree to which a doctor could serve his patient.[47] Moreover, it resulted in a lack of clinical training for birth, as medical schools at the time did not permit their students to attend births because it was considered immodest. It was typical in the earlier portion of the 1800s that new doctors be sent into the field with virtually no experience in a birthing space. It was unlike midwifery training in its hands-off approach and because doctors were practicing uninformed by the instructive assistance of a life full of gossip about birth.

Because of the general dehumanization of women during this time period, there was little to no conversation between doctor and mother prior to, during, or after labor. The usual fear of women in childbirth at this time was exacerbated by the compounded effects of purity politics—a cultural obsession with modesty made it such that women were poorly informed on the subject of their own bodies, discouraged from asking questions of or divulging too much information to their doctors, and oftentimes being operated on by young men whose collective understanding of the female form and its processes had come not from years of apprenticeship, but rather out of books written by other men.

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[46] "Nineteenth-Century Moms Faced Familiar Issues - Racing Nellie Bly." *Racing Nellie Bly*, 8 May 2022, https://racingnelliebly.com/trailblazers/nineteenth-century-moms-faced-familiar-issues/.

[47] O'Neill, Therese. "How to give birth (100 years ago)." *The Week*, 10 1 2015, https://theweek.com/articles/454290/how-give-birth-100-years-ago.

In the alternative event that students of medicine *were* getting hands-on experience, it was at the emotional and physical expense of the women in their care. Because wealthy women were still opting for doctor-led home births, early nineteenth century maternity hospitals were places for disenfranchised women to give birth. Their ultimate purpose was to provide a place of labor for women who didn't have the means to give birth at home. Hospitals were not yet paying doctors on a per-birth basis, but, rather, they acted as spaces of education where low-income and non-white women received medical treatment in exchange for their participation as clinical laboratory subjects. Functioning under the assumption that they held lower expectations of modesty and general care, they made for the perfect patients.[48]

By the end of the nineteenth century, medical means of intervention in birth were enacted regularly, across the spectrum, from routine to precarious labor. Because the medical birthing industry had yet to establish itself as unquestionably essential, its employees were tasked with the job of justification. The intention of the doctor was to find trouble, and find it he did. It came to be that most every birth was treated as if it harbored the potential for disaster. It is important to note that any birth in any era can go wrong in a second. However, with a handful of exceptions, most birth is not *inherently* dangerous in the way that the medical world has portrayed it to be.[49] What makes a once-standard birth dangerous is a lack of concord between a mother and the person(s) assisting her in labor — the cognitive distance between these two units can instill fear in the mother and render her provider intellectually and contextually disadvantaged. Instead of both parties recognizing their mutual loss and remedying it, the participating women internalized

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[48] Wertz, Richard W., and Dorothy C. Wertz. *Lying-in: A History of Childbirth in America*. Free Press, 1990.

[49] "4 Common Pregnancy Complications." *Johns Hopkins Medicine*, https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjW9NCpu6X-AhWIGlkFHVd8A8IQFnoECCYQAw&url=https%3A%2F%2Fwww.hopkinsmedicine.org%2Fhealth%2Fconditions-and-diseases%2Fstaying-healthy-during-pregnancy%2F4-common-pregnan.

these methods and approached their own labors with trepidation, thus creating ample space for the medical establishment to assert firmer control and means of intervention.

Hinged on the fear of complication or death, the dynamic between the scared woman and the all-knowing doctor was mutually strengthening. Male doctors' lack of intuitive knowledge surrounding the female body resulted in their treating its deviation from the male body as means for medical treatment. In effect, they considered pregnancy an urgent medical phenomenon, and saw all of the natural processes that accompanied it as symptoms in need of treatment. The legitimacy provided to male doctors by their institutional education cloaked this misinformed perspective and garnered them the trust of their female patients. In this historic moment, at which a pregnant woman's leaving her own home had been deemed potentially harmful to her child, talk among pregnant women about pregnancy was virtually non-existent. The gossip—as in, informational exchange between women *and* the women present at a birth—had gone extinct.

With little to no discourse on the subject of birth, much less at the time of birth, about what was typical and what demanded worry, gossip was silenced, and the social function of the event began to lose its cultural footing. It was in this window of non-talk, in which women were losing confidence in themselves for lack of mutual encouragement and feelings of shared reality, that the medicalization of birth was able to gain traction. Gossip's capacity to gather women together, to enact informational exchange, and to imbue their life experiences with meaning according to their shared nature, was not being employed.

Overlooked until years later is the truth that many of the threats associated with childbirth were, in fact, products of the medical environment—from the germs harbored in the hospital setting to the faulty treatment provided to patients by their doctors. One danger posing any pregnant woman in a hospital setting in the late nineteenth century was puerperal fever, a

profoundly painful bacterial infection of the reproductive organs that arises in the days following labor. A relatively new threat, medical professionals quickly shifted their practices accordingly. This meant an increase in the standardization of the birth routine. In large part, those introducing and spreading the infection were assumed to be the female patients. As a result, all women, regardless of status, were treated as if they had the disease. The issue, however, was ultimately revealed to be the collective foregoing of hand washing by physicians working in hospitals.[50]

Dr. William Goodell established his birth practice in the time of the fever. He explained that those times required regular doses of medicine, the manual rupturing of the amniotic sac, the removal of the baby with forceps, and an expedited extraction of the placenta by means of pushing on the mother's stomach. After birth, the new mother was given hourly doses of morphine.[51] At this point, consistent and candid dialogue between doctor and mother was off the table—beyond the doctors' disinterest, the haste with which births were being conducted left virtually no time for questions or niceties. In the hours (sometimes days) following her labor, a mother might be left alone without her family or her baby, much less regular visits from her doctor.

In the 1896 publication of her book *Preparation for Motherhood* Nurse Elizabeth Scovil writes of the importance of a mother's being left alone after she gives birth:

> Excitement is dangerous and no visitors must be permitted to enter the room, nor should conversation be allowed, even if she wishes to talk. Neglect of this precaution may cause serious disaster, even when all seems to be going well.[52]

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[50]Hallett, Christine. "The Attempt to Understand Puerperal Fever in the Eighteenth and Early Nineteenth Centuries: The Influence of Inflammation Theory." *NCBI*, 2005, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1088248/.

[51]*Goodell, William. "On the Means Employed at the Preston Retreat for the Prevention and Treatment of Puerperal Diseases." Collins, 1874, https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101665230-bk.*

[52]Scovil, Elizabeth. *Preparation for Motherhood*. Henry Altemus, 1896.

