

College of Charleston

Home v. Hospital: Power and Birth

An Examination of Control Within Birth Models in the United States

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Abstract

Approximately 1% of births in the United States take place at home (Merg, Carmoney 70). In this paper I examine why some women choose midwife attended homebirth over the medical model of birth. Why do women make this decision and what are the outcomes? I examined both qualitative and quantitative data on homebirths and have identified key reasons why women chose to give birth outside of the hospital. I focused on how the mother's feelings of control impacted her satisfaction with the birth experience, and how women's control is affected in home versus hospitalized birth. My findings reveal that home births allow the woman more agency and an environment in which she feels empowered. It is important to note the differences in the types of midwives available to mothers, as the Citizens For Midwifery website explains, "two broad categories of midwives exist in the United States: nurse-midwives and direct-entry midwives. Nurse-midwives are educated in both nursing and midwifery, while direct-entry midwives focus their professional preparation on midwifery alone" (Finding A Midwife). In my research I focused on low-risk, planned home births, attended by a certified nurse midwife.

I was interested in finding out why some women are choosing home birth in a society where there is a strong cultural norm of giving birth in a hospital. Through my research, I found the main reason women choose home birth is because they strongly believe they have more control of the birth experience at home than in the hospital. I have identified two main factors that affect women's feelings of control during birth: (1) The health care provider's ideas about interventions matching the mothers, and (2) the power balance between the healthcare provider and the mother.

Interventions vs Natural Birth

The continuation of the growing medicalization of birth would seem indicative of lower death rates. However, as researchers from the University of Michigan School of Nursing, Bernhard et al. found, “despite spending more money per capita on birth than any other developed nation, the United States ranks 50th in the world in maternal mortality and 39th in neonatal mortality, indicating that a critical analysis of the current system is needed” (165). The increasing medicalization of birth means an increase in the amount of medical interventions being done on pregnant and laboring women in hospitals. One of the main reasons women are choosing to get out of the hospital and give birth at home is to avoid these, many times, unnecessary medical interventions. In the collaborative study by Professors Fleming et al., they found a clear division between home and hospital birth mothers in what interventions the women were okay with (4). While both groups had negative feelings about interventions, “in comparison to the home group they [the hospital group] gave significantly more positive rating to all interventions, with the exception of labor induction and general anesthetic.” Interestingly, “the hospital group was also less positive about rooming-in with the baby” (Fleming et. al 8). Women who are adamantly against interventions are much more likely to seek out a midwife to assist them in a homebirth because they are aware the desire to have a natural birth is not always taken seriously in the hospital setting.

It is becoming increasingly more difficult for women to choose natural birth in a medical setting. In Malacrida and Boulton’s interviews with women planning natural births:

21 women indicated a preference for as intervention-free a birth as possible ... However, 11 of them experienced emergency caesarean sections, and with the exception of two women who gave birth without any interventions, the remainder experienced medical

treatments ranging from pain medication and epidurals to inductions and episiotomies.

(Boulton, Malacrida 47).

In another study, Fleming et al. found there was a vast difference in the amount of interventions performed during home births versus hospital births, “not surprisingly the hospital group received significantly more interventions” (Fleming et al. 5) as seen in Table II. None of the women who gave birth at home had any anesthetics, acceleration, induction, use of forceps, vacuum, or episiotomies. This is significantly different from the women who gave birth at the hospital. Out of these women, 79 had an epidural, 25 were administered oxytocin, 42 endured induction and/or acceleration, 55 had use of forceps or vacuum, and a staggering 88 had episiotomies.

TABLE II
PERCENT OF WOMEN GIVING BIRTH IN THE HOSPITAL AND AT HOME WHO RECEIVED DIFFERENT INTERVENTIONS AND NUMBER OR EXTENT OF INTERVENTIONS RECEIVED (excluding cesarian sections)

Values in parentheses refer to women who were transported.

	Hospital (n = 38, excluding 6 cesarian sections)	Home (n = 15, excluding 2 cesarian sections)	P
Labor induction and acceleration (oxytocin or prostaglandin)	18	7 (castor oil)	
Acceleration only (oxytocin or prostaglandin)	25	0	*
Labor induction and/or acceleration	42	0	**
Amniotomy	50	13	
Forceps or vacuum	55	0(12)	**
Episiotomy	88	0(6)	**
Lacerations			
1st degree	16	33	
2nd, 3rd, cervical	11		
Regional anesthetic			
Continuous epidural	79	0(12)	**
Block or epidural	8	0	
Local	13	0	
Fetal monitoring			
Internal	50	0	**
External	50	0	**
Cesarian section (of total populations)	14	12	
Total number of interventions	$\bar{X} = 4.5$	$\bar{X} = <0.5$	**

* Significant by a χ^2 test ($df = 1$), $P < 0.05$.

