The Medicalization of Birth and Its Effects on Women's Perceptions of Birth

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This research was funded in part by the Undergraduate Research Fund at Tufts University

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For my grandmother, Mary Rose Seibel,
who taught me to be a fighter.
Norman Rockwell

Abstract

This thesis explores the evolution of the birth model in America from a woman-centered, natural event to a medical procedure that occurs under the supervision of a doctor in a hospital. This transformation reflects the medicalization of birth. Medicalization is a phenomenon in which common or natural life events are problematized, labeled, and treated as an illness or disease. This thesis aims to answer these questions: How has this model of medicalized birth become so dominant in America? What are the effects of this medicalization? Is birth now safer under this new model of care? To answer these questions, I found resources at the Melrose Public Library and Tufts University's Tisch Library, including its online catalog; I found relevant statistics on the Center for Disease Control and Prevention's and World Health Organization's websites. I also interviewed 20 Tufts women regarding their perceptions and expectations surrounding birth. I recruited my participants through convenience and snowball sampling. After reviewing the literature and conducting the interviews, I found that the medicalized birth model has become so dominant in America that it affects the way my participants perceive the birth process. Though it is the prevailing birth model in America, the medicalization of birth has not provided women or their infants with better care. In fact, care has probably gotten worse.

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Introduction

An unlikely person inspired my initial interest in birth: Ricki Lake, the former daytime talk host. Her documentary, *The Business of Being Born,* provided me with an indelible image of a woman participating in her own birth. I will never forget how Lake moans, wades, squats, bends, and moves throughout her labor. She finally reclines in a tub where she gives birth to her son. Before watching this documentary, I perceived birth as a process that occurred in the hospital with doctors monitoring the laboring woman who stayed in the hospital bed. This documentary challenged my limited understanding of birth, empowering me with options that place the woman in control of her birth.

As a student at Tufts University, I consider myself an educated and informed woman. After watching *The Business of Being Born* in my *Women and Health* class at Tufts, I was surprised to learn about the different variations embedded in the birthing process. For me, birth was a woman lying on a hospital bed with her legs up in the air or in stirrups. While connected to beeping, high-tech machines, she would huff and puff and push according to the doctor's instructions. After this class, I became aware of the "natural" birth process.

I recognize that "natural" is a loaded term in American culture that may conjure up a range of images from a simple landscape of trees to a cult of free loving hippies. Instead of avoiding the term altogether, I will use the term to denote a birth that has minimal to zero medical intervention in which the medical assistant, whether it be a doctor or a midwife, plays a non-invasive role. The birth process is a spectrum with the Cesarean section at one end and a home birth with minimal medical assistance at the other. A home birth and a hospital birth with few medical interventions are not

necessarily polar opposites but are different points along the spectrum. To use a real world and personal example, my mother describes her three births as natural because she did not have an epidural or any other forms of pain medication. However, the midwife did intervene during my mother's labor by artificially rupturing the amniotic sac and applying prostaglandin gel to thin the cervix and induce labor. For the purposes of this thesis, I characterize my mother's birth experiences as closer to the natural end of the spectrum though there was still an element of intrusion. Another way to think of a natural birth is a "physiological birth" in which "labor begins and progresses spontaneously, the woman is free to move about for the duration, and she pushes in advantageous, intuitive positions" (Block, 2007, p. xvii).

For me, going to the hospital means dealing with something serious that I cannot handle alone. Since birth predominantly occurs in hospitals, I have attached this sentiment—medically serious—with birth. Seeing Lake labor in her bathtub normalized birth, making it seem more manageable. I was amazed that I had no idea about these alternative ways to give birth outside a hospital. At 19 years old, I was so ignorant about a process that I would most likely experience within the decade. Moreover, if I, a Community Health major taking a class geared towards women's health, was so ignorant about this process, what about my friends who were engineers or English majors?

Upon returning to my freshman dorm after watching this documentary in class, I was eager to share this startling information with my friends. With disgust, my friends claimed that they wanted all the drugs in the world for their labor or preferred a Cesarean section so they would not damage their bodies. As much as I tried to explain to them what labor could look like, they thought the idea of squatting, giving birth in a tub, or

choosing a home birth was ridiculous. Even after sharing some of the health benefits of these non-invasive labors, my friends reasoned that they would rather just give birth the regular way—in a hospital with doctors—since that is how they were born.

Most women do not actively seek out information regarding birth unless they are pregnant or are seriously considering having children (Lothian, 2006). Most undergraduate women at Tufts University do not fall into either of those categories. Unless studying medicine or public health, most Tufts student will not learn about birth in detail. The media is one of the limited sources of information for female students to learn about birth; unfortunately, the media generally offers only one form of birth—the highly intervened one—and even mocks the natural ones. For example, during *Knocked Up,* Katherine Heigl's character goes into labor but she does not have a ride to the hospital. She frantically calls the father of the child, played by Seth Rogen, to drive her; in the meantime, she settles into a soothing bubble bath, listens to Enya music, and focuses on her breathing. When Rogen arrives he cannot believe that she is wasting time in the tub and rushes her to the hospital where, of course, the birth takes place.

This limited knowledge of birth leaves women unprepared, leading to potential harmful consequences—whether emotional or physical—for these women and their children. After coming to this realization, I began to feel that an injustice was occurring to women. I have no problem with the use of intervention when necessary but I am concerned that women are not given enough information to make an informed decision about their birth plan. For women who are able to access helpful resources and information, it often comes too late, after they have been bombarded with the clinical

image of birth. At that point, a natural birth seems like an option for only earthy-crunchy women who wear Birkenstocks and do not shave their legs..

As its history and the current situation will demonstrate, the birth model has been a contentious issue in America. The number of interventions and options available are increasing and yet national maternal and infant mortality rates are high in comparison to other developed countries. Women, wanting the best for their baby, are lost in this overload of information, often trusting the doctor's opinion and complying with the social norms. While I am not here to argue that there is a perfect model, I want to challenge American society's preconceived notions of birth. Utilizing one's general knowledge of gravity, does it seem logical for a woman to lie on a hospital bed with her feet in stirrups as she gives birth? Does a Cesarean section, which increases the risk of infection by ten times in comparison to a vaginal birth, seem like a safer and easier alternative? And if so I ask for whom?

Medicalization is a phenomenon in which common or natural life events are problematized, labeled, and treated as an illness or disease. First, I will further discuss medicalization and examine a subset of this process, the control dynamic regarding the doctor-patient relationship. Then I will briefly describe my methods. In my first chapter I will investigate how birth has changed overtime in America through various lenses: the location, the authorities and professionals, and the common practices. In my next chapter I will outline and analyze the current birth model in America. In my third chapter I will present the results from the twenty interviews I conducted with Tufts women. In my discussion I will analyze these results, exploring the societal view of birth. Finally, I will

conclude with the implications of this prevailing birth model and recommendations on how to effectively and accurately inform women about the birth process.

Defining Medicalization and Control Within the Context of Birth in America

Birth is a life process that connects humans to other species and serves as a reminder of our humble, animalistic origins. In American history—and even today in some developing countries—childbirth was not uncommonly a fatal event for both the mother and the newborn. In America the maternal mortality rate in 1920 was approximately 950 deaths per 100,000 births (Loudon, 2000). A change in maternal care was necessary to address this high rate of death and this change involved the medicalization of birth. A mere 30 years later, the maternal mortality rate had already improved to only 100 deaths per 100,000 births (Loudon, 2000). The medicalization of birth was one of the many factors—as well as the articulation of germ theory, better nutrition, and improvement in sanitation—that mitigated the fear of childbirth.

Zola, one of the first scholars to use the term "medicalization," describes it as a "process whereby more and more of everyday life has come under medical dominion, influence, and supervision" (Zola, 1975). Conrad (1992) questions if the direct involvement of the medical profession is needed for an area of human life to become medicalized. A father may view his son's drug addiction as a medical problem, as opposed to a personal failing. However, his son may never contact or meet directly with a medical authority. Medicalization still occurs because of the way his father labels his problems, impacting how both the father and the son will deal with this issue. In the context of birth, Americans approach this process as one in which things could go terribly wrong; therefore, the most logical place for it to occur is the hospital, where it can be

closely monitored and managed by doctors who have access to advanced medical technology. Thus, medicalization is both labeling a set of behaviors, actions, or feelings using medical language and framing that issue in a treatable way through the use of medical intervention (Conrad & Schneider, 1992).

Embedded in the process of medicalization is social control—the process by which society ensures adherence to societal norms and thus promotes conformity (Conrad & Schneider, 1992). The professionalization of medicine has affected the control dynamic in the doctor-patient relationship in the birth model. Some examples of this increasing formal social control can be seen throughout the history of the birth model: the metamorphosis of the female midwife to the obstetrician; the establishment of various institutions surrounding medicine such as the American Medical Association (AMA), the hospital, and medical schools; and doctor's routine use of medical technology. Within this dynamic, doctors are respected professionals and the patient rarely questions their authority, making it difficult for a laboring woman to achieve informed consent. Moreover, those who research their options, shed their preoccupation with social norms, and choose a birth model that differs from the hospital norm, can be viewed as selfish or irresponsible pregnant women (Block, 2007).

Methods

To initiate my research process, I met with a family friend—Robin Snyder-Drummond—who is a doula, lactation consultant, and childbirth class educator. Robin has been instrumental in supplying me with the literature that doulas and midwives read as well as introducing me to the essential works of the major figures within the natural birth space—mainly books and essays by Sheila Kitzinger, Penny Simkin, and Ina May

Gaskin. I also searched "history of birth in America" in the Melrose Public Library's catalogue and found two relevant books—Tina Cassidy's *Birth: The Surprising History of How We Are Born* and Jennifer Block's *Pushed: The Painful Truth About Childbirth and Modern Maternity Care.* Professor Balbach also suggested that I read Peter Conrad's and Joseph Schneider's *Deviance and Medicalization: From Badness to Sickness* and Paul Starr's *The Social Transformation of American History*. The sources referenced in these books directed me to other works that were helpful in writing my chapter about the history of the birth model. For example, Richard and Dorothy Wertz's *Lying In* and Donald Caton's *What a Blessing She Had Chloroform* consistently appeared as sources. Besides using these books, I utilized the Centers for Disease Control and Prevention's (CDC's) website to search for statistics.

For the current birth model in America, I relied on the Tufts University's online database catalog through Tisch Library. For databases, I used Ovid Medline, Academic One File, Wiley Online, Web of Science, Google Scholar, and JSTOR. Some of the search terms I used were (medical malpractice insurance rates) in Academic One File, and ((((medical malpractice insurance rates) AND (obstetrics)) OR (OBGYN)) OR (obstetrical care)) as well as ((defensive medicine) AND (C-sections)) in JSTOR. For statistics, I searched within the CDC to find national data and the World Health Organization (WHO) to compare data across countries. On the CDC's website, I used the table builder function under National Vital Statistics System to target specific information, such as the percentage of breeched babies born vaginally

For my interviews, I used convenience and snowball sampling. When selecting my participants, I chose people who had not heard me talk about this subject before. I

recruited my participants through mutual friends. Since my housemates are from different social circles, I took advantage of this diversity and recruited participants from different groups. For example, I recruited students who danced, studied abroad, acted, and worked with my close friends. My participants also referred me to other people that they thought would be interested in my interviews. I have assigned pseudonyms for all of my participants to maintain confidentiality.

I conducted 20 interviews, which was the point at which I reached theoretical saturation. I recognize that my sample is not representative of the Tufts community nor the rest of the American female population within the age range of 19 and 22. That being said, I did select students who came from a diverse range of backgrounds. My sample included women from Massachusetts, Maine, New York, California, Texas, Washington, Illinois, and even Singapore. My sample also included females who identified as White, Latino—specifically Puerto Rican or Dominican—Biracial (black and white), and Asian American—specifically Vietnamese, Filipino, Japanese, and Indian. In terms of religion, my sample ranged from Catholics, Muslims, Jews, Buddhists, and Protestants. I did not interview any freshman. My sample included two sophomores, one junior, and 17 seniors. In terms of sexuality, one participant identified as a lesbian and another participant identified as bisexual. I thus had an interesting cross section of women.

Chapter One: The History of the Birth Model in America

Birth began in America as a natural, woman-centered event in which female care providers would help guide the woman through her labor without intervening in the process. The main function of the female health provider was comforting and nurturing the laboring woman while nature took its course. During colonial America, midwives did not believe in heavily intervening in a process that was in God's hands. For example, there was the colonial idea that pain was expected and even necessary during childbirth, a reminder of Eve's punishment in Genesis. The gradual assimilation of medicine into the birthing world reflected a larger expansion of the role of medical institutions. This co-optation has placed birth in a hospital setting, offering the laboring woman advanced medical technology such as anesthesia, use of forceps, and episiotomies. This shift towards an invasive nature in the birth model has not provided women with better care. In fact, care has probably gotten worse.

Female-Attended Home Births

Childbirth in colonial America was a social event characterized by engagements and interactions instead of isolation and confinement in a hospital. For example, birth attendants in Europe and early America were called "God-sibs" or "sister-in-God" (Cassidy, 2006, p. 51). These women, usually relatives or friends, would stay with the mother for the entirety of her labor, often chatting throughout the process. In fact, "God-sibs" is the root of the word gossip. Birth would take place in the "borning room"—a small room near the central chimney or, in larger homes, the master bedroom (Cassidy, 2006).

Most women probably labored on their beds or on birthing stools. First used in the medieval ages, the birthing stool had a cut-out seat, which allowed the midwife access to the birth canal; to preserve modesty, laboring women wore long skirts. Midwives often brought a collapsible stool to the birth. After the birth, there was a lying-in period of three to four weeks in which female friends would help the mother with her housework as she recovered from labor and spent time with her newborn (Wertz & Wertz, 1977). To show their appreciation for all of the help and support, new mothers in New England would hold a groaning party for female friends and relatives. This party referred to the groans of pain during labor as well as the groans of the women who ate a lot of food at the party (Wertz & Wertz, 1977).

This idea of a social birth is also reflected in the names of the lay practitioners who would also help during a birth. In Europe, these women were referred to as "grace wives," since mothers would often pay for their services with gifts—also known as graces—instead of money (Cassidy, 2006). In Old English, "midwife" translates to "with woman." During this time period, the practice of a midwife staying with the mother throughout her labor was the norm. In some cultures, midwife is the same word as grandmother, reflecting the close emotional connection between the birth attendant and the mother. For example, in Jamaica a midwife is "nana" and in Japan "samba" (Cassidy, 2006).

All birth attendants were female, a natural and logical arrangement since women have either experienced the process themselves first-hand or, at the very least, have the anatomy to do so. This arrangement benefits both the laboring woman, who can appreciate that the woman helping her has also personally experienced this process, and

the lay practitioner, who has an intimate, first-hand knowledge of this process, furthering boosting her confidence. Midwives were respected in their communities, and some New England cities offered living spaces rent-free under the agreement that "she doth not refuse when called to it" (Dexter, 2009).

Beyond the scope of childbirth, women were the main figures of medical care in colonial America, tending to the sick at home (Starr, 1982). Without any formal training, these women learned the practical knowledge of medicine and health by observing their mothers or other older female relatives perform the duties in the home when they were young girls. This basic set of knowledge was a tradition embedded in the domestic economy that passed from one generation of females to the next. Caring was exclusively under the province of women (Wertz & Wertz, 1977).

