DOULA ADVOCACY

Strategies for Consent in Labor and Delivery

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Introduction

I am a teacher of writing, a rhetorician, a feminist, a part-time doula, and, when I began drafting this chapter, I was pregnant for the first time. Before entering into this new subjectivity of “pregnant woman,” I believed that my education, professional experiences, and background would help me to navigate bureaucratic systems with more ease than some of my pregnant peers. My philosophy as a feminist, I thought, would help empower me to advocate for my best interests within these systems. Though nothing can replace first-hand experience of actually giving birth, I reasoned that my training and experience as a doula was educative and thorough. I was already familiar with childbirth: the stages, the behaviors, the sounds, the smells, the options, the common interventions and their outcomes, and the most common symptoms of fetal distress. However, even with this strong background knowledge, I could not successfully advocate for myself to have the kind of birth I would have liked to have had: a low-intervention homebirth.

My ideal birth was not some strange approach (not that there’s anything wrong with that). My heart’s desire for childbirth was fairly simple: It was informed by my past experiences and should have been available to me, but it was not. My own experiences illustrate that in childbirth, like so much of the lived, physical, female experience, options are limited, sometimes violently, by sexist bureaucracies and their practitioner enforcers. In this chapter, I look at the unfortunate link between violence and childbirth to theorize how doulas might employ rhetorical strategies to increase consent and to protect women from violence in the medical system. A central argument of this chapter is that excessive medical interventions can inhibit consent and that doulas can help women to resist such interventions. Those strategies are: birth plans and stories, dialogic communication and concordance, strategic contemplation and rhetorical listening.
Birth Violence and Consent

Historically, women have been consistently violated in the process of receiving medical care. According to Rich (1976), this violence stems from “patriarchal technology,” which “turned against woman her own organic nature, the source of her awe and her original powers” (pp. 126–127). Rich continues, “In a sense, female evolution was mutilated, and we have no way now of imagining what its development hitherto might have been; we can only try, at last, to take it into female hands” (pp. 126–127). In the hands of well-trained doulas (traditionally female), the childbirth experience might be much less violent.

From my experience, I know that many doulas in my community have witnessed women being told not to push because the doctor was not yet present. Worse, there are many stories of doctors holding the baby in until a woman agrees to comply with the doctor’s proposed interventions. Commonly, a woman is laboring on her side or on hands and knees, and the doctor will ask her to move to her back—a position known for increasing pain in labor and inhibiting the benefits of gravity. When the laboring woman, in the final stages and pushing with contractions, doesn’t comply, the doctor holds his hand to the woman’s vagina and holds the baby’s head in until she agrees to move into a position that is easier for the doctor. Several doulas in my community refuse to work with providers who regularly employ these violent tactics, but these are exactly the circumstances in which a good doula’s presence is especially necessary. In the blur of childbirth, some women do not recall the violence, whereas doulas stand as witnesses, and they can and do share their experiences.

Many women are so used to having their bodies manipulated without their consent that they fail to experience these violences as violences. Additionally, if a woman experiences birth trauma, such as an episiotomy without her consent, frequently the care provider only has to say that the baby’s life was in danger to quell any arguments or concerns that the new mother might have. What may seem horrific to a doula or birth worker who knows better might seem normal to a woman who has never experienced or witnessed childbirth. Of course, birth is intimate and somewhat unpredictable; there exists a wide margin for a “normal” childbirth experience. This reality poses a challenge for medical establishments, which increasingly rely on tools such as algorithms and protocols for decision-making. No doubt these save many lives from human error, but they also mean that women in labor, during what is a deeply physical, intense, and varied experience, are subject to hospital procedures that may or may not serve their unique experience.

Often, hospital protocols take precedence over the wishes, desires, and even consent of the patient. Anthropologists like Davis-Floyd (2003) have argued that in a “technocratic mode of care … the human body is a machine,” and “[w]ithin the techno-medical model of birth, some medical intervention is considered necessary for every birth” (p. 185). Seigel (2014) puts it another way:
The role of the user of the technological system of prenatal care—that is, the pregnant woman—is to work at disciplining her body and practices in accordance with public pregnancy narratives and to submit to the authority, guidance, and surveillance of medical professionals.