** Significant by a χ^2 test ($df = 1$), or by ANOVA ($df = 1, 51$), $P < 0.01$.

These findings are surprisingly common. The rejection of natural birth in the hospitals is reflected in the rising rate of cesarean sections across the country, “In 1970 the cesarean section rate was approximately 6 percent. In the intervening years, this rate has increased over fourfold ... In the United States, in 2004, it was 29.1 per cent” (Boulton, Malacrida 43). These interventions tend to fuel the myth that birth is inherently painful and risky, and thus that the process should be medicalized.

Ina May Gaskin is a notable midwife in the United States. In an interview with blogger Stacy Fine, she explores the system that fuels this myth of inherent risk:

Currently, midwives in the US are attending only 10 percent of all the births. About 1 percent of these take place at home. When there are such low rates of midwife-assisted birth and out of hospital birth, there is automatically a great deal of fear and ignorance about allowing labor and birth to proceed without disturbance. Most nurses and physicians never see undisturbed birth during their training period. This makes them unlikely to allow it, even if their hospitals would allow such deviations from the usual way of doing things. Add to this a for profit medical industry, with little or no accountability built into the system and a situation in which insurance companies and hospital chains have more influence in creating medical policy in certain areas than physicians (and certainly midwives) have, and you have a recipe for too many interventions in birth and rates of infant and maternal mortality and morbidity that are getting worse instead of improving (Fine).

As Gaskin points out, doctors are exposed to less and less natural births. There is a fear in the hospitals of a natural birth due to the perception that birth is intrinsically painful and hard. The midwifery model is at odds with this idea that all birth must be painful.

In childbirth educator Kim Wildner's article *What's Pain Got to Do With It?*, she examines the concept of a drug free painless birth and rebukes common myths surrounding cultural acceptance of painful birth. She explains, "If birth is intrinsically painful, it would be so for everyone. Yet it isn't. ... Homebirth mothers often experience labor and birth as comfortable, or at least manageable." (1).

She believes one of the main factors contributing to the expectation of painful labor is the Bible, where God punishes Eve for eating the forbidden fruit by making childbirth painful. However, Wildner explains that, "the word translated as 'pain' is the Hebrew 'etzev'. This same word is used sixteen times through the Bible. Nowhere else is it translated as 'pain'. In fact, in the very next verse, Genesis 3:17, it is accurately translated as it is in all other instances, as 'toil'" (Genesis).

In response to the commonly held assumption that contractions are always painful, Wildner points out, "the uterus contracts painlessly during the Braxton-Hicks contractions (also known as practice contractions) of pregnancy" and that "the uterus contracts painlessly in its normal functioning at times other than birth", such as during menstruation or an orgasm. In fact, she points out that "every muscle in the body functions by contraction and release. No other healthy muscle going about its normal function hurts" (2). Finally, she argues against the claim that birth must be painful because something so large is coming through such a small opening:

The cervix has stretch receptors in it that signal the brain to release endorphins. These are the body's own strong painkillers. The cervix thins as it opens over the baby's head, as a turtleneck sweater stretching when being pulled over a head. This means there is 'extra material' to work with, so to speak, as it goes from very thick and soft, to paper thin, disappearing as it is taken up as a part of the uterus, which it is ... By childbearing age,

the genital area is composed of many folds of skin. During birth, as with the ‘extra’ thickness of the cervix, these folds are ‘taken up’. They smooth out around the baby’s head until they are gone completely, like an accordion. This built in give is why episiotomies are so rarely needed (Wildner 2).

Interestingly, episiotomies, a surgical cut made in the area between the vagina and perineum, were performed on 100% of women giving birth in a medical setting from 1940-1990. They are still performed on more than 50% of women today, even though there is no scientific evidence proving any benefits from them (Cohain 23). In fact, CNM and researcher Judy Slome Cohain found a rate of:

99% intact perineums, [and] 1% sutured perineums, in a group of 80 primipara in their early 20s at attended home births, [with an] average birth weight [of] 3150 gm [6.94 lbs]. Primipara women in their late-20s with 3400 gm [7.5 lbs] babies experienced a 28% sutured tear rate at planned home births. This suggests that homebirth with a motivated attendant, young age and birth weight of 3150 gm [6.94 lbs] can almost always deliver vaginally without perineal damage (Cohain 24).

