Birth and Death:

Reciprocal Relationships Between Society's Culture, Technology, and Industry

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Abstract

Over the course of several centuries, the procedures for birth and death changed as innovations in science and medicine developed to establish an industry of professionals employed for utilizing them. While reviewing how these procedures shifted and evolved, I've drawn parallels to suggest they have undergone similar changes, at similar rates, during the same time. Additionally, my research considers the steps taken to reclaim or reimagine birth and death procedures and frames these movements as reactions to the implications of standardized care. By drawing parallels between the evolutions of beginning and end of life practices in America and comparing the approaches of two modern professionals, my research builds on previous discussions by offering modern narratives.

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Chapter 1: Introduction

In recent literature by sociologists, anthropologists, historians, health policy analysts, and gender researchers; there is growing skepticism toward the dominant role of doctors and hospitals and their use of medical interventions for monitoring pregnancy and childbirth. Through processes known as **medicalization**, otherwise normal bodily processes, and states, such as pregnancy and birth, tend to be **pathologized** (*Inhorn, 2006*). Researchers conclude that such pathologization considers pregnancy and birth as events requiring routine medical management and intervention because they are understood and treated in ways similar to that of an illness or disease. As this paradigm of medicalization dominates our discussions and treatments of health and wellness, the opportunity for considering alternate concepts and models of care may be diminished. The researchers who criticize the standardized medicalization of birth often provide that this model is relatively recent in the long evolution of American birthing practices. Previous and long-lasting models for birth were once centered at home and managed by small networks of women whose assistance rarely intervened in the natural progression of labor and delivery. This model relied on the knowledge and experience of women rather than the expertise of physicians who, at the time, were predominantly male. Additionally, this early model embraced the biological process of labor and delivery, as they naturally occur and did not seek to alter it. However, without medical interventions that eventually allowed safer experiences of childbirth, pregnancy and birth were long considered dangerous times as the rates of either resulting in morbidity or mortality were high (*Kaplan, 2017*).

Similar to the way that early American births were centered at home, the arrangements for early American funerals and memorial services were also once centered at home. For a long time, funeral preparations were handled by female family members and rituals were observed in

accordance with the natural process of decomposition. Unlike modern procedures for death that employ professionals to handle, and significantly alter, bodies of the deceased -- early procedures made interacting with death, in its natural state, a commonplace experience.

Over the course of several centuries, the procedures for birth and death changed as innovations in science and medicine developed to establish an industry of professionals employed for utilizing them. As these changes culminated, they grew to be multifaceted forces that still inform and negotiate how American individuals experience, observe, and interact with occasions of birth and death.

As the abilities and trust in professionals expanded in the 19th century, practices for birth and death shifted away from their tradition of being centered at home and managed by non-professionals. By the 20th century, birth was viewed as a medical event that primarily took place in hospitals where predominantly male professionals monitored and intervened. In the same timespan, roles for handling bodies of the deceased and producing funerals and memorial services were assumed by professional authority and took place outside of family homes.

As the percentage of medicalized births taking place in hospitals increased, physicians assumed the dominant authority over childbirth. As many researchers contextualize it, this authority arrives significantly at the expense of women's practical knowledge and experience being discounted or ignored as their traditional domain was lost (*Woliver & Kevin, 2006*). By examining the early power struggles between male medical experts and low interventionist female birth attendants, researchers reveal a history of childbirth that is relevant to studies of gender roles and gender equality. Additionally, it reveals how the spread of medicalization altered our concepts of pregnancy and birth to be understood as events requiring management by professionals with medical expertise.

The literature review in chapter two provides a brief and chronological overview of how American practices for the beginning and end of life events shifted in similar manners between the 18th and 20th centuries. The methods and results sections, found in chapters three and four, present conversations with two professionals about their respective careers relating to either birth or death. These sections, as well as the discussions and conclusions following in chapter five, explore their professional insights on opportunities we lose to standardized care. These sections also explore the approach that these professionals take to intentionally reclaim experiences of birth and death and allow them to be opportunities for empowerment.

Ultimately, my research considers the steps taken to reclaim or reimagine birth and death procedures and frames these movements as reactions to the implications of standardized care. By drawing parallels between the evolutions of beginning and end of life practices in America and comparing the approaches of two modern professionals, my capstone builds on previous discussions by offering modern narratives.