(p. 13)

When rigid protocols and medical interventions are considered a necessary and routine part of the childbirth experience, the wishes of the patient are not prioritized. Wertz (1977) noted the benefits of movement during childbirth and the difficulties women might experience in contemporary birth postures: “Pain seems to be greatly reducible when persons are free to move their bodies to find a more comfortable position. For the restrained, body pain can be excruciating. Yet the modern delivery table prevented women from adjusting their position” (p. 197). Likewise, certain routinely used medical interventions, such as IV drugs like epidurals for pain, put women at a “fall risk.” Once they’ve been administered, women have to stay on the bed, further limiting their mobility and, thus, the ability to get more comfortable during childbirth.

Kitzinger (2015) argues against unnecessary medicalization of childbirth. Kitzinger found that “behavior in hospitals is not always as rational and scientific as it seems and that a lot of action is heavily ritualized” (p. 167). In order to avoid the negative practices in hospitals:

Women choose homebirth largely because they wanted to be protected from interventionist obstetrics, could have one-to-one midwife care from someone they knew, and thought that they could bond more smoothly with their babies in a setting where stress was reduced.

(p. 167)

In that regard, depending on the care provider, women might also be safer from unnecessary interventions into the natural process of childbirth in a home birth. An example of an unnecessary intervention is the “husband’s stitch” (p. 71), a practice that is still used today wherein doctors stitch up episiotomies and tears beyond the cut or tear in order to make the vaginal opening smaller, theoretically improving sexual enjoyment for men, but increasing sexual pain according to many women—including Kitzinger, who had the “husband’s stitch” against her wishes after her first birth.

The “husband’s stitch” is a strong example of why advocacy and strategies for consent are needed—women need to be protected in the vulnerable space of labor and delivery—especially in a culture that understands the value of technologies and bureaucracies better than it understands that individuals have a say in what happens to their bodies. To address this injustice, birth doulas—often invited to be present at hospital births—are in particularly advantageous roles to function as mediators for consent within the medical industrial apparatus and to
offer rhetorical strategies for maintaining consent during childbirth. Doulas can employ the following rhetorical tactics: encouraging the writing of birth plans and birth stories, dialogic communication and concordance, and strategic contemplation. These moves could help women by promoting consenting exchanges between patient and healthcare provider. Each will be explained in turn in the following section.

**Birth Plans and Stories**

One rhetorical means of facilitating consent during labor and delivery is through birth stories. Sharing narratives function to increase birth literacy which, in turn, empowers interlocutors. Lay (2000), for example, argues that women use “one another’s birth stories to enhance their understandings of their craft, to debate proper procedures and interventions and, where possible, to find common ground with other practitioners” (p. 68). Hensley Owens (2015) writes about childbirth as a way to regain power in what feels like a very disempowering system. She begins by telling the story of her own birth, which almost occurred in a Volkswagen bus because the actors involved failed to take her mother seriously. She writes that her mother had to assert “her rhetorical agency twice before anyone … fully believed or acted upon the message that she was in labor” (p. ix). Stories of this nature pervade narratives of the childbirth experience, illustrating just how little women are trusted to make decisions, to trust experience—even when it comes to the childbirth that is happening to their own bodies. Hensley Owens writes, “Women absorb, respond to, and share many kinds of childbirth stories, with a variety of rhetorical and material effects that extend far beyond childbirth itself” (2015, p. x), making birth plans a feminist rhetorical act. Yet, she notes that attempts to reclaim agency do not always work in childbirth, and she considers this a failure of feminism (p. 10). Not only are women routinely met with skepticism or distrust, the authority of the doctors and science consistently outweighs the authority of a woman in labor. Doulas are a promising space to think through how women might overcome seemingly insurmountable obstacles to being taken seriously as rhetorically authorized subjects in labor and delivery.

Hensley Owens argues that birth plans (many of which are now shared via online forums) are an attempt for women to regain power in childbirth. She claims they are an example of attempted feminist rhetorical agency—“attempted” because the outcomes are not always “positive” in that women are sometimes (often) still disempowered during childbirth: “The genre of the birth plan is relatively new and has fairly explicit rhetorical intentions: women write birth plans to claim agency, to some extent, over the circumstances of labor and delivery” (2015, p. 39). She later adds, “Birth plans, a written form of resistance, work together with women’s voices to codify particular resistances” (p. 88). Birth plans help facilitate consent and agency. The emergence of the birth plan as a
genre indicates a reclaiming of agency in the childbirth process—a process that has been too often removed from women’s wisdom and experience and replaced with medical authority. If birth plans work not by giving women stronger agency, but by educating women on their options, doulas strengthen this outcome and make it more likely that women will take what they learn and insist on the kinds of birth experiences they wish to have.

