into these hands

wisdom from midwives

edited by Geradine Simkins

Spirituality
& Health
My involvement with midwifery came relatively late in my life, but my involvement with the needs and issues of women of color has been with me all of my life. My belief in the essential worthiness of all human beings and in the right of women to be treated with respect and dignity—especially when they are engaged in bearing the future of humanity—is at the core of my beliefs. I believe in the power of women to change the world, and this belief is grounded not only by my own experiences, but also by twenty-five years of listening to women from all over the world. I believe in women’s ability to radically transform the social fabric because I have witnessed the struggles of women of every race and creed, women
determined to make a better life for themselves and their children. In the birthing room, the sick room, the home and the marketplace, I have witnessed the power, love, and steadfast endurance of women who are rich, poor, educated or illiterate. I have experienced the brilliance of women who educate and teach, pastor and preach, found and head organizations, and offer leadership to their countries. In attending the births of women from over seventy countries I bow in homage to the awesome power of the womb, the brilliance of Spirit, and the Mystery of Life. May we be sheltered by all that is good; may we continue to heal; may we finally turn away from war and shelter and nurture the life of this planet! Ashe!

I am a sixty-year-old, mixed-class, African American woman who was deeply influenced by the civil rights struggles of the 1960s. I grew up during a time when African Americans were denied full citizenship rights in the country of their birth. It was taken for granted that a woman’s ability, intelligence, and competence were absolutely less than those of men. This was doubly true for women of color, who were always judged against middle-class standards of femininity that they rarely could achieve. Struggles against racism and injustice, as well as struggles to provide just and equitable health care for poor and minority populations are essential parts of why I became a midwife, and my experiences in these struggles have dictated where and how I chose to practice.

My son’s home birth was my first experience with midwifery. However, during the course of an unplanned but thoroughly welcomed pregnancy at the age of twenty-two, it was my experience in the Civil Rights Movement that helped me believe that I could have a home birth. While I read work about Grantly Dick-Reed and Dr. Lamaze, I understood that African people had been having babies for millennia. For most of that time, we had not had the support of modern western medicine—and we had not died off awaiting the arrival of contemporary biomedicine. My belief in the inherent capabilities of African Diasporic peoples led me to question the Euro-centric medical establishment. I passionately believed in my body’s ability to meet the physical challenge of birth. And, while my sense of feminism was still new, I embraced the notion that a woman could do anything that was needed.

I had the sacred experience of having my first child at home with the support of my community. I had called the midwife late in labor; when she arrived she told me I would deliver in about an hour and a half. She never examined me, but her timing was impeccable. After about an hour and a half, I squeezed her hand as I felt the urge to push—and she told me that I needed to release her hand so she could catch the baby. I pushed three times, and for a moment I felt that I had
a universe between my legs. An image of the Hindu Goddess Kali giving birth to the Universe—standing upright and ecstatic—flashed through my consciousness. In the next moment my son was born. The birth was safe, well-attended, and left me joyfully ecstatic. It changed my life forever.

However, my decision to become a midwife has a second, more difficult root. I witnessed one hospital birth during my obstetric rotation as a nursing student. This birth was so upsetting that the two nursing students with me said they didn’t ever want to have babies. I couldn’t believe that what I observed was related to the process I had experienced at home. The attending obstetrician was cruel and unsupportive. After waiting a half hour, he stormed out of the delivery room, snarling at the nurse, “Don’t ever call me when one of those primips thinks she needs to push.” During a prolonged episiotomy repair performed by the medical student, the patient complained of pain. The doctor denied her request for medication and stated: “That’s what you Lamaze patients get for wanting to do it naturally.” It was not the length of the labor or the woman’s pain that made the birth difficult; the birth was horrendous because of the scorn of this provider who had total disdain for the birthing process.

The father of the baby was also not very supportive. After many hours of labor, the birthing woman stated that she wanted something for pain. “Oh no,” said her husband, “we don’t want any pain medicine.” While I knew his job as a coach was to support an unmedicated birth, I instinctively knew that denying his wife’s feelings was entirely inappropriate.