Chapter 2: Literature Review

Changes Among the Rituals, Technology, and Industry of Birth

> *"By understanding childbirth, we can understand significant parts of the female experience. Of course, childbirth, like other human activities has not remained static over the course of history, nor has women's relationship with childbirth remained constant. Both have undergone significant and revealing changes.."*
>
> *- Judith Walzer Leavitt 1986 Brought to Bed*

Introduction

In Judith Walzer Leavitt's (1986) research, she uses women's diaries and letters as well as physicians' letters and debates on medical techniques to blend the medical and social history of birthing in America (Rosner, 1987). In the two-hundred-year period examined by Leavitt (1986), she illuminates how the power dynamics between childbearing individuals, female midwives, and physicians have shifted as a result of advancing technologies, professionalization, and creation of industries relevant to childbirth. In her discourse, Leavitt (1986) emphasizes the historical role of women as " the most active agents of change" in birthing practices. However, she more convincingly demonstrates that birth experiences can be framed as negotiations informed by our society's cultural preferences, available technology, and medical industries.

Early Models of Birth Prior to the 18th Century: *Relied on Women's Knowledge and Rarely Intervened in Labor's Natural Course*

The vast majority of births in early American society took place at home. The care provided to support pregnancy, labor, delivery, and postpartum care was learned, taught, and managed by women and female midwives. Men rarely played a role in home birthing rooms or

practices because, unless women were not available, their presence was excluded until after delivery. Supported by a small network of female friends, family, and midwives; birth traditionally took place in female-dominated spaces. No formal training programs, curricula, licensing processes, or other official standards for birth attendants existed until the 18th century. Instead, the skills and strategies for supporting births along their natural course were passed along through generations of women through practical experience. By attending births in their family and community, delivering their own children, or through loose apprenticeships with already established midwives, women assumed the authority over birth (*Kaplan, 2017*).

Midwives and other non-physician birth attendants, intervened as minimally as possible and worked to assist labor along its natural course. Male physicians were invited only in emergencies if their intervention was deemed appropriate for reducing an individual's risk or complication. Otherwise, "normal" or healthy births rarely sought services from male physicians and instead relied on the superior knowledge, experience, and support of female midwives and other women in their network. Even when male physicians were present at home birthing rooms, their role was subordinate to women's larger presence and authority. Prior to the 18th century, physicians were exclusively male and lacked practical or theoretical preparation for assisting in labor and delivery. When called upon by women and midwives to assist in emergency cases, physicians too often arrived with no prior birthing experience, not even as a mere witness.

Until later technology, medicine and professionals initiated radical change; pregnancy, labor, delivery, and postpartum were frightening and highly dangerous times for mother and child (Kaplan, 2017). Early writings reviewed by Leavitt (1986), reveals that women spent considerable amounts of time anticipating and/or accepting childbirth as a painful, dangerous, and potentially fatal event. High rates of life-long morbidities or maternal mortality resulting

from birth left many women fearing what seemed inevitable. Women who did survive childbirth and the postpartum period often experienced vesicovaginal and rectovaginal fistulas from unrepaired lacerations or infections. The resulting lifelong incontinence (loss of bladder control) and vaginal, cervical, and perineal prolapses of these fistulas caused painful sexual intercourse and difficulties with future pregnancies (*Kaplan, 2017*). In one journal from 1885, a woman wrote “Between oceans of pain, there stretched continents of fear; fear of death and a dread of suffering beyond bearing” in anticipation of her third birth (Leavitt, 1986).

Slow Shifts Begin the Early 18th Century*: Dynamics Change as Male Physicians with Increasing Abilities are Invited into Birthing Rooms*

As many women found pregnancy, labor, delivery, and the postpartum period to be overwhelmingly difficult and dangerous, they united in this experience to offer strength, support, and strategies for enduring natural births with minimal interventions. However, by the early 18th century, the expanding abilities of male physicians offered new options for increased medical intervention. These innovations were promised to improve women’s birthing experience as well as reduce the high rates of maternal morbidity and mortality (*Kaplan, 2017*).

Leavitt (1986) theorizes that by the mid 18th century women’s control over childbirth practices faced opposition for the first time as a result of these spreading medical models. She suggests that male physicians, who equipped themselves with new instruments and drugs to increasingly attended “normal” labor and delivery, threatened women’s traditional authority with their growing ability. Physicians, who initially faced a disadvantage for commanding authority in home birthing rooms, armed themselves with stronger strategies of professionalization through increased practical and theoretical obstetric training. As a result, medical professionals were able to gain authority over this realm of women’s health where they previously could not.

Middle of 18th Century: *Male Physicians Assume Dominance Through Strategies of Professionalization*

Female midwives and non-physician birth attendants maintained their presence in home birthing rooms through the 18th century. However, their authority now competed with that of male physicians resulting in a power struggle that was arguably gendered. The introduction of new technologies and professionals in the mid 18th century also spread a significant attitude that childbirth can be "manipulated and altered according to specific activities planned and executed by experts" (Leavitt, 1986). Physicians, who were exclusively male, promoted their expertise and practices as safer, less painful, more convenient, highly sophisticated, and modern in comparison to past conventions performed by female midwives. To assert their dominance, male physicians actively distinguished their practices from those of "outdated" female midwives and even barred them from receiving formal education when obstetrical programs and curriculums were established.

