

## Clinical Relationships and Feminist Values: How OBOS Benefits Collaborative Relationships in Women's Health

Barry DeCoster and Wendy Parker

---

**Abstract:** This article takes up the question: to what extent are the Boston Women's Health Book Collective's (BWHBC) values of collaboration and agency enacted today in women's health clinical practices? First, this article investigates the BWHBC archives—work that eventually became *Our Bodies, Ourselves (OBOS)*—to articulate how the authors used collaborative and interdisciplinary methodology to present a new way of engaging health information for women. Second, this article draws from the BWHBC's methodology to conduct interviews with women and clinicians on their working collaborations around birth. Ultimately, this article finds that the work started by *OBOS* continues in modern birth practices and clinical relationships, as women today still navigate the complexities of individual and collective values through uptake or the origin of the BWHBC.

**Keywords:** agency, birth practices, circulation, clinical relationships, uptake, women's health

[D]octors insulate themselves from the rest of society by making the education process (indoctrination) so long, tedious, and grueling that the public has come to believe that one must be superhuman to survive it. (Actually, it is like one long fraternity "rush" after which you've made it and can do what you like. Only members of the club get to learn the secret, which is that doctors don't know much to begin with and are bluffing a good deal of time.) Thus, a small medical elite preserves its own position through mystification, buttressed by symbolic dress, language, and education. (Candib, 1970)

At a workshop on "Women and Their Bodies," we discovered that every one of us had a "doctor story," that we had all experienced feelings of frustration and anger toward the medical maze in general, and toward those doctors who were condescending, paternalistic, judgmental, and uninformative in particular. As we talked and shared our experiences, we realized just how much we had to learn about our bodies, that simply finding a "good doctor" was not the solution to whatever problems we might have. (*OBOS* Founders, Judy Norsigian)

## Introduction

In order to understand both the creation of *Our Bodies, Ourselves (OBOS)* and its impact on contemporary women's health issues, this project develops two research threads, both focused on understanding collaboration and agency within clinical relationships. Beginning with the women writing *OBOS*, who took their personal stories and built them into recipes for action, we wanted to understand how *OBOS* was empowering to both the founders creating it and the women reading it for decades to come.

In writing *OBOS*, the women of the Boston Women's Health Book Collective (BWHBC) created a living document, which transformed collaboration and agency within women's health: medicine for women and by women. In this article, we take up the question: to what extent are these values of collaboration and agency enacted today in women's health clinical practices? To answer that question, we integrate two research threads. In the first, we begin with an investigation into the archives of the BWHBC: the files of the women who ultimately created *OBOS*. We articulate how they created a new way of engaging health information for women. But in addition, the members of BWHBC utilized a methodology for engaging interdisciplinary work, allowing for both collaborative and individual goals to be expressed. In the second thread of our research, we interviewed women and clinicians on their working collaborations around birth. We conclude that the work started by *OBOS*, although not finalized, continues in modern birth practices and relationships.

Because *OBOS* was premised on a desire to empower women in clinical encounters and asked for women to encourage other women to work together/collaborate, we focus on the themes of both collaboration and agency. The women of BWHBC decided to work together towards shared goals. Interestingly, women when using contemporary OB/GYN services also speak of working with their clinical partners, articulating the goals of a "successful" birth experience. This work echoes the models of shared, collaborative expertise, which is part of the *OBOS* framework. In this way, *OBOS* opened up new spaces for women to participate in their overall health experiences, and in birth experiences specifically. We draw heavily upon the rhetorical concepts of critical imagination and social circulation, drawing new connections between the work of developing *OBOS*, and the resonance in contemporary doctor-patient relationships created for successful birth experiences (Royster, 2012). The power of *OBOS* resonating today is more than language or a mindset, "[m]embers developed ways of speaking their own embodied experience and of bracketing that experience as partial and local" (Wells 2008: 698). Wells helps us to see that *OBOS* is more than a medical teaching text—through the text, *OBOS* articulates new possible agency, both for clinicians seeking to center women in their care, and for women as active agents in their own health decisions. *OBOS* created such space by "creating vocabulary in which women could talk about their bodies, forging discursive styles and modes of argument, and inventing narrative forms that, but by building authority and solidarity, could establish health work as a field of practice for the women's movement" (Wells, 2008, p. 698). We show how these textual foundations have received uptake in modern clinical practices.

## **The Writing of *OBOS* and Its Legacy**

The women of the BWHBC came together to address problems in clinical medicine, long before they wrote—even planned to write—*OBOS*. The women of BWHBC were riding the waves of important changes from the 1960's: the women's movement, health technologies like the pill and IUD, which separated sex from reproduction. But today, it's often difficult to put ourselves in those moments. It's important to remember that BWHBC were meeting before the legalization of abortion, and decades before the internet brought health information to the tips of our fingers. In fact, access to health information—including women's health, specifically—has come to be so easily accessible, *OBOS* will

no longer be updated.

In this same period of writing, medicine itself was coming under greater scrutiny and critique. Academics were crystalizing the language to articulate what many women were experiencing within interactions with healthcare providers. “Medicalization” is often the theoretical lens describing how non-medical problems become taken up as medical problems, or problems that only clinicians can speak clearly about (Conrad). Feminist scholars have since argued that medicalization impacts women, people of color, and queer folks more frequently and with greater damage (Brubaker; Conrad and Angell; DeCoster; Garry; Halfmann; Riessman). Here, the creation of *OBOS* was a response to these medicalized systems.

Yet *OBOS* as a creative response did not aim to reject medicine, given that women needed the real benefits of healthcare systems. Instead, *OBOS* became a novel how-to manual for women as patients, but a new kind of patient: one who took a kind of control and agency over her own health, rather than leaving it to experts. Through the text, women were informed about their own bodies, a revolutionary tool. *OBOS* did not aim for women to become medical experts, independent of physicians. Instead, *OBOS* was to be a tool to improve the interactions between both women (as patients) and clinicians. Meant to be read by both ‘sides’ of the clinical relationship, *OBOS* reflected on the specific health needs, challenges, and responses needed to care for women, working to create “women’s health” as a new domain of study. *OBOS* drew from clinical research, making it accessible to women, allowing women to be active participants in their own health matters. But it also drew from non-biological determinants of health, clarifying for both women and physicians how social dimensions of health and the social situatedness of clinical responses were necessary in understanding overall health. While putting medical information into women’s hands was itself a political move, *OBOS* also wove the political into discussions of women’s health, rather than seeing these as separable aspects.