Without modern technology, midwives and female relatives would often use resources that were available at the home. These home remedies include brandy as an anesthetic, string and scissors to cut and tie the umbilical cord, and lard to massage the perineum throughout labor to reduce the risk of tearing (Cassidy, 2006). The perineum, an area between the vagina and anus, is susceptible to tearing during childbirth because of the intense stretching that occurs; besides lard, olive oil and manual massaging are natural ways to prevent this tearing. To induce labor, women would often drink castor oil, a vegetable oil that is most known for its laxative effect (Block, 2007). Because castor oil induces cramps in the bowels, lay practitioners believed that this cramping triggered contractions, which are also just cramps, in the uterus. The use of castor oil during labor dates back to the Egyptians, who also used honey to heal the womb after birth. Similarly, in colonial America, sugar was used to heal the womb. Throughout the labor, midwives

encouraged the mother to eat food that would sustain her energy such as toast, buckwheat gruel, mutton, broth, and eggs. To relax the mother, midwives would also administer red wine. For a difficult birth, midwives would apply warm compresses on the stomach, administer an enema, or put snuffing powder into the mother's nose (Wertz & Wertz, 1977).

Birth attendants did not view childbirth as something that required active intervention or interference. For these women, childbirth was a natural process that they could minimally intervene in to ensure safety—using sterile scissors to cut the umbilical cord—and make this painful process as comfortable as possible for the mother—massaging lard or olive oil into her perineum to prevent tearing. A common procedure today, the Cesarean section, was rare during the 16th and 17th centuries and performed when all hope was lost (Cassidy, 2006). Until the use of antiseptics to treat infections in the early 1900s, a Cesarean section was a fatal procedure that was often performed after the mother was dead to deliver the baby (Scully, 1986).

Many also viewed the pain associated with labor as normal and even necessary. Pain in labor was closely associated with divine punishment for sins. God, in the Old Testament story of Adam and Eve in the Garden of Eden, punishes Eve by increasing her pains in childbearing. Many women in early America accepted the pain in childbirth as their punishment for sins (Caton, 1999). To eliminate the pain seemed like an unfair shortcut. Women also worried about death resulting from childbirth. Rickets and tuberculosis caused pelvic deformities that led to long, complicated labors that often resulted in maternal death. During the 19th century, one in ten women died in childbirth; during epidemics, this number could get as high as one maternal death per two births

(Caton, 1999). As the rates of maternal and infant mortality remained high throughout the 17th and 18th centuries, Americans continued to associate birth with death. Midwives and other female birth attendants recognized the unpredictability of birth and acknowledged that this process was beyond the realm of human control, surrendering authority to God (Dye, 1986).

Though caring fell under the realm of informal local women, the physician did exist during the 18th and 19th centuries; however, the position of a physician was not prestigious or lucrative in pre-industrial America. The compensation for his services was usually low, and the use of his services was uncommon. This low compensation and demand for his services required a physician to have a second job, most commonly as a farmer or local town druggist (Starr, 1982). It was uncommon that a physician would attend a birth (Wertz & Wertz, 1977). When men did try to enter this domain, they adopted the female titles. For example, before the 1750s, the few first men who attended births called themselves "male midwives" or "man midwives" (Wertz & Wertz, 1977).

Besides the self-sufficient culture of early America, the logistics of the pre-industrial era caused obstacles for the physician in terms of access, resources, and convenience. Many rural communities had only rudimentary roads and pathways. Hospitals would not become common until the late 19th century and even then they mostly served the poor (Eakins, 1986). Without a central locus to treat patients, a physician would have to travel to them without the benefit of modern innovations such as good roads and the automobile. The resources—both time and money—spent on traveling to these remote communities often greatly outweighed the payment that doctors received (Starr, 1982). Also, the time it took to travel to a patient's home often consumed

the entire day, limiting the physician on the number of patients he could see. This unsustainable arrangement forced the position of physician to change. Instead of becoming obsolete, the physician has accomplished one of the biggest transformations in American history.

Beginning to Professionalize the Physician

The physician entered the industrial revolution as a poor workingman and exited as a professional on the way to becoming one of the most lucrative and respected positions in America. For all of the reasons that pre-industrial America limited the physician and made his job nearly impossible, the effects of industrialization allowed the physician to prosper. With the invention and development of the telephone (1876), automobiles (1890), and hard roads (late 1800s), doctors were more connected and available to their patients. These advances reduced the traveling time, enabling a doctor to care for many patients in one day. This reduction in the indirect costs placed professional care as an affordable commodity for most Americans (Starr, 1982).

Another factor that led to the success of the American physician was the influence of European medical institutions and the increasing inclusion of men in midwifery. During the medieval ages, men were only involved in difficult births when the midwife needed a surgeon to save either the mother or the baby. In England, these men were called “barber surgeons” and would use hooks, knives, and perforators to extract the baby either by pulling it out or puncturing its head (Wertz & Wertz, 1977). Often these men would have to kill the infant in order to save the mother. In the early 17th century in England, a member of the Chamberlen family—believed to be Peter Chamberlen the Elder—invented the obstetrical forceps, a tool that would allow the extraction of the fetus

without killing the mother or infant. This invention was kept a secret within the family for four generations since it brought the family such success (Dye, 1986). Eventually the forceps became commonly used in birth by the mid 18th century. Since many female midwives associated the forceps with the other mutilating tools used by the barber surgeons, they were less likely to use forceps than male midwives. Elizabeth Nihell, a famous 18th century English midwife, criticized the use of forceps as "insignificant and dangerous substitutes for their own hands" (Wertz & Wertz, 1977, p. 39). Nihell argued that the forceps were less effective and caused unnecessary pain to the patient. Also, the costs of these instruments were too expensive for the midwife to afford. The tradition of male use of tools and female use of hands and touch persisted into the 18th century, a dichotomy captured in Figure 1 (Wertz & Wertz, 1977).

Figure 1: A 1793 cartoon of a midwife bisected into male and female halves: a Man-Midwife

After 1750, American men returned home after studying medicine abroad—mostly in London and Edinburgh—and established medical establishments in America similar to the European ones. Whereas the European governments provided funding for medical education, including the training of midwives, the American government did not, leaving this form of training accessible to only the wealthy. The first medical school in America was founded in 1765: the Medical College of Philadelphia. Shortly after, King's College Medical School—which would later become Columbia—was established in 1767 and Harvard Medical School in 1782. In 1817 Dr. Thomas Ewell tried to establish a school for midwives that would be connected to a hospital; however, the inclusion of female midwives in this new system of formal training never developed (Wertz and Wertz, 1977).

The nature of midwives' decentralized and informal training meant that no institution grew around this profession. Midwives did not have a collective body such as schools or institutions that connected these women from different regions. A midwife was a local woman whose main goal was to serve the needs of women rather than form an institutional body that promoted and reinforced some abstract medical goal or philosophy. Without a central body or network, communicating with other midwives was difficult. This decentralization would be detrimental to midwives when physicians attacked midwifery since these women were either not aware they were being ridiculed or, if they did, had no supportive organization to retaliate from (Wertz & Wertz, 1977).

To first be involved in births, men adopted the female title—midwife—to promote familiarity. Once these men attained creditability, they wanted to lose the name "man midwife" since it was too reminiscent of the female position and did not reflect the

scientific and medical value of the physician. During the 19th century, physicians referred to themselves as simply physicians or doctors. Later, in 1928, an English doctor suggested that "man midwife" should become "obstetrician." In Latin, this term means "to stand before" (Wertz & Wertz, 1977). The amiable coexistence between midwives and physicians remained from 1750 to 1800 with midwives attending all births and, when a difficult labor arose, educated physicians would assist with tools. During the 19th century, with the rise in technology and emphasis on formal training achieved through attending medical school, American women began to embrace doctors over midwives, a sign of their modernity and movement up the social scale (Gaskin, 1998). During the 19th century, the female midwife gradually disappeared from the birth room. By the end of the century, she only served immigrants and the poor, further perpetuating the image of a midwife as uneducated and inferior (Wertz & Wertz, 1977).

While medical education offered a license to practice medicine in America, it did not expose these students to clinical training in obstetrics. During 19th century Victorian America, there was a societal emphasis on modesty and morality, especially among women. While motherhood was the defining identity for Victorian women, the pregnancy in and of itself brought shame and embarrassment to some women since it was linked to their sex life (Wertz & Wertz, 1977). Women of the upper class stayed indoors while their body changed. Susan B. Anthony's mother felt so ashamed and embarrassed during her pregnancies that she "secluded herself from the outside world and would not speak of the expected little ones" (Harper, 1969). This societal prudery did not foster the male doctor—female patient model since it required a man to examine and observe a female's physical body.

To deal with this self-conscious culture, male physicians created certain rituals to preserve the modesty of the women and ensure the respectable intentions of the doctor. For gynecological exams, a physician would avoid eye contact with his patient and perform the procedure under a long skirt or some sort of drapery to cover the woman (Wert & Wertz, 1977). Since it was culturally immoral for a practicing physician to observe the female genitalia, training medical students received limited or no exposure to births or gynecological exams before they became doctors. In 1850 Dr. James White of Buffalo demonstrated how to assist in a birth to some of his students on a poor, Irish immigrant woman. Fellow colleagues were outraged with Dr. White's exposure of a woman and a committee of the AMA denounced this exposure as unnecessary since a physician had to learn how to assist in labor through touch alone; otherwise, he was an unfit doctor. In essence, the fit doctor of the 19th century was a blind man. This system of training led to inevitable issues of quality in terms of care (Wertz & Wertz, 1977).

After J. Whitridge Williams, a professor of obstetrics at John Hopkins, administered a survey to his professors, he realized that his staff was unqualified, lacked confidence in delivering a baby, and, in most cases, had never even observed a birth (Cassidy, 2006). This system of formal training to become a doctor was different from the hands-on, experienced approach of the midwives during pre-industrial America. After recognizing these flaws in formal training, Williams concluded that:

> It is impossible to do away with the physician, but he may be educated in time; while the midwife can eventually be abolished, if necessary. [So we should change our efforts] as to make the physician of the future reasonably competent (Cassidy, 2006, p. 41).

Although the industrial revolution made the physician more available and the establishment of medical institutions made the physician more legitimate, this group of

professionals was still lacking in quality, noted, however irrationally, from physicians themselves.

By the second half of the nineteenth century, there were many medical schools enrolling a large volume of students, including women. By 1900, there were 7,000 women physicians in America (Starr, 1982). In 1904, the AMA founded the Council on Medical Education to begin reforming medical schools, raising the standards of education in terms of duration of study and number of required courses. These new standards raised price of tuition, making medical school an unaffordable option for many. With fewer enrollees, many medical schools had to shut down (Starr, 1982).

A pivotal criticism, but at the same time reinforcement, of the male-dominated medical institution was the 1910 Flexner Report. In working to comply with the Flexner Report guidelines, medical school administrators enacted certain changes, including the discrimination against women in the admission process. Administrators argued that since women would not return to medicine after marriage they would not accept them into their schools. After 1910, medical schools maintained quotas that limited women to about 5% of admissions (Walsh, 1977). The Flexner report also damaged the practice of lay practitioners, who were mainly women, since it "effectively made all nonscientific types of medicine illegal" (Conrad & Schneider, 1992, p. 14). Without formal training, females were no longer able to practice medicine in the home.

Framing the Hospital as the Central Location for Care

Hospitals in pre-industrial America were usually funded and managed by charities or religious organizations and catered to the poor (Starr, 1982). The names of Boston hospitals—Good Samaritan Medical Center, St. Elizabeth's, New England Baptist

Hospital, and Beth Israel Deaconess—reflect the original organization of hospitals. Because of their limited funding and strained resources in the 19th century, hospitals were regarded as dangerous places; the sick were safer and more comfortable at home. Those who were sick and could not receive adequate care at home—such as seamen in a foreign port, those who lived alone and were incapable of caring for themselves like the elderly, or the homeless—ended up at the hospital as a last resort (Starr, 1982). The hospital offered no benefits that the home could not provide and even served as a major health risk because of the spread of infections. On a social level, the image of a hospital as a place of charity dissuaded many patients from going there when sick since it would be an offense to their social status (Starr, 1982).

Hospitals began to transform themselves into places of caring and curing during the late 19th century largely because of the popularization of anesthesia during childbirth. In 1853, John Snow administered chloroform to Queen Victoria of England during the birth of her son Prince Leopold. The Queen's acceptance of this new technology popularized and legitimatized the use of anesthesia during birth. Physicians began to think of pain—which was commonly viewed as a normal and even necessary part of birth—as something that should be controlled (Caton, 1999). The first recorded administration of chloroform was on January 19, 1847 by Scottish Dr. James Young Simpson to a woman with a deformed pelvis. Simpson argued that the use of anesthesia during childbirth did not affect its religious significance. Utilizing the Bible, Simpson highlighted the passage in which God puts Adam under a deep sleep before he extracts a rib to create Eve (Caton, 1999).

The feminist movement had the most impact on popularizing anesthesia. The year of the Seneca Falls Convention—1848—marked the beginning of the American feminist movement; one of its first priorities was addressing the issues of maternal and child health. Many feminists believed that pain medication was their right and regarded doctors who would not administer anesthesia as cruel and inhumane. They pressured doctors to use anesthesia, most commonly in the forms of ether, chloroform, or laughing gas (nitrous oxide) (Caton, 1999). These early feminists—who were usually educated and from upper class backgrounds—also utilized Whytt's theory of pain. According to Whytt, education and culture permanently affect the structure and function of the nervous system so that "savages" do not feel pain as much as civilized people (Caton, 1999). Elizabeth Cady Stanton[1], the feminist in charge of initiating women's suffrage, affirmed this idea of pain and believed that "refined, genteel, civilized women have worse labor pain" (Caton, 1999, p. 122).

Early hospitals had poor success rate in terms of improving the health of their patients. Without any knowledge of bacteriology, doctors treated their patients without gloves and without washing their hands, increasing the risk of infection. Puerperal fever or childbed fever, an infected wound in the birth passage, was widespread throughout the 19th century and first identified by Dr. Ignaz Semmelweis of Vienna. To prove his point, Semmelweis had his students in the first clinic of Vienna's Lying-in Hospital wash their hands in chloride of lime solution. By March of 1848, there was not a single death due to puerperal fever in this teaching clinic (Mitford, 1992). But American doctors and medical associations—whose very mission was to help their patients—did not accept this explanation that blamed them for making these women ill. At the Boston's Lying-in

[1] Stanton spoke about her births as virtually painless so she considered herself of the less civilized or less refined class.

Hospital, 75% of the patients contracted puerperal fever and 20% died from it in 1883 (Wertz & Wertz, 1977, p. 126).

In the 1860s and 70s, Pasteur and Koch discovered bacteria as a cause of disease, leading to the "germ theory" of illness. Based on this identification, Joseph Lister implemented antiseptic surgery in 1867 in Glasgow by administering carbolic acid to wounds, surgical tools, and the operating area in the hospitals. Lister even instructed his surgeons to wash their hands with a diluted form of carbolic acid before and after surgery.[2] Coupled with the development of antiseptic surgery, the articulation of germ theory promoted hospitals as places of sterile cleanliness (Starr, 1982). In 1880, the medical world slowly began to accept the explanation for puerperal fever: any bacteria that entered the birth passage could easily enter the bloodstream and spread an infection. This recognition led to increased sterility and hygiene in hospitals (Wertz & Wertz, 1977).

