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Knowledge (of) Reproduction: Examining the Role of the Alternative Female Healer in Contemporary Caregiving in the Mid-Atlantic Region of the U.S.

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Knowledge (of) Reproduction:
Examining the Role of the Alternative Female Healer in Contemporary Caregiving in the
Mid-Atlantic Region of the U.S.

by

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Submitted in fulfillment of the Honors Requirements
for the Department of Women's, Gender, and Sexuality Studies
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Abstract

In 2018, midwives, doulas, herbalists, acupuncturists, and yoga instructors continue to perform healing that is adjacent to, if not entirely separate from, conventional, institutional medicine. When situated within the historical context of the systematic erasure of female healers constructed by feminist scholars including Barbara Ehrenreich and Deirdre English, Karol Weaver, and Kathy Davis, the contemporary presence of these practitioners is radical, particularly within dominantly conservative areas. Drawing upon seven original, qualitative interviews conducted with local female healers in the Pennsylvania and broader mid-Atlantic region, this research suggests that these alternative practitioners both explicitly and implicitly recognize how the patriarchal capitalist medical institution seeks to control female bodies by restricting bodily knowledge and subjecting the latter to the clinical gaze, as defined by Michel Foucault. In turn, alternative healers resist the discipline of female bodies through education, spatial design, and the recreation of what feminist theorist Silvia Federici terms the “commons.” While their work is disruptive and radical, it also often relies on a neoliberal approach to medicine. In this way, alternative female healing has endured over time by occupying a space of simultaneous resistance and privilege.

Introduction

I have three daughters, and so I have tried to always be very open, not only just about pregnancy and birth, but menstruation and you know, just all of it because, I mean I can recall back nobody ever taught me about that stuff and so it was a huge learning curve when I was at that time of life. So I just feel like, of course! Why would I not want to prepare them with all of the information about their body and the potential ramifications of being in a female body? I want them to know everything because knowledge is power.

— Holly,¹ yoga teacher and birth doula

Scientia potentia est. Knowledge is power. Once profound, this Latin adage now pervades modern discourse to the point of the cliché. It is incessantly echoed by politicians and celebrities, in reference to everything from foreign policy to youth education to winning a football game.² Thus, it is perhaps unsurprising that the concept is also central to the mentality of Holly, a Baltimore mother, yoga instructor, and birth doula in her 40's. In the epigraph above, Holly explicitly seeks to educate her daughters about their bodies and the “potential ramifications of being” in those bodies in order to empower them. Though the link between knowledge and power is commonly attributed to Sir Francis Bacon in 1597, its earliest documented occurrence can be traced back to the words of seventh century caliph Imam Ali. Ali's original Arabic, which is preserved in the tenth century text, *Nahj al-*

¹ All research participants in this study have been assigned pseudonyms in order to protect their confidentiality. Although the current political climate is perhaps more lenient towards female healers and alternative medicine than previous eras, a systematic effort to delegitimize and eliminate these practitioners is still present throughout the United States. For this reason, I have chosen not to reveal the identities of the participants. I do this fully acknowledging that it stands in contradiction with my intent to preserve and relegitimize these knowledges; a history without traceable identity is an incomplete history. However, the safety and comfort of the participants at this moment in time is paramount. Pseudonyms were chosen using an online baby name generator to locate names that would preserve the subtle marks of gender, race, and age that exist within names, while maintaining confidentiality.

² The late president of the National Football League (NFL) Films Steve Sabol is quoted as saying, “I think that in the NFL knowledge is power and you try to get that knowledge by whatever means,” during the 2007 video scandal involving the Patriots and the Jets (Carpenter 2007).

Balagha, can be translated to “Knowledge is power and can command obedience. A man of knowledge during his lifetime can make people obey and follow him” (“Nahj al-Balaghah” n.d.). This extension of knowledge not only as power, but as a means of control links the theories presented by French philosopher Michel Foucault in his books, *The Birth of the Clinic* and *Discipline and Punish*. In *The Birth of the Clinic*, Foucault asserts that the act of observation, particularly that of a medical nature, leads to knowledge and understanding (1973, 89). Put simply, the examination of the body generates knowledge of that body. This is crucial to the move Foucault makes in *Discipline and Punish* to suggest that the intimate knowledge of bodies becomes essential to regulating them. He complicates the familiar adage of “knowledge as power” to reveal what he calls “power-knowledge relations.” This refers to the dynamic “that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (Foucault 1995, 27). In other words, knowledge creates power, but those in power also control the production and reproduction of knowledge. Foucault brings his argument full circle from *Birth of a Clinic* in *Discipline and Punish* by applying the framework of power-knowledge relations to the medical examination. There, the doctor is given the power to observe the body based on their presumed knowledge, yet in the act of observation and documentation, the doctor reproduces this knowledge and thus maintains the hierarchical power structure between the physician and patient, in part by constructing for the patient the meanings attributed to their bodies (184-194). The application of power-knowledge relations on bodies harkens to another of Foucault’s concepts, bio-power, which he describes as the implementation of “numerous and diverse techniques for achieving the

subjugation of bodies and control of populations” without the use of physical force or will (1978, 140). A departure from the absolute power of a sovereign over the life and death of their subjects, bio-power is produced within institutions. These institutions, including the family, the military, education, and medicine, regulate and shape populations by harnessing power-knowledge relations to study life, and develop hierarchical ideals of what constitutes a good life based on these studies (141, 144). People accept these norms and “relative control over life [because] it avert[s] some of the imminent risks of death” (142). However, the apparent decentralized and analytical nature of bio-power masks its breath and influence on populations.

Missing within Foucault’s analysis of medicine as a site of power-knowledge relations and bio-power is a gendered discussion of who controls this relationship and why this came to be. Specifically, Foucault omits any analysis of gender and the ways in which medical knowledge, and thus power, has been stripped from women in order to serve as a means of disciplining the female body in ways that serve patriarchal capitalism. In the following work, I will utilize Foucault’s theories as a foundation as I examine the role of “alternative female healer” in relation to institutional medicine, in order to uncover how these alternative healers resist power-knowledge relations, as well as enable them. I define the “alternative female healer” as woman-identifying people³ who provide care specifically to

³ For this research, I chose to focus on healers who identify as women. Unlike their clients, for whom I focus primarily on those who are sexed as female, this does not exclude transgender women.

female-bodied people⁴ in a way that is in somehow separate from institutional medicine. Some contemporary examples of alternative female healers include midwives, doulas, acupuncturists, yoga instructors, and herbalists. These healers have varying relationships with institutional medicine; some work within but not *for* hospitals, others accept doctor's referrals but have a separate practice, still others cut most ties with institutional medicine altogether. The figure of the female alternative healer is particularly intriguing in that she is not new. As feminist scholars like Barbara Ehrenreich and Deirdre English point out, women have served as the healers of their own bodies for centuries, until patriarchal capitalism identified that it could profit from the control of the female body, and that medicine could be the tool to achieve this control (Ehrenreich and English 2010, 28). Therefore, the continued existence of the alternative female healer cannot be read as a reactionary form of resistance, rising in response to oppression, but as an enduring resistance that pushes back through its continued existence. The following work seeks to illuminate this enduring resistance and identify what is gained and what is lost in the work of the contemporary alternative female healer. Chapter 1 situates the alternative female healer within the turbulent history of medicine in order to demonstrate that her existence in the modern day is radical and intentional. This chapter specifically traces out how feminist scholars in the 1970's transformed the epistemology of medicine in the U.S. to show how patriarchal capitalism enabled the systematic shift from female healers to professional male doctors. The chapter

⁴ In this project, I chose to focus on people with bodies assigned female at birth. I recognize that this essentializes bodies to sex, and excludes transgender or intersex people, which is a limitation of my work. However, I made this choice because I was specifically interested in comparing caregiving for female reproductive systems, as these are the bodily structures that are unique to a female sexed body. Another worthy avenue for research would be to examine the ways in which alternative healers treat trans- bodies. My brief discussion of radical herbalism in the concluding section, "Futures of Alternative Healing: Radical Herbalism?" touches on this area.

focuses primarily on scholarly work done in the mid-Atlantic region of the U.S., as this is where the interview research took place.

Chapter 2 builds on the history outlined in Chapter 1 in order to contextualize the contemporary female healer in relation to institutional medicine and the feminist reframing of the former's development. This chapter relies on seven original qualitative interviews⁵ conducted with alternative female healers currently practicing in the mid-Atlantic region, and primarily in Pennsylvania and Maryland.⁶ These healers' experiences and words are analyzed to determine why they do the work they do, and how they go about performing this labor. Through the interviews, it was revealed that most of the healers, like Holly, the doula referenced above, were motivated by a sense that they did not have knowledge or control in their own interactions with institutional medicine. Their experiences fit within Foucault's framework of power-knowledge relations and bio-power. The chapter specifically highlights their experiences with the restrictions of knowledge and the clinical gaze. Then, it traces how the healers interviewed work to resist this control of female bodies through their own work. Specifically, three common themes appeared within the interviews, indicating that the alternative female healers use the tactics of education, spatial design, and the reestablishment of the commons as (often explicit) efforts to intervene in the power-knowledge relations

⁵ Interview research was approved by the Institutional Review Board at Dickinson College on November 10, 2017. It should be noted that knowledge shaped by interviews is inherently framed by the interviewee's experiences and subject to their conceptions and memory. It is possible not all the information reported from the interviews here is factually accurate, however it is still useful as a lived experience.

⁶ This region, and states within the region, were chosen as a focal point because my physical presence there enabled research. However, the moderately conservative nature of Pennsylvania and its extralegal approach to regulating alternative healing made an interesting comparison to Maryland's relatively progressive policies that legalize midwifery, including Certified Professional Midwives (CPMs), but subject them to regulation.

present in institutional medicine, and most seen within the hospital and the birthing room. Chapter 2 concludes by critically examining these acts of resistance. While the alternative female healers do disrupt medical institutions and, in doing so, return bodily knowledge and autonomy to their clients, who these clients are requires examination. Although patient details are confidential, the overwhelming majority of the healers interviewed reported that their clients are primarily white, well-educated, and able to pay for services out of pocket. This indicates that alternative female healers, at least those interviewed, may not be as accessible, and thus not as radical, as they could be. This critique places the healers within a culturally neoliberal ideology, examining how their engagement in wage labor, separation from institutional support, and mantra of “free choice” restrict the scope of their impacts to primarily white, upper class women. This critique does not serve to discredit their work, but to point to its limits.

The concluding section builds upon the radical, but limited figure of the alternative female healer, as revealed through interviews, in order to imagine ways of extending their work. One such way is radical herbalism, or a practice of healing that makes direct ties between human and environmental health, and seeks to return the knowledge of and power over bodies to those who have been particularly disadvantaged by patriarchal capitalism, including Indigenous people, people of color, and queer and trans people. Placing radical herbalism in conversation with the alternative female healer points to areas for improvement for the latter as well as coalitions between both parties. Ultimately, this work extends and builds upon Foucault’s theories of knowledge and power to analyze the role of the alternative female healer in contemporary society, in order to point to how institutional medicine

continues to restrict bodily autonomy by controlling the reproduction of knowledge, specifically about female reproductive systems. It then examines how this knowledge might be returned to those with these reproductive systems, so that they might reclaim power over their bodies and reproduce this power through knowledge as they see fit.

Chapter 1: A Feminist History of Female Healing

Women have always been healers. . . . Medicine is part of our heritage as women, our history, our birthright.