From today’s perspective, it is often a challenge to remind ourselves of what women’s health resources looked like prior to *OBOS*, and to articulate how this text shaped current clinical interactions. Resistance requires a kind of imagination, and *OBOS* was the product of the thoughtful and imaginative response of the BWHBC. These authors articulated new possibilities, new solutions, and new interactions for women with their physicians, and these goals are seen in today’s contemporary doctor-patient relationships as we navigate medical systems. Additionally, these women articulated ways of knowing themselves and their bodies that provided space for women’s agency to be an “equal knower” in a clinical space. In this project, we argue that the creative work of the women of the BWHBC has, in many ways, been given uptake, although it has not provided final solutions for women, especially those navigating their first birth experiences. Instead, *OBOS* has provided a model for an ongoing re-examining of the doctor-patient relationship, one that benefits women to allow for uptake in everyday life. “This is why uptake matters; uptake is relevant to the study and teaching of genre performance maintenance, and change and uptake compels us to pay attention to the historical-material conditions that shape genre performances” (Bawarshi 2012).

Reflected in the legacy of *OBOS* is the creation of both women as lay-individuals thinking about

medicine and collaborative relationships as patients. These new engagements with medicine are connected and re-inscribed activities, what Emmons describes as “uptake.” For Emmons, uptake is the “bidirectional relation” that holds between genres or concepts (Emmons, 2009: 92). In the pre-OBOS writings—*Women and Their Bodies: A Course*—we see the textual connections that show how outsider/insider status works within medicine. As Candib writes on the first page, in early OBOS work, clinicians were seen by patients as “other” and elite—superhuman, fraternity members, or knowers of secrets. But this description is the beginning place for clinical relationships according to the BWHBC authors. “OBOS was a grand public telling of secrets. The collective raided medical libraries to collect the secrets of physicians and told them shamelessly: they demonstrated how doctors dismissed women’s problems and maintained their ignorance of women’s bodies...The collective insisted that these narratives were not just private matters, that they were not to be confined to either the consulting room or the kitchen table. They opened the public sphere to new issues and new agents...” (Wells, 2010, p. 55). Through the popular distribution of OBOS, women and clinicians found new language to think about women as they engaged them as health care consumers. Below, we explore this in two moments: the meetings to write OBOS, and modern clinical engagements of women with OB/GYNs.

## **Our Location as Authors**

Our engagement with rhetoric theory as a tool for our analysis comes from the side, rather than straightforward as scholars of rhetoric. Given the themes of our paper, including the complex personal and professional interactions of the BWHBC and modern-day health care for childbirth, we want to take a moment to describe our own backgrounds and locations as researchers. Much like the members of BWHBC, we began this work as an interdisciplinary project grounded in shared academic curiosity. While we are both teaching at a health sciences school, our disciplinary homes and methods are rather different. Parker’s disciplinary home is in medical sociology, with a focus on health concerns for women and children. DeCoster is trained as a philosopher, with a focus on how gender and sexuality impact bioethics analysis and health improvement possibilities. Methods diverged: Parker’s empirical leanings means she relies on data; DeCoster’s normative methodology rarely relies on it. Our campus leans to the conservative end of the spectrum, and lab-based sciences are the most visible disciplines. While we were not the only folks who identify as “feminists”, frankly our feminist allies are limited. It also became clear that we were both teaching using feminist theory, and our collaborative connections began in those shared interests and shared language from our feminist training. This gave us a common location to work past seeing disciplinary differences and assumptions as barriers. Instead, this shared space gave us the foundation to work towards trust (not skepticism) of our disciplinary differences. We were able to eventually, with moments of interest, of humor, and frustration, develop this project.

We are interested in how the text of OBOS developed themes that have ripple effects on contemporary health care practice. As Wells (2010) writes, “As a rhetorician, I am as interested in how texts work as in what they say: I do not see the text as a transparent window into social reality, or

primarily as a formal structure; rather I see it as a work of language that organizes social agency” (4). The language is itself a means to understand the political goals of its authors. So, we began with a shared interest in women’s health and in interdisciplinary collaboration. Although these were shared sentiments, these are not immediately obvious why they warrant further research and scrutiny around *OBOS*. For DeCoster, his first memory of *OBOS* was in a health class in grade school. For Parker, she was unaware of *OBOS* until her years in college. However, for both of us as researchers, it became clear that this text was pivotal in changing how we understood both women’s health (as an academic field) and our own personal lives. As such, the ongoing impact and uptake from this text is undeniable. We took on the work that Kirsh and Royster ask of us—to “tack out”—that is, in order to find meaning from what is both written and unwritten, explicit and unspoken, requires us to

use critical imagination to look back from a distance (from the present to the past, from one cultural context toward another, from one sociopolitical location to another and so on) in order to broaden our own viewpoints in anticipation of what might become more visible from a longer or broader view, where the scene may not be in fine detail but in broader strokes and deep impressions. (Kirsch et al.)

We as researchers worked to articulate meaning, but at different levels: for the patients we studied, for the original BWHBC authors, and for ourselves.