The physician transformed from the "the nineteenth century local traveller who knew the inside of his patients' home and private lives" (Starr, 1982, p. 76) to an operator of machines in hospital wards during the twentieth century. These machines further reinforced the function of the hospital since they were not transportable like a doctor's bag. Diagnostic tools—such as the microscope, X-ray, and other machines that generate data on a patient's condition—offer information independent of a patient's reported symptoms (Starr, 1982). The routine use of this equipment reduced the dependence on the patient in terms of the doctor-patient relationship. Instead of listening to a patient's reports of pain and other symptoms, a doctor can turn to a consistent source of information: a machine.

[2] Listerine, the antiseptic mouthwash, was named after Joseph Lister.

In the context of birth, this standardization frames the laboring woman as just one of many patients, making a personal and connected relationship between the doctor and the patient unusual (Mitford, 1992). The reliance on diagnostic tools and machines has framed the healing hand as an obsolete tool. Midwives often focused on the use of touch to ease the pain of childbirth through vaginal massage, back massage, and "the double hip squeeze"—applying pressure with firm hands at both sides of the hips to relieve lower back pain. Since the 20th century, it would be inappropriate for a doctor to massage a patient's back.

Twilight Sleep

At the start of the 20th century, less than 5% of American women gave birth in the hospital. By 1939, half of all women, and 75% of urban women, gave birth in the hospital (Wertz & Wertz, 1977, p. 133). The hospital provided women with medical advances in the hopes of having a pain-free childbirth. The widespread use of anesthesia during birth was fully articulated in 1907 in the form of Twilight Sleep in European hospitals. Two German obstetricians—Carl Gauss and Bernhardt Kronig—popularized Twilight Sleep, which involved administering morphine to deal with the pain and scopolamine to cause confusion and amnesia (Caton, 1999). In larger doses, scopolamine has a hallucinogenic effect as well (Wertz & Wertz, 1977). This mixture would allow the mother to maintain her consciousness during birth while forgetting the pain.

Yet to be introduced in America, wealthy mothers traveled to Germany to deliver their babies under this new technique. In 1914, *McClure's Magazine* sent two of their journalists to Germany and one of them gave birth under Gauss' care. When they returned to America, both journalists collaborated on a magazine article that praised

Twilight Sleep. Shortly after its publication, American women founded The National Twilight Sleep Association in 1914 (Caton, 1999). Similar to the narrative at Seneca Falls, women wanted to control their births by demanding their right to a pain-free childbirth. While ether and chloroform did relieve pain, they also posed serious health risks and slowed down labor. Ether often caused patients to vomit and chloroform caused damage to the liver (Caton, 1999).

The publicity surrounding Twilight Sleep ignored some of its disadvantages. Women under Twilight Sleep still felt pain and, under their disorientated state, would often thrash about during labor. To eliminate this reaction, Gauss would reduce external stimuli by keeping his patients in a dark, quiet room, blindfolding their eyes with gauze, and covering their ears with wads of cotton soaked in oil (Caton, 1999). Since the laboring woman posed a danger to herself and others, she was often confined to a bed and, during delivery, her arms were strapped down with leather thongs. One of the negative effects of the memory loss is that the mother would awake to a baby that she did not remember giving birth to. This lack of memory lead to an emotional dissociation between the mother and the infant:

> The next thing I knew I was awake [...] and then I thought to myself "I wonder how long before I shall begin to have the baby," and while I was still wondering a nurse came in with a pillow, and on the pillow was a baby, and they said I had had it—perhaps I had—but I certainly can never prove it in a courtroom (“Twilight Sleep,” 1915).

As with all surgeries and procedures that involve the administration of anesthesia, there is a health risk if the pain medication is not administered properly. While Gauss argued that Twilight Sleep shortened the time of labor, morphine is an opioid and is known to slow down labor to the point of almost stopping it. Twilight Sleep posed a

greater risk for stalled labors and postpartum hemorrhaging (Cassidy, 2006). These drugs often had depressive effects on the fetus' central nervous system, making it difficult for the infant to breathe (Cassidy, 2006). Despite these health risks, Twilight Sleep was heralded by both women and physicians since the mothers would no longer experience, or remember experiencing, pain and the doctors now had more control over their patients. As part of the feminist movement, women felt empowered to have the choice to use advanced care.

The Hospital Culture

At the foundation of the hospital birth was the opinion that all births had the potential to become problematic, requiring the intervention of doctors and advanced medical technology. In 1920 Dr. Joseph DeLee of Chicago published an article, *The Prophylactic Forceps Operation*, in which he recommended the routine use of outlet forceps and episiotomy for all births. DeLee would sedate the woman and, once her cervix was dilated, he would perform an episiotomy, a cut in the muscle and skin of the perineum; once the fetus' head was visible DeLee would use the forceps to deliver the baby (Wertz & Wertz, 1977). DeLee believed that, if unaided, the process of labor would often kill either the mother or the fetus:

> So frequent are these bad effects, that I have often wondered whether Nature did not deliberately intend women to be used up in the process of reproduction, in a manner analogous to that of the salmon, which dies after spawning (DeLee, 1920).

This fear of danger in birth, coupled with the popularization of Twilight Sleep, motivated women to give birth at the hospital where they felt it was safer.

Women also gave birth at the hospital because they believed that their houses had more germs. In the 1920s, magazines and advertisements for cleaning products alerted

women to the dangers of the "household germ" (Wertz & Wertz, 1977). Also, hospital births provided the mothers with postpartum support. Up until World War II, mothers stayed an average of two weeks after giving birth in the hospital (Wertz& Wertz, 1977). Hospitals in the 1920s disguised their institutionalized nature by brightening up the rooms with different colors, maximizing privacy, and designing the interiors to reflect the home environment. These rooms offered the best of both worlds by making the patient feel comfortable but also offering the use of new technology like a buzzer system that summoned a nurse and beds that did "everything but talk" (Wertz & Wertz, 1977, p. 157).

But the rates of maternal and infant mortality did not improve after shifting the main location of birth to the hospital. In 1933 the White House Conference on Child Health and Protection issued a report—*Fetal, Newborn, and Maternal Mortality and Morbidity*—which found that the number of infant deaths from birth injuries increased by 40 to 50% from 1915 to 1929 (White House Conference on Child Health and Protection, 1933). The American Board of Obstetrics and Gynecology, established in 1930, evaluated the current hospital practices and enforced various standards and routines across all hospitals to prevent these deaths. In 1930, the American maternal mortality rate was 673.2 per 100,000 births. By 1960, the maternal mortality rate had dropped to 37.1 per 100,000 births (Hoyert, 2007). While many attributed this success to the standardization of care, there were concurrent advances that influenced this improvement. In 1928, Alexander Fleming discovered the antibiotic nature of penicillin and, soon, antibiotics were routinely used in hospitals and outpatient care, making puerperal fever

an illness of the past. Also, in 1936 hospitals acquired blood banks, which saved many women's lives after postpartum hemorrhaging (Wertz & Wertz, 1977).

This concern over the quality of hospital care shifted the focus of hospitals from welcoming and comforting each patient to increasing standardization. Motivated to promote sanitation and good hygiene, hospital procedures were implemented to protect the mother and the baby; however, sometimes these practices were in the best interest of the hospital instead of the mother or newborn. When the woman was ready to deliver, the hospital staff would wheel her into another room and the doctors would have her in a bent position with her legs strapped high in the air in stirrups. This position was known as the lithotomy position and was first developed to remove bladder stones (Wertz & Wertz, 1977). Because this position worked against gravity, many women needed episiotomies and forceps to help deliver their baby. Also, the use of one intervention commonly necessitated the use of another intervention. Since hospitals had certain standards on how long a woman could be in the delivery room, doctors would alternate between speeding up and slowing down labor. Anesthesia often slows down the process of labor so doctors would combat this effect with Pitocin—an artificial form of oxytocin first discovered in 1906 (Wertz & Wertz, 1977).

In the hospital, husbands were not allowed in the room during labor or birth. Hospitals often had "stork clubs" or other rooms where husbands could wait while their wives gave birth. During the 1940s, Dr. Robert Bradley studied the presence of husbands in the delivery room and noticed that their inclusion relaxed the mother. Bradley, who became known as the "Father of Fathers," helped to reverse the Western tradition that excluded men from their own children's births (Cassidy, 2006). Instead of being isolated

to a separate room, Bradley advocated for husbands to become active labor partners. By the 1960s and 70s, hospitals were finally allowing the presence of fathers in the birthing room (Davis-Floyd, 1992).

The separation of mothers and infants was also a common protocol of hospitals. During the postpartum period, mothers would recover in one room while their newborns stayed in the nursery. When the mother and newborn were together, the hospital staff managed their time, regulating when and how often she could breastfeed her newborn (Cassidy, 2006). By the 1940s, mothers began advocating for "rooming-in" which allowed the newborn to stay in a crib beside the mother in the postpartum room—an arrangement that became common in the late 1950s (Temkin, 2002).

"Natural Childbirth" with Read and Lamaze

Because of the hospital routines and standards, women began to question what type of birth they wanted and there was a shift towards "natural childbirth." During the 1930s, a British obstetrician, Dr. Grantly Dick-Read, wrote *Childbirth Without Fear*, which gained popularity in America by the 1940s. Read believed that the widespread use of anesthesia and routine episiotomies were unnecessary and led to complications that hindered the birth experience for both the mother and infant. He argued that the regimentation of hospital care assumed that one birth model would satisfy all women and failed to cater to the needs and preferences of the variety of female patients (Caton, 1999).

Read also argued that there was no physical difference that could explain the pain associated with childbirth today compared to primitive times; instead, this heightened fear regarding pain was a reflection of the state of mind of the women (Caton, 1999).

Biologically, a woman's state of mind has a considerable effect on labor. If a woman is frightened during labor, her flight-or-fight response is activated, releasing neurohormones such as adrenaline. Neurohormones cause constrictions, preventing cervical dilation (Caton, 1999). Read did not suggest that all women should undergo birth without anesthesia; for those who can not overcome their fears, some form of anesthesia or pain medication would be helpful in relaxing the mother and ensuring a safe delivery. Read believed that, with a change in the state of mind, motherhood would be returned to women (Wertz e & Wertz, 1977).

During the late 50s, Ferdinand Lamaze popularized his technique of natural childbirth in France. Unlike Read who promised childbirth without fear, Lamaze offered childbirth without pain. Deriving his technique from Pavlovian theory of conditioned reflexes, Lamaze argued that women could condition themselves to interpret contractions as painless through rapid, shallow breathing. Instead of trusting nature to run its own course, Lamaze placed women in charge of their births. For him childbirth "is not something that you simply let happen to you…it is something that you *do*" (Karmel, 1959, p. 42). In 1956, Lamaze wrote *Painless Childbirth* (Caton, 1999). By the 1960s, the birth model in America was beginning to return to its origin as a social childbirth.

The Return of the Midwife: Certified Nurse Midwives to the Farm

The feminists of the first half of the 20th century lobbied for the use of anesthesia and new technological interventions during birth, while the feminists of the 1960s and 70s advocated for a return to the "natural" birth model. With the foundation set by Read and Lamaze, American women began to realize the physical and mental consequences of unnecessary medical interventions during birth. Instead of giving birth in a hospital with

a doctor, some women wanted to give birth at home, at a birthing center, or at the hospital but under the care and assistance of a midwife. This movement was a reaction to the medicalization of birth.

In 1916 in Arkansas, Mary Breckenridge mourned the loss of her daughter, a mere six hours old, who was born prematurely. Two years later, her four-year-old son died of appendicitis. In 1920, after divorcing her unfaithful husband, she decided to go to Europe and dedicate her life to nursing. While in England and France, Breckenridge was introduced to the profession of nurse-midwifery. Recognizing the benefits of this profession in rural America, Breckenridge devoted her life to incorporating nurse-midwifery into her home country. After she was trained and certified in England, Breckenridge returned to America and on May 28, 1925 founded the Kentucky Committee for Mothers and Babies, which later became the Frontier Nursing Service (FNS) (Cassidy, 2006). The main goals of the FNS were assisting the underserved, rural populations and educating women to become nurse-midwives. By 1954, the FNS had assisted in over 10,000 births. Compared to national rates, the FNS had better birth outcomes. For example, the FNS had a maternal mortality rate of 9.1 deaths per 10,000 births whereas the national maternal mortality rate was 34 deaths per 10,000 births (FNS, 2012). Between 1952-54, the FNS' rate of premature births was only 3.8 per 100 births compared with the national premature birth rate of 7.6 per 100 births (Kitzinger, 1988). While a carefree, naturalistic woman riding a horse through Appalachia may be the dominant image associated with Breckenridge, her true legacy is reasserting the role of the midwife. Breckenridge positioned nurse-midwifery within the realm of contemporary obstetric care, ultimately ensuring that nurse-midwifery was accessible to women.

In 1955 the profession of nurse-midwifery was formally incorporated into American professional medicine with the establishment of the American College of Nurse-Midwives. Today, certified nurse-midwives practice in hospitals, clinics, and birthing centers. One main advantage of the nurse-midwife certificate is that, unlike direct entry midwives who have no formal education, certified nurse-midwives are not vulnerable to threats of practicing medicine without a license (Mitford, 1992). In 1971, the American College of Obstetricians and Gynecologists (ACOG) officially approved nurse-midwifery for uncomplicated births (Cassidy, 2006). This professional form of midwifery was a small but effective step in the re-integration of women as the authorities over birth. While some women were complacent becoming midwives in a medicalized setting, others felt that births did not belong in the hospital and mobilized efforts to establish midwifery in a non-medical setting (Gaskin, 2002).

During the late 1960s, a group of men and women from San Francisco traveled across the country in a caravan of remodeled school buses, vans, and campers to ultimately settle in Summertown, Tennessee. By 1971, their community—called the Farm—consisted of 300 members and, at its peak, would reach a population of 1,200 members (Mitford, 1992). Two leaders of the Farm, Steven Gaskin, a former professor at San Francisco State College, and his wife, Ina May Gaskin, both believe in mysticism, Zen, and spirituality. During their cross-country trip, three women gave birth in the buses or tents with the assistance of other members. Ina May developed an interest in childbirth and educated herself on the topic by reading medical texts, learning from local obstetricians, and gaining first-hand experience (Mitford, 1992).

In 1975, Ina May wrote her first book—*Spiritual Midwifery*—which outlines birth stories of mothers on the Farm as well as her advice on helping a mother during her labor. For example, Ina May encourages the sexual arousal of the woman during labor. One of the reasons that Ina May encourages the active presence of the husband is so that he can sexually arouse his wife—through hugging, stroking, kissing, stimulating the nipples, or even having sex—which would relax the laboring women and help dilate her cervix (Mitford, 1992). Although this concept may seem extreme, Aristotle himself suggested that, though a couple should refrain from having sex during pregnancy, a husband should have sex with his wife right before she gives birth to "shake up the child and bring it out more easily" (Cassidy, 2006, p. 201). Moreover, sperm contains prostaglandin, a hormone that opens the cervix (Gaskin, 2002).

In *Spiritual Midwifery*[3] Ina May also addresses two complications that would normally result in a Cesarean at the hospital: a breech baby and shoulder dystocia (Mitford, 1992). When a baby is in breech position, its feet or buttocks emerge from the womb first. Ina May encourages pregnant women with a breech baby to spend 10 minutes each day in the "tilt position" to encourage the baby to position itself in the vertex alignment—head emerging from the womb first. The tilt position is when a woman lies on her back with her knees bent, feet on the floor, and bottom supported by large pillows, similar to supported bridge pose in yoga (Gaskin, 2002). If the baby does not turn on its own, Ina May, like many other midwives, usually performs external version, which simply means placing her hand on the mother's abdomen, applying pressure, and turning the baby around. If external version is unsuccessful, Ina May will

[3] Which is currently in its 4th edition produced in 2002.

lubricate the vagina with oil and, reaching her hands inside, help ease the baby out during birth (Mitford, 1992).