She continues to make the claim that “episiotomy, hospital birth for healthy pregnancies and elective cesarean surgery are commonly practiced, dangerous, and out of date medical routines unsupported by research” (24). Cohain backs this up by explaining that research has found episiotomies do more damage than natural tearing does. When compared to natural tearing, episiotomies cause “more third degree extensions, more anal muscle damage, more short and long term fecal incontinence, more bleeding, more pain, and more short and long term sexual discomfort and dissatisfaction” (24). Wildner, Cohain, and other natural birth advocates

understand that women's bodies are designed to give birth and unnecessary medical interventions are a large contributing factor in making birth painful (2).

In a safe and comfortable environment with a low risk pregnancy, birth can be a peaceful and easily manageable experience. However, in the hospital, our bodies are put into a fight or flight response mode (Wildner 3; Lothian 5). When a mother is in labor, she is surrounded by beeping monitors, bright lights, and unfamiliar people. She is hooked up to several monitors and unable to move around freely, putting her body under a lot of stress. As Lothian explains, "laboring and giving birth in most hospitals create[s] a set of physiologic responses that actually occur when we feel unsafe and unprotected" (Lothian 5). When we are stressed, our brains release hormones called catecholamines. These hormones cause contractions to become ineffective by becoming too strong or too weak. This reaction is caused by an evolutionary need to protect the baby from harm and would allow the mother time to find a safer spot in which to give birth (Lothian 5). However, when contractions slowdown in hospital births, it leads to doctors starting interventions such as Pitocin, a synthetic version of oxytocin, to speed up the contractions. While Pitocin does speed up the contractions, it also makes them much stronger. Due to the drug induced strength, these contractions can be much more painful than natural contractions, leading doctors to recommend an epidural to relieve the pain. The epidural slows the contractions again, causing the need for more Pitocin. This is called the Pitocin- epidural cycle, it can send babies into distress and lead to emergency C-sections (*The Business of Being Born*; Holihan). In order to avoid this cycle, Wildner suggests giving birth in a setting with four elements to promote relaxation, "1. A comfortable/ safe environment, 2. A mental device such as a word, prayer, or sound, 3. A passive attitude, which she explains as "not worrying about performing well", and 4. A comfortable position" (3).

Fleming et al. found that in accordance with Wildner's suggestion of a safe environment, in every home birth the mother knew the people in the room, compared to hospital births where women usually had 5-7 strangers in the room (Fleming et al. 8). Knowing everyone who is present at the birth is critical for building a safe and trusting environment so the birth can continue at its natural pace (*Business of Being Born*).

The women in the hospital seemed to follow the typical medical model of giving birth in a delivery room, in a supine position, using stirrups. In contrast, home mothers assumed whatever position they felt most comfortable in (usually semi-sitting (54%), side-lying (31%), or squatting (15%)), none gave birth in a supine position (Fleming et al. 8). These home birth mothers were allowed both element 1 and 4 of Wildner's suggestions for birth.

Allowing mothers to change positions during labor is critical aspect of natural birth and it lessens the chance of needing medical interventions. Lying in the supine position can "keep a baby from descending into the pelvic outlet and, at the least, slow things down" (Claramitaro 1). Furthermore, lying down for birth does not allow the pelvis to fully open. A mother birthing in the "hands and knees and squatting positions can actually open the pelvis and entire centimeter" (Claramitaro 2). Changing positions during birth is also beneficial for minimizing pain: "If a baby is pressing a bony part into the sacrum, a hands and knees position can alleviate the pressure/pain" (Claramitaro 2).

In her interview with Stacy Fine, Gaskin talks about some benefits of movement during birth. There is a special use of movement utilized by midwives that was named after Gaskin when she made the technique popular for assisting in moving the baby when its shoulders are stuck. While many American doctors are still using episiotomies in these situations,

“a new study examining 94,842 births over a 10-year period suggests that ... despite historical recommendations for an episiotomy to prevent brachial plexus injury when a shoulder dystocia is encountered, the trend we observed does not suggest benefit from this practice” (Margulis).

