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The Medicalization of Childbirth Within the United States

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The Medicalization of Childbirth Within the United States

By
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Submitted in partial fulfillment of the requirements for Honors in the
Department of Anthropology and Science, Medicine and Technology in Culture

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Abstract

The World Bank rates the United States last amongst developed countries for maternal mortality, with 14 deaths per 100,000 live births compared to Canada and the Netherlands with 7 deaths per 100,000 live births, and the UK with 9 per 100,000 live births. This paper argues that these deaths are strongly linked to excessive use of Cesarean sections, resulting from increased access to technology, and explores the attendant medicalization of childbirth in the United States. Drawing on interviews with patients, midwives, and physicians, in addition to participant observation of hospitals and private practices within the Tri-state area; I compare the medical or physician-led model to the midwifery model. In doing so, I describe distinct aspects of care each model provides to expectant mothers today, and consider the historical evolution of midwifery in the American health care system. I contend that we can improve women's birthing experiences, regulate the provision of care, improve health outcomes, and reduce high Cesarean section rates through education.

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Introduction

“The problem is that doctors today often assume that something mysterious and unidentified has gone wrong with labor or that the woman's body is somehow "inadequate." For a variety of reasons, a lot of women have also come to believe that nature made a serious mistake with their bodies. This belief has become so strong in many that they give in to pharmaceutical or surgical treatments when patience and recognition of the normality and harmlessness of the situation would make for better health for them and their babies and less surgery and technological intervention in birth. Most women need encouragement and companionship more than they need drugs.”

-Ina May Gaskin¹

This thesis addresses the medicalization of childbirth within the United States.

Medicalization is “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness or disorders” (Conrad 1992: 209). Using data from a Global Health System’s comparative course along with drawing from personal observation and experience while on the National Health Systems study term abroad program, such comparative research shows that the United States poses maternal and infant mortality rates highest of all developed countries and higher than many developing countries around the world (*Image 1*). It was after this discovery that my own research on the topic began. In doing so, I came to understand that the United States is the only country to maintain a standard system of care surrounding childbirth, in which the majority of births are handled by physicians and the minority are provided care by midwives. Conversely, most everywhere else in the world, the

¹ Goodreads. *Ina May Gaskin Quotes*. Goodreads Inc, 2016. Web. 23 May 2016.

standard system is exactly the reverse. I sought to ultimately discover the reasoning behind why the United States stands alone, and the effect that has had on both the providers and receivers of such care in this country.

Concerning our country's standard system of care surrounding childbirth, it is important to address the two distinct and separate models of care that exist; the medical model approach and the midwifery model approach. The medical model approach to care within this country is provided by trained physicians, while the midwifery model approach is typically attributed to Certified Nurse Midwives.² The standard system of care in the United States is provided predominantly under the medical model approach by physicians, whereas most everywhere else in the world, the opposite is the case. Midwives handle the majority of births under the midwifery model approach and work collaboratively with physicians (who provide the medical model approach) when complications arise. Because the midwifery and medical model operate separately with the medical model approach predominantly utilized (even for the uncomplicated cases of birth), the result is a lack of utilization of the midwifery approach to care.

This thesis explores the negative consequences the providers and receivers face as a result of this country's standard system of care surrounding childbirth. Drawing on interviews and direct personal observation, I will examine how current levels of medicalization in the United States contributes to our country's high infant and maternal mortality rates and further perpetuates an inefficient system of care for pregnant women. I will also address the historical

² This model is not confined to midwives the way it is for physicians under the medical model approach. For instance, I interviewed both an OB/GYN and doula who practice under this model of care.

and contemporary role midwives play in the American health care system, and ultimately provide my recommendations for how to improve the quality and efficiency of care, birth outcomes, and women's overall birthing experience through changes to our country's standard system of care provided in childbirth.

The organization of my thesis is as follows. I begin this thesis with my Literature Review, which references existing research concerning the subject of the medicalization of childbirth. This chapter gives important historical context to the discussion through the history of midwifery in this country, and establishes the inefficiencies of care provided in childbirth through the existing literature on the subject that I will aim to reconcile. Following the Literature Review are my three main chapters in which I present the main findings of my interviews. Each chapter identifies a key player who has an important yet different role in the current system of care surrounding childbirth in America. First, I explore the role OB/GYNs play within the field and their approach to the care they provide. I then do the same with responses from three midwives and one doula, only to conclude with patient's personal birth narratives and their opinion of the system of care they each received. I conclude my thesis with my overall findings from such interviews and present my final recommendations to improve upon the gaps in care I discovered in doing so.

Chapter 1: Literature Review

“Many of our problems in US maternity care stem from the fact that we leave no room for recognizing when nature is smarter than we are.”

-Ina May Gaskin, *Birth Matters: A Midwife's Manifesta*³

Maternal and Infant Mortality Rates and Our Medicalized Society

According to the most recent data concerning maternal mortality rates, in 2015, the United States comes in last to most developed countries with 14 deaths per 100,000 live births compared to the UK with 9 per 100,000 live births, and Canada as well as the Netherlands with 7 deaths per 100,000 live births (The World Bank 2016). Such statistics are crippling to the United States' health care system and even more so to the women who are or may potentially become pregnant within the States. In order to improve such rates it is essential to determine the factors that contribute to these concerning statistics, one factor arguably being the medicalization of childbirth.

As mentioned in the Introduction, Peter Conrad, a sociologist and author of *The Medicalization of Society*, defines medicalization as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders”

³ Goodreads. *Ina May Gaskin Quotes*. Ina May Gaskin Quotes (Author of *Birth Matters: A Midwife's Manifesta*). Goodreads Inc, 2016. Web. 23 May 2016.

(Conrad 2010: 4). Conrad goes on to show the relevance of medicalization by revealing how “Some analysts have suggested that the growth of medical jurisdictions is ‘one of the most potent transformations of the last half of the twentieth century in the West’”(Conrad 2010: 4).

For decades sociologists, anthropologists, and historians alike have acknowledged the process of medicalization by providing examples within their own field of study through categories such as ADHD, eating disorders, anxiety, menstruation, aging, mental disorders, etc. Medicalizing experiences and events within our culture is a perpetuating trend that “most have taken a somewhat critical or skeptical view of” (Conrad 2010: 4). The issue analysts tend to critique or question is not that we medicalize events within our society, but that we tend to over medicalize. For instance, “some conditions such as death, childbirth, and severe mental illness are almost fully medicalized” (Conrad 2010: 6).

Conrad continues to define medicalization by fundamentally explaining how it is “bidirectional, in the sense that there can be both medicalization and de-medicalization, but the trend in the past century has been toward the expansion of medical jurisdiction. For de-medicalization to occur, the problem must be no longer defined in medical terms, and medical treatments can no longer be deemed appropriate interventions” (Conrad 2010: 7). It is important to note that this paper does not argue de-medicalization cannot and does not occur because masturbation and homosexuality for instance, have become completely de medicalized within our society; rather, this paper contends that the process of medicalizing the childbearing process

has become over medicalized and has thus contributed to certain negative outcomes surrounding childbirth.

As a result of such a large degree of medicalization to the birthing process within the United States, we have negatively affected not only the outcomes of our healthcare system, but also the health of women and fetuses themselves. In accumulation with an already medicalized society, it is also apparent that the trend of medicalizing childbirth, in particular, is one of the many contributing factors to our high infant and maternal mortality rates. As a measure of the care provided in childbirth within this country, such high rates are essential to improve; and in order to do so we must reform the way in which our healthcare system handles childbirth. We are endangering women's health (physically, mentally and emotionally) and becoming a culture that is continuing to alter natural events by masking or transforming the effects of such events with the use of technological advances at the expense of our country's healthcare system and our own individual health statuses. The following section will show how it is we have come to treat childbirth in such a manner as we do today.

The Rise of Obstetrics and The Fall of Midwives

Childbirth within the United States has been “radically transformed in recent years with ‘natural childbirth,’ birthing rooms, nurse midwives, and a host of other changes, but it has not been de-medicalized. Childbirth is still defined as a medical event, and medical professionals still attend it. Birthing at home with lay midwives approaches de-medicalization, but it remains

rare” (Conrad 2010: 7). As a result of the status of birth within this country being as such today, it is imperative to understand the history of maternity care within the United States in order for reform to be efficient and effective.

For over 150 years women practiced “social childbirth” in which expectant women looked to female friends and family for aid and comfort and turned to midwives for skillful attendance all while in the comfort of their own home (Wertz and Wertz 1977: 1). Therefore, it should come as no surprise that the history of maternity care and the history of midwifery are directly correlated, for the rise of obstetrics was the fall of midwifery (Rothman 1982: 50).

Birth had been entirely female driven, female run, and female supported until the revolutionary period within the United States (1750s-1760s) when male doctors sought to attend births while expecting mothers and midwives alike welcomed their assistance. Upon experiencing complications during labor, midwives turned to “male midwives” or what they called “barber-surgeons” whose alternative technique to birth included the use of the latest technologies and the newest drugs. Male doctors’ expertise were thus desired by women of the 16th and 17th century for their use of forceps, drugs (chloroform and bloodletting), the influence and power of their gender, and the understanding that they were more “educated” comparably to midwives concerning the topic of birth, which ultimately by 1900 led to 50 percent of American births attended by midwives and 50 percent by physicians (Ettinger 2006: 7).

Throughout the 18th and 19th century doctors were categorized into two groups; “regular” or orthodox doctors who included surgeons and physicians (all men) and the “others,” which

meant the midwives, natural healers, homeopaths, etc. (Ettinger 2006: 5). Though this division existed, it was a time when anyone could proclaim himself or herself a “doctor,” for no true formal education or licensing was required; therefore, although orthodox doctors claimed to be more educated and to possess the latest and greatest approach to birth, this was most often times not quite the case. Midwifery education was by no means a formal one but based on years of experience (both personal or professional) and apprenticeships with other midwives. Their approach to birth was much more about supporting the birthing mother and waiting for nature and gravity to take their course. Male physicians felt that in contrast to midwives they were present at birth in order to “do something.” As a result of such an approach to birth, historians have shown how too often physicians were overeager to use forceps and caused disability and death for many mothers and babies (Ettinger 2006: 7). To their credit however, for years barber surgeons, male midwives and male physicians had been called into the home by midwives and laboring mothers alike to do just that: do something. In addition to unnecessary intervention, even more dangerously, physicians unknowingly spread infection with their hands and their tools (Ettinger 2006: 7). As a result of male physicians’ inexperience with such a natural phenomenon as opposed to midwives, and their lack of microorganism and germ theory at this time in history that today shows how the maternity care they offered and so many women desired was not in fact superior to that provided by midwives; in fact, according to Wertz and Wertz (1979) as cited in Reissman (1983), rates of infant and maternal mortality rates actually rose between 1915 and 1930 when midwife attended births abruptly declined (*Image 2-5*).

It was over the second half of the 1800s and throughout the 1900s that birth began to become no longer about the female birth experience (“social childbirth”) but rather a fight for power and a mechanism to attain a higher professional status for physicians and an improved social status for expecting mothers. According to Jan Halsey (2015), after the infamous administration of opium to Britain’s Queen Victoria during the birth of her eighth child, Prince Leopold in 1853, the choice to use a physician over a midwife in facilitating birth became easy for British women who revered the Queen and, it is not difficult to imagine that such a high status associated with physician handled births and the use of drugs during birth influenced the way births were handled in the United Kingdom, and ultimately within the United States as well.

Orthodox doctors, in order to further legitimize their practice, demonized and delegitimized the practice of all other health professionals, midwives most predominantly (*Image 6*). Physicians denounced midwives in their writings suggesting that they were unsafe, unhygienic, and uneducated. This became somewhat of a class, gender, and race war because many midwives were of an ethnic race, older, and serving women of lower classes, thus associated with the lower class. Midwives were seen to male physicians as competitors, professionally speaking, and so these “regular” doctors even went to the extreme of trying to establish professional medical societies and licensing laws, which advanced their own interests and kept other practitioners out (Ettinger 2006: 6). It was thus a combination of “public, male-generated criticism of female midwives, a growing number of middle-class urban women cho[osing] physicians to deliver their babies, believing in the promise of science and medicine to

make childbirth safer and associating a physician-attended birth with higher status” that contributed to a critical shift in maternity care, which was once provided by primarily midwives to predominantly controlled by physicians (Ettinger 2006: 7). Ultimately, physicians, though not necessarily superior health professionals at the time, were successful for the first time in history at beginning to reshape our country’s birthing system standard through the power of public perception and societal belief. It is thus through such a shift that one can see the first stage of the medicalization of childbirth here in the United States (*Image 7*).

Moving Birth From the Home to the Hospital

The second stage of medicalizing childbirth was with the change in the location for delivery from home to the hospital; thus further perpetuating the legitimacy of the male physician and ultimately eliminating midwives’ primary role in birth within this country. Throughout the 19th century, no more than 5 percent of births occurred within the hospital setting, and the 5 percent that were not by choice (Ettinger 2006: 8). These women were predominantly of a lower class whose home conditions were not clean or safe enough to undergo the birthing process in, therefore, they were transferred to the hospital to give birth. By the 1920s and 1930s however, women with middle to upper class statuses increasingly entered the hospital to give birth. By the 1920s hospitals had transformed themselves into a place of modernity by marketing to the middle and upper class through means of advertising “standardized medical procedures, notably surgeries and obstetrical deliveries, and a restful, modern

environment—clean rooms, good food, radios, telephone, and call buttons for nurses” (Ettinger 2006: 8). Such an environment became more and more appealing to women of the time due to three factors. 1). Women believed that the hospital, with the newest science and medicine, would be safer and make their birthing process less dangerous. 2). They were drawn to the predictability of the birthing process that the hospital setting provided. “A woman and her physician could decide in advance the day she would deliver her baby, and she could know that she would have medication to induce her labor, as well as medications to forget her pain” (Ettinger 2006: 8). 3). During such a period of urbanization, families increasingly moved to the city where women faced a life without their family network as they had once before. Thus, the hospital acted as a place where an expecting mother could seek support and assistance during labor, a role female family members once fulfilled.

An increase in hospital births during this time in the United States is statistically evident (*Image 8*); however, how did such a shift further perpetuate the medicalization of childbirth here in this country? As a matter of fact, it is from 1915 to 1929 that maternal mortality rates increased simultaneously with an increase of hospital births from 61 deaths per 10,000 live births to 70 10,000 live births (Ettinger 2006: 9), also confirmed by *Images 2, 3, 4, and 5*. The biggest factor that contributed to such an increased rate of mortality for mothers was the exposure of foreign microorganism and germs, which women were exposed to within the hospital setting. Joseph B. DeLee, a preeminent early twentieth-century obstetrician concluded himself that “home delivery, even under the poorest conditions, is safer than hospital delivery” on account

women and their fetuses at home are exposed to germs their immune systems are exposed to every day, whereas in the hospital they are exposed to new germs, which neither individual have built up natural defenses against prior to the birthing process (Ettinger 2006: 9).

The result of such a drastic change in whom primarily handled birth as well as in where birth was experienced, by 1930, midwives had completely disappeared from the birthing experience in the U.S. thus propagating a changed societal and medical perception of childbirth, which we see today. As explained first by Shaw 1974 and cited again by Rothman 1982, “In modern birth, the woman is removed from familiar surroundings, from kin and social support, and subjected to a series of technical procedures—many of which are dehumanizing and others of which carry significant health risks” (Reissman 1983: 7). A woman’s experience of birth at this period in time became (and still today often is) alienating because the social relations and instrumentation of the medical setting remove her control over the experience entirely redirecting control and autonomy to the physician who “knows best” (Reissman 1983: 7). In many ways the medical model is an unsuitable way to approach pregnancy on account being pregnant is “something one *is*, not something one *has*. Childbirth may be better viewed as something one *does*” (Rothman 1982: 39). Childbirth from the 1930s on, however, entirely stopped being conceptualized as something one does but rather what someone is and more importantly something one can control with the help of science, medicine, and technology.