## Archival Work on BWHBC

Taking into consideration the guidance from Royster and others to approach this work methodologically in a way that allowed, in as much as is possible, for the participants to speak and to tell of their own lived experience, our project had two major aims. First, we spent 2 weeks working in the Schlesinger Library (Cambridge, MA), which holds the archives of the BWHBC. This is where much of the materials are held, both of the writing of *OBOS*, but even the paperwork prior to this, notes from the BWHBC and more recent publications stemming from the original *OBOS* (Boston Women's Health Book Collective "Boston Women's Health Book Collective Records"). Although this group ultimately authored *Our Bodies, Ourselves*, this was not their original aim. As they write on the *Our Bodies, Ourselves* website:

We never planned to write a book. We believed then as we do now that there is no substitute for a small group of women—in a spirit of mutual trust and respect—speaking and listening to the truth of our own lived experiences. (*OBOS* Founders)

Using the tools of rhetorical analysis, we were influenced by several concepts of Kirsch and Royster as well Royster’s questions in her earlier book investigating literacy and social change for African-American women. Critical imagination, which according to Kirsch and Royster, is the art of educated guessing in historical and archival work and exploring: “How do we transport ourselves back to the time and context in which they lived, knowing full well that it is not possible to see things from

their vantage point? How do they frame (rather than we frame) the questions by which they navigated their own lives?...How do we make that was going on in their context relevant or illuminating for the contemporary context?” (Kirsch et al.). In our project, we are interested in how the women of the BWHBC came together, trusted one another and began working towards *OBOS* and what evidence we can find of alliance building and collaboration in the archives of their origin. In other words, we were curious about the process of the creative collaboration that resulted in *OBOS* in phase 1 of our project and then carrying those ideas forward to retaining uptake in a contemporary moment. The hope is that this understanding of the lasting rhetorical impacts on clinical interactions for both women and providers during pregnancy and birth can continue the collaborative potential of the BWHBC and *OBOS*.

The other concept that for us was significant is that of social circulation (Royster et al.). In Royster’s earlier work she asks about literacy and the ways in which literacy was a tool of empowerment for African-American women. For her, and for us, this leads to our questions of what strategies, if any, were in place in those early BWHBC meetings and interactions? How did the personal relationships of the women influence the texts and the women then and now as they are read fifteen or twenty years later? Using the idea of social circulation that allows us to bridge from the past, present, and future to understand the influence and longevity of *OBOS* and BWHBC while forcing us to begin with the women and their written texts.

This led us to the second phase of our research, where we sought to understand how *OBOS* and the BWHBC have influenced modern medical interactions around pregnancy and birth. We completed 11 interviews with women who had recently given birth to at least one child along with OB/GYNs and midwives to understand the experience of giving birth from both the women (n=6) and the clinician perspective (n=5) to think about the lasting influences of *OBOS* on modern clinical practice and to review the differences in clinical care between midwives/doulas and OB/GYNs to better understand the way the clinical staff interact with women during pregnancy and labor.<sup>1</sup> For both the interviews with women and clinicians we followed a similar guide of questions we wanted to cover in our interviews. For women, we started with their birth experiences and listened to their stories, both good and bad, about their interactions with clinical providers. We also asked them about a few words or concepts, from our archival work, which we thought were important to understand from their perspective (e.g., autonomy, empowerment, and collaboration). In our conversations with clinicians, we asked a similar series of questions to elicit the reasons why they became the type of provider they are, where they work, and how they engage with patients. They were also asked to define, in their own words, the concepts that we talked to women about, e.g., collaboration or empowerment. The transcript and interviewer notes were used for analysis using a grounded theory approach (Strauss et al.) to create themes from the re-reading and review of the transcripts using the conceptual framework and outline from our archival project. The goal here is to allow for the women and clinicians to speak for themselves and their experiences and for us as researchers to utilize the actual words of the participants to describe the complexity of the situations and interactions that they experienced.

In “A Good Story” BWHBC members articulate their own struggles over power dynamics. The BWHBC

chose a consensus model for decision-making and had a fluid-leadership model, similar to many other women's health organizations (Morgen). As they grew they fought to maintain personal relationships and sharing, but some felt that this limited growth and efficiency because they were not always on the same page. "But adaptation had a price: paradoxically, the more the group developed medical knowledge and skill, the less access they had to vernacular bodily experience or to the lay experience of medical care" (Wells, 2008, p. 699). Wells helps to remind us that as BWHBC grew and came closer to the OBOS development, crafted subsequent revisions, and endured complexity around publishing over time, the women involved were more removed from their original location and the body.

In our archival work what we went in search of and ultimately found most interesting was the origin stories of the OBOS founders and their handwritten notes of the early planning meetings. These meetings were a simple group of women coming together typically in the evenings at someone's home. The meetings were both formal and informal (Boston Women's Health Book Collective "Minutes Notes September 1973-January 1975") with collaborative goals as well as personal perspectives. The language was at times angry, resistant, personal, emotional, and ranged from a focus on "time to get ourselves together" to heated discussions over the pages allotted to each chapter. BWHBC was a group of friends and colleagues who had a desire to engage women and provide them with knowledge and information on their own, as well as to help empower them to advocate or engage with the medical system. In one particular set of meeting notes we found that after a discussion each individual was asked their own goals and the notes show a mini drawing of each woman from the note taker along with goals from each person that sometimes were connected to the larger book project (e.g., whether they were ready for revisions to the book) or were personal about "side" projects for further education, art projects, separate book proposals.