"In 1762, Dr. William Shippen, Jr. of Philadelphia, after training in midwifery in London and Edinburgh, became the first American male physician to establish a normal obstetrics practice in the US. Shippen also pioneered formal midwifery education through a lecture series initially taught to both male physicians and female midwives, but later limited to male physicians. Other male physicians subsequently offered courses in other large American cities, and medical schools progressively incorporated obstetric education into their curricula" (*Kaplan, 2017*).

Accelerating Changes by the 19th Century: *forceps, anesthesia, and antiseptics*

As the number of physicians formally trained in midwifery and obstetric science increased through the 19th century, the wealthy, urban elite—who perceived male physicians as

superior in education and training—were progressively more inclined to pay the higher physician fees (*Kaplan, 2017*). Presuming that a physician's modern interventions would result in a safer and more comfortable experience, the popularity of physician-assisted births increased. A physician-assisted birth, as it was more expensive, also served as a marker of status and wealth for those who could afford it.

The most radical interventions employed by early 19th century physicians were the use of instruments (such as forceps for obstructed labor), bloodletting to relieve pain and accelerate labor, Ergot to stimulate contractions, and drugs (particularly opium) for pain relief (*Kaplan, 2017*). However, the new techniques initially caused as many issues as they aimed to resolve (*Kaplan, 2017*). Physician's hands were relatively inexperienced and no standard regulations existed for how or when each intervention ought to be employed. Despite ongoing debate in the medical community, many physicians distinguished themselves from low-interventionist midwives by routinely utilizing interventions in every delivery. As a result, individual practices differed substantially and interventions were frequently caused more problems. For example, physicians used forceps routinely in every delivery and misapplication resulted in increased perineal lacerations, uterine trauma, and fetal defects (*Kaplan*). Through the 1920s, mortality rates for midwife-assisted and physician-assisted births remained similar, with physician-assisted deliveries often faring worse (*Kaplan, 2017*).

The Civil War's impact was felt in all aspects of American life including changes in transportation, communication, urbanization, and particularly in medicine. Perhaps the most relevant of these was the invention of anesthesia which changed both battlefield surgery and childbirth (*Aldin, 2001*).

As with the early use of forceps, the use of anesthesia was not regulated. The appropriate qualifications for the use and dosages of anesthesia were debated tremendously and practiced inconsistently. Consequently, improper anesthetic use caused numerous complications, particularly prolonged labor due to decreased ability of the uterus to contract, breathing difficulty in newborns, and hemorrhage (*Kaplan, 2017*).

However, once offered the radical prospect of pain-free childbirth, an "immediately vocal" contingent of American women embraced and advocated for the use of pain-relieving drugs in their deliveries. As Judith Walzer Leavitt (1986) concludes from her readings "next to the fear of death, pain was probably the single part of birth most hated by birthing women."

After the first public demonstration of ether in 1846 by dentist William Morton at Massachusetts General Hospital in Boston, Fanny Appleton Longfellow was the first woman to use it during childbirth in 1847, writing "I feel proud to be the pioneer for less suffering for poor, weak womankind. This is certainly the greatest blessing of this age" (Kaplan, 2017).

Due to the limitations and risks of various early drug cocktails, women demanded and their physicians searched for a superior anesthetic. In the early 20th century, Austrian and German physicians—followed by American physicians a few years later—began experimenting with a combination of scopolamine and morphine in childbirth. Alone, scopolamine acts as an amnesiac, erasing all later memory of childbirth. Given with an opiate, it also has an anesthetic effect. Scopolamine-morphine, named "twilight sleep," permitted the patient to be semiconscious with intact contractions during labor, allowing the physician to coach the woman through childbirth without her remembering the experience afterward (*Kaplan, 2017*).

"From 1914–1915, the National Twilight Sleep Association—organized by wealthy upper- and middle-class women and led by prominent leaders such as Dr. Bertha Van Hoosen in

Chicago and Mrs. Francis X. Carmody—advocated relentlessly for physicians and women to adopt twilight sleep, which allowed painless childbirth. In the words of Mrs. Carmody: "the twilight sleep is wonderful but if you women want it you will have to fight for it, for the mass of doctors are opposed to it" (*Kaplan, 2017*).

The use of twilight sleep faced widespread controversy in the medical community for its enormous discrepancy in practice. Despite the drug's amnesic effects, women under scopolamine still experienced intense labor pains with screaming. Women receiving twilight sleep often thrashed so much during labor that they were placed in "crib beds" to avoid accidents (*Kaplan, 2017*). Inappropriate use of the drug by physicians frequently led to adverse events, including maternal delirium and the asphyxiation of newborns (Kaplan, *2017*). By 1915, the twilight sleep movement sharply declined in popularity.