This woman’s birth was so different from my own. Instead of being restricted to a hospital bed, I walked or sat whenever I wanted to, and my midwife later said I had danced through my labor. I rocked back and forth in “cat-cow” positions, and I crouched in a chair by the living room window. I never even sat on the bed my son was born in until five minutes before his emergence from my body. I had experienced strong back pains throughout my labor, and I instinctively responded by changing positions to make myself feel better. I know now that there isn’t any magic position that makes labor pains stop, but just being able to move around alleviates some of the anxiety and fear that labor elicits in women.

Unlike me, my hospital patient was limited to the bed. We didn’t have fetal monitors then, but walking around just wasn’t allowed. Her options for moving or shifting were entirely limited. Lots of people came in and out of her room, but none of the staff was there to support her. No one offered her any real comfort: the medical students and nurses examined her; the nursing students observed. The husband responded to her pain and his fears in the classic way that men are
taught to manage feelings: denial and stoicism. In witnessing this birth, I realized that the role of the coach—which at that time was modeled on the actions of male athletic coaches—was totally inappropriate for supporting women in labor.

My own experience of labor was very different. While much of my laboring time was alone, I was quite comfortable with this. Labor had started at midnight, but I didn't believe I was truly in labor. Early in pregnancy, I read an article on birth in the New York Times. It indicated that many doctors found normal deliveries quite boring. Obstetrics was no longer required in many medical schools, and doctors spoke scornfully of being called in to attend first-time mothers who were having "false labor." After reading this, I decided I wasn't going to be one of those women who called the doctor too early. So, I spent my first two hours of labor denying the pains that came like clockwork every fifteen minutes. At 2 A.M., still convinced I was having false labor, I got out of bed and began breathing exercises. An hour later, my breathing woke Star, my roommate. She sat and breathed with me, and told me I needed to call the midwife. I called the midwife, and in a way that was entirely organic, she validated my intuitive and instinctive knowledge. I had followed my body, and when the midwife came, she continued to encourage me to follow my body.

What I learned from these two birth experiences is that there is a huge difference between a birth grounded in respect for the body, and the body's intuitive knowing, and a birth grounded in the belief that the body is flawed, faulty, and potentially harmful. This difference is as palpable as the difference between pleasure and pain, or suffering and surrender. It is a difference to which our psyches are acutely attuned, and which is etched indelibly in the memories of birthing women.

I was afraid of dying, just as the woman I witnessed in the hospital was afraid of dying. I felt that the pain was more than I could bear. She felt this, too. I needed, just as she needed, the intimate and knowledgeable support of those who were skilled not only in the management of normal birth, but also in the management of the difficulties of birth. She, like me, deserved the support of people who respected and honored her emotional and physical struggles—and who deeply believed in her body's ability to birth safely and ecstatically.

I had this support, but she had only a piece of it: her support team only addressed the physical aspects of birth. They were unable or unwilling to address the emotional and psychological aspects or to offer her true understanding and respect. While both of our births encompassed fear and pain, in my case the ecstasy of giving birth in knowledge and power transcended my experience of pain and suffering. The doctor that came to my house gave me "two stitches" to
repair a tear. He congratulated me and the midwife. The doctor that sewed her up took pleasure in making that experience difficult and more painful. He never acknowledged the power of her body and psyche, and the success of her labor. While she, like me, experienced the miraculous joy of giving birth to a healthy child, the attitudes of the staff diminished her knowledge of her own power and dimmed the radiant joy that accompanies a successful birth.

My understanding of the need for respectful and appropriate support in the labor and birthing room has deeply influenced my work as a midwife. Just before I entered midwifery school I performed a small anecdotal survey. I collected stories of women who found their first birth so traumatic that they chose to never have another baby. All the women I interviewed were women of color who had given birth in the hospital. They were middle and working class, college educated and/or college graduates. In a moment of utter vulnerability, they had all undergone a profoundly traumatizing experience at the hands of a cruel and uncaring medical institution.