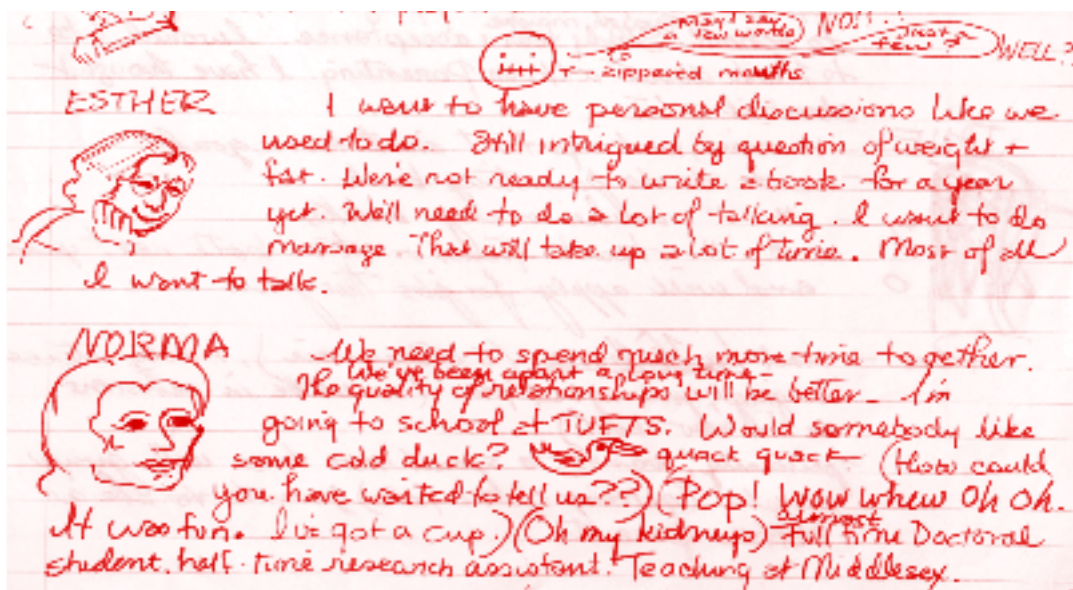


Fig. 1. Schlesinger Library. Boston Women's Health Book Collective. Minutes Notes September 1973-January 1975.

Two archival examples are worth noting here, drawing from minutes of BWHBC. First, Norma [Swenson] is clearly moving across the private/public spectrum. She articulates her own professional development, “I’m going to school at Tufts.” But at the same time, she calls her colleagues together for further collaboration: “We need to spend much more time together. We’ve been apart a long time. The quality of relationship will be better.” There’s something important here: the importance of both individual and collective work is being articulated in this brief moment. Along with a reference to sharing food—quite literally—as she asks if others would like “some cold duck,” Swenson here is noting her desire for ongoing, engaged activity within the BWHBC group. Yet simultaneously, she articulates her own individual needs to grow, to expand her interests and her professional identity.

Esther [Rome], too, asks for more “personal discussions like we used to do.” There’s an important understanding here that individual and collaborative goals are deeply intermeshed: that for one to be successful, the group (BWHBC) must meet and also be successful. Esther, too, articulates her own side interest and projects, when she says she’s “still intrigued by [the] question of weight + fat...I want to do massage. That will take up a lot of time.”

In these meeting notes, we again see how themes of collaboration are reflected in the text.<sup>2</sup> Planning meetings typically started with *OBOS* planning, then transitioned to individual discussion time for each of the attending BWHBC members. In the images, here, a cartoonish doodle of each speaker appears next to the text of each woman, describing her current interests and personal research themes. But even these individual reflections, Norma and Esther are referencing the “we” of the group and its work.

Beyond mere meeting minutes, these images and notes provide evidence of transition and transformation of individuals of BWHBC and the group itself. We see here that medicine can be studied, but that the women are collaborating in studying medicine and their own lives, interests, and values. And that the collaborative nature is better—“like we used to”, or “we need to spend more time together”—for such critical reflections. An outside critique of medicine is limited: working as a collaborative insider is more effective.

At a quick glance, the meeting minutes resemble little of what we might think of in more traditional academic circles of formal accounts of organizational meetings (Boston Women's Health Book Collective "Minutes Notes September 1973-January 1975"). Engaging critical imagination, though, means we must be able to see the non-explicit work done in these meetings. For example, the note taker (unidentified) has crafted lovely doodles of her colleagues. These are brief sketches/doodles of the person herself and her colleagues, not just the recorded language of her arguments. While we describe them as doodles or cartoons, this is not to minimize them or their value. There is both formal and playful (or even loving) articulation of the work of the BWHBC recorded here. These moments describe the person and her goals—not just the health facts and themes—as relevant to the project at hand. Perhaps long-term this can help to explain the longevity and power of the BWHBC and *OBOS* because the personal was political. This work was not full of abstractions, it was individual and meaningful to each involved woman and this was translated to readers over decades that engendered support and engagement for themselves and with the clinical encounters (Wells 2008). For us, as



researchers, this has meant thinking beyond the drawings and the simple “not knowing” of who the artist is in order to attempt to re-visit the time and space of that room and place. This helps us to theorize how politically important each word might have felt to the individual participants and how complex the compiling of information and collaboration together was for each of them.

Clearly, there was a lot more work being done at these meetings than “simply” the production of the *OBOS* pages. At this time, while the group was processing the project of reflecting on the first *OBOS* edition and considering the next revision, they were also reflecting on the nature of their group. Engaging critical imagination allows us to read deeper than what was recorded in the minimal meeting minutes. We see here that the members are bifurcated on how to proceed with their work, which projects to take up, and which to give priority to. There is the private work among the founders to determine who to trust and rely on within the group, and who to work with sitting on their couches with their young children nearby having a potluck dinner. There is the call for the development of both individual and collective expertise, but the articulation that these are intertwined in complicated ways.

Central to these minutes are how the members want to spend their collective and individual energies and time. We see repeated requests for the women of BWHBC to return to spending time together, both for social and individual goals, or writing (Esther: “We’re not ready to write a book for a year yet. We’ll need to do a lot of talking.”) and educational goals (Norma: “I’m going to school at TUFTS.”). It is here that their original models emphasizing collaboration and agency (individual and collective) are evident. These requests for talking—in face-to-face settings—is about individual health and well-being, the support generated between friends and respected colleagues. But critical imagination allows us to return to this work space, and describe what might have been a part of the conversation not contained in the minimal meeting notes. We see the BWHBC authors articulating the core values for their own collaborative system, and with a flexible sense of agency. In this way, we recover a richer meaning for these working meeting minutes. Although they are about developing the improved book product, they are also about refining the Collective and upholding its values.

At the same time as the public release of *OBOS*, teaching through the women and body course, and advocacy within the feminist women’s health centers led them to choose a path of negotiation within the medical establishment rather than completely working outside the medical system. What we did not find entirely within the archives were the answers to why these women trusted each other or engaged in this particular manner to arguably change the course of women’s health forever.

## ***OBOS*’s Legacy and Contemporary Connections with Birth**

Building upon these archival concepts articulated from the BWHBC archives, and with our own remaining questions, through interviews we asked providers and women who had recently had at least one child how they identified who they could work within contemporary clinical practice. Specifically, we were interested in how practitioners and women understood the patient/provider relationship, when they thought it would work, how they knew it would not, and what they did to engage with each

other. Perhaps unsurprisingly we found differences between how OB/GYNs and patients interacted compared to the interactions described by women and midwives.

