Marshall here, welcome back to The Realignment.
Ever since Saga and I launched The Realignment back in 2019, we've done our best to avoid particularly controversial cultural war issues.
Not because they aren't important, just because we have a really mixed, very heterodox audience and it's hard to pick a topic or an issue that is going to piss off one side or the other.
With that said, it's just a clear reality of American politics now that questions of abortion policy, pregnancy, birth, or at the center of our politics and a show focused on the realignment of the American political system cannot ignore the phenomenon.
So I thought I would take the issue from the perspective of birth, pregnancy, and motherhood in America.
I've got a great author to discuss this with today, Rebecca Grant.
She's the author of Birth, Three Mothers, Nine Months and Pregnancy in America.
And this conversation is really set up around addressing the factors that anyone in this country, whether they're pro-choice, pro-life, pro-abortion, anti-abortion, pick your means of describing the situation politically is going to have to confront.
You are going to have to confront the fact that America has incredibly high maternal mortality despite the fact that we are a wealthy industrialized country.
You're going to have to confront the fact that even after you control for education and income, black women are much more likely to die in childbirth than white women.
And of course, you're going to have to contend with the fact that race, all those issues aside, it is just much more expensive to have a child in the U.S. than it is in other countries.
All these phenomenon present different opportunities for folks from different sides to engage.
So I hope they do so accordingly.
All that said, quick other notes before we get in.
Number one, so I'm going to be back next week with our next Q&A discussion episode.
So if you have not subscribed to the Realignment Supercast where you could submit your own questions, upload others and check out what's going on, you can go to realignment.supercast.com or click the link at the top of the show notes.
And for our final reminder, Lincoln Network is now the foundation for American Innovation.
The foundation for American Innovation is the Realignment Chief Sponsor.
So really excited about that name change.
There's a link in the bio to the new website and you can learn more about the foundation for American Innovation work.
Hope you all enjoy this conversation and I'll see you all next time.
Rebecca Grant, welcome to the Realignment.
Thank you for having me.
A question that I got from Melissa recently is what is an issue or a topic that really has shocked you in terms of its prominence?
And I would just say that if you talk to me in 2016, 2017, where I was really thinking about the American political space, always big debates, I would not have expected pregnancy, childbirth, to be at the center of the American political scene, but also just a broader social cultural discussions, regardless of how you feel about all the attached topics we're going

to really hit from election results to just broader conversations that people are having
as like the millennial generation, just ages, if people start getting married, having children,
or maybe not getting married and having children the other way, it just seems to be at the
center of everything.
So could you place your book, birth, where does this book fit in this conversation we're
having right now?
I think that I sort of noticed, I don't know exactly how many years ago, but like a couple
years ago, it felt like just kind of as you touched on the conversations around maternal
health care and the U.S.'s maternal mortality rates, and just sort of it felt like there
was a surge of interest and there was some really amazing reporting that was coming out
from places like ProPublica and the New York Times.
And I think that there was a lot of interest kind of in maternal health care as an issue,
but then over the past year or so, as we've had the TABS decision and as the kind of landscape
around reproductive health in the U.S. has changed, I feel like I've been seeing people
kind of maybe thinking about these two issues as more connected or talking about them in
relationship to each other, which is something that I have been interested in for a long
time because my background really was I started out mostly reporting about abortion.
So I think it's an interesting issue for a lot of reasons, but one of them is also that
when you're talking about maternal health and kind of midwifery, it's really not that
ideological. You get people from all sides of the political spectrum who will be aligned
on sort of certain issues like the accessibility of home birth or the accessibility of midwifery
and then kind of the inverse as well. So yeah, I don't know. It's a really interesting issue
that's very much kind of moving and changing and the rates about a hospital birth have really
shot up over the past five or six years or so, in part kind of spurred by COVID. So I
think that it does feel like things are changing and that's certainly connected to politics as
well because there are laws around kind of where midwives can practice. So yeah, I think I hope
that answers the question. No, it does. And to your point about this bubbling up, okay,
I'm going to go off the serious for a second. Just ask, why is it midwifery? Shouldn't it be
midwifery? Do you know the pronunciation? Is there a reason why that is? I don't know.