The Current Status of Childbirth and the Role Midwives Play

During the twentieth century, all Western nations saw infant and maternal mortality rates as the biggest concern of childbirth. While the American trend was toward medicalizing childbirth and illegitimizing midwifery, all of Europe on the other hand, was further regulating and legitimizing midwives' role in childbirth, "fostering collaboration between midwives and physicians and successfully integrating midwifery into the prevailing maternity care model" (Midwives Alliance North America). For instance, ever since the 1865 Medical Act in the Netherlands, midwives practice independently in handling all low risk cases of pregnancy and birth (Ettinger 2006: 17). Britain also created an important piece of legislation to further improve the status and recognition of midwives with the Midwives Act of 1936 as well as creating the Central Midwives Board through the Midwives Act of 1902 (Ettinger 2006: 19). This board in Britain (just like the Netherlands) requires all low risk births to be handled by midwives and the high risk or complicated pregnancy cases be handled by physicians, a standard childbirth model, a proven successful model, which we see all over the Western world except the United States.

The Result of Not Following the "Proven System" of Care

Presently, here in the United States, birth is considered and treated as a pathological condition in which physicians and OB/GYNs primarily treat. The United States is an outlier to all developed countries (and even some developing countries) when it comes to its' system in place for delivering newborns. As Marsden Wagner, M.D. (former director, Women's and

Children's Health World Organization) stated in a interview in the documentary the *Business of Being Born* (2008); the "proven system" everywhere in developed parts of the world is to have "midwives attending 70-80% of all the births and the doctors are there to take care of the small percent the develop the complications. The U.S. stands alone." Due to the increase of 'intervention' in the U.S. within the hospital setting, such as C-sections (which account for 30% of births today and are only increasing), and the fact that midwives attend less than 8% of births, the result has been crippling infant and maternal mortality rates (**Image 9** and **Image 10**).

According to the National Center for Health Statistics, from 1996 the C-section rate in the U.S. has risen 50%, and in 2013 WHO findings, the U.S. was reported with 28 maternal deaths per 100,000 live births and 596 infant deaths per 100,000 live births. Comparably to the other developed countries in the study, that attributes the U.S. with the highest infant mortality rate of them all (**Image 11**). In comparison, the Netherlands (with Wagner's "proven system" of care in place), in 2010 had only 3.8 infant deaths per 1,000 live births. Here we see the direct correlation of medicalization of childbirth with higher infant and maternal mortality rates (**Image 12** and **Image 13**). Such a correlation is the result of unnecessary intervention in which a mother and child are placed under unnecessary risk. We are constantly given the impression that "natural" childbirth, in the home setting, without a doctor present, is the most dangerous and risky thing a laboring mother could do for the safety of herself and her unborn child, however; we must acknowledge the undisputable risk and danger we put ourselves in when undergoing surgery or being injected with high doses of painkillers and other drugs. In all other aspects of health, we as

a culture tend to shy away from the option of surgery and use it as somewhat of a last resort, whereas; concerning childbirth within this country, surgery has become the norm. Such a norm however, is concerning due to the correlation high C-section rates has with poor infant and maternal mortality rates within the U.S. as opposed to countries that encourage and normalize less intervention within their culture surrounding birth.

The Midwifery and Medical Model Approach to Childbirth

Although it is clear that the more natural approach to birth practiced by midwives for centuries (which women have showed interest in recent years), does not fit into the medical model; it is more important to understand that the medical model has proven to be a less efficient approach than the midwifery model (a model that consists of less intervention) based on the increase of maternal deaths. The negative influence on maternal death rates based on which model one receives care by is exhibit in *Image 7*, which compares the maternal mortality from the year 1920 of various countries based on their standard model of care. Because births outside of the hospital setting accounted for only 1.36 percent of all births in the year 2012 (CDC 2014), it is safe to say that pretty much all births are experienced within the hospital and thus handled through the medical model approach rather than the midwifery model. The result can be measured by the C-section rate of 32.7 percent in 2013 (WHO 2015)—well above the “medically necessary” target of 10 to 15 percent that WHO says is ideal (WHO 2016). “A 2015 study that compared the care of traditional private practice doctors to midwives or laborists (salaried

doctors who work by shift) within the same community hospital found that women laboring with a traditional doctor were significantly more likely to have a C-section than women laboring with a midwife or a laborist (31.6 percent vs. 17.3 percent). Because they're salaried, laborists have no incentive to push for expensive C-sections, and nurse-midwives tend to be more patient and supportive" (Almendrala 2014). This illustrates how different the medical model and the natural model approach to childbirth truly is even within the same birthing environment and how it is possible to undergo a natural birth within the hospital setting (more readily under a midwife's care however). It is important to note that several factors contribute to such statistics, however, even though the "ability to perform a cesarean delivery, and have both mother and infant survive, is considered one of the most important developments in modern medicine" (Gregory 2011: 12), the current high C-section rate within this country is undoubtedly concerning (*Image 14*); especially considering 90 percent of pregnancies are considered low risk and yet one in three women will undergo a cesarean delivery (Gregory 2011: 12).

The Importance of Midwifery Model Approach to Care

With the loss of midwives within the standard maternal care model here in the United States, in order for midwifery to persist they had to redefine themselves entirely, thus the creation of Nurse-Midwives. A Nurse-Midwife or Certified Nurse-Midwife (known as a CM or CNM) is dually trained in nursing and midwifery with hospital based training; therefore, often times they remain in the hospital setting; however, because of their specific training, they are

technically allowed to practice in any birth setting. Within the States, Certified Professional Midwives (CPMs) as well as Certified Midwives (CMs) exist in addition to CNMs. CNMs practice legally in all 50 U.S. states and the District of Columbia, CMPs are legally authorized to practice in 28 states, and CMs practice legally in only three states (Midwives Alliance of North America 2015). Because no national midwifery licensing exists within our country CPMs must be certified through the North American Registry of Midwives (NARM), which issues licensing only within the state of practice. Through such restrictions state-to-state you can see how the social and political setbacks midwives faced throughout the twentieth century in the United States continues to affect their practice today; whereas European countries (where midwives were further legitimized in the maternity care system well before the 1930s), do not face this issue.

Patients Influence on the Medicalization of Childbirth

“Very little about the medical management of childbirth has changed in American hospitals in the past fifty years, apart from an increase in medical technology and intervention. What has changed has been the patient who comes in. The modern patient is frequently prepared: she knows what to expect and how to behave appropriately” (Rothman 1982: 80). Since the “natural childbirth” movement in the 1930s-1940s, women’s desire for less intervention and more control over her own birthing experience has been made clear ever since, however, the natural childbirth approach women desire conflicts with our country’s current medical model of

birth, which is all about efficiency, intervention, monitoring and scheduling. Birthing rooms and labor wards have been the result of such a movement, which are midwife run (by CNMs), however, birth remains in the hospital under the rules and regulations of the medical model, which again, is not consistent to the natural childbirth model and what it stands for.

Though it's true that the majority of pregnancies and births are of a low risk and may be termed as "normal," studies suggest that complications during childbirth are not rare but are more common in cesarean deliveries (Gregory 2011: 14). Concerning complications during labor, the risk of hemorrhage is less in planned C-sections (birthing plan prior to labor) compared to unplanned C-sections (changed birthing plan during labor as a result of some complication) but higher in cesarean as compared to vaginal deliveries (Gregory 2011: 15).

A current trend here in the States is what's called "elective" C-sections or a Cesarean delivery on maternal request (CDMR), which is defined as a "cesarean delivery in a singleton, term pregnancy in the absence of other maternal or fetal indication" (Geller 2010: 676). Women who are considered a high risk pregnancy will undergo planned C-sections either before or during labor depending on the circumstances and the risk level, however, recently it has not been used for only such cases. Women, who fear the pain of labor, have the money, don't wish to undergo natural labor for vanity reasons (such as vaginal tearing, etc.), in recent years have asked for a CDMR by their OB/GYN. C-section is what OB/GYNs know and do best. They are trained surgeons, therefore, they most often would rather do surgery then wait 24-48 hours for the baby to come naturally when in many scenarios they would end up doing a C-section anyway as a

result of the distressed and often dangerous state the various forms of medical interventions create for mother and child while in labor. Such interventions most frequently include the distribution and rapid increase of drugs (epidural, Pitocin, etc.), as well as the pressure and fear placed onto the expecting mother to speed up her labor from her doctor who again, is trained to get the baby out as quickly as possible.⁴ Such a physical and emotional state of distress ultimately leads to resorting to a C-section for the safety and health of the mother and child alike.

The increased tendency of resorting to C-sections within this country, however, contributes to the risk of mother and child. For instance, according to King and Lang's 2008 study on maternity mortality in the United States, the three leading causes of maternal death are thromboembolism, hemorrhage and hypertensive disorders (King and Lang 2008). Of these three, two of which (hemorrhage and embolism) are more prevalent with cesarean delivery (Gregory 2011: 15). "Cesarean delivery itself is a significant risk factor for maternal mortality. It is hard to attribute its true risk due to confounding illnesses and/or whether the cesarean occurred with or without labor. However, estimates suggest that the MMR⁵ is two to threefold higher in women undergoing elective scheduled C-sections (without labor) as compared with vaginal delivery, and fourfold in emergent cesarean delivery (with labor) (Gregory 2011: 15), which is also clearly indicated by *Image 15*. The high rate of elective (and often times unnecessary) C-sections within this country, therefore places women and their fetuses at a higher risk of complications and even death when such could be avoided with less intervention. Through

⁴ I will discuss this in more depth within a number of the chapters to follow.

⁵ Maternal Mortality Rate.

acknowledging this preventable yet often practiced risk so many women undergo; one can see the way in which unnecessary medical intervention during childbirth can negatively influence our country's infant and maternal mortality rates.

Conclusion

Giving birth is a natural process that requires two kinds of maternity care: physical and socio-emotional. Up until the twentieth century, American women looked to midwives in order to provide all encompassing maternity care just as much of the rest of the world has continued to do so. Such a standard system of care at the time created a sense of normalcy to childbirth and instilled confidence for expecting mothers in the capability of their bodies during such a seemingly foreign experience.

Male midwives and physicians emerged into the birthing scene and with them modern medicine and technology was introduced to the labor experience. With birth still in the home and socio-emotional support provided by a midwife and the woman's female family members, expecting mothers remained the one in control of her own birthing experience whether she welcomed the introduction of more intervention or not (i.e. forceps or opium from the physician). A mother's birthing experience was forever changed here in the United States however, with the change in location of birth from the home to the hospital accompanied by the abrupt disappearance of midwives replaced instead with physicians. The result of such changes on the female birthing experience was profound. In the early decades of the twentieth century,

physicians offered medication to help women endure the pain, which placed them in what they called a “twilight sleep,” under which the woman was physically absent and unconscious for the delivery. The drug that caused such a state was a combination of morphine for the pain relief during early labor and then scopolamine, which was believed to be an amnesiac (Rothman 1982: 60). It was with the introduction of such a state that not only was the birthing experience changed; it was entirely *eliminated* for the woman in labor. To put the experience of labor for a woman in a twilight sleep into perspective, here is how sociologist Barbara Rothman explains it as within her book, *In Labor*: “A woman under twilight sleep can feel and respond to pain; the claim is only that she will not remember what happened. Women in twilight sleep therefore must be restrained, or their uncontrolled thrashing can cause severe injuries, as the scope leaves them thoroughly disorientated and in pain. Current obstetrical nursing texts include pictures of women with battered faces who were improperly restrained and threw themselves out of bed” (Rothman 1982: 59).

It is by this point that I would argue birth became fully medicalized, on account the approach to a woman laboring moved from nonintervention (unless otherwise necessary or desired by the mother to be) to *complete* intervention where the expecting mother was forced to play a sick role through an induced drugged state in which she became a danger to others and worse, a danger to herself and her fetus. And yet this was what most women wanted as their birthing experience, thus they became direct consumers of medicalizing birth. Even movies, which depicted and advertised for twilight sleep births (*Image 17*).

Although there have been several movements over the late twentieth and twenty first century to bring back a more “natural” birth, today; through the power of science, technology, medicine, fear, and the societal perception of birth, we’ve lost the innate experience of childbirth and created a medical condition in need of constant monitoring and often times leading expecting mothers (with a low risk pregnancy) to anticipate and feel they need drugs or even surgery.

The truth of the matter is that 90% of births are low risk (Reissman 1983: 6), however, that is not the perception most women have about birth. They aren’t led to believe birth is normal through the stories they hear or the way health professionals and society treat pregnant women; rather they’re led to believe that something is bound to go wrong, the uncertainty only lies in when.

The current status of childbirth within the United States is one that has led us to an overall poor health status for expecting mothers. Whether it’s the loss of socio-emotional support through the standard maternity care offered or the haphazard health care system in which comparably we stand with the highest infant and maternal mortality rates of all developed countries; we must face the fact that change is vital and the first step in doing so is by normalizing birth again through the help of midwives once again.

Chapter 2: Methods

With any area of study one wishes to explore further, in order to comprehend the topic and say something new about it requires an aspect of passion, which I have found with the topic of the medicalization of childbirth. Throughout my college career, now a senior, I have turned any and all research opportunities to incorporate the medicalization of childbirth since I was first exposed to the topic my first year of college through a 2012 documentary titled *The Business of Being Born*. The treatment of birth as a medical event, in which women are exposed and encouraged to unnecessary intervention, is a problem we face in this country and it is through this thesis that I propose my recommendations to improve the standard of care surrounding childbirth within this country.

Sample Population

With a clear topic of research in mind, I sought to accumulate my own research on the topic of medicalization through means of interviews. While abroad, on the National Health Systems program, we comparatively approached the health care systems of the United Kingdom, Canada, and the Netherlands to that of the United States. During this time, I intended to conduct interviews with health care providers who would speak to me on the topic of the medicalization of childbirth within their own country. In order to do so, prior to traveling, I submitted a Human

Subjects Proposal to the Review Committee at Union College asking for permission to engage in research with human subjects. With formal permission from the Review Committee, I was able to conduct interviews while in the Netherlands, Canada and the UK, as well as within the U.S. upon returning from my travels at the end of the summer.

For the sake of this specific research, I ultimately decided to condense my sample population to the United States within the three specific states of New York, New Jersey, and Connecticut (also referred to as the Tri-state area). However, while abroad, I did conduct an interview with a midwife in the UK as well as accumulated a significant amount of information concerning my topic of research in each of the three countries we visited through personal observations while visiting several health care facilities. Although I do not explicitly discuss the information accumulated while studying abroad within this paper, my cross-cultural research on the topic of the medicalization of childbirth provided me with a more comprehensive understanding of birth models both within and beyond the United States. Such direct personal experience with different systems of care surrounding childbirth ultimately helped to provide a lens into comparative healthcare systems in order to critique and fully understand the United States' standard model of care.

Prior to seeking out potential human subjects to interview, I determined that for the sake of this particular research topic I would need to conduct interviews with OB/GYNs, midwives, and women who had undergone childbirth at least once in order to understand the two types of care provided under our countries birthing model (the medical model and the midwifery model),

as well as to accumulate the personal narratives of actual patients' experiences of birth. Again, I only conducted interviews within the Tri-state area for the sake of convenience. As a student in New York, living in Connecticut, and having a personal relationship with an employee of a hospital in New Jersey, interviews within each of these three states were the most accessible to me.

In order to find human subjects to interview within each of the three categories of human subjects, I used both a purposive and snowball technique, for instance; once I purposively sought out one person from each category of human subjects, I was then put into direct contact with another human subject of that category through the one I had interviewed and the rest followed through a snowball effect.

My research throughout has been grounded predominantly with an anthropological, sociological and scientific approach, and over the course of my entire interview process; I conducted a total of 11 interviews (four providers, three midwives and four women who gave birth). Under the OB/GYN category of human subjects, I spoke with two men and two women all with a similar number of years of experience within the field and two of which who worked within the same hospital. Of the midwives, I interviewed all women⁶, two of which are CNMs and one doula. Finally, the four patients who I spoke with were all women currently between the ages of 34-37, all of which had (or was about to) experience more than one birth.