**Dialogic Communication and Concordance**

Segal (2008) offers “concordance” as a way of navigating the healthcare system in general, and the strategy can especially be applied to medicalized childbirth. Segal reminds us,

> We have not … really received *orders* from our doctors; we have received *advice*. We stand, then, needing to be persuaded. … We may cooperate more readily when we participate in decision-making and when prescriptions accord with our health beliefs.

*(p. 149)*

In this way, Segal uses a rhetorical strategy to help patients move from strict compliance to the system’s rules, toward concordance, a two-way agreement on how to proceed.

This type of agreement is necessary because currently, too often, women are not consenting to these procedures. Wolf (2001) recalls an interview with a midwife who said,

> I have never yet seen a physician show the respect of informing a woman of what is required—“I need to do this procedure”; instead they just cut, often without even telling the woman—sometimes when the baby is just about born; sometimes the husband is shouting for the doctor to stop. Many women find this cut the most traumatic part of the birth. Yet episiotomy is seen in the same light as taking a temperature—it’s that routine.

*(p. 193)*

In fact, over time, my role as a doula has increasingly become one of advocacy; I help facilitate consent. Perhaps there is no other place where women’s bodies are physically acted upon than in a typical hospital setting during childbirth. It is not uncommon for nurses to approach a woman, stating, “Let’s get an IV in you.” Proclamations are made: “We need to break the bag of waters,” “We might need to section her,” and “Up the pit” are all common phrases heard throughout the labor and delivery floor. These phrases or commands do not allow for dialogic communication or concordance, which involves a mutual decision about the care plan and procedure. In part, this happens because the process is oftentimes so very
routine for these workers. But, it’s also because the US medical apparatus often
wields unchecked power resulting in the objectification of women’s bodies.

Too often in medicalized childbirth, individuals lose sight of their own autonomy. It makes sense that one weighs their own personal desires, gauges their own personal bodily risks and benefits along with the suggestions of the practitioner, even as they are informed by the larger bureaucratic medical institution’s policies. Doulas can facilitate concordance by clearly asking questions of both the care provider and the patient.

**Strategic Contemplation and Rhetorical Listening**

In addition, strategic contemplation is a rhetorical strategy that “allows scholars to observe and notice, to listen to and hear voices often neglected or silenced, and to notice more overtly their own responses to what they are seeing, reading, reflecting on, and encountering during their research processes” (Royster, & Kirsch, 2012, p. 85). A doula’s role here can be in witnessing, supporting, sharing stories, and facilitating the meaning making of it all.

Similarly, Ratcliffe’s (2005) “rhetorical listening” is a rhetorical techne that can be used to facilitate consent in medical situations, especially childbirth: “Rhetorical listening may be employed to hear people’s intersecting identifications … the purpose being to negotiate troubled identifications” (p. 18). Certainly, there are “troubled identifications” between the actors (patients, midwives, doctors, bureaucracies, etc.) involved in the medicalized childbirth setting. Ratcliffe’s rhetorical listening functions to facilitate “productive communication” (p. 25). Rhetorical listening is a strategy that is often used for those seeking to improve communication. After all, those who are most disadvantaged by a communication are most likely to seek improved communication through rhetorical strategies, and those people tend to have less power in the rhetorical exchange. So, many of the rhetorical strategies that are available as means of effective communication are not used by those who need it most (medical doctors) or entities with the most power (medical institutions). Instead, the burden and risks involved with communication in medical settings lies more with the patient.