And I think it's perfectly okay to say midwifery. I just don't say it that way for whatever reason.
But no, I mean, it's a good point because we call them midwives. So
I review my own personal things because I got an argument for a fiance about the pronunciation.
So that's why when you say you pronounce it that way, most nodding of there are other people in
my life who pronounce it the way that you pronounce it too. So I was just curious. Okay, so let's
about a biggest step back as we can. So I do a lot of work in the deindustrialization space. So
talking about labor unions, post-globalization, Rust Belt, et cetera, et cetera, et cetera.
And let's put race aside for a second. In that conversation, you'll talk about a golden age of
American employment. So back in the 50s, if you're a white male in Detroit, there's a situation where
you could graduate from high school, maybe not even graduate from high school, and you can get a
job
at General Motors and you could work there for the rest of your life. You have a great pension,
this, this, and that. That is seen as the golden age of a specific vision of American employment
in a very specific point of time. Is there an equivalent in the birthing and pregnancy

state topic of a golden age where our high mortality rates, the high cost, we've left some Eden that we used to have? Is there an equivalent in your space?
That is such an interesting question. And I've never really thought about it in those terms, but I love thinking about it like that. I mean, I would say nothing immediately comes to mind, although there are, there are sort of these like pivotal moments that really ushered in like a measure change for the positives. So I would, you know, I would say one of those sort of like moments was when, you know, there was the advent of like antibiotics and, you know, drugs like penicillin and blood banks became more accessible because those types of medical or technological advances really helped decrease maternal mortality rates and made childbirth exponentially safer. And so for so long, I mean, throughout like most of history and very much still today, you know, people are worried about their sort of survival in childbirth.
And so it used to sort of be that you realized you were taking your life into your hands any time that you were kind of embarking on pregnancy or on childbirth. And so I do think that all of those kinds of advances, you know, when there was a time when you felt people felt like they could go to give birth and that it actually was like relatively safe overall or relatively speaking, I think like that was probably a major sort of milestone. But then the sort of flip side of that is that like as I talk about in the book and some of the history sections, that technology and those sort of medical advances could almost be said to have gone a little bit too far or at least to sort of have become too much of a part of it to the point where it isn't necessarily the best thing for patients or what they want. And so that's part of why I talk a lot about midwives in the book. And so then if you're thinking about like a golden age for midwives, I mean, they were really thriving and like sort of the pride, predominant errors of people. Can you define a midwife before we go further? Oh, sure. Yeah, I mean, it's also a little bit tricky because there's multiple categories. And so, you know, midwife, like the root of the word translates or stems roughly kind of from like with women. And so historically, they have been women typically kind of elders who already had their own family who are respected in the community, who learned through apprenticeship and training and observation, who within their community would deliver babies would, you know, go to people's homes and help deliver babies and or attend those births. And so that is still true today, although now we have these two categories. So there's a certified nurse midwife who those are nurses, they're, you know, fully trained registered nurses who get a midwifery credential and predominantly practice in hospitals, but also outside. And then there's the direct entry path, which is also that credential is called certified professional midwife. And those midwives are really sort of like extending that legacy of those midwives I was speaking about before that were really community based and kind of learned through apprenticeship. So those are, I mean, there are more categories, but I think for most intense and purposes, those two big buckets of midwives are kind of what we have today.