Gaskins method does not involve episiotomies but instead utilizes the mobility of the mother,

instead of twisting and trying to rotate the baby, they merely got the mother to turn over from her back to a hands and knees position with her back arched. This change of position usually solves the problem of stuck shoulders and the mother is able to push her baby out without further ado (Fine).

This use of movement in medically scary situations highlights the importance of allowing mothers natural alternatives in situations where many times hospitals jump to medical interventions.

Factors of Control and Support

A birthing experience where a woman is surrounded by people she knows and who support her birth plan is critical. This allows a woman to feel in control and successful in her birth experience. In Professor Dr. Fair and BSN Taylor Morrison’s research, they identified four aspects of control: Preparation, Communication, Support, and Respect Wishes. Midwives help women prepare by having them make birth plans, allowing them to communicate their expectations for their birth, listening to their wishes and supporting them through their pregnancy, labor, and postpartum. All four aspects of control are being met, leading women to feel more in control and empowered, creating a higher satisfaction level with the birthing experience. Women who were more prepared for their labor felt more in control when the time came. The women they interviewed said things such as “reading, researching, and making birth

plans” helped them to feel more prepared. Along with these they also identified social support as an important part of their preparation (Fair, Morrison 22).

Two facets of communication were identified as helpful in building the women’s feelings of control: “Women-initiated and provider-initiated” (Fair, Morrison 23). Women-initiated was focused on women asking questions of their healthcare provider, whether midwife or OB, making sure that they felt that their ideas lined up with the healthcare providers, and gaining knowledge. Provider-initiated was especially helpful in increasing control when the women felt that the healthcare provider was allowing her to share “a role in decision making. One woman noted, ‘I was able to wait until I wanted to push’” (Fair, Morrison 23).

Support was offered in four main ways that empowered the women’s feelings of control: “reassurance, encouragement, physical assistance, and supporting the mother-infant relationship” (Fair, Morrison 23). Most important of these, according to Fair and Morrison’s findings, was the mother-infant relationship, about half of the mothers brought it up in their interviews.

Experiences such as breastfeeding, holding the baby, and touching the baby were critical in the mother-infant relationship and in the mother's feelings of control. Fair and Morrison illustrate this with these quotes: “They let me bond with my baby before taking her to nursery” and “He put baby straight on my chest, didn’t suction her or anything” (23). As for the control aspect of Respect Wishes, women’s experiences that lined up with their plans and their previous discussions with healthcare providers tended to have higher feelings of control about their birth experience. “One woman reported she appreciated her provider ‘standing up for our discussions’ and ‘working to prevent unwanted interventions’” (Fair, Morrison 24). Bernhard et al. notes that the relationship between the mother and the birth care provider is an important factor in birth satisfaction across birth methods,

Feeling they had a relationship with their provider regardless of place of birth was an important part of creating a positive birth experience. When women felt connected to their providers and felt that they were cared for, they reported that it was easier to also trust the birth process. Without exception, women who described their hospital birth experiences in more positive terms had strong and trusting relationships with their providers (Bernhard et al. 163).

Fair and Morrison conclude that “knowledge of the childbirth process seems to enhance women’s experiences of control” (Fair, Morrison 24). What about when women feel that their knowledge is being ignored and they feel a lack of control?

Power Imbalance in the Medical Model

Throughout my research, I found a recurring theme of a power imbalance in the hospital. While a woman may plan during her entire pregnancy for the birth experience she wants, this agency can be stripped from her once she enters the hospital, regardless of how well informed she is:

The notion of an autonomous, fully informed, ideal medical consumer, who is not only capable of evaluating medical information but can also *implement* her informed choices, is a thorny one because women’s choice has always been politically constrained... and shaped by hegemonic discursive orders and social practices that privilege the interests of one group over those of the individual (Boulton, Malacrida 45).

In this case, the woman's choice over her own body and her birth is not as important to the hospital as their own interests. On top of that, there is a societal pressure that women have internalized that tells them that in order to be a good mother they must do everything the doctor suggests. This leaves them feeling a lack of power to question the doctors or stand up for what

they feel they need. Natural birth advocates have suggested that, “Once a birthing woman enters a hospital, there is a seemingly natural transfer of power and responsibility for birth from a woman to her doctor” (Boulton, Malacrida 44).