Emmons's process of uptake is useful here to understand how patient talk can result in medical directives. We utilize this concept to analyze the words needed for collaboration on both sides of the patient/provider relationship or how either a person or a provider can see his or herself as part of a collaboration. "Language manifests itself within the body via a series of intergeneric translations: A consultation interprets patient talk as a series of symptoms; a diagnosis responds to symptoms with a prescription; a pharmacist transforms a prescription into a medication; and a patient ingests the medication in accordance with the directives on the bottle, thereby incorporating in to the body a material response to an initial, purely rhetorical locution" (Emmons). Most notably we see differences in language used by midwives and doctors to talk to and with their patients and how that impacts the women they encounter. Looking back to the early days of the BWHBC and the "Women and Their Bodies: A Course" we see that language was used then as well to professionalize medical providers and another "...important way doctors set themselves off from other people is through their language. Pseudoscientific jargon is the immense wall which doctors have built around their feudal (private) property, i.e. around that body of information, experience, etc. which they consider as medical knowledge" (Candib).

Just as the women of BWHBC developed a complicated sense of shared expertise, so too did many of the women and clinicians we interviewed. In one way, it may seem perhaps jarring to talk about birth as a "collaborative process." It is the pregnant woman who is giving birth, no matter who else is in the room. But as our interviews articulate, the work of finding collaborators—that is, women finding the right clinicians to support their delivery—parallels the individual/collaborative work of the women of BWHBC.

I really believe in empowering women and respecting their autonomy to make decisions about their health and their bodies and their birth...just seeing that, has driven me in supporting women as a doula, and then now, as a midwife, to be able to help educate women about [what] their options are, and help them make informed decisions, and then ultimately respecting the fact that they have the power to call the shots most of the time... (Interview #27 p. 3; Midwife)

Well, I've always felt like—a couple of things—pregnancy was a normal state of good health. And clearly, as I gained more experience and more confidence, I think I also realized that this is the patient's experience, not mine. My job was to assist the patient in her experience of pregnancy and childbirth. And this was not something where a pregnant mother would come in and could turn over her healthcare to me. So really from the get-go, it's been more of a neutral, agreed upon relationship. I would encourage patients, for example, to write down their questions, stuff to ask me. I would be free to counsel patients and talk to them. Sometimes patients ask for things that I don't think are medically indicated or medically correct, and we have a discussion about that. (Interview #11 pp, 3-4; OBGYN)

Collaboration is more than just language and words. While these two approaches sound similar in

rhetoric, the way the practices are enacted often results in highly different experiences for women. This leads again back to our archival work where we understand the process is sometimes as important as the outcome, especially for women.

So she [midwife] was much more confident and relaxed about pregnancy and birth in general. Until there is something wrong, everything is okay. Whereas I felt like with the obstetrician, he just had an attitude of expecting something to go wrong. (Interview #13 p. 6; Mother)

Women indicate clearly that the experience with different providers can be unique. While it stemmed from language differences, it was much deeper and more powerful. For example, the clinical providers we spoke to use the medical language of providers and patients, but the midwives talk about clients. One of the mothers we interviewed that had experiences with both midwives and OB/GYN practices explained this to us in the following way:

When a woman goes to a doctor, obviously, doctors—when they treat you—they refer to everybody, regardless of whether you're pregnant or not, as patient. But I think that sets women up to not understand that their doctor works for them and that ultimately the medical choices are their choices not the doctor's choices. So, I think that using the term client is beneficial to midwives and could be beneficial to the doctors if they wanted to use it to create that understanding that, as a human being, it's your body. It's your right to do whatever you want. (Interview #14 p. 13; Mother)

We do not believe this is a subtle distinction, but that this rhetorical choice matters. It alludes to the power dynamics at play in the patient-provider relationship and the manner in which women and midwives have sought to disrupt that power dynamic. It also provides evidence for the uptake of the language of collaboration.

And there is a difference, I feel like there's a difference between—a patient to me—a level of hierarchy? In—the way that client doesn't necessarily, like it's—I don't know exactly what the distinction is, maybe you can—look that up in a dictionary or something but—it's—it definitely feels like more of a partnership. (Interview #1 p. 30; Midwife)

Think about that idea in its simplest form. What does a partnership entail between a woman and a clinical provider? How has that evolved over time? Do most women see their providers as partners? What role does the living text of *OBOS* have on such interactions? How did empowering women to understand their own body impact clinical encounters?

Our interviews illustrate that women with some providers, almost exclusively midwives, see a collaboration and a partnership that involves teamwork. Most women and clinical providers, however, do not emphasize or value this language and context. So much so that in the early work of these authors, one of us (Parker) thought the idea of collaborating with a provider for childbirth was beyond ludicrous. It seemed to undermine or minimize the work and importance of the woman in the birth process and to offer “credit” of some kind to providers, who can be disengaged bystanders to the

process. If we take to heart the guidance of *OBOS*, the language of collaboration and equalizing power is critical. And, in fact, as noted above many of the women we spoke too and some of the providers demonstrate such language. While perhaps we have not accomplished this equalization for all women, it seems still an important and distinctive goal to seek.

Looking at the space and time surrounding the creation and evolution of the BWHBC and *OBOS* allows us to better understand the impact and consequences of the *OBOS* work in a more modern moment. In other words, looking beyond the book itself, to the values, perceptions, methods, and rhetoric of the book that matters for medical discourse, the engagement between patients and doctors, and, primarily, for providing patients with agency in health care interactions. Midwives are asking for a safe/healthy baby and a positive birth experience for women. Clinicians focus on a safe baby and mom in a similar way, but often worry less about the experience. For midwives, and arguably for women, the process matters, sometimes, as much as the outcomes.

In describing modern midwifery practice, midwives focus on relationships and the empowerment of patients rather than the language of OB/GYNs who speak about patient autonomy but reliance on clinical expertise.