The Next Big Push: *Hospital births become routine in the 20th Century*

Although the twilight sleep movement was brief, the appeal for a painless delivery remained as a long-lasting motivator for radical changes to birthing experiences. Women and physicians remained determined through the 20th century to seek drugs and other means that ensured childbirth would be as painless and convenient as possible. This attracted many women, who would have otherwise chosen home births, to choose a physician-attended and increasingly medicalized hospital birth. Additionally, as infection had long been a leading cause of postpartum death or complication, the sterile and standardized environment of hospitals were increasingly encouraged and preferred by the 20th century. Despite movements and protocols established for promoting infection control in home birthing rooms, it was difficult for a patient's home and non-hospital birth attendants to compete with high standards of hygiene promised in hospitals.

Thus, to avoid the numerous complications of unregulated home procedures relating both to hygiene and proper use of increasingly desired interventions, childbirth shifted away from its traditions as a home-centered and female-controlled domain. By the 20th century, Americans primarily chose to deliver in standardized institutions where their childbirth would be increasingly monitored and medical interventions would be performed by predominantly-male professionals. Despite the promise of hospital births as safer, the numerous advances in obstetric medicine in the 19th and the first decades of the 20th century did not immediately translate to improved safety during labor and the postpartum period. There was no decrease in maternal mortality between hospital and home births until the 1940s.

Changes Among the Rituals and Industry of Death

Research by Virginia R. Beard and William C. Burger (2017) provides a historical overview of how the modern concept of a "traditional" funeral developed to routinely include embalming, caskets, spiritual services, viewings of the deceased, cemetery burials, and a reliance on professionals. Their research provides evidence that these rituals and the industry around them culminated as a result of technological and scientific advancements realized during the Industrial Revolution, the necessity of changed death protocols during the Civil War, an increase of economic affluence in American society with a corresponding desire to display status, and finally by cultural shifts in attitudes regarding death.

Early Funerals Prior to the 19th Century

The authors report that in early American society, most funerals were short events, handled by the family of the deceased that included direct burial in a simple wooden casket without embalming (*Beard, 2017*). This may be explained by shorter life spans causing deaths to occur too frequently to have lengthy and expensive rituals for each family member.

In the early days of New England settlement, funerals did not have a religious component because the Puritans did not want to emulate services held by Catholics. Women of the time were responsible for preparing the home, preparing a feast, and preparing the body for burial. The most expensive component of a funeral was often food and drink.

By the end of the 17th century, funerals became more ceremonial when ministers were invited to offer prayers and words of comfort to the bereaved and displays of wealth were incorporated. For example, the location of "interment" became a large signifier of class. Elites of the wealthier classes were inspired by English customs to be buried in churchyards with lavish headstones while others afforded less expensive burials in family-owned cemeteries with simple headstones. The type of hearse that carried the remains to the grave also served to display wealth.

19th Century Industrial Revolution: *New Railroads, The Civil War*

Early death, which was historically commonplace, became increasingly less so as a result of medical and technological advancements that accelerated by the 19th century. Death became a less routine event due to the eradication of many diseases, better hygiene, and longer life spans. Mobility also increased with the invention of railroads that served to spread families across the country. New manufacturing processes allowed for the creation of metal caskets that offered the body protection from the natural elements and prevented by-products of decomposition from leaking into the ground. This was assumed to promote environmental and public health.

As a result, funerals became more ritualized and increased in length as families gathered from greater distances. Embalming was also rediscovered during the Industrial Revolution when new chemical compounds were introduced and their use became widespread during the Civil War. Options of embalming became a widely accepted solution to complications that emerged when handling the remains of soldiers who died far from home. Prior to embalming, bodies were

shipped in airtight metal caskets but this method was problematic because they did not protect against degradation in transit. The decaying body released gasses into the confined airtight space and frequently caused explosions. The practice of embalming gained further popularity after the embalmed body of the assassinated President Lincoln was shipped over 1,600 miles and viewed by millions of citizens, while it remained largely intact (Beard, 2017). The acceptance of embalming provided an opportunity for viewing the body prior to its final disposition and remains a ritual of many funerals today.

The rediscovered practice of embalming and its eventual routine use not only provided a new ritual and view of death (literally), it also created a new profession. A previously uncommon practice provided only by specially trained surgeons, was taken over by undertakers whose previous role was transporting, literally undertaking, the body. New schools called mortuary schools were established to train these new professionals in various funeral preparations and services. By the end of the 19th century, most American states had regulations and licensing requirements for professions.