—Barbara Ehrenreich and Deirdre English, *Witches, Midwives & Nurses: A History of Women Healers*

The scientific process, and in turn, its application within medicine, have widely been perceived as objective pursuits, immune to the influence of societal pressures. Science is attached to everything from child rearing, to weight loss, to dating in order to serve as a seal of confidence. Sandra Harding, a feminist philosopher of science, describes how this expected objectivity has “permeated not only the modes of thinking and acting of our public institutions but even the ways we think about the most intimate details of our lives” (1986, 355). Harding’s description is overly reminiscent of Foucault’s notion of bio-power; in other words, scientific institutions, like medicine, are constructed as objective in order to legitimize and monopolize their knowledge production, which is then used to shape populations through, as Harding writes, “economic, political, and social accumulation and control” (Ibid). Harding is one of many scholars who have begun to apply feminist theory and critiques to science. These feminist epistemological critiques, which began in the U.S. in the 1970’s (Morantz-Sanchez 2001, 51), seek to examine how scientific knowledge production is gendered and subject to, rather than separate from political, economic, and social dynamics (Harding 1986, 357). For example, feminist epistemologists may critique the historical barring of women from scientific inquiry, how this barring effects which questions are asked, the implicit values that lie at the root of scientific knowledge production, and the ways in which science has been used to propel systems of oppression (357-359). Feminist critiques

of medicine embark on a similar mission. According to Sandra Morgen, these arose from the women's health movement in the U.S. in the 1970's, which also witnessed the creation of feminist health clinics (1995, 235). Morgen describes this movement as "a radical critique of the U.S. healthcare system, including a condemnation of medicine as an institution of social control" (236). The concept of critiquing medicine has led feminist scholars to rethink the ways in which the history of medicine has been culturally constructed. The following section is a sampling of some of these critiques as they relate to female healing, with a particular focus on the mid-Atlantic region of the U.S. While some of these works have themselves been subject to critique,⁷ their contributions to contemporary feminist approaches to medicine are undeniable. For this reason, it is important to begin a contemporary examination of alternative female healing with an outline of the feminist epistemological reframing of medicine, in order to gain insight into how current healers orient their work.

According to many feminist medical historians, women have been caring for one another's bodies since the beginning of humankind (Green 2008, 490-491). In fact, some scholars believe the presence of female healers may be the edge that allowed humans to evolved to the extent they have today. Although many mammals have trouble with childbirth, according to anthropologists Karen Rosenberg and Wenda Trevathan, humans are

⁷ One of the seminal early feminist critiques of medicine, Barbara Ehrenreich and Deirdre English's *Witches, Midwives & Nurses: A History of Women Healers*, has been criticized on many accounts for its lack of primary source analysis, over-estimation of midwives in those accused of being witches, and a reliance on Margaret Murray's research on witches, which has since been discredited (Green 2008, 489-493 and Ehrenreich and English 2010, 21-25). Ehrenreich and English address several of these concerns in the 2010 edition of their book, explaining that their work was a product of its time and rightly pointing out that much of the scholarship used to discredit them would not have existed in the first place without the creation of their book (Ehrenreich and English 2010, 21). Ehrenreich and English's work is useful in that it laid the foundation for much of the scholarship to follow, including potentially the work of the contemporary alternative female healers interviewed in Chapter 2.

the only species “to routinely seek assistance when they give birth” (Rosenberg and Trevathan 2002, 1199). Robert Engleman draws upon Rosenberg and Trevathan’s assessment of fossil records in his compelling, yet at points troubling,⁸ book on population growth to further challenge common theories of evolution that point to the development of tools or cooperative hunting strategies as turning points in the rise of *homo sapiens*. Instead, Engleman suggests that humans have evolved to their current state thanks primarily to birth assistants, or midwives (Engelman 2008, 39). Like Rosenberg and Trevathan, he notes how the move to bipedalism likely shifted the pelvic bone structure, narrowing the birth canal in women, just as the hominid head was expanding to accommodate an unusually large brain. These physical evolutionary changes resulted in babies being born headfirst, with their faces turned downward, rather than up towards their mothers, as is common in all other primates (Rosenberg and Trevathan 2002, 1120-1121; Engelman 2008, 36-37). The occiput posterior, or front-facing, position of the baby allows primate mothers to easily catch their offspring, wipe away any mucus, untangle the umbilical cord, and bring the infants up to breastfeed. However, when babies are born in the occiput anterior position, or facing away, mothers have less control, and risk bending the infant’s spine at a dangerous angle if they attempt to maneuver it during delivery (Rosenberg and Trevathan 2002, 1120-1121; Engelman 2008,

⁸ In *More*, Engelman aims to provide readers with a feminist approach to population control necessitated by environmental limits. However, in focusing almost entirely on providing women in developing countries access to contraception and abortion, he falls in the same neoliberal and population control-based traps as many other contemporary scholars who suggest that women’s capital is limited by excessive reproduction and that lack of access to family planning is the only hinderance to female empowerment. Further, Engelman's argument places the individual responsibility for climate change on the wombs on poor, brown women and assumes that given the “choice,” women will always have less children. While I find Engelman’s use of evolutionary history intriguing and at points useful, his implication that rape can be an inherent result of biological difference between men and women and an evolutionary adaption is extremely concerning, misguided, and dangerous (Engleman 2008, 45).

37). Therefore, Rosenberg, Trevathan (2002, 1121) and Engleman (2008, 39) all surmise that, despite innate animalistic instincts to seek solitude when giving birth, early humans reached out for assistance—a move necessary for survival as well as one that may be responsible for the rapid evolutionary and social advancement of humans. Engleman even hypothesizes that the need for assistance during birth and the role of the midwife could have contributed to the development of language, as female hominids struggled to communicate and care for one another during labor and delivery (2008, 37).

Women have and do give birth independently, like Holly, the doula and yoga instructor mentioned in the introduction, who had her second child “accidentally unassisted,” and her third in an “accidental on purpose unassisted home birth.”⁹ Some feminist scholars argue that unassisted birth is in fact the more natural method of giving birth and that any outside intervention is unnecessary and disempowering (Brotsky 2008, 11-12). Rixa Ann Spencer Freeze has done extensive research on the growing unassisted childbirth movement in North America and captures these sentiments in great detail. Her work, which draws primarily upon interviews and surveys with women in the unassisted childbirth movement, brings to light perspectives about birth that go largely unnoticed, such as the rejection of doctor or midwife dichotomy as the only options for birth (Freeze 2008, 1). However, many of the viewpoints Freeze illuminates are inspired by essentialist ecofeminist “goddess” perceptions of womanhood and the female body (Freeze 2008). Other feminist scholars have found this form of ecofeminism to be problematic because it essentializes women as embodiments of their reproductive capabilities, relies on womanist concepts of spirituality,

⁹ Holly, interview by Julia Mercer, February 16, 2018.

and reinforces the links between the natural and the female, which they argue leads to the domination of both women and nature (Seager 2003, 946). Concepts of the “natural” aside, it is clear that human birth did become a largely assisted phenomena. Engelman acknowledges the possibility that these early birth assistants may have been male, however based upon accounts of birth in recorded human history, he find this extremely unlikely, writing, “Midwives in nearly all cultures have been almost exclusively female, and the delivery room a female realm” (Engelman 2008, 38).

For many, this designation of the birthing space as “female” was accurate for centuries. From “wise women,” to “midwives,” an Old English word meaning “with woman,” to herbalists and neighborhood women, the role of not just assisting with birth, but healing in general, has historically been occupied by a woman (Ibid). Barbara Ehrenreich and Deirdre English use this assertion as the foundation for their pivotal feminist book, *Witches, Midwives & Nurses: A History of Women Healers*, which traces the broad shift in medicine from a woman’s domain to a male profession. According to Ehrenreich and English, women deemed to be witches were some of the first healers. Characterized as poor and overwhelmingly female, these figures treated peasants who often had no other options for healthcare, thus fulfilling a valuable and necessary role in the community. However, Ehrenreich and English argue that, over time, witches’ practice began pose “a political, religious, and sexual threat to the Protestant and Catholic Churches as well as the State” (2010, 33). Christian doctrine is built on belief in the interpretations of the word of God by men. Female witches who used empiricism and observation in their work, rather than faith, directly challenged the patriarchal faith-based authority of the Church (48-49).

Ehrenreich and English contend that the extensive witch hunts in Europe, which spanned from the fourteenth century to the seventeenth century and led to the deaths of between 50,000 and 100,000 people, around 85 percent of whom were women, were driven largely by a desire to suppress this threat posed by female healers (14, 33-35). Witches were also accused of being sexually perverse, or simply exhibiting any sort of sexuality, and of providing contraceptives and abortions which permitted non-reproductive sexuality in their patients (40-41). Another potential threat lay in the integral role these female healers played in their communities and the fact that they appeared to be assuming leadership positions within the peasantry which stoked class fears about peasant uprisings (35).¹⁰ Thus, as the Church began to grow as a patriarchal, capitalist moral hegemon, witches, midwives, and other female healers stood in direct opposition to these values, making them a threat in need of elimination.

According to Ehrenreich and English, in the thirteenth century, just before the Church began this quest of persecution, a male-dominated upper-class medical profession began to develop. Unlike female healers, early male physicians found support from the Church and became strong allies of the crusade against witches. These men were trained in theology, worked alongside priests, and would often only treat those who confessed their sins. In contrast to Ehrenreich and English's characterization of the empirical witch, male physicians rarely experimented or even treated actual patients during their training, relying instead on literature and theology to guide their practice (50-52). It was this theoretical approach that

¹⁰ Ehrenreich and English speculate about the full extent of witches in class tensions in Europe between the fourteenth and seventeenth centuries. It is included here to support the class-based analysis of the persecution of female healers, however I also acknowledge that there is need for more research on this subject.

led to the institutionalization of the humor theory of medicine, or the idea that “health was achieved by a proper balance of four bodily fluids—blood, phlegm, choler (or yellow bile), and melancholy (or black bile),” and that ill-health arose from an imbalance of these fluids, or humors (Ulrich 1990, 55). This approach would come to characterize much of western medicine up until the nineteenth century, including the practice of many female practitioners, like eighteenth century American midwife Martha Moore Ballard, whose life and work was immortalized and analyzed by Laurel Thatcher Ulrich in 1990 (55-58).¹¹ While the existence of women like Ballard demonstrates that female healing did not die out during the European witch hunts, this violent era does foreshadow a systematic persecution of female healers that would continue into Ballard’s lifetime and beyond. According to Ehrenreich and English, as male physicians gained popularity in the fourteenth century, the latter identified female healers, including midwives, as competition, and used their newly respected platform of “medicine” to discredit witches, arguing that they were mentally unstable or hysterical (Ehrenreich and English 2010, 35-36, 50). A variation of this logic would later be applied to justify barring women from medical schools in the eighteenth and nineteenth centuries, on the basis that they were too emotional (Dary 2008, 233). This argument is ironic in light of the Church’s accusation that female healers relied too much on science, rather than emotion.

¹¹ Ulrich also describes Ballard as an “empiric,” which she defines as “a person unconcerned with theory (53). Likely by the time Ballard was practicing, experiential evidence had been accumulated to support the notion of the humors, accounting for its continued popularity over four centuries. The reaffirmation of the humors theory based on later research serves as an example of Foucault’s power-knowledge relations; those in power controlled the reproduction of knowledge in order to reinforce the dominant theories as correct. Ulrich contrasts the notion of the humors with the solidistic medicine, which was based on physics and sought to control the “solids” of the body, or the blood and nerves (57). While the two theories overlap in many of their treatments, Ballard did not support solidistic medicine (57-58).

To further the irony, just a few centuries later midwives would be outlawed due to their lack of scientific training (233).

Other scholarly works go on to demonstrate that, as medicine became more and more popular, especially among the wealthy, trained physicians came to hold a place in the insular upper-class that controlled entire communities. This can be witnessed within Ulrich's contextualization of Martha Moore Ballard's diary in *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. In eighteenth-century Hallowell, Maine, where Ballard lived and worked, the four existing male physicians were also powerful politicians, landowners, and bankers (Ulrich 1990, 59-60). They controlled the political, economic, and moral climate of the small town. Meanwhile, female midwives, like Ballard, did most of the community's caregiving and healing, only calling on the doctors in times of emergency (49, 56, 61). Ulrich identifies the relationship between the two practitioners as hierarchical and patriarchal; the skills and expertise of men were valued above those of women, as seen in the fact that only men were allowed to perform surgery in Hallowell. However, Ballard's diary demonstrates a complicated relationship with the local doctors that was mutually respectful, competitive, and oppositional all at once. For example, while they did not perform surgeries, midwives were invited to observe these events, which Ulrich considers an acknowledgment of ability and respect on the part of the doctors (54). Further, placing male doctors only in the realm of the emergency allowed female healers to maintain control of the majority of the health concerns in their communities. A fairly conservative woman in the newly-formed republic, Ballard is careful to never overstep her position as a wife, mother, and midwife. Still, in her private diary, she does quietly disagree at times with the doctors, especially when

she feels they, themselves, are overstepping their role by becoming more involved in births (176-178).¹² Midwives themselves represented an upper-echelon of care in Hallowell; most of the day-to-day caregiving at the time was provided by lay women. Ulrich identifies three categories of lay female healers within Ballard's dairy: unmarried woman who served as servants and nurses, "helpful neighbors," and skilled healers who would eventually become midwives themselves. These women performed odd chores in the sick rooms, sat watch over patients, or directly assisted Ballard, depending on how they fit into these categories (64). However, despite their varying levels of expertise, most women in eighteenth century America seemed to have some knowledge of healing, making health a communal effort. The interview research in Chapter 2 demonstrates that some contemporary female healers seek to return to this concept of bodily knowledge as a communal resource. However, by Ballard's death in 1812, Ulrich argues that this commonality would be challenged by growing preoccupation with the class, regulations, and qualifications of caregivers, which further privileged male physicians over midwives and lay healers, eventually shattering the carefully constructed hierarchy of care, only to reestablish it again with the employment of female nurses.