Another birth complication, shoulder dystocia—the baby's head has entered the birth canal but the shoulders are stuck behind the mother's pubic bone—normally results in a C-section at a hospital. Ina May recommends a position—referred to as the Gaskin maneuver—that she learned from a Guatemalan midwife who learned it from Mayan Indians. The Gaskin maneuver is when a woman is on all fours with a slight hunch in her back (Mitford, 1992). Because of gravity, this position widens the pelvis from posterior to anterior, allowing the baby's shoulders to pass through the birth canal. Since 1976, when the Farm began using this all-fours maneuver, they have been able to approach shoulder dystocia without the invasive interventions of an obstetrician (Gaskin, 2002). In 1989, out of 1,700 births, the Farm had a 1.5% Cesarean rate and a .5% forceps use rate (Mitford, 1992). In comparison, the 1989 national rate was a 23.8% Cesarean rate (Taffel, Placek, Moien, & Kosary, 1991) and a 7.1% forceps use rate (Curtin & Parks, 1999).

The history of the birth model in America has swung from one extreme of minimum intervention under the care and guidance of women to another extreme of maximum intervention under the supervision of mostly male physicians. The medicalization of birth, while pursued for ostensibly good reasons, has led to a model that is not necessarily better for the woman, her baby, or her partner. Regardless of these poor outcomes, the medicalization of birth still persists as the dominant birth model in America in the 21st century.

Chapter Two: The Current Birth Model in America

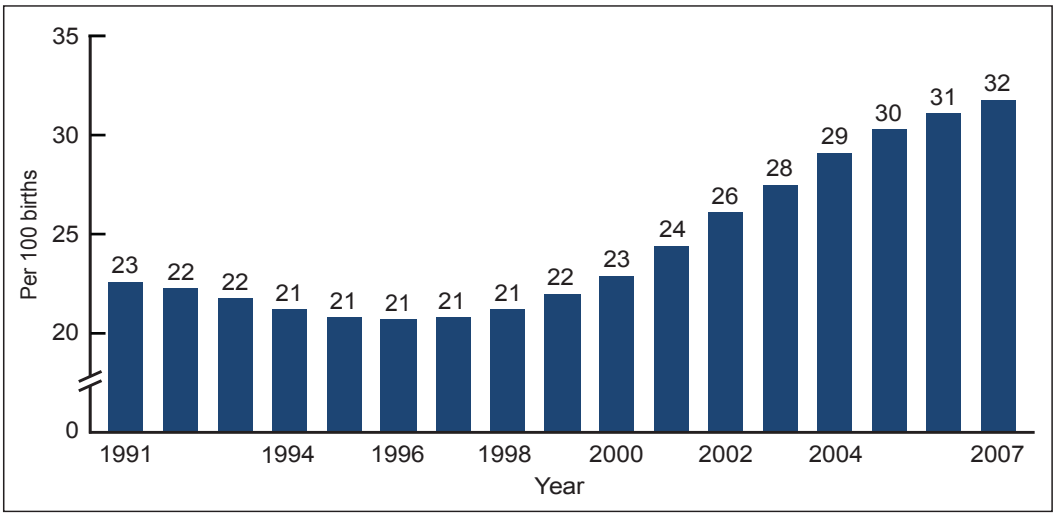
The current American birth model provides the mother with advanced health services. This level of healthcare would be acceptable and understandable if it improved the health of the baby and the mother; however, these services do not improve health and, in fact, are often harmful. An increasing rise in interventions during labor has transformed the birth process into an orchestrated event. The Cesarean section is the ultimate form of intervention, placing the woman as a passive bystander and the doctor as the active participant. These interventions not only negatively impact the mother's birth experience but also place her and her baby at higher risks for morbidity and mortality. As Dr. Welch states, "we are making people sick in the pursuit of health" (Welch, Schwartz, & Woloshin, 2011).

The Cesarean Section

The Cesarean section began as a final effort to save a baby's life, while killing his or her mother. While the Cesarean section, or C-section, likely began during the reign of Roman Emperor Julius Caesar, it was not until the 16th century that the procedure was performed with the intent to save both the mother and the baby (Cohen & Estner, 1983). In 1500, Jacob Nufer, a Swiss pig gelder, operated on his wife and performed the first known successful C-section (Mitford, 1992). In 1881, Ferdinand Adolf Kehrer performed the first known successful C-section with a transverse incision of the lower segment of the uterus, a method widely used today. In 1882, Max Sanger—a German doctor—performed the first modern version of the C-section by suturing the uterine and abdominal wall with silk threads, a material containing anti-bacterial agents (Wertz and Wertz, 1977).

Though C-sections became safer, the notion of choosing to have a C-section without a medical reason did not begin to become popular until the late 1970s and early 1980s in America. During the 20th century, the C-section transformed from a safe option for mothers with obstetric emergencies—like transverse positioning, when the baby lies horizontally in the uterus, or a prolapsed cord, when the umbilical cord precedes the fetus upon exiting the birth canal, cutting off fetal oxygen supply—to a choice made by either the doctor or the mother for a variety of reasons—fear of childbirth, more reimbursement from the insurance companies to the hospital, body image issues, convenience for both the mother, since she knows what day she will be giving birth, and the doctor, who does not have to wait through the long process of labor, and institutional policies like prohibiting vaginal births after cesarean (VBAC).

By 1987, 1 in every 4 births in U.S. was a C-section, compared to 1 in 20 in 1970 (Mitford, 1992). As of 2010, the C-section rate is 32.8%, a slight decline from the 32.9% C-section rate in 2009 (Hamilton, Martin, & Ventura, 2011). Figure 2 illustrates this increasing trend of C-section rates in America. Out of the 34 OECD—Organization for

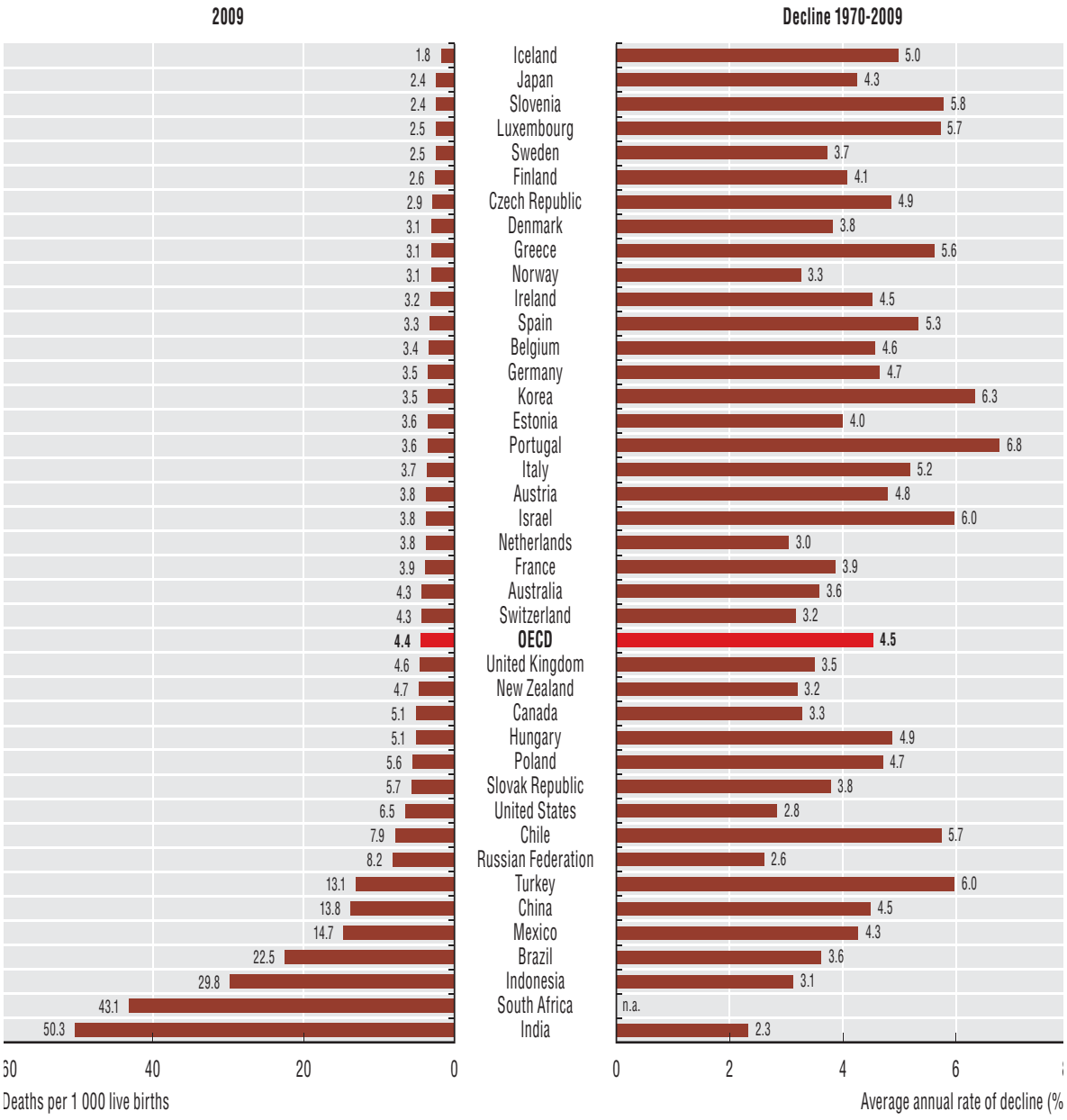


SOURCE: CDC/NCHS, National Vital Statistics System.

Figure 2: C-section rates in the US from 1991 to 2007

Economic Co-operation and Development—countries, the U.S. has the 8th highest C-section rate (OECD, 2011). In 1985, the World Health Organization (WHO) found no justification for any region to have a C-section rate over 10-15% because the C-section is associated with an increased risk of short-term adverse outcomes for the mother and higher costs to the healthcare systems (WHO, 2010). On average, in America, C-sections cost twice as much as a vaginal birth (Russo, Wier, & Steiner, 2009). There is also a concern about the rise in antibiotic resistance since hospitals implement routine use of antibiotics during or after a C-section (Beigi, Bunge, Song, & Lee, 2009).

Out of 172 countries in descending order, the U.S. ranks 121st for high maternal mortality rates with 24 maternal deaths per 100,000 births (CIA, 2008). The U.S. has the same maternal mortality rate as Saudi Arabia and has a higher rate than Czech Republic, Slovakia, Puerto Rico, and Bahrain. Out of 222 countries listed in descending order, the U.S. ranks 174th for highest infant mortality rate, with an infant mortality rate of 5.98 (CIA, 2012). As Figure 3 demonstrates, for OECD countries, the U.S. is one of three countries—along with India and Russia—that has reduced its infant mortality rate less than 3% since 1970 (OECD, 2011). In comparison, other countries, like Israel, Portugal, and Turkey have reduced their infant mortality rates by at least 6% since 1970 (OECD, 2011). From 1970 to 1990, the infant mortality rate in the U.S. was well below the OECD average, but it is now above average with a 6.5 infant mortality rate (OECD, 2011); although the U.S. is one of the only OECD countries without universal healthcare, these statistics are important considering how much money America spends on healthcare.



ource: OECD *Health Data* 2011; World Bank and national sources for non-OECD countries.

Figure 3: Infant mortality rates, 2009 and Decline 1970-2009

After Malta, the U.S. spends the most on healthcare (CIA, 2009). For example, in 2009 the U.S. spent more than twice as much on healthcare per person than Spain and yet Spain had an infant mortality rate that was half that of U.S. Figure 4 demonstrates America's disproportionate spending on healthcare per person compared to other countries.

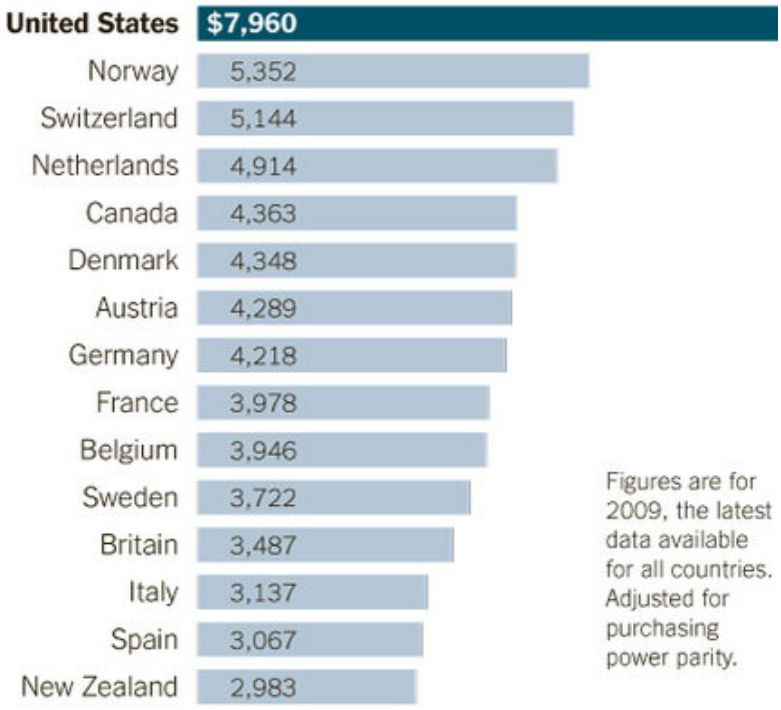


Figure 4: Spending on Healthcare Per Person in 2009

Another way to measure infant health is through low birth weight statistics. Low birth weight, defined by the WHO as less than 5.5 pounds, is associated with high infant morbidity and mortality rates (OECD, 2011). Low birth weight results from a pregnancy that did not reach its full term or a complication in the womb that inhibited and restricted fetal growth. Since 1980 the rate of low birth weight infants has increased 20.6% in America, with a current rate of 8.2%. Compared to the other OECD countries, the U.S. falls within the top 10 highest rates for low birth weight infants. Among the reasons for this increasing rate are artificial inductions of labor and cesarean delivery (OECD, 2011).

Some of the consequences of a C-section include the inability to eat for a day or more, limited mobility, and pain for 6 weeks after the procedure especially when urinating or defecating. After a C-section, most women need a urinary bladder catheter for a day or so and remain at the hospital for 4 to 7 days to recover, increasing the mother's risk for infection (Mitford, 1992). Other disadvantages include failed initial

attempts at breast-feeding (the pain may even suppress milk production), placenta abnormalities in future births, and a negative birth experience for the mother (Cassidy, 2006). The risk for placenta accreta—the placenta implants along the cesarean scar causing severe hemorrhaging when the placenta detaches from the uterine wall—increases with each successive C-section. For a mother's fourth C-section, her chances of developing placenta accreta is 1 in 50 compared to 1 in 400 for the first repeat surgery (Landon et al., 2006). A woman is four times more likely to die from an emergency C-section and two times more likely to die from a scheduled C-section than from a vaginal delivery (Enkin et al., 2000). Also, a woman undergoing a C-section is 10 times more likely to get an infection than a woman who has a vaginal birth (Summey, 1986). In 2006, out of 5.7 million U.S. births, infants born by cesarean with no medical risk factors were nearly 3 times more likely to die within the first month of life than those born vaginally (MacDorman, 2006).