The historical context demonstrates that changes to funeral rituals were gradual in the 17th and 18th centuries and accelerated through innovation and professionalization by the 19th century. In order to analyze the motivations for these changes, the researchers identify culture and business as significant forces to be considered. Their findings illuminate the relationship between our society's culture, technological advancements, and industry as reciprocal motivators changing the way we observe death. Meaning, that the conventions created by each of the three forces: culture, technology, and industry, are motivated and served in response to the others. What happens after we die is a culmination of cultural preferences informed by the available technology and hinges on negotiations with an industry that seeks to stay relevant and profitable

while meeting consumer demands and cultural expectations. Many complain that the industry is significantly motivated by profit and largely operates in an unethical manner by "price gouging the bereaved." As the funeral arrangements available range in prices that can become exorbitant, distinctions based on socioeconomic status emerge. Other distinctions can result from cultural and religious customs that preside over the observance of death.

Chapter 3: Research Methods

Phase One: Reviewing Literature

To inform my research and discussion of birth and death in America, I reviewed literature by sociologists, anthropologists, historians, health policy analysts, and gender researchers. I utilized the SUNY Purchase Library database and interlibrary loan system to collect my sources. I used an array of relevant keywords in my search and I narrowed the results by their relevance to my focus, the quality of writing, and their status of being peer-reviewed. The literature review provided in chapter two is structured chronologically as it presents a historical overview spanning several centuries. It is further organized by subheadings to signify the time period, phenomena, or topic being discussed. The purpose of this section is to situate the reader by providing a synthesis of the history and discourses relevant to my topic.

Phase Two: Speaking with Professionals

To gain insight from contemporary professionals working with birth and death, I contacted a professional funeral director and a practicing doula. I became aware of these individuals and their work through my personal network as I asked friends and family if they know professionals in either of these fields. After receiving their names, I contacted each individually.

Contacting a Funeral Director

The first conversation I held was with Amy Cunningham, a New York State licensed funeral director and the founder of Fitting Tribute Funeral Services, an eco-friendly funeral firm in Brooklyn. Prior to our conversation, I reviewed her company's website which describes her as “specializing in green burials, home funerals, cremation services and memorial events of all

sorts." The website also presents her company and its services as providing a "welcoming and factual" resource for those facing death. Cunningham received a bachelor's degree in English from the University of Virginia, mortuary training from the American Academy McAllister Institute, and was certified as a home funeral guide by Jerrigrace Lyons and Olivia Bareham (*The Inspire Funeral, Website*).

I reached out to Cunningham by filling out a contact form provided on her website. I introduced myself as a student at SUNY Purchase College, hoping to have a conversation about professional work related to death. I told her that our conversation would serve as research for my Capstone. I provided her with a broad scope of topics that I wanted to discuss including but not limited to: the types of services provided by professional death/funeral planners, how one becomes qualified for this profession, how the cost and payments for these services are navigated, how these services interact with other institutions, and strategies for making these services accessible. Cunningham responded quickly, providing me with her personal contact information for further correspondence, and ultimately agreed to a phone call scheduled to occur on November 22nd, 2019 at 5:54 pm. This call lasted just under an hour.

After this arrangement was confirmed, I prepared specific questions and talking points to offer as a loose guide for our discussion. Although these initially steered our focus, I allowed the nature of our conversation to be flexible and equally guided by Amy's input. I encouraged this flexibility by modifying or improvising several questions, as we spoke, to reflect the information that Cunningham provided.

Contacting a Practicing Birth Doula

My second conversation was with Kendra Potter who currently practices as a DONA-certified birth doula part-time in Missoula, Montana. Potter received her certification by training

in New York City under Debra Pescali in 2009. Since then, Potter has assisted as a doula at many hospital and home births in both New York and Montana. To balance her other responsibilities as both a yoga instructor and mother of two young children, Potter attends fewer births per year than an average full-time doula. However, her credentials, vast experience, and insightful knowledge allowed her to discuss the nature of this work from a commanding standpoint.

After receiving Potter's phone number from a mutual friend, I reached out to her via text message and asked if she was willing to speak with me. Expressing an immediate and eager willingness, we quickly scheduled a phone call for the following morning. This conversation took place on January 10th, 2020 at 12 pm and lasted just under an hour.

I prepared for this conversation by revisiting the questions I'd asked Cunningham so I could update and repurpose them. This process created another loose conversation guide, consistent with the last one. Also consistent with my previous approach, I allowed the nature of our conversation to be flexible and equally guided by Potter's input. I encouraged this flexibility again, by modifying or improvising several questions, as we spoke, to reflect the information that Potter provided.

Chapter 4: Results

Conversation with a Professional Funeral Director

In my conversation with Amy Cunningham, she explained that the professional role of a funeral director ranges widely and has several sectors that she referred to as “trades.” She stated that every funeral director takes a different approach by choosing which parts of the profession to specialize in. Officially, Cunningham is a mortician but prefers not to use that title as she claims it is “old fashioned and too anatomical” for her liking. Unofficially, she refers to herself as an “agent of compassion” for New Yorkers who are facing death.