From its emergence as a profession in the thirteenth century, some feminist epistemologists suggest that the success of male medicine rested on class dynamics (Ehrenreich and English 2010, 51). They attribute this to the interlocking, gendered

¹² Ulrich examines Ballard's use of the verb "to choose" in her descriptions of some of Hallowell's younger doctors' interventions, suggesting that the word implies disapproval. Ulrich explains that, "rather than deferring to the midwife, as would have been proper with one of her age and experience. . . they *chose* to participate in the routine work of birthing" (1990, 177 - emphasis original).

dynamics of expertise, cost, and fashion. Male doctors who trained at universities were seen as more knowledgeable than female midwives who lacked formal education. Medical historian David Dary notes that around 1770 a growing number of upper-class American women began to employ “accoucheurs,” or male doctors who were educated in Europe. These men were believed to “make labor less painful and dangerous,” and thus were more desirable to women at a time when the maternal mortality rates was still about 800 deaths per 100,000 births (2008, 229; see also Roser 2018).¹³ Male physicians did introduce the use of anesthesia during childbirth in the mid-nineteenth century, however they also more frequently employed surgical methods of enlarging the vaginal opening, known as an episiotomy, which could cause more pain (231-232). Still, doctors became increasingly associated with progress in the public eye. In turn, the fact that they were trained and male allowed doctors to charge far higher rates than midwives for their services. Midwives during Ballard’s era typically charged around 2 dollars for their services, while doctors charged 6 dollars, and sometimes as much as 20 dollars, per visit (Ulrich 1990, 179; Dary 2008, 230). Midwives also engaged in informal economies, bartering with their neighbors (230). The discrepancy in price literally valued male physicians higher than midwives and marked employing a doctor as a sign of wealth and class, further increasing their popularity. Still, male physicians’ high fees were barriers for lower class women, who continued to employ midwives.

This same class negotiation around medicine can be witnessed within poor, immigrant communities in the Anthracite Coal region of Pennsylvania during the early

¹³ Data for maternal mortality in the United States is general unavailable before 1900. This rate was drawn from data collected in Finland (Roser 2018).

twentieth century. In her article and subsequent book on caregiving in this region between the late nineteenth and early twenty-first centuries Karol Weaver describes how immigrants, who came from first northern, and then southern and eastern Europe, to work in Pennsylvania's coal mines brought knowledge of folk medicine with them and incorporated these into their healthcare (Weaver 2011, 2). Rather than calling upon the notoriously ineffective, biased, and costly coal company doctor, neighborhood women cared for their own, using herbs found either in gardens or in the surrounding woods to replicate recipes for treatments they brought from their homelands (59-79). Not only was the use of herbs more thrifty than the expensive company doctor, many of these neighborhood healers refused any compensation for their services (62-65, 73).¹⁴ This dynamic demonstrates the extremely valuable role female healers provided in communities, even as late as the twentieth century. Like the witches of the Middle Ages and the midwives of the seventeenth through nineteenth centuries, these neighborhood women provided an essential service to entire communities of women in ways the latter could afford. Thus, while the discrepancy in payment between male and female healers indicates how patriarchal notions of gender and medicine devalued women's work, it also points to methods women employed to help one another retain agency over their health and bodies in the face of growing male dominance over medicine. Contemporary female healers today preform the same payment negotiations. The healers interviewed for this research try to make their services more accessible to women by implementing payment plans, scholarship systems, or bartering. However, many of these practitioners are also deeply aware of how gendered work is undervalued, and therefore

¹⁴ The coal company doctor also did not provide reproductive healthcare at all (Weaver 2011, 59).

emphasize their need, in Holly's words, to be "recognized [for] providing something of value."¹⁵ A deeper analysis of the valuation of female healing will be explored at the end of Chapter 2.

While the first generation immigrant women Weaver interviews whole-heartedly engaged in the neighborhood network of non-institutional healing, their daughters felt otherwise. In addition to representing wealth and class, employing male doctors came to represent national belonging as well. Weaver traces how younger generations in the Anthracite coal region began to reject their parents' healing practices as "Old World" (73). After World War II, there was immense pressure specifically on immigrants to practice caregiving in "American" ways. This meant focusing on nuclear families and cutting ties to neighborhood care networks (126). It also meant purchasing medicine instead of foraging and making one's own remedies (73) and giving birth in hospital rather than at home (128). The ideal American citizen was a consumer, an individual, and did not have ties to the "Old World," as many first generation immigrants did. Thus, medicine became a site where latter generations practiced their national belonging. However, this cultural performance of citizenship also meant the erasure of many traditional, informal healing practices.

The concept of shifting the primary site of birth from the home to the hospital would have been shocking in the nineteenth century Anthracite coal region. At the same time that Weaver's interviewees were foraging in the woods, the first hospitals in this region were being constructed. Hospitals had existed in Pennsylvania, and the U.S., since 1751, when Benjamin Franklin and Thomas Bond established the Pennsylvania Hospital, the first of its

¹⁵ Holly, interview by Julia Mercer, February 16, 2018.

kind in the nation (Howard 2014). The concept of institutionalizing medicine within hospitals came from similar efforts in Europe during the eighteenth century. It was thought that the creation of hospitals would consolidate and legitimize medicine by “formaliz[ing] instruction and practice norms, and... ensur[ing] that upcoming physicians had clinical experience” (Ibid). These institutions began to replace the almshouse as the method of treatment for the sickly poor, homeless, and mentally-ill. However, as they continued to develop, they began to restrict their patients to those with curable diseases only (Ibid).

In the Anthracite coal region of Pennsylvania, the hospitals developed in the nineteenth century specifically to treat the chronic and traumatic ailments of coal minors, who were all men, structuring the hospital as a site of male healing, from which women and children were entirely excluded (Weaver 2011, 40). Weaver argues this development was “driven by economic motives and the need for a healthy and whole labor force” (41). In other words, the institutionalization of medicine, epitomized by the construction of the hospital, arose as a capitalist effort to preserve the mode of production, here the labor force. Even Franklin’s conception of the Pennsylvania Hospital reveals this goal. He wrote, “the function of a hospital is to restore sick individuals to their useful place in society” (Howard 2014). Feminist Marxist Silvia Federici would identify a similar dynamic within the admittance of women into hospitals; she argues that the medicalization of birth as far back as the sixteenth and seventeenth centuries functioned as an effort to control women’s labor, specifically reproductive labor (Federici 2004, 89). In order to enact this control, it was necessary to intervene in the privacy of the home by first inserting the doctor into the delivery room (Ibid), and later transferring women from the home to the hospital, where she

could be observed continuously, a dynamic which many of the interviewees note continues today.¹⁶ Before women in the Anthracite region entered hospitals as patients however, they were recruited as nurses in an attempt to curb the “overwhelming masculine” atmosphere of the hospitals, which included activities like gambling, cursing, smoking, and drinking (Weaver 2011, 47). Female nurses were also desirable because they allowed “hospitals [to] benefit from the cheap labor of young women” (Ibid). Again, the historical impacts of this undervaluation and exploitation of female caregiving are tangible in the interviews with contemporary healers (see Chapter 2).

Even as they employed women, it would be some time before hospitals in the Anthracite coal region accepted women as patients. Weaver writes,

It wasn't until the early twentieth century that Ashland [Hospital, also known as the State Hospital for Injured Persons of the Anthracite Coal Region at Fountain Springs] admitted female patients; this change resulted in part from state nursing regulations that required nurses to have experience and training in handling obstetrical cases (48).

Thus, as Federici theorizes, it not a demand from women, but a decision by the state that introduced women to hospital births. One contemporary doula and birth educator in Pennsylvania, Sarah, notes that the first women who did give birth in hospitals did so not because they found them more desirable or luxurious, but because they were homeless and could not have a home birth.¹⁷ She goes on to argue that many of the procedures that are standard in hospital births today were originally developed to treat these high risk patients, just as the hospitals themselves were first developed to treat traumatic work-related injuries.

¹⁶ Kayla, interview by Julia Mercer, February 16, 2018; Holly, interview by Julia Mercer, February 16, 2018.

¹⁷ Sarah, interview by Julia Mercer, March 9, 2018.

For example, the rule that women may not eat or drink during labor was established as a precaution in the event they need an emergency cesarian section (Brodsky 2008, 138). The construction of birth as a dangerous, pathological event rationalizes the use interventions, which Foucault identifies as mechanisms of asserting power (1973, 89). A more in-depth discussion and analysis of interventions as tools of institutional control will appear in Chapter 2.

In order to use medicine as a means of controlling laboring bodies, it was necessary to solidify this control within the hospital, rather than the home. To achieve this shift, professional medical institutions and states worked together once again to persecute female healers; this time, instead of torturing and burning witches as they did in the fourteenth through seventeenth centuries, they banned and jailed midwives. The height of structured opposition to midwives in the United States fell between 1910 and 1935, with states like Massachusetts banning midwifery all together at times (Brodsky 2008, 123). These regulations were explicitly driven by concerns that were that American midwives were untrained, “dirty and ignorant,” and that their practice endangered women (124-125). However, there was also an underlying fear among male physicians that the continuation of midwifery would threaten their growing practices. An outspoken critic of midwifery during the early twentieth century, Dr. Joseph B. DeLee’s words reflect this sentiment: “If a delivery requires so little brains and skill that a midwife can conduct it, there is no place for him [the physician]” (129). However, despite opponents like DeLee, formal restrictions on midwifery eventually eased as studies began to demonstrate the medical and economic value of midwives. A report by the 1925 White House Conference on Child Health and Protection

which found that “untrained midwives approach, and trained midwives surpass, the record of physicians in normal deliveries” (129). Therefore, instead of official banning midwives, doctors and state governments played on women’s fears of pain and risk in childbirth. Campaigns portrayed hospital births as safe, sterile, and painless, while midwife-attended home births were dirty and dangerous. The rhetoric was attached to social pressures to perform capitalist American citizenship, urging women to invest in secure care, rather than trusting “old wives tales” (125). The pressures of this bio-power propaganda, which appeared in Weaver’s interviews with second-generation immigrant women in the mid-twentieth century (2011, 128), drastically increased the popularity of hospital birth. In 1940, 55 percent of women gave birth in hospitals, and by 1951, this number had reached 90 percent (Brodsky 2008, 132). In 1969, the percent of women who gave birth outside a hospital was just one percent (MacDorman, Mathews, and Declercq 2014, 1).

1969 also marked an important shift in conversations about women’s health. Spurred by the Civil Rights Movement and anti-war demonstrations of the 1960’s, what is considered to be the second wave of feminism swept the United States (Brodsky 2008, 151). This growing concern about gender and sexism touched many aspects of contemporary society, including medicine. In 1969, a group of woman met Boston for a conference called “Women and Their Bodies Workshop.” From this gathering sprung the pivotal Boston Women’s Health Book Collective (BWHBC), a collective of women who collected and shared information about health. By 1970, they had developed the feminist health book, *Our Bodies, Ourselves* (Davis 2007, 1). According to Kathy Davis, author of *The Making of Our Bodies, Ourselves*, the book “combined a scathing critique of patriarchal medicine and the

medicalization of women's bodies with an analysis of the political economics of the health and pharmaceutical industries" (2). It provided women with "information on nutrition, sexually transmitted diseases, self-esteem, childbearing, and the health care system," helped them to relearn about their bodies through self-examination, and shaped how the next generation of women perceived their health (Brodsky 2008, 151 and Davis 2007, 2).