Something I'm curious about when you're talking about how it's possible we've gone too far in the technological sense, is that in reference to the fact that it's incredibly expensive to give birth in this country in the sense that, you know, if maybe there was like a midpoint, so just talk about that dynamic. It's super expensive to give birth here. I mean, I think a vaginal birth in the US is something like five times the cost of what it costs in Spain. And so certainly cost is a part of it. But I also think the way that birth tends to work in hospitals, and it's hard to make generalizations

because many hospitals, there's a lot of diversity within them, but it's sort of like a preparation for a worst case scenario. It's like we have all of the things. We have the operating room, we've got the surgeons, we've got this tool and this medicine, and all of those things are absolutely life-saving or can be when someone needs it, when there's a complication, when there's an issue. But for people who are just sort of having a routine relatively normal to the extent that that exists birth without any major complications, relying to heavily on those tools or on those medical interventions can actually be harmful potentially. So like we have a C-section rate of one in three in the US and C-sections are major abdominal surgery. So they're super important to save lives when it's indicated. But if it's not necessary, then you're putting someone through this major surgery that can have all kinds of kind of adverse side effects potentially. So it's really kind of about using the right types of medical tools at the right time. And I think we have this idea sometimes in the US of like more is more is more, like the more science, the more technology, the better, the more you do. And I think with birth, that's not always the case. And I want to go back to your point about how it costs five times more in the US, world to the Spain when it comes to childbirth. Is that because as people know, like obviously the United States does not have a conventional, you know, European style health care system. So when you say, when you say that cost, are you saying, because once again, like it's a public subsidy versus like you're paying, are you saying a average American patient is going to pay five times more than a Spaniard would, or it's that the overall cost, whether or not the state is paying for it, or whether it's coming off of someone's like insurance or credit card is, here's the better way to phrase it, have the Spanish found a way to make the process cost less, regardless of who's actually paying the final bill. My understanding of that, that study, that statistic that I had referenced is yes. And so part of the reason that the costs are so high in the US is just sort of the way that our health care system is structured in which like everything is really expensive. And so when someone's going into the hospital, part of what is being paid for by someone, the hospital, the insurance company, the patient, usually a combination of all three, it's access to all of those tools and resources. So you're like paying for the anesthesiologist's time, if they're going to come to place an epidural, you're paying for access to the operating room, if you need, if you end up needing a C-section or some sort of surgical intervention, you're maybe, there might be a NICU in that hospital where if there's like the baby needs extra kind of medical attention. So you have all of these very expensive resources that are available and you're kind of, everyone is collectively paying for all of access to all of those resources, whether or not they're used, just because you're in the building. And so that's one of the arguments for midwifery care, is that you're making sure, if midwives are sort of like a frontline or for people who are interested in that, because it's so much more affordable, it's so much lower cost, you're saving then those more expensive, more intensive resources for the people who really need them or want them. And then that could potentially help lower costs overall. And so one of the doctors in the book who helped open a birth center that we talk about, his entry point to being interested in birth centers and the wifery care, was that he was in a working group as part of his healthcare organization about lowering costs. And then that kind of question of like, how do we lower the cost of maternal healthcare led him to midwifery and birth centers. So I think that conversation about like how we use technology is very much related to that question about cost. And what is a birth center?

A birth center or a freestanding birth center, meaning it's unaffiliated with a hospital,
I think of them as sort of being like a midpoint between a home birth and a hospital birth,
because it's an actual like facility, it's a building, they usually will have
certain types of equipment and tools there. So they're not going to be doing an epidural,
but they might have birth tubs or nitrous tanks for pain relief, they're going to have you know,
iodine or just like stuff that is sort of medical ish, or kind of like certain types of
clinical tools. So it's not like being, you know, in your home, but it's also not a hospital,
there's not an operating room, no one is kind of doing anything that is kind of could be considered
a medical procedure, but and the vibe is usually at least in the ones that I have spent time in,
you know, there's going to be a bed like an actual bed instead of a hospital bed and they're
usually decorated kind of nicely. So it feels like a home like environment, but with many of the
sort of basic types of tools or equipment that you need for, you know, for making sure that
a birth happens safely. And so for someone who's giving birth in their own home, they kind of
have to bring everything in or you know, the midwives or the patients. So yeah, I think a
birth centers is kind of being that midpoint between and you know, they vary in size and
it's just like a place where you can go to give birth without going to a hospital.
And I'm just to go back to the the cost conversation is the high cost conversation
not related to the high maternal mortality conversation, as in it's just like an unfortunate
fact that it's so expensive, but that expense doesn't necessarily lead to us having bad health
outcomes, correct? That's just like a it's just that seems bad, but they're not they're separate
phenomenon, right? I think they they are, but I think there's a way in which you could make
an argument that looks at them as being connected because there are so many things that
contribute
to our maternal mortality rates, it's a really complicated and layered problem. But one of the
factors I argue I can argue is that we rely really heavily on these sort of, you know, medical
interventions that can then lead to other complications. So like the C-section rate is a
good example of that. And so those like that heavy kind of reliance and routine use of
medical interventions and hospitals during birth is both driving up the cost. And then also I think
you could argue is contributing in some ways to the maternal mortality rate. And so, you know,
it's not like a direct kind of positive effect thing, but I think they're sort of related
phenomenon driving both. And I grew up in Portland, so shout out obviously, like that's where your
book is taking place. And that's where you are based. I'm curious, so I'm sure there's like a
narrative reason why you would as you're a writer, so you would base things where you're based.