Many women are not trained midwives or doctors and feel uncomfortable questioning their medical provider’s authority. This is especially true when they are in a state of stress. This is problematic for women who want natural birth because it is beneficial from the doctors perspective to get the woman through labor as quickly as possible: “research has found that malpractice premiums were positively associated with rates cesarean sections and negatively associated with VBAC [vaginal birth after cesarean] rates” (Bibeau 168). Not only are hospitals incentivized to have more cesareans but, as Bernhard et al. found in her interviews, they are also turning away women from their practices who express interest in having home births. One woman, who chose not to tell her in-hospital midwife she was planning a home birth, described her inner turmoil about keeping the process to herself based on the fear of losing the option to transfer to the hospital if needed.

I really genuinely loved my midwife in the hospital . . . I thought she was wonderful, and I felt terrible as I got closer to the end of my pregnancy. I started feeling extreme guilt ’cause I wanted to tell her, ‘Look, I’m thinking of a home birth’ . . . I didn’t know what kind of reaction I would get because I had heard horror stories that they send you home and you get a certified letter in the mail saying, ‘Don’t come back.’ Another woman received a certified letter dismissing her from the practice within 3 days of notifying her hospital birth provider that she had had a home birth (Bernhard 163).

Rebecca Woolf described her experience of feeling pressured into medical interventions during her labor in an interview with the Huffington Post

In her prenatal visits, she had been explicit about not wanting an episiotomy. Her doctor said, "Oh yeah, it shouldn't be a problem. Sounds good," Woolf recalled. "But when we got into the delivery room, it was, 'I've got to do this, I've got no choice. If I don't cut you, you're going to tear. It's going to be terrible. It's going to be way worse' (Pearson). He pressured her into feeling that she needed an episiotomy after she had only pushed once. This experience is all too common.

Many women develop a Birth Plan to help gain a sense of control during their birth experiences. Birth Plans can include what interventions they do or do not agree to, music they want to be played during the birth, etc. Birth Plans are very popular, especially among natural birth advocates as many Birth Plans are aimed at limiting medical interventions. Many women have been discouraged by the hospital setting from using Birth Plans. Such as Stacy, a woman from Boulton and Malacrida's study, who said, "I didn't even bother with a Birth Plan because my girlfriend is a nurse, and she said, 'We don't follow your Birth Plan'" (Boulton, Malacrida 50). Having an advocate can help the mothers retain control, Malacrida and Boulton interviewed a mother named Judith who spoke about her doula's advocacy for her Birth Plan while in a hospital setting:

I mean you're at your most vulnerable then. You're not in a state of mind, you don't have ... Like, me sitting here right now, I would be able to say to a doctor, 'No, don't do that to me!' But in that position, you just can't. Like, maybe with a second birth, but not my first. (Boulton, Malacrida 49).

This attitude, according to Malacrida and Boulton, is an illustration of the feeling among women who want a natural birth that "doctors are to be defended against" (Boulton, Malacrida 49). Even when doctors seemed to be offering mothers some control, many women felt that it was a false

sense of control. One woman explains in an interview with Bernhard et al. during her research on home births after hospital births,

Choices within the hospital setting seemed to some women to be perceived choices rather than actual choices. For example, one participant was told by her provider at a challenging point in her labor that her only options were to have either an epidural or a cesarean, when she really wanted neither (Bernhard et al. 162).

In Gender Studies scholar, Monica Campo's interviews with mothers, she found just how common this dismissal of women's ideas is in the medicalized model of birth;

This [dismissal of the woman's wishes] was even from the supposedly 'low intervention doctors'. For example Sandra's doctor told her to 'forget it' in response to a question about a birth plan and that as far as he was concerned the 'plan is to get the baby out'. Jasmine's obstetrician told her that 'only women who don't trust us use birth plans [and doulas]'. Jasmine, a health professional in the maternity field, claimed that she'd often seen obstetricians 'scoff' mockingly at 'silly women's' birth plans, so she knew that even if she wrote one it 'would mean nothing'. Sally, pregnant with her first baby, wrote a birth plan however she says her doctor 'didn't even look at it 'telling her to 'give it to the midwife'. In this way, medical authority is reinforced and women's autonomy is undermined (Campo 4).

This discouragement from the medicalized birth institution can leave women feeling powerless. When women are not made to feel powerful in their birth experience it can have serious impact on the mother's mental health:

Birth satisfaction increases, specifically when she is able to take an active role in decisions such as pain control, body position, method of delivery, and medical

interventions. Research shows that high levels of control during labor and delivery significantly increase birth satisfaction and may aid in decreasing the incidence of traumatic perceptions of birth and postpartum depression (Fair, Morrison 21).