As a funeral director, Cunningham is responsible for keeping her phone handy at all hours of the day and night, never knowing when she might receive a client’s urgent call. The initial contact made between funeral director and client is commonly known as the “first call.” It can be made at a variety of moments leading up to or closely after an ended life. While some clients may call upon Amy’s service for advanced arrangements, others may require more immediate service. It is not uncommon for Cunningham to receive a client’s call just moments after a death has taken place.

For every type of call, Cunningham is prepared with strong sensitivity. This has meant arriving with flowers at hospitals or homes to preside over the body of the deceased, offering words of compassion and/or spiritual guidance to the bereaved, seeing that the body is safely transported, filing death certificates, helping to plan for burial and cremations, and producing all other funeral and memorial events.

Knowing that Cunningham was once a very successful journalist, I ask what led her to pursue the work she does now. Considering the education and training required to become a licensed funeral director, this career jump is a major commitment. However, it appears that

careers in journalism and funeral direction share considerable commonalities, as both are employed by a need for story-telling.

Cunningham provides that when her father died ten years ago, in the care of hospice, she and her family prepared a memorial service that left a powerful impression on her. Cunningham recalls that although she was grieving the loss of her 94-year-old father, she felt empowered by the ability to produce such a positive and creatively inspired experience. She felt that in every aspect, the arrangements were made exactly as they wanted and eased the grieving process. Taking place in Orangeburg, South Carolina, the arrangements were guided by the small community's local funeral director and Presbyterian church.

After returning to her home in Brooklyn, Cunningham realized how much of this experience was enabled by the sense of ease that the small town's support and protocol provided. Suppose she had needed to make those arrangements in New York City? Would she have known where to turn? Cunningham felt certain she would not have known how to access this support in the urban community.

Thus, from her family's experience planning what she calls a "glorious memorial service," that was supported by the community, Cunningham was driven to make opportunities for positive grief experience, more accessible. She explains that in the heavily diverse and individualized urban environments of New York, she continues to perceive a lack of "go-to protocols" for times of grief and loss particularly among families who do not find themselves connected to members of the clergy or a spiritual community or those struggling to navigate interfaith religions. She aspired to bridge this perceived gap in the community, by providing support for New Yorkers during their most difficult times. Six months later, Cunningham began

taking classes in embalming, restorative arts, anatomy, and chemistry at the American Academy McAllister Institute of Funeral Services on the West Side of Manhattan.

After receiving her license, Cunningham was hired at Green-wood Heights where they prepare many kinds of funerals. However, they specialize in green funerals that offer environmentally sustainable options for burial or cremation. Although many of their clients are Catholic, Cunningham reports an increasing diversity of religions and backgrounds that calls for more mixed faith ceremonies. In a New York Time's write-up on Amy, New York is described as "a place with many transplants who have drifted from their native customs" and Amy's work may "reintroduce them to their pasts and at other times help them invent new personal rites" (*Chumsky, 2014*)

During our conversation, Cunningham describes how she encourages her clients to be creative and inspired while making their arrangements and how this might mean straying from typical conventions.

Cunningham emphasizes the importance of maintaining the family's opportunity to be engaged and present in all preparations, to the extent which they desire. Since conventional models are less encouraging and restrict participation by family, Cunningham is responsible for presenting such options without over-imposing. In more traditional settings, families may be prohibited from touching and interacting with the body post mortem while Cunningham finds this activity incredibly healing. She encourages families to participate in the preparation and grooming of the body. This may mean combing the hair, applying make-up, choosing outfits and accessories, and dressing the body. She also encourages other physical participation by families such as shoveling the soil at burials, lifting the casket to feel its weight, and participating in processions.

Cunningham also reports that in some houses of worship, such as the Roman Catholic church, only members of the clergy have been permitted to speak during funeral masses until relatively recently. She finds that many of her clients express reluctance or fear when offered the opportunity to recite a eulogy, usually because they would rather avoid appearing vulnerable in front of others. However, Cunningham advocates that eulogies can be an incredibly empowering and healing act and many who initially struggle with it, later thank her for encouraging them to deliver one.

As Cunningham maintains her storytelling inclinations, she is currently conducting her own research into grief and memory. Her research involves contacting clients with whom she worked with three years prior, to ask them questions about their memories of the experience. So far, she has found that her clients significantly remember the physical tasks and ways they engaged with the body or remains.

Additionally, the insights of her clients as well as her own lead Cunningham to believe there is a specific kind of "human dignity" and "wisdom" that emerges when we are faced with death. She says that although "no one asks for it," facing death has the potential to be powerfully transformative for the ones left to observe it, in ways that are often unexpected. She feels strongly that grief and loss can inspire creativity, resilience, and a new perspective on living as well as dying.