Where would you say the epicenter for all these debates and dynamics and interplays would be?
Because I just on a variety of levels, demographically, obviously referring to race, when it
comes to like organs and incredibly pro-choice states, so like you're not going to have some of
like the pressure points you're going to have in a bunch of other states, especially like red states,
where would you say if you're if you're someone just looking at this broad topic,
and then we'll get into the book specifically, but you're still getting this broad topic of
where would be the state where there's just like the epicenter of all these things you cover?
Alabama, I think. So in 20, I think it was 2018 that it published, I did this story about Alabama
women who were crossing state lines to give birth with midwives. So currently there's something
like 13 or 14 states in the U.S. and a couple territories where direct entry midwives CPMs

cannot legally practice. And so what that does is essentially potentially criminalizes
out of hospital or the practice of out of hospital midwifery, which means people can't
give birth outside of the hospital. And so Alabama changed their law in 2017 and legalized
direct entry midwifery. However, they had these sort of exclusions, like if you've had a previous
C-section, you can't give birth out of the hospital. And so all of these women were there's
this whole ecosystem around Alabama in Tennessee and Georgia and Mississippi, where people were
renting these cottages and the midwives were delivering their babies there. And so
that was sort of what introduced me to like midwifery culture kind of in the first place,
to be honest, was that project. And so I think Alabama in particular is a really interesting
case because things are very much ongoing. Their law recently, you know, relatively recently
changed in 2017. And so they started to build in the wifery infrastructure kind of from scratch.
And so they were like, they were writing the laws and figuring out the regulations. And
there's this wonderful midwife who was actually based in Boston, and she was a nurse. And then
she moved to Alabama because that's where her husband's family was from. And she's trying to
open a birth center there. And it's been extremely challenging just to sort of get the approvals and
the permissions and everything that she needs to do it. And a huge part of why she wanted to
found this birth center was to serve this rural, predominantly African American community in the
western part of the state where there's this real dearth of maternal health care options and
where the outcomes aren't great. And so she's sort of like, here's I'm trying to build this resource
or trying to build this birth center, her name is Stephanie Mitchell. And she's running into all of
these kind of obstacles from the state who are making it difficult. And so I think like,
for all of you know, Alabama is really interesting, because the history of midwifery there is an
incredibly rich history. And then you also have this very kind of active ongoing situation where
the law has changed and they're trying to build something, but it's proving to be challenging
and the need is really strong. So yeah, that's, that's what I would say, I think if I kind of had
to pick one state where things feel, oh, and of course, they have banned abortion now, which
abortion
bans we know lead to upticks and maternal mortality and other sort of adverse outcomes.
And so that's another factor now that people are contending with.
I kind of understand like, almost to that, and it sounds foofy, but almost to the philosophical
level, why a state like Alabama would be hostile or potentially hostile to midwifery,
just in the sense that we already have this broad crisis in America of like rural hospitals
closing. And it just seems like at a basic level when school choice is a whole entire
other policy area, but like the basic argument with school choice is, hey, like you as a parent,
you should be able to decide like what your child's education looks like and always like
different contexts, this, this, this or that. So it seems that when it comes to birth, like
separate from abortion, just for a second, like when it comes to the active giving birth, hey,
like maybe you live in a rural part of the state, maybe you want this, maybe you want that on a
philosophical level, I'm just struggling to understand what the objection is,
given those different challenges and priorities.