This is telling of why some women are choosing to give birth outside of the medical setting. In interviews with women who had their first birth in a hospital and their second or third at home there was a feeling of trust in midwives that they would allow the woman to have control over her birth while still keeping her safe: “Without exception, each participant relayed feeling that her homebirth care providers wanted for her what she wanted for herself” (Merg, Carmoney 72). One woman said of her home birth after her hospital birth “My home birth was healing in a lot ways for me . . . I actually had a choice and I felt empowered” (Bernhard page 162).

By getting to know their patients, midwives get to understand what it is a woman wants out of her birth experience and can help her prepare for it. An example of the differences in prenatal appointments between a doctor and a midwife are seen in Kat and Kimberly’s interviews with sociologist, Alana Bibeau. Kat described her prenatal visits at the hospital, “The appointments are pretty fast. It was like 15 minutes in and out of there. Check this, do that and then, ‘Yeah, we’ll see you in 2 weeks or a month’”. However Kimberly’s experience with a midwife was very different: “Every appointment was an hour. I remember my midwife asking me once, ‘Have you been able to find maternity clothes that work for you? It’s so much more than just in and out’” (Bibeau 170). The difference in prenatal appointments is critical in building up trust before the birth. However, in hospital births it is common to have a different doctor at the delivery than the one who was at the prenatal appointments. Monica Campo, points out that “of the 13 women I interviewed 5 ended up with alternative and sometimes unknown, obstetricians” (Campo 3). Even if the obstetrician does show up, the hospitals are not set up for

them to stay with the mother for the entirety of the labor as is the case with an at home midwife.

As Olivia, an interviewee of Campo's explains,

...yeah what happened was, the obstetrician, in that whole time I was in the hospital from 1:30 in the morning till the ob. got there about 10:20 that night to do the cesarean, other than that, the only time I saw the ob. was about 1 o'clock in the afternoon for about 2 minutes... she told me than that she would be back between 6 and 7 but she never came ... I only saw her for a total of 20 minutes not including the cesarean (Campo 3).

This lack of connection and relationship with an ob., as well as the power imbalance between mother and ob., is what is leading many women to choose home births.

Doctors are trained to look for illness and places to intervene. A woman named Susan, who was interviewed by Malacrida and Boulton, said the following about her Birth Plan,

I really, really was opposed to being induced - I felt that that is the beginning of the end for natural childbirth ... My hope was to call my doula, do most of my labor at my sister's house with the doula there, so she could help us spend the least amount of time in the hospital as possible (Boulton, Malacrida 50).

For women who want a natural birth, there is a theme that in order to avoid interventions during birth you must stay out of the hospital for the entire birth or as much of it as possible. Once you have entered the hospital, power shifts from the mother to the doctor and unless you have a Doula or a Midwife advocating on your behalf, it can be challenging to stop what Malacrida and Boulton term a "cascade of interventions" (Boulton, Malacrida 51). A woman they interviewed, Carmen, explains this term, "If you get induced your chance of a C-section goes up. If you get induced your chance of an epidural goes up, if you have an epidural your chance of a C-section goes up again. Once that ball starts rolling one thing tends to lead to another" (Boulton,

Malacrida 51). A mother's inherent fear of hurting her child puts the doctors in a position of control. Abby, another woman interviewed by Malacrida and Boulton, explains “I think women, you know, trust their doctors, they don’t want to hurt their babies ... and so the doctor says we have to do this, then they do it” (Boulton, Malacrida 52). Shirley, another interviewee of Malacrida and Boulton, shares her experience with this cascading of interventions, even after she had planned a natural birth,

You can’t really just leave it once you started it [having an induction] and I didn’t realize that. And he [the doctor] didn’t really explain that to me ... I thought you could just try it ... but I didn’t get that option, because once I started it he came in and said, ‘Ok we’ll break your water next’. And I didn’t feel qualified to question that ... But at that point I felt like I’m on a train and I have to keep going where it was going (Boulton, Malacrida 52).

The problem with this, besides the impact on the mother’s control, is that this cascade of interventions commonly ends in a cesarean. As we saw with the Pitocin epidural cycle, and despite how common cesarean sections are, they are not without risk. In fact:

Risks to mother include pulmonary and circulatory problems, post-partum infections, evisceration and long-term risks associated with uterine scarring and weakening; risks to the child include surgical injuries and prematurity and poor lung development if fetal age calculations are inaccurate” (Boulton, Malacrida 43).