Today, the number of women choosing to give birth outside of hospitals is growing once again (MacDorman, Mathews, and Declercq 2014, 2). In the first decade of the twentieth century alone, the number of home births in the U.S. rose 29 percent (Declercq 2015, 10). During the same period, the number of births attended by midwives almost doubled (Kozhimannil, Avery, and Terrell 2012, 436). Despite the efforts of religious institutions, governments, and the institutionalized male medical profession to control women's health through the suppression of knowledge, female healers have persisted. As outlined above by feminist medical scholarship that arose from the U.S. women's health movement of the 1970's, this comes in the face of violent persecution, criminalization, and economic and cultural pressures to conform to patriarchal capitalist conceptions of bodies and health. In spite of all this, many female healers, including midwives, doulas, acupuncturists, herbalists, birth educators, and yoga instructors continue to provide alternatives for healthcare outside of hegemonic medical institutions. The stories of some of these healers, their knowledge and expertise, as well as motivations and limitations will be explored at length below.

Chapter 2: Contemporary Control of Female Bodies

Restricting Knowledge

The systemic effects of the restriction of women's knowledge of and consequential control over their own bodies is still acutely felt today. When asked if she felt her expertise was important to pass on to children even if they weren't working within a medical field, Kayla, a Baltimore nurse who is training to be a Certified Nurse Midwife (CNM), leaned forward and launched into a passionate, frustrated response. "Yes," she said emphatically.

I think that normalizing women's health and kind of like, sexuality in general, is important... I think that you can definitely see the people that have not had breastfeeding and like self care and... contraception, like things like that have not been talked about in their communities and they are... not comfortable... They're uncomfortable talking about their bodies and about the things that their bodies are doing.¹⁸

She went on to explain how this complicates her ability to provide care, as her patients often do not understand the words she uses or are profoundly embarrassed by them. "I have patients who are unable to say the word 'vagina.'"¹⁹ Not only does this cultural resistance restrict Kayla's capacity to communicate important information to her patients about their bodies and health, it also inhibits the patients themselves from playing an active role in their own healthcare. Stripped of the words to describe what they are experiencing, patients forfeit the power of diagnosis and treatment to the doctor. Foucault identifies this shift as being intrinsically linked to the development of clinical, or observation-based, medicine in the

¹⁸ Kayla, interview by Julia Mercer, February 16, 2018.

¹⁹ Ibid.

eighteenth century (1973, xviii). This form of medicine, encapsulated by “the clinic,”²⁰ is a drastic pivot from the theoretical, humor-based medical approach of previous centuries (vii). In fact, it is more akin to the observational empiricism for which female healers were persecuted as witches during the fourteenth through seventeenth centuries in Europe (Ehrenreich and English 2010, 50-52).²¹ In describing the clinic, Foucault writes, “This new structure is indicated...by the minute but decisive change, whereby the question: ‘What is the matter with you?’... was replaced by that other question: ‘Where does it hurt?’” (1973, xviii). In this way, the patient is assumed to have no knowledge of medicine or health; their only addition to the healing process is to articulate their bodily experience in the most basic sense, by indicating the location of pain. The power of interpretation, diagnosis, and ultimately treatment is then left to the physician (89). Contemporarily, Kayla sees this power imbalance as shaping hospital interactions so far as to limit the extent to which patients can even answer “that other question,” or locate their pain; “You’re like ‘Where is your pain?’... And they’re like ‘Uhhh it’s in my coo-coo’... you know, like they can’t say.”²² While slang for anatomy and bodily functions related to sex is common and culturally salient, it also indicative of a society’s relationship with bodies. On one level, patients may use slang because they are uncomfortable using what they see as “scientific” or “medical” terminology, a dynamic that implies they feel it is not their place to use these words. On the other hand, patients may not

²⁰ Foucault’s translator, A. M. Sheridan, notes that Foucault uses “*la clinique*” to describe “both clinical medicine and the teaching hospital” (vii). In order to avoid confusion and wordiness, Sheridan chose to use the term “the clinic,” to describe this form of medicine. Similarly, Sheridan chose the term “gaze” to translate Foucault’s “*regard*.”

²¹ Yet women were barred from working in the clinic (Dary 2008, 233).

²² Kayla, interview by Julia Mercer, February 16, 2018.

have ever been taught other words for their bodies, suggesting that society deemed this knowledge unnecessary for them to learn.

In her interview, Holly indicates that the fear of this inability to articulate what is happening within her own body was one of the forces that drove her to become a birth educator. When she became pregnant with her first child, she didn't know where to turn and relied on the advice of her sister-in-law, who was a mother of four at the time. This tactic led her to a clinic she describes as being "huge" and "a factory assembly line," where she was subject to an unnecessary, invasive prenatal vaginal examination.²³ Afterward, she recalls thinking, "I don't know anything about all of this stuff, but there has got to be something better than this," a dissatisfaction that led her to research alternatives and eventually become a birth educator herself.²⁴ This service is more than a profession to Holly; educating women about their bodies is personal. As quoted in the original epigraph, she explains,

I have three daughters, and so I have tried to always be very open, not only just about pregnancy and birth, but menstruation and you know, just all of it because, I mean I can recall back nobody ever taught me about that stuff and so it was a huge learning curve when I was at that time of life. So I just feel like, of course! Why would I not want to prepare them with all of the information about their body and the potential ramifications of being in a female body? I want them to know everything because knowledge is power.²⁵

While Holly is the most overt in her articulation of her motivations, many of the female healers interviewed shared the belief that knowledge is power, and that providing knowledge to women about their bodies and health was a method of reasserting their autonomy and

²³ Holly, interview by Julia Mercer, February 16, 2018.

²⁴ Ibid.

²⁵ Ibid.

power. As a doula, Sarah sees her role as primarily a translator.²⁶ She is not there to make decisions for her clients, nor will she even speak directly to the doctors. Instead, she simply rearticulates what doctors have said in a way that her client understands.²⁷ This empowers the patient and affirms their right and ability to make educated choices. In this way, Sarah positions herself as a bridge over the chasm chiseled between institutional medicine and patients through centuries of suppression of knowledge.

The Clinical Gaze

In tracing the development of the clinic, Foucault couples the shift in the expectations of expertise with the reconfiguration of the medical gaze. Rather than “the gaze of any observer,” Foucault notes that, within the hospital, the gaze of the doctor is “supported and justified by an institution” (1973, 89). This structured affirmation “endow[s the doctor] with the power of decision and intervention” (Ibid). Foucault goes on to argue that hospital physicians not only have the power to intervene, but, in fact, the construction of the clinical gaze promotes intervention. It is a gaze that is simultaneously attentive and distant. On one hand, doctors are trained to observe acutely, to always be aware of “variations, tiny anomalies, always receptive to the deviant” (Ibid). However, this type of gaze separates the symptoms from the whole, shaping the patient as an object of study, rather than the subject of care (83). As Foucault writes, “the doctor’s gaze is directed initially not towards that concrete body, that visible whole,” but to its functions and inconsistencies (8). In labor and

²⁶ Sarah, interview by Julia Mercer, March 9, 2018.

²⁷ Ibid.

delivery units, this micro-observational technique often results in hyper-intervention. Kayla describes a common course of events which begins with a doctor administering an epidural to a pregnant woman to treat her labor pains.²⁸

If you get an epidural, then your blood pressure drops... And then, because your blood pressure drops, baby's heart rate went down. Because the baby's heart rate went down... we're going to put a monitor on the baby's head, like an FSE [Fetal Scalp Electrode] ... And then we'll put an IUPC [Intrauterine Pressure Catheter] in, which is like to measure the intensity of contractions so we can better titrate your Pitocin. And then you've got your Foley catheter in because you can't get up to use the bathroom... And then you need this SCD [Sequential Compression Device] machine on your legs because there are blood clots because now you're not moving around anymore... And by the end of it, you look at this woman who's now laying in bed because she can't necessarily move that well, who's got like wires coming out of her vagina, attached to her legs, on her belly, and you're like, 'What did we just do?!'²⁹

Thus, by observing and treating one particular symptom, in this case, labor pain, the doctor has entered into a systematic, yet progressive series of further observations and treatments. When observed from a distance, as Kayla does, these specific, targeted interventions create a whole that is dissonant with the intention of the treatment. One assumes this intention is shaped by the Hippocratic Oath, which states, "I will use my regimens for the benefit of the ill in accordance with my ability and my judgement, but from (what is) to their harm or injustice I will keep (them)" (Miles 2004, xiii).³⁰ However, the dissonance between this

²⁸ Here the disempowering question of "Where does it hurt?" is combined with the narrow clinical gaze.

²⁹ Kayla, interview by Julia Mercer, February 16, 2018.

³⁰ Miles' introduction to *The Hippocratic Oath and the Ethics of Medicine* traces some of the complex debates about the relevance of the Hippocratic Oath in contemporary medicine. Some of these critiques include its reference to a separate ethic for treating slaves and its failure to mention informed consent. These elements are products of the Oath's era and therefore must be examined through a historical lens. However they do bring up valid questions about whether this oath is still relevant to contemporary medicine. This debate aside, as the Hippocratic Oath remains central to Western medical ethics, I believe my critique of the disconnection between its principles and actual medical practices remains applicable. Parenthetical insertions added by Miles.

stated approach and the reality seems to indicate that other motivations are at work. One such motivation, which Kayla points out, is the fear of litigation.³¹ A 2009 study of the rates of cesarean sections in relation to malpractice liability insurance premiums found that there is a statistically significant relationship between increased premiums and increased rates of cesarean section (Yang et al. 2009). In other words, physicians are more likely to perform interventions, like cesarean sections, in order to protect themselves. However, I would argue that beneath this concern lies another motivation, which is likely reinforced by issues of legality: the disciplining of the female body.

This discipline through the clinical gaze and its connection to intervention can be seen specifically within the current widespread use of Electronic Fetal Monitoring (EFM) in labor and delivery rooms. EFM refers to the method of monitoring the fetal heart rate through an ultrasound probe that is attached to the mother's stomach. This rate is then compared with the rate of contractions during labor to determine if the fetus is under any stress (Johns Hopkins Medicine n.d.). According to Kayla, EFM is "basically how we make our clinical decisions" in hospitals.³² Mothers are routinely attached to these monitors, regardless of their personal condition or preferences, and the data reported is one of the sole factors doctors use to make decisions regarding pregnancies. Additionally, like the concoction of other interventions described above, EFM restricts the mother's mobility, confining her to her bed or nearby, so that the doctors may "'observe' [her] in the same way that [they] observe the stars or a laboratory experiment," in a static, controlled manner

³¹ Kayla, interview by Julia Mercer, February 16, 2018.

³² Ibid.

(Foucault 1973, xv). This method of constant monitoring echoes another of Foucault's notable theories, the Panopticon. This "architectural apparatus [is] a machine for creating and sustaining a power" through constant, conscious, yet internalized surveillance (Foucault 1995, 201). Although the Panopticon is most commonly associated with prisons, Foucault begins his analysis of this method of discipline with a description of a similar process used to control a plague outbreak during the seventeenth century. To stop the spread of the plague, residents of a town were confined to their homes, a mandate that was enforced by constant, militant surveillance (195-197). Thus, there exists a medical precedent for this method of discipline. Its key components—the limitation of movement, constant surveillance, decisions made by a hierarchical, omnipresent force— can all be identified in EFM. Bedridden patients are made aware they are being monitored, even when the doctor is not physically present in the room, by the presence of the machine itself and its physical connection to their bodies through sensors and wires. This aura of continuous surveillance establishes a clear understanding of who holds the power in the hospital labor and delivery room and makes patients complacent, docile objects. In turn, this submission allows doctors to intervene further and, as Kayla noted, for interventions to cascade.³³

The extreme use of interventions within the context of labor and delivery is notable because, unlike other medical conditions, the pregnant female body has the ability to progress independently. While some interventions are life saving and necessary, in many cases, allowing the body to advance at its own rate produces equal, if not improved results. In her critique of EFM, Kayla is quick to mention that there has been no documented

³³ Ibid.

improvement to fetal or maternal health based on continuous monitoring, a sentiment also echoed by Holly and her colleague Christina, a doula and founder of a placenta encapsulation business in Baltimore.³⁴ Indeed, several studies found that the continuous use of EFM does not improve babies' Apgar scores³⁵ (Creedon et al. 2013), nor does it improve the perinatal death rates; however, using EFM has been found to increase the rate of cesarean sections by 63 percent and the use of interventions during vaginal births by 15 percent (American College of Nurse-Midwives 2010). Anecdotally Kayla recounts how fetuses with terrible EFM "strips"³⁶ often turn out to be healthy babies, while others with normal data are revealed to be sickly once born. Once again, the inconsistencies between the intention and results of a method are brought into question. If interventions like EFM do not garner improved, or even anticipated outcomes, why are they so widespread? One possible explanation lies in gynecologists' sense of pride and identity as doctors. According to Kayla, her position is often mocked by doctors who specialize in other fields as "easy," because it simply facilitates nature taking its course. While she denies that the desire to be taken seriously as a doctor is directly correlated to the high rates of intervention, it seems plausible that the desire to properly perform the clinical gaze, regardless of necessity, has unintentionally led to needless interventions. Even as she denies this relationship, Kayla's own explanations are telling:

³⁴ Kayla, interview by Julia Mercer, February 16, 2018; Holly and Christina, interview by Julia Mercer, February 16, 2018. Holly and Christina were interviewed at the same time, as they work together closely and preferred to structure the interview in this way.