Thank you. Me too. I agree. I think it's, I find it all a little bit mystifying,
but I think my understanding from folks I've spoken to and some of the reporting that I've
done is that there's a very long entrenched history of kind of antagonism between doctors and

midwives,
and that is one, you know, with roots that go way, way back because really the practice of midwifery when it was being phased out and made illegal in the U.S. was sort of an indirect correlation with the strengthening and the formalizing of the medical establishment, and that was a predominantly white male medical establishment. And so they have, I mean, historically always seen midwives as a threat, as sort of these like rogue practitioners who are not capable men of science, who are sort of, you know, shouldn't really be practicing. And so there is this kind of legacy that still lingers today in which people who are, whether they're physicians or whether they kind of work in like the sort of mainstream like hospital or medical space in a lot of places are pretty antagonistic towards midwives and the idea of midwifery, and they don't think that they should be practicing. They think that out of hospital birth is too unsafe. And so I think that's sort of my best answer of like why, because it is such an incredible and underutilized, midwifery is such an underutilized kind of resource, I think, but I think it really kind of stretches for back to that history and that sense of midwives as sort of, you know, quote unquote rogue practitioners. Man, that's so interesting, because when you're giving me that answer, I just start thinking about the nature of this like 19th century onwards, like medical progress story to ourselves in the sense that, okay, so they figured out, aside from just like penicillin and everything like, hey, like we should really like wash our hands before like operating on people. They figured out, hey, like the Germans are the Germans have always like innovations, like we should bring these innovations in from Mike Prussia and this, this, this, that, and that leads to all sorts of like construction of like the modern medical school, etc, etc, etc. Putting aside, I think, obviously, it's hard to do this by the, but I want to do it, putting aside like the racial dynamic, especially in the south of like the midwives and like the white male medical establishment, I could entirely see a white state like Oregon, which also had its own racial issues, but let's just keep it to white people for a second, saying, just as we've agreed, you know, we're going to have like medical schools, and we're going to like wash our hands in own births without people who've been through medical school, don't have these certifications of these processes, that's another three 19th century thing we're going to throw out. So I guess what I'm really asking you is like, how does this make you think about the way we tell like the history of like medical progress and like what is like actual progress versus like what is a social construction. So like we definitely at a scientific level need to wash our hands like props to the 19th century. I think medical school is a good thing, especially relative to, you know, quack science and all that stuff you're having during the progressive era, but that could be taken too far in the context of like a rogue practitioner, because it's easy to say that loud and see that extending very, very, very far to unreasonable state, maybe to the case of like Alabama's in that context. So this isn't really a question, just more of a can you like reflect on this dynamic? Yeah, I think that like one thing that was really important to me with the book is that I certainly would say the book is, you know, it's pro-Midwife, but I wouldn't say that it's anti-hospital. Like I don't think that like we need hospitals, they do really important. Hot tech. Right, I know, right. I know, but I mean, you know, I feel like that is because there's this long history of kind of antagonism, like I was just talking about between doctors and midwives, I feel like sometimes you actually do have to say it of like some of these medical tools and these interventions are like wonderful

and great and people who want them should have them, which maybe that feels like a silly caveat, but I do sort of feel like I have to make it. And so I think that it's the challenge is that you want to be able to take advantage of those advances and those resources, but you need to be able to kind of have them be the kind of tools that you're taking advantage of like have to be the right one for the right patient in that particular situation. And you know, birth isn't like getting knee surgery or getting your appendix out in that it's not a purely medical event, right? I mean, first of all, you can do it without any sort of like official medical tool, you can do it outside of a hospital, which like is not recommended for knee surgery. And it's also this like cultural and emotional and family. I mean, there's like so much other stuff that's wrapped up into it. And so I think that, you know, that sort of sense of like personal care and that kind of like we're going to be doing the things that you want and need and not just medically, but also sort of like emotionally, I feel like birth has this really unique place and that you're you really need to touch on all of these aspects, which I think is sort of why it's like you want to have these medical resources available when they're necessary. But then that's what midwives and birth centers can offer is that it's really like the sort of holistic model where you're getting to know people and their families are talking about their fears or anxieties. So you're trying to build, you know, midwives really try to build these deep and long term relationships with clients so that when they're giving birth and when things are really stickier, when things are changing, that they're really able as a care provider to kind of understand what's needed and what's best for the client in the moment. Because a lot of people do emerge from birth feeling pretty traumatized and mistreated. And that's not necessarily just from sort of like the physical thing that happens to their body, although that's part of it. A lot of it is about treatment and whether people feel like they have control and agency over what happened to them, whether they feel like they went into a hospital and were sort of steamrolled and like all of their preferences were thrown out the window. And so I think, yeah, like it's really sort of like you want the kind of best of both worlds. If you want this holistic midwifery approach, but then you also want those medical tools when you need it. And you want for safety, like the smooth integration between out of hospital and in hospital so that if a patient needs to transfer or if they have some sort of complication, the doctors and midwives are talking to each other and sort of like able to provide all of those things that the patient needs. And being a devil's advocate is unfashionable, but I will be a quick devil's advocate. What is just because like, you know, this right doing this type of reporting stories are never tidy. Is there a midwifery stop birthing center worst case scenario, right? So like, is there this example of, oh, actually, this like went too far or this like wasn't a good idea or actually turned out they actually were rogue practitioners? Because that's just to my mind, is there a version of that?