During a C-section, doctors block a woman's view of her body with a tall blue tarp. Some women who have had C-sections report feelings of detachment, as they were not the first ones to see their babies and were treated like a minor part in the birth of their own child. Some women even describe their C-section as a form of rape, referring to the procedure as a birthrape or birth trauma (Block, 2007). Sidney Wolfe, a physician and director of a health advocacy group—Public Citizen's Health Research Group—calls this high rate of C-sections "doctor-caused violence against women" (Block, 2007, p.146).

While C-sections are necessary and life-saving procedures under certain conditions—including some cases of maternal diabetes and high blood pressure, active genital herpes, hemorrhage from the uterus, prolapsed cord, or transverse lie—the rise of

C-sections in America cannot be explained by these reasons alone (Mitford, 1992). Some explanations for this rise in C-sections are cosmetic reasons, fear of childbirth, medical malpractice insurance rates, hospital regimen, and an expanding list of criteria that prompt American doctors to deem the C-section as medically necessary.

Too Posh to Push

Some women worry that childbirth will ruin and stretch out their vaginas, leaving their genitalia looser, aesthetically unappealing, and less pleasurable for their partner during sex. One way to circumvent this worry is to forgo a vaginal delivery and opt for an elective C-section. On a blog for expecting mothers—cafemom—one woman claimed that her obstetrician / gynecologist (OB/GYN) in Utah would often use the motto: "Have a C-section, save a vagina" (cafemom, 2010). The concern over the aesthetic appearance of the vagina is reflected through the development of a new cosmetic industry in the late 1990s: female genital plastic surgery. The specific procedures for this type of surgery range from laser vaginal rejuvenation, laser reduction of the labia minora with reduction of excess prepuce, reduction of the thickness of the minora, and more which all aim to effectively enhance vaginal muscle, tone, strength, and control to increase sexual gratifications (Laser Vaginal Rejuvenation Institute, 2012).

Some celebrities who delivered their children via C-section include Victoria Beckham, Angelina Jolie, Christina Aguilera, Brittany Spears, Gwen Stefani, Kate Hudson, and, most recently, Beyoncé. Out of all these celebrities, the former Posh Spice Girl, Victoria Beckham, is the most notorious for scheduling her C-sections around her husband's soccer schedule. Because of her fame, the term "too posh to push" has materialized for women who opt for a scheduled or elective C-section. Laura Berman, a

sex therapist, wrote in the Chicago Sun-Times: “Why undergo a process that is strongly associated with later problems, when another option is available? Or, as I like to put it to my friends, why ruin a perfectly good vagina?” (Berman, 2004). The C-section is a sexual epidemic, not a medical one (Dworkin, 1981).

Women are also afraid of the actual process of childbirth, specifically the pain. The term for the fear of giving birth is tokophobia (Block, 2007). For a non-pregnant woman, the uterus is the size of a fist; for a pregnant woman at full term, the uterus is the largest and strongest organ in the body and weighs over 2 pounds excluding the placenta and the fetus (Cassidy, 2006). The uterus is made up of smooth muscles and contracts on its own. The pain associated with childbirth is attributed to the contractions of the uterus and the opening of the cervix. Compared to our primitive ancestors, humans have narrow hips, which allow them to walk upright, and, in Western culture, humans are often constricted to chairs for the majority of their day, a position that tightens the pelvis (Cassidy, 2006).

Some argue that pain should not be a deterrent for women since its just part of the process of labor, an important element that will affect the end result. By eradicating the pain, the levels of endorphins that act as an immense relief diminish along with the high and joy achieved after birth (Block, 2007). On a more scientific level, women who do not experience the pain, do not release endorphins, and thus do not release prolactin, the hormone that is responsible for the initiation of lactation. Michel Odent, a French medical doctor that is an advocate for natural childbirth, argues that “you cannot extract the pain and keep the rest, it’s a chain of events” (Odent, 2001).

Hospital Regimen and Medical Malpractice

According to the anthropologist Brigitte Jordan, there is no known society where birth is treated merely as a biological function. At the foundation of birth lies cultural and ritual practices that vary from region to region; in the U.S "childbirth ritual…is hospital ritual" (Eakins, 1986). When a woman enters a hospital there is an immediate change in her identity from an independent person to a patient. Her entrance into this institution is a sign of her surrendering to medical opinion and expertise instead of trusting her own personal opinions (Eakins, 1989).

With this responsibility, doctors have standardized their procedures for labor and delivery to ensure that each woman delivers a healthy baby. One way to measure birth is through the different stages of labor. In 1954 Emanuel Freidman of Harvard Medical School studied the length of labor from a large sample of women and, from this data, constructed "The Friedman Curve," which outlines the expected amount of time for each stage of labor by focusing on cervical dilation and fetal descent (Mitford, 1992). If a laboring woman deviates from this curve, the doctor may deem her labor as "failing to progress" and intervene by artificially inducing the woman, utilizing forceps or a vacuum extractor, or performing a C-section. Doctors are becoming more aware that this curve is more of an ideal rather than a genuine representation of labor (Cesario, 2004). This concept of "failure to progress" is iatrogenic in origin, an illness caused by medical treatment, since many hospital procedures—the limited movement of the mother, the use of epidurals, the denial of food, the use of an IV—can actually cause labor to slow down (Mitford, 1992).

Thus, the processes of labor and delivery are rigidly defined in hospitals. In some hospitals, once a laboring woman is deemed ready for delivery she is wheeled into a separate room. Instead of viewing childbirth as a process with vaguely defined stages, some hospitals segment the process completely by physically relocating the mother. Also, the time since the laboring mother was admitted to the hospital will affect the treatment she will receive. Though two women may be equally dilated, a woman who enters the hospital before her water breaks and is in the labor room for 15 hours will be treated differently than a woman who enters the hospital after her water broke and has been at the hospital for 6 hours (Rothman, 1986).

A factor that affects the decision-making process for hospitals and medical practitioners is the legal liability. Because of the increasing rates of medical malpractice insurance and the rising number of lawsuits against healthcare providers, many physicians are either deterred from entering fields where medical lawsuits are the most common, like obstetrics, or practice defensive medicine. Defensive medicine is taking certain measures, whether diagnostic or therapeutic, to not necessarily ensure the patient's health, but to avert potential malpractice liability. For example, a 2003 ACOG survey found that 14% of respondents stopped practicing obstetrics because of the high and costly risk of litigation. The survey also found that 76.3% of American OB/GYN doctors experienced at least one lawsuit during their career (Kim, 2007). Those in obstetrics may practice defensive medicine to either avoid a lawsuit or increase their chance of winning a lawsuit. The complaint of the failure to perform a C-section is commonly listed as the reason for a lawsuit and, because it is hard to measure the doctor's control or lack of control over a vaginal birth, it is harder for a doctor to defend a

vaginal birth in court (Sachs, 1989). Also, since asphyxia or nerve damage may happen during vaginal birth to a baby, some will argue that the doctor should have performed a C-section to prevent the nerve or brain damage that occurred to the baby (Sachs, 1989). Though malpractice litigation should not be the main focus for reducing C-section rates, a reduction in the liability pressure would likely reduce the number of C-sections (Yang, et al., 2009).

Expanding List of Criteria that Leads to a Cesarean Section

In 1916, Dr. Cragin said "Once a cesarean, always a cesarean," declaring that women who had a C-section for their first baby would also need to deliver any future children via a C-section. At this time, the national C-section rate was less than 1% and doctors used the classical incision, a vertical cut in the upper segment of the uterus (Cohen & Estner, 1983). Since the 1930s, doctors have routinely used the lower segment incision, a transverse cut made in the lower part of the uterus. The lower part of the uterus is thinner and less muscular, and, compared to the upper part, is not as affected by uterine contractions. This change in incision allowed a vaginal birth to follow a C-section (Cohen & Estner, 1983).

Though Dr. Cragin's golden rule was no longer applicable, the rates of vaginal birth after cesarean (VBAC) were low with many hospitals refusing to do the procedure. In 1980, 98% of women who had a C-section for the first birth had another C-section for their second (NICHD, 1980). In 1988, the ACOG issued a statement that approved VBAC as a safe option for many women and warned against the increase in repeat C-sections (Mitford, 1992). While the rate of VBAC did increase 10% from 1989 to 1996, it decreased from 1996 to 2003 by 63%. For women with previous C-sections, the

likelihood that subsequent deliveries would also be a C-section was 90% in 2003 (MMWR, 2005). Today, the VBAC rate is around 7%, even though it was once almost

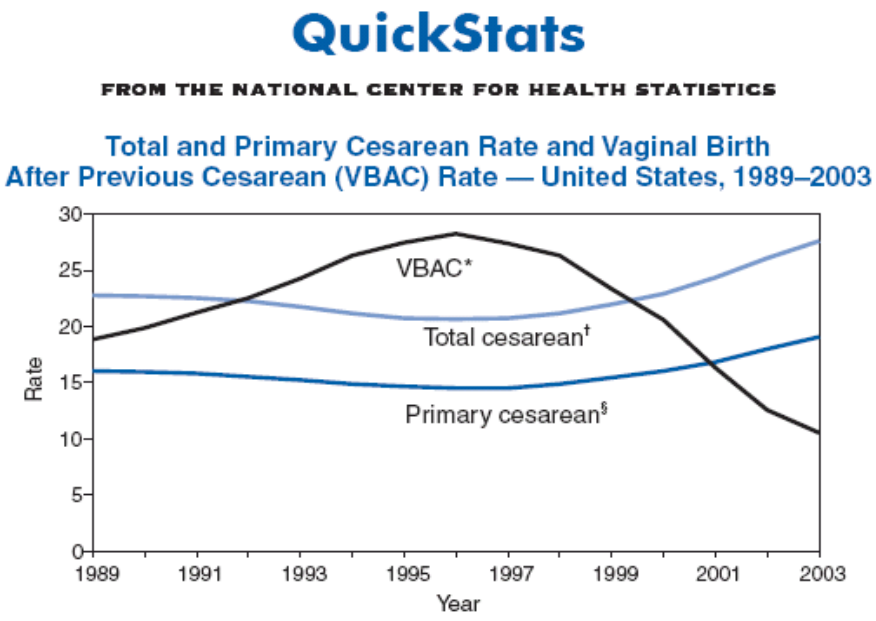


Figure 5: Decreasing VBAC rates since 1996 in the U.S.

at 30% (Haney, 2010).

A breeched birth, or when the baby is positioned feet or buttocks first, is another common reason for the high C-section rate. This trend in American hospitals reflects a change in the training of doctors. Instead of educating doctors on external version or vaginally delivering a breeched baby, formal medical education focuses more on teaching the C-section, a technique that can be applied to numerous "complicated" births. The modern day obstetrician needs to also be a surgeon (Mitford, 1992). Between 1970 and 1978, breeched babies that were born by C-section jumped from 11.6% to 60.1% (Cassidy, 2006). As of 2009, 82% of breeched babies in the U.S. were born via C-section (CDC, 2009).

Another "birth complication" that increases the rate of C-sections is cephalopelvic disproportion (CPD). CPD refers to an obstetric complication in which the woman's hips

are too small or narrow for the baby. While some people claim that women are having bigger babies because of the change in American diet and lifestyle, the birth weight has only increased 2 ounces during the same period in which the C-section rate doubled in the U.S. (Marieskind, 1983). Also, the legitimacy of CPD as a reason for C-sections is questionable, especially when it is diagnosed before labor. During labor, the central portion of the perineum and the connective tissue ligaments of the pelvis soften and relax; internally, the fetus' head softens and molds to decrease its circumference as it descends deeper into the pelvis (Cohen & Estner, 1983).

Developed and refined by the 1960s and widely used by the 70s, electronic fetal heart rate monitoring (EFM) enabled doctors to monitor the fetal heartbeat as well as the uterine contractions. A shortage of oxygen to the baby—fetal hypoxia—can cause disability or death during or shortly after birth (Alfirevic, Devane, & Gyte, 2006). Since abnormal heartbeat or rhythm is a sign for fetal hypoxia, doctors routinely use this tool to ensure the safety of the fetus. There are two types of EFM: external—a band with a monitoring device strapped around the mother's belly—and internal—an electrode is placed directly onto the baby's skull, offering a more accurate read of the heart rate. Both forms of EFM require the woman to remain sedentary to ensure an accurate reading of the fetal heartbeat and uterine contractions (Davis-Floyd, 1992).

The EFM is an example of "looking hard to find something wrong because of the belief that early diagnosis—and subsequent intervention—improves health" (Welch, Schwartz, & Woloshin, 2011, p. 102); however, sometimes improved health is not always reached. While this tool does provide additional information to the doctor, EFM confines the laboring woman to the bed, slowing down the process of labor. Exercise is commonly

used as a natural way to induce or speed up labor. For example, midwives often recommend that women walk, climb stairs, or squat. Active movement increases uterine contractions and decreases the mother's perception of pain during labor (Arena & Maffulli, 2002).

Another major disadvantage of the EFM is its accuracy. Several randomized controlled studies performed during the 1980s found that the only benefit EFM offered was a small but statistically significant decrease in neonatal seizures (Thacker, Stroup, & Chang, 2011). EFM increases the number of interventions during labor, particularly the number of unnecessary C-sections and instrumental vaginal births (Banta & Thacker, 1990). The study from the 1980s found that monitoring increased the rate of C-sections by 66% (Welch, Schwartz, & Woloshin 2011). Before the invention of the EFM, midwives and other birth assistants would use intermittent auscultation using a fetal stethoscope (Alfirevic, Devane, & Gyte, 2008). EFM was also popularized since it could detect cerebral palsy; however, the accuracy of this detection is low with one reported false positive rate as high as 99.8% (Nelson, Dambrosia, Ting, & Grether, 1996). Besides inaccurate readings, EFM is often interpreted differently from provider to provider. The subjectivity and inaccuracy of these machines often lead to more problems instead of ensuring the delivery of a healthy baby. As Dr. Filly stated, "the identification of these 'abnormalities' in low risk women has crossed the line of 'more harm than good'" (Welch, Schwartz, & Woloshin, 2011, p. 109).

Other Forms of Intervention

Interventions tend to have a domino effect, with one small intervention leading into a cascade of more and more interventions. When a woman's water breaks, she is at

an increased risk of infection; the amniotic fluid is contained within the amniotic sac and protects the fetus from external threats or germs. The term "water breaks" refers to when the amniotic sac ruptures and releases the amniotic fluid. If the amniotic sac does not rupture and the mother is in active labor—4 or more centimeters dilated—some doctors will perform an amniotomy or artificial rupture of the membranes and break the amniotic sac with a small hook. Doctors will perform an amniotomy to induce labor since the amniotic fluid is rich with the hormone prostaglandin; to receive a more accurate reading of the fetal heartbeat with internal fetal monitoring; and to check the color of the fluid to verify if the baby's meconium, first stool of the fetus, is present (Cohen & Estner, 1983).

Since the amniotic sac acts as a protective barrier for the fetus, doctors are concerned with the amount of time between when the water breaks to when the mother gives birth since the fetus is at an increased risk of infection. However, if the mother is not exposed to foreign bacteria or viruses that could cause an infection, she will not spontaneously contract one just because her water has been broken for a certain amount of hours. Instead, the environment that the mother is in after her water breaks is important. At a hospital, there are more germs, simply because there are so many different people in a confined area, many of whom are sick, than in one's home. After the mother's "water breaks" there is a limit to the number of vaginal exams that a doctor can perform since these internal exams greatly increase the risk of infection for her and the fetus (Simkin, 2001).