³⁵ A rapid method of evaluating the condition of newborns developed by Dr. Virginia Apgar in 1952. It consists of ranking an infant's vitals (color, heart rate, reflexes, muscle tone, and respiration) on a 0-2 scale, and then adding these. A score of 10 represents an infant in perfect health (Committee on Obstetric Practice 2015, 1).

³⁶ EFM data sheets. Kayla, interview by Julia Mercer, February 16, 2018.

“It’s hard as practitioners to sit there and not do anything...It’s natural to want to intervene.”³⁷

Acts of Resistance

It is in the face of this overt disciplining of female bodies, under the clinical gaze, that contemporary females healers like Brenda, Kayla, Holly, Christina, Duyen, and Sarah work. These women employ many different methods of resistance, including education, the creation of a space that disrupts the clinical gaze, and a reinstatement of the “commons.” As referenced earlier, the primary role many of these alternative practitioners assume is one of an educator. Holly and Christina both refer to themselves literally as birth educators, in addition to their role as doulas, yoga instructors, and placenta encapsulators, respectively.³⁸ Still, education is at the core of all the work these alternative healers do. As explained previously, doulas, like Sarah and Kayla, see themselves as educating their clients about potential procedures they might encounter when giving birth, and their rights in these situations.³⁹ Even Brenda views education as a core element of her acupuncture and herbal work, stating, “the way I practice acupuncture is half educator, half practitioner.”⁴⁰ While several interviewees explicitly state that they attempt to fill a knowledge void through their work, any act of sharing knowledge with women about their health within the historical

³⁷ Ibid.

³⁸ Holly and Christina, interview by Julia Mercer, February 16, 2018.

³⁹ Sarah, interview by Julia Mercer, March 9, 2018; Kayla, interview by Julia Mercer, February 16, 2018.

⁴⁰ Brenda, interview by Julia Mercer, February 13, 2018.

context of the suppression and isolation of this knowledge within institutional medicine is an act of resistance, no matter how explicit or intentional.

For Foucault, the isolation of medical expertise and bodily knowledge within institutional medicine was made possible in part by shifting healing from a private, often familial space to “a collective, homogeneous space” where patients could easily be observed (1973, 196). In order to counteract the clinical construction of patients as objects of study, many alternative healers seek to recreate a space that is separate from institutional medicine, and in turn the clinical gaze. This is achieved in a variety of manners, depending on the practitioner’s job and the location of their care. As Chinese herbalists and acupuncturists, Brenda and Duyen both physically constructed workspaces outside of any medical institution. Brenda works within an apartment complex, while Duyen works out of her home. Unlike a stark, impersonal hospital room or doctor’s office, both practitioners’ offices had low lighting, and warm colors, as well as kitchens for preparing herbs directly in front of their clients.⁴¹ Similarly, Holly and Christina created their own flexible, shared workspace where they teach prenatal yoga and birth classes, as well as rent space to other practitioners. Like the acupuncture offices, this space was located outside of any medical institution and resembled a yoga studio rather than a medical office.

Despite having this separate workspace, in her role as a doula, Holly spends more time in hospitals.⁴² Sarah, Christina, and Kayla, who are also doulas, also indicated much of

⁴¹ Ibid; Duyen, interview by Julia Mercer, March 3, 2018.

⁴² Holly and Christina, interview by Julia Mercer, February 16, 2018.

their work takes place in hospital settings.⁴³ As Holly explains, “Home birth mamas don’t need doulas as much as hospital mamas do.”⁴⁴ Even, or perhaps especially, within the hyper-medicalized space of the hospital, the doulas interviewed work to create a space that is tailored to their clients and noticeably separate. The first step in this spatial formation that many indicated is designing a birth plan as part of prenatal care. The birth plan develops based on several interviews with the mother and her partner and/or support system to determine how they would like the birth to be. According to Sarah, this gives parents an opportunity to share desires and expectations with one another that might not otherwise come up before the birth. It also allows the mother to design a space in which she is most comfortable. For example, Sarah asks her clients to consider who they want in the room at the birth, suggesting a technique she attributes to Ina May Gaskin’s “Sphincter Law.” She explains, “Don’t have somebody in the room that you wouldn’t poop in front of... If you’re not comfortable pooping in front of this person, then you’re not going to be able to relax and open up and have this baby.”⁴⁵ While potentially embarrassing, this test gives the mother permission and autonomy to invite or exclude people from her birthing space based on her personal comfort. In controlling who is present to observe her birth, the mother is able to push back against the medical gaze that asserts its right to observation. Even if she is unable to exclude the doctor, making intentional choices about the other observers challenges the presumed inherent privilege of the medicalized gaze. Furthermore, this potentially limits the

⁴³ Sarah, interview by Julia Mercer, March 9, 2018; Christina, interview by Julia Mercer, February 16, 2018; Kayla, interview by Julia Mercer, February 16, 2018.

⁴⁴ Holly, interview by Julia Mercer, February 16, 2018.

⁴⁵ Sarah, interview by Julia Mercer, March 9, 2018.

other clinical observers who enter the birthing space. Holly has observed that nurses are often less vigilant when a patient has a doula because “they know that they can give that couple a little more space without abandoning them because they have this extra person.”⁴⁶ Thus, by actively choosing a doula to observe their birth, mothers are able to indirectly influence other gazes they might experience, over which they may not otherwise have control.

Another tactic of resistance through spatial formation is the use of essential oils. Again, several doulas and practitioners noted in their interviews that they use essential oils to create an ambiance in the birthing space. In her capacity as a doula, Kayla asks mothers which scents they find most relaxing during their prenatal meetings. Then, she diffuses these scents through essential oils during the labor and birth. While she notes preferences are fluid and that in “the birthing space... nobody knows what it’s going to feel like and how they’re going to react,” she also believes scents are a powerful method of establishing an environment.⁴⁷ Holly also uses essential oils to create a space that is separate from the hospital, by replacing the scents of antiseptic and illness with ones which the mother chooses.⁴⁸

In addition to creating a space that pushes back against the clinical gaze, several of the alternative healers interviewed seek to form spaces that resist capitalist medicine. Feminist marxist theorist Silvia Federici would call these the “commons.” In her book *Caliban and the Witch*, Federici critiques and extends Foucault’s concept of bio-power, or the

⁴⁶ Holly, interview by Julia Mercer, February 16, 2018.

⁴⁷ Kayla, interview by Julia Mercer, February 16, 2018.

⁴⁸ Holly, interview by Julia Mercer, February 16, 2018.

power gained through the control of bodies, to trace its nascency alongside the rise capitalism in the face of population decline (Federici 2004, 16). She goes on to link the privatization of land and the consequent “hedging of the commons” to the privatization of knowledge, specifically bodily knowledge (84, 184). Federici argues that the destruction of the commons, or the public swaths of land used by communities and in particular women, shifted women’s labor from the public sphere to the private, and in turn inhibited the practice of community healers. At the same time, as detailed in the previous chapter, healers and midwives were being persecuted as witches. Examining the European witch-hunts through the lens of capitalism, Federici suggests that,

Just as the Enclosures [sic] expropriated the peasantry from the communal land, so the witch-hunt expropriated women from their bodies, which were thus ‘liberated’ from any impediment preventing them to function as machines for the production of labor. For the threat of the stake erected more formidable barriers around women’s bodies than were ever erected by the fencing off of the commons (184).

In this way, Federici positions the witch-hunts, which primarily targeted older or sexually deviant women, as a method of bio-power aimed at controlling the reproduction of workers within a capitalist economy. Yet, this control reaches far beyond the physical bodies of those who were punished for witchcraft, or those who feared persecution. It also does not only target physical reproduction, but the reproduction of knowledge.

With the persecution of the folk healer, women were expropriated from a patrimony of empirical knowledge, regarding herbs and healing remedies, that they had accumulated and transmitted from generation to generation, its loss paving the way for a new form of enclosure. This was the rise of professional medicine, which erected in front of the ‘lower classes’ a wall of unchallengeable scientific knowledge, unaffordable and alien, despite its curative pretenses (201).

In summary, as capitalism developed, public land was privatized and women lost their right to public space and were restricted to their homes to perform reproductive labor. Those who did not comply were accused of witchcraft and punished. Then, in addition to enforcing the reproductive labor mandate, the witch-hunts destroyed large caches of knowledge held within female healers.

While none of the contemporary female healers interviewed for this research indicated any awareness of Federici's theory of the commons, many did express values and practices that are consistent with the recreation of the "commons."⁴⁹ First, as mentioned briefly above, Holly and Christina pooled their resources to create a physical space where they, and others, can practice collectively. This studio is not completely accessible to public; for extending access, people have to be clients of Holly, Christina, or one of their other colleagues.⁵⁰ However, it is more communal than a standard office. Brenda also shares her office with another practitioner.⁵¹ In addition to creating physical communal space, some of the healers contribute to and maintain communal bodies of knowledge. Christina often meets with new doulas and people interested in placenta encapsulation to freely share her knowledge, even as she admits it is a strain on her time.⁵² On the other end of the exchange, Sarah learned to be a midwife through an apprenticeship with an older, more experienced midwife. Then, once she had established her own practice, she took on an apprentice herself.

⁴⁹ Interviewees were not specifically asked if they are familiar with Federici's work, however they were asked what sources influenced them.

⁵⁰ Holly and Christina, interview by Julia Mercer, February 16, 2018.

⁵¹ Brenda, interview by Julia Mercer, February 13, 2018.

⁵² Christina, interview by Julia Mercer, February 16, 2018.

She found education extremely rewarding, and hopes to one day solely train doulas and teach birthing classes.⁵³ Furthermore, all of those practitioners interviewed were very willing and excited to share their knowledge and experience as part of this research. Finally, in addition to making physical space and knowledge more accessible and public, several of the healers seek ways of making their services more communal. Most do not engage with private insurance, a decision that demonstrates their criticism of the privatization of medicine. That being said, it is also one that may not have been an independent decision, as many insurance companies also refuse to cover their work, and actually may lead to greater inaccessibility that will be explored in the next section.

Another technique that has had more success reconstructing access to bodily knowledge to the “lower classes,” as Federici describes, is bartering (201). The healers interviewed have varying opinions about bartering, however it was something with which all were familiar. Brenda, Sarah, and Duyen are the only healers interviewed who currently and officially engage in the barter economy. Brenda and Duyen both noted exchanging services with other healers, such as massage therapists or yoga instructors. Brenda also created a scaled payment plan and scholarship program to allow those who need acupuncture to access it. Sarah also has engaged in the barter economy, including the exchange of both goods and services for her doula work.⁵⁴ While some of the other healers expressed opposition to bartering and engagement in informal economies that will be explored further in the next section, it is evident that within the network of alternative healers, there are efforts to share

⁵³ Sarah, interview by Julia Mercer, March 9, 2018.

⁵⁴ Brenda, interview by Julia Mercer, February 13, 2018; Duyen, interview by Julia Mercer, March 3, 2018; Sarah, interview by Julia Mercer, March 9, 2018.

space, knowledge, and access to healing, just as the commons were shared by their predecessors.