If what Scovil shares with her reader was as generally accepted in 19th century birthing practice as she suggests, it indicates that the postpartum experience was a lonely one during which a new mother was relegated to a literal room of silence. Scovil's illustration positions itself in contrast to Martha Ballard's description of the post-partum period as one of celebration and togetherness among women in communion.

Evidenced here is the presence of little [if not zero] conversation shared in early iterations of medical birth. In the absence of gossip, and under the veil of the treatment, prevention, and fear of disease, doctors in hospital settings were able to socially alienate women by isolating them physically and ideologically from one another, and, in doing so, effectively convince them that they needed medical means of assistance in birth—more than they needed to simply know what was being done to their bodies—in order to survive.

Well-respected obstetricians of the time argued for a myriad of interventional practices. One Chicago doctor, Joseph DeLee, beseeched his contemporaries to employ the use of forceps and episiotomy in every birth. These practices, Dr. DeLee argued, expedited the labor process, and preserved a mother's "virginal conditions."[53] Moreover, he posited that the length of a labor was directly related to the mental wellbeing of the child. Because afflictions of mental cognition were, then, associated with criminality, Dr. DeLee hinged his argument on the notion that his method could prevent mental impairments and, in turn, quell criminal behavior. Quoted in writing to have "often wondered whether nature did not deliberately intend women to be used up in the process of reproduction," Dr. DeLee's national prestige—his having been named the father

[53]Jones, Hope, and Alexis Darby. ""The Prophylactic Forceps Operation" (1920), by Joseph Bolivar DeLee | The Embryo Project Encyclopedia." *The Embryo Project Encyclopedia*, 18 April 2021, https://embryo.asu.edu/pages/prophylactic-forceps-operation-1920-joseph-bolivar-delee.

of modern obstetrics and his having introduced the first portable infant incubator—is significant evidence of the systematic objectification and pathologization of pregnant women.[54]

By the first decade of the twentieth century, figures like Dr. DeLee had done much of the groundwork to ensure that hospital birth become the norm in most American cities. By the beginning of the second decade, the growing economic prosperity of the average citizen inspired the regular use of automobiles. The mobility provided by this new technology meant that mothers-to-be living outside of major cities had access to their hospitals all the same. Women were told that hospital birth was the safer choice, and therefore desired it, and doctors saw the career opportunities within the growing medicalization of birth. Hospital birth seemed mutually beneficial.

Beyond the collective desire for prestige among medical professionals, a significant force in the doctor-lead transition from home birth to hospital birth might have been convenience. The general inconvenience of travel paired with the transportation of the amount of medical equipment considered necessary by that point rendered the idea of physician-led homebirth practically impossible. The ease felt by doctors in a standardized hospital setting might also be attributed to the division of work therein. In many ways, the emotional labor entailed in the performance of "bedside manner" ceased to be the sole responsibility of the doctor. Instead, he was called in, when necessary, in some cases staying for but a matter of minutes, only to leave and tend to his next patient. In his stead, nurses, cleaning women, and hospital chaplains might aid in the missing aspects of social birth—a role still often filled by such women in the contemporary moment. That is, until the actual birth process began, at which point the question of who was in attendance was left up to the doctor's preference.[55]

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[54]"Joseph DeLee." *Wikipedia*, https://en.wikipedia.org/wiki/Joseph_DeLee.
[55]Wertz, Dorothy C., and Richard W. Wertz. *Lying-in: A History of Childbirth in America*. Yale University Press, 1989, pp 153

At this, the national implementation of a standardization of natal care, it is impossible to ignore the doctors' delegation of a task such as conversation. The task of talk was handed off to the women employed at all levels by the hospital. It was up to these already overloaded women to deal in matters of communication with new or soon-to-be mothers. This broad range shirking of bedside manner made clear the general thinking among doctors on the matter of conversation as something that takes up time better spent practicing physical medicine.

The early twentieth century marked a collective recognition of the importance of prenatal care. In 1912, the federal government established the United States Children's Bureau, and tasked it with the issues of child welfare. A central focus in its earlier years was the pressing issue of infant mortality. In addressing the issue, the Bureau investigated the causes of such high death rates. What they found was that a lack of financial means in combination with a general absence of information on infant care and pregnancy were the primary contributors to the high rates of infant mortality. It was evident that the missing health and hygiene knowledge among women was putting them and their babies at higher risk of illness and death.

Having processed this new information, the Bureau enlisted Mary Mills West to write a booklet entitled *Prenatal Care*, which they would distribute to women across the United States. The booklet was a collection of words of advice related to exercise, diet, and hygiene. She explained the reality of miscarriage, delineated a how-to guide in the case of an emergency home birth, and advised her reader on breast-feeding techniques. In the seven years of its distribution, the result of *Prenatal Care*—an urgent and pioneering attempt at the pervasion of birth related information—was a national decline in infant mortality rates.[56] This is a notable departure from

[56]*West, Mary Mills. "Prenatal Care (1913), by Mary Mills West." The Embryo Project Encyclopedia, 18 May 2017, https://embryo.asu.edu/pages/prenatal-care-1913-mary-mills-west.*

the years of non-talk in the realm of birth. This resurgence of gossip– or perhaps, this attempt to fill the hole that gossip left– into the public sphere is significant as it manifests in the large-scale publication of birth-related information.

What is evidenced by the studies and subsequent work of the US Children's Bureau is the profound impact that knowledge, and its absence, have on the experiences of a mother and her baby. Without open conversation, the watchful and knowing eye of an elder, or the prying curiosity of the young, childbirth became an event so anti-social it was life-threatening.

The social function of gossip

Gossip, as a historical artifact, as well as its existence in the contemporary space, carries meaning. While many existing theories on gossip characterize it as anti-social behavior, the argument exists that the network of informational exchange that gossip is capable of cultivating holds the potential to foster relationships within groups and between individuals and, in doing so, categorizes the act as one that is inherently social. What inspires the cultural construction of gossip as something in need of elimination is its rejection of the world in which it is being used. Gossip fails its patriarchal judge in that it does not respect the seemingly universally implemented social and intellectual bounds of society. Instead, it encourages personal theory often born of anecdotal evidence.

By abandoning the unwritten rules and rituals of academia and their emphasis on "traditional" styles of thinking and writing, gossip is placed at odds with masculine American values. There is a stark difference between the ways in which men and women have historically existed in society. Mainstream histories document the building of hierarchical positions and networks by men, while illustrating the feminine focus on creating community and family. The societal disdain for gossip reflects not only the patriarchal dismissal of alternative styles of

thought, but it also hints at what might be the perceived threat of informational exchange among women. Evidenced here is the notion that communication between marginalized people under an oppressive system poses a danger to that system.