...we believe that we're not necessarily your care provider, you are your care provider. You're the one, every day, making all kinds of decisions that influence you and your pregnancy, and your health and your baby's health, and we're checking in with you on that, and we're acting as guides on that and we are—I think it's educators who are giving lots of information or interpreting information that you're getting from other sources. But you're really the one that's taking care of yourself, and we want to kind of put that in your lap, it's yours. And that really takes the Western medicine view and kind of flips it on its head. (Interview #1 p. 6; Midwife)

The patient doesn't want to see the doctor, and no doctor that I know wants to see a patient who doesn't want to see them. That's just accepted. So we try to accommodate those [requests] as best we can. But there's a big demand...I'm short. So that creates a problem in terms of availability and backlog. It's not an answer, but it's still all by the chart. (Interview #11 p. 8; OBGYN)

The medical providers we spoke to, who appear to have the best intentions, still do not approach care in the same method or language as the midwife. For lack of a better description, the midwives and women talk about the women and child as a centralizing force and the clinician doesn't really utilize the language of empowerment or talks about the support people or doulas as empowering rather than the women themselves. For example:

I think that pregnancy and birth are really a life-changing time for people, for better or for worse, and sometimes people's personal histories. So I think that pregnancy and birth have the ability to be very empowering for people and help them kind of own their power. And so having a doula or a midwife or a doctor that respects that and recognizes that and is willing to advocate for you or help you to advocate for yourself can influence the way that pregnancy and birth are. (Interview #27 p. 14; Nurse-Midwife)

Even if these are “aware” or supportive doctors, the physician often sees the doula as a tool of empowerment, rather than seeing a role to empower the woman directly. The argument from the women we spoke to is that without the “right” clinical support, they do not feel empowered, in control of their own bodies, or that birth is anything but a medical procedure. Here are just a few examples from our interviews of women indicating what lasting influences there were from their clinical interactions.

I’ve noticed that the midwives I’ve seen—most of them, regardless of whether they are a home-birth midwife or based at a center or regardless of differences, those that are midwives have kind of tended to take more time during each visit. They’ve kind of been more thorough in their explanations and listened well. I’ve had a couple of doctors—I don’t know—you know. Like I said, with my first daughter, he [OBGYN] listened and stuff, but the visits were short. Being a first-time mom, I didn’t really know what to ask, so I really didn’t ever have any questions. My second hospital visit for birth, I guess, was at a military hospital, so I don’t know if that implemented the abruptness of the visits. I’m sure it does. I know they’re very busy. You know. So they were just very different experiences, and they were both men and women. That could be a difference, too. The two hospitals—my first two, I saw men for my OB visits, and all of my midwives have been women. So, I don’t know if that contributes to the difference or not. That is very true. I think some of it is just a feeling you get. The doctors that I’ve seen—I’ve noticed how they tried to quickly explain something or just kind of, oh, trust me; whereas if I had a question, most of the midwives I’ve seen have taken the time to either pull out a picture or draw a picture or make sure that I was understanding the answer to my question in order to make the best decision for myself. (Interview #14 p. 4; Mother)

Because I feel like the relationship that you develop with a caregiver might be compromised because of poor interactions...Sometimes they’re [OBGYN/clinicians] not set up to really give or establish a caregiving relationship. Often it feels a lot more clinical. It’s about checking boxes. And again, that’s like totally over-simplified. (Interview #9 p. 2; Mother)

How does this notion of “checking boxes” feel to a patient? It seems unlikely that it is empowering to women or feels anything but an abstraction. Connecting this back to our archival work, we see the projects of the BWHBC as focusing on experiential knowledge of women; the idea that “women’s experiences, not clinical research produced by physicians, represented the most empowering, most liberating source of knowledge” (Kline).

Additionally, there are complex relationships and interactions between midwives, hospitals, providers, and patients that illustrate the levels of interactions and collaboration that must all work to facilitate a successful birth process for all involved.

Yes, for me that’s the easy part, the hardest part is the collaboration with the—the physicians because they don’t have this collaboration model as strongly as we do. And they don’t—I guess we worry, sometimes, that when we—that we are working with clients on one level and they’re working with clients on a level—on a different level and sometimes there’s not—we are free but they’re not going to get the same level of respect that we have for our clients. (Interview #1 p. 33; Midwife)

Okay. I think that OB/GYNs are really, really good at dealing with high-risk pregnancy. That's what they oftentimes should be doing. They're good at surgery. They're good at handling complications. They're really great to have around to consult with if something unusual or more complicated arises. Midwives are excellent at taking care of women who are low risk, or maybe have higher risk things going on but are still able to be under the care of midwives. So for example, like women with gestational hypertension often can be cared for by midwives in consultation with a physician. I think midwives in births are really good at supporting women and sitting with them while they labor and offering emotional support, whereas doctors generally don't do that. They tend to run in when the baby's crowning and catch the baby and that's it. So I think that midwives are good at helping to keep things normal when they are normal, and helping women who maybe have higher risk pregnancies still have the kind of birth experience that they want, to the extent that they're able to preserve that, and offering emotional support. (Interview #27 p. 7; Nurse-Midwife)

Tying this to the *OBOS* archival work, we find evidence in the contemporary world of the need from both clinical staff (OB/GYN and midwives) and women to navigate, articulate, and redefine their values individually and as a group as they work together on the "project" of a healthy birth/baby. Midwives seem to have addressed this, they have created more flexible ways of working with women, with physicians. Physicians are stuck in the self-critique model: do our way better, not create new ways of acting. Here, we again notice that uptake occurs between these systems of clinical care. Clinical decision making is something that was once made only by physicians. Yet we see the slow change, that patients can be active in their own decision-making. Decisions on how birth should occur is no longer the arcane or specialized domain of clinicians. Instead, it is shared experiences between clinical experts and the women that are impacted most.

Lastly reflecting on the work of the BWHBC and the founders of *OBOS*, we see lasting consequences today in the clinical relationship and how patients and providers engage and forge a relationship, in particular when they negotiate trust or when they determine it cannot work. Women and midwives talked about how they "just knew" or it just felt like their people when they interacted. In other words, there was a kind of social "chemistry" that allowed for some work to progress. doctors as "having taken a role of 'honorary men'" (186), this does not prove particularly surprising. After all, patriarchal society has caused all women to objectify one another and be disgusted with their own bodies; female doctors naturally share in these prejudices.