A Neoliberal Critique

Neoliberalism is an economic and political philosophy that emphasizes the individual as an actor within a capitalist economy. Economic neoliberalism suggests that minimal economic regulation leads to exponential economic growth, which is said to “benefit everyone” (Susskind 2003, 3). Cultural neoliberalism suggests that all challenges, whether economic, social, or political, can be best addressed by the private, individual entrepreneur (Čakardić 2017, 36). This form of neoliberalism intersects with some iterations of contemporary feminism, primarily along concepts of the equal valuation of labor and an emphasis on “free choice.” In regards to the latter, both viewpoints place value on individual autonomy, as either a source of empowerment or economic freedom (38). While the alternative female healers interviewed for this research do position themselves in ways that emphasize and recreate the “commons,” a concept that is at odds with neoliberal values, they also act within a partially neoliberal framework. The influence of this framework appears in the ways these women engage in a capitalist economy, separate themselves from institutions and states, and speak about their work as fostering “free choice.” In true neoliberal form, they rely on these individualistic tactics in order to achieve the social change for which they strive: women-centered healthcare. In other words, while alternative female healers do resist many of the institutional pressures imposed by patriarchal capitalistic medicine, they are also vulnerable to the influence of capitalism, and more specifically neoliberal feminism.

Feminist economic discourse is framed by tensions between efforts to restructure capitalist systems in a more equitable manner, a complete rejection of capitalism as a viable system, and the inevitable need to engage with capitalist systems, as they shape societal interactions. In the first camp, there is an emphasis on the need for recognition and compensation for unpaid care work, performed primarily by women, which was initiated by feminist scholars Selma James and Mariarose Dalla Costa. James' and Dalla Costa's work developed into the Wages for Housework Campaign in 1972, a movement that spread internationally and begot the Global Women's Strike, a current tactic aimed at bringing attention to women's unpaid labor and advocating for compensation (Elson 2017, 55 and Federici 2004, 7-8). The cultural neoliberal emphasis on human capital and "entrepreneurial energy" aligns itself with this objective, stressing the market as means of valuation of the individual (Čakardić 2017, 36). In other words, individuals are expected to be motivated by the market, a concept that requires monetary compensation for labor. This motivation is complicated by the economic philosophy of neoliberalism, which relies on unpaid labor, specifically that of women and poor women of color (Susskind 2003, 1). Evelyn Nakano Glenn, a feminist scholar who writes on care work, mediates this by advocating for "an appropriate level of economic return, whether in wages or social entitlements" for caregivers (2000, 88). However, her work also indicates the paradoxical nature of linking care valuation to neoliberalism. That is to say, the historic undervaluation of caregiving stems in part from its transition from a public responsibility to a private, familial duty (84).

While James' and Dalla Costa's work brings essential attention to women's unpaid labor as a tool of patriarchal capitalist oppression, economist and sociologist Diane Elson

points out that monetary compensation for this labor is not necessarily the most relevant goal, as it strengthens gendered divisions of labor, has barriers to implementation, and ignores how care work might be reduced or redistributed by state and cultural shifts, such as the implementation of paid maternity and paternity leave. Like Glenn, Elson sees the monetary valuation of unpaid labor as a useful marker for the value of care work within a society, however both scholars acknowledges that monetary and social valuation are not analogous (Elson 2017, 54-55; Glenn 2000, 88). Similarly, while Federici draws heavily upon the work of James and Dalla Costa in *Caliban and the Witch*, she also adopts a Marxist criticism of wage labor as a means of subjugation and “enslavement,” especially when coupled with the loss of the “commons” (Federici 2004, 72). Thus, it is unlikely she would advocate for women’s care work to be waged because she is critical of all capitalist waged economies.

For the alternative healers interviewed in this project, the rejection of waged labor is less apparent. It is clear from their responses and the multifaceted ways in which they grapple with compensation, from price negotiation to bartering, that they do not completely subscribe to neoliberal capitalism, however they also express a desire for wages as a means of recognition and survival. Although she admits she often negotiates her rates or barter, Sarah has made an effort to establish set fees, even for friends or family, because she finds it “important to value yourself and make sure other people value what you do.”⁵⁵ For her, this valuation needs to be expressed economically, and more specifically, monetarily. Holly and Christina express similar sentiments, adamantly defending their decisions to charge four figure fees for their respective services. When asked what motivated these choices, Holly

⁵⁵ Sarah, interview by Julia Mercer, March 9, 2018.

responds, “Money is a recognition of value... My taking money for my services is a recognition that I’m providing something of value. It’s really, really, really hard work and you can’t do it for free.”⁵⁶ This attitude is reflective of the neoliberal framing of the individual in terms of their capital and productivity. Christina even goes as far as to critique other doulas and birth educators for what she feels is an undervaluation of their work, complaining that when other healers charge less, it makes her less competitive. Interestingly, she does not see their low rates as an effort to engage in a competitive, capitalist market, but as a reflection of a sense of “shame for being paid money to do this work.”⁵⁷ Here, she is pointing to what she sees as internalized, hierarchical valuations of labor based on gender, a dynamic central to Federici’s critique of patriarchal capitalism. Christina perceives that her colleagues undervalue their work not in an attempt to make it more accessible, but because they feel an internalized sense of shame for charging for work they feel they are obligated to do by nature of their gender. While Christina feels outrage at this internalized marginalization, the root of her concern is actually the fact that these healers are undermining of her individual economic competitiveness, a tenant of neoliberalism. By charging low rates, they undercut her efforts to receive appropriate compensation for her labor. It should be mentioned that the interviewees’ desire for monetary compensation does extend beyond their prescribed need for a tangible recognition of labor as a indication of value. One must also consider that wages are necessary to live within a capitalist society. As Christina asserts, “I’m not going to bust my butt and run all over town for people and not be able to provide for

⁵⁶ Holly, interview by Julia Mercer, February 16, 2018.

⁵⁷ Christina, interview by Julia Mercer, February 16, 2018.

my family.”⁵⁸ Sarah also implicitly echoes this sentiment when she laments her need to work other jobs beyond her doula in order to support her family. The implication is that she would prefer to spend her time working as a doula, but this is not possible as she is not compensated enough, even though the work is incredibly time consuming.⁵⁹

In addition to relying on capitalism as a foundational principle, neoliberalism emphasizes the power of the individual entrepreneur over that of the state or an institution. Ankica Čakardić clarifies that this hierarchy does not lead to the abandonment of the state, but rather the “reshap[ing] all of the institutions of society, including and especially the state, to promote markets” (Čakardić 2017, 37). Still, the concept remains that individuals acting privately within capitalist markets are the most adept at addressing social concerns. While alternative healers’ efforts to separate themselves from institutional medicine can be viewed as an act of resistance against the hegemonic control of women’s bodies fostered within this institution, it can also be seen through a neoliberal lens. This neoliberalism is most apparent in their choices regarding certification and insurance. It should be noted regulations regarding certification are constructed by the state, based on advice from professional medicine, however alternative healers do have the ability to navigate these requirements. In Pennsylvania, only Certified Nurse Midwives (CNMs) are allowed to obtain licenses and prescribing powers (Midwives Alliance of Pennsylvania n.d.). While this disadvantages Certified Professional Midwives (CPMs) and other direct entry, lay midwives by restricting their authority and abilities, a few of the practitioners interviewed found practicing outside of

⁵⁸ Ibid.

⁵⁹ Sarah, interview by Julia Mercer, March 9, 2018.

state regulations to be preferable. One such practitioner is Patricia, a CPM in Pennsylvania. According to the Code of Maryland Regulations Title 10, Subtitle 64, Chapter 1, as of 2016, Maryland allows CPMs to be licensed, creating an opportunity for Patricia to obtain a license there, as she already met all of the requirements. However, she made the decision not to do so. When asked about what motivated this choice, Patricia explained, “They have certain guidelines in place for those [licensed] midwives that they need to follow. And I don’t feel that the way I practice right now I could sign and say I’m willing to follow that.”⁶⁰ The two biggest conflicts Patricia sees between her practice and the Maryland CPM licensing requirements are regulations that would prevent her from attending breech births and Vaginal Births After Cesarean (VBACs). While she does not actively seek to assist with breech births, she does provide this service. Furthermore, she is highly committed to providing care for VBACs, explaining that they are “a big reason why I do what I do because VBAC families need support and most times they can’t find it other places.”⁶¹ Thus, Patricia refuses to engage in legal licensing practices because she believes it would inhibit her ability to provide essential care. Conversely, there are no state or federal regulations for doulas, as they do not perform medical treatment (Doula Training n.d.). However, there are other institutions that regulate and certify doula work, the most well-known being Doulas of North America (DONA). As a doula, Sarah completed a DONA training course, however she ultimately decided not to obtain her certification, even though she had fulfilled all the requirements. Like Patricia, she made this decision based on belief that she was restricted by

⁶⁰ Patricia, interview by Julia Mercer, April 6, 2018.

⁶¹ Ibid.

the certification requirements, rather than enabled. Specifically, DONA prohibits its doulas from using peppermint oil on pregnant women based on one case which garnered poor outcomes, a move with which Sarah fundamentally disagrees and feels she could not abide, as she has seen numerous positive outcomes from using peppermint oil appropriately to manage nausea. Therefore, she prefers to individually explain her experience and training to clients rather than relying on the authority of a certification.⁶² In this way, Sarah, like Patricia, expresses a neoliberal sentiment, believing her ability to provide doula services for pregnant women is aided by her independence and individuality, rather than institutional support.

Alternative healers' negotiations with insurance are more varied and complex, however they often reveal the same belief that acting within established institutions restricts their work rather than enhancing it. What is covered or not covered varies depending on the insurance company and plan, and even if services are covered by insurance, alternative healers do not necessarily choose to accept insurance as a payment method. For example, Brenda knows that many insurance companies in her area do cover acupuncture, however she doesn't "participate with insurance. By choice," as it requires too much effort on her part.⁶³ Another acupuncturist, Duyen, expresses a similar sentiment, recalling a time she tried to help a client use insurance to cover her services, only to have all her work go to waste when the company lost her records.⁶⁴ For midwives and doulas, insurance coverage is less certain, with many plans only covering hospital births. Under the Affordable Care Act, Medicaid

⁶² Sarah, interview by Julia Mercer, March 9, 2018.

⁶³ Brenda, interview by Julia Mercer, February 13, 2018.

⁶⁴ Duyen, interview by Julia Mercer, March 3, 2018.

does cover midwifery and birth center services, however these require licensing to qualify (Rosenthal 2013). As a CPM, Patricia does accept private insurance, however often her clients have plans with high deductibles that make it unreasonable to use this insurance to pay for her services.⁶⁵ Overall, the relationships between the insurance system and alternative healthcare are wrought with complications, leading practitioners like Brenda and Duyen to abandon participation with insurance altogether. Like decisions about certification, this choice reflects a neoliberal outlook that frames individual entrepreneurship outside of regulation as the most direct and beneficial.

The third tenant of neoliberalism, beyond an acceptance of capitalist economies and an emphasis on individualism, is a reliance on the ideology of “free choice.” Čakardić explains economist Milton Friedman’s belief the “the right to personal choice [is] the assurance of progress of the individual as the foundation of society” as indicative of a neoliberal approach (Čakardić 2017, 36). She then goes on to link this concept of personal economic freedom to the choice rhetoric adopted by feminists. While the personalization of feminism is a contribution from second wave scholars, “choice feminism” has been developed with third wave feminism. Most commonly associated with abortion access, choice feminism refers to the idea that the very act of choosing is feminist in itself, regardless of what that choice may be. The essence of choice feminism lies at the root of many of the perspectives expressed by the alternative female healers interviewed for this project. Within their acts of resistance described above, from education, to spatial design, to the recreation of the “commons,” there is an overarching effort to reestablish a sense of autonomy over one’s

⁶⁵ Patricia, interview by Julia Mercer, April 6, 2018.

body, one's knowledge of that body, and, in turn, decision-making power for one's own body. This is driven home by the healers' personal accounts of traumatic experiences within institutional medicine when the ability to choose was stripped from them, whether in the case of Holly's forced vaginal examination, or when an obstetrician threatened Christina with a cesarean section if she did not consent to have a Foley bulb inserted.⁶⁶ In these cases, the politics of choice were made very personal. For many, their experiences went on to shape the ways in which these healers practice, leading to an emphasis on informed consent and choice.