Gossip is commonly understood as the exchange of juicy tidbits of information from one person to another. Through a stereotypical lens, these two people are, more likely than not, assumed to be women. It is something that women of all ages are cautioned to avoid—a social faux-pas. If it is, in fact, wrong to gossip, then why does it satisfy so? What does the sharing and collection of information do for those who participate? One's own stance on the subject, gossip, does much to elucidate how one feels about other things as well. Because of its stereotypical linkage to the feminine, its reception sheds light on one's understanding of the woman's proper place in the world—where that is and how it can or should be enforced.

Doctor Samuel Johnson, author of the 1755 publication of A Dictionary of the English Language, provided three definitions of 'a gossip:'

1. One who answers for the child in baptism.
2. A tippling (drunk) companion.
3. One who runs about tattling like women at a lying in. [57]

The third definition, a call to early social childbirth and the "gossips" in attendance, speaks to a resentment, held widely and historically by men, for expressions of intimacy between women. In particular, it illuminates an insecurity whose activation can be traced back to feelings of exclusion from bonding processes. While men and women both participate in gossip, it has been, nonetheless, relegated to the gendered realm of feminine activity. The lying-in ceremony—a gathering of women in celebration, conversation, and support of an event exclusively

[57]Johnson, Samuel. *A Dictionary of the English Language*. 1755.

experienced and understood by women— perhaps represents precisely that which the average man might resent, or even fear.

Martin Heidegger famously argued in opposition of what he called “idle talk,” describing it as “this gossiping and passing the word along, a process by which its initial lack of grounds to stand on increases to complete groundlessness.” [58] Idle talk functions as any content that does not open one’s mind but, rather, limits it. What is considered limited thinking is that from which conclusions drawn cannot be widely located or applied. In other words, real information focuses on the abstract—on broad and historical trends—while trivial information explores provincial, often case-specific details. The writing of thinkers like Heidegger works to further the general assumption that gossip is simple talk born of empty heads and stemming from small-mindedness. In the realm of higher thought, there is a focus on broadly applicable truths. In the realm of gossip, however, can be found the value of smaller, communal truths. It is within these smaller, community settings that I seek to solidify my own definition of gossip.

If gossip is presupposed to be a feminine activity, then perhaps that is where the inquiry should begin—in women’s talk. Pushed on young girls of most cultures is the idea that gossip is wrong. Jamaica Kincaid writes in ‘Girl,’ (1987), an essay of commands delivered from a mother to her daughter, set in the Caribbean Island of Antigua, “don’t sing benna in Sunday school.” [59] She condemns benna, a call-and-response genre of Caribbean music, which is marked by the divulgence of gossip from one singing woman to another. Among other life lessons, like “wash color clothes on Tuesday and put them on the line to dry,” is the firm order to avoid too much informational exchange. Here, a woman advises another, younger woman away from gossip. She

[58]Gelley, Alexander. “The Speech of Dasein: Heidegger and Quotidian Discourse.” *Duke University Press*, 1 May 2017, https://read.dukeupress.edu/boundary-2/article-abstract/44/2/75/6593/The-Speech-of-Dasein-Heidegger-and-Quotidian?redirectedFrom=fulltext.
[59]Kincaid, Jamaica. “Girl.” *The New Yorker*, 19 June 1978, https://www.newyorker.com/magazine/1978/06/26/girl.

suggests that gossiping, or singing benna, is poor etiquette for a young girl whose introduction into society is imminent.

It might be fair to argue that this essay is evidence of a woman's awareness of the vapidness of gossip, but, on the contrary, I would argue that the order itself is a form of protective gossip. In a laundry list of life lessons, she is sure to caution her daughter to keep in line with the behavioral parameters set by their community—effectively transferring her knowledge of their world onto her female offspring. Here, gossip itself is subtly woven into an order against gossip. The mother says to her daughter, in other words, "If you want to be safe in this community, be careful who you share your information with." She recognizes and conveys that the act of gossip is frowned upon by their society but, also, that *thoughtless* gossip can be particularly taxing on one's reputation.

This understanding of gossip—wherein information is exchanged between women who care for one another—is an act of bonding and community building, as the information itself can provide the gossipers with a protective layer of knowledge against harmful individuals or systems, and in that the act itself is intimacy creating due to the mutual trust which defines it. When it comes to talk among the marginalized, communication has always been threatening. In American history alone, there is too much evidence of this truth. One example is the forbiddance of enslaved persons from learning to read and write, as well as their punishment for talking too much, or too intimately.[60] Female friendships, as well, have earned much criminalization across history. In the United States and South America, accusations of witchcraft and its punishment were a common response to the closeness of two or more women.[61] It was clear that society's

[60]"Slavery and the Making of America. The Slave Experience." *Thirteen PBS*, https://www.thirteen.org/wnet/slavery/experience/education/docs1.html.
[61]Schiff, Stacy. *The Witches: Suspicion, Betrayal, and Hysteria in 1692 Salem*. Little Brown, 2016.

most powerful figures believed that, given the opportunity to exchange words and experiences, marginalized individuals would form cohesive groups, and ultimately turn their backs on a set of social rules that benefited so few. In order to oppress a group, it is crucial that the oppressor cut off its inter-communication, and that is what happened to gossip.

For the patriarchy to function effectively, it is also crucial that women feel alienated from one another's experiences, rather than bonded by them. It is for this reason, I argue, that gossip between women has been so demonized. If, in fact, gossip has the power to gather individuals in their shared experiences and inspire them to turn against the systems that don't serve them, then it is crucial that those who are served by said systems prevent that gathering at all costs. Gossip functions as a social tool in its ability to rally the oppressed against their oppressor. Because birth was once an event exclusive to the presence and practice of women, it was a prime location for gossip to transpire. This fact cannot be ignored in the consideration of why the work of childbirth changed hands so forcefully from women to men and why gossip was erased from the practice in that transition.

Gossip as manifested in the birth story

Midwife Ina May Gaskin writes, on the role of the birth story,

> While stories can't let women know what their own experience will be like, they can illustrate how wide the range of normal behavior is. Much of the pain experienced by women in childbirth can be attributed to fear and lack of knowledge about the true physiology of birth. [62]

She speaks to the power and import of the transfer of birth-related knowledge from woman to woman. I seek to use the following birth stories as evidence of gossip's power in birth as well as its necessity in times of absence.

[62] Gaskin, Ina May. *Birth Matters: A Midwife's Manifesta*. Seven Stories Press, 2011, pp 12.