To induce labor, doctors will administer artificial hormones such as Pitocin via an IV. Pitocin is the artificial form of oxytocin, a hormone that surges during labor and after birth to stimulate milk production. Colloquially, oxytocin is known as the "love

hormone" as it plays a role in orgasms, pair bonding, and maternal behaviors. Oxytocin is released during labor to help dilate the cervix and cause uterine contractions. Oxytocin is also released in response to nipple stimulation, activating milk production in the breasts. In fact, during the first few weeks of lactation, this release of oxytocin causes mild uterine contractions, which helps the uterus contract to its pre-birth size and clot at the point where the placenta was attached (Gaskin, 2002).

Since Pitocin causes strong uterine contractions, the risk of cutting off the fetal oxygen supply for a longer period of time increases. It is hospital procedure to use a fetal heart monitor after Pitocin is administered—after the mother is "pitted"—to ensure that the fetus is receiving enough oxygen. Contractions caused by Pitocin are different than naturally induced uterine contractions. Often the use of Pitocin will lead to an epidural if the mother has not already asked for one. An epidural slows down labor, which can require the use of Pitocin to speed up labor, rendering a balancing act between these two forms of interventions (Block, 2007).

An epidural is regional anesthesia that is administered in between the vertebrate in the spinal cord, blocking the brain from picking up the pain signal from the rest of the body. Unlike the hallucinatory medications of Twilight Sleep, the epidural eliminates pain for women with the smallest amount of drug without her loss of consciousness (Simkin, 2001). In terms of control, the woman cannot feel below her waist and is restricted to the bed; when it is time to push, she may not be able to feel her legs and is told when to push based on the doctor's or nurse's reading of the EFM. Women on epidurals need urinary catheters since they do not feel the urge to urinate (Cassidy, 2006).

Some other drawbacks of the epidural are artificial induction like Pitocin, confinement to the bed, and an increased chance of blood pressure dropping or development of a fever. The epidural has

> Replaced chants, herbs, and breathing techniques with a kit and a power button…just as Twilight Sleep erased the true experience of childbirth for a generation of women, epidurals may be doing much the same thing. And almost no one is complaining (Cassidy, 2006, p. 102).

Also, the notion of a walking epidural is a misnomer. Because of hospital liability issues, a woman who has an epidural is not allowed to freely and independently leave the bed (Block, 2007).

Another form of intervention is the episiotomy. The rationale for the episiotomy is that it will open up the vagina, preventing it from tearing fully into the rectum when the baby comes out. An episiotomy guarantees that every woman's vagina tears and "this innocent slice of the knife turns every birth into a surgical procedure" (Cohen & Estner, 1983, p. 193). If no episiotomy is done, there is a 30-50% chance of tearing but, if an episiotomy is done, there is a 100% chance of a tear (Simkin, 2001). Vaginal tearing can be prevented through perineal massage and the use of oil or lard. Additional alternatives to the episiotomy are: warm compress on the perineum to promote circulation and relaxation and, as the baby's head is coming out of the vagina, the midwife can provide slight counter pressure by pushing back on the perineum so that the baby does not come out quickly and suddenly, which will increase the risk of tearing (Simkin, 2001).

Natural tearing occurs when the perineum is stretched to its fullest whereas the episiotomy is performed at the thickest part of the perineum. According to Kitzinger, women with an episiotomy experience more pain after birth than those whose vaginas tear on their own, naturally. Though the intention of an episiotomy is to prevent tearing,

third degree tears are actually more common with an episiotomy rather than without (Cohen & Estner, 1983). Gladys Milton, an American midwife, believed that routine episiotomies "would be just like cutting off everybody's breast to keep them from getting breast cancer" (Bovard & Milton, 1993, p.73). Since 1997, episiotomies have decreased 55% (Russo, Wier, & Steiner, 2009).

Although the shift towards medicalization is dominant in the current American birth model, the natural birth movement still exists which can be seen through the popularization of doulas, presence of birthing centers, and the slight increase in the occurrence of homebirths. Doulas are non-clinical birth attendants who support the mother before, during, and after labor. DONA International, a non-profit organization that trains and promotes doulas, recognizes 3,256 birth doulas in the U.S. (DONA, 2012). This number does not include postpartum doulas—doulas that support the mother after birth—or doulas that are not certified through DONA International. Birthing centers and one's own home are alternative locations to give birth outside of the hospital. In 2009, the percentage of births at free-standing birth centers was .2% (CDC, 2009). This percentage is probably higher since it does not include birth centers that are affiliated with a hospital. From 2004 to 2009, the percentage of homebirths increased from .56% to .72% (MacDorman, Mathews, & Declercq, 2012).

While there are remnants of the 1960s and 70s natural birth movement, the medicalization of birth prevails as the dominant birth model in America despite the poor national birth outcomes in comparison to other developed countries.

Chapter Three: Results of Interview Surrounding Perceptions of Births

After learning about natural births, I was surprised that I had spent 19 years of my life with only one image of birth: the medical one. To determine whether I was an isolated case or if my peers also had similar experiences, I conducted interviews with 20 Tufts women. Has the medicalized birth model also come to dominate their images of birth?

Visual Image of a Woman Giving Birth

When asked to describe a woman giving birth, all 20 participants described a hospital setting with the woman on the bed surrounded by doctors and nurses. Half of the participants specified that her legs would be in stirrups and wide apart. Though all of the participants described the physical position of the woman, only two commented on the logistics of this positioning. Mia, a senior who has taken *Medical Anthropology* where she studied the general concept of medicalization, described this positioning as "very convenient for the doctor but not necessarily for her." Gabrielle also noted that this position is accessible for the doctor since it is "the same as when [she goes] to the gyno, legs up, doctor in, with hands coming out."

Eight of the participants described the laboring woman as sweaty, upset, and drained from the exertion. Beth described the laboring woman as "holding [her partner's] hand, which she's probably crushing because she's probably in a lot of pain." Beth admitted that this image is unattractive:

> Women never look good in birthing…it's always like oh my god I'm contorted in pain, my hair's plastered to my head because I've been doing this for 10 hours and sweats dripping kind of thing.

Also highlighting the anger of the laboring woman, Gabrielle envisioned the husband as most likely in the room "filming her, and she's like 'get the fuck out of here, I hate you, why did you impregnate me?'" Four participants described the room as frenzied or crowded, reflecting the mental state of the women. Sophia mentioned that in the hospital room "there are people buzzing around."

Expectations and Perceptions of Birth Attendant

Half of the participants stated that they would prefer to have an obstetrician-gynecologist (OB/GYN) to attend their birth instead of a midwife. Eva associated midwives with the past from watching *Como Agua Para Chocolate.* When I explained that a certified nurse midwife could work at the hospital and use a lot of the same medical technology as the doctor, she said:

> Eva: I don't want someone like that. I want someone who is trained and knows what they are doing. Definitely.
> Me: And so for you, someone who is trained is someone who has gone to school for it rather than someone…who has experienced the births first-hand?
> Eva: Yes. I am very to the rules. I need you to know all the rules. What if something goes wrong? I need you to have all the tools like ready for me.

This distrust in midwives was a trend among all of the 10 participants who would rather have the OB/GYN. Kate expressed her guilt in her lack of confidence in midwives:

> I don't have as much faith in midwives to deliver. Which I don't like hearing myself say…but…I just trust medical personnel more, even though I know how much midwives have been trained. Especially because I know there's a lot of politics around the midwives versus doctors in the US and it's…like a pretty solid way of taking women out of the professional realm of birthing and I think that really sucks. But I guess honestly I would rather have a doctor. I feel that's just what society ingrains in you. Well I think they're doing it on purpose. I'm trying not to be a conspiracy theorist, but I think there's been a lot of emphasis in the medical world that midwives aren't qualified and doctors are and so you should have faith in doctors. And it worked.

For these 10 participants, a competent birth professional was someone who had graduated from medical school with a degree.

Three participants preferred a midwife. Jade wanted a midwife and a doula since "doctors are in higher demand, so midwives probably would be able to, to pay more attention." Gabrielle explained that:

> A midwife, for me is just someone who is more accommodating in terms of what you specifically want for your birth rather than a doctor's orders, where if you go to a hospital and everything's pretty standardized, but I feel like a midwife is "Oh you want it this way, you want it this way? I'll work with you throughout the entire pregnancy, make sure everything's fine and when it comes time to actually deliver, I'll be there."

Six participants said that the title of their birth attendant does not matter as much as the connection and relationship they have with the person.

Fourteen participants did not really know what a midwife was, and there was confusion surrounding the differences between the roles of the midwife and the OB/GYN. Eleven participants did not know that a midwife could work at a hospital. Beth understood a midwife as "specifically trained in helping people to give birth in their homes or settings that aren't hospitals." Erin separated the role of these two health professionals as the "OB/GYN can prescribe medicine, whereas the midwife might not be able to." Tammy described an OB/GYN as "a very professional role" in which "the doctors kind of has to distance themselves to a certain extent because they have to do it so often…after a certain amount of time they're just going through the motions."

In contrast to the "distant" attitude of the doctor, Sophia believed that the midwife has a deeper, emotional attachment to the experience:

> Midwives come out of this sort of tradition of…having a community involved in the birthing process and the midwife being…one of these people that's ordained to kind of help you through the process and is…more involved emotionally than a

> doctor would be and is more involved in the pre-birth and then also afterwards. Whereas a doctor when I think of a doctor you go in for the checkups…and then he pulls out the baby and then…the nurses take over from there.

In terms of the availability of the OB/GYN, everyone but one participant recognized his or her minimal role during the actual labor. Kate expected the OB/GYN to be present for the majority of her labor:

> Oh! They better be there. I don't have any idea of what will actually be done, but it's just my gut instinct that they will be there…I guess like in and out as contractions are getting closer and closer. Or in and out checking and measuring, but by the time there's any…I don't know…by the time it could happen in the next hour, I'd want them to be there, right next to me.

On the other hand, Heather thought that the doctor would be more present towards the end of the labor: "I imagine a more stereotypical image of birth with the doctor receiving the baby." Dana also commented that the doctor would only be available towards the end of labor:

> I think the doctor—and when you said doctor I'm picturing a man doctor, I'm not sure why. The man doctor is just delivering the baby and he's not saying "breath, breath" or like holding my hand or anything. Like we are not looking at each other. Just delivering the baby…he's not like a participant in the experience.

In comparison to the OB/GYN, Sophia described the midwife as someone who "would hang out with me the whole time and…make sure everything is going well."

Besides the title of the birth attendant, the participants also responded about the gender of the caregiver. For the 14 participants who preferred women, some expressed general comfort with women over men when it comes to their physical bodies while others specified that they would prefer a woman who had gone through the birthing process before. Lea rationalized her preference for a female birth attendant since "it would just feel so much more natural for it to be another woman." Paige said her trust in the doctor would vary depending on gender:

> You can't really be telling women about something you personally haven't experienced, I think that there's just a very fine line in how you can tell—obviously they're doctors and professionals and…they've studied it, but it's just—especially in giving birth, I'd probably want to be talking to someone who—if not gone through it, could potentially go give birth. And I think that that puts a lot more weight into what my doctor is saying, so if I had a female OB/GYN I think I would probably trust her a lot more.

Only one participant preferred a male since she has always had male doctors so it is what she is familiar and comfortable with. Kate attached sexuality to the gender and specified that she would either want a straight woman or a gay man:

> My first instinct was to say male…like my instinct was to spit it out, which I wonder if it has something to do with the sexism to assigning men to take care of women's bodies…but...I guess I feel ambivalent, like I have feelings both ways but there's something comforting about the idea of …logically speaking I'd rather have a woman's hands in my vagina [laughs] I guess it would also depend on the sexual orientation of the person who was doing it? I know it's not supposed to be sexual, but I'd rather have either a straight woman or a gay man.

Just Like in the Movies…

While all of the participants knew some aspects of their own births, even if it was just surface details or anecdotal tidbits, most of them knew more about births portrayed in the media. Some of the common television shows or movies that the participants mentioned were *Friends*, *Knocked Up*, *Gilmore Girls*, *Glee*, *Grey's Anatomy*, and *Juno.* All of the participants described the setting for a birth scene as in the hospital. Eight participants felt that the media depicted birth as a volatile woman yelling. Sabrina described Katherine Heigl's character in *Knocked Up* as "kind of crazy and screaming and…violent."

Participants also mentioned that a medication-free birth fails in many birth scenes in the media. Mia described the mother as initially "screaming because it's her first baby and she doesn't know what to expect." The scene normally calms down once the mother

has agreed to take medication: “and then she gets an epidural and she’s happy.” In fact, screaming is so dominant that the lack of yelling or chaos is noticeable. Phoebe, who watched the season finale of *Keeping Up with the Kardashians* when Kourtney gave birth, could not believe that “she wasn't screaming.” She also mentioned that the doctor asked Kourtney if she wanted to hold her baby as it was coming out and “then she just pulled it out, I was like oh my—!”

All of the participants recognized some element of unrealistic depictions in the media since the main function of these Hollywood movies and shows is to entertain, not to inform. Mia recognized that while the media may not accurately depict birth, it has been her main source of information: “What I imagine birth to be at this point in my life is exactly what happens in the movies, which is not true I’m sure.” Paige was the only participant that thought the media unrealistically “paints this pretty picture” of birth. In contrast to Paige’s view that the media idealizes birth, Dana felt that:

> They don’t try to fancy it up too much unrealistically with people looking good when they are having babies. [For example, on] *Friends*… when Rachel’s giving birth, she’s all nasty and sweaty and there’s like all the different moms keep coming in having their babies and leaving. There’s a funny juxtaposition…There was one mom who was like “Oh ow contraction” and then she just like had her baby and was like “oh ow oh that hurt a little.” Rachel was moaning and groaning and hating on the other girl who was just like “ow.”

For Carmen, one of the most overly dramatic, and thus funny, birth scenes in popular media is Quinn giving birth in *Glee*:

> It was this really awesome, mixture—because they mixed it with Bohemian Rhapsody—and so she's screaming and Puck, who's the father is like “oh my God,” she's like “I'm going to kill you this hurts so much,” she's like “I hate you why did you do this to me,” but at the end it was beautiful and rewarding…but in general I feel like its one of those things that's over-hyped as awful and painful, but worth it.

Besides popular media, five participants commented on the documentaries that they had seen in either middle school or high school. Jade immediately imagined "a grainy, old film" and described the typical school health class video as:

> A bunch of kids in a health class, watching a movie on—you know those big black, big square TVs that they roll in on the cart, that the AV nerd rolls in, and…the teacher's like 'This is the mystery of birth,' and then it's just this screaming woman and it's just like shot right at the vagina and the baby's coming out and everyone's just screaming (*laughs*).

Out of the five participants who mentioned birth documentaries, only one had a positive experience. Lea, having seen documentaries like *The Business of Being Born*, became aware and exposed to other aspects of birth, which ultimately made her less fearful of the birthing process. She remembered "feeling betrayed by *Gilmore Girls* when Soki wanted to have her baby at home and Lorelei thought it was really gross."

Stories of Their Own Births

Except for one, all of the participants' mothers gave birth in the hospital. Cassie's mother gave birth to her in an ambulance in the parking lot of the hospital because they did not have enough time to go inside. Four out of the twenty participants were born via Cesarean. Four of the participants' mothers did not use any pain medication. For the other 12 vaginal births, three of the participants knew that their mothers had used pain medication while nine were unsure.