⁶ Although I did not interview male midwives, it is important to note that males do practice midwifery within the United States.

Interview Process

My interview procedure consisted of initially reaching out via email to describe my study, how they may be of use to me, and whether they would feel comfortable meeting with me in person to participate in my study. All who I reached out to consented and together we set up a time to meet either in their place of work or at a neutral location, such as a coffee shop. In person I presented every participant a formal consent form (attached in **Appendix B**) for the participant to read through and sign. I also made a point to explain the purpose of interview in greater detail, including why I am interested in such a topic, as well as in what way they could be helpful to this project itself. I made it clear that they had permission to refuse to answer any questions or end the interview at any time and that the interview would be completely confidential. Prior to conducting the interview, participants were all assured their identities would be kept confidential. Names and other personal information have been protected and remain anonymous throughout the thesis. Any recordings I had of the interviews were only replayed for my own use and have since been deleted upon completion of my data analysis. Recording did not include the name of the individual, but rather by number, position, type of medical facility, and health care system they belong to (i.e. participant #1 from each category: Midwife A, Patient A, or Dr. A). Only my two thesis advisors (Melinda Goldner and Michelle Osborn) and myself had access to transcripts and I was the only one who had access to any recorded interviews.

Once the consent form was signed and the participant agreed again in person to speak with me, while being recorded (which all signed off providing permission for), I began to ask a series of questions individually customized for each of the three categories of human subjects (all of which are provided within **Appendix C**). Prior to each scheduled, always in person, relatively informal interview, I personalized the questions in which I intended to help guide my interviewing process based first on whether he/she was a health professional of some kind or a consumer of the health care system, and next on my prior knowledge of the individual's background, job history, number of children, notable work, age, health status, etc. For instance, if I knew that a patient had undergone care under the midwifery model of care and not in the hospital setting, I made sure to alter questions concerning interventions during labor accordingly. All subjects were made aware of the research I was accumulating through such interviews and all were recorded upon each subjects signed approval. Recordings were used only upon the participant's approval and participants were informed that the interview could be stopped at any point. The duration of the interviews in the end ranged anywhere from 40 minutes to an hour-and-a-half.

I found interviews to be the most efficient way to understand the perceptions, beliefs, and experiences associated with childbirth in the Tri-state area in which I live and go to school as well as to apprehend the more specific and current ways in which birth is being medicalized through these subjects' own personal narratives and in some cases their illness narratives.

Data Analysis

Upon completing each interview, I revisited each individually and took detailed notes while simultaneously listening to my recording of the interview. I made sure the typed out transcription of each interview included the list of personalized questions I asked of that specific participant, their codename (ie Midwife A), which category they belonged to (midwife, patient or OB/GYN), as well as a running track of notable similarities or differences I came across among my other interviews. My detailed notes of each individual interview included direct quotations from the interviewee and the specific time denoted to each answer to specific questions of mine. I also made a point of revisiting each transcribed interview after all interviews were completed in order to organize the specific quotations and responses to my questions, which highlighted examples of specific common threads I found that ran through each discussion. Such common threads included the discussion of fear associated with birth by midwives, physicians and patients alike; and the importance of being educated on the birthing process expressed, again, by each of the three types of human subjects. As I read through my interviews as part of my analysis process I also separated each patient, midwife and OB/GYN into a sub category of being associated with the medical model of care or the midwifery model of care, which I was surprised to find was not as straightforward as I had thought; for example, one of the OB/GYNs who I interviewed ultimately was categorized as practicing care to patients under the midwifery model.

It was through such an analysis of my interviews however, that I was ultimately able to gather the overarching themes, which ran through each interview I conducted.

Though overall an extremely tedious process, I ultimately became better at re-listening to an interview and understanding what was most useful for the purpose of my research question. That does not mean, however, that after my typed transcription of the interview was complete, I never re-listened to the recording because even in the final revision process of my thesis I found myself returning to such recordings to reaffirm a finding or search for clarification. Such a process was made easier through my note taking technique in which I incorporated not only direct quotations and my own personal thoughts, but also the specific time each response was discussed within the duration of an average hour long interview.

It is through all the methodologies mentioned above that I was better able to understand the role physicians and midwives play within the birthing process, how they work together, their individual approach to birth, and where they fit in the medical field itself. From the patients of such care I discovered the personal fears they experienced or intended to experience during childbirth, their place of birth, complications or aspects they had questioned or wished they'd have done differently, and the quality of their overall birthing experience; all of which I urge are essential to understand and more importantly take into consideration when enforcing steps to reform and improve upon the United State's standard birthing system.

Chapter 3: Hospital Bound

“When you destroy midwives, you also destroy a body of knowledge that is shared by women, that can’t be put together by a bunch of surgeons or a bunch of male obstetricians, because physiologically, birth doesn’t happen the same way around surgeons, medically trained doctors, as it does around sympathetic women”

-Ina May Gaskin⁷

In moving birth from the home to the hospital setting, we as a culture have inevitably adopted and applied a medical approach to this natural process. Through interviews with OB/GYNs, I sought to fully conceive the care provided under our country’s standard model of birthing (the medical model); in which birth occurs in the hospital setting, under the primary control and supervision of a physician. Additionally, I intended to discover the role that physicians play under such a model of care in the continuing trend of medicalizing childbirth here in the United States.

Within the hospital setting, we find that birth is treated as an illness or condition through means of drug intervention, high levels of monitoring, and high rates of C-sections. It is in such an environment that we find the players at the center of care in the hospital setting to be physicians. I argue that physicians’ role within childbirth perpetuates the trend of over-medicalizing the process, by means of three contributing factors; the fear of malpractice suits, physician’s education process, and OB/GYNs perceived versus expected role during childbirth.

⁷ The Midwife Plan. *Top Ten Ina May Gaskin Quotes*. The Midwife Plan Southern Cross Insurance Solutions RSS. Southern Cross Insurance Solutions, LLC, 06 Aug. 2013. Web. 24 May 2016.

It is important to clarify however, that I do not argue these factors are in direct control or even conscious knowledge of all physicians, but rather inevitably the result of what comes with working in such an environment as the hospital and providing care under the framework of the medical model.

The Fear of Medical Malpractice Suits

At the forefront of the minds of most OB/GYNs when working with laboring women are malpractice suits, and rightfully so. “In a 2012 ACOG (American Congress of Obstetricians and Gynecologists) survey, 77.3 percent of responding obstetricians reported having had at least one lawsuit filed against them in their career, with an average of 2.69 lawsuits per obstetrician” (Morris 2013:33). Additionally, obstetrician’s average claim payment is about 20% higher than the overall average claim for all specialties (Morris 2013: 33). Dr. C, an obstetrician for 32 years in New Jersey whom I interviewed, explained to me how often times “doctors make decisions in order to stay in business.” She went on to remind us that “medicine is not perfect. And people can’t be held to a standard of perfection.” Here lies the scariest part to physicians working in this field; “it can be no fault of your own, an act of God, or just a spontaneous event, and you still get sued, and you still lose” (Morris 2013: 46). For a physician to face litigation following a birth in which he/she has facilitated, it is ultimately based on whether the result of labor is a healthy child and safe mother. It is important to note, however, that a negative outcome concerning the health of a mother or child is not necessarily due to the care provided by a physician, but rather in most

cases due to the emergence of an unexpected complication in which not much could have been done to rectify it. “Although confidential inquiries into stillbirths and deaths in infancy repeatedly show that suboptimal care is a serious problem contributing to preventable deaths, death is probably unavoidable in some babies. The courts are not always good at distinguishing between preventable and unavoidable deaths” (Wiley 2000 as quoted in Johanson, Newburt and Macfarlane 2002). Americans have a tendency to place blame on their providers of healthcare when something is to go awry and “As perinatal mortality is reduced and medical science becomes increasingly sophisticated, public expectations change. There is a tendency to believe that most if not all deaths could have been prevented” (Johanson et al 2002). Such a tendency is attributed to various factors; however, I would argue (and I intend to discuss within my concluding chapter), that the most prominent factor is the lack of a strong doctor-patient relationship, one which is founded on trust. Because the doctor-patient relationship is instead based on authority (the doctor knows best), it makes placing the blame on one’s healthcare provider that much easier, which is thus demonstrated by the high rates of lawsuits placed against physicians within this country.

In dealing with the risk of malpractice suits, maternity providers (including certified nurse-midwives) carry malpractice insurance. Such insurance coverage may be mandated by hospitals to protect their maternity providers or purchased independently if, for instance, a physician or midwife works privately. Dr. C for example, practiced privately for years in what she referred to as an “ideal practice” in which she shared a partnership with two CNMs and six

OB/GYNs. Together they provided care to expecting mothers based on their patient's individual style of pregnancy and what they wanted from their birthing experience, using surveys to obtain such information. The longingly reminiscent manner in which Dr. C spoke of such a period in her career revealed to me just how ideal she felt such a practice was for she and her patients, and then how devastating it had been to see "medical malpractice that undid it." As she explained to me, "from 2002-2003 MedMal⁸ was skyrocketing and some were paying over \$100,000 in malpractice insurance." She and her partners calculated that in the end, they were only making about a "12% profit because of what they were paying for insurance protection." After such a finding, one of the partners in her practice moved to California where insurance was less expensive, and she could therefore make a better profit than if she were to have stayed. After losing a partner, learning from more of the partners the intention of retiring, and additionally discovering that "if a verdict was rendered that was over your policy limits it was fair to go into your child's college fund and personal assets" (at the time sending her first daughter to college); this ideal maternity care group disbanded. Stories such as Dr. C's are by no means few and far between in the field of obstetrics, which goes to show just how significant the potential of malpractice suits are for physicians within our country's healthcare system. In the end, the state of New Jersey lost a medical practice that was providing effective, efficient and individualized care to expecting mothers, not due to the quality of care but rather to the constant battle physicians face in protecting themselves from possible litigation.

⁸ Direct-write medical malpractice insurance company

Such real fear instilled in the minds of physicians results in the practice of defensive medicine. Such an approach to medicine can be defined as when physicians “perform procedures and tests not to protect the health of the patient but rather to prevent malpractice liability” (Morris 2013: 43). Within this climate of litigation we see the practice of defensive medicine as a significant factor contributing to the high C-section rate here in the United States. Upon my studies abroad, physicians in the Canada, and the Netherlands, spoke directly to our group about defensive medicine as a distinct aspect separating the United States healthcare system from their own because they never face such litigation the way American physicians do.⁹ According to Dr. C, the “C section rate is high because when something bad happens in labor you try to see in your crystal ball what’s going to happen and what to do next. Academic training says wait but because of malpractice doctors feel they can’t.” Additionally, “If doctors say no to intervention and things go wrong, professionals' defensive behaviour will rise further” (Johanson et al 2002).

Practicing defensive medicine follows the moment in labor when a physician experiences a lack of control and an inability to predict what is coming next. Physicians are thus instilled with fear through the uncertainty of the progression of labor. When should they intervene and when should they wait? If only they could see into that crystal ball. Dr. A, another obstetrician I interviewed, claims that as a physician “you want to prevent everything” that may possibly go wrong in labor and because “There are so many ‘what ifs’ on top of readily available

⁹ Within the UK, 70% of litigation relates to obstetrics and of such cases, most are related to labour ward practice, and 99% of these relate to “failure to intervene” or “delay in intervention” (Johanson et al 2002). Such may be a large contributing factor to their recent bill for medical negligence of £2.6bn (\$5.9bn; €4.2bn).

interventions,” it makes intervening somewhat inevitable for physicians operating in this environment under such conditions. Therefore, the fear of the unknown cumulative with readily accessible intravenous equipment, technology, and medicine is what prompts physicians to most often lean on the side of intervening rather than waiting.

Poor or undesirable outcomes are often unrelated to the quality of care provided by an OB/GYN, and yet litigation will follow a negative outcome of a birth unless physicians can prove they have done all they can. In order to prove they have done their job to the best of their ability, physicians most often do so through the utilization of all technology, surgery, and other forms of intervention available to them. What *is* related to such litigation requires looking at this topic of discussion through a more cultural context. Because physicians within our culture are often times held responsible for any negative outcomes of labor (though such may not be the reality); the fear of litigation is thus taken with the physician into the delivery room, influencing their behavior and decision making process while simultaneously affecting the doctor-patient relationship (the patient, most times unaware of such an influential factor determining her physician’s actions). Unfortunately, too often physicians are portrayed as the bad guy when unwanted intervention is encouraged or overused, however; in light of all that goes on politically and economically behind the work of physicians we can somewhat better understand their behavior and how in many ways it is due to the legal pressure they face.

Medical School Education

I argue that medical education in the United States not only provides physicians with the tools and knowledge necessary to be a health professional in their field of choice, but also plays a role in the medicalization of childbirth. The reason being that upon graduating from medical school and finishing one's residency program, physicians have been molded to approach patients in a predominantly biological and emotionally detached manner. Even for a natural process such as birth, all physicians go through the same transformative process in which "a doctor should value emotional detachment, trust clinical experience more than scientific evidence, master uncertainty, adopt a mechanistic model of the body, trust intervention more than normal bodily processes, and prefer treating rare acute illness rather than common or chronic illnesses" (Weitz 2007: 275). There is a psychological contribution to health that is missing here surrounding the process of birth in the United States, which I contend is essential to establish at the educational level for physicians, especially those going into obstetrics.

From my interviews conducted with OB/GYNs, Dr. B shared with me the moment in his career where he "lost trust in what [he] was taught." While practicing as an OB/GYN he had a patient who was adamant about believing she had breast cancer. He explained to me how "conventional medicine said that her breast lump was not cancerous;" however, "her gut told her there was a problem and I kept dismissing her and reassuring her" and so he biopsied it for her own piece of mind. Following these tests, he officially diagnosed this patient with breast cancer.

In response to her diagnosis she began asking questions about her diet and if there were any types of food she should steer clear of. Dr. B sent her back to her oncologist who informed her it didn't matter, which he felt confident she could trust since "he studied at Harvard" he must know what he's talking about. To be cautious, Dr. B next sent her to a nutritionist who informed her that she should remove sugar from her diet because cancer feeds on sugar. His response to such information was, "that's ridiculous, if that were the case I'd know about it." He decided then to conduct medical research with a librarian (no internet at the time) and she discovered over 12,000 articles on cancer and sugar. From that point on, for Dr. B, "everything shifted within me because I lost trust...Not to know anything, that's just wrong. I felt betrayed and I lost trust." It is from such experiences as this one that he began to instill a more integrative approach to medicine and eventually an integrative approach to birth.

Dr. B's story reveals the confidence medical school instills in physicians that they know best, and yet there are times they will know nothing at all. As affirmed by Dr. C's statement I previously mentioned that "medicine is not perfect. And people can't be held to a standard of perfection," and yet we believe and expect both to be true! This moment is one that brings great discomfort and fear onto physicians, especially after being taught they know it all. This is a moment that occurs quite frequently within obstetrics given the unpredictable and unique process of birth, and yet physicians seem to be unprepared for dealing with such unpredictability. Unfortunately, unlike Dr. B's response to such a moment of uncertainty in which he transitioned to a more integrative approach, physicians most often resort to the medical intervention readily

available to them instead. Much of this can be attributed to the fact that medical school creates a subculture, which instills the idea that they “must hide their sense of uncertainty if they are to be regarded as competent by their professors and patients” (Weitz 2007: 278). By turning to more of what they know and were taught in school, it reaffirms the authoritative role they are given and expected to exude within such a medicalized setting as the hospital.