18th century social childbirth

Martha Ballard was a midwife in the colony of Hallowell, Maine, between the years of 1785 and 1812. Beyond that, she was a nurse, mortician, pharmacist, wife, and a meticulous record keeper. A pillar in her community, Martha delivered over 1000 babies in her career while simultaneously participating in the women-led economy of quilting and spinning.[63] Because she was involved in so many elements of life in Colonial Maine, Martha's diary serves as a revealing illustration of the every-day, and as evidence of the social terms on which birth transpired at the time that she practiced. The economy of women, which was a dynamic combination of the trade of goods and of mutual service to one another, was founded on friendships between the women of the town. It was, in a way, a community built on gossip.

Martha's entries focus on matters of fact, with flickers of explicit emotion sprinkled sparsely throughout. For the most part, the birth entries included the following: father's surname, child's sex, paid/unpaid, location, and delivery number. Oftentimes she also included the time of her arrival, of the birth and of her departure, the wellbeing of the baby and its mother, and the details of her journey to and fro. Regularly included were the names of those in attendance, with note taken in the event that a doctor had been called prior to or during her presence. Unaccompanied, a single entry might fail to illuminate very much to its reader. As a collection, however, Martha's entries paint a detailed picture of what it was to give and assist in birth in the colonies—specifically, of course, in Hallowell, Maine.

Labor, then and now, is understood to consist of three stages. At present, the stages are: (1) uterine contractions and cervical dilation, (2) the baby's journey through and out of the birth

[63]Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991, pp 7.

canal, and (3) the delivery of the placenta, or afterbirth.[64] Martha's delineation of these same phases in the colonial moment is reflective of the sociality therein, and of the gossip responsible for that sociality. Instead of using biological language in her entries, she marks the progress of a birth according to who is present. The three stages according to Martha were: (1) the arrival of the midwife, (2) the calling of "the women," and (3) the entrance of the afternurse. [65] During the first stage of a woman's delivery, she was likely still on her feet, working when she needed to and resting when possible. The second stage of labor was marked by the calling of the women, or the gossip. The presence of "the women" represented the impending closeness of the birth—in other words, first came gossip then came baby. In this way, such a call expressed the physical transition from the first to the second stage of labor. Martha writes that one woman's labor *Came on so great that her women were Calld.*[66] Once the afternurse arrived, the third period—the lying-in—began, and Martha would take her leave— *Mr Parker went for his Nurs. I left his Lady at 4 pm*.[67]

It is fitting, then, with this intertwinement of the social and the "medical," that the biological particularities of a given birth are conveyed in Martha's accounts in precisely the same style as the social. Across her entries, the documentation of birth is not isolated from that of other events, such as trades made, or gatherings attended.

> *Mrs Coin (Cowen) was Lingering and very much deprist in Spirits. We called Mrs Fletcher. Mrs Soal Called there. Mrs Savage & Fletcher tarried all night. The patient was delivered a few hours later with 5 pains after my inquiring into her Case.*

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[64] "Stages of Labour." *Healthy parents Healthy Children*, https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjShPWktKT-AhVPjYkEHfdvDTYQFnoECBUQAw&url=https%3A%2F%2Fwww.healthyparentshealthychildren.ca%2Fim-pregnant%2Flabour-and-birth%2Fstages-of-labour&usg=AOvVaw2bqm3nvdW0k-H.

[65] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991, 183.

[66] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991, 185.

[67] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991, 189.

Here, Martha speaks to the dual psychological and physiological aid provided by a woman's gossip. While the calling of the women was often a response to signs of impending delivery and the anticipated need for more hands, it also functioned as a means by which to inspire labor in the event that the laboring mother hit an impasse. In the above entry, Mrs. Cowen's depression is brought on by her *lingering* progress, and inspires the calling of her women, which may have been just the supportive push she needed in order to continue. There is a symbiotic relationship between the arrival of the women and the progress of the birth. The women are typically called upon at the advent of the second stage of labor, when it is time for the mother to actively push her baby out. Their role, at that point, is to support the midwife in her efforts, while maintaining a helpful level of supportive and communicative dialogue (for some mothers, that means being updated and encouraged throughout the entire process; for others, it means minimal instruction and silence when possible).

Another way that the dynamic between a mother and her gossip works to the benefit of the labor process is that the arrival of the gossip can (a) lift her spirits to the point of progression in labor by providing fresh and encouraging energy or (b) indicate to her and her body that it is time to push—that she has made it to the point in her labor that the women are called, which intimates her close proximity to delivery. Closeness between friends and relatives, and the likelihood that one's midwife be either, made possible a birthing room of women with intimate insight into how exactly the laboring mother wanted to be treated.

Gossip presents most evidently in these colonial depictions as "the women" and the support that they provided—at times, with their presence alone. Martha notes the names of the women called at most births:

> *Find his mother and Ben Chambers wife there. We calld the McCausland wives after Sunsett.*

My company were Old Lady Cox, Pitts, Sister Barton, Moody, Soal, & Witherel.
Mrs White sent for her women. They were with her all night, Viz. old Mrs White, Norcross, Moses, and Benn Whites wives, Jackson, Stickney, Coburn, & Lydia his sister [68]

She also attests to the likelihood that any given gossip might stay the length of the night or perhaps longer. Part of Martha's role in this setting was to organize for the coming of the women—to communicate with the mother to figure out who she wanted at her birth and to relay to the father the appropriate time to call for them.

Martha's entries also evidence the use of gossip as a means of measurement.

George Thoma's son weighed more than the lite side of Mr Densmore'stilyards would weigh.
Captain Ney's baby measured round the Breast (after being dressed in thin Cloaths) 18 ½ inches. [69]

With reference to her decades of accumulated data on the habits and conditions of mothers and their babies, Martha is able to assess causes for concern at birth, and later. She writes that George Thoma's child weighed significantly more than Mr. Densmore's, but does so without urgency, which implies that this was not cause for concern. She uses the wealth of gossip in her records to measure the health of the newborn. Her writing on the size of Captain Ney's baby would likely serve as a reference point soon thereafter, because being that the average chest measurement of a newborn is between 12 and 13 inches, this was documentation of the birth of a relatively large baby.[70] In the event that another baby was born that big, Martha would be able to cite the entry on Captain Ney's baby, perhaps just by memory, in order to quell the nerves of a mother

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[68] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991, 186.
[69] Ulrich, Laurel Thatcher. *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. Knopf Doubleday Publishing Group, 1991, 167.
[70] Rinehart, MD J. "The Normal Neonate: Assessment of Early Physical Findings." *GLOWM*, 2009, https://www.glowm.com/ section-view/heading/The%20Normal%20Neonate:%20Assessment%20of%20Early%20Physical%20Findings/item/147.

concerned with her baby's size. Here, gossip is a measuring tool. It is norm-instilling as well as reassuring.