In discussing their experience, these women never referred to the length of labor. They did not say that their birth was so painful that they thought they would die. Their birthing trauma did not arise from the experience of pain. What defined a traumatic birth was almost always the birthing staff’s attitudes. Gender and race were not the cause of their negative treatment; the offending staff was often the same race or gender as the pregnant woman. What was most significant was the way in which boundaries between patients and providers provided a license for unthinking cruelty and lack of perception of a common humanity.

The women I interviewed said, “I came to the hospital, and when I asked for something for pain they told me I was a big strong country woman and I didn’t need pain medicine.” A common variant was, “When I was in pain, they told me to shut up; if it didn’t hurt when I was making the baby, I should be quiet now.” Being left alone in labor was especially traumatizing: “I came to the hospital and told them the baby was coming. They told me I was wrong—and they put me in a room by myself and I delivered all alone.” A common variant was being put on a gurney in the hallway and delivering alone.

Women told me of nurses holding their legs closed when they tried to push because the doctor hadn’t arrived. They told stories of doctors who laughed at their labor or their post-partial pain. One woman, a young African American medical student, had changed obstetricians so she could have natural childbirth in an Alternative Birthing Center. At her six-week check up, she told her physician that intercourse was still painful. “He grinned at me and told me that he had given me a couple of extra stitches. ‘Your husband will love it,’ he said.”
These stories deeply influenced my subsequent work as a midwife. While I apprenticed with a direct-entry or “lay midwife” and was trained and certified as a nurse-midwife, the story of my own pregnancy and home birth, and the stories and experiences of other women of color who gave birth have been the greatest influence on my later work as a midwife. My midwifery care was also deeply impacted by notions of cultural sensitivity and social justice, for I grew up in New York as the daughter of a community activist. My mother believed that it was our social and spiritual duty to make the world we lived in a better place for everyone regardless of race or status. At the time I entered nursing school two years after my son’s birth in 1972, I had no idea that I would become a midwife. However, I decided to apprentice with the woman who caught my baby in order to learn more about how and why my home birth experience had been so different from the hospital birth I witnessed.

June, the midwife with whom I apprenticed, provided home birth services and childbirth preparation classes. She didn’t offer prenatal care, which had to be obtained from an obstetrician. While her clients were predominantly Euro American, I met African American, Jamaican, and African women who all planned to deliver at home with her. Some were having their first baby and others were former clients. About 25% of the births during my apprenticeship ended in the hospital. June later told me that if she had experienced as high of a transport rate in her first thirty births as I did in my apprenticeship, she wouldn’t have become a midwife.

Since I had no expectations, I wasn’t turned off by our high transport rate. In birth after birth I witnessed the power and strength of women as they moved through the birthing process. I offered my clients the comfort given to me: I rubbed backs and hands, walked with women in their homes, and verbally encouraged them. I saw husbands who were supportive and sensitive and/or fearful and inappropriate. While a woman might have decided that she wanted music, food, or particular friends around her, there was always a moment when she had to engage more deeply with the forces moving through her body. The world fell away and her energy turned inward; for a moment she was the equal of forces moving life from one side of the veil to the other. In that moment, I saw the face of God/dess creating the world—and my Spirit was touched with awe and wonder.

June taught me the power of patience—of waiting like the earth waits—of trusting in the moment and moving in harmony with the elemental power of the body. She didn’t touch women as much as I did, but she didn’t discourage my doing so. Early on, she said, “We’re the oldest profession, not the hookers,” and I’ve always remembered that comment. She told her prenatal class once that the
reason men climbed Mt. Everest was that they didn't have babies, something I'd never thought about but with which I immediately resonated.

She was a solo practice midwife, and in the summer I worked with her, I was on call 24/7. While this worked for her, it did not work for me. I've learned since then that something in me doesn't relax when I'm on call: I'm always psychically "listening." In this era before beepers or cell phones, I could neither enjoy going to the movies nor relax enough to easily make love. I learned that summer that I couldn't be a solo practice midwife.

I also realized that I didn't want my role with the woman to end if she went to the hospital. Since we had such a high number of hospital transports, I experienced the hospital's contemptuous denial of a lay midwife's right to be with her clients when they entered the hospital. June or I often spent twelve to twenty hours with a woman before we decided to go to the hospital. We knew the woman intimately; we had seen her struggle with or against her body; we had seen her naked, sweaty, powerful and vulnerable as she danced with inner and outer demons of pain and fear. Sometimes we transported because we—and she—understood that there was a risk to the baby and that birth at home was no longer safe. But often that summer, we transported because the woman could not trust her own body, and had unconsciously decided birth was safer in the hospital.

When we arrived at the hospital, June and I were routinely barred from the room in which the woman was examined. The medical staff assumed that we knew nothing about labor and birth in general, and nothing about the particular woman we brought in. Our reports of cervical dilation, length of labor, rupture of membranes, and a host of other concerns were routinely ignored. In a few cases where our concerns were for the welfare of the mother and baby, valuable time was lost as medical personnel chose to ignore our diagnoses, simultaneously berating the mother for choosing a dangerous home birth and ignorant providers. Once the woman was admitted, June and I were excluded from the labor room because we were not personal family or next of kin.

During the early 1970s, if a woman deliberately or accidentally disclosed to her physician that she planned to have a home birth, the physician usually refused to continue her prenatal care. This is still true for many physicians. At that time in California, there were very few practicing nurse-midwives—and an even smaller number of them were delivering at home. It was obvious to me that this was an inhumane and dangerous way to treat patients, and my desire to become a nurse-midwife stems from my frustrations with this dangerous, fragmented and hierarchical care. I maintained a small home birth practice after
finishing my apprenticeship with June in 1976. I also worked part-time with Sinem, a highly experienced direct-entry midwife who had a successful collaborative relationship with doctors at San Francisco General Hospital. Unlike my experience with June in Berkeley, the physicians at General regarded Sinem as an experienced and valued clinician. She was able to stay with clients she brought in from home, and she was able to manage uncomplicated labors in consultation with the attending obstetricians.

While I loved doing home births, I realized I wanted to attend women through the full spectrum of pregnancy and childbirth. I also wanted to work with women of color who were the most oppressed by the hospital system. Initially, I was concerned that my direct-entry colleagues would see my desire to pursue nurse-midwifery as an act of betrayal, but I was pleased to learn that they fully supported my decision to obtain nurse-midwifery certification. After receiving my Master's in Public Health (MPH) degree in 1978 I worked in a hospital for six months so that I could meet the prerequisites for applying to the UC San Francisco's Nurse-Midwifery Program.

While I've discussed my ecstatic experience of home birth in California, I also need to describe my prenatal care experience at a public clinic in New York City. This experience provided a standard against which I measured my own later role as a health care provider for indigent women. It taught me that we have at least two standards of health care in the United States. One is for the poor and the undocumented, and another is for people with private insurance. In 1971 when I was pregnant in New York, there were only two ways to receive public medical assistance. You either enrolled from your hospital bed or you came to one clinic in Manhattan. The waiting line was so long that if you didn't arrive by 7:30 A.M., you couldn't be seen that day. And the clinic didn't open till 9 A.M. Waiting in line on a cold, wet, January morning, I remember thinking, I'm not sick; I'm just pregnant. Could I wait like this if I were really ill? Could I wait outside for public assistance? I knew then that our health care system didn't care about the poor and that it was also a system that I could not trust.

During this pregnancy I was taking medical pre-requisite classes at the Old Westbury campus of the State University system. This new college had no residential dormitories so we were bussed in every day from another state institution. There was no cafeteria and lunchtime meals came from on-site vending machines, unless you had a car and could drive into town. I purchased a lot of yogurt from the vending machines during my pregnancy, but I knew I wasn't nourished in the way that I wanted. My prenatal care, which was my first
encounter with the health care system, was impersonal, uncaring, bureaucratic and confusing. I experienced it as horrendous, and I later vowed never to give the kind of care I received. All the patients had block appointments, which meant that everyone came at the same time. Unlike today’s group appointments, which provide health education and support patient interactions, our two- and three-hour waits were rarely broken up by interactions with others.

No one ever explained what was being done to my body, so the care I received never seemed important. It was fragmented and dehumanizing: one person weighed me, someone else collected my urine, and another person put his or her hand on my belly. There were no explanations: no one ever told me what was being measured, and no one ever talked about what the measurements indicated. The nutritionist lectured me about foods I should eat, but I had no way to acquire or cook them. I spent my whole pregnancy convinced that some part of my care was missing. Surely in private settings, middle-class doctors gave White middle-class clients the competent and personalized care that I was denied. My experience of being a poor client in a large, urban, indigent care setting is a critical part of my understanding of midwifery. It helps me understand why properly trained and culturally sensitive midwives are so successful in working with populations demographically at risk for infant mortality and preterm deliveries. My experience taught me that extending competent, loving, and individualized support is an integral part of being a good midwife. It taught me the importance of talking to patients, and embodied the idea that there is no substitute for cultural sensitivity and cultural awareness.

My experience of substandard, dehumanized care mandated that I always explained to women what I was doing and why it was significant; it meant that when I could not speak another’s language that I always called a translator. In a birth, when a translator was not available, I used the human technologies of sound, touch, and soft tones to convey compassion and support the birthing woman. One of my most moving births was with a Cambodian woman who was positive for Hepatitis B. We could not speak each other’s language, and I wore a mask since Hepatitis B is transmitted through blood and amniotic fluid. I knew that my mask and gown did not support patient comfort—but being splashed with birth fluids was quite common and I needed protection. Without a shared spoken language, I used humming to support this woman’s labor, and after she delivered, she spontaneously reached out to stroke my cheek, acknowledging the loving care she knew I had felt for her.

What I learned over time was that physically competent care is not the only measure by which midwives are judged. Sensitive, caring, and respectful
providers make a real difference to clients. While our clients didn't always know if our actions were competent, they were experts in recognizing—and evaluating—our sensitivity and compassion. If we provided empathetic and respectful care, they forgave our logistical problems: in spite of long waits, missing records, repeated labs, or occasional dirty rooms, our patients came faithfully to their appointments. Sometimes after waiting for hours, they declined the services of the physician, continuing instead, to wait for the midwife.

Today, I believe that many of the important things I know and understand about life were learned or tempered by my twenty-five years as a midwife. As I say to my students, you can't believe that women are the weaker sex and work with women having babies. Midwifery grounded my belief in feminism and in women's power and exposed me to the reality of a spirituality that is immanent, embodied, democratic and ubiquitous.

As an inner city midwife I learned all the good, bad and ugly ways that women get pregnant. I saw women who didn't trust their bodies and who didn't trust birth. But what I witnessed again and again, as women lay down on a primal bed of pain was their absolute willingness to suffer, to trust, to endure, and to triumph. I witnessed the ordinary and extraordinary heroism of women as they entered a ritual that brought them to their knees, and I witnessed the absolute uncompromised joy that suffused their body-minds as they held a living child in their arms.

While I came to midwifery because I deeply cared for those who are poor, helpless, female and alone, and since I have at one time in my life been a member of each of these groups, I learned, as a midwife, that courage, endurance, self-sacrifice and love are universal qualities that have been given to all races, classes, genders and nationalities. I learned in the deepest part of myself that to be poor and indigent is simply to be part of the human race. It does not mean that you are stupid, lazy or ignorant; it does not mean that you don't care about your children.

My midwifery practice has taught me that most women love their children. You can convince a pregnant woman to do many new things if she believes it's for her baby's health. I've learned that a little kindness goes a long way. Patients whose names and births I really don't remember have remembered me for decades, whether I attended them prenatally or had the joy of catching their babies. My name is not an easy one to say or remember, and White and Black clients have named their babies after me in order to honor the love and respect I offered them. I've also learned how competent and able working class women are. With so much less than what I've been given, they struggle everyday to make a better way for themselves and their children. They care for multiple offspring
and other nuclear and extended family members—and they deal every day with a system that rejects them.