Cesareans and other interventions are common despite their dangers. In Bibeau’s research she found that “Of the 59 participants [in his study, all of whom gave birth in a hospital], 81% experienced at least one intervention during labor and birth and 67% experienced more than three (Bibeau 169). Mothers who have had a hospital birth and were unhappy with the cascade of

interventions and the power imbalance many times choose to have their second or third births at home. A woman in Bernhard et al. research of home births after hospital births explained,

Women expressed feelings of being pressured into interventions because the timetable and agenda belonged to the hospital rather than their bodies and their labor experiences.

‘It was more about my body [at home] doing its thing, versus the hospital was more about it took a team and chemical[s] and drugs and monitors . . . it took all these things together to get a baby out . . . at home it was . . . just my body . . . it will just come out’ (Bernhard 162).

As we have seen so far, the best way mothers know how to avoid this cascade of interventions and power imbalance is to get out of the hospital for as long as possible. If it is necessary to go to the hospital than it is best to have a doula or midwife, who has gotten to know them and their birth plan well, at the hospital with them as an advocate.

Expectations and Satisfaction

The amount that the birth varies from the mother's expectations has a huge impact on the mother's feelings of satisfaction with her birth experience and can also lead to self-blame.

Carmen and Shirly, both interviewees of Malcrida and Boulton’s expressed their self-blame about giving into medical pressures, both of them ended up having C-sections. Carmen wondered, “Would this have happened that way ... if I hadn’t had to lay in bed so much [do to fetal monitoring] and could have moved around ... Lots of questions like that” (54). While Shirley questioned if her choice to agree an induction lead to the “cascade of interventions” and if she should have done something differently, “The only thing in the back of mind, is that if I wouldn’t have said yes to the induction then maybe I wouldn’t have had to have a C-section” (Boulton, Malacrida 54). Another woman in the same study talked about how having a

medicalized birth after planning a natural birth affected her, “I just felt like my birth was taken away from me, really ... I think it’s really just that I thought the whole experience was just kind of taken” (53). The woman believed she would have some degree of control over her birth situation, but when it ended in a C-section her loss of control of the situation made her feel as though the experience had been taken from her. Due to her C-section, she was unable to hold her baby immediately, denying the bonding skin to skin contact, she recalls “I started crying and thinking, ‘I really, really missed out’” (53). This woman felt that she was denied the experience of bonding with her baby that is allowed only through a natural birth experience. Ina May Gaskin explains the importance of natural labor to the mother and child,

Labor is important, because during labor, both the mother's and the baby's body is prepared for birth. The levels of certain hormones rise and ebb during labor. For instance, the mother's oxytocin levels rise markedly just before the baby is pushed out of her body. This protects her against postpartum hemorrhage. High oxytocin levels in the mother (which are accompanied by higher levels in the baby, too) prepare the nervous systems of both to be attuned to each other. This creates a special "sensitive" period during which these special hormones remain at high levels in undisturbed birth, and this period is best spent by mother and baby in skin-to-skin contact with each other as the baby begins to nuzzle and nick the mother's breast or the two just look into each other's eyes and adore each other. The euphoria that follows an unmedicated labor is a very special time for anyone who is privileged to witness it. It's even better for those who get to experience it. When the mother experiences labor, she also has higher levels than usual of beta endorphin. This hormone then triggers another hormone, prolactin, which prompts her

body to get ready for milk production at the same time that it prepares the baby's lungs for more efficient breathing (Fine).

Furthermore, when skin to skin contact is allowed immediately after birth, mothers may have an easier time breastfeeding. Which has many benefits, “Early breastfeeding helps the mother stop bleeding, clears mucus from the baby’s nose and mouth, and transfers disease-fighting antibodies in the milk from mother to baby” (American Pregnancy Association). This is the experience many women choosing home birth are seeking. When a woman has planned for a natural birth and has the experience taken from her, she loses her sense of control and satisfaction. However, as we have seen previously, most women are not allowed the birth they planned for once in the hospital setting. (Fleming et al. 11)

TABLE V
PERCENT OF WOMEN FEELING POSITIVELY OR NEGATIVELY ABOUT THE DIFFERENT INTERVENTIONS DURING PREGNANCY, AND EITHER RECEIVING THE INTERVENTIONS OR NOT