20th century medical childbirth

Grantly Dick-Read was a doctor who wrote extensively on the topic of and advocated for natural childbirth—the crux of his work being his conviction that relaxation before, during, and following labor had the potential to allow 95 to 97 percent of births to be sentient, happy experiences for the women giving birth.[71] This ideology hinged on his belief in the power of information and education amongst birthing women (relaxation, exercise, and proper diet). Information, here, works as a sort of sobering sedative, in that it inspires in the mother-to-be confidence in her doctor, in herself, and in the holistic practice of childbirth. Fear, then, is activated by a lack of knowledge. While Dick-Read's work did much in the vein of empowering women to fancy themselves capable of giving birth without excess medical intervention, it unfortunately carried other, potentially dangerous assertions as well. Particularly controversial is his positing that no amount of labor pain warranted the administration of drugs. He did not, however, withhold drugs from his patients in the event they insisted or needed them. Dick-Read's studies served to bolster his greater goal: the overall increase in pregnancy and the follow through of labor.

Following the 1942 publication of Dick-Read's book, *Childbirth Without Fear,* which explored and advertised the joys of natural childbirth, women across England and the United States wrote to Dr. Grantly Dick-Read, in intimate detail, accounts of their birth-giving experiences. The letters speak not only to the medical norms of pregnancy and labor at the time,

[71]Dick-Read, Grantly. *Childbirth Without Fear: The Original Approach to Natural Childbirth*. Edited by Harlan F. Ellis and Helen Wessel, Harper & Row, 1987

but also to what it was to coexist and interface with industry, society, and family as a woman during and following World War II.

While I will use some of the stories in this collection of letters to Dr. Dick-Read to bolster my argument that informational exchange in the birth space is vital to the experience and livelihood of those giving birth and those being born, it is important to draw a clear distinction between Dr. Dick-Read's narrative and my own. While I concur with his assertion that the medical model of birth has historically abused the use of labor-related drugs as well as the women to whom they were administered, it is the letters from these women *to* the doctor that evidence my claim, *not* Dr. Dick-Read's responses to them. He was, I believe, attempting to assert control over the birthing process with just as heavy a hand as those in the medical industry. He had simply found an alternate ideological vehicle with which to do so.

"Correspondence 1"
August 17, 1946

> *Before my first baby was born when I was twenty-five, I longed to know the facts of which you speak, and begged my husband who is a Veterinarian, to inform me of what he knew, since I had come through college with an appalling ignorance as to the functions of birth and its related responsibilities. However, he, in company with all my mother-friends, and my over-worked harassed doctor believed in the bliss of ignorance and happily evaded all my queries, for which I cannot completely forgive them ever for. Loneliness… I can testify is the most soul-starving experience of all. I was left alone for twenty-four hours of labor in a strange bare room with only the occasional examinations and hurrying away of impersonal interns. For this (next) baby I have selected a 'specialist' in this large city, who seems most efficient, but completely ignores the fact that I am human and have a mind.*[72]

This new mother recounts to Dr. Reed her experience of hospital birth. She begins her articulation of that event with an emphasis on her desire for knowledge on the matter of

[72] Thomas, Mary, editor. *Post-War Mothers: Childbirth Letters to Grantly Dick-Read, 1946-1956*. University of Rochester Press, 1997, pp 24.

childbirth and her inability to locate any. She goes so far as to "beg" her veterinarian husband for any insight into the process of animal birth in hopes that it might shed some light on the human process as well. Nobody in her life, she says, would share with her any such anecdotal content. She searched for gossip, looking even in unlikely places for its presence, but came up short. This mother is not unique in her outsourcing of gossip, and, while some are more fortunate, she is not alone in her inability to find it elsewhere. It is interesting that her expressed hunger for information is followed by descriptions of loneliness at the time of birth. It seems the effects of the lack of gossip during her pregnancy and labor were twofold in that she had no infrastructure of conversation to rely on leading up to the birth of her child—no gossip—and she also had no family or friends—no gossip—surrounding her at the time of labor. This mother speaks to the profound loneliness, "the most soul starving experience of all," of medical birth sans gossip.

"Correspondence 8"
February 26, 1949

> *Seven obstetricians turned down the method as 'taking too much time' before our first child was born; the eighth said that I needn't have anesthesia if I didn't want it. When I was having 2-minute 'pains,' however, (having been unattended in the labor room for two hours—my husband being barred), the obstetrician entered with a nurse forcibly (I mean that—I didn't want anything, except some company) administered Demerol, scopolamine, (and later ether), and I didn't regain consciousness for 12 hours. He later answered my protests by explaining bitterly that my request had been the result of a 'pregnancy hallucination': that men were too intelligent to let women suffer because of their 'notions'—and wasn't I lucky that he had been wise enough to humor me along until delivery time?* [73]

This mother writes to Dr. Dick Read in search of another doctor willing to follow Dr. Dick Read's ways of birth and asking for a contact in the Midwest. To reiterate, Dr. Dick Read's method emphasizes the natural process of the human body in birth and employs patience as its primary tool. In her search for a doctor willing to engage in a slower, more natural labor, this

[73] Thomas, Mary, editor. *Post-War Mothers: Childbirth Letters to Grantly Dick-Read, 1946-1956*. University of Rochester Press, 1997, pp 52.

woman finds rejection seven times from doctors naming it too time consuming, before being met with one who agrees not to administer anesthesia should she choose against it. Already, her experience demonstrates the medical obsession with efficiency. The explicit criticism of a slower labor process translates directly into an industry's disinterest in matters whose purpose serves anything but speed. Specifically, then, the function of gossip in the birth space is not one worth entertaining.

Despite the doctor's promise that anesthesia use be up to the mother's discretion, it wasn't until her contractions began that this mother was forcibly administered Demerol and scopolamine without any forewarning or consent. She recounts having been alone for two hours prior to receiving the drugs, and remembering nothing for the twelve hours that followed their administration. In this mid-century iteration of hospital birth, a mother's request for bodily autonomy was dismissed–and she was lied to. The doctor's behavior reflects modern medicine's tendency to treat its (female) patients like pieces of machinery, incapable of making their own decisions and simple enough to fall for empty intimations of respect. In her gossipless birth, this mother was promised one thing and experienced another. Entirely absent from her birthing experience was the sense or proof that she was being listened to by her birth team. Instead, she was humored into pacification, left alone in the impressionable hours leading up to her labor, and, finally, treated against her will.

Had this birth reflected a social iteration of childbirth—at which a gossip and her gossip would be present—this doctor might have spent more time acquainting himself with the particularities of the mother's condition (gossip as question asking), perhaps he would have preexisting insight into her or her story (gossip as informational exchange among community members), or maybe her friends and family would have been at her side for those two hours

preceding labor (gossip as a support system of women at the time of birth), or, finally, perhaps the doctor would not have been a man at all, but, rather, a female midwife. These are the iterations of gossip that are lost in medical childbirth.