The desire to foster autonomy, especially within the historical context of a medical institution that stripped this right from women for centuries, is admirable and important. However, a focus solely on choice without any reflexivity is limiting. The result of choice feminism is the creation of a myriad of options, which give the illusion of autonomy. However, as Miranda Kiraly and Meagan Tyler point out, "More choice, or even a greater ability to choose, does not necessarily mean greater freedom" (38).⁶⁷ Instead, choice feminism, and neoliberalism, ignore the other social factors that might limit someone's ability to choose, even when it appears they have multiple options. In the context of alternative healthcare in the mid-Atlantic region of the U.S., these factors include one's class, race, and level of education. In this case, class is primarily apparent through clients' ability to pay for services. As stated above, complications with private insurance or Medicaid coverage often inhibit clients' ability to afford alternative healthcare services, limiting access to these services to those who have the ability to pay out of pocket. While many of the

⁶⁶ Holly and Christina, interview by Julia Mercer, February 16, 2018. A Foley bulb is an inflatable catheter that is inserted into the cervix and inflated to encourage dilation and quicken labor.

⁶⁷ Čakardić quotes the introduction of the introduction of *Freedom Fallacy: The Limits of Liberal Feminism*, of which Kiraly and Tyler are editors.

healers do try to help low income clients access their services, the former are also adamant that they receive appropriate compensation for their labor. They simultaneously acknowledged the need for payment flexibility while qualifying that they try to avoid this as much as possible. Ultimately, their participation in capitalism limits the people who can access their care to those who can afford it.

Kayla, a Baltimore nurse, cites these barriers to access for low income women as one of the reasons she is seeking to become a CNM, rather than a direct entry midwife.⁶⁸ As CNMs do work under the umbrella of established medical institutions, they are able to accept Medicaid and many more insurance plans. In turn, it is likely not a coincidence that Kayla is the only interviewee who cites her client population as being racially diverse. The systematic marginalization of people of color has disadvantaged them within the capitalist market, creating intersections between race and class that affect healthcare options. However, studies have shown that race alone disadvantages black women within healthcare. Currently in the U.S., black women are three to four times more likely to die from complications related to pregnancy than their white cohorts, regardless of class. Similarly, infant mortality rates for black babies are 11.3 per 1,000, compared to the rate of 4.9 per 1,000 for white infants (Villarosa, 2018).

The substantial number of patients of color within the hospital where Kayla works is certainly tied to its location within a primarily black Baltimore neighborhood, as compared to the overwhelming white populations of central Pennsylvania served by the other alternative healers interviewed. However, I would also suggest that the type of healthcare, in this case

⁶⁸ Kayla, interview by Julia Mercer, February 16, 2018.

institutionally-supported medicine, influences who is able to access it. Holly and Christina, who also work in the Baltimore area, serve primarily white women. I posit this as an effect of their neoliberal compensation model. To further this point, many of the healers, Holly and Christina included, note that their clients are often highly educated, a marker that suggests elevated class. Additionally, all but one of the healers themselves hold master's degrees, which may influence, or at least reflect the level of education in their clients. It should be noted that my knowledge of the demographic dynamics of alternative healthcare clients is limited to what the practitioners shared in their interviews. I had not contact with clients or their records during my research, thus my analysis of these populations is based on secondary information, and is therefore inherently limited. Still, with what anecdotal information I do have, I feel I am able to map out trends between the practitioners that indicate they primarily serve white, well-educated, middle to upper class women. These characteristics demonstrate that the alternative healthcare clientele are generally a privileged group, a trend that problematizes the centrality of “free choice” within these methods of healing. The healers interviewed may view their work as increasing access, however the insular, privileged makeup of their clients suggests their work is not as radical as they might think. I attribute this disconnect to their acceptance of neoliberalism, specifically in their support of capitalist economies, separation from institutions, and uncritical application of “free choice.”

Perhaps a counterpart to this approach to healing can be found in the work of the Birthmark Doula Collective, a group of doulas in New Orleans, LA, who aim to provide support for women in the area “who most needed support during pregnancy but couldn't afford it” (Villarosa 2018). Unlike the healers interviewed for this research, Birthmark Doula

Collective serves a racially and economically diverse population in the city, ranging from “wealthy women who live in the upscale Garden District to women from the Katrina-ravaged Lower Ninth Ward and other communities of color” (Ibid). It is in serving such as diverse population that the Birthmark doulas are able to provide sliding-scale fees and pro bono services to those in need (Villarosa 2018 and Birthmark Doulas n.d.). However, compensation still proves to be an issue, and most of the Birthmark doulas hold more than one job because they cannot make a living off of their doula work alone (Villarosa 2018). Additionally, like many doulas, Birthmark practitioners work within hospitals, rather than isolating themselves completely from medicinal institutions. Although this is a complicated tactic as demonstrated above, it allows these doulas to serve women with high-risk pregnancies, such as Simone Laundrum, the woman at the center of the recent article featuring Birthmark in *The New York Times* (Villarosa 2018). Furthermore, Birthmark, and similar organizations’ engagement with other institutions, such as health clinics, schools, and social-services allows them to connect with the women who most need their care (Ibid). However, participation within medical institutions does come at some costs, as described previously, most notably the continued presence of the clinical gaze. Still, by resisting the neoliberal frameworks in which many of the healers interviewed fall, Birthmark gets closer to providing “free choice.” Generally unrestricted by income and education, doula services aimed at serving poor women of color are able to reach populations that other healers, like those interviewed, cannot. Furthermore, these are the populations who demonstrate the highest benefits from care. As shown above, black women continue to experience some of the worst maternal-fetal outcomes in the U.S. A recent study revealed that black women who

had doula during their pregnancy and birth had lower rates of preterm birth and low birth-weight than those who did not receive the same services (Thomas et al. 2017, S59). It is likely that Kayla, the nurse in Baltimore, is searching for a way to create similar outcomes for her patients. However, instead of focusing on doula work, she views becoming a CMN as the best method of improving the reproductive health of women of color.⁶⁹

The contemporary presence of alternative healers alongside institutional medicine is simultaneously revealing, radical, and flawed. Their continued existence, despite centuries of persecution and erasure, points to an undercurrent of dissatisfaction with institutional medicine; in other words, their work exists because it meets a demand for other methods of care. I have found through original, qualitative interviews with some of these healers that they both explicitly and implicitly position their work in resistance to institutional medicine. This is achieved through education, spatial design, and the reconstruction of the “commons,” or a shared space and body of knowledge about healing. However, their work is made possible by their general acceptance of neoliberal principles, specifically their engagement within the wage economy, their separation from institutions, and their reliance on an uncomplicated mantra of “free choice.” In this way, the role of “alternative” female healers in contemporary medicine can be read as a complicated negotiation that pushes back against the control of women’s bodies and their knowledge of these bodies, yet often only does so for small privileged groups, with the work of doula services like Birthmark Doula Collective as

⁶⁹ Kayla, interview by Julia Mercer, February 16, 2018. It should be noted that Kayla also works as a doula, although it is unclear what kind of client population she serves. In her interview she does prioritize her efforts to become a CNM over her doula work.

the exception. The precarity of this position allows female healers to continue to exist, but ultimately limits the scope of their work.

Futures of Alternative Healing: Radical Herbalism?

It's a lot like gardening. Does this person needs a little bit more light? Is their mood dark and they need a little lift? ...Is this person dry and they need some water? So maybe a menopausal woman who's having theses hot flashes but it's not a true fever its like not enough moisture... Is their diet crappy? Or do they eat too fast...? Is it they need fertilizer? Is it they need to be pruned? They've got too much going on and now they're so extended... that they can't get enough vital nutrients to the extremities... So, that's how Chinese medicine looks at health.

—Brenda,⁷⁰ Chinese herbalist and acupuncturist

It is 2018 and Patricia, a middle-aged mother of four in central Pennsylvania, holds one of the oldest professions: a midwife.⁷¹ In an age where over 98 percent of women in the U.S. give birth in hospitals (MacDorman, Mathews, and Declercq 2014, 1) and less than 10 percent of all U.S. births are attended by midwives (Kozhimannil, Avery, and Terrell 2012, 433), Patricia's very existence seems contradictory. What role do midwives even play in contemporary healthcare? Hospitals are thought to be safe, sterile, and thus preferably, yet a network of "alternative" female healers, including midwives, doulas, acupuncturists, herbalists, and yoga instructors, has developed adjacent to, and at times separate from, institutional medicine in the mid-Atlantic region of the U.S. The presence of alternative healers, especially within predominately conservative areas such as central Pennsylvania, is radical when situated within the historical development of modern professionalized medicine. According to feminist epistemologists, the contemporary construction of medicine as objective, and thus apolitical, masks the historical role patriarchal capitalism plays in the formation of the professional medical institution. Barbara Ehrenreich, Deirdre English,

⁷⁰ Brenda, interview by Julia Mercer, February 13, 2018.

⁷¹ Patricia, interview by Julia Mercer, April 6, 2018.

Karol Weaver, and Kathy Davis trace this development as a shift from health being managed by women to healing as an area of male control, mediated through capitalism (see Chapter 1). The rise and violent fall of the witch healer, the defamation and replacement of the eighteenth century midwife and then the female community healer, the extended barring of women from medical schools, and the development of hospitals as a site for performing consumer citizenship are some of the signposts along this evolution. These scholars argue that as healthcare became a male profession within a capitalist market, women were erased as healers, as was their knowledge of their own bodies.

When read through a Foucaultian lens, the historical suppression of women within medicine can be seen as an application of bio-power. By shifting health from the realm of female peasants to that of the male elite, bodily knowledge became concentrated within the latter group, solidified by restrictions on education, the application of the clinical gaze, and the privatization of the “commons.” Under these conditions, women were simultaneously stripped of their own bodily knowledge, including the words used to describe their experiences within their bodies, and the networks in which they shared this knowledge, located in the commons. Instead, the female body was reconstructed as an object beneath a distant, analytical gaze. Today, this can be seen in the widespread reliance on EFM in the labor and delivery unit. The alternative female healers interviewed through this research employ several methods of resistance to reestablish individual women’s control over the information and decisions regarding their health, including the space in which they receive care. However, these healers limit the scope of their work by ascribing, by choice or

necessity,⁷² to neoliberal principles that support the wage economy, separate them from institutions that provide support to low-income people, and are constructed on the ideological notion of “free choice,” which obscures the limitations within their practice.

Limits aside, midwifery is on the rise in the U.S. A 2015 study found that there has been a steady increase in the use of midwives during birth between 1989 and 2012. The percentage of births attended by a CNM rose from 3.3 percent to 7.9 percent, with the percentage of vaginal births attended by a CNM reaching a historic peak of 11.9 percent in 2012 (Declercq 2015, 10). Vaginal births attended by direct entry midwives⁷³ including CPMs and lay midwives, who are grouped as “other midwives” in the study, also reached a recent peak at 0.7 percent, or 28,343 births, in 2012 (10). In the first decade of the twenty-first century alone, midwife-attended births increased by 48 percent (Kozhimannil, Avery, and Terrell 2012, 436). These statistics garner even more significance in the context of an overall decline in birth rates in the U.S. In 1990, there were an average of 71.2 births per 1,000 women, however by 2010, this fell to 64 births per 1,000 (Livingston and Cohn 2012, 1).⁷⁴ Thus, less women are having children, but more are receiving care from midwives

⁷² Or both. In pushing back against the critique of free choice, I recognize that practitioners are subject to the same complications with choice as their patients. For example, Sarah would assist any and all clients if possible, however she has had to make choices about limiting her work in order to provide for and be present with her own family.

⁷³ Direct entry midwives are only measured in the context of vaginal births, as, unlike CNMs, it is unlikely that they will attend cesarean section births. However, it is not clear if the statistics in this study include births that were attended by direct entry midwives but then transferred to hospitals.