Sure, of course. You know, just like there are with doctors in hospitals, I mean, you can sort of, I think, find like, I don't know, a quote unquote horror story anywhere you look. And so a term that you often hear that is kind of mentioned by doctors or hospitals is trainwreck. And they'll talk about that in the context of a patient or client, I guess midwives call them clients, but whatever patient who someone who had an out of house out of hospital birth and needed to transfer for some reason. And then they show up to the hospital. And it feels like, you know, kind of from the hospital staff, staff's perspective, it feels like, you know, it's too late, or we don't know what's going on or like, it's got so much worse than it could have as like this person

had started in the hospital, they'd come in earlier and they refer to those as trainwrecks. Because then the doctors feel like they're sort of having to like, clean up the sort of this mass or like respond at, you know, past the point when it was kind of would have been like more straightforward, I guess you could say. And a lot of physicians that I have interviewed have talked about that, you know, whether they're speaking about why they were resistant to out of hospital birth and midwives or, you know, just kind of like on the topic, like a lot of doctors do have these kind of trainwreck stories they will refer to and not necessarily to say that they're against midwifery, but just like they have them in their mind. And so that's, I think, that's certainly a thing that can happen, just like there's horror stories that you kind of get from the hospital. And that goes back to the point I was making about integration, where if the midwife is practicing in a state where she's really not supposed to be, or if they know that the local hospital is really hostile to midwifery, that is going to create a deterrent to sound like if someone's going to transfer their patient there, like they're going to, you know, be nervous about that. And so that kind of hostility and antagonism, I think, can contribute to that dynamic. And so most states that are all states, most that regulate midwifery, they have specific guidelines and rules for when you have to transfer. So it might be like if you've been in labor for X number of hours, or if your water broke, but your contractions didn't start for X number of hours, or if this complication arises. And so a lot of states will sort of have regulations and rules that say, if this happens, the patient has to be transferred to the hospital, really just sort of try to prevent those types of things that you were mentioning before. But then that can be complicated in its own right, because a patient who might not want to go to the hospital might hear that they kind of have to go because they've been in labor for however long. And then they sort of feel like, you know, the state is making their decision for them. And so it is kind of like a nuanced issue. But yeah, I mean, ultimately transfers are inevitable, they happen, there's transfers in the book, and birth is unpredictable. So I just think the challenge for our healthcare system, if we want midwifery care to be more accessible and integrated into the mainstream, is to make sure that these two systems are working together. Having just, you know, entered my 30s, I'm definitely at the age or whenever I like open up Facebook, like every six months, like every other person I knew from middle school is now either pregnant or having a baby. And what I'm kind of wondering here is, could you speak, we're from like the same generation of cohort, could you speak of how different generations think of these dynamics? So for example, is there increased interest in midwifery when it comes to Gen Zs and like millennials, is there like a difference in like the early, early, early, like 1980 millennials versus like the 94, 95, 96, 97 cohort that I'm like adjacent to. How should we think of this on a generational level? I'm like, how many generations back do you want me to go? I'm like back in the 1900s. Yeah, I won't go that far. Let's leave it to as all things in American politics. Let's do boomers on hurts. You know, I've had conversations with some kind of, you know, boomer generation folks that were about the book or interviewed them as part of the book or sort of whatever. And I think something, and this is just anecdotal, but I think that the idea that you could sort of have like a birth experience, like it's not just sort of like having the baby, but that it's something you could sort of like make these decisions around and choose something around and kind of have hopes or expectations for beyond just I want to be healthy and I want the baby to be healthy. I think that was not something for that was particularly present for a lot of boomers. I

mean, I think even though this is still true, it was very much the like you go to the nearest hospital, of course you have the epidural and you do whatever the kind of like doctor hospitals are going to say and then you like go home and you know, maybe like sort of do formula and all of those kinds of things. Like I think it was just sort of there was like a way of doing things. And certainly those things are all still very much in place. But I think with millennials, there's a couple of different things that are at work. One of them I think is social media. You know, certainly like there are baby message boards and chats and forums and that stuff like all over the place. But I think people are also have been sharing stories of things that have happened to them or sort of like birth experiences that they've had. And they're sort of able to like express what happened to them, particularly I think if they felt like they were mistreated or coerced or something went wrong in this way that has really circulated around social media. And there so I think that has sort of helped to chip away at the idea that the hospital is always the safest place to go that it's always the best place that that's you know, you shouldn't go anywhere else. And then I think along those lines, like, I don't know, we talk about millennials and like we love our experiences and sort of our our Airbnbs and our like, you know, I don't know, our activities and we kind of like things to reflect our personality in some way or like we like sort of the choices that we make to feel reflective of our larger world view. And I think that maybe like some kind of interest in like maybe I'll look at a birth center because it feels more comfortable and it feels like reflective of my ethos or whatever.
I think like that's potentially part of it too. So yeah, I think I mean the generational question is interesting because midwifery has really gone through these like ebbs and flows over the decades and it has for the most part been a pretty small percentage of overall births and out of hospital birth has always been below 1% or has been for you know, the most recent past. And now that's starting to shift and like out of hospital birth went to 1.6% for the first time since 1990 and that felt like a big milestone. And so, you know, I think there's these questions of like whether midwifery and this uptake and interest is here to stay. And that is kind of partly a generational question, right? Because it's like, what are the people who are giving birth now and will be in seven years or 10 years? Like, are they still going to be interested in pursuing this? Or will we just sort of see another like ebb? I think it's here to stay, but we'll see.
So in these last few questions, I guess the first question, to what degree is the long-running BBC television program called the midwife at all? I've never watched called the midwife, but it's always in the like Netflix or Amazon queue in a certain direction.
I'm just curious to that like at all. It's not like Mad Men where like I have like, I understand how this like affected like American fashion culture, but I've always been seeing it, but did call the midwife at all like make any impact on the discourse here?
I feel like maybe, I mean, I don't know. But I don't see why. I mean, people watched it and enjoyed it. And I mean, like midwives are still in the UK. That's like the main person who attends people during birth, like you get a midwife and then you're sort of only elevated to like an OB-DYN if there's some sort of a complication. And so, you know, I think like that idea of midwives as being these community health professionals who are like, in the show, like they're going to people's homes, but they're really trained and they have like their cute little nurse caps on. I think that was probably a pretty different paradigm for what a midwife could look like in the type of role they could serve in a community than

anything that we really had here in the US. Because midwifery in that show is very much treated as like a legitimate profession that involved training and it's really rooted in the community.
And I think that where sort of the midwifery in the US is trying to go like is sort of in some way in that direction. So yeah, I think like, sure, why not? I think it could totally have had an impact. So then last two. The book obviously is about you following three mothers during this period. Was there any obvious book question? Did that process overturn any longstanding beliefs you had beforehand about this process?
Hmm. And do you mean that like in any way or kind of about like maybe in any way? Did you you do a project like this? I'm sure you had assumptions, expectations, etc. Did just surveying and integrating into three different people's lives say, Oh, that was just incorrect.
Or maybe it confirmed everything. I'm just, yeah, I can go out their direction. You were totally, you were totally right. Totally wrong to be in between.
I think that I don't have personally had children. I don't have kids myself. And so I have reported on this for a long time. Of course, I have friends with kids. So I think I had some, I knew it was hard. I knew that kind of going through this process can be emotional and stressful. Like I knew all of those things sort of like on an intellectual level, but I think because even with my friends, like I'm not spending hours with them every week talking about how they're feeling. I'm not sitting in on their appointments, you know, and so I think having the opportunity to spend so much time with each of these, my three characters and just really kind of like mine, the minutiae of everything that they were going through and feeling was just really eye-opening and in a way that felt kind of visceral in a way that really gave me just even more tremendous sort of awe and respect for the fact that like, I mean, frankly, but anybody goes through this because it's really hard. And you put your, you go through a lot and a lot of levels to sort of embark on this process. So that wasn't really like a belief that was overturned, but it just really opened my eyes in a way that like, I kind of thought they were open, but really just understanding like what sort of it's like for people who are just navigating this all the time. And like the fact that like the sort of complexity and intensity of these experiences is replicated at and been a number like, you know, anyone.
I just think it's like pretty astonishing.
And to wrap, I think the real hook for this topic for anyone who hasn't really thought about it that much at a personal or, you know, soon to be parental level is just these maternal mortality rates, right? In terms of, so the internal mortality rates, how devastating this is for black women in terms of even taking into account education and income, just the fact that it's 243% higher. Then obviously the cost thing we said at the start of the episode, a lot of like, this is like a really like policy centric podcast. So I think a lot of like policy maker types are listening. What are the takeaways when it comes to that? Because like our conversation
up until now has been very focused on like the personal, like what are you choosing?
Also some states should have better policies when it comes to midwives, but just like, how do you just reflect on that side of these issues? Like the highest stakes, is this like a policy failure? Is this like a cultural failure? Is this one of those?
The US is just different than Portugal things. Like how do you think about this?
Yeah, I think it's a little bit of all of the above. And I think that it's absolutely

a policy issue because there are so many, I mean, but it's not just one policy issue. Like
there are so many ways that we could go about addressing maternal mortality that will sort of
address the problem from these different angles. And so, I mean, one of them is insurance coverage,
right? I mean, one of them is making sure that people have ready access to preventative healthcare,
because if you go into a pregnancy or childbirth with some sort of untreated condition or an
undertreated condition or chronic condition, that can potentially lead to complication.
It's also expanding like Medicaid coverage for longer postpartum because a lot of maternal deaths
are happening after delivery. I think there's sort of this idea that like,
when we talk about a maternal death, it's something that's happening kind of like in the
delivery room, but for a pretty significant proportion, it's actually happening after. So
something like expanding Medicaid coverage longer into the postpartum period can help prevent
some
of that. There's also things around like the midwifery kind of state laws as we've talked about,
so making sure that it's more, that it's like legal everywhere. And there's also things around
like midwifery education and training. So like, if we want to have more midwives, we need to make
sure that people can get access to the education and the training that we need. And we need to
make
sure that those people are not just, you know, middle class white women, we have to make sure
that there are people from lots of different backgrounds and socioeconomic levels and geographies.
And so, you know, you could also talk about like insurance reform could be part of it. It's really
hard to run a birth center and keep them open and part of that has to do with insurance coverage.
So yeah, there's a lot of different kind of policy things. And there have been efforts,
there's an act or a bill that was sort of called the mom-n-bus bill that had like lots of different
provisions of things that could happen, like, you know, including like, how do we count maternal
deaths? The way that we count maternal deaths in the US is pretty fragmented. And it can be hard
to
sort of get accurate information sometime because different states might count things in different
ways. And so that might sound like a sort of small thing, but actually being able to have
real kind of consistent data on the problem can then potentially lead to
greater insight that can lead to solution. So I think there's, you know, so many different
policy type initiatives or things that could go into addressing racial disparities and making
the whip-free care more accessible and addressing maternal mortality rates overall.
That's an excellent place to leave it. The book is Birth, Three Mothers, Nine Months and
Pregnancy in America. Rebecca, this has been really great and it's a quarter check into somebody
who's
not with this recording, but coming to us from Portland, Oregon. Thanks for joining me on The
Realignment. Thank you for having me. Hope you enjoyed this episode. If you learned something
like this sort of mission or want to access our subscriber exclusive Q&A,
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