21st century medical childbirth

In, "'A scene from a horror movie:' 9 mothers speak out about alleged mistreatment during childbirth," (2016) an article of compiled stories from women in their accounts of traumatizing medical birth, Annie Burns-Pieper sheds light on the reality of hospital birth for so many. It is important to clarify that these stories were likely sought out for their negative depictions of hospital birth. While there are, of course, beautiful stories of birth in the hospital and traumatizing stories of those in the home and in birthing centers, the aim of this exploration is to understand the dangers of hospital birth–particularly, the psychological dangers therein. The focus here is on lack of communication in moments of unexpected turbulence. Childbirth always has the potential to be dangerous or even fatal, but how the people guiding a given birth respond to the threat or existence of danger is what is being analyzed. Moreover, how do those responses affect the mother in her labor and how does that imprint on her after the fact? This is the fruit that can be extrapolated from these stories.

"Raylene Hrecka"
2015

> *The nurse started to scold me for not relaxing and lying still. One of the comments made was 'This would be a lot easier if you cooperated. 'My legs were being held down as the procedure continued. The doctor thanked the nurse for her help. I had done all this preparation, got the doctor to put it in the file and then I still totally felt re-traumatized. I already just felt so broken and there was no consent and there were people messing around in a very private space and it hurt as well. I guess not having any communication around it just made me feel like something was being done to my body against my interest.*[74]

[74]Burns, Annie. "'A scene from a horror movie': 9 mothers speak out about alleged mistreatment during childbirth." *CBC*, 7 November 2016, https://www.cbc.ca/news/health/hospital-mistreatment-stories-1.3834899

Raylene is a survivor of sexual assault, a fact she asked her primary care physician to make note of in her file before sharing it with the medical team attending her birth. It is unclear whether or not the team saw the note, but the experience that followed her request failed her. Language is important in the birth setting. That it be used, first of all, is crucial and not always considered so. When talk is happening, the kinds of words used can inform the birth giver's experience in meaningful ways. In the event that that person has a history of sexual violence, speech—its content and its delivery—is accompanied by with a platter of intimations. Oftentimes, survivors struggle with the—presence or absence of—feelings of helplessness, trust, pain, physical or emotional intrusion, and control. Birth engages many, if not all, of these. Hospital birth might be chosen for virtue of its more official nature. There are rules and guidelines in place, orders of operation to be followed, ideally plenty of documentation, and seemingly more rigid plans—all of which can provide a mother-to-be with expectations of security by means of lessened ambiguity. However, as evidenced in the case of Raylene, who made her best effort to protect herself and her baby from a triggering and consequently traumatizing birth experience, such hopeful expectations are not always reached.

Penny Simkin and Phyllis Klaus, long-time educators, and writers in the field of childbirth, published a workbook on the subject of childbirth for the sexually traumatized. *When Survivors Give Birth (2004)* outlines several factors with the potential to define a woman's labor as a natural miracle or a nightmare. One of these is the childbirth educator, who often takes the form of a birth class instructor. Because of the pervasiveness of sexual abuse, the odds that any given birth class will contain one or several sexual abuse victims are strong. Simkin outlines several examples of potentially retraumatizing language that ought not be used in an instructive class, much less in the event of birth itself. Raylene's experience evidently counters all of these

teachings. "Reminders to yield, surrender, to open yourself up to the pain… may inadvertently convey the opposite message to survivors, who have been forced to yield and surrender during their abuse."[75] To have her legs held down while being instructed to lie still and relax can immediately send a survivor into the explicit memory of her abuse. As a result, her first moments with her baby are informed by that darkness.

This sort of communication—unexplained commands, orders for silence or compliance—is not communication at all. Raylene's birth story depicts but one iteration of the dialogue-free reality that is hospital birth for so many. Not only is there no gossip in the sense that there are no stories told or questions asked, but there is also no gossip in the original sense of the word. Raylene did not have her gossip surrounding her. She was without a sister, a mother, a pack of girlfriends, or even a midwife. The only other woman in the room with Raylene was a nurse who had evidently abdicated her fellow-woman's duties before she even set foot in the delivery room. Instead, she acted only on the behalf of the male doctor and, in effect, failed Raylene in her search for gossip at the time of her labor (as a result of the gossip devoid system under which she was trained and employed).

21st century social childbirth

Midwife Ina May Gaskin is a decades-long champion of natural and social methods of childbirth. Her work on the subject of birth fills the theoretical spectrum from the sociological—analyses of the motivations behind its medicalization, to the biological—scientifically grounded critiques of the medical model, all the way to the psychological—explorations of the emotive experience of giving birth and its factors. The writing in Gaskin's book, *Birth Matters: A Midwife's Manifesta (2011)*, touches on each of these elements in detail. Woven throughout her

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[75] Klaus, Phyllis, and Penny Simkin. *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women*. Classic Day Publishing, 2004, pp 168.

theorizations are the powerful stories of so many women in remembrance of their journeys to and experiences in natural birth. These depictions of natural childbirth reflect the gossip inherent therein as manifested in wealths of knowledge, informational exchange, supportive language, emotional connection, and norm-instillment. They do not, however, reflect the cases in which natural birth is not a safe option. In advocating against the oftentimes excessive use of intervention in hospital birth, it is crucial to hold space for the legitimacy of the experience in which it is necessary and lifesaving.

"Chloe at The Farm"
2011

> *I wanted to be alone with Carol, so I could look deep into her face and let her eyes guide me. She was so reassuring every step of the way. I think if you trust in birth the way she does, it just emanates from you and gives women confidence. Carol reassured me that this was all fine. Carol reassured me that this was normal and told me not to be discouraged. Carol placed a mirror under me so I could see the baby's head, which was very encouraging. She then warned me that it would burn and probably be painful, but that all the stinging did not necessarily mean that there was a tear. She said I shouldn't worry about that.*[76]

Chloe's birth speaks to the significance of the connection between midwife and mother. Depending on its strength, that closeness can provide emotional support powerful enough to affect the body. Chloe emphasizes the contagious confidence of her midwife, Carol, and credits it for her ability to make it through her own birth. Gossip presents here to the tune of "Other women have done this before me, and I know that because they have told me." It transforms the women around a laboring mother into a metric against which she can understand her own birth. Phrases like "Carol reassured me" indicate a trust in the woman assisting a mother in birth and, particularly, in her wealth of knowledge on the births of women before her. In this story, gossip

[76]Gaskin, Ina May. *Birth Matters: A Midwife's Manifesta*. Seven Stories Press, 2011, pp 102.

is norm-instilling, albeit in an untraditional way, in that it tells the expectant mother that certain kinds of pain are normal, that her body *is* capable of getting that baby out, that certain perceived setbacks are normal and should not discourage or worry her.