Another factor that contributes to an over tendency to intervene through the use of medicine and technology, is that “learning to distrust natural processes is intimately interwoven with learning to value medical intervention. During the first two years of medical school, most students only receive minimal instruction in using tools such as nutrition, exercise or biofeedback to prevent or treat illness; during the rest of their training, such tools are rarely--if ever--mentioned” (Weitz 2007: 278). I therefore attribute Dr. B’s differing approach to working with midwives during his residency. From them he told me he “learned a lot” about childbirth and I believe it is from acquiring a midwife’s perception and approach to birth that he possesses such an integrative approach to medicine and childbirth. Merely witnessing a natural childbirth (no medical intervention) within residency and understanding the experience that goes along with that has a significant influence on the way doctors perceive and approach birth. However, as Dr. C and I spoke about, many obstetricians have never even witness a purely natural birth. Medical students lack of experience with a natural birth throughout their education seems inconceivable, and yet, upon further introspection I began to understand how such has become the reality we face. It is within the hospital setting where medical students begin their education

process. It is also within this setting that they are taught the medical model approach to care. Such an approach is to actively practice medicine and/or surgery while in the birthing room and not wait too long without intervention (skills you can only learn in medical school), due to the fear of a malpractice suit. These students then go on to the next phase of their career only to continue practicing in the hospital setting where any and all intervention is at their fingertips and the medical model is the only approach to birth. It is thus no wonder medical students complete their residency without ever experiencing the natural approach to birth because the medical model approach is (and most often times will always be) the only approach to birth they have ever known.

The problem I find with physicians turning to intervention at the first moment of uncertainty is easily demonstrated by the use of learning mechanisms such as the Friedman Curve, which is taught and used by obstetricians and feeds into the trend of unnecessary intervention and over medicalizing birth. The Friedman Curve, created by Dr. Friedman in 1955, is a graph that obstetric care providers traditionally use to define a “normal” length and pace of labor (*Image 18*). “If a woman’s cervix doesn’t dilate according to this schedule, she may be assigned a diagnosis of ‘failure to progress’ and taken to the operating room for a Cesarean” (Dekker 2013). Care provided through such an approach puts women on what I like to call a “conveyor belt of intervention.” In which, they are treated as if such biological processes are separated from the individual who experiences them. Therefore, women who receive care under the medical model within the hospital setting are too often considered and treated as a machine

or factory undergoing an illness, similar to a mechanical breakdown in need of intervention. Due to the unique education of physicians, they are trained to *do*, not to *facilitate*, which ultimately conflicts with a natural process such as birth. For instance, Dr. C mentioned how often she hears the excuse of “failure to progress” as the “number one documented excuse for a C-section.” According to her, obstetricians during labor look at “where is she in the curve, if fallen off the curve: intervene.” This approach attempts to standardize and thus better predict the progression of labor by categorizing a women as progressively normally or abnormally based on the timing of their labor stages. The continuous use of such a frame of reference as the Friedman Curve by physicians providing care today, further supports my argument that the approach to care physicians learn during their education process contributes to and perpetuates unnecessary intervention during birth within this country.

In referencing the Friedman Curve it is also important to keep in mind that this study was conducted in a period of history when birthing women were often times under what I referred to previously as “twilight sleep.” In fact, in Friedman’s study, “96% of the women were sedated with drugs” and all births were every mother’s first, which greatly differs from women’s second birthing process (Dekker 2013). Since then a lot has changed in the way birth is experienced and treated within the hospital setting. For instance, today, modern researchers have come to the definitive conclusion that we can;

“no longer apply Friedman’s curve to women of today’s world. Too many things have changed since 1955. Women are no longer sedated during labor, but epidurals are commonplace; Pitocin is used much more frequently for both labor induction and augmentation, women are older and tend to weigh more, and

forceps are hardly ever used. All of these things can either slow down or speed up the rate of labor” (Dekker 2013).

How is it then that such a frame of reference is still used today among physicians? At the most fundamental level of education, it is the teaching of tools and techniques such as the Friedman Curve in medical school that I argue must be reinvented and include more of the holistic and non-interventionist approaches to handling uncertainty in labor progression in order to improve upon providing unnecessary intervention when handling the birth of women in the hospital setting here in the United States.

Byron Good and the “Medical Gaze”

Through a more anthropological lens, Byron Good 1994 presents his ethnographic work among Harvard Medical students in order to discuss “how medicine constructs the ‘objects’ to which clinicians attend, *arguing that medicine formulates the human body and disease in a culturally distinctive fashion*, using students’ descriptions of how they learn and how they change as a base of insight into this process” (Good 1994: 65). It is from his interviews and observation of these medical students that he reveals how through their education process, they learn “an alternative way of seeing,” which he refers to as the “medical gaze” (Good 1994: 73). Good explains that “within this redefined context, the human body is given a new meaning, and a new manner of interacting with that body is appropriate” (Good 1994: 72). With such a redefined context of the body it leads to the doctor-patient interaction and relationship that we find today;

one in which a medical student Good interviewed clearly conveys when he says, “I have a job to do here and I’m doing something for you, so I’m going to just do it as efficient as I can” (Good 1994: 78). From Good’s research on Harvard medical students, there is a clear emphasis placed on doctors to actively *do* rather than monitor and wait through means of their education.

Therefore, it is no surprise to find that when it comes to childbirth, physicians (who are trained in the same manner as all other medical students), are more prone to intervene than wait and let a female’s body run its’ natural course in labor. As Good believes, and I have argued myself, there are “terrible costs of such a narrowly biological view of the human person, of such devotion to maintaining the biological life” (Good 1994: 87). More specifically, he goes on to mention how, “Infant mortality rates have come to be seen as almost the sole criterion of the success of international public health programs” (Good 1994: 87). From the United States’ surprisingly high infant and maternal mortality rates (which I presented in Chapter 1), we note just *one* contributing factor as being the medicalization of childbirth within the United States, or as Good would put it, just *one* of the many costs of this “narrowly biological view of the human person” (Good 1994: 87).

Physicians Perceived Role in Childbirth

A question I asked of all of the OB/GYNs I interviewed was what they felt their role was during the birthing process. From such a question I hoped to better understand the kind of care these physicians intend to provide their patients in order to later compare the responses of patient

expectations of physician's role in their own birthing experiences. It is from such a comparison that I can ultimately identify the gaps in care that exist within the hospital labor room in the area of study.

Dr. A, when answering this question informed me that he is in the birthing room “in case there’s an emergency, the rest happens because it’s natural.” He went on to add that he would hope the nurse would be there to “coach” the patient throughout her laboring process, however, he feels as if that’s something he’s found nurses more frequently don’t provide his patients. Similarly, for a patient, Dr. B claims it is her role as a doctor “to look at you and the baby in a predictable way” by having the “big picture in mind” while “the nurse does the bedside support.” To the same question, Dr. C explained how she’s “the one ultimately responsible for well being of mom and baby” and yet he referenced the ideal situation of having a doula present as a third party who can support and coach the mother without her feeling any guilt or pressure. His belief is that if you are paying for such care rather than expecting it from a significant other, family member, or friend you remove the pressure off of your loved ones as well as feel more comfortable asking for help. Such responses led me to make two overarching conclusions about doctors’ own perception of their role in birth.

First, for each physician's described role in childbirth they are seemingly expected to possess all-knowing, godlike attributions. Someone who must “predict” while simultaneously keeping the “big picture in mind” who is ultimately held “responsible” for the life of two distressed beings in case “there’s an emergency.” On top of it all, all expectations hold true for a

physician during a process that has proven to be uncontrollable and unpredictable time and time again.

The second conclusion I made from these results is arguably more significant than the first for the sake of my research. Each and every OB/GYN made reference to their hope and anticipation of someone other than themselves present to “coach” and provide “support” to the mother while in labor when describing their *own* role. From this, we can infer that when envisioning the process of birthing a child, physicians place significant emphasis on the necessary emotional and psychological support for the mother in labor. Although all were in agreement that such a role should be fulfilled in an ideal birthing process, they were united in communicating that their intended care does not include such a responsibility.

Conclusion

Physician's role within the birthing room has been to offer their preeminent knowledge, skills, technology and tools ever since their role was first introduced as “male midwives” or “barber-surgeons” in the home environment (Ettinger 2006: 7). In moving birth from the home to the hospital setting and predominantly into the hands of doctors, birth was thus defined as a medical event. Through interviews with 21st century doctors from the Tristate region of the United States, one can gather that the distinct care they provide is not the result of physician's individual mentality but rather what has been structurally imposed onto them through the culture of the hospital and their medical education. It is within such an environment in addition to the

politics and economic burden behind medicine, which have cumulatively perpetuated birth's definition as a medical event; ultimately leading us to the point we are at now where "the mechanistic model of the body and illness leads naturally to a distrust of natural bodily processes...As a result, doctors typically view pregnancy as a disease" (Weitz 2007: 278). It is through acknowledging this distinction of care provided by physician that we become one step closer to understanding where reform efforts would be most effective in improving the birthing standard of care within the United States.

Chapter 4: Modern Day Midwives

“Many midwives work as employees in large hospital practices, where the techno-medical model of care is still the rule. In practices like these, midwives are used to attract women who desire midwifery care, but they may in fact be under constant pressure to practice within the techno-medical mode.”

- Ina May Gaskin, *Ina May's Guide to Childbirth*¹⁰

A midwife, as defined by Midwives Alliance North America (MANA), is a trained professional with skills and expertise to help women maintain healthy pregnancies, have optimal births, as well as successful recovery postpartum. At a larger scale, “Midwifery is a woman-centered empowering model of maternity care that is utilized in all of the countries of the world with the best maternal and infant outcomes such as The Netherlands, United Kingdom and Canada” (MANA.2016). As I have discussed previously, midwives around the world are the primary health care providers for childbirth, whereas in the United States only 10% of births are supported by midwives (MANA.2016). Rather than utilize the midwifery model of care, the United States predominantly handles pregnancies within the hospital setting and under the medical model in which physicians are the primary providers of care regarding childbirth. Enthusiasm and encouragement towards a higher degree of utilizing the midwifery model of care does exist here in the U.S. among consumers and large healthcare institutions alike. Expecting

¹⁰ Goodreads. *Ina May Gaskin Quotes*. Ina May Gaskin Quotes (Author of *Ina May's Guide to Childbirth*). Goodreads Inc, 2016. Web. 23 May 2016.

mothers seeking a more holistic approach to birth and institutions such as The American Congress of Obstetricians and Gynecologists; which look to lower healthcare costs, improve efficiency of care, and better overall health outcomes by publishing standards of care through recommendations, have kept alive the practice of midwifery within our medicalized culture. In order to re-introduce the midwifery approach to birth after midwives had been entirely replaced by physicians within this country, it required redefining the midwife. Thus the creation of the Certified Nurse-Midwife (CNM), the new, modern, and more culturally accepted midwife who can practice in all 50 states (unlike Certified Midwives and Certified Professional Midwives whose legitimacy varies state to state). As a result of CNMs dual education in midwifery and nursing (comparable to OB/GYNs), midwives today have the tools, technology, and skills to do everything an OB/GYN does during a birth except surgery.

Midwives reemerged into the birthing scene in a completely new form with the addition of nursing degree. Based on such a renewal of the midwife, one must question how the care they provide has been affected as a result? In order for me to fully comprehend the aspects of care provided in the modern midwifery model, I conducted interviews with two CNMs (both work in the hospital setting) and one doula (who practices both privately and in the hospital). It is important to mention that prior to my research on the topic of the medicalization of childbirth, I knew nothing about the role a doula plays within the context of childbirth and did not intend to include a doula in my interviewing process; however, after discussing my thesis topic to an employee at a hospital I was interviewing physicians and CNMs in, she encouraged me to

include a doula into my research and put me in direct contact with one. Ultimately, interviewing a doula was immensely important because I came to find the care they provide pregnant women today is reminiscent of the care provided by the earliest version of midwives. Therefore, interviewing a doula helped me conceptualize where the modern midwife fits into the context of birth today, as well as the specific care doulas provide exclusively (I will go into further depth as well as define doulas later in this chapter).

Included in this chapter are the results of such interviews, in which I address the specific aspects of care healthcare providers using the modern day midwifery model offer to patients, their unique and differing contribution to maternal health during pregnancy to that of OB/GYNs (who use the medical model of care), and finally, the way in which working in the hospital setting and being educated partly in the medical model of care has affected modern day midwives and the care they provide.

The Standard of Care Provided by the Midwifery Model

While interviewing a CNM who works for a hospital in the state of New Jersey (who, for the sake of anonymity I will refer to as Midwife B), she spoke to me of her various roles in childbirth over the course of her career. Midwife B had not always been as a midwife, in fact, she began as a labor nurse. It wasn't until her children were grown that she left nursing and embraced a midwifery approach to birth to become a CNM. Above her desk I glanced at a sticker that read "Keep Calm and Wait For Labor," as she told me about returning as a bedside nurse

only to find epidural rates the highest she has ever seen them and she “couldn’t take it.” At the time she said to herself, “maybe an epidural is part of evolution and I’m a dinosaur who needs to get with the program? Nah. I either have to change things or get another job,” and change is just what she devised overnight. The outcome was a holistic birth program offered within the hospital, which Midwife B has worked in for many years. Such a program, even today, provides expecting mothers the education, support and ultimate control over their own birthing process and birth experience specific to their needs and desires. If a patient of the hospital chooses to use such a program she meets with Midwife B three times over the course of her pregnancy. The first meeting is a therapy session of sorts where the midwife aims to get to know the patient’s needs, fears, and hopes. The second, they discuss the actual labor process; for instance, Midwife B educates the patient on what to expect, the possible complications, and of course all of their options. Finally, they meet a third time in order to compile what she calls the “summation,” which is a formal write up of what the patient wants out of her birth experience. The “summation” is tailored specifically to each patient’s needs, goals, wishes, etc. and may include for example, the patient’s medical history, things she doesn’t wish her partner to know during her labor, interventions she wishes to avoid, recommendations from Midwife B, even ice breakers that may be used during labor to aid in the patient’s experience. Midwife B made it clear that no matter what, “whatever the two of them feel is important gets written down.” Midwife B has thus created a program through which she acts as a liaison between the patient and whomever the patient’s health care provider ends up being during their actual labor within

the hospital. Through the summation, Midwife B ensures that no matter which healthcare provider her patient chooses, her needs will be taken into account and addressed throughout the entirety of the birthing process. Her primary role at this point in her career is no longer to facilitate labor in the birthing room as traditional CNMs may do, but rather to create a prepared, well-educated, and confident expecting mother who will go into her *own* birth responsible for her *own* birthing process. From the words of Midwife B, “we must own what we don’t prepare ourselves for. You have to be accountable for this. You can be as unprepared as you want to be.”

The importance of the care provided by Midwife B that I have outlined above reflects the midwifery model of care, which is something our culture is somewhat unfamiliar with due to the fact that the medical model has been so prevalent in my generation’s mother’s, grandmother’s and even great grandmother’s childbirth experience. Prior to Midwife B’s program, she explained how “the epidural rate was over 84% at this hospital but is now around 50% for those who partake in this program, and 80% for the overall hospital.” This compelling outcome affirms the importance of the kind of care provided by a midwife, which for too long in this country has been underutilized.

Historically, women within one’s community who had gone through birth themselves shared their experience and supported other women during their own labor process prior to conventional midwives (Ettinger 2006). With the emergence of midwives, their care was ultimately very similar to that of women in the community and family members who had previously aided in the process; however, they simply had more experience and witnessed more

births. Therefore, the midwifery model of care in the most simple and traditional form is to support an expecting mother through one's prior experience and knowledge in the process order to guide another through her own experience of childbirth. Today, as seen through Midwife B's approach to birth, the role of the midwife has become a bit more complex with an increase of knowledge, interventions, and of course a new birthing environment; and yet, what has remained is the distinct type of care the midwifery model provides mothers to be.

Care provided through the midwifery model today, based on my interviews with those who practice under such a model of care, is predominantly focused on guiding and supporting expectant mothers through their pregnancy by normalizing their conception of birth, empowering them to be responsible for their own birthing process through means of educating, and personalizing the care they provide to each patient. In order to clearly demonstrate such three aspects of care, I will present the results of the three health care providers I interviewed (similar to Midwife B) who provide such care in the Tristate area.