A kind of reciprocal communication is required for rhetorical listening. If one side of the conversation has less incentive to create effective communication, as is the case in medicalized childbirth, the communication will obviously be less effective. Those entities with more power (such as medical establishments) do, however, have some incentive for communication in order to establish a good reputation, avoid litigation, and improve birth outcomes, for example, and that incentive needs to be amplified in these rhetorical communications. As such, the effective use of dialogic communication (Kent, & Taylor, 2002), wherein every relevant channel is negotiated, can be an effective strategy for facilitating consent.
How Doulas Might Employ Rhetorical Strategies for Consent

Doulas can employ these rhetorical strategies in the childbirth setting. Birth doulas provide non-medical labor assistance to women during childbirth. Although doula work frequently entails comfort measures such as counter pressure, massage, and words of encouragement, increasingly, because consent is not well understood, the doula’s role is also one of advocacy. Doulas can teach and enable conversations that cultivate an ethos of consent within the medical industrial complex and more broadly. In doing so, they can create a cultural shift in how women navigate healthcare systems.

In a more traditional doula relationship, doula and client have educational meetings and bond to some extent in advance of labor and delivery, and the doula typically meets with the woman at least one more time postpartum. In this traditional relationship, the doula can better manage the channels of a dialogic communication, which unfolds over time. The doula is well aware of the patient’s background and can best help facilitate her birth plan during childbirth. Because consent is often not implicit or widely practiced, this doula work provides a critical avenue for understanding and facilitating an ethos of consent for these women during labor and delivery. In addition to traditional comfort measures, doulas now have an important role in making consent a key aspect of a feminist medical rhetorical practice.

When one sees women’s bodies as people with agency and is concerned with consent, these phrases and mandates change their tone and purpose to become actual questions for the patient, which she is at liberty to answer truthfully. In a consenting exchange there are at least four parts: the provider gives information about the procedure, they give an explanation of why the procedure is recommended, space is provided for questions or concerns, and finally request for permission to proceed is made.

Like the earlier example of the doctor who gave the woman an episiotomy despite her pleas, I have witnessed similar violations where consent was not established. In fact, one must only attend a few labors before witnessing these grave violations. Imagine supporting an unmedicated, laboring mother, who had an episiotomy without her consent just before the baby was born. The laboring mother has requested no medicine and no episiotomy in her birth plan. In the intense final moments of childbirth, the midwife engages the husband in eye contact, lifts the scalpel, and raises her eyebrows as if to ask, “Is this ok?” The worried husband, clutching his partner’s leg, nods approval, though he knows his wife wanted to tear if necessary, instead of sustaining a surgical cut. He thinks this must be the only option. Consent has not been sufficiently established. The perineum is severed, and the baby is born after a few more pushes.

As a doula, my job is also to help women process their birth, and their trauma if necessary, but not to introduce trauma. Afterward, using strategic contemplation, I can ask the woman how she felt about her delivery. She is usually obsessed
now and smiling at her new baby; she is happy. So, although I might know, as a trained professional, that the midwife should have gained consent before administering the episiotomy, if the patient was not disturbed, I will not introduce trauma by bringing it up. Commonly, these types of traumas sink in over time, as strategic contemplation occurs, and women are able to process their birth. Often, they realize that things could have and should have been different.

Although doulas do not provide medical advice or administer any medical procedures, they can and do try to catch an unconsented procedure before it happens. When the midwife has the quiet exchange with the husband to indicate that she is about the cut the woman, a doula can advocate by saying, “It looks like you’re considering an episiotomy,” to the midwife. Then, the doula will turn to the patient and say, “It looks like they’re considering an episiotomy. Would you like to discuss your options?” Sometimes the woman reaffirms that she does not want the episiotomy. Other times she agrees to the procedure, usually in no condition to “discuss.” Frequently, and ideally, this intervention slows down the process. A conversation (although it may be brief) can happen and concordance can occur. An opportunity to establish consent emerges, and either way, the woman usually leaves her childbirth experience feeling more empowered and less traumatized than if she had been acted upon physically without her consent during her delivery.

Wolf (2001) argues that “The medical establishment too often produces a birth experience that is unnecessarily physically and psychologically harmful to the women involved” (p. 6). In her study, “A number of women who had given birth described a moment at which they felt the medical institution simply took over; oblivious to the mother’s wishes, experience, or concerns” (p. 149). She continues, “I heard comparable ordinary traumas among many women I talked to—what I have come to call ‘ordinary bad births’” (p. 145). Wolf’s antidote to birth violence is midwifery care. She writes, “Midwives working on their own terms do not try to guide births along a path determined by unnecessary medical interventions. Rather, midwives wait, encourage, and prepare the way, successfully keeping medical intervention to a minimum” (p. 151). In fact, Wolf likes the birth center setting, where women have more time for nurturance, and dialogic communication is a key aspect of the exchange. Wolf is emphatic: “Women carrying babies must be nurtured and supported intensively” (p. 114). In the birth center, women often have access to both a more woman-centered delivery, but also more extensive medical intervention. However, Wolf warns against in-hospital midwives and birthing suites, which she argues serve as a kind of bait and switch and essentially have the same or similar outcomes as birthing in a typical hospital. The hospital’s protocols are so rigid that very few women are actually able to labor within the institution’s guidelines and end up delivering in Labor and Delivery, with a midwife who has to proceed very much like an OB and where the risk of cascading interventions is just as high.
In Wolf’s own experience, she started in the birthing suite, but her birth eventually escalated to a cesarean section in an operating room. During her second pregnancy, her doctor said, “You had to be sectioned last time. You probably have an unusually narrow birth canal. Maybe your body just is not made to have babies.” She continues, “my doctor wanted to be right about my being in need of his surgical help more than he wanted to heal” (p. 278). Thus, she illustrates once more the need for a strategy for consent and advocacy within a system that so typically distrusts and disempowers women’s bodies.

**Rhetorical Strategies in Action**

I became pregnant after several years of volunteering as a doula and working on scholarship in feminism and the rhetoric of health and medicine. I offer parts of my birth story in this chapter to demonstrate how these rhetorical strategies can play out.

After a positive pregnancy test, I called my OBGYN, a woman with whom I have a good rapport and whom I have seen for several years. During that first phone call, the office staff told me they needed bloodwork to confirm my pregnancy. Once my pregnancy was confirmed, I had a first appointment where I was told I would have various screening tests. I would also be given an ultrasound to confirm the pregnancy and ensure it was not ectopic. None of this seemed necessary to me. I felt healthy and normal and pregnant. I also felt excited. I wanted to talk to someone about the strange new feelings in my body and my hopes and expectations for this journey. I thought my OBGYN would be the perfect person for this conversation.

At my early OBGYN appointments, despite my work in advocacy and consent, I already found myself compromising and feeling the need to “go with the flow” at the OBGYN’s office, such as submitting to blood tests. I did not want to establish myself as a difficult patient. After all, maintaining a positive relationship with my doctor could improve the care I would receive during a time when so much was at stake.

At the appointment, I told nurses that I was opting out of the ultrasound. Even still, the OBGYN’s routine was entrenched, and she assumed the normal practice of bringing the ultrasound machine into the room. Despite my declining of the ultrasound, the doctor continued into the room with the machine. She explained that she needed to confirm my pregnancy, my due date, and that the pregnancy was not ectopic. I told her I did not think those steps were necessary for me, and I wanted to skip them. Immediately, I felt at odds with the establishment. I was astonished by how hard I had to work to maintain a positive interaction while advocating for my wishes.

I also revealed my hope for childbirth: If all went well, I would labor and deliver my baby at home. However, having attended several births lasting more than a day, I was also well aware of some of the benefits of epidurals and other interventions in long labors. I wanted to have access to that care if needed.
one hand, if my labor lasted 8 to 10 hours, progressed steadily, and if I was managing the pain well (something I had frequently observed as a doula), why not stay in the comfort of my own home with a midwife, eating my foods, using my bathroom, and avoiding the cascade of interventions that can occur in a hospital?

Knowing that induction increases the rate of cesarean section and that first-time moms gestate on average for 41 weeks and 3 days, I asked how long I could be allowed to gestate in her care. She answered that after 41 weeks I would be monitored daily and possibly allowed to go as long as 42 weeks, though I got the distinct feeling this almost never happened. However, throughout the appointment, I was repetitively warned against the dangers of my pregnancy with comments such as “your placenta just gets too old and can’t sustain life at that point.” In this way, the OBGYN used our appointment time to warn against the dangers of pregnancy and childbirth, reaffirmed that she was uncomfortable with homebirth, and even shared a few horror stories. Generally, no person is more concerned with the health and welfare of their baby than the parents, and healthcare professionals need not spend so much time fear mongering pregnant women. For the most part, pregnant women are trying to make the best decision for themselves and their babies. The new flood of hormones that sustain pregnancy also tend to make women hypervigilant about safety and possible dangers. Warnings from healthcare professionals about everything that can go wrong can come across as emotionally manipulative. With this pressure, I could not establish the kind of dialogic communication that I hoped for.

It is true that many women enter childbirth with fears of hospitals or needles, or they worry that something bad will happen to their babies or worry about pain. After my experience as a doula, my biggest fear is of being violated by medical interventions with and/or without my consent. That is by far the most common trauma I have witnessed and the one I wanted to guard against if at all possible. Yes, things go wrong with the body, but in my experience, things go wrong through intervention far more frequently. Fears are not always rational, but research bears this out—many European countries have far better outcomes with fewer interventions.

Therefore, after my first interactions with the OBGYN, I decided to establish a relationship with a well-known, highly recommended homebirth midwife who had all the necessary certifications and decades of experience. The appointments were hour-long, rambling sessions, where I sat on a comfortable couch. Concordance was much more achievable in this setting. For example, I was given several different options for taking the glucose test, a routine test to check for gestational diabetes, which otherwise involves drinking a glucose solution to achieve a hypoglycemic episode, as is the standard practice of care in more traditional medical settings.

However, to be fair, these appointments with my midwife were not perfect. In fact, she also shared horror stories, but they were less related to my choices and more relayed as interesting anecdotes. I still did not want to hear them and
sometimes had to remind her of that. However, it was much better than the chaotic, short visits at the OBGYN, where the predominant message was that the process of making a baby was dangerous.

During my fourth month of pregnancy, my OBGYN officially “fired” me. She said she was not comfortable with my desire for homebirth and was not willing to continue working with me if I chose to also see a midwife. My insurance paid 100% for the OBGYN and 0% for a midwife. My hope was to do some prenatal work through the OBGYN since the out of pocket costs for the midwife would have been prohibitively expensive. I could have proceeded with this plan unbeknownst to the OBGYN. She may have only noticed when I failed to show up for birth at the end. However, I was honest with her, and she refused to participate. My preference to have co-care throughout my pregnancy proved impossible, failing less than halfway through my pregnancy.

Accordingly, I now identify with Hensley Owens (2015), who writes about her own birth experience: “[T]he birth I wanted was most readily achievable at home … I wanted options that a hospital birth simply could not provide” (p. 147). She gave birth at home and says her own birth choices were deeply informed by birth stories shared by other women, in addition to the “sanctioned experts” (p. 160). Like Hensley Owens, I found that the best birth option for me was not available, and homebirth would come closest to meeting my preferences. Still, like many other women, I did not have the resources or health insurance coverages necessary to make that goal an option. Left with a hospital birth and all of its attendant interventions, I needed a doula to help me to craft the birth experience I wanted to have. That said, if doulas like my own were trained in the rhetorical strategies I describe in this chapter, perhaps my own birth story would be an even more compelling example of agency in labor and delivery.

In my recent experience giving birth, with the help of my own doula, concordance was achieved with almost every decision, and my labor and childbirth experience was mostly a positive, loving, and exciting time. Still, I struggled with having to wait to push to accommodate hospital staff shift changes. Doulas as advocates for women’s consent in birth, then, could be strengthened by strategic rhetorical work; this chapter is a move in that direction.

My own experience as a doula and new mother illustrate just how much agency and consent is lacking in the US childbirth experience, but it also shows how the use of rhetorical strategies can help to alleviate some of these issues. As Rich (1976) writes,

As long as birth […] remains an experience of passively handing over our minds and our bodies to male authority and technology, other kinds of social change can only minimally change our relationships to ourselves, to power, and to the world outside our bodies.

(p. 185)
My hope is that promoting doulas as advocates can decrease negative incidences in childbirth. Because not every birthing person has access to the rhetorical strategies described in this chapter, doulas and other birth workers can use them to increase birth literacy, to help establish true consent, and to eliminate trauma and violence in the childbirth setting.

**Note**

1 Throughout this piece, the term “consent” refers to any situation in which a doctor or medical practitioner would be expected to ask permission and/or discuss the consequences, risks, and benefits of a procedure with the pregnant or laboring woman.

**References**