⁷⁴ Livingston and Cohn’s report through the Pew Research Center also identifies a dramatic decline in birth rates among immigrant women in the U.S., falling from 112.8 births per 1,000 women in 1990 to 87.8 per 1,000 in 2010. This decline sharpened between 2007 and 2010, with a 14 percent decline in birth rate for immigrant women. For Mexican women living in the U.S. during this three year period, births decline by 23 percent. While this does not have direct implications on my research, it is interesting when considered alongside state regulations of reproductions and narratives of hyper-fertile women of color. This drop in birth rate could either be read as disproving the racist claims of the latter, or as evidence of the form in action.

when they do, implying that the proportion of pregnant women receiving care from a midwife is also on the rise. The data reflects this shift, finding that while the odds of a pregnant woman receiving care from an obstetrician-gynecologist remained stable between 2000 and 2009, the odds of a pregnant women receiving care from a midwife during the same period increased 4 percent annually (Kozhimannil, Avery, and Terrell 2012, 436). Much of this shift is occupied by CNMs, who typically work in hospitals and are covered by Medicaid in the wake of the 2010 Affordable Care Act (ACA). CNMs account for 94 percent of midwife-attended births, or 11 times the number of births that direct entry midwives attend,⁷⁵ though this shouldn't obscure the increase in direct entry midwife attendance (Kozhimannil, Avery, and Terrell 2012, 433 and Declercq 2015, 11). In fact, Eugene Declercq found that, "states with a higher proportion of CNM-attended births generally had a higher proportion of births attended by other midwives" as well (11).

Based on these statistics, three trends emerge. First, it is clear that midwifery is experiencing a resurgence, particularly in recent decades. When analyzing this trend, Katy Backes Kozhimannil, Melissa D. Avery, and Carrie Ann Terrell suggest that this increase can potentially be attributed to "integrated practice models,⁷⁶ referrals, or switching providers" (2012, 436). They also hypothesize that the inclusion of CNMs in the ACA will also increase the births attended by these practitioners (437). While these are likely some of

⁷⁵ The exception to this statistic is Alaska, which reported almost equal rates of CNM and direct entry midwife birth attendance (14.4 percent CNMs and 14.1 percent direct entry midwives).

⁷⁶ The "integrated practice models" are defined as a collaboration between different practitioners to provide care that meets "the diverse needs of clients" (Kozhimannil, Avery, and Terrell 2012, 433). The birth center is an example of an integrated practice model. Kozhimannil, Avery, and Terrell note that these collaborative approaches are on the rise in the U.S., especially as they are funded under the ACA (Ibid).

the surface reasons for the increased use of midwives, based on my analyses of institutional medicine's manipulation of women's bodies, and midwives' (among other practitioners') resistance to this control, I would argue that women are seeking out midwives as a means of reclaiming knowledge and autonomy over their bodies. In short, this rise in the employment of midwives points to a growing sense of dissatisfaction with institutional care and a need for an alternative. Patricia echoes this, attributing her recent increase in clients in part to "the fact that maternity care has done such a poor job of meeting women's needs."⁷⁷ From a client perspective, Holly's previously quoted reaction to her traumatic experience with an obstetrician summarizes the same sentiment: "there has got to be something better than this."⁷⁸

However, the second trend these statistics illuminate is the vast divide between CNMs and direct entry midwives, which may complicate this notion of an alternative. Both camps have experienced increasing popularity, however CNMs continue to be far more widespread. Additionally, CNMs are extending beyond their usual hospital environment to attend home births, a realm traditionally handled by CPMs and other direct entry midwives. Declercq found that the number of CNMs attending home births doubled between 2004 and 2012 alone. The number of home births in general also rose by 29 percent during this time frame, from 0.56 percent of births to 0.72 percent (MacDorman, Mathews, and Declercq 2014, 1). One explanation could be that CNMs are attending the additional home births that perhaps direct entry midwives are too busy to attend. Patricia remembers a year when she and

⁷⁷ Patricia, interview by Julia Mercer, April 6, 2018.

⁷⁸ Holly, interview by Julia Mercer, February 16, 2018.

another direct entry midwife collectively attended 80 births in one year, which she found extremely taxing.⁷⁹ However Declercq makes it clear that the *proportion* of home births attended by CNMs has also increased between 2004 and 2012 (2015, 11, emphasis mine). Thus, home birth is increasingly becoming the realm of CNMs, and by association professional institutional medicine. While CNMs, like Kayla, are often critical of the institutions in which they work, they also rely on these institutions' resources and are subject to their regulations. Kayla chose to pursue a CNM degree specifically because it was "more a part of the healthcare framework," yet in doing so, she is required to perform interventions with which she might not agree, such as administering Pitocin, a drug used to strengthen contractions and quicken labor, on the majority of patients.⁸⁰ In the context of this compromise, the appearance of CNMs in home births can be read as the beginning of institutional medical control within these private, autonomous spaces. This shift suggests that while woman may be seeking an alternative to institutional care, they may not be as removed as they think. Given this dynamic, coupled with the neoliberal critique of other alternative healers detailed above, it is useful to consider other ways women might reclaim knowledge of and power over their bodies that are free from these limitations.

A third trend in reproductive care may get closer to this goal. Although the discussion at the end of Chapter 2 primarily addressed the work of Birthmark Doula Collective, doula services aimed at serving women of color have been on the rise recently (Villarosa 2018). Monica Reese Basile refers to these doulas as "community-based," meaning the practitioners

⁷⁹ Patricia, interview by Julia Mercer, April 6, 2018. This is compared to her typical average of 30 births per year.

⁸⁰ Kayla, interview by Julia Mercer, February 16, 2018.

usually belong to the same racial and/or socioeconomic demographics as their clients, and aim to “serve communities that have been self-defined as underserved” (Basile 2012, 163). When Basile wrote her doctoral thesis on doulas in the U.S. in 2012, there were approximately 44 community-based doula organizations in 16 states across the U.S. (Ibid). Now, according to the same database, HealthConnect One, there are at least 73 community-based doulas across approximately 24 states (HealthConnect One n.d.). While community-based doula work is not completely separated from institutional medicine, and thus carries some the same negative impacts as that CNMs, such as the continued hierarchical privileging of doctors’ knowledge over that of other healers or women themselves. However, community-based doulas do not work directly for hospitals, and thus are not subject to the same levels of control. Furthermore, they have access to underserved communities that other private doula services do not reach.

Another method of healing that reaches marginalized populations is radical herbalism, A tactic that is being explored by activists, but less so by scholars, according to radicalherbalism.org.uk, radical herbalism is centered on the idea that “everyone should have the basic knowledge & skills to look after themselves naturally” (Radical Herbalism Gathering n.d.). At its core it acknowledges the historic and contemporary harm to bodies caused by state and capitalist institutions, the disastrous effects of colonialism on Indigenous lands and medicines, and the links between the health of humans and the health of ecosystems (Ibid). Radical herbalism affirms people’s right to accessible healthcare and to the knowledge that lies at the foundation of this care. It emphasizes “harm minimization,” an ethic central to the Hippocratic oath, as well as self-care, mutual aid, and the diversity of

methods within herbal medicine (Ibid). Organizations like the POC Herbal Freedom School promote the work of queer and trans herbal healers and healers of color, as an effort to reclaim the medicinal practices that have been stripped from these communities, as well as provide comprehensive, “anti-oppression” care (Queering Herbalism n.d.). Radical herbalism differs from other forms of alternative healing in that it emphasizes the reproduction of knowledge specifically within queer communities of color, rather than relying the false paradigm of “free choice.” In this way, it reaches beyond the current scope of the healers interviewed, who engage primarily within white networks.

One of the goals of this research is to record, preserve, and disseminate the knowledge held by alternative female healers in the contemporary mid-Atlantic region of the U.S. However, after conducting several interviews, I have identified that while the knowledge held by the interviewed healers is empowering and radical, it is only a piece of the picture. Another portion of this knowledge can be found within radical herbalism. Inspired by this type of healing, I designed and built a small medicinal herb garden as an extension of my research. I drew from contemporary herbal texts, historical references to remedies, and knowledge that presented itself within the qualitative interviews.⁸¹ The garden is located in a small bed on the campus grounds of Dickinson College in Carlisle, Pennsylvania. While the majority of the campus itself does not does fit radical herbalism’s intended demographic of queer, low income, or communities of color, the location of the garden is just blocks from a low-income neighborhood. Originally, I sought to build the

⁸¹ I recognize that as a white, cisgender woman within an institution of higher academia, I am not the most appropriate person to initiate a radical herbal garden. This positionally, coupled with the physical locus of the garden are some severe shortcomings of this project.

garden in one of Carlisle's community gardens so that it would be more accessible to community members. However, for the sake of continuity, I ultimately decided to build the garden on Dickinson's campus, where it will be maintained by the Dickinson College Farm after my commencement. Furthermore, the absence of large communities of queer, low-income, or people of color should not negate the importance of providing resources for some members. I believe the very existence of this garden embodies some of the methods of resistance employed by alternative female healers, but in a manner than is free from the neoliberal constraints.

The garden contains a small selection of herbs whose medicinal qualities address health issues specific to female bodies. Specifically, one will find herbs for treating the pregnant female body, such as nettle (*Urtica dioica*), which is a source of iron, calcium, and vitamin A that can be used during pregnancy to enrich mothers milk and help relieve water retention (Gladstar 2001, 205; Duke 2000, 157-158)⁸² and red raspberry (*Rubus idaeus*), whose leaves are rich in iron, calcium, potassium, phosphorus and vitamins B,C, and E, making them a sought-after tonic during pregnancy (Gladstar 2001, 204).⁸³ Growing alongside these plants are other herbs dedicated to treating non-pregnant female bodies, specifically those experiencing menstruation or menopause. Motherwort (*Leonurus cardiaca*), is an herb that promotes delayed menstruation and treats symptoms of premenstrual syndrome and menopause (Gladstar 2001, 204; Duke 2000, 152). Similarly,

⁸² Patricia, interview by Julia Mercer, April 6, 2018; Sarah, interview by Julia Mercer, March 9, 2018.

⁸³ Patricia, interview by Julia Mercer, April 6, 2018; Sarah, interview by Julia Mercer, March 9, 2018; Kayla, interview by Julia Mercer, February 16, 2018; Christina, interview by Julia Mercer, February 16, 2018.

mugwort (*Artemisia vulgaris*) helps regulate menstrual cycles in young girls and can be applied as moxa⁸⁴ to treat period pain (Gladstar 2001, 205; Ulrich 1990, 356-357). Yarrow (*Achillea millefolium*), another plant whose properties treat muscle spasms and can help relieve cramps, will also be present (Gladstar 2001, 204; Duke 2000, 228; Ulrich 1990, 357-359).⁸⁵ Finally, within the garden one can find herbs used to sooth the body, such as calendula (*Calendula officinalis*), an anti-inflammatory, anti-spasmodic plant that is good for bruised, burned, or scraped skin, including cracked nipples, and diaper rash,⁸⁶ as well as lavender (*Lavandula angustifolia*), which contains anti-bacterial as well as calming properties that are particularly useful when healing scarring.⁸⁷ All of the herbs were sourced from a local farm in Harrisburg, Pennsylvania and are labeled with their uses and both the physical plants and this knowledge is free and public. In this way, this garden, entitled “The Midwife’s Garden” acts as both a public informational site and a recreation of the “commons.” It places both the knowledge and resources needed to treat low-risk health concerns directly in the hands of the public. I chose to include information about higher-risk remedies, such as abortifacients,⁸⁸ but not the physical plants as a way of navigating the legal

⁸⁴ Moxa is a form of Chinese herbalism that consists of applying small quantities of burning mugwort to the skin to relieve pain. Brenda, interview by Julia Mercer, February 13, 2018; Duyen, interview by Julia Mercer, March 3, 2018

⁸⁵ Sarah, interview by Julia Mercer, March 9, 2018.

⁸⁶ Brenda, interview by Julia Mercer, February 13, 2018; Sarah, interview by Julia Mercer, March 9, 2018; Christina, interview by Julia Mercer, February 16, 2018.

⁸⁷ Sarah, interview by Julia Mercer, March 9, 2018.

⁸⁸ Some herbal abortifacients include ergot, pennyroyal, and blue cohosh. These are also used to reduce labor pains, alleviate cramps, and bring on delayed menstruation, as they relax the muscles and promote blood flow (Ehrenreich and English 2010, 47; Gladstar 1993, 119; Gladstar 2001, 204; and Ulrich 1990, 355-357). According to Ehrenreich and English, ergot was used as the primary ingredient in a contemporary drug used to “hasten labor and aid in the recovery from childbirth” (2010, 47).

limitations of the College without restricting knowledge. The Midwife's Garden is not designed to be a complete replacement of institutional medicine or the care provided by alternative healers; it is simply another method of reproducing knowledge and providing women with resources to reclaim control of their own health and bodies.

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