Yeah, I think it's like any relationship where you just—you know, you look at somebody and you're just like, "Ah, you're my people." Sometimes the opposite happens where—we have *amazingly* too where we had a couple that was with us and I just cannot for the life of me figure out why they were with us. They just didn't feel like our people. (Interview #1 p. 32; Midwife; emphasis added)

I think that it depends on the level of trust, and that goes both ways. So you get a sense for if someone trusts you pretty quickly in the relationship. And then you have a feeling about the patient. If you—I don't really know how to explain it very well. But there has to be trust in both directions. (Interview #27 p. 9; Midwife)

Women describe two key features for collaboration and to forging relationships with providers. Listening is key.

I think a big part of it is whether the provider is listening—like listening to you and not just sort of brushing things off or addressing things in a very superficial way, but if you have concerns, I think that I want someone who I felt like is really listening to me. In the last practice, I have to say, they were five very different women. And for the most part, I met with most of them in various ways, because I had a non-stress test and things going on, a lot of providers. And I felt like that practice did a great job of actually listening to you. They may not always be able to solve what's going on, but there wasn't that sort of giant separation between you and the doctor, just sort of dismissing—dismissive attitude, that's the word I'm looking for. So I think that I would look for a provider that I felt like was listening to me, probably someone that was—these days, that was a little bit—the reason that I would be more interested in a midwife is that I felt like—the second time was better. I went overdue the second time, but they were pressuring, somewhat, me to schedule an induction. And I ended up going into labor naturally. But I feel like for my third child, I want someone who is more flexible. I haven't had—I've had easy pregnancies, easy, uncomplicated births, and I would like someone who listens a little bit more to what I want and is a little more flexible and less rigid about how things have to be, like you can only go so many days before I induce you, or—and so for those reasons, I think that a midwife would probably be a little bit better fit, if that makes sense. (Interview # 17 p. 12; Mother)

And the other important factor is humanizing them as patients.

Just that they were—the two female[s] I felt like were personable. One was more reserved than the other, but both just treated me like a person...There wasn't much you could do, but they were both reassuring about that. And just in general, pretty positive about the thing...the one male doctor, was very—fatherly, a little bit. Not really my style, but still fairly warm. And then the fourth doctor was just very chilly and very impersonal, and a little too familiar too, for someone I hadn't met at all...“I'm getting close to the time, and how is this all going to go?” and was starting to ask legitimate questions for a first-time mom. And he's like, “Yeah, I understand that you're worried. People like you always—women always worry. But it's going to be fine.” And I was like—first of all, I didn't say I was worried. You don't know me. So yeah, he just was not—yeah, and just a little too familiar, making too many assumptions about me without having actual...actual information. I felt like he didn't humanize the experience very much, was sort of putting himself distant from—and I don't think that's a male-female thing. I don't think a male doctor has to necessarily make himself distant from that, or a female doctor has to be closer to that experience. But I felt like he was just very, very distant from it, and turned me into more of a “her” as opposed to a—you know, he didn't refer to me. Well, actually, I think he did refer to me once, talking to the nurse as “she.” “She needs to blah blah blah.” I'm lying right here with my legs up. You don't need to—you can actually refer to me as a person. (Interview #17 pp. 3 and 6; Mother)

Perhaps unsurprising it is easier to determine when a provider is a “no” rather than being able to define when a provider selection is positive and the variable characteristics. Again taking us back to the *OBOS* and *BWHBC* work, we went to the archives looking for evidence about why their

collaborations work and why they were able to connect with each other to forge such an amazing change in women's health care and did not find much of that evidence. Likely this is because those relationships faded or did not continue or were already in place prior to the 1970s timeframe of the BWHBC archives. We believe this is similar to the women who can't articulate precisely when collaboration or a relationship exists with a provider, but are clear when it doesn't work.

With the other doctor, I don't even know. I don't know if I've had a pleasant—I don't think there was a pleasant interaction with him—you know—for the entire time I was there. Even after it was all over and he came to see me the next day...and I really wasn't in that much pain, and he was like, "Oh, well, wait until that epidural wears off." He was just not a nice guy. And then I saw him again for my six-week postpartum checkup. I don't know why I made the appointment with him because I probably could have seen anybody. During that appointment—you know—it came up that I was like trying for a VBAC with my next pregnancy because I was already thinking that. After a c-section, I was like, "I'm not doing this again." Right away he shot me down. (Interview #13 p. 8; Mother)

I don't think there's anything that they could have done. I mean, we interviewed a couple midwives on paper, and in their philosophy, they were perfect for us. But we didn't feel—it just didn't feel right. We didn't have that natural easiness with them that you do when you first meet some people and like we did when we met our midwife at the birth center. So, our general feeling, I'd say, was the deciding factor more than the facts on paper were. (Interview #14 p. 11; Mother)

It is tougher. It is. And I think that one of the things that he didn't do that other providers did do, one of the goods, is asking questions. Like how are you, what do you need, what fears do you have—those sorts of things. And it's not even a level of concern about you as much as it is just like, I'm asking you questions because I want to know what's inside your head. I'm opening up some sort of dialogue. It's not that I'm worried about you or I need to be, or it's not that we need to get emotional or personal, but I'm trying to have a conversation with you, because you're going to have a baby, so let's ask about you. And I think that, combined with reacting compassionately but calmly to all your rational fears—Is pretty key, goes a long way, and—I don't know. It's hard, because you can tell when a doctor sees you as a person and when a doctor just doesn't want to interact on a personal level. [...] Yeah, not just are you okay, but like, are you feeling depressed? Are you sleeping? Are you showering every day? Blah blah blah. That kind of stuff. Also, are you regaining bladder control?...at least a few leading questions to try and get into what's going on in your head. (Interview #17 p. 18; Mother)

There is an engaged dialogue, empowered dialogue. Notice how she continues to show the importance of asking questions, how questions set up the foundations of relationships. By asking questions, we engage the arcane knowledge of clinical medicine, but also create the foundations for clinical relationships. She is advocating for herself, but passively. And she sees signs of collaboration from the provider because he seems interested in her beyond her symptoms and into what she is thinking and feeling.