Letting women know that they have survived and triumphed in an incredible rite of passage is very important to me. One of our teens spent her whole pregnancy hiding the pregnancy from her parents. She came to us during a school strike so her prenatal visits could be hidden from the school. She planned to give the baby up for adoption; when she went into labor she called the labor coach to get a ride to the hospital. She scaled a fence, went to the hospital and delivered her child. She left the hospital a few hours after the delivery so that she could register in school for the day. When I saw her postpartum, I told her that she could do anything, for her ability to birth was a marker of her ability to do whatever was necessary in the course of her life.

Working in a hospital taught me that getting along with all sorts of people was key to our survival as a midwifery service. I was not only a hospital staff nurse-midwife, but for about the first four years of our service I was the Director. The first Obstetrics Chief I worked with told me that translation services for non-English speaking patients were totally unnecessary. After seeing a father leave “his place” at the shoulders of his wife in order to witness the child’s arrival, this obstetrician concluded that “fathers had no place in the delivery room.” In this setting, many of the long-time nurses had adopted the negative attitudes of the attending physicians. They laughed at Laotian patients who were unused to high beds and used our sheets to make a pallet on the floor. They were contemptuous of our addicted women patients, and rarely exhibited love or compassion for women in labor.

Working with these negative staff attitudes in the early years of the service was very challenging. As I was a subordinate in this system, I learned to work around these issues rather than to confront them directly. I spoke kindly to staff whose treatment of patients horrified me, and I sometimes remained silent rather than publicly disagree with doctors or nurses whose attitudes were inflexible. I recognized the value of saving face even when I felt that my backup OB was wrong. And I used humor and subtlety in my communications. I can’t always speak with pride about this, but I do know that compromise was a good strategy for me.

Many of the midwives who confronted the doctors directly ended up leaving our service. Their births were watched; their management was questioned; their consulting doctors rejected collaboration in favor of physician control. I was regarded as a team player who accepted medical authority, so I was routinely left alone. I delivered women in alternate positions and in birthing chairs; I permitted my Native American patients to burn sage; I covertly worked around the ridiculous time limits that we were given by individual physicians. I never lost a patient; I
never lost the respect of the nursing staff; and over time, some of the most difficult medical personnel became my partners in the loving dance of caring for women.

To be a midwife in this country is to take risks. In the early years of the service I secretly worked with community organizations that were trying to make obstetric services better for women and children in the local community. The midwives worked openly with the hospital's community advisory board and with progressive nurses and physicians. We demanded translators for non-English speaking patients. We also worked clandestinely with grassroots community groups lobbying for safe and adequate levels of staffing, and culturally sensitive, family-centered care for poor women of all ethnicities. We had political meetings with the Board of Supervisors and met with other elected officials to ask for funding to improve patient care and access.

Sometimes there were consequences for this. I have been yelled at so loudly by a hospital administrator (who was rumored to have thrown a chair at another woman in a meeting) that people in the cafeteria later asked what had happened. I have stood up to my physicians and demanded that they hire more midwives so that we could adequately serve women; and I have led a unionizing effort to make this happen. When I was the Director, I made sure that we hired midwives who wanted to work with the poor and the indigent. My efforts—in conjunction with the lobbying of others—helped change perinatal services at our hospital. The midwives used the Alternative Birth Center that had been unutilized for two years; we ended the requirement that childbirth classes be a prerequisite for birth center deliveries since there were no prenatal classes for our non-English speaking patients. Before our hospital engaged translators, midwives in my service located volunteer translators in the community. One of my staff created a program that allowed the midwives to provide intake services to drug-using women at their first point of entry; we examined them at their first Emergency Room visit, drew their blood, and ordered sonograms, which gave them a strong incentive to return.

I believe that it is our steadfast advocacy for patients that has led to our service's greatest success: thirty years later the midwifery service that I helped establish and shape still serves women in the county. And perhaps most importantly we have helped to change the local African American community's perceptions about midwifery.

When our service began, Latin American women familiar with parteras routinely chose midwives. New Southeast Asian immigrants who had delivered at home also wanted midwives. Counterculture Euro Americans sought alternative birth services and midwifery care. But African American women, whose
mothers and grandmothers had been denied hospitals and obstetricians in the segregated South, were reluctant to have their daughters and granddaughters attended by midwives. They wanted a "real doctor" and were suspicious that midwifery was second-class care.