For the three participants whose mothers did not take pain medication, there was a sense of empowerment and willpower. For example, Eva recounted how her mother "would always boast about [giving birth naturally]… because she's like, I'm strong." Sophia's mother also prides herself on the fact that she did not use pain medication during birth:

> She told me a bunch of times – that when she gave birth to me and my brother and my sister, she didn't use any drugs or any medication. Because she told me she didn't want any of her babies to be born drugged up – so that's something that she actually talks about a lot—"well I didn't use any drugs… I just did it."

For the three participants who knew that their mothers used pain medication, they framed it as a safer option for longer labors. Kate knew that her mother was induced because her blood pressure was rising. Kate also assumed that her mother used pain medication since "36 hours [of labor] is a long time." Lea knew a lot about her birth since hers was so much different than her younger sister's. Lea's mother planned to have a homebirth for her but, since Lea was 2 or 3 weeks early, her midwife was on vacation so she ended up at a hospital where they induced her and administered an epidural. Lea's mother claims that Lea's allergies are "from the fact that she let them give her something for the pain."

For the four who were born via C-section, one was planned based on religious preference, two were planned because of health risks, and one was an emergency. Sabrina believed that her mother opted to have a C-section because her birthday is the same as one of the leaders in her Buddhist community. Lindsay's mother had a health condition that put her at a high risk for a vaginal birth so her doctor suggested that she plan a C-section for both her and her sister. Jade was a breech baby so her mother had a C-section for her. Gabrielle's mother needed to have an emergency C-section because, as she was pushing, Gabrielle's hip became stuck.

Thinking About Giving Birth

When I asked my participants if they could see themselves giving birth within the decade—that would put the participants between 29-32 years of age—19 participants said yes and 1 participant said she was unsure. When I asked where they would most likely

give birth, 15 participants said a hospital, 1 said a homebirth, 1 said a birth center, and 3 were unsure. Eva said she wanted to give birth at a hospital because "it just sounds plain...a nice clean, hospital room." Kate, who characterized herself as "a germaphobe" also preferred a hospital room for its cleanliness.

Other participants choose a hospital because they felt that it was safer. Madison felt that birth would seem more secure:

> There's more people on hand in those situations and it would feel more controlled as opposed to on my floor at home, would feel kind of a little out of hand…I don't know I wouldn't want to be like "Oh look there's the rug I gave birth on" (laughs), I feel like separating out the birth experience from the home life—that's kind of an appealing concept to me.

Paige recounted her own personal experience with home births in regards to her cousin, Amy:

> My cousin's mother made my uncle, the landlord, tell Amy that there was something in her lease that said that she couldn't have a home birth, because my aunt was like "No, we're doing this in a hospital, I am not letting that happen, not letting her do that in a bathtub"…her mom is a very nervous person and I think that there's a lot that can potentially go wrong with home births, or at least that's the stigma against it…Not having a doctor around makes people nervous, especially with childbirth, makes them very very uncomfortable.

Cassie did not quite understand why someone would choose a homebirth since "medicine has come to a point where it makes sense to go to the hospital." Lucy has seen documentaries of homebirths, which have influenced her to definitely give birth at a hospital:

> It would just be too messy and chaotic in my house… I've seen documentaries of people giving birth in water pools in their houses [and it] just freak me out. I think also being in a hospital would just – it's a safer thing to do in case any complications arise, whether for myself or for the baby. Which you wouldn't be able to deal with as well if you were in a house.

Heather, Dana, and Mia all preferred a hospital birth even though they took classes or heard information that questioned the safety of hospitals and promoted American woman to seek out alternative locations for their births. Heather took *Women & Health*, a Community Health course at Tufts University:

> We learned a lot about natural birth and while I was taking that class I was definitely like, "oh I would consider that." But then when I think about it again it seems very scary…I'm definitely a victim of, "What if something goes wrong and there's no doctor there!"

Mia took *Medical Anthropology* at Tufts:

> I think there's…the fear of so many things going wrong…and I understand that these are things that we culturally create. You know, all of these are…perceptions that we create via our discourse and via media. But…at the same time, we buy into it. We are all scholars. We take these classes, but we still feel the need to be in the hospital when we give birth.

Lea, whose mother had a homebirth for her second child, would prefer a homebirth because it is "such an obvious choice" given the options of her "home or a white linoleum room."

The Fears Surrounding Childbirth

When asked what they were most afraid of when it came to birth, 2 participants said everything from the 9 months of pregnancy to the actual process of labor, 1 said she was worried more about the pregnancy than the actual birthing process, 8 said birth complications, and 9 said pain. For the two who said everything, Madison described pregnancy and the birth experience as "not super appealing," "debilitating," and "sacrificing a lot of your life." Phoebe "can't imagine having something grow inside of" her and was also worried about the labor since she "can't even stand cramps now!"

For those who said birth complications, they were afraid of something going wrong during labor that could adversely affect their child for the rest of his or her life. Heather said she "can think of 100 things" that could go wrong during birth. Mia explained that her fear of "messing [childbirth] up" stems mainly from popular culture since "today we live in a world where so many things can go wrong" and "if you don't do these things you're an irresponsible pregnant girl whose not doing the best by her child." Sophia was also nervous that something might go wrong because birth is "such a traumatic process for everyone involved, and also delicate." When I asked her why she characterized birth as traumatic for everyone, she said:

> The baby is in this little soft cushiony world and it's dark and they're comforted and it's fine and then all of a sudden they're just thrust out and they have to breathe on their own and they're crying and they have to open their eyes…it's sensory overload. And the mom, her body goes through this crazy ordeal and the people around, they want to help but they can't.

Nine participants were concerned about the actual mechanics of birth in terms of proportion. When asked whether body image was an issue for her, Madison said she was "less concerned about saggy vagina" and more concerned about "the actual process of pushing something that size out of it." Erin said she has "little hips" and would rely on her doctor to tell her what type of birth is best for her:

> It will depend on what my doctors says if like "This is going to be difficult for you, you have very small hips," or if they say, "Actually your hips—your proportions are correct." I don't really know right now if my proportions are good or not *(laughs)*.

Pain Medication

When asked about their opinion on pain medication during labor, 5 participants said they would definitely want it, 4 said they would definitely not want it, 8 said they would first try to give birth without pain medication but would want it available, and 3

did not have a strong opinion either way. Only 11 of the 20 participants knew what an epidural was. Out of these 11, only 2 knew the basic details of an epidural. Heather described the effects of the epidural as "frightening" and would prefer to "feel everything" than have an epidural because "it freaks [her] out more to have no control over what's going on."

After hearing the basic details of an epidural—administration into the spine through an injection and partial numbness to complete loss of feeling over one's lower body—seven participants were surprised and had mixed feelings about using an epidural as a way to ease their pain. Though Carmen had already decided she wanted to have a medication-free birth, she was still surprised because:

> When I think numb, I think like, losing control… but I want to have full control…it feels like the most important thing in the moment is to have control over my body so I can understand what is happening and feel what's happening and be there in the moment…and I also personally just—I feel like the pain is part of the process.

Dana, who was not completely against pain medication for her own labor, said that the idea of an epidural scared her:

> I feel like you should be able to feel so you could tell if something is wrong…in principle I'm opposed to strong medication for that reason, because if you have a headache and you keep taking Advil, like your headache goes away, but you didn't fix it…Pain is there so that you can tell that something is wrong…and during birth you would want to be totally in touch with your body.

Paige, who wanted pain medication, commented on the stigmas against pain medication:

> I think a lot of people are turned off by pain medication because it's not a natural thing, it's not how we gave birth back in the day or whatever, but I would want pain medication as long as I needed it, as long as there were no negative effects on the child… But…all the shit about "you have to do it the natural way," you shouldn't be going through this pain for some weird masochistic whatever.

The 8 participants who wanted to try to give birth without pain medication but would still like it accessible were afraid they could not handle the pain. Jade admitted that she would probably fall victim to the common birth story surrounding pain medication:

> For my first birth, I would be like "Oh I'm above that, I just want to experience it and be natural…" and then it would start happening and it might be so excruciating that I could envision that I would just start yelling like "Drug me, drug me!"

Mia would first try to give birth without pain medication since that is what her mother did but she does not "have that much faith in [her]self as far as pain goes."

For the 4 who said they did not want to take pain medication, 2 of them had mothers who did not use pain medication for their births. Like her mother, Eva also would not use pain medication because "something about drugs and being injected with something while a child is in [her], its just wrong and dirty and harmful." Again, even though some of the participant's primary fear was pain, 13 would either not want pain medication or try at first without it.

Body Image

When asked if body image was a concern for them when thinking about pregnancy and labor, 15 participants said no and 5 said yes. For the 15 who said no, they reasoned that, at that point in their life, they would either be in a stable relationship, not care as much about their body, or could trust their body to recover from the birthing process. Kate does not understand why

> People have this really anti-aging thing…they don't want your body to show the life that you've lived. I'm not saying that I want to look old or have saggy boobs but you know that's a life that you live, you get laugh lines 'cause you laugh…your boobs get saggy because you give birth. I'm not afraid of that because it marks the way you're growing, living your life. I'm not saying I'm gonna be pumped, but I'm not afraid of it.

Lea joked that it may have a positive impact on her body image since "it would be kind of nice to have bigger boobs!" Carmen would not want to "let herself go" after childbirth but believed her body would gradually return to its pre-birth. She appreciated reading an

> Interview of some celebrity and she was just like "Yeah, I've got a muffin top right now, I've got a stomach, I just had a baby, leave me alone!" and I think that's a beautiful way of looking at it. I think a woman just inherently by the fact that she just had a baby is beautiful, there's something inherently beautiful about the fact that your body just did that. And so…I'm going to take care of myself afterwards…but I don't think I'm going to be like "Okay, I just had a baby yesterday, get me on the treadmill."

Three other participants also viewed a woman's pregnant body as physically stunning. Sophia thought that "physically being pregnant…is something that is seen as beautiful" and, in her house, they celebrated it by putting "pictures of…[her] aunts when they were pregnant" all on the wall.

For those 5 in which body image was an issue, 3 were varsity athletes and 1 exercised on a regular basis. Jade, an athlete who competes in both the fall and spring, admitted:

> I don't want to get fat, I don't want stretch marks, but it's less about that and more about not being able to do what I want…I'm an athlete, I run cross country and track, and I just, I need to be able to do what I want to do…And the idea of—I mean, to me, pregnancy just sounds really, well it's kind of cool because it's like a science experiment, but it's also probably really uncomfortable. And I just hate being uncomfortable in my own body.

Cesarean Sections

When asked if they would prefer to have a C-section, 16 participants said no, 2 said yes, and 2 said maybe. For those who would not want to schedule a C-section, their reasons included a long recovery time, having a scar, worrying that the baby is not fully developed, and wanting to avoid unnecessary surgery. When Madison thought of a C-section, she just fixated on the "scars" and Dana believed that the woman "ends up

having to recover for six weeks." Lea worried that a schedule C-section "endangers your child" since "there's a reason the baby comes when it comes." Though Paige trusted that "the doctor wouldn't jump the gun" on performing a C-section, she said:

> There's something to be said for when the child is ready, its like its first step in the world, its first choice almost, like clearly its not an accomplished decision at all, but I don't know, I think having an elective C-section is a little, maybe its the being raised Catholic in me, but I think its a little too playing God.

Seven participants stressed the "unnaturalness" of this procedure. Eva felt that, if she had a C-section, "[she] wouldn't feel like [she] gave birth." She elaborated:

> For some reason to give birth it needs to go the hard way. Well I don't know if that's considered the hard way or the C-section is considered the hard way, but you know the vaginal way, so I just feel weird...Because in my mind I don't associate C-section with giving birth.

Cassie described the unnatural nature of the anecdotal scenario of a scheduled C-section: "If you're like, 'yeah I'm going to have my baby tomorrow at 4:30,' that's just kind of awkward to me." Gabrielle viewed the C-section as unnecessarily disturbing and intervening in a human's life when he or she has yet to enter the world:

> I can't think of any process that's more important than the forming and development of a person, so I think you should just leave it as is…it's just one of those things where I think it's just best left naturally, because…it's such a fundamental stage of the forming of the individual that I don't think you should fuck anything up, because there will be so many things later on that will be…harmful it's just one safe place…where everything can be good.

Five participants viewed the C-section as more orderly and less risky. Though Mia—whose mother had vaginal births without medication—had conflicting thoughts, she would prefer a C-section:

> At this point, I feel like medically we've gotten so good at it that it might be statistically healthier for my baby because then it doesn't have to go through that tiny little hole. But then, we, babies have gone through that tiny little hole for thousands of years and that's what they're supposed to do so I don't want to mess…with nature…There's also been this rise with doctors being like well you

> know if the time comes you have to sign a release and if we think that's it medically necessary for you to have a C-section then we're just going to make you have a C-section and you have no say in it…so in that sense I don't want one if they get scared [and are]…covering their own ass…but, at the same time statistically it seems safer like I'm not going to be in pain and the baby will just come out (*laughs*) and it will be healthy. I feel like we've done so many of them that, at this point, there are more things that could do wrong with a vaginal birth than with a C-section.

Other participants thought the reasons behind an elective C-section were superficial, self-centered, and egocentric. Gabrielle thought the whole idea of a schedule C-section is selfish: "when I hear scheduled C-section I hear 'Okay, well I want it this way, and if the baby still has three weeks to develop, too bad.'" Out of the 12 participants who commented on whether they saw the C-section as a way to preserve the female body, 10 said no, 1 said maybe, and 1 said yes. Eva viewed women who undergo a C-section to avoid getting a saggy vagina as self-centered:

> I don't know how getting a scar (preserves) the body image…your vagina is meant to stretch and close… It is a bit selfish to worry about how you are gonna look. You are going to give birth to a child. And your main concern…is, oh my god, I don't wait to strain my vagina. You are having a child! Don't get pregnant if you are worried about straining your vagina. Because obviously you strained your vagina at some point to get pregnant.

Jade agreed that a C-section is not preserving the female body since "you're slicing my stomach open." She added, "if you're thinking about preserving the female body, you probably shouldn't get pregnant…or old."

Alternative Forms of Birth

Six participants had heard of some alternative positions, such as walking and squatting, and knew of other birth models, such as waterbirths. These participants associated these alternative positions with things that were either foreign or primitive. The only alternative position that Lindsay knew of was that "in ancient Greece, they used

to walk around." Jade knew that "some people crouch and some people stand" from reading *The Red Tent,* a fictional version of Dinah's story in Genesis 34. After watching a movie with Richard Gere who helps a woman in Africa give birth, Gabrielle described the birth scene as "very very primal" since it occurred "in a hut." Cassie said that the only reference to non-hospital births she has heard of is from a line in *Knocked Up* where they talk about "women in Asia" who "squat in the rice patties and give birth and keep working."

When asked if they would like to have a waterbirth, 6 participants said yes, 8 said it sounded cool but probably would not have one, and 6 thought it sounded weird and definitely would not have one. Lea thought "the pain would scare [her] less in water." Gabrielle would prefer a waterbirth:

> Just because water is so soothing and so calming, every time you're in water it's such a relaxation…and just your body feels better, it's not "Here's a sheet and here's a bed and here's all this bright white light and everyone's looking at you"… giving birth in water, it's very natural and cleansing and organic.

For 8 participants, the idea of a waterbirth sounded interesting and comforting, but they could not imagine ever choosing one. Jade said that a waterbirth "sounds really pleasant…except for the babies drown part." Mia admitted that a waterbirth sounded relaxing, but she would not choose it since most of her knowledge comes "from movies where they paint those people as really weird hippie people who want to give birth in tubs."