Midwife A, a CNM who practices in the state of New York, works in a midwifery run program within a hospital (I will further explain shortly). This relatively new program consists of six midwives who work shifts (only one midwife per shift), and is located in the labor ward of the hospital. As a result of working in the hospital environment, they have access to a number of collaborative physicians if complications do occur. Such a program arose from a local survey conducted by the hospital itself, in which they intended to find the needs and demands of their consumers. The responses from the women of this community revealed the need and desire for

midwives. As a result, patients of her current place of work are offered the option of the midwifery program but are in no means placed into such a program.

When asked to describe the birthing process through her eyes, she characterized it as an “emotional experience,” an extremely “personal experience,” and one that is difficult to predict on account “everyone’s experience is different.” Midwife A explained to me that what is most important to the care she provides is giving her patients choices throughout the process due to the fact that it is such a personal and emotional experience in which their decisions must be heard and taken into account.

In order to provide the opportunity of choice and thus personalize the birthing process accordingly, educating expectant mothers on the birthing process and all of their options is essential within the midwifery model of care. Midwife A, for instance, explained to me that, “a huge part of being a midwife is empowering, through teaching and reassurance and education. Being the guide to help them achieve that. It’s sad that now that’s what a midwife is, the alternative instead of the norm.” The latter part of this quote infers that educating and empowering women is care provided only through the midwifery model of care rather than the medical model, which the physicians I personally interviewed confirm. Within our culture’s personally explained to me that he did so through intimate meetings with his patients. The goal of such meetings was to “de mystify and de-medicalize the process,” which he believes to be “a major shift that women *must* make in order to continue” with a pregnancy. To reach such an objective, he began in the initial meeting with his patients by asking, “where are you” in your

understanding and perception of birth? It is from such a discussion with his patients that Dr. B gained a comprehensive understanding of their perception of pregnancy and childbirth through their own intimate experiences, the cultural perception they possess, as well as the message they have received from friends, family members, books, movies, etc. With such an understanding, Dr. B could then know where and how to begin to de-mystify and de-medicalize the process, unique to each patient. It is in this way that Dr. B was able to normalize birth for his patient in a personalized manner; thus instilling confidence and trust in his patient's perception of him and the decisions the two of them may have to make further into the process.

In comparing Midwife B and Dr. B, it is evident that even with all that makes them distinct from one another, it is through their use of the midwifery model of care that one can see how their narratives of care similarly incorporate instilling confidence through educating patients their options, normalizing the birthing process, and making an effort to personalize care specific to each patient.

As I mentioned previously, I also interviewed a doula who provides care to expectant mothers within the framework of the medical model of care, comparatively to Midwife A, Midwife B, and Dr. B. This particular doula, is employed by the same hospital as Midwife B in New Jersey, and also practices privately. Prior to us meeting, I knew nothing of her profession or the kind of care she offers to soon-to-be mothers; however, in her own words, a doula is “a person (usually a woman) who provides, physical and emotional support for a woman and her partner prenatally, through her labor and a couple weeks after the baby is born.” No aspect of the

care a doula provides is medical but rather about addressing the psycho-health of client's well-being. Doula's work places a great emphasis on acknowledging that her clients require their own unique kind of care because they are each their own unique individuals with unique and differing needs throughout their own childbearing and birthing processes. Generally speaking, however, the doula provides emotional support, physical support¹¹, information on any aspect of pregnancy and labor, or even is simply there to listen (a therapist of sorts). In accordance with the aspects of care that I have attributed to the midwifery model of care; Doula provides her clients personalized support throughout the entirety of their pregnancy, instills confidence, and empowers them by ultimately never speaking for her clients but rather "giving them the tools they need to speak for themselves." It is also important to note that she works with each client prenatally, throughout the entirety of her pregnancy, as well as during her labor, which she is always present for. Therefore, a doula provides hands on care to women throughout the entirety of her pregnancy and delivery, which is another way in which the care she offers differs a bit from CNMs.

More generally speaking to the profession and the process of employing a doula, women who wish to hire a doula within the U.S. must pay a fee ranging anywhere from \$500-\$2,000 out-of-pocket, which means that such care is only accessible to pregnant women who occupy a high socioeconomic status. "The vast majority of insurance companies do not reimburse the patient for doula fees whether the contract is private or through the hospital," Doula informed

¹¹ An example of physical support may be something like massaging a client during her pregnancy or even during labor.

me, which thus provides an economic barrier for much of the population. However, Doula A went on to explain how “Interestingly enough, Medicaid is beginning to cover some fees for low income, at risk mothers but this varies by state.” Evidently, certain states have acknowledged the lack of accessibility for women of lower socioeconomic status to receive this resource of care and have implemented ways to make doulas more accessible. Childbirth Connection’s 2013 nationwide survey initiative, Listening to Mothers, indicated that the percentage of women hiring doulas for labor went from three percent of births in 2006 to six in 2013.¹² According to Doula A, “the number of Doulas have doubled in 11 years,” which she believes reflects how “women today are starting to explore their options.” Although there has been an increase in the use of doula’s within this country, unfortunately, in doing so, it speaks volumes to the fact that our society has recognized the importance of the kind of care doulas provide to women throughout their pregnancy, such care that is under the midwifery model framework of care. Such a state-wide movement supports the previous statement of mine that the desire and push to more readily utilize the midwifery model of care has been acknowledged and acted upon within this country in an increasing number of ways.

Doula A believes that the work she does “bridges the gap between techno-medical aspect of birth and old fashion female support” and that in this way, her role is to be “the glue that binds things together.” She is not alone in this belief. Dr. B believes “the ideal is that there be a doula

¹² This organization’s ongoing surveying of women’s birthing experiences at a national level measures the quality of care provided to women within this country. Through such survey questionnaires, the results of Listening to Mothers help identify gaps present in care in order to make improvements concerning childbirth nationwide.

during labor.” He recommends that “if you can afford it, have the doula there because it takes the pressure off” of whoever is expected to provide the woman in labor with support physically, mentally and emotionally. In Chapter 3, I mentioned how each physician I interviewed spoke to the importance of someone being present during labor to coach and support the laboring mother-to-be in response to my question of their perceived role in labor. Although Dr. B was speaking to the fact that a husband, partner, family member, or friend would be the one relieved of such pressure to continuously provide support, care, and attention to the laboring mother by hiring a doula; with what physicians revealed to me as a critical aspect of care being fulfilled by a doula, hiring a doula ultimately takes the pressure off of physicians to accommodate such a role just the same. Through a somewhat serendipitous interview with Doula, I was thus able to gain an understanding of the work she does in order to ultimately piece together the overarching connection between the care provided by a physician and the care provided by a midwife.

Even prior to the OB/GYN and the CNM ever coming into existence, birth has required the care provided by both of these two modern professions, the reason being, birth itself has not changed. For a woman in labor, it is and has always been an emotional experience in which support, encouragement, and assurance are essential aspects of care to receive. However, childbirth is just as unpredictable as it is emotional and personal, which requires specialized care from an individual specifically trained in the complications of birth as well. In a country that for many years has promoted and normalized the medical model approach to birth, the result is a lack of the psychological care being provided to women in labor. With the reemergence of

midwives in this country as CNMs, a personalized approach to care that includes the normalizing of birth, empowering women through educating them on the process of labor along with their options has been integrated back into the birthing scene where it is imperative. Interestingly enough, the Doula therefore became the glue that bound my own understanding of care between the two differing models provided to pregnant women within our country.

The narratives of care that Midwife A, Midwife B, Dr. B and Doula A shared, enabled me to accumulate and present here the overarching aspects of care provided by the midwifery model. In doing so, I found that contrary to what I thought, care provided under the midwifery model is not exclusively implemented by midwives but also by differing healthcare providers, such as doulas and physicians. Such a finding in and of itself speaks to the importance and efficacy of the midwifery model approach to care in childbirth. This finding is also promising for a hopeful increase in the utilization of the midwifery model of care within this country than it has been previously.

The Importance of Education

Collectively, each health care provider working within the framework of the midwifery model of care whom I interviewed, spoke to the importance of empowering patients through education. This is a distinguishing aspect between the two models of care because it is an aspect of care physicians do not traditionally provide. The emphasis on educating women within the

midwifery model as well as the positive outcomes of doing so, make this aspect of midwifery care something I would like to therefore further examine and discuss.

While speaking to Midwife B about the purpose and function of the holistic birth program she founded and implemented, she was the first to address the lack of proper education women have on the process of birth and pregnancy in this country today. Through her many years working in the field of childbirth (again both as a labor nurse and later a midwife), she revealed to me the trends she has seen over the years concerning educating on the subject of birth. For instance, when Cesarean sections were at the lowest she has seen them, “Lamaze classes were a must.” Later, when speaking to Doula A, she also mentioned how 1960-1980 was a period of time when Lamaze classes were not just the norm but a requirement. At this time, in order for the father of the child to be present in the birthing room during labor, he was required to accompany the mother to Lamaze classes prior to her due date. In this way, childbirth education *did* used to be somewhat of a requirement. Lamaze International was created in 1960 by a French doctor, Dr. Lamaze, who created this non-profit-organization with a mission to “advance safe and healthy pregnancy, birth and early parenting through evidence-based education and advocacy” (Lamaze International.2016). A Lamaze Certified Childbirth Educator (LCCE) provides educational programs internationally, which Midwife B and Doula A refer to as Lamaze classes. Much like the health care professionals I interviewed, who provide care under the midwifery model, “Knowing that access to credible information and research is key to a healthy pregnancy, childbirth and a good start to parenting, Lamaze works to educate women and

provide support so they are equipped to effectively partner with their care provider, navigate their options in care and push for the safest, healthiest birth possible (Lamaze International.2016).

Today, “women think they can learn everything online,” says Doula A; however, “Dr. Google does more bad than good” for providing women with information on pregnancy and childbirth, which I will return to shortly. Because midwives realize and have acknowledged a shift in the kinds of resources used to provide information on childbirth, they actively incorporate what they feel to be useful and educational sources into their framework of care. For instance, both Midwife B and Doula A provide what they refer to as “homework” for their patients prior to meeting with them one-on-one. Midwife B sends all her patients three to four books to read, all of which she feel accurately and efficiently provide pregnancy and childbirth information to expecting mothers. Doula A also provides useful resources for her clients in order to prevent them from exploring Dr. Google blindly, because she believes that this can result in . reading misleading information in addition to reading too many horror stories, which only further promote their fear of childbirth. This brings me to the fundamental reason why midwives feel providing information to their patients is so important.

Childbirth is scary, and in a culture where childbirth is only made scarier through the frequent use of interventions, monitoring, and technology; women are made even more fearful through their lack of informational resources that conceptualize birth as a natural and normal experience. It is therefore a responsibility midwives have taken on in modern day midwifery care

to help reduce fear by replacing it with knowledge. Thus instilling confidence in women through knowing the normalizing truths surrounding birth.

I discovered through my interviews that the education midwives provide comes in many different forms. One specific example of the way in which a midwife may reduce fear through educating women is how Midwife A spends a significant amount of time “educating women about what to expect and how to get through the pain” through the care she provides. This is an immensely useful tool for pregnant women to bring with them into the birthing room because by educating a woman who is fearful of the anticipated pain during labor on options of ways to reduce such pain, she gains a feeling of preparedness and confidence rather than walking into things blindly, fearful, and with no set of mechanisms to combat the pain. Pain relieving techniques such as breathing exercises, bath tubs, showers, massage therapy, even the use of music, are a central aspect of the education provided in Lamaze classes (which again, are not readily utilized in the same way they have been in the past). Therefore, it is important that through midwifery care, some women today are being provided such useful information and becoming more prepared and confident about their laboring process. It is without the knowledge of such options that women today most often go into labor, however. This means that when most women are actively experiencing the pain of labor, which they have been fearful of for so long, and are then offered pain medication or an epidural, they feel no other option but to comply. Therefore, one way in which midwives educate their patients is by making them aware of all of

their options and providing them with potential tools to make use of while in labor. Whether they choose a more medicalized form of relief or not, it is important they have the option.

Another form of educating is the way in which Doula A explains how for some clients, she focuses on “untying the bad stories they’ve heard” surrounding childbirth. This is another way in which “Dr. Google” provides useless information regarding pregnancy and childbirth that speaks to a consistent trait our culture has, which is that we tend to speak of the bad more often than the good. Women’s birth horror stories are much more accessible on the internet as well as spoken about amongst friends, family members, and peers than positive accounts. This may be partly because “what is on the internet is geared to the consumer rather than the person seeking reassurance, confidence, and security in the birthing process,” as Dr. C proposed. It is thus through spreading positive accounts of birth she has personally experienced that Doula A feels prepare her patients mentally and emotionally for the most positive birth outcomes themselves. She states that, “if we surround ourselves with positivity we are more apt to have positive experiences with birth, although, there’s a mystery card and I always remind my clients about that.” When I asked Midwife B what she believed her role is during a woman’s birthing experience (which recall she is not actually present for), she responded, “memory.” In one specific instance during Midwife B’s career, a former patient, while speaking to her about the birth of her child, said how during labor she “felt like she was going to explode but that she then remembered I told her how during the labor of my own children, I myself felt as if I were going to explode. She told me how in that moment she told herself, ‘I get it now. Well, if she’s

[Midwife B] still here I can move on and do this. I remembered what you told me and I held onto that.’ It makes me realize how important this is.” By “this” she is referring to the importance of telling stories, the normal stories of what it is to feel when your baby is being born with her patients. Therefore, the moments of uncertainty while birthing can easily be pushed aside (as Midwife B’s patient proved) in knowing women have done this before and have felt a similar way. It is by retelling experiences of birth that do not include the rare complications but rather normalize the process that women can feel encouraged and confident in proceeding without the use of medical interventions or drugs and instead allow the naturally normal event to run its course.

Midwife B mentioned to me that through her program she has had several women come to her “with baggage from their previous birth or births.” Many share with her stories of during their birthing experiences, “feeling bullied, coerced, manipulated, pushed. These are their *own* words.” Because the majority of births are handled under the medical model of care provided by an OB/GYN, in combination with a current trend of women lacking formal education on childbirth; accounts such as the ones Midwife B has seen firsthand presented of women feeling coerced, bullied, pushed, etc., are somewhat commonly experienced in our current birth culture. Physicians traditionally do not produce such empowerment and confidence in their patients’ perception of birth through education; not because they don’t feel it to be important but rather they don’t perceive it to be their role in childbirth (as I mentioned all physicians I interviewed revealed to me), or do they share the same approach to care as midwives do. Doula A told me of

a moment in labor that I believe quite accurately distinguishes the two models of approach concerning the topic of educating patients in order to proceed with the labor process accordingly. A client of Doula A and the patient of this particular physician, had a complication emerge while she was in labor. Through the confidence and surplus amount information that Doula A had provided her client throughout the entirety of her pregnancy, she knew the facts and her options well enough to take responsibility for her own birth and tell the doctor she would not take an antibiotic, not to spite him, but because it was her decision and it was the decision that they were all going to have to accept. The physician pulled Doula A aside and told her, “why don’t you tell her she doesn’t want a dead kid.” Doula A responded, “I don’t have to play the dead baby card. Instead of scaring her, I gave her the information she needed to make her own decision.” Often times, while attempting to do their job to their own best ability, physicians will use this form of guilt as a weapon used against the laboring mother to move labor along as quickly and effectively as possible. Physicians do so because that is their model of care and that is what they were taught to do: *do* don’t wait (in direct opposition of the approach expressed by Midwife B’s *Keep Calm and Wait for Labor* sticker). As Doula A said to me, “when your doctor says you may hurt your baby everything else falls apart,” so therefore, this is a very effective tool in convincing women to use certain drugs or interventions to move labor along. She finds her job is thus to make sure her clients know the facts and all of their options in order to stand strong, be it that this weapon is ever used against them. For women in childbirth, the midwifery model promotes that “we have to be responsible for ourselves and our decision making,” Doula A

explained, whereas; she went on to say, how the medical model of care supports this idea that “the doctors word is law.” Physicians are taught such a role, only then to take on the role, and act accordingly (as seen by this example).

The purpose of properly educating and informing women on the birthing process and their options is, as I’ve mentioned, is to instill confidence in their ability through normalizing and familiarizing the process as well as to ultimately place full responsibility onto the expecting mother for her own birthing process and birthing experience. In reaching such a goal, it ultimately doesn’t matter whether a physician is the woman’s health care provider or if it is a midwife. By taking hold of her own birthing plan and being confident of her role in labor, she is bound to receive an overall more empowering and satisfactory birthing experience, one in which she never feels pushed, coerced or bullied. It is when a woman finds herself in labor, unprepared and immensely fearful that she will deem her physician’s word to be law and rely completely on medicine; which most often times leads to unwarranted use of drugs and other technological interventions, perhaps even surgery. It is from such an experience that women walk away having felt bullied, coerced, pushed, and unheard by her doctor. What this does it remove the woman from her own birthing experience entirely. By the patient not knowing and understanding the role she plays during her own birth through a lack of education on the process of birth and of other women’s empowering and normal experiences, she risks unfavorable outcomes and an overall poor birthing experience (emotionally, physically and mentally).

The Creation of “The Medwife”

By having presented the way in which the midwifery model provides differing care to that of the medical model; I will now address how working predominantly in the hospital setting (as confirmed by *Image 19*), which promotes, practices, and requires the medical model approach of care, has affected the modern midwife and the care she provides to her patients.

In speaking specifically with health care providers who administer care through the midwifery model, I discovered how much of what they do comes from the passion they have in assisting women through the process of childbirth. This is not to say that the physicians I spoke with are not passionate about their patients, quite the opposite in fact; however, I do argue that midwives’ passion to provide their care is extremely distinct from any other I’ve found among healthcare providers. Midwife A for instance, explained how she had decided on a pre-med track until she “took a woman’s studies course and a midwife came in to speak one day. I fell in love and just knew it was my calling.” A “calling” is the same explanation both Midwife B and Doula A used when attributing why they do what they do. Midwife B took it upon herself to create her own program centered around the midwifery model of care because of how wrong it felt within her entire being to continue practicing in such a medicalized way within the hospital setting she returned to work in. Doula A on the other hand, had her own personal birthing experience in which she felt “bullied,” and felt she had no one to “advocate” for her. It was after this personal experience of hers that she claims to be when she “knew this is what I wanted to do,” to advocate

and support other women during their own birthing experiences. Similarly, I myself can describe a similar feeling in choosing this research topic. Being a 21 year old who has never personally gone through birth or witnessed a birth for that matter, often times people question how it is I am so passionate about the subject of childbirth. This is a topic that spoke to me (a calling of sorts) from the moment I was exposed to it; and my passion only grows the more I learn, the more I read, and the more I personally observe pertaining to it. I can perhaps therefore attribute it to a female instinct of sorts that is inherently within some of us and thus provoked through eye opening personal experiences or simply being made aware of alternative approaches to birth. Such a rationale cannot be too far fetched because women for centuries within the United States (and even currently in other parts of the world), with no medical background, have aided in the process of birth merely based on their own personal experiences and natural instincts.

I also spoke with Midwife B for a long period time about “one reason C section is so high is that OBs coming out of residency have such little experience with natural births.” This goes back to my discussion on education of physicians, which instills a completely different approach to caring for patients than that of midwives. Midwife B went on to say how, “OBs coming out of residency where there are midwives have a better, more well rounded experience,” which is directly supported by Dr. B (the “physician-midwife”), who, by spending a period of his residency exposed to the midwifery model, ultimately led him to adopt such an approach later in his career. The shift from birth being supported solely by women who have themselves labored to today hiring a physician who potentially has never even seen a natural birth is dumbfounding;

no wonder so many women today come away from their birthing experiences feeling misunderstood. By not requiring medical students intending to work in obstetrics to neither be educated on the midwifery model of care nor ever experience first-hand a natural birth, physicians may never even have the opportunity to gain such passion the midwives I spoke to have had (especially if they are a man and will never experience birth firsthand either).

Because of midwives distinct passion for the care they provide, and a sense of their role in birth as a “calling,” it helps sustain their less prominent approach to birth even within such a medicalized society as this one. In this way, it is important to acknowledge the fact that much of the care such healthcare providers working in the midwifery model provide is the result of a strong personal belief in this philosophy on how to approach childbirth more holistically.

Through my interviews I discovered that much of what leads predominantly women to practice the midwifery model of care helps sustain the continuity of such an approach even within a medical model driven culture. However, that is not to say that the medicalized environment in which they work in, in addition to often collaboratively working with physicians who approach childbirth under the medical model of care, do not affect their profession. According to Midwife B, “a midwife who, because of where she’s practicing, can’t always practice as a midwife and has to succumb sometimes to more of a medical model because of the doctors she works with;” these kind of midwives she terms as “medwives.” The effect of working in the hospital setting is thus the medicalization of midwifery. Midwife B experienced the process of becoming medicalized as a midwife firsthand, which is why she left that particular

hospital to then develop a holistic birth program within another hospital she had worked in previously. As a midwife practicing in the hospital setting, Midwife B explained how “sometimes you get stuck in a rut and you can’t get out of it.” It is almost as if when they lose sight of their passion and their sense of purpose in providing such care, they ultimately lose sight of the midwifery model altogether by working in the hospital setting where the medical model prevails. Midwife A shared with me about feeling for herself the effects of becoming a medicalized midwife in a previous job where she “acted as a physician.” The hospital, the physicians, and the patients she worked with “just wanted someone to get the baby out and the problem is you can’t keep your hands off, medicine you can’t keep your hand off. A woman’s body knows how to do this if you let them be most of the time. And interventions are great if you need them, it saves lives.” With pressure to act in a medicalized manner within the hospital setting and the incorporation of a nursing degree in order to practice the midwifery model of care at all throughout the country, the medicalizing of midwifery is inevitable.

Midwife A shared with me a similar frustration in how drugs and interventions readily available and encouraged within the hospital affect caring under the midwifery model when describing to me the difficulty in remembering that “if we take a step back and let the body run its course sometimes,” which becomes “terribly hard in the hospital setting with monitoring and the current legal system.” By referring to the legal system, Midwife A re-emphasizes the high degree of lawsuits healthcare professionals responsible for providing care through the birthing process face within this country. As she explained, “by working in the hospital it’s a real fear for

midwives especially in a midwife run program with no physician to blame.” Midwifery run programs are found within the hospital in their own designated area where midwives fully control and handle care. The draw to such programs are to receive care under the midwifery model and if anything were to go wrong or become complicated during a woman’s birthing process, she has readily available access to the rest of the hospital where a specialist can take over. It is within such a program however, that a midwife has the potential to be fully blamed for an aspect of a woman’s labor going wrong, and with no ability to displace responsibility onto anyone other than the midwife herself, she may be legally at risk.

As Midwife noted above about the importance of intervention and the medical model when the natural course of birth can no longer continue (which does happen), we are reminded that in order to provide laboring women with the most efficient care in this country, the medical model and the midwifery model must work in accordance with one another, and (ideally), simultaneously once complications do arise. When there is the highest degree of dissatisfaction from patients, and the most inefficient form of care is when the medical model of care is the only form of care provided. It is thus discouraging to find that the current trend is towards midwives becoming medicalized and operating more and more under the medical model of care.

Ultimately, unlike all other developed countries, we find immense utilization of the medical model of care and a lack of the use and integration of the midwifery model in childbirth. In the conclusion to come, I present my recommendations for the way in which I believe we can better utilize such aspects of care the midwifery model provides in order to supply women in this

country with the most effective and efficient form of care in childbirth. I will do so after first addressing next my results from speaking with patients who received care from each distinct models of care.

Chapter 5: Playing Patient

“Giving birth should be your greatest achievement not your greatest fear.”

-Jane Fraser (Weideman)¹³

In childbirth, as Doula A reminds her patients, there is always a “mystery card.” More often than not, our bodies know what to do and we can allow nature to run its course; however, birth is unpredictable, and the experience of birth is never the same. Just as every birth is different, every patient is different as well. Each pregnant woman in the U.S. goes into the laboring room with a different personality, medical history, birth history, age, weight, etc. Because women do not experience birth the same, it makes one question how the standardization of birth under the medical model, through the use of drugs, technology, and interventions, affects the women receiving such care. Through interviewing four women living in the tri-state area, who have experienced birth (most, more than once), I sought to understand the effect the medical model of care has on patients. In order to provide the most advantageous recommendations for our country’s birthing model of care to women, I felt it imperative to understand from the patient’s perspective how the standard current birthing model meets their needs and where exactly the gaps of care lie.

¹³ Birth Without Fear. 22 *Favorite Birth Quotes and Affirmations*. Birth Without Fear RSS. Birth Without Fear, 29 Nov. 2010. Web. 24 May 2016.

It is important to note that prior to meeting with each woman, I knew nothing of their birthing history, their age, or whether they received care under the midwifery model or the medical model. After conducting all four interviews, I found that of this small sample of patients, three received care from an OB/GYN under the medical model of care, and only one received care from a midwife under the midwifery model of care. All gave birth within the hospital, even the one patient who received care from a midwife.¹⁴ Again, though a small sample, these findings support the standard model of care in this country with three out of the four women having received care in the hospital setting under the primary care of a physician.

Within this chapter, I address the common themes that emerged while assembling the birth narratives of each of the four patients I spoke with. Such themes include similar perceptions of birth, a strong notion of fear, and comparable sources of information concerning pregnancy and the birthing process. In addition to discussing such common themes, I will then specifically address from the women who received care under the medical model, both the positive and negative aspects of their birthing experiences, in addition to accounts of their specific experiences with drugs and interventions.

¹⁴ The midwife this patient used has a business agreement of sorts with certain hospitals in order to use their facilities; however, the hospital and its' staff are never involved in the birthing process, they simply rent out a room.

Similarities Among Patient Birth Narratives

Regardless of which model of care they ultimately received, all the patients I interviewed shared a similar perception of birth in addition to similar fears associated with birth. Such similarities are revealed and discussed below through each patient's birth narrative.

The Perceptions of Birth

Midwife B has found that “about $\frac{3}{4}$ of the women I've worked with” over the course of her career, whether they made use of her holistic birth program or not, “have come to me with an initial interest in giving birth naturally without intervention.” In support of such a finding, every patient I interviewed informed me of initially desiring a natural birth as well. Patient B, for instance, had told me she had always “intended on a natural birth” but that she had “read enough to know it doesn't always go as planned.” Some were a bit more adamant about following through with their intentions of a natural birth than the others, such as Patient A, who not only wanted a natural birth, but a natural birth that was “as natural as could be.” Her conditions for achieving a natural as could be birth were to be left alone in a dark room with her husband, “no unnecessary testing,” the baby placed on top of her the moment he/she came out, and for her, “drugs were never an option.” (Patient A, as you may have expected, is the only patient I interviewed who was cared for under the midwifery model of care by a midwife). Because she had run a marathon prior to becoming pregnant for the first time, she explained to me that as a

result she “trusted she could do it naturally and told herself there was no looking back.” Those who were a bit less adamant about an entirely intervention free birth experience were Patient C and Patient D. Both, however, did express their hope to specifically avoid a C-section prior to giving birth each time. Both attributed their understanding that the recovery process is much harder and longer to several friends who had undergone C-sections personally, and therefore explicitly expressed discomfort in the idea of surgery for themselves. Patient C, in fact, informed me of how “the process of labor naturally is important,” for instance, “there is less swelling of the baby by coming through amniotic fluid.” As a personality trait, she also explained how she doesn’t “like excessive processes” and was thus uncomfortable about doing surgery to get her three children out. Patient D had felt her first birthing experience to be such a positive one that she wanted that same experience the second time around. She was therefore “upset about the prospect of a C section” and that she knew for a fact “surgery I’d like to avoid.”

The Fear Factors: Pain and Uncertain Normalcy During Labor

Although these women shared such similar perceptions of birth, even the most adamant patient I spoke with about experiencing a natural birth (Patient A), made a point of noting that her strict birthing plan “would have changed if the health or safety of the baby changed.” Patient D, though serious about avoiding surgery expressed the same sentiment when she stated that, “at the end of the day I’ll do whatever to have a healthy baby.” Herein lies the notion of fear associated with childbirth. It is a variety of fears, which inhibits the natural progression of birth

and generates the ultimate use of drugs and interventions. Through Dr. B's years of working as an obstetrician, he disclosed to me the three most frequent fears he encountered with his own patients. The most common being the fear of pain, the next, fear of complications for the baby, and lastly, the fear of not being in control. There are a multitude of fears associated with birth, however, from this point on, I will only discuss the fears I gathered through interviews with these four patients.

From the birth narratives I personally acquired, I discovered similar trends associated with fear and childbirth, the most prominent is without a doubt the fear of pain. However, an additional fear factor that I found through my own research but that Dr. B did not mention as being one of the three most common, is the fear of uncertainty in the normalcy of the experience of birth. In speaking with these four women, all spoke of how during birth they said something along the lines of "can I do this?" "How long will this feel like this?" And, "is this normal?" Such a factor of fear without a doubt goes hand in hand with the fear of pain, as demonstrated through these patient's birth narratives. In order to most effectively demonstrate such a finding, I present three of the four patient's perceptions of fear associated with their own birthing processes separately as follows¹⁵.

¹⁵ Patient D is not included within such a section only because she did not speak much with me about her fears associated with her births. This is not to say she did not have any but rather that I did not accumulate enough information in order to discuss it here.

Patient B

Patient B responded to my question of what her biggest fears were for each of her two births with the fear of, “managing the pain during labor.” Her desire to avoid pain was evident in discussing the time leading up to her due date, as she explained wanting to “experience it naturally if the pain was manageable” but how while actually undergoing labor she kept “waiting for it to get worse and worse and when is it going to be enough where I need an epidural.” She also mentioned being concerned that she would miss her opportunity to have an epidural because “Sometimes the anesthesiologist is busy or not available and [I] may miss the opportunity.” The pressure to proceed along with the uncertainty of the amount of pain she would be able to handle, led her to use an epidural for both births. Ultimately, Patient B’s fear of pain and fear of uncertain accessibility to intervention at a later time were the driving factors that led her to the use of an epidural, which therefore, ensured her pain would be managed while the opportunity to receive an epidural was readily available.

Patient B, in addition to being concerned about her ability to manage the pain of labor, shared with me her fear of all the unknowns the first time she gave birth. “The unknown was really hard for me to process. How hard is it going to get? How long is it going to take? I think that’s what I struggled against and I don’t think there’s anything that can train you for that.” Midwives instill confidence through retelling stories of births, thus avoiding such fear of uncertainty in their patients. Similarly, Dr. B found through his own work with patients that when he “can remove the fear women have concerning childbirth, they no longer feel the need to

rely on drugs and interventions.” This is specifically demonstrated by the fact that even though he refuses to do elective C-sections, he has never had to refer a patient who had initially expressed interest in such a procedure to another physician who would, unlike him, do it. He’s found that by eliminating fear through addressing them head on with his patients, they do not feel a need or desire to rely on drugs and interventions while in labor.

Patient C

Patient C, just as Patient B, spoke to me about her fear of pain. She received an epidural for all three births through the influence of her friends who told her of the relief they themselves acquired through getting an epidural. Unlike Patient B, however; Patient C felt the need to justify the use of the epidurals by explaining how through each of her long lasting labors she kept asking herself, “how long is this going to last and how much more of this can I take?” She ended our conversation of epidurals by mentioning the stigma associated with receiving an epidural in her mind when she said to me that she knows she’s “soft” for getting one every time.

Patient A

Finally, Patient A, who is the only patient I interviewed who proceeded with two completely natural births both times under the care of a midwife, also spoke with me about her fear of pain and uncertainty in the process of birth in a similar way as Patient B and Patient C had. She told me how, “as the pain builds you ask, can I take this? But there’s really no way to

escape the pain.” What is especially important about Patient A’s birth narrative is that she is the only one of the four who endured the pain entirely naturally without any medical or drug interventions. When I asked her to describe the pain of laboring, she attributed it to being like “waves of pain” while you are enduring contractions and then how later in labor “it’s just about survival.” She explained birth to be very similar in this way to running a marathon, in fact. It is from experiencing the ebbs and flows of pain while running a marathon and the true desperation to simply get to that finish line that she told me made her feel well prepared for the process of childbirth because it was through such a past experience that she could feel confident to “trust [her] body even through all that pain.”

The Implications of Fear

It is through these three accounts that I argue fear is a key factor that leads women within our country to resort to drugs and interventions during labor. From the narratives that I have presented above, it is evident that the fear of pain along with the lack of confidence in the overall process of birth due to the immense amount of uncertainty surrounding the entire experience, for most women, puts them in emotional and physical distress. It is no wonder that without a previous experience (such as a marathon for Patient A), which instills trust and confidence in one’s own body, or someone to assure a woman of the normal processes she is experiencing, a laboring mother finds herself in a distressed state. The result of being injected with Pitocin, is an increased degree of pain a laboring mother experiences due to the forced quickening of her labor.

Such a state of discomfort and distress leads to a need for pain control, which may have never been needed had labor ensued at a natural rate. Women who receive care under the medical model, therefore, find themselves resorting to drugs and interventions, when encouraged and pressured by providers of the medical model whose primary focus is to speed along the progress of labor. In doing so, the side effects of such drugs used to induce labor further increase the need for intervention, such as continuing doses of pain medication.

What is most important to note, however, is that even though three of the four patients I spoke with resorted to drugs and interventions to aid in their laboring process it was not the outcome that they had necessarily wished for. Again, as I discussed, all patients spoke to me about their intentions to birth naturally without intervention. Patient D for instance, also openly discussed with me her intention to avoid intervention but would ultimately “see how it goes.” Although she was evidently somewhat open to the idea of drugs or interventions, she did express an interest in receiving neither because as she explained she “wanted to experience how bad the pain really was.” Although each patient wished to avoid intervention at varying levels, they did each express an initial desire to avoid a certain degree of intervention, which leads me to believe that the fear of pain in accumulation with the lack of confidence through a lack of reassurance in the “what if’s” of birth, we find a gap within patient care among the medical model of care.

Comparable Sources of Information on Pregnancy and Childbirth

As I discussed within Chapter 4, the midwifery model incorporates education in their framework of care, which instills women with confidence and a sense of empowerment going into their birthing process. I therefore, made a point of asking the patients I interviewed what sources they sought out in order to accumulate information about the process of birth.

Patient C

Patient C took no formal informational classes (such as a Lamaze class), and in response to my question of where she gained information on the process of birth she told me that, “you just figure it out. You *have* to figure it out.” Patient D similarly took no formal classes prior to each of her births, however, she explained how in order to understand all of her options she did “individual research on the internet and researched the heck out of everything.” In addition to online research, she spoke to her friends about “what they wished they had done differently” pertaining to their own pregnancies. Predominantly, however, her information, in her own words, was a result of “digging it up on my own.”

Patient A

Patient A was the only woman I interviewed who had taken any sort of formal informational classes on pregnancy and childbirth. She, in fact, began her pregnancy under the

care of her regular OB/GYN who she saw yearly for her gynecological exams. It was not until she and her husband fell upon the Bradley Method that everything changed. The Bradley Method is a method, which encourages natural childbirth that was developed in 1947 by Dr. Robert A. Bradley. This method became popularized after he published his book *Husband-Coached Childbirth* in 1965 and resembles the Lamaze technique by providing comprehensive educational classes to pregnant women and their partners on ways to achieve optimal and healthy birthing experiences. According to *BradleyMethod.com*, “couples are taught how they can work with their bodies to reduce pain and make their labors more efficient.” One way in which this method differs from the Lamaze technique, which Patient A and her husband were drawn to, is its encouragement of the husband or partner taking an active “coaching” role at the time of birth. Herein lies the source through which Patient A received the majority of her information on pregnancy and the birthing process.

I find it imperative to also disclose the birthing experiences Patient A’s mother and sister endured because, as she explained to me, both of their experiences ultimately influenced her own birthing plan. Her mother had “horrible birth experiences;” the first resulted with a C-section in which she did not get to hold or even see her baby for over 24 hours after the fact (this was in the 1970s). Each of her births to follow were not surprisingly C-sections, and as Patient A explained, the most horrible experience of them all was when her mother was receiving pain medication and they “hit a nerve and had to put her down”¹⁶. The strong influence of Patient A’s

¹⁶ Although I never got the chance to ask her specifically, I assume “put her down” meant that she was placed under general anesthesia and a C-section followed while she was unconscious.

mother retelling her experiences of childbirth clearly resonated with each of her daughters because Patient A's sister, who gave birth prior to her, refused any and all forms of intervention, and as Patient A recalls it, "had two days of natural labor" prior to finally giving birth. Patient A was present for her sister's birth and as a result has always had the mentality that "if she can do it I can do it." It is through her hearing about mother's negative experiences with drugs and interventions in the 1970s, and witnessing her sister's entirely natural birth, that Patient A accumulated the most powerful source of information on pregnancy and childbirth. It is with such advice and knowledge on the subject of medical interventions that led her to become so adamant herself about remaining intervention and drug free throughout her own labor.

The Influence of Efficient Sources of Information

Properly educating women about the experience of birth is a major aspect of my formal recommendations for a more efficient model of care within this country concerning childbirth, which I will present in my conclusion. By asking the patients I interviewed what sources of information they used prior to their own birthing experiences, I was able to gain a better sense of the different avenues women use in acquiring useful information on the subject of childbirth within this country today. I argue that with proper sources of information provided to expecting mothers we can help remove the fear factors associated with birth, which I have presented above. For women who have not experienced an event similar to childbirth such as a marathon or observed someone else's birthing experience (as Patient A had), such proper educational

resources are imperative to reaching the ultimate goal of an intervention free birthing experience. That is not to say that Patient B, Patient C, and Patient D did not reach their own birthing goals because they received medical interventions; however, I do believe that many women within our country miss out on the opportunity to experience birth in a way they initially desire but would never even know exists due to unnecessary medical interventions provided within the hospital environment, which tends to hijack the female experience of birth. Once a woman in labor agrees to any sort of drug or intervention within the medical model, they fall onto what I like to call the “conveyor belt of interventions,” where one intervention quickly leads into the next. Such a process ends by ultimately stripping away any responsibility and control a woman possessed over her birth in the first place. It is from this point that she becomes the sick patient and the doctor the expert. With the ultimate goal in birth to bear a healthy baby, as long as this is reached, women tend to recount their childbirth experience as a successful one. However, the experience of childbirth is so much more than the production of a healthy baby and it is my project of passion to aid in bringing all the possibilities to light. Therefore, it is from my discussions with patients, physicians and midwives alike that I can confidently contend that with proper education of all her options, an expecting mother can help prevent falling victim to such unnecessary interventions and avoid being placed on the conveyor belt of interventions, which often leads to a C-section.

Recipients of the Medical Model of Care: Their Experience

It is only through the personal accounts of patient's experiences under the care of the medical model that one is able to see the effect such a model has on women's birthing experiences within this country. In this section I present patient's perceptions of the positive and negative aspects of the medical model. To begin, I present the kinds of intervention each patient endured in their birthing experiences and their opinions of such.

Experiences of Being Induced in Labor

The first form of intervention I will discuss through the accounts of the patients who I interviewed, is induction. Merriam-Webster defines the word induction as "the act of causing or bringing on or about," and the induction of labor is just that; any act that causes a change in the female body in order to bring on the process of labor. Such acts vary across the spectrum of medicalization from least invasive acts such as stimulating the nipples, exercising, or even eating spicy foods; however, for the purpose of this discussion, I will focus on the most invasive and most utilized methods of induction used within the medical model approach. Such methods include the scraping of a woman's uterine lining, artificially breaking a woman's amniotic sac (aka "breaking her water"), and infusing intravenous fluids or injecting Pitocin¹⁷ intramuscularly.

¹⁷ Pitocin is a clear, sterile, aqueous solution of synthetic oxytocin and is a chloroform derivative. By injecting this hormone, it speeds up contractions of labor and thus aids in the progression of labor (Newkidcenter.2016).

Patient B

Patient B was four days over her due date when her physician made the decision to induce her by first manually breaking her amniotic sac and then injecting her with Pitocin to speed her labor along. As she explained to me, the pain was “so unbearable as a result of being induced” that 4-5 hours after the induction she chose to get an epidural in order to reduce her pain. She said that she understands “after getting an induction things speed up a lot and thus the pain.” Patient B’s second labor process began naturally by her amniotic sac breaking on its’ own while she was at home. Upon arriving at the hospital she walked around for six hours in the attempt to “get labor going” on her own but was ultimately convinced by her OB/GYN to be induced. After Patient B continued to refuse her doctor’s preferred choice of inducing her to speed her labor along and instead walked the halls for six hours, her doctor presented the option over and over again until Patient B finally gave in to the pressure after being told by her physician that she was putting her baby at risk by waiting too long after her water breaking “because it could lead to infection.” Once induced, Patient B pushed for a total of 5 minutes and her second child was born. Once she gave birth so quickly after being induced, her doctor turned to her and told her that had she “delivered earlier we could have all gone to dinner earlier.” Patient B explained to me her interpretation of her doctor’s comment; “The impression was that she was giving me a choice, but then she seemed a little resentful I didn’t take the opportunity sooner. She really had a choice in mind and I didn’t take the right one.” It was from such an

experience that she felt all along she had been on the schedule of her doctor and not the schedule of her own birth, and that felt wrong.

Patient C

Patient C gave birth to her three children within a program that provides primary care by a physician with a midwife present. Rather than provide the kind of care I described within Chapter 4; however, the midwives in this specific practice seemed to take somewhat of a backseat in which they acted more as a labor nurse, which is why I do not categorize the care she received as being under the midwifery model. This is important in order to understand the care Patient C received and the intervention she experienced. Concerning induction, Patient C explained how during her third birth she was 40 weeks pregnant and “done being pregnant.” She told me she thought about being induced with Pitocin but that one of the midwives in the practice took her “through that option fully” and in the end she decided that “it felt wrong” because she “would be playing God and there was nothing actually wrong with [her]” to speed up labor using drugs. Instead she opted to get the membrane of her uterus scraped and labor began shortly after. Upon discovering that her baby was posterior¹⁸ it was not long into her pushing that the baby’s neck got stuck. At this point she explained to me that “the epidural was not enough” and so she opted for stronger pain medication called Phenol. The result of receiving Phenol was that her fever went down and the baby’s heart rate went up. The doctor then turned to her and said “you need to do something now,” she replied, “just get the baby out.” Ultimately, Patient C’s third

¹⁸When the baby is head down but facing the mother’s stomach rather than her back

child was vacuumed out of her birth canal. “Her head was bruised and misshapen but it did not matter because she was healthy and nothing was wrong with her.” Had the vacuum not been effective in getting her out, Patient C told me that “a C section was the next option,” even though going into each of her three birthing processes that was the one form of intervention she had wished to avoid.

Patient D

Patient D had her water broken manually by her physician and was “not entirely sure why.” Though never informed why, she presumed that “it hadn’t happened naturally and labor was progressing” and in the end “I think what they wanted to happen happened.” Ten hours into natural labor she opted for an epidural and “laid down from that point on” because she “was exhausted, wanted to sleep,” and after walking and using a birthing ball in attempt to move her labor progression along naturally, her husband told her, “enough is enough. Get the epidural.” Upon awaking after a long time asleep, she received another epidural and asked “in order to avoid a C section” for them to scrape her membrane, which caused “excruciating pain,” but her labor as a result began to hasten. In her opinion, “the epidural helped my experience because I was able to sleep. I was so exhausted.” What she disliked concerning intervention was the “monitors and being hooked up because it’s uncomfortable and frustrating. But it’s a necessity because so much can go wrong and when you’re a mom you’re worried all the time.” She tolerated her frustration and discomfort throughout monitoring because she “just wanted to be

assured” that everything was as it should be throughout her labor process and that “if something went awry, we could address it quickly and easily.”

Through these three patients accounts, it is made evidently clear that through being induced in various forms, they were all able to move their labor process along more quickly than had they not been induced. In the hospital setting, under the medical model of care it is not surprising that they all experienced such intervention because that is the standard of care; to move labor along as quickly as one can. Any means available to do so are, as demonstrated by these women’s accounts of being consistently encouraged and in some cases somewhat pressured by physicians onto their patients through the tool of fear, or as Doula A termed, the “dead baby card,” which gives women no other option than to comply.

The result of the initial intervention is merely more interventions to follow for the patient. As I mentioned earlier, she is placed on a “conveyor belt of intervention,” in which the interventions only increase and become more and more invasive. What I find most perplexing about increasing intervention with the process of childbirth is that in all other areas of medicine, the medical model standard has been to perform treatment and surgeries in the least invasive manner possible. Doula A was the one to have brought such an anomaly to light when mentioning to me how “in every other area of medicine we seek to minimize the amount of disruption to the body.” She specifically made her point through comparing childbirth to the transformation we’ve seen in gallbladder surgery over the years;

“20 years ago, if you had to get your gallbladder taken out they cut from almost your diaphragm all the way to you belly button. They basically filet your abdomen. Today, it is

done laparoscopically and the patient is home in a couple of hours. And isn't that great that we found a way to solve the problem by causing the least amount of distress to the body?"

How is it that we've gone in the complete opposite direction concerning childbirth within this country? As Doula A explained, and the patients I interviewed supported, today, "most people recognize surgery is not the ideal and our bodies were designed to birth our babies. But there's just so much fear attached to it." The fear attached to birth is not only coming from the patients who physically experience the birthing process, but equally from the providers of care in childbirth. It is within such a fearful climate that make interventions seem to be the most optimal choice, and yet, after the initial intervention is performed, the fear only grows as the body is put into either rapid progression of labor or the mother and child are physically and emotionally put into a dangerous degree of distress. The latter case scenario was one in which Patient C, following an injection of Phenol, experienced a decrease in her body temperature simultaneous to an increase in her baby's heart rate. It was at this time that her OB/GYN told her it was time to "do something," and by this, she was referring to a C-section. It was Patient C's last ditch effort in order to avoid surgery by instead opting for her doctor to vacuum her baby out of her. Patient C's birth narrative of her third child exhibits how patient's unknowingly find themselves on the "conveyor belt of intervention" and quickly become face to face with a C-section as the only option left in order to save themselves and their baby. The moment emerges where it is clear to all involved that someone must "do something" to get the baby out; and with so many drugs and interventions prior to this point, that have in actuality contributed to this moment of complete

desperation and state of emergency, surgery is the only answer. Ultimately, it is fear that has led us to this point, and it is fear that will perpetuate the medicalization of childbirth if not addressed.

Experiences With Scheduling

Another commonality I discovered among all the patients I spoke with who received care under the medical model by physicians, which I briefly mentioned with Patient B's induction experience, is the importance of scheduling and both the negative and positive effect that had on each of their birthing experiences.

The positive aspect of such scheduled and standardized care to the patients I spoke with was the professional and organized manner in which they received care. For instance, upon asking Patient B the strengths of the care she received she explained appreciating the "organized step-by-step" manner in which she was cared for by her physician and nurses within the hospital setting. Additionally, Patient B described her OB/GYN as being very "knowledgeable," which Patient D also spoke to when she explained how she "never felt she wasn't with a professional" and that she "felt at ease in the hospital setting" knowing that if something were to go wrong, she was where she was meant to be, with those most equipped to handle complications in labor.

The scheduling approach to care, although organized and professional, was predominantly perceived negatively by the patients I spoke with. For instance, Patient B explained how "OB/GYNs make you feel like there was a schedule" and only saw her doctor

three to four times prior to the delivery itself. In the meantime, she was cared for by various labor nurses who switched according to their shift schedule (this means she never had the same nurse by her side for too long). In comparison to her OB/GYN who she saw barely ever, Patient B spoke to how “the nurses were very warm and supportive” especially comparably to the OB/GYNs who were “clearly there for a job and then out,” which they made evidently clear through the way in which they “never seemed to linger.” Patient D agreed with being “surprised how little you interact with your doctor” and expected more. She, in fact, compared it to going to the dentist where “you spend more time with the nurse than the actual doctor himself,” and the care provided she also explained to feel “very in and out.”

Patient B also spoke to me about the strong sense of strict scheduling and management surrounding any form of intervention proposed by her doctor and thus the pressure and even guilt she was made to feel as a result. Again, as I mentioned above, Patient B felt her OB/GYN had given her the perception that she had a choice to be induced or not, but when she chose instead to walk around for six hours, she was made to feel she had made the “wrong choice” in the end. As she explained to me, “my body was ready but there was no danger and my child wasn’t too large,” and yet, her doctor “seemed resentful that I chose the wrong choice.” It becomes more about the doctor’s schedule and the convenience of when to intervene for the sake of their schedule rather than the wishes of the expecting mother and her body’s own natural schedule. Doula A expressed a similar experience with one of her own births when her doctor made her

feel a sense of guilt for going into labor when she did. She told me how she was made to feel bad for “having the audacity to go into labor on Friday night when my doctor had things to do.”

What also emerges out of speaking with these patients is the way in which they felt they weren’t actually given any real *choice* in their own birthing experience. For example, as Patient D explained, “everything has to be so scheduled and I was told what to do just because,” it made her feel that she was being “led through it” somewhat blindly by her doctor. In the end, she had wished she was given more options rather than told what to do as interventions increased and complications emerged as a result. Patient B also spoke to feeling she was not prepared well for the “full experience” of birth. For instance, visits to the doctor prior to going into labor “were all focused on medical health rather than my emotional health,” but that “sometimes the nurses talked to her about life and kids,” which she appreciated during those visits. Looking back on her experience, however, there was “no time spent discussing the right choice for me” or time spent “weighing the pros and cons” of all the options. It is from these accounts that I see an additional gap in the care provided to expecting mothers in birth, which is the lack of feeling prepared, not having a voice or choice, and finally not receiving any emotional support from their physicians but rather from the nurses.

Patient D: Case Study

Patient D had an extremely unique experience under the medical model of care, which by walking through in detail, demonstrates very well each of the negative aspects patients of such a model revealed to me and as I discussed above. By presenting her experience as a sort of case study, I intend to more explicitly reveal the collective response of all the patients experiences with the medical model approach to care of whom I interviewed.

With Patient D's second child, she routinely went in to visit with her doctor who, upon examining her at 38 weeks into her pregnancy, found that her baby was not only much larger than her first born but was breach. What this means is that her baby was facing in an improper birthing position in which he was in what is called the vertex position ("butt up") rather than head-down. Because women typically go into labor naturally anywhere between 39-40 weeks today, at 38 weeks, with a large, breached baby, Patient D's OB/GYN was feeling the pressure and overcome with fear of all the "what ifs." Evidently, she redirected such fear and pressure onto Patient D by in her own words, "really pushing to schedule a C-section." Against her own will, Patient D complied and together they scheduled a C-section at 39 weeks seemingly on Patient D's part in order to ease her doctor's personal discomfort in her now identified "complicated" pregnancy. In the meantime, Patient D asked prior to the scheduled C-section to schedule an external cephalic version (aka version)¹⁹ in her last attempt to give birth vaginally.

¹⁹A procedure used to turn a breech or side-lying (traverse) positioned fetus into the proper head-down (vertex) position, in which a medical professional attempts to move the fetus using their hands over a woman's abdomen.

Her OB/GYN was extremely hesitant about performing such a procedure, the reasoning Patient D explained to me as being that versions are “not something they do often so they are more apt to do C sections because it’s what they know and few doctors of the practice I use have actually done it,” her physician at the time included. Because of her physician’s own fear of performing such a procedure with which she had never done before, she attempted to dissuade Patient D’s wishes to try a version by instilling fear of pain and fear of endangering the baby onto her patient by telling her the “risky and painful” nature of such a procedure. Whether it was because this was her second birth and therefore she had gained confidence in the process by experiencing it once before, or it is simply an aspect of her personality, but Patient D sustained her own wishes and demanded to proceed with a version.

She explained feeling the day of the procedure “as if I were going into labor. You pack an overnight bag, once you get there you’re hooked up and you’re on a hospital bed.” Medical students were in the room when she arrived because of how rare such a procedure was and she was feeling discouraged, “I didn’t expect it to go well.” She told me that she “felt really *weird* about the whole process” and kept thinking to herself “what are we doing here?” Prior to beginning the procedure, Patient D’s doctor checked the positioning of her baby once more and discovered he in fact flipped over on his own and was in the proper head-down position. It was at this point in Patient D’s retelling of this experience that she revealed to me how prior to the scheduled version, she researched and performed several home remedies and was convinced one of them worked. For instance, in the attempt to reposition her baby she “remained in several

yoga positions for long periods of time, which are thought to encourage the infant to move.” She also massaged her stomach and “placed an ice pack on the uppermost part of my stomach with the idea that the baby moves downward because he is discomforted by the cold sensation up top.” Whatever was responsible for making her baby flip over, it was clear that it had nothing to do with any drugs, technology, or interventions that the medical model of care would have provided to her.

Patient D’s story only continues. At 40 weeks and exactly one day after her due date, her doctor told her it was time to schedule a C-section. She explained being “very confused because I thought two weeks post due date is when we’d consider it, it’s only been one day!” The primary reason for scheduling the C-section was that her doctor was not going to be available the following week, and she made it very clear to Patient D that they had to do this now or else she wouldn’t be able to be her provider of care through her birthing process were she to wait for it to happen naturally. Patient D explained how ultimately her doctor, “wanted to do the C section because of her scheduling but this is my baby not about your schedule.” In order to, “take away from the C section, I asked her to scrape my membranes instead and she did it right there. It was excruciating pain and I ultimately did it for her convenience. I really wanted to wait but she was pretty adamant.” Even after scraping Patient D’s membranes, her doctor went through with scheduling the C section “just in case.” Much to Patient D’s relief, she experienced contractions the very next day after having her membranes scraped and avoided the surgery her OB/GYN pushed so eagerly and actively for.

It is through Patient D's detailed account of her second pregnancy with which we find the effect the medical model of care can have on expecting mothers receiving such care. Not only was scheduling a prominent determinant of the care she was provided (scheduled for the physician's convenience that is), there are several moments within her narrative where she was instilled with fear under the medical model rather than provided the facts along with all her possible options. Once her pregnancy had in her physician's eyes become complicated, she was given few options and a lack of control; as explicitly demonstrated when she explained taking a step back and asking "what are we doing here?" Patient D instead decided to take on full responsibility of her own birthing process and did the research on her own. This led her to perform techniques at home, which she read had some efficacy for other women in repositioning a breech baby, and in the end, one of which seemingly worked. She also demanded the scraping of her membrane prior to resorting to surgery; however, had she not taken on such an active role as the patient and instead played along with the sick patient role, she would have found herself on the conveyor belt of intervention unable to get off until surgery was complete and her baby was out. It is under this standard medical model of care in childbirth that patients first and foremost perceive such care to include scheduling for the wrong reasons, that is not scheduling around the needs of themselves and their babies but rather around their physicians. Second, they felt somewhat coerced and guilted into interventions to some degree with which they had the intention to avoid at all costs. And third, patients revealed to me as feeling unsupported, uninformed, and undervalued through their physician's lack of time spent with them concerning

both quality and quantity. From my interviews, it is encouraging, however, to see how many of these women at some point in their birthing process took responsibility of their own birth and played an active role in avoiding interventions they did not desire to resort to and they knew they did not have to succumb to in some way. It was by doing so that they were able to all successfully avoid a C-section, which was the goal of all of their birth plans.

Interventions Experienced Under the Midwifery Model of Care

Within this discussion of interventions under the medical model of care, I find it also important to acknowledge the types of interventions Patient A experienced under the midwifery model of care and her perceptions of such. In presenting an account of a patient's perception of interventions under the midwifery model of care, I hope to instill the understanding that interventions come in many forms concerning the process of birth and vary widely in their degree of invasiveness to an expecting mother. The kind of intervention, which Patient A encountered during her birthing experiences was monitoring. She specifically recalled how the worst part of her experience the first time around to be, "when I got to the hospital, the midwife wanted to check me and I didn't want it. Then, she wouldn't let me get onto the toilet until she checked me." She told me how she was very frustrated and complained to the midwife about not wanting to be checked or monitored because that was a part of her birth plan, which she was very adamant to stick to. For the first birth she was also annoyed with how frequently the midwife

came in to check on the baby once she gave birth, Patient A said, “it was too many times and was very annoying.” Concerning her second birth experience, she was told by her midwife that the nursing staff at the location she gave birth at the first time around had an issue in which “certain nurses weren’t allowing the natural process” of birth, and thus encouraged her to go to another hospital location this time. It was her birth plan to have a water birth²⁰ for her second child in the hope to reduce the degree of pain she would feel. Prior to getting into the bath however, she was forced by her midwife to be monitored for twenty minutes to ensure the normalcy of her baby and her own vitals. This, she told me made her “feel restricted” along with being uncomfortable and again, the annoyance of it all. Patient A’s perception of the degree of intervention she experienced speaks again, to the varying degree of intervention a woman may face while giving birth as well as the fact that interventions occur across models of care, not just under the medical model.

Patient A’s account of intervention under the care of a midwife also supports the concept of the medicalizing of midwifery, which I mentioned in Chapter 4. Because Patient A’s midwife worked within the hospital setting, she was inhibited by the hospital's strict protocols concerning monitoring to adhere fully to her patient’s birth plan wishes. Midwives constantly face instances such as this one within this medicalized climate of birth, especially working within the hospital setting; and it is through Patient A’s frustration and complaint about such unnecessary

²⁰ A water birth is when a woman gives birth while in water, normally a large tub is set up within the home or the hospital setting in order to facilitate this.

intervention that we can see the effect the medicalization of midwifery has on the patients themselves.

The Female Experience of Childbirth

My final question to each patient I spoke with was, “what was the single most memorable moment of each of your birthing experiences.” By asking such a question, I had hoped to gain a better sense of what specific aspects or moments during birth women today in this country experience as the most emotional or moving moment. Again, I stress how lost the emotional experience of birth (or as I’ve previously referred to as the “female experience”) is within the typical American birthing experience; and with the intent to ultimately bring such an aspect of birth back through changes in the standard framework of care concerning birth, this question had the potential to reveal something special about the subculture I have been studying over the years.

Ultimately, the responses I received by asking this question did in fact shed light on a deeper dimension of childbirth, which I was pleased to find still existed even under the constraints the medicalized approach to birth has on the female experience of childbirth. I will focus particularly on two of the responses I received, one from Patient A who experienced birth under the midwifery model of care and the other from Patient B who received care under the medical model. In revealing these two particular responses, I intend to define the female

experience with which I hope to promote through means of my ultimate recommendations for the standard of care provided in childbirth.

In response to my question, Patient B told me how the most memorable experience for her births was the way in which they were both a “primitive experience even with the medical surroundings.” Specifically, she most nostalgically recalls the moment she received her epidurals and both times broke into tears because, “the nurses grab you and it creates this mothering sort of moment, the caretaking. And I think the nurses really create that environment more so than the doctors that you’re being cared for and that’s a really interesting thing, especially for the person who is about to be the caretaker.” Patient B laughed a bit to herself when she realized how this was the most memorable and “primitive” moment for her, and “yet the most medical moment” at the same time. Another interesting aspect about this moment that Patient B pointed out was how “your spouse can’t really touch you during this procedure, I think he could only hold my hand, so it’s really just you and the nurses” that create this entirely female support system and in her opinion created a “pretty powerful” moment for her in both births.

Patient A, similarly spoke to me about her most memorable moment in her first birth being when she was on her side holding her midwife’s hand and her husband’s hand simultaneously while she pushed. She ultimately gave birth in this position and recalls not wanting to let go of specifically her midwife’s hand because, as she explained to me, “I felt like if I let go of her hand, everything would fall apart.”

The most compelling aspect of such similar responses to my question is that they are from two women who experienced birth in completely different ways under the care of two different models. Even so, they distinctly recall a moment during their birthing process where they had a true female experience. Whether it was with a midwife or a nurse, they both expressed this indescribable and inexplicable connection with a female figure who had experience in childbirth personally and was passing it on (simply through touch) to each laboring mother. It was such a moment that resonated powerfully within each of these two patients who I interviewed, and that is the female experience of birth with which I had hoped had not been eradicated through years of medicalizing birth within this country and is the moment I intend to promote through my final recommendations.

Conclusion

“Birth stories told by women who were active participants in giving birth often express a good deal of practical wisdom, inspiration, and information for other women. Positive stories shared by women who have had wonderful childbirth experiences are an irreplaceable way to transmit knowledge of a woman's true capacities in pregnancy and birth.”

-Ina May Gaskin, *Ina May's Guide to Childbirth*²¹

I began my research on the medicalization of childbirth with the intention to show how the surprisingly high infant and maternal mortality rates within this country are partly influenced by our medicalized standard system of care provided to women in childbirth. I conclude, however, with a different objective. In conducting my own interviews with patients and providers under both the medical and midwifery model of care, what has emerged is an even deeper understanding of the gaps in care, which have negatively impacted outcomes. I consequently find it my obligation to provide recommendations in order to improve the birth model of care based on the results of my own research.

It is through my research on this subject that I recognized, beyond our country's statistics on infant and maternal mortality rates, childbirth within this country is ultimately surrounded, controlled, and imposed by fear. Physicians fear possible litigation for not doing or using everything in their power to save a mother and child. Midwives are fearful of the medical model

²¹ Goodreads. *Ina May Gaskin Quotes*. Ina May Gaskin Quotes (Author of *Ina May's Guide to Childbirth*). Goodreads Inc, 2016. Web. 23 May 2016.

in which they practice under in the hospital setting to have an effect on their distinct beliefs about and approach to childbirth. Most importantly, the experience of birth for patients has become clouded by all the fears surrounding the process. These fears lead to an over-reliance on medicine, technology, and drugs. Therefore, I believe that in order to improve upon the care provided to women in this country, the solution lies in finding and eliminating such fears, rather than placing blame on one party, as we so often times do. What I present in these concluding sections is first, an ideal solution, followed by a hopeful solution, only to conclude by offering the most likely accepted and easily integrated recommendation to improve upon the current dominant system of care provided to expecting mothers within this country.

The Ideal Proven System of Care

Ideally, the United States would follow what Dr. Wagner calls the “Proven System,” in which 70-80% of births are handled by midwives and the complicated cases are handled by physicians (*Business of Being Born* 2008). Unlike most developed countries in the world, however, the United States practices a system in which 88% of births are handled by physicians (CDC 2014). Through such a reversed system of care, compared to the rest of the world, one would expect the United States to have done so in order to benefit the quality of care provided to expecting mothers. It is from the feedback of such a system, which I accumulated through my own interviews, in combination with our country’s poor standing concerning maternal and infant mortality rates that I can confidently say, such is not the case.

The history of midwifery, as discussed in the Chapter 1, speaks to the way in which the United State's present system of care surrounding childbirth is significantly culturally constructed. Due to the move from birth in the home handled by midwives, to hospital births managed by physicians (around the mid 1900s), birth became a business in this country in which the medical model of care reached ultimate dominance through means of eliminating the midwifery model of care altogether. Whereas, everywhere else in the world, there was a trend of integrating the two models of care in order to provide the best quality of care to expecting mothers.

Because we are unable to change history, such a proven model does not exist. It is also unfortunate to confess that such a proven model *cannot* exist within this country. Through the removal of the midwifery model approach to care for a period of time within this country, the result has been a fairly recent reconstruction of midwifery seen nowhere else in the world. With the creation of the Certified Nurse Midwife, we were able to reintroduce such an essential model of care back into birthing in a way that our medicalized society would somewhat accept as a legitimate provider of health care. Upon the introduction of the midwifery model and the care such a model provides, women within this country have come to find that where the dominant medical model approach provided by physicians falls short, the midwