Darla Torres: —Missoula midwife. How long have you been in practice?

Michele Neal: Twenty-four years.

DT: Twenty-four years. So, can you, first of all, just describe what kind of midwife you are, how you got started, and, you know, what you do as a midwife?

MN: I’m a homebirth midwife. I started being interested in practicing as a midwife with my first pregnancy. My daughter was born in 1976, and she was born at home. I was living in Tucson, Arizona. Midwives were practicing there legally because the state didn’t recognize it as illegal or legal. They started a midwifery school, and we went and started our own little curriculum. That’s how I actually got into it. There were other women, who I met, who were interested in doing the same thing because they were also pregnant. So we started our own curriculum and self-study and started a clinic, so that women could come and do their own prenatal care. Then find a mid...whoever, who had the most experience, and who would attend their births. It was the grassroots of practicing. It was pretty simple and basic. But I did all my own prenatal care under the supervision of other moms that were pregnant and women who had attended a few births. Had my first daughter in Tucson. Had a great experience, and realized that there was no other way that women should be having births. I came from a philosophy, anyway, my upbringing was to take care of ourselves and not go to a doctor for every little thing. That pregnancy—you weren’t sick. It was a healthy phenomenon. Then, I after my daughter was about nine months old, actually moved to Montana. Then realized I didn’t find anybody who had the same interest in Darby, Montana. So I came to Missoula and went to the Women’s Resource Center and met Dolly [Browder].

DT: What year was that?

MN: That was probably 1977. Or was it called the Women’s Center? I can’t remember what it was called.

DT: Women’s Center at the time.

MN: Dolly had had a daughter at home, unattended—you know, an unassisted home birth. So we just got to talking and found out that there were other women who were interested. We just started doing a self-study class like once a month or every six months—I don’t even remember how often it was—and would commute to Missoula how ever often there was
workshops. In the meantime I bought lots of obstetric books, and...that I could get my hands on. Other families heard that I had had a homebirth and asked me if I would just come as a friend and help them. Really, that’s how I got started. I just got invited to go to other couples’ births who thought that I might know a little more than they did.

DT: Did you want to be a midwife? I mean, back in Tucson had you thought, “I want to be a midwife.”?

MN: Well, I thought about it when I was doing my own care, that this was really an important need. That there were women who were wanting to do this, and there wasn’t anybody that was offering it that had...that was licensed or had come from Europe. You know, there was nothing like that, that there was in other states. It was just women wanting a different choice rather than going to the hospital, and so they were practicing.

DT: So what is it do you think that makes certain women who have home birth experiences later on want to become midwives, rather than just leave their home birth experience alone. What is it in a person that makes them want to take it further and actually provide care to other women?

MN: Wow! For me, I guess because I was so young, it empowered my strength more, and I felt like it was an important step for other moms. I wanted just to expand on that, share information, knowledge with other families who are coming from an alternative background. I guess I feel like a lot of things that I’ve been involved with I fall into, and they...it just feels right, and I go with it. And if it doesn’t feel right I discontinue, so...Probably the most important thing was that there was a need.

DT: Yes. A need for a different model of care for pregnant women?

MN: Yes.

DT: What’s different about what you do than what a nurse midwife might do or an obstetrician might do?

MN: Oh, working with families in a whole perspective with them, and involving myself in their lives, doing counseling, nutrition counseling, sharing what beliefs and knowledge I have that they’re interested in. Basically being an avenue for information. And working with them as individuals. If they have certain idiosyncrasies that someone else might be...I don’t even know the right word...It would intimidate them and they wouldn’t want to deal with it. So, I look at every mom and dad as an individual, and finding what best care that they need. I mean, some people want nutritional information and I can give it. Some people don’t want to change their diet too much, and you can’t demand of them that they eat a certain way, or act a certain way, so working with everybody as an individual. Letting moms know that birth...it’s real important to let moms know that birth is normal. I really think that a certified nurse midwife and physician
still often give scary information to moms, and they go into their labor really fearful and that doesn’t do them any good.

DT: Why do you think they do that?

MN: Because they’re afraid. The medical training—has taught them everything is high risk, pregnancy isn’t normal, there’s complications. They also create complications by interfering with either inducing or with monitoring, or restricting mom’s movement during labor, or offering pain medication. All of that has interfered with how moms labor, and their self-confidence. Then problems are created.

DT: Then do you see differences in babies too, later on, that are born at home versus at the hospital?

MN: Oh, no. I guess I couldn’t go as far as that. I don’t know. I mean, I think intuitively I feel like parents have a, often a better relationship with their kids. But I’ve also seen moms who had really hard labors at home that are distant from their babies initially too. You know, they have a struggle, so...I do believe that in the long run, that the medical model is that it’s not necessarily the best health care or babies, because we don’t know what we’re causing. Hasn’t been enough studies on ultrasound to really say that it’s safe. We don’t really know the effects of epidurals and Demerol and cesareans. We don’t have any idea really what the effect is long term.

DT: Pitocin induction?

MN: Yes. There’s all those questions out there and they’ve not been answered so I can only imagine that babies are...We know risk factors of fetal alcohol, alcohol and fetal alcohol effects and syndrome and smoking in pregnancy, we know all of that. But no one’s really willing to do the studies on all the other things that are involved in the environment and during labor.

DT: You’ve been a midwife now for 25 years, right?

MN: Yes.

DT: So, what kind of women come to you? Can you say that a certain kind of woman wants a homebirth, or—?

MN: I would say a lot of women who’ve had prior birth experiences that went in and turned over their care, and then were totally dissatisfied with their previous birth experience—that they didn’t have any say where they thought they were going to. Or they had pain medication, and then ended up having a cesarean or forceps, or vacuum extraction, and so they actually felt like...I’ve had some parents say they felt like they were raped by their birth experience, and so they wanted something different. They wanted to have more control. I get that kind of family coming to me, or the family who has fear of hospitals and doctors from either prior experiences
or family experiences in their parents, grandparents. The majority of families who are choosing a homebirth, I think, are already alternative minded. They see health care in a different aspect, either herbally or through dietary. They just approach life differently. They don’t just go into a physician routinely. They’re also realizing that birth is normal, and that it’s not complicated and high risk. I also work with a lot of families who just want to do it for financial reasons.

DT: Because you’re more inexpensive?

MN: Yes. Because they can’t afford to have a hospital birth. I don’t feel like they’re the best families to be choosing a homebirth strictly on financial reasons, but I also feel like you have nine months to work with them to realize that, that they’ve made those choices for other reasons too, even though it may have initially been based on financial.

DT: Do you see those people having higher transport rates or more difficult labors than the ones that—?

MN: If they’re still really fearful during their whole pregnancy, I would actually then suggest they have a hospital birth and have it covered under Medicaid if they’re still really that fearful. Most families turn around after one or two prenats. They come into it not really understanding what midwifery care is all about, what kind of one on one they’re going to get, what kind of information and education they’re going to get, what kind of support they’re going to get. Once they actually see that, they feel differently about it. Then they actually want to have a homebirth. But initially, I would have had my doubts with some of the families. There’s certainly some families that after a few visits you realize they’re not good candidates for a home birth, unless—

DT: For whatever reason, emotional or physical or whatever, and then you’re comfortable transferring your care out to another practitioner?

MN: Because I’m not being the best professional that they need. They need somebody different. If someone doesn’t want to do any reading, can’t come to prenats on a time on a regular basis, they have no...they want to like turn over their whole care, then they shouldn’t be having a home birth. They have to take a lot of responsibility for themselves to have a homebirth.

DT: So you see clients here in your home?

MN: Yes.

DT: And do you see clients at their homes?

MN: If they live in Missoula, I do all the prenatal care at their home. If someone lives out of town, then they come here, except for initial blood work.
DT: So how does it affect your home life to have clients coming in and out of your house all the time? And you’re gone for births and—?

MN: Well, since I have an office in my home, it’s actually pretty simple, except for when my husband’s home eating lunch, and then they have to smell whatever he’s making. And then they get hungry and they want to stay. I actually prefer to do prenatal care at the families’ home, because then I feel like it’s another avenue to get to know them. I certainly will do one or two home visits at someone’s home if they live out of town, just so that you get familiar with their space, and that is where they’re going to have the baby anyway, so...The only time it’s a problem is if...There’s been a few families who live far enough away from the hospital that it’s not conducive to have a home birth at their house, and then I’ve had them have their babies here. My husband’s been...I wouldn’t say he’s thrilled about it, but he’s actually can be quite supportive when it’s actually happening. And so—

DT: How many births do you do a month? Are you doing less births?

MN: I’m doing less births now. I’m averaging one or two a month.

DT: Why do you think you’re doing less births?

MN: Because I took my ad out of the yellow pages. I’m not advertising. It’s just word of mouth now.

DT: Just because you don’t want to be so busy? Are you really wanting to slow down?

MN: Actually, I wanted to slow down because when my oldest two daughters—the 25-year-old and the 23-year-old moved away from home, I actually wanted to have more time to be able to visit them, and not be on call all the time. So it’s actually been a perfect balance.

DT: So let’s go back to the beginning days of when you were first studying, and, and educating yourself. Did you form the original group of women that you studied with, was there any doctors or anyone around at the time that was helping you or supporting you?

MN: Not in Arizona, but in Montana actually, we would invite some of the family practice doctors, and a couple of the OB doctors into our home, and ask them about information, and they would share with us. That actually all changed when we tried to get licensed. Then they were no longer receptive.

DT: No longer friendly?

MN: No longer friendly.
DT: So were you involved in that childbirth conference that—?

MN: With Michelle O’Daunt (?)?

DT: No. Was it with Michelle O’Daunt? Yes.

MN: Yes.

DT: In ’78?

MN: I don’t know what year it was. But yes, when Michelle O’Daunt came here, I was come up to Missoula, and be involved. Yes. I was one of the original midwives who would get together twice a year and have conferences with CAPLE (?), and out of Santa Cruz, and Jenny Walker when she was practicing.

DT: Yes. So you—?

MN: So that’s where we got some of our training is through work shops and self-study groups.

DT: And the doctors were pretty supportive at the time?

MN: Yes.

DT: Then the whole legislation thing started happening.

MN: Yes, then we had a new physician who came into Missoula, who decided that “Hey, these women can’t be practicing.” Went after one of Dolly’s transports, and the whole climate of midwifery changed. It became hostile then. So we no longer had support.

DT: How were you involved in the legislation?

MN: The legislation of going over there, I was president for a few years organizing the phone trees, working with the information to the legislators, helping Dolly...I think, pretty much when we first started I think Dolly was the president of the MMA, and then the next two years I was so I was always active in going over there, and speaking at the legislation.

DT: And the MMA is what?


DT: Is that still an active organization?
MN: Yes. Kind of. We have no money in our account. Honestly we all got burned out of getting licensed. It was way too much work.

DT: What do you think of licensing and legislating midwives? I mean, would you support it now? Do you—?

MN: Knowing everything I know now, yes, I would. I think it’s been a good thing. There’s a lot of things that would have been nice if we could have had differently, but all in all, I actually think that we have a great board. We have pretty good regulations. The protocols and regulations are pretty easy to go by. There isn’t anything that’s outrageous. I wish the physician had a better understanding of what our protocols and regulations were, so that they knew that we had certain guidelines that we could follow. I think a lot of times they think we’re just loose cannons out there, and we’re doing whatever we want to. There were enough midwives in Missoula, and the way we all practice, self-practice, we actually came up with our own protocols—that we needed a consistent protocol for everyone to practice under, so that there wasn’t ever a question from one community to the next.

DT: So all the midwives in Montana pretty much practice the same?

MN: Basically. I’m actually glad that we’re licensed. Besides all the paper work, it’s pretty darn simple to know what’s right, and what’s wrong, and not feel like...There’s certain families that you work with that would have a tendency to push the limit, with saying, “Well, please do this,” and “Please do that,” and “No, I don’t want to be transported,” or “No, I really want to have twins at home.” It made it standardized that, “No, this is the way it is.” It actually gave the midwives if they felt like something was high risk, it actually allowed them the ease of saying, “No, you’re outside of the protocol, and you need to have a hospital birth.”

DT: Midwives have been legislated now since 19—

MN: Ninety-one.

DT: Nineteen ninety-one. In that period of time, so you think that licensure has raised the credibility of direct entry midwives in the eyes of the public or with doctors?

MN: In the eyes of the public, but I don’t think...maybe subtly with physicians. I still think that they really don’t know what we do. I think they’re still really naïve. Often I still, you know, “Oh, you do that kind of testing?” “Oh, you use a Doppler in labor?” “Oh, you...?” They just have no idea.

DT: Yes. They think you’re all lies.

MN: Yes, that we go to births and have not done any prenatal care. I think that they’re just being naïve. They just don’t even want to look at it.
DT: So do you remember who was originally licensed, the original—?

MN: Ollie. Do you want? I don’t...can’t...won’t say last names. Ollie, Dolly, Pat—

DT: And yourself?

MN: Myself, but there was seven of us I thought. Ollie. Ollie. Myself. Pat. Patricia. There was another Pat and Patricia. Wasn’t she one of the original ones? Yes. There was another midwife who lived over towards Bozeman. I can’t remember her name though. I don’t know.

DT: Wasn’t there one in Kalispell or Whitefish?

MN: Oh, that’s right. What’s her name? She’s been gone for so long now. Katie took over her practice. I can’t think of the name.

DT: So she’s not practicing anymore. Are the rest of them still practicing?

MN: No, Pat left. And so the midwife in Whitefish left. And Ollie is no longer in Billings, she’s in Great Falls. And the woman in Livingston, Bozeman area, she moved away for a couple years, but came back. And now she’s practicing again.

DT: What was her name? Is that?

MN: That’s the one I can’t remember. She had long dark hair.

DT: Oh well. We’ll find her.

MN: You don’t, you don’t remember the names either?

DT: Is it Willow?

MN: No.

DT: Michael Anne?

MN: No, it wasn’t a certified nurse midwife. Willow was a naturopath. Michael Anne was a certified nurse midwife. It was someone that worked with Michael Anne though. Can’t think of her name.

DT: Oh, well. That doesn’t matter.

MN: I can see their faces.
DT: Yes. So, let’s see. How has midwifery changed in, like on the national level? Do you keep up with midwifery on a national level?

MN: Oh, nationally I think it’s a lot more trying to educate the public about midwifery care, and the safety of midwifery care, standardizing education, so that there’s...for the licensing—national licensing—that it’s a standard. I think basically it’s the education of the community is probably what’s been the biggest changes.

DT: Yes. How do you think most apprentices or most new midwives get their training, aside from in Montana where it’s (unintelligible)?

MN: Well, I still think it’s mostly through apprenticeship model, but there’s a lot more. I mean, there’re so many schools now that offer programs—one year, two year, three, three year programs. And I think a lot of midwives are taking advantage of that, rather than going through the apprenticeship model.

DT: So do you think that, that home birth and midwifery is going to become a more and more common thing, or...I mean, right now it’s sitting at about one percent. If you could go about making home birth more common, what would you do? Do you think that that’s possible?

MN: I think it’s possible. I don’t have energy for it, but I think that’s what the goal is with MANA is to educate the public and educate physicians that this is a viable alternative to having a hospital birth and that it’s safe. But I also think that it’d be changing people’s perspective of...that birth is normal and that this isn’t a scary thing and that it isn’t high risk and that every mom out there isn’t going to have a problem and bleed to death like they do on TV and will have horrible cesareans. So I think we need to change the perspective of how we look at birth through media, and word of mouth. That it isn’t all high risk.

DT: Do you see that happening in the last 20 years—that birth has become more normalized?

MN: No! I haven’t. I haven’t. At least I haven’t seen that in hearing people’s stories, or from watching TV. I think the birth stories are even worse. I mean, if I was 20 now, and I saw...That’s all I got to see was that program on TV that I keep hearing about, that babies, or whatever it is, or...I would go “Wow! Who wants to have a baby? That’s pretty scary!”

DT: Let alone have a baby at home.

MN: I know, it’s like...I feel really bad for young women for that reason because I feel like they have no clear perspective of what a normal birth should look like.

DT: Because their mothers had hospital births and—
MN: —and their friends are all having hospital births with epidurals. Most women that call me who just want information will just say, “Well, I can’t have pain relief at home?”

It’s like, “Well, not epidurals and interfecals and stadol, but you can have a water birth. You could have a doula. You could have a midwife who will support you and help you breathe through your contractions.” So it can be scary if they think that they don’t want to feel any pain at all.

DT: Yes. Because women are afraid of pain.

MN: Yes.

DT: Do you think that it changes things for women when they do go through that pain? I mean, do you think that...What do you think it is about? Do you think it empowers women who actually—?

MN: It empowers them and I think there’s a huge...women’s self-esteem is completely different if they have a natural birth whether they have it in the hospital or they have it at home. If it’s natural and they got through it, they’re going to be a lot stronger than if they just resign themself, and say, “Okay, hook me up. I’m going to do this and not feel anything.” Because they’re not even in tune to their own body. They don’t even know the strength of their own body, so it’s a huge difference. Women are missing out on that.

DT: Do you see midwifery as, as its own discrete movement of...on its own, or is it part of a larger picture of moving towards a more natural medical model or moving towards women’s empowerment? Is it integral to a larger issue for you, or do you just do it as that—as midwifery?

MN: I think it’s integral to everyone. How they take care of themselves, how they take care of the environment, how they take...raise their children. They’re all inter-related. You can’t just have a home birth if you’re going to go and eat hamburgers and smoke cigarettes and drink everyday. They’re all related. If a mom is...Say she has a hospital birth and she has a really hard labor and she has an epidural and then she ends up having a cesarean, she’s less likely to try to make other changes in her life then someone who worked really hard in their pregnancy to eat really good, take...exercise, take care of herself, inform herself. She’ll come from that birth experience and actually even do more stuff with her family and go on with that learning experience. It’s just part of a building, learning experience and building on it. I feel like if you don’t learn from your birth experience, then you’re going sit stagnant in the rest of your life. You’re not going to grow on your experience.

[End of Tape 1, Side A]
DT: So this interview is part of the Montana Feminist History Project. Do you consider yourself a feminist or do you call yourself another name or what do you think about feminism and the way it’s moved in this country?

MN: Thanks Darla. I guess probably when I was younger I probably considered, “Oh, yes, I’m a feminist,” you know. “I have these ideas, and that’s probably, you know, must be the classification that I should give myself.” But honestly, as I’ve gotten older, I felt...I’ve struggled with the word feminist. I felt like by calling myself a feminist often I distanced people that I didn’t necessarily want to distance. I was raised to believe that I was equal to anybody—a man, older person, or whatever—and that I was capable of doing whatever I felt capable of doing. My dad was always telling me that I could do whatever I wanted to do, and I grew up believing that. So probably what happened is I became more...My philosophy is arguing. If I felt like something wasn’t right, or it didn’t fit into what I wanted as my role model, I would do it out of being a martyr or for whatever reason in striving to do whatever I felt like I should be able, capable, of doing.

So, using the term argumentist would probably be better instead of feminist. Because I just feel like we should be able to do whatever we feel like is right, for ourselves. And I certainly work with families who, you know, it would be the husband who would call and set up a prenatal or ask the questions and wonder, “Oh, you know, what’s this all about? What is the woman’s role in this?” But in the end, find out working with them, that is just the role they’ve taken with each other and she’s as part of the pregnancy and what she wants out of it as he is. Even though I would have that initial impression of what’s wrong here, you know? Why is the dad doing all this? But maybe it’s their way of him participating, and then she doing the rest as far as participating. I certainly wouldn’t want to tell a family like that, and announce that, quote, unquote, “I’m a feminist,” because they would have a hard time working with me. I do believe that we work with a lot of families who are fundamentalists or Christians, and I don’t want to set myself off as being different from them even though we have a different philosophy.

I don’t think I raised my daughters to be feminist per se. I just have raised them that they’re capable of doing whatever they want to be able to do, that they’re strong. It probably would have been different if I lived when women couldn’t vote. I’m sure I would have felt differently about it, and been a lot more active in those issues, but that isn’t currently how we live.

DT: Well, see, that was good. That’s a really tough question for a lot of people to answer especially midwives. Everybody has had trouble, except for Dolly, answering that question. I think that that issue, midwifery, or the feminist issue, is something that is more and more coming up because of the excesses of, or the perceived excesses of some feminist philosophy. I think that’s a very important question for us to ask because in some ways, I mean do you think that midwifery as an act is...could be described as a feminist act. How would you describe the process of being with woman? Would that—?
MN: Probably the process, the beginning process really was... had to do with issues about feminism. But I don’t necessarily feel so strongly that way now. I certainly didn’t choose to have a home birth myself because I was being a feminist. It had to do with that I wanted a certain quality of care, a certain kind of experience that I didn’t feel like I was going get anywhere else. It had nothing to do with that I was going be this radical woman, and do it my way. It just was the right way for me.

Maybe for some women—if they have a tendency to turn over all their power to a physician or their husbands or whatever—for them to have a home birth, it would be more of a feminist thing for them because it’s not their norm. But I honestly think most families we work with, the husband’s just as involved as the mom, and so it becomes this cooperative effort for them. It’s not her doing it her way, and so... But probably for a lot of families, when we first started having home births, there probably was that issue for a lot of women.

DT: Do you, do you find that men are as time goes on during the prenatals like... Oh, what am I trying to say?

MN: As far as how they participate?

DT: How they participate. In my experience, men, a lot of times they come in, they think that the whole thing is going to be just disgusting, and they don’t understand why their wives or their girlfriends want to have home births. They’re very stand-offish. Towards the end, they want to get more and more involved.

MN: I would say it’s—

DT: Do you think that it empowers men too?

MN: Yes. I think it’s pretty equal. When men first come to some prenatals, you can tell, oh, they’re just, you know, like “Why am I here? Why do I have to come to a prenatal?” There are other dads—they don’t want to miss anything, so they’re taking notes the whole time, checking out the books, watching the videos. They want more information sometimes than the mom does, but usually the moms have already done reading and have a basic understanding because of their mothers’ experiences with them. But some of the dads will literally lay on the couch and take naps during the prenatals because they’re so uninterested if you try to get them involved. Then as time goes by, you see a change, that you start talking to them. You start asking them what they feel, how they best see their role in the pregnancy, and then they start joining in. They actually awake for the last half of the prenatal visits. So, there are certain dads that you think, “Oh,” you know, “lost cause. They’re not even going to be there,” and they pull though. Most of them pull through. I’m always amazed. If I was to give them a score at the very first prenatal, I would say, “A dog! It’s not going happen.” That’s part of my responsibilities too, is to get them interested and involved. Ask them questions about what they want out of the
birth experience for their child. Because I let them know, it’s just not the mom. So it’s a family experience.

DT: Yes. I always consider it, like, the triumph. I’ve done my job right if I can get the father to look at the placenta.

MN: Oh, yes.

DT: I always drag them in there and go, “This is the placenta.” Most of the times they won’t touch it.

MN: Yes. I wouldn’t say that placenta is the scariest in my mind, but suturing.

DT: Suturings, yes.

MN: That’s usually when I lose the dads.

DT: Yes.

MN: I’ve had some bad experiences with dads, but I’ve had mostly all good. They’re beaming just as big as the moms are often after the birth so I encourage them to help catch the baby with the mom if they want—if they want to share in doing that together. We talk about that they can just sit right next to their partner, or they can participate as much as they want to. Most often they’re participating more than they said they wanted to originally. They like to have hands on.

DT: So you do a lot of water births?

MN: Yes.

DT: Will you just talk about water birth, why you think it’s a good thing, the differences between the two?

MN: Probably the biggest difference with water birth...When people say “What are your favorite births?” I say “Oh, my water births.” When the baby’s born in the water and the dad and the mom and the baby are in the water, it’s what my ideal of a romantic home birth is. You can’t get any closer to being romantic at a labor. Everyone’s relaxed and happy—elated. Usually if their siblings are there, that’s when they jump in, and the siblings are in the birth tub also. But water birth’s a lot more work for me. So if it ends up happening that it’s been the birth, I’m pretty exhausted afterwards, but my back’s killing me from leaning over into the tub. But for labor women have a completely...If they’re choosing to use water during their labor, usually they’re having...they’re struggling through a labor, having a hard time staying on top of the contractions, a lot of breathing techniques aren’t working for them, you suggest they get into
the water. Their demeanor completely changes. They become a new woman. They’ll start
smiling again and talking and cracking jokes and laughing. Contractions slow down for a little
while. They get a little break. Then the intensity picks up, but they manage it in a completely
different aspect. They’re easy to work with. Those are the kind of births when they’re in the
water, I feel like, “Oh, I can just sit back and relax because they’re doing great without a whole
lot of intervention.”

DT: The fathers are usually in the tub with them?

MN: Yes. Most fathers. Some dads don’t like to think that they’re going to be mixing with bodily
fluids, but—

DT: As they didn’t do that before?

MN: Most dads are hesitant though at first because they see all the birth videos, and the books
and they see the moms naked, and their fear is...they usually ask their partner outside of
prenatal, “Well, do we have to get into the birth tub without our clothes on?”

It’s like, “You can be in there in your swim trunks if you like, or you don’t have to. It’s up to
you.” But they’re more vain then the moms and self-conscious.

DT: Well, I think most women understand that clothes on aren’t really necessary for giving
birth, and they can wear them another time.

MN: Yes. Some women will still wear their bathing tops or bras in the birth tub though. But, it’s
just—

DT: Yes, I’ve noticed though that the most modest women lose all sense of—

MN: Eventually they do.

DT: Eventually they just—

MN: Eventually they do. Yes, when I tell them they probably should take it off if they want to
hold the baby because their bathing top is sopping wet and cold. Then they don’t have a
problem with taking it off. When someone comes to me and had a hard time or they have a lot
of fear about pregnancy and labor and dealing with contractions, I usually recommend that
they at least have the tub available because they’ll be amazingly surprised at what a big
difference it makes. I’ve had a lot less transports for pain medication since I’ve been using the
tub.

DT: So, a lot of women don’t actually give birth in the tub?
MN: Right. Some of them just use it for laboring. Then come time for pushing, they feel like they can’t push very well there or it doesn’t feel right, and they get out. Or if we’re having a hard time getting the baby’s heart tones or if there’s been meconium or if there’s any problems, then they have to get out. But the main purpose I always tell moms, “Don’t get stuck with the thought that you’re going have it, you want to have a water birth. That you’re going to have this baby in the water because it could easily change, and then you’ll have to get out.” But that you look at it as that you’re going to use it as a relaxation technique when you need it.

DT: So, after all these years of being a midwife...so you still have the...are you still as satisfied? Do you still have the same excitement level, or have there ever been times that you just thought about quitting? Do you think you’re going to be a midwife for a long time?

MN: I think I’ll be a midwife forever. I actually don’t see it changing anytime soon. I certainly have had moments when I thought, “This is too stressful,” when there’ve been problems. I either got a lot of grief from the medical community or started feeling bad about maybe a decision I made, then I’d start second-guessing me, and go, “Oh, well, you know, this is too much. This stress is not healthy, you know? It’s going to kill me, the stress, because I take every birth personally.” You know, I take it on, I wear it. If someone doesn’t feel totally content with how their experience went, or if there’s been a problem, or if someone ends up having a cesarean, I actually carry it with me for awhile. And I wish I knew how to not do that, but I do. And it is in my personality, so I can’t imagine that it will ever change, but when I get past that, and work through it, and talk to other midwives about it. And we all have thought or contemplated quitting at some point when it just feels like it’s just too overwhelming. But for the most part, I like working with the families. I like sharing information with them. I like meeting new people that way. That’s my interaction with people, is working with new, new families. I like working with their kids, if they have other siblings, and working with them at the birth and the prenatals, and sharing information. The thing I don’t like anymore is being on call all the time. Once, getting up at two o’clock in the middle of the night, and you know, I’m like, grumble about it for a couple of seconds while I’m taking a shower and getting ready, but once I get on the road and get there, you know, I enjoy myself. I have a good time.

DT: You just don’t like that three week wait?

MN: Yes, yes, and sort of going, “Okay. What’s going to happen now? They’re going overdue,” and feeling like you don’t want to make things happen before the mom’s really ready being patient. Sometimes it’s hard to be patient. It’s hard waiting. I don’t like going out and doing a lot of things away from the phone. When I’m on call, I take it literally. “Oh, I’m supposed to be around.” But I’ve learned from that experience too. I sew all the time. I work in my garden all the time. I found things that I can be really great at when I’m on call. So I think I’ve found the balance. It’s hardest on my family when I say, “No, I don’t want to go floating up the Blackfoot, because someone can’t get a hold of me.”

DT: Yes, and having two births a month still means that you’re—
MN: On call all the time. Yes.

DT: Would you be willing to share some of your more challenging emotional experiences? You don’t have to use any names or anything, but just talk about some of the things that have been really a challenge for you ion your career? And then...how you resolve that?

MN: Oh, you don’t want to go there. Well, probably my hardest birth was a baby that died after we transported. It was a birth that was out of town, so it was further away from town, to get to a hospital safely. It was a learning experience. I learned a lot from this birth. I learned that I had to be the one who ultimately put my foot down and said, ‘This is what we’re going to do.’ This particular couple had had a cesarean before, had really bad hospital experiences, really wanted to have a home birth, really wanted to have a vaginal birth, but lived further from a hospital. They were 50 miles from a hospital or 50 miles from a hospital, so it wasn’t the best scenario for someone to be having a vaginal birth after a cesarean. But they were totally committed to having a home birth, and so I agreed to work with them. I really liked the couple. They were a great family. Well, it ended up being that the mom’s uterus ruptured.

DT: Why did the...her uterus rupture?

MN: Well, actually her uterus ruptured not on her previous cesarean, it actually ruptured up her left side of her uterus. The only thing I can think of is that her placenta came off. She had an abruption, and then her uterus started having really hard contractions—what we call titanic contractions. Titanic? I can’t remember how exactly to say it. I think in order to her uterus started doing those, having those really hard contractions to control the bleeding, and then it ruptured out her...left side of her uterus. When she’s had a little bit of breathing. I listened to the baby. The baby was doing fine, and within about ten minutes, she started having these really strong contractions. At that time, that’s when I wanted to transport to the hospital. I said, “I’m going to call 911 and get the ambulance.”

They said, “No, no, no, no, no. It’ll be okay. We’re not going. We’re not going. We’re not going.” So I waited like another 15 minutes. Then I just called and got Life Flight coming in. The baby was still alive when they transported her in Life Flight but died in route from complete abruption and a uterine rupture. Then mom had a hysterectomy at the hospital to save her life. My world fell apart after that. I was ready to quit midwifery then. I was done. I just couldn’t handle the fact that a baby was...could die. Even though I have always known all these years that birth and life are intertwined. They’re exactly there together at the same moment, that we don’t always have total control. It’s part of birth, is that babies die. But I just never felt like it was really going to happen to me or someone I was working with.

So, the parents were really strong. They had a firm religious belief. They were LDS. They really felt like the baby that they carried had its purpose, and that its purpose had passed when it was supposed to be born. We hung out a lot together. I would go up and visit them all the time.
They would come by and visit me all the time. Call. We just kept in really close contact. I think that family and myself got through it because of each other. They equally got me through it as much as I helped them get through their experience. They went on to go over to Helena and testify to the Board of Alternative Health Care that they felt like it was a right for all parents to be able to choose to have vaginal home birth, if after a previous cesarean if they wanted to. They felt still very strongly about their convictions of parents' rights. In the large part, we can do vaginal after cesarean births at home because of this family.

DT: So how did you resolve that wanting to quit, or that heartache...I mean, did you just wake up one day and say, “I’m still going to be a midwife,” or was it...Did you stop doing births for a while?

MN: I didn’t stop doing births for a while because I had births already lined up. Those first few births after that were really hard to go to. I struggled going to them. They were emotionally draining. I had to explain to parents why I was a little bit more, you know, iffy at their birth as far as being...wanting to like check every little thing constantly. I was kind of a pain in the butt, actually, when it came to monitoring the baby and the contractions. It was only honest for me to share my experience with them and say, “This is why I was doing that,” and if they...I had, actually, had one couple decide to have a hospital birth that was due within six or eight weeks after that couple. I respected their decision. That kind of scared them, and so they chose to have a hospital birth. But everyone else I was working with, I managed to get through those births, and it was...the parents kept telling me, “Michelle, you do a wonderful thing. What you have to offer is really important. We wouldn’t change anything.” They would like to have had their son, but they wouldn’t have changed. If they had known that there was that risk, they still would have attempted to have a home birth. It was them encouraging me that it was okay, and that I should keep doing it. That it was a freak birth, that there was no way to predict it. Everyone thought that, “Oh, well if you’re going to have a uterine eruption, your uterus is going to rupture on the old incision,” but that is not what happened.

DT: So it may not have had anything to do with the cesarean at all. It had to do with the fact that she had an incompetent cervix that wouldn’t open up, and the uterus was working really, really hard to try to open it. And it never did. Just for your information, when they did the autopsy, or it’s not an autopsy is it, when they remove your uterus and look at it? What’s it called? Biopsy? I mean, they did the hysterectomy, but then they actually sent it off and had it looked at that the lower uterine segment...her cervix was completely effaced. In fact, it was the thinnest cervix I have ever felt. It was like paper. She was like got completely paper thin, thin, thin, thin, but it wouldn’t dilate like past one and a half. To me, that would be a warning sign, now, that if a cervix and the lower uterine segment is getting that thin but not opening, something’s not working right. So she tore from the cervix up because it got too—

DT: (unintelligible) eating primrose oil, was she?

Michele Neal Interview, OH 378-009, Archives and Special Collections, Mansfield Library, University of Montana-Missoula.
MN: Gosh, I think she did. She did. Yes, it was just this unrelenting cervix that wouldn’t open, but yet it kept getting thinner and thinner and thinner.

DT: Kathy has a theory about that...I’m going to cut this part of the tape out.

[This section of the interview is restricted at the request of the interviewer and interviewee.]

DT: Well, we’ll cut that part of the tape.

MN: Yes, thank you. Yes, it was a...ugh! It was a hard learning experience. But I learned to be stronger with people rather than feeling like I was just going to let them walk over me, so that I definitely don’t regret that. Now it’s easy for me to say, “Nope. Can’t do it. It’s not safe for you or baby.” No matter how much they plead with me. They may be right, that everything is going to be fine, but there’s no guarantee. I’m willing to push it a little bit, but—

DT: So you feel like it made you stronger as a midwife?

MN: Yes. So, but it was an awful hard lesson to learn.

DT: If another baby died, do you think that you would continue?

MN: Oh, God! I don’t even want to go there.

DT: I’m sorry for asking you these hard questions.

MN: I guess it would really depend on why. I mean, I’ve certainly gone to births where, you know, babies have Downs, and that’s very trying. But I feel like I have so much experience that I can offer to those parents to get them through it too, and so, no, that wouldn’t scare me. I don’t want people to have babies that have problems either or babies that die, but if it was actually...if I made a blatant mistake, yes, I probably would quit because, maybe I’m not paying attention. I’m going to go move in the snow. Fun, fun, fun. I would just have to look at it individually. The baby that got tetanus—I thought about quitting then.

DT: But that wasn’t your fault.

MN: But still, I was made to believe it was my fault. Until the CVC finally came back with all the information, but...It’s hard—

[End of Tape 1, Side B]
DT: So when you went through this birth with the baby dying, did you get a lot of support from the other midwives?

MN: Yes. Actually in Missoula we have a great support system of the midwives, between Dolly, myself, Sandanho, and Kathy. And when Patricia was living here. It’s not like we were best buddies or friends, but we certainly have always been able to call each other and get together and talk about birth experience, getting suggestions for if there’s something that’s unusual in someone’s pregnancy that we need to consult on and get advice. When anyone’s had a difficult birth, we’ve all been able to get together and talk about it. This one birth where the baby died, it wasn’t like anyone...everyone asked questions about what was going on and this and that, but it wasn’t a judgmental thing at all. It was easy to be honest about what transpired, what I felt like I could have done different, and the midwives were...In fact no one said I could have done something different, but even though I felt like I was the one that was there. I knew that there were subtleties that maybe I could have acted a little bit sooner, but I felt nothing but great support about the experience.

It was actually a learning experience also for those midwives because they hadn’t experienced, had that kind of a tragedy in their practice yet. We actually got to see how the medical community tried to polarize us or to encourage the parents even to sue me. When they were still in the hospital, the physician came to them and said, “You should sue your midwife.”

The parents just looked at him and said, “No. You know, she was doing what we asked her to do.”

He said, “Well, only because she held your hand during your prenatal care.”

They said, “Well, that’s why we went to her.” That’s what they wanted. So, I think he was taken aback by that. But he came out and said that they should sue me. A complaint was filed, but it was resolved, and so the midwives got to learn from that experience too. As far as the rest of the state, it’s been a little bit more difficult. It’s lack of communication and getting together. It’s become a little judgmental with some of the midwives, with the midwives. The midwives in Missoula are labeled as these alternative, hippie women, and not all of us are. We’re all on the fringe, and we have been just as judgmental about some of the other midwives practicing in the state. But as a whole in the last few years I think we’ve all tried to communicate a little better.

DT: Is there any particular issues that you think that the midwives, as a whole, need to work towards in Montana?

MN: Well that we’re all, that we’re all in, we’re all into it for the same reason, to promote women’s health care, the way that they want their birth experience, and that we all actually want to practice safely. It’s when we feel like other midwives are pushing the regulations and
the protocols, and that they’re no longer practicing safely, then it becomes that we all get a bad name. That we really have to strive to work towards that...we get respect from the community and from the medical community rather than looking at that we don’t know what we’re doing. That’s been the problem, why doctors just have labeled the midwives as being freaks because there have been midwives that have practiced and did really bad things. They did. They did unappropriate things in home births. I could have been labeled that way too, by having this baby die at a vaginal—attempted vaginal—birth after a cesarean. But at that time it wasn’t illegal or legal. We have protocols now, and regulations because of it. But we do have strict protocols that say we can’t attend a breach birth. We know midwives out there who have attended home breach births and try to cover up and say it’s an accident when it’s not. They should know when they’re going to have a breach birth.

DT: So do you think that midwives should be allowed to do breach births, if they have the, you know—?

MN: If they have the experience, and but you really actually...Most midwives in Missoula don’t have...we weren’t trained somewhere where there’s a lot of breach births. I’ve been to two breach births, one at home and one where I had to assist in the hospital, and both of them were hard. I would like to have a lot more experience before I could say, “Oh, well I can manage a breach birth at home safely.” I don’t have that experience, so, no I—at this point because of how I got my training—I don’t want to be doing breach births.

DT: Do you think that the new, the younger midwives have...because a lot of them have trained in, in a different way than the older midwives, do you think that they, that midwifery home birth, and direct entry midwifery is moving more towards that—towards a medical model? Do you—?

MN: It is to some extent because a lot of apprentices are going to a lot more hospital births. We’re also trying to get recognition from physicians that were not...that we’re practicing within somewhat their protocol and safety, so it’s a little bit more medial model. But more though it’s we will...can practice a medical model, but give parents some choices so that they will make informed choices about what kind of care and testing that they do want. Where, if they are seeing a physician, it’s just standardized. They have everything. They don’t get a choice. So that would be a difference, is that, at least, for a home birth if they’re working with a midwife, they can say, “This is available if you were to see a physician. We can do it also. If you want to have a triple screen done and strep screen done and, you know, you name it—all kinds—and an amnio [amniotomy] done. That stuff can be done if you want it, and here’s the information. You need to figure out if you want it or not, or if it’s needed.” So there’s that difference there. Not all the testing has to be done if the parents are not choosing it.

All midwives practice differently in that aspect too. Maybe not necessarily in Montana, but in other states, some home birth midwives do all the same testing as physicians. They practice exactly the same.
DT: With routine sonos [sonograms] and all?

MN: Yes.

DT: So this interview and the transcripts from this interview are going to be moved into the archives at The University of Montana. And they’re going be available for research projects, or for whatever for years and years to come. This is an opportunity for you to say something to posterity, Michelle. What would you like to say to someone in 50 years that is listening to this tape or reading the transcript, what do you want to say to them about your life, home birth, midwifery, alternative medicine?

MN: Well, that I hope that home birth is still around in 50 years. Then the fact I hope that it’s a prevalent choice of where moms would want to have their babies. I really do hope that the younger generation realizes that it’s a viable, safe option for the babies, and that if they want to do it as a profession, it’s greatly rewarding. You couldn’t do anything more rewarding than working with families and being there when their babies are born and being part of that, feeling privileged that you were invited to that experience with them. I certainly hope that home birth is—

DT: Still around for your granddaughter to have her baby?

MN: Yes. My kids will have home births, except for one of them. She’ll do it out of spite. “I’m not having a home birth.”

DT: Well, thank you so much, Michelle. That was great.

[End of Interview]