"Teresa at Home"
2011

> *Even though I am a nurse and read as much as I could to avoid induction and unnecessary medical interventions, I felt a bit helpless. Despite my best efforts, when the situation actually arose, I felt I had few options, no words, and no alternatives in my arsenal. When I inquired about the amniotic fluid levels, I overheard a physician assistant (when talking about me) say, "She's in denial." I ultimately had a vaginal delivery without an epidural. Essentially, for every intervention suggested, I negotiated for a small walk or allowance to get out of bed. When I was told my water would need to be broken and internal monitoring would be required because I was not progressing, I negotiated for thirty minutes to walk around and use the bathroom. During those thirty minutes, I went to the bathroom and my water broke. I stood for as long as I was allowed. By the time the doctor returned, much to his surprise, I was fully dilated and ready to push. I felt I had secretly succeeded in my quest for a natural delivery.*[77]

Teresa's first birth took place in the hospital and was led by a male obstetrician. This style of birth is typically devoid of gossip, but she was able to manipulate the process in order to secure a less medical experience. Her situation was unusual in that she was a nurse, and which provided her unique insight into the goings on in the labor room and their implications. But this did not protect her from potentially harmful and oftentimes dehumanizing language used in so many hospitals at the time of birth. Rather, she found herself with "few options, **no words**, and no alternatives in [her] arsenal." Teresa emphasizes the uselessness of spoken word in the hospital setting, especially for first time mothers.

[77]Gaskin, Ina May. *Birth Matters: A Midwife's Manifesta*. Seven Stories Press, 2011, pp 134.

With neither personal experience (physical familiarities or doctor-receptive vocabulary) nor the respect of their attendants to support them, words often fail primigravid mothers. Mocked when she asked her team for intel on her amniotic fluid (standard obstetric practice calls for induction in cases of fluid levels at or lower than 5 centimeters),[78] Teresa's attempts at involving herself in the conversation about her own labor fell on deaf ears. The response of the physician's assistant, "she's in denial," indicates that person's understanding that Teresa would, of course, need to be induced. This small moment can provide insight into the pervasiveness and normalization of intervention. Roughly 25 percent of labor in American hospitals is induced, but only 25 percent of those inductions are considered medically necessary.[79]

While there are, of course, very legitimate reasons for inducing labor, it can be dangerous to a mother and her baby when their circumstances do not call for it. Both parties are at risk of dying in the event of amniotic fluid embolism—a condition with significant linkage to the administration of an epidural. A Canadian study found that amniotic fluid embolism was twice as common in women whose labors were induced.[80] Induced labor is also more likely to lead to cesarean surgery. Hard contractions can place undue stress on a baby who is not yet ready to travel down the birth canal. Far too often, labors are not induced for the benefit of the mother or her baby but, rather, because induction makes possible the scheduling of a labor (at times more convenient for medical personnel).

I digress, but the point in highlighting Teresa's disregard when inquiring about whether or not she will need an epidural speaks to the truth that intervention (like epidurals) is

[78]Klein, Risa. "How to Avoid Induction of Labor Ensuring Your Baby's Swimming Pool Stays Full!" 18 January 2017, https://www.manhattanmidwife.com/single-post/2017/01/18/how-to-avoid-induction-of-labor-ensuring-your-baby-s-swimming-pool-stays-full.
[79]Reilly, Kathleen M. "Inducing Labor: Why it's Necessary and How it Works." *Parents*, 11 June 2015, https://www.parents.com/pregnancy/giving-birth/preparing-for-labor/health-101-inducing-labor/.
[80]Elia, Joe. "Induction of Labor May Contribute to Amniotic Fluid Embolism." *NEJM Journal Watch*, 5 December 2006, https://www.jwatch.org/jw200612050000005/2006/12/05/induction-labor-may-contribute-amniotic-fluid.

commonplace and demonstrates a lack of trust between medical staff and mother. The physician's assistant did not trust that Teresa (whose body was a relevant subject in that setting) had any right to, or insight on, information regarding that body.

While Teresa did manage to deliver her baby without an epidural, she did not do so without resistance or, ultimately, being induced with Pitocin. She writes that, in order to avoid medical intervention, she would "negotiate" for walks and that, when told her water would have to be forcibly broken, she found peace in the bathroom, and immediately felt her water break on its own. She infused her traditionally medical birth with questions, conversation, and other elements of natural birth like standing during contractions. Teresa demonstrates the active search for gossip in an environment entirely unconducive to it.

On her 2nd birth, at home

> *With my home birth, I had a great team on board, including my midwife, her assistant, my doula, my mother, and my husband. Each provided outstanding emotional support and I received fabulous, nearly constant back rubs. Being in a conducive environment and knowing that every person present was 100 percent supportive of our process and goals really helped me move past my fears. My thoughts were that I couldn't do this. I didn't think I could push. Around the twentieth hour of labor, my tolerance for the pain and fear of how long this could really go on began to get the better of me. But the support I felt from my team and the voice and words of my midwife focused me on the task at hand. I know absolutely, without a doubt, that had I not had a scheduled home birth with a midwife that I would not have been allowed to begin my own labor with my second delivery. I would have been induced again. I kept telling myself that if I ended up at the hospital, they would give me Pitocin. The thought of more painful contractions while being confined to bed was all the motivation I needed to keep going and stay on course for my home birth. The person who benefited most, and most unexpectedly, from this was my three-and-a-half-year-old son. New York had recently prohibited sibling in-hospital visits, and not being separated from my son greatly assisted in keeping our entire family cohesive, which has a significant impact on his transition into being a big brother.* [81]

[81] Gaskin, Ina May. *Birth Matters: A Midwife's Manifesta*. Seven Stories Press, 2011, pp 134.

At the advent of her second child, Teresa's wish for a natural home birth was realized. Her previous experience in the hospital setting gives Teresa unique insight into the stylistic differences between that medical framework and this more natural model.

Parous women, or those who have given birth before, are significantly less likely to experience intervention in labor in all birth locations (home, hospital, or birthing center) than are nulliparous women, or those giving birth for the first time. The rates of maternal and infant mortality are also notably lower in cases with mothers who have already given birth.[82] This data may be reflective of the power of past experience in the event of birth. Perhaps gossip flows more freely when the laboring woman has a muscle memory for that process and can recognize sensations as normal or abnormal, or when she has witnessed the capability of her body to birth a baby and finds confidence in that—maybe these factors inspire her to voice her opinions, needs, and wants at the time of birth. With this thinking, the expectant mother has her own wealth of knowledge about birth and is, as a consequence, not wholly reliant on the discretion of those assisting her for intel on the matter, so she is more likely to initiate dialogue or make certain requests. She acts as her own gossip by using her previous lived experience as a barometer for that which she encounters at present—telling her what is "normal" for her body and reminding her of the kind of practice best suited to her.

While Teresa had no experience in 24-hour labor pains, she did have memories of constant negation about intervention and of confinement to a bed despite her body's messaging that it wanted to labor vertically. She also knew that after just 12 hours of labor, the obstetrician leading her first birth insisted on inducing labor and relegating her to her bed, which meant that the 20-

[82]"Planned Home Birth." *American College of Obstetrics and Gynecology*, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/planned-home-birth.

hour mark would guarantee induction and horizontal labor. This knowledge, paired with the support and intimacy provided by her team at home, was enough to keep Teresa in her own house. Her previous experience in birth allowed her to recognize the challenges while still maintaining confidence in her body's ability to birth her baby.

Finally, Teresa makes a nod to traditional social childbirth in emphasizing the power of familial and community closeness in the moments during and following delivery. She notes that her choice to give birth at home allowed for deeper connection in her family. In a moment during which children were not permitted to visit their mother and new sibling in the hospital, the family-oriented nature of home birth allowed for the immediate integration of a new member into Teresa's family. She also names her gossip—the midwife, the midwife's assistant, the doula, her mother, and her husband. And by noting her human surroundings as an active agent in coloring her birth experience, she speaks to their significance. On conversational, informational, and interpersonal levels, Teresa's birth stories illustrate the beauty and safety provided in a gossip-filled birth, while also mourning the reality of loss for want of gossip's presence.

Conclusion

The decision to close my study with the above collection of birth stories is twofold – both reasons, I would argue, bolster the assertion that gossip was and is a present and positive force in childbirth. These stories are here, in part, because of how much of my theoretical thinking was inspired by firsthand accounts of birth. In nearly every birth story I came across, a mother credited gossip for her positive experience or grieved the losses permitted by its absence. While the term gossip is rarely used in these accounts, emphasis on the existence or nonexistence of words that signal gossip ("communication," "connection," "knowledge," "stories," "explanation") is expressed almost universally.

Complementary to the above reasoning for this birth-stories-as-data approach is my intention to highlight their existence in the first place. Across geography, culture, and time, storytelling on the matter of birth prevails. Birth stories, which were once exchanged in the home, before, during and after delivery, are now often expressed online, in forums designed by and for mothers of all ages and backgrounds.[83] It is my thinking and my finding that evidence of gossip in childbirth can be found across history in women's articulations of their experiences therein, but, before that, I would argue that the very existence of the birth story (with its shareable utility and nature) is an act of gossip itself.

Women are so often guided by the stories of other women. In American culture, there is a deceptive and poorly intentioned bifurcation drawn between the credible knowledge of professional men and that extracted from the anecdotal material of women. Childbirth is but one example of women drawing on their own lived experiences to provide protective armor to the other women in their lives.

Across this history of American childbirth, there are two narratives: one of medical advancement in birth and one of the experience of giving birth. At the moment that the people assisting in birth (midwives) stopped being women with personal and anecdotal knowledge on the subject and became men in white lab coats with time crunches, gossip was lost. What can be found in contemporary depictions of birth, however, is the search for (and for a lucky few, realization of) gossip in those spaces. Raylene Hrecka looked for gossip by asking questions and divulging personal information, but her medical team was unreceptive.[84] Teresa, having experienced a gossip-less birth once before, fought to give birth to her second baby in an

[83]Sanders, José. "Sharing Special Birth Stories: AN explorative study of online childbirth narratives." *Science Direct*, Women and Birth, December 2019, https://www.sciencedirect.com/science/article/abs/pii/S1871519218306061.
[84]Burns, Annie. "'A scene from a horror movie': 9 mothers speak out about alleged mistreatment during childbirth." *CBC*, 7 November 2016, https://www.cbc.ca/news/health/hospital-mistreatment-stories-1.3834899.

environment conducive to gossip, and succeeded.[85] Gossip, and the intimate communication it encourages and permits, is a powerful and necessary actor in the execution of a safe and positively-memorable birth. The results of gossip's presence and absence in childbirth illuminate the necessity of anecdotal and informational exchange therein, for any given story is ripe with insight on the matter to which it speaks.

Today, there is a growing movement away from the medical framework of childbirth and in the direction of more social, collaborative practices. The Center for Disease Control finds the 2022 home-birth rate to be at its highest in 30 years.[86] Women of color, especially, are turning to midwifery as a means of reclaiming their experiences in birth. Against the landscape of repeated failure at care provision in and after labor, a progression away from the employment of the system perpetuating said failures feels not only appropriate but pressing. Black women are twice as likely to deliver a stillborn baby, and they also die due to maternal causes at a rate three times that of white women.[87] Because of these disparities, many women of color have transitioned from medical style birth toward (or, back to) midwifery.

Before childbirth had been medicalized on the national scale, many of the midwives practicing in the states were Black and Indigenous women. At the point that medical birth was being explored by top doctors across the country, it was on the bodies of Black women that those novel technologies were researched.[88] And, by the time that maternity wards were freshly established in major cities, poor women and women of color were provided free maternity care in exchange for the use of their bodies as obstetric teaching tools.[89] This brief timeline is meant

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[85]Gaskin, Ina May. *Birth Matters: A Midwife's Manifesta*. Seven Stories Press, 2011.
[86] "Home Births in the U.S. Increase to Highest Level in 30 Years." *Centers for Disease Control and Prevention*, 17 November 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20221117.htm.
[87]Farzan, Yusra. "Why Pregnant Women of Color Are Going Back to Midwives." *Insider*, 13 July 2022, https://www.insider.com/bipoc-women-of-color-pregnancy-midwives-postpartum-care-2022-7.
[88]Holland, Brynn. "The 'Father of Modern Gynecology' Performed Shocking Experiments on Enslaved Women." *History*, 29 August 2017, https://www.history.com/news/the-father-of-modern-gynecology-performed-shocking-experiments-on-slaves.
[89] Wertz, Richard W., and Dorothy C. Wertz. *Lying-in: A History of Childbirth in America*. Free Press, 1990.

to demonstrate that, across the historical narrative provided in this project, the broad-scale assault of the medicalization of childbirth on women has been particularly harmful to and targeted at women of color. At almost every turn, they have been present in this story. The effects of this process, with specific attention paid to the roles held and impacts felt by women of color, demand further research, and thought. I would like to return to this line of study in order to explore and incorporate that history in greater depth.

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