In addition, poor women of color in the United States have often been targeted for medical experimentation. This is especially true in the reproductive arena: enslaved African American women were subjected to surgeries without anesthesia by Dr. James Sims, the father of gynecology; and the American eugenics movement championed birth control as a way to limit immigrant working class populations.

While these issues are not usually linked to midwifery, the legacy of these issues was quite real for many of the women I attended. I was profoundly happy that our hospital enforced California's mandatory thirty-day waiting period for elective sterilization. In our hospital, the midwives and doctors worked really hard to make sure that we obtained appropriate adult translators so that sterilization procedures were competently explained to the women we served. Since the reproductive rights of Black women are often contested or denied, I am proud of the fact that our hospital service declined to forcibly impose Norplant on women who used drugs.

Twenty years later, many African American women in the county freely chose midwives. They know that we provide safe, empathetic and competent health care. Our drug-using women often lied and said they were midwife patients when they presented in labor. They wanted the support and understanding midwives provided.

We also made a difference in perinatal outcomes. While we delivered less than a thousand patients in our first three years, an early retrospective review documented that our clients had rates of preterm delivery, and low birth weight that approximated the state's averages for all women—indicating that we had successfully impacted the high infant mortality rates of young, indigent and African American populations.

In my twenty-five years of midwifery practice, I have personally impacted the health and self-esteem of hundreds of women. One story that I am especially proud of concerns a woman whose first birth I attended, but who had subsequent deliveries elsewhere. Several years later she spoke with a lawyer I knew and told him that she didn't let the doctors do certain things to her when she was in labor because of that first birth with me. She resisted because she believed in her body, and this empowered her to stand up for herself. For me this is a real success story, for I believe that our job as midwives is to empower women. It's not the birth site that does this; it's what we reflect back to the woman.
Over the course of fifteen years I have watched health care go from bad to worse. Long waits, short visits, and inadequate counseling times are the norms even in the private setting. The health care system is broken, and I don’t think it will be fixed in my lifetime, although Obama’s election gives me hope. Machine technology has also had a huge impact on birth. Symbolized by fetal monitors—which I believe are here to stay—our culture’s emphasis on technology is symptomatic of disdain for the “natural” and increased preference for the mechanistic. The Alternative Birth Center in our hospital, called the “Little House” by our Lao and Mien patients, was taken over by the doctors and became doctor sleep rooms—and this embodied a reminder of birth’s utter normalcy that will not return soon. I am saddened that birth in the hospital and birth at home are more and more different and that normal births are increasingly difficult to obtain.

I grieve that young women accept the notions that birth is so inherently difficult and that every woman needs an epidural. Having studied Buddhist philosophy for over ten years, I accept that pain and suffering are fundamental parts of our physical human existence. I believe that progress through life’s pain can be redeemed through our body’s ability to surrender, our psyche’s ability to make sacrifice, our mind’s ability to understand, and our Spirit’s ability to accept. For women, the pain of birth is often transcended by the experience of joy that accompanies new life and the empowerment we feel serving as the doorway to human existence.

I also believe that our progress towards a more evolved or spiritual state of being can be accelerated by our work with suffering. This can occur through our own suffering or through witnessing the suffering of others. After sitting with laboring women for over twenty years, I often found myself asking why women suffered in birth. I don’t believe that birth is inherently painful, but since it often is, I now ask “what is it that we learn from pain?” Birth teaches me that pain is a universal life experience; it humbles and softens us, opening the gates of compassion, empathy and understanding in ourselves as well as others. Birth teaches me that I can transcend the limits of my physical body, and that it is my willingness to accept my pain and surrender to its force, that is my ally in moving through it. Finally, I believe that pain is redeemed by our ability to “make medicine” out of our suffering, and that this ability lies at the heart of a spiritual response to suffering. I am grateful to be a woman who learned this wisdom as a mother and midwife.