	Felt negative and had procedure	Felt negative (did not have procedure)	Felt neutral/positive and had procedure	Felt neutral/positive (did not have procedure)
<i>Interventions</i>				
Labor induction	24	58	5	13
Forceps	38	49	8	5
Continuous monitoring	41	5	51	3
Episiotomy	37	13	45	5
Regional anesthesia	28	5	59	8
<i>Contact</i>				
Rooming in	3	21	29	47
Nurse baby within 1 h	0	5	49	46

Pressure from the doctor to start the interventions is illustrated by Fleming et al. in Table V. This table examines mother's feelings about the interventions they had during birth. Following trend, “the hospital population experienced largest discrepancies between what they expected would

occur at the childbirth and what actually did occur” (10). For example, “28% of the hospital women who expressed a dislike for epidural blocks before childbirth in fact had one” (Fleming et al. 11). It should be noted that “Since there were only two women in the home group who experienced a discrepancy [between what they expected would occur and what ended up happening] it was not possible to include a home-discrepant group” in the table (Fleming et al. 11). As for satisfaction with their births, Fleming et al. found that the “highest satisfaction or control levels [were] among the home-non-discrepant group and lowest among the hospital-discrepant group” (11). This power imbalance women face when trying to have a natural birth in the hospital setting is an institutional problem, going far beyond the individual mother and doctor. We need institutional level change if we as a nation are going to get to a place where mothers do not have to fight for a birth experience where they feel in control.

Conclusion: A Part of the House

Women’s expectations of control and positive emotions during (home) birth [are] associated with reports of positive birth experiences. It may be that homebirth midwives are more thoroughly preparing their clients for the experience of childbirth, therefore the women’s experiences are more in line with their expectations (Merg, Carmoney 74).

This relationship between a woman and her midwife is drastically different from that of a woman and her doctor. There is more trust and communication because midwives take time throughout the pregnancy to get to know the women. The midwifery model of birth views birth as a natural event that has the best success when not interfered with. Midwives and other “natural birth advocates argue that the medical model focuses too heavily on the risks of birth, instilling fear in women and preventing them from fully embracing their natural ability to give birth” (Boulton, Malacrida).

A woman who is given the name Persephone in, childbirth educator and Professor, Merg and Carmoney's work says of her midwife "...she did kind of have to urge me to do things a little differently than what I'd wanted to do, but because I trusted her it was fine" (72). This relationship of trust between woman and midwife plays a large part in a woman's sense of control in her birth experience. In fact, every woman in Merg and Carmoney's research "emphasized the time and attention given by her homebirth midwife" and "described building relationships with their homebirth midwives" saying that the midwives "became part of the house" (72). One woman described in her interview what it was that made her feel comfortable with her midwife, "Just the care we received from the midwife, and it was just one midwife. Just her being available for questions and just sitting like an old friend and chatting and just being so genuinely interested in not just my pregnancy but also our lives and the birth itself" (Bernhard et al. 163). Having this trusting relationship with their midwives allows women to feel more relaxed and in control during their births. They know the midwives understand and respect their wishes for the birth and are there to support and advocate for them. In Merg and Carmoney's study on women who gave birth at home after having a first birth in a hospital they found that:

Without exception, the participants experienced feeling respected; being autonomous; trusting the staff at their birth; feeling accomplished; feeling empowered; feeling that their care providers were their allies; and feeling satisfied during and after their homebirth experiences (72)

One reason women who gave birth at home felt so empowered may be because with a midwife attended home birth they were allowed to have control over what happened to their bodies and when. A majority of women in Bibeau's study defined control as "decision making power" and

women who reported the least satisfaction with their births felt that they had not been given choices (Bibeau 170).

So:

Why do women continue to go along with this stuff?' [Such as] interventions and practices such as electronic fetal monitoring, induction of labor, epidural and surgical births all of which despite lack of evidence regarding their effectiveness, or their ability to produce better outcomes for mothers and babies, continue to be routinely used in most hospital births (Campo 1).

Americans are raised in a society where the dominant discourse surrounding childbirth is focused on the medical model, which once entered into allows little control to mothers. I hope that my research will help others become interested in learning more about the midwifery birth model and non-medicalized birth. More research needs to be done into how we change the dominant discourse surrounding birth models to be more inclusive of home births and how we can help mothers achieve more control within the hospital setting. As we have seen, the most important aspects of a positive birth experience are that the mother's ideas surrounding interventions are in line with that of a health care provider that she trusts and who allows her to retain autonomy throughout labor and delivery.

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