## Conclusions

In this project around women's health, we have woven together two threads. First, we have begun with our own archival work in the BWHBC files. Here, we have found evidence for collaborations in the foundational writing of *OBOS*, that have thus far not been articulated. In challenging ourselves to see historical records of this canonical text, we have articulated that collaboration, the choice of collaborators, and the issue of shared agency were methodological decisions embraced by the women of the BWHBC, who crafted *OBOS*. These methods allowed the founding women of *OBOS* to articulate both individual and shared research objectives. The women epitomized the idea that the personal was political and sought to share personal knowledge, empower friends/colleagues, and engage women in the medical establishment.

Similarly, we have traced the legacy of *OBOS* to contemporary birth experiences through our interview data to understand the uptake, if any, that exists for women and providers today in thinking about their collaborations together for the project of birth. Both women giving birth and their clinical staff collaborators have identified personal values that shape the experiences of a successful birth. Just as with the crafting of early drafts of *OBOS*, women today still navigate the complexities of individual and collective values through uptake or the origin of the BWHBC.

## Acknowledgment

This work was done with support from the Albany College of Pharmacy and Health Sciences Scholarship of Discovery grant: "The Collaborative Self: Virtues for Seeking and Building Alliances in Health Care" (2016). We also would like to thank the reference librarians at the Schlesinger Library, Cambridge, MA.

## Endnotes

1. Using snowball sampling techniques, we approached a number women in our broad social network including that of our research assistants and emailed 10 women and 10 providers, roughly in an even split between OB/GYNs and midwives. The email contained a link to a REDCap intake survey hosted by the Albany College of Pharmacy and Health Sciences to ensure they were qualified for our study and to assess their availability for interviews. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies (Harris). Once potential participants completed the survey, they were called by a member of the research team to verify their interest in a telephone interview, consent the person into study participation, and schedule the interview. A trained interviewer, Parker, then called the participant at the appropriate time, verified consent for the interview, and asked permission to audiotape the interview. The interviews ranged in length from 30-60 minutes.

2. To our knowledge, these small but powerful sketches have not been articulated or recorded elsewhere in the literature about the crafting of *OBOS*. Susan Wells, in her book *Our Bodies, Ourselves and the Work of Writing*, includes a similar doodle, “The Dragon of Our Joy” (p 30). However, here, we are interested in how other meeting minutes reflected the work of the various *OBOS* authors.

## Works Cited

- Boston Women's Health Book Collective. “Boston Women's Health Book Collective Records.” <https://www.radcliffe.harvard.edu/schlesinger-library/collection/boston-womens-health-book-collective-records>.
- . “Minutes Notes September 1973-January 1975.”
- Brubaker, Sarah Jane. “Denied, Embracing, and Resisting Medicalization.” *Gender & Society*, vol. 21, no. 4, 2007, pp. 528-552.
- Candib, Lucy, editor. “Women, Medicine, and Capitalism, an Introductory Essay.” Boston Women's Health Collective and New England Free Press, 1970.
- Conrad, Peter. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Johns Hopkins University Press, 2007.
- Conrad, Peter and Allison Angell. “Homosexuality and Remedicalization.” *Society*, vol. 41, no. 5, 2004, pp. 32-39.
- DeCoster, Barry. “Structural Concerns for Msm Health in Revising the Precautionary Principle.” *The American Journal of Bioethics*, vol. 17, no. 3, 2017, pp. 50-52.
- Emmons, Kimberly K., editor. “Uptake and the Biomedical Subject.” Parlor Press, 2009.
- Garry, Ann. “Medicine and Medicalization: A Response to Purdy.” *Bioethics*, vol. 15, no. 3, 2001, pp. 262-269, doi: <https://doi.org/10.1111/1467-8519.00236>.
- Halfmann, Drew. “Recognizing Medicalization and Demedicalization: Discourses, Practices, and Identities.” *Health*, vol. 16, no. 2, 2012, pp. 186-207.
- Kirsch, Gesa E. et al. “Feminist Rhetorical Practices: In Search of Excellence.” *College Composition and Communication*, vol. 61, no. 4, 2010, pp. 640-672.
- Morgen, Sandra. *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990*. Rutgers University Press, 2002.

- OBOS Founders. "We Sparked a Women's Health Movement by Speaking and Listening to the Truth." <https://www.ourbodiesourselves.org/2015/11/obos-founders-jumpstart-womens-health-movement/>, 2019.
- OBOS founders: Judy Norsigian, Vilunya Diskin, Paula Doress-Worters, Jane Pincus, Wendy Sanford, and Norma Swenson. "BWHBC and 'Our Bodies, Ourselves': A Brief History and Reflection." <https://www.ourbodiesourselves.org/issues-impact/articles-books-media-about-our-bodies-ourselves/bwhbc-and-our-bodies-ourselves-a-brief-history-and-reflection/>. Accessed 28 April 2019.
- Riessman, Catherine Kohler. "Women and Medicalization: A New Perspective." *Social Policy*, vol. 14, no. 1, 1983, pp. 3-18.
- Royster, Jacqueline Jones. *Traces of a Stream: Literacy and Social Change among African American Women*. University of Pittsburgh Press, 2000.
- Royster, Jacqueline Jones et al. *Feminist Rhetorical Practices: New Horizons for Rhetoric, Composition, and Literacy Studies*. Southern Illinois University Press, 2012.
- Strauss, A. et al. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Sage, 1998.
- Wells, Susan. "Our Bodies, Ourselves: Reading the Written Body." *Signs*, vol. 33, no. 3, 2008, pp. 697-723. JSTOR, [www.jstor.org/stable/10.1086/52371](http://www.jstor.org/stable/10.1086/52371).
- . *Our Bodies, Ourselves and the Work of Writing*. Stanford University Press, 2010.