For the 6 who definitely would not choose a waterbirth, they mainly just thought it was too weird. Lindsay described homebirths as "interesting in a funny way" based off of the documentaries she has seen where "they're usually in a blow up pool in a living

room which…is really weird and also kind of gross because everything's in the water." Sabrina said how she would not want to do a water birth because:

> It's just weird to be naked…I mean it's kind of silly to think about it like that but I don't know if I'd want to just be in a tub like chillin' while my doctors and everything were around me, you know?

Sixteen participants said they would be willing to try any position if it eases labor pain and is safe for both the mother and baby. Dana thought squatting was strange but "having something to do would make it better" since she "equate[s] lying in a bed with being so useless." Lea did not think any of these positions were strange relative to the birth process since "birth is kind of weird when you think about it." The remaining 4 participants were not as open to trying these new positions. Though she recognized she might be irrational, Madison would not be open to squatting since "that's an awkward position." Mia felt that these positions "seem too progressive for [her] taste."

When talking about these alternative positions, 8 participants brought up the issue of gravity. Kate said "gravity might help" and Lea thought that walking and squatting seemed "more logical because the baby is coming down so maybe it could…have gravity on it's side." Dana thought that squatting:

> Seems like the obvious way to squeeze a baby out of you…lying down you would need someone to like pull the baby out of you; where with squatting I think that's the ideal position to get a human out of you.

Two of the participants who mentioned gravity mentioned it in a negative way. Madison would not want to try an upright position because she "wouldn't want to mess with gravity" in case the baby "drop[s] out of you." Paige also cautioned against interfering with gravity:

> I've heard that its much more comfortable and better for you than lying down, but it just seems gross because it's like gravity, and the baby's like slimy. Yeah it's gross because of everything falling on the floor.

When specifically asked if they would be open to labor on a yoga ball, 15 participants said yes and 5 said no. Beth said the yoga ball sounds efficient in "maneuvering the body to kind of…loosen up" and "get your system in sync." Madison liked the idea of a yoga ball since she would be "taking control of the situation" because "it's like 'I'm doing something to help along this process' instead of just…being a bystander."

When given the hypothetical situation of shoulder dystocia—the baby is stuck behind the pubic bone—they were given the options of Gaskin maneuver—getting on all fours and arching the back, similar to cat-cow pose in yoga—forceps, or vacuum extractor. Fourteen participants chose Gaskin maneuver, 4 chose forceps, and 2 were unsure. Beth chose the Gaskin maneuver and was shocked to learn that the vacuum extractor existed as a form of delivery method since "vacuums are for cleaning the house not for going in my vagina thanks!" Tammy laughed and said the Gaskin maneuver is "a very interesting image in [her] mind" but realized that she would "rather have that than seeing the doctor…squeeze [the] baby out."

As the results show, my sample is also affected by the medicalization of birth. Nineteen of my participants were born in a hospital, 15 of which also prefer and plan to have a hospital birth. These results reflect at least two generations of women affected by the medicalized birth model—we can safely assume more since most of my participants' grandmothers gave birth in the 1950s or 60s.

Chapter Four: Discussion

The medicalization of birth has triumphed in framing the way that all of my participants think about childbirth. As the media portrays and reinforces this single birth model, other ways of childbirth are denounced as foreign or outdated. In the medicalized version of birth, the woman is incapable, often screaming until she has received an epidural. To control the helpless woman in labor, the skilled doctor uses the latest medical technology and his educational background to ensure a safe delivery.

All of my participants envisioned a woman giving birth at a hospital, highlighting the success of this institution's incorporation and monopoly over the birth process. Physically, they described the laboring woman in the lithotomy position, on her back with her legs up in the air. This position, as Mia noted, is convenient for the doctor, but can be counterproductive for the woman in labor. Not a single participant described the laboring woman in a positive way. In terms of the woman's mental state, the participants described a volatile and unstable woman yelling at her husband or partner and crushing his or her hand during the painful contractions. Reflecting the crazed image of the woman, the birth room—which was always a hospital room—was also described as crowded and chaotic as the doctor and nurses frantically tried to regain order.

Furthermore, fourteen of my twenty participants did not know what a midwife was, a testament to the professionalization of the doctor and his dominance within the birthing world. The rise of the physician and the development of specialties such as obstetrics and gynecology have pervaded the birth model in America, eradicating the role of the midwife from public knowledge. The fixation on science, technology, and the standardization of practices in the hospital has separated and alienated the midwife from

the medical world, a space she never intended to inhabit. Many participants were unaware of the varying forms of midwives, such as the certified nurse midwife, a development that enabled the profession to reemerge but only under a medical context. This integration of the midwife into the medical world has not been successful considering that 17 participants did not know that a midwife could work at a hospital.

Distrust in midwives also stems from the participants' desire to have access to the most advanced technologies and medical tools in case something goes wrong. Many of the participants assumed that the midwife did not know how to use hospital technology or could not prescribe medicine. Besides performing a C-section, a certified nurse midwife can fulfill the same roles as an OB/GYN, from prescribing an epidural to artificially rupturing the membranes. For the 10 participants who would definitely want an OB/GYN to attend their births, they valued formal education over an apprenticeship. This preference reflects the participants' unwavering trust in the doctor, highlighting his or her reputable status in American society today.

It was encouraging to see that the three participants who wanted a midwife identified her role as accommodating and free from the burden of standardization. Since the midwife is in small demand in America, they believed that she would be more available for each individual laboring woman. Participants also highlighted the active role of the midwife in helping the laboring woman birth her baby, rather than the more distant, clinical attitude of the doctor. Since the doctor has probably "received" many babies, this process is not as personal or meaningful for him or her. Dana noted the doctor is not a participant in the birth experience since he or she does not form a connection with the mother or newborn. But some participants still preferred these qualities—impersonal

but educated—over the more caring, present, and accommodating attitudes that they attached to the midwife.

One of the main depictions that the participants highlighted was the birth narrative in which the laboring woman goes into the process wanting to have a medication-free birth, but after screaming, crushing her partner's hand, and shrieking obscenities, she ends up asking for the epidural. The media has ingrained in the participants' minds how painful birth will be and how, in efforts to cope with this pain, the woman loses her dignity and self-control as she becomes a hysterical mess. Some of the participants found this narrative disheartening and admitted that it was hard to imagine going through birth without pain medication. While it was encouraging that the participants were aware that the media does not depict birth accurately, they did admit that it was their only source of information. The participants explained that their perceptions of birth were largely dependent on this medicalized version of birth where the woman is helpless, only becoming calm and stable once she has received medication.

The strong presence of a screaming woman and the fixation on a scary, long labor are such salient aspects of birth depictions in the media that, when missing, are noticeable. Phoebe was amazed at how calm and serene Kourtney Kardashian was during labor, not screaming or threatening to kill her partner. Instead, Kourtney's water broke at her house and she calmly walked around, took a shower, and put on make-up. Once at the hospital, the doctor told her that she could reach down and touch the baby. As she pushed, Kourtney pulled her baby out and placed him directly on her chest. While this birth model is still a medicalized one that relies on the doctor's authority—Kourtney asked the doctor if it was okay for her to touch her own baby—Phoebe was surprised at

how calm Kourtney was. Of course, after the clip of the birth scene, Kourtney's sister Khloe says that the birth was not normal and could not believe that her sister pulled her own baby out of her vagina. After this show aired on E!, Chelsea Handler talked about the clip on her talk show *Chelsea Lately*, saying that the Kardashians are superhuman and able to do anything better than the average person, like casually pulling a baby out of their vaginas.

The institutionalization and standardization of hospital births have been successful based on the fact that 15 participants would prefer to give birth in a hospital for reasons including safety, cleanliness, and familiarity. Even Heather, who has taken *Women and Health,* the course that first educated me on this topic, said she would still feel nervous not being in a hospital in case any complications occurred. The medicalization of birth has framed this process as something that can go severely wrong and has treated it accordingly. The medical world has framed the hospital, where the ill and dying convene along with the healthy, as a place that is germ-free. The medicalization of birth has successfully revered the hospital as a safe haven for women to give birth under the educated opinion of the doctor.

It was encouraging to see 3 of my participants questioned giving birth in a hospital. These women would rather give birth at their home instead of a hospital where they are just one of many patients. At home, the laboring woman follows her own rules. At a hospital, a woman needs to follow the institution's standards and policies.

Since the medicalization of birth fixates on potential problems and pain, it is no surprise that my participants' main fears were birth complications and pain. Instead of looking forward to this opportunity to give birth, my participants dread this moment and

are even afraid that they will somehow ruin the birth process. This fear again reflects the pervasive authority and dominance of the doctor—framing him or her as the first and foremost authority on the woman's body and what is best for her throughout the birthing process. While some of my participants were aware that this level of trust in a doctor is not productive, they felt that they do not have enough information to question the doctor's authority, negating their own bodily signals and basic biological functions as a source of accurate information. This sentiment reflects a monopolization of knowledge in which the woman follows the doctor's orders almost blindly; moreover, if the woman does not follow the doctor's advice, she is labeled as the irresponsible pregnant woman who feels guilty for not following the protocol.

Out of the 11 participants who said they wanted pain medication, 9 were unaware of its effects. For example, after learning about the details of an epidural, participants were afraid of losing control and feeling impotent and useless during the birthing process. One of the scary aspects of birth is the unknown. Women do not know how they are going to act during labor and, in a society where women can micromanage virtually everything including their periods, this uncertainty frightens them. In America, the image of a woman squatting and grunting while she gives birth is thought of as primitive or barbaric. However, the image of a woman dressed in a sterile johnnie and lying passively on a hospital bed as the doctor performs a C-section is socially acceptable. American women may find it more comforting to plan a day to have a baby in a controlled setting directed by a doctor who has had experience performing this procedure. However, it was encouraging that some of my participants would chose to have a medication free birth to maintain control rather than yielding it to the doctor.

It was encouraging that 16 participants would not want to schedule a C-section and were also aware of the increasing C-section rate in America. That being said, 4 participants did feel that the C-section was safer than waiting for labor, demonstrating the medical world's success at framing the C-section as safer than vaginal birth. Has the medicalization of birth suggested that we eradicate the process of labor altogether? Dr. Lovejoy speaks about the concept of the "obsolete pelvis":

> What people don't realize today is the explosive advancement of technology that can override evolution…Given the rate of technology, one hundred years from now no one will be giving birth. We'll make children up from artificially conceived fetuses, all done technologically (Cassidy, 2006, p. 26).

While the reasons for having a C-section are diverse and varied, it is important to remember, "freedom of choice does not exist without full information" (Block, 2007, p. 165). An image of an empowered, successful businesswoman scheduling a C-section to better manage her time at work and forgo the unpredictability of birth is not necessarily a wrong choice, but I argue that it is not an informed choice. Because of the permeating societal and cultural traditions that disperse biased information about birth, women are not given the opportunity to make a fully informed decision on the birthing process.

Many of the participants viewed alternative forms of birth as either primitive or outdated, a model from the past that society has since improved upon. Some participants felt that these positions were strange. This sentiment is reminiscent of Victorian modesty, where a woman was valued for being refined and classy. It is nicer and tidier for a woman to remain static and stoic on the hospital bed rather than squatting, grunting, and walking. Cassie thought that most people might have an aversion to alternative childbirth options because the medicalized birth model has become the norm and seems to be working for people.

American women are complacent with this model, asking why fix something that is not broken? I, too, pose the same question: Why are we altering the process of childbirth when there is no need for a "fix?" In fact, this "fix" may be harming women without their knowledge.

Conclusion

My results from the participants' interviews confirm the dominance and prevalence of the medicalization of birth in America. Nineteen of my 20 participants all planned to have a medicalized birth. This preference is a concern because this model is associated with health complications for both the mother and infant. The extreme embodiment of the medicalization of birth is the scheduled C-section. Twenty percent of my sample would choose to have a C-section over a vaginal birth; add 10% for medically necessary C-sections, and my sample nearly reflects the national C-section rate of 32.8%.

The media—which portrays and perpetuates the medicalized version of birth—is the main, and often the only, source of information on birth for my sample. Instead of ignoring this outlet of information, I recommend harnessing the media as a way to spread positive and helpful information regarding birth. For example, in December 2009 Giselle Bundchen, the Brazilian supermodel and wife of New England Patriots quarterback Tom Brady, gave birth to her son at home in a bathtub. According to ABC news, Bundchen was influenced by the documentary *The Business of Being Born,* which led her to research and explore the possibility of a home birth. At the time, news headlines read "Gisele Bundchen Makes Water Births Sexy After Delivering Son in Bathtub" or "Gisele Bundchen: Water Birth 'Wasn't Painful.'" Other celebrity mothers who have had home births include Jennifer Connelly, Cindy Crawford, Pamela Anderson, and, of course, Ricki Lake.

Focusing on and promoting these home births among celebrities is a way to begin a dialogue on natural births in the popular media. It would be naive to underestimate the influence of these famous figures. During the 19th century, Queen Victoria of England

popularized the use of anesthesia during childbirth when she used chloroform during the birth of her son, Prince Leopold; similarly, if Kate Middleton chose to have a home birth with a midwife and doula, this form of birth would become popularized and normalized. After focusing on the birth processes of these celebrities, natural birth scenes should also be incorporated into television shows and films. These birthing scenes should depict women as active participants in their own births outside of the hospital setting. I am not suggesting that the media glorifies or idealizes natural births; if the media portrays natural birth, American women may consider it a more viable, socially acceptable option.

The media will be one of the fastest and most influential ways to reach American women and potentially change their minds on birth. Once American women become more knowledgeable about the birthing process, they may make different, more informed decisions regarding their birth plans and become less dependent on the doctor's knowledge. While it may be appealing to have the hospitals and medical organizations—like AMA and ACOG—focus on promoting natural births, it would be more effective to sever the supply-demand chain. These medical institutions do not feel pressured to change their methods because the public still demands and seeks out their services.

A change in the birth model is not a hopeless cause. Ignorance may be bliss, but in this case it is compromising the health, and sometimes even the lives, of mothers and their infants. It is time for women to become active and informed participants in a process that connects us across generations, countries, and cultures: birth.

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Appendix

The Medicalization of Birth and Its Effect on Women's Perceptions of Birth
Principal Investigator (PI): Stephanie Calnan
Faculty Advisor: Professor Edith Balbach
Department: Community Health

Procedure Section for IRB Protocol Application:

Questions for Tufts University undergraduate women:

1) What does birth mean to you?
2) At what age can you remember first learning about birth?
3) When/ where did you learn about birth?
4) In terms of popular media, when you think of birth, what do you think of? What image comes to mind?
5) What position do you think of when a woman gives birth?
6) How long do you generally think labor lasts for?
7) What are you most afraid of in terms of birth?
    a. Your body?
    b. The pain?
    c. Emotional/ hormonal change?
8) Have you at all considered what type of birth you may want to have?
    a. Would you prefer a C-section?
    b. Have you ever thought of a homebirth as a viable option?
    c. What do you think about giving birth in a tub? (a "water" birth)
    d. Would you consider using a doula? (Do you know what a doula is?) Would you want a doctor or a midwife?
    e. How do alternative positions of giving birth—squatting, on all fours (hands and knees), on a birth ball etc.—make you feel now?
9) Can you see yourself given birth within the decade?
10) Have you seen a birth?
11) What are some of your basic expectations surrounding birth?
12) Is there anything else you wanted to add that we didn't touch upon in regards to your perception of birth?

General demographic questions:

13) What class year are you at Tufts?

14) How old are you?

15) What are you studying at Tufts? (What is your major)?