Conversation with a Professional Doula

In my conversation with Kendra Potter, she first provides the Greek literal translation of Doula, which is "a servant or slave". However, she follows that by explaining "doulas have been put to use as a reaction," to the lasting repercussions of the medicalization of birth seen in the 20th century, and to "reclaim" many aspects. She described that modern movements for doula-

assisted births, take intentional steps to "rediscover" the potential of having a supportive "sisterhood of women" during birth. Potter subsequently describes a time before medicalized births, when "by the age of adolescence, people would have already attended births in their family or community" and learned from practical experience what entails. However, after this era of birth as commonplace ended, many people became lead by a "misrepresentation of birth" as a fearsome event necessitating medical management. Potter feels that this way of thinking often diminishes many opportunities for feeling empowered by childbirth as they are informed by negatively preconceived notions. The expectations with which we approach childbirth, can in many ways act as a "self-fulfilling prophecy," says Potter.

As a doula assisting 5-10 births a year, Potter feels that in many ways her purpose is to offer an alternative model, or language, for supporting pregnancy and birth. Often, this service can extend beyond the person giving birth, although she emphasizes that the experience of the person giving birth is always the top priority. However, easing this experience of the mother often means guiding the support of any family members present. For example, Potter describes that in cases of an involved partner, she observes their presence and then encourages ways that they can go further in support. For each couple, her guidance is different, as their dynamics are always unique. This often means encouraging the partners to connect with communication, physical touch, and emotional attention. Potter says she usually models her suggested language, touch, and support so that the partner can effectively recreate it and provide it themselves.

Potter also explains that partners and other members present can sometimes lose sight of what the person giving birth is going through by getting caught up in their own feelings and experiences. While she acknowledges distraction and excitement as understandably human and well-intentioned, she consistently acts to shift the room's attention back to the needs of the one

giving birth. She assumes responsibility for mediating the energy and the presence in the birth room so it is most accommodating of the mother's experience. From her own intuition or through communicating with the mother, Potter may find it necessary to task someone with something to either realign their priorities or get them out of the room completely. She jokes that she usually pulls this tactic with nervous or stressfully overbearing soon-to-be-grandparents. If Potter feels that the staff at a hospital birth are overlooking the emotions of a mother, a common strategy she uses is vocalizing questions to the mother such as, "Are you doing okay? Is there anything you need?" This action allows the mother to feel acknowledged by offering her a chance to speak up and also serves to focus the hospital staff's attention on her emotional wellbeing.

When Potter attends a birth that is not the mother's first, there may be one or more siblings, whose presence and support she is also responsible for guiding. She expresses that protecting a present child's experience is usually a major concern for parents and a doula's attention to that child can ease everyone's overall experience in many ways. In conversation, Potter recalls a home birth she assisted earlier this year, where a 6-year-old sibling was present throughout labor and delivery. Humorously, she remembers how the child resembled a car mechanic as they laid between the squatting mother's legs, shining the midwife's flashlight as if to "take a peek under the hood." But, as Potter points out, birth is not an experience all children can handle. Sometimes there's lots of blood and very often there is loud screaming. All of which can be very scary and potentially traumatizing. When a child is present, Potter may need to explain what's happening and try to relieve their concerns. Or better yet, guide the family's ability to do this when they can.

While speaking, Potter stressed that she does not consider a doula's role to be one of advocacy. Instead, she considers her role as offering support for the parents' ability to advocate

for themselves. She strongly believes that her main purpose is to provide the tools and guidance that encourage personal advocacy, or partnered advocacy, so childbirth can ultimately be an empowering experience. As she mentions this, I admit to her that I've read previous literature that directly refers to doulas as advocates, particularly in the case of them advocating to maintain original birth plans. So, I ask why she deviates from this.

She responds by saying that although she may "undermine" a medical care provider, she never (ever) contradicts or advocates for going against their counsel. It is not her position, nor is she qualified to advise on the medical or safety aspects of childbirth. Although she is of course invested in both of those aspects, she strictly can not advise on it. Instead, she supports and creates space for the mother's ability to feel empowered and in control of her birthing experience. While others service the many medical aspects, a doula's services are complementary by being focused on the overall emotional well-being.

Potter offers the example of a birth she assisted in a hospital, where the mother was determined to have a natural birth but had already spent 40 hours in labor. When a doctor visited the room, the doctor advised that it might be time to change plans and go forward with a cesarean section, claiming that the mother must be tired by now and ready to switch. Knowing that the overall environment of a hospital can lead people to feel pressured to adhere to the timelines set by its staff, Potter commanded space and time for the mother to consider her options. To remind the mother that this is ultimately her decision, she slowly walked her through all the things to be considered.

"This is your decisions and I know you're scared. But there are no signs of distress or emergency. Everything you are experiencing is very normal. If you want to keep going and revisit this option later, you can because we have time." After the mother said she wanted to

keep going, she labored for another 12 hours until she eventually chose to go forward with a cesarean section.

Although the ultimate outcome was to take the option the doctor suggested hours ago, Potter believes the last 12 hours of labor were crucial. That the time was essential for the mother to embrace the fact that she wasn't having the experience she expected. Since this wasn't the birth story she originally wanted, this time allowed her to shift the narrative and find the opportunity to still feel empowered. Potter insists that whenever it is safely possible, time and space should be taken for processing the feeling that she describes as "mourning the loss of the original plan." She says, "If mom wants to cry, she should. She should cry for as long as she needs and without interruption."

Potter often sees that when a mother's experience deviates from her original plan, her feelings may be invalidated by those rushing her adjustment period. Sometimes people say things like "don't worry, you're going home with your baby either way!" Despite always being well-intentioned, someone who is feeling shame or disappointment because they didn't achieve the experience they wanted may need time to process. Mothers often grow very attached to their birth plans and may even ascribe certain meanings or values to whether or not they are able to achieve them.

Upon asking Potter about the specific rates for her services, she informed me of a few unique services she passionately provides. Included in her general rate of $500 per birth, she includes 1-2 prenatal meetings (lasting 2 hours each), her availability for the full duration of birth (with the agreement that she'll show when requested and stay until shortly after a latch is achieved for breastfeeding), a postnatal meeting within the first week postpartum, and her specialty: a written birth story.

Potter explains that the passage of time can feel significantly warped in birthing rooms. That some five minutes can stretch to feel like 5 hours, while another 10 hours may pass can feel like no time at all. For this reason, she finds it beneficial to provide a detailed timeline of all the events. It offers a way for the family to preserve and reflect on each moment. She expresses a general appreciation for documenting births, particularly in photos and videos. However, birth can be a traumatizing experience and graphic images may be triggering for some. So she feels that the written medium, whether in addition to other documentation or not, can be a sacred way of remembering the experience. She describes writing's ability to “protect a perception” of a birth experience, as perceptions can change over time.

Potter also shared that she often donates her time and services to families who would be unable to afford it otherwise. She describes that she feels inclined to take advantage of her privileged ability to work for free. Often those who can’t afford a doula’s support may benefit from it the most.

Chapter 5: Discussion & Conclusion

While reviewing how the procedures for birth and death have shifted and evolved, I suggest they have undergone similar changes, at similar rates, at the same time in response to the same social forces and technological changes. The early models that were home-centered, managed by family and friends and embraced biological processes shifted to rarely take place at home, increasingly rely on professional expertise, and natural biological processes are altered by interventions of science and technology.

As a result of innovations developed during the Industrial Revolution and the events of the Civil War that popularized their use, funeral preparations were no longer centered in the home, handled by families, and rituals were no longer observed in accordance with the natural process of decomposition. The same innovations in medicine pioneered in the civil war, especially the use of anesthetics, also transformed and medicalized American childbirth.

The shifts in these models of care spread ways of thinking about birth and death that became the norm. A primary example is that normal bodily processes and states, such as pregnancy, birth, and decomposition, can and should be improved upon.

Now, as a result of advanced technology and the introduction of industry professionals, both birth and death are no longer viewed as natural progressions that were once considered unavoidable and inevitable. Instead, birth and death both have come to be mediated by medicine and manipulated once they occur. Just as the tasks of preparing the dead are increasingly officiated by professionals and the opportunities for the bereaved to engage are diminished, so has childbirth come to be overseen by professionals. As the procedures surrounding the beginning and end of life are performed in standardized ways by a professional class, both are similarly hidden from view and separated from common experience

Speaking with Amy Cunningham opens up alternative narratives for death. Cunningham strives for grief's potential to be an inspiring experience for her clients, but too often this means overcoming forces in our society such as culture, the overuse of technology, and a funeral industry that does not always have the client's best interests in mind. Speaking with Kendra Potter reveals that similar narratives for birth is being embraced by a modern generation of women. Potter also speaks of overcoming a medical professional culture and the overuse of technology.

Both discuss the availability of traditional and less traditional options, and from this emerges the realization that some rituals of birth and death have become standardized and taken for granted. Notably, both treat the events of birth and death as narratives with a high value placed on the experience and the memorializing of it. As society becomes increasingly dissatisfied with the limited options afforded by both "traditional" funerals and "traditional" birthing both women strive for a more "back to basics" and minimum intervention approach that affords greater transparency and connection in the observance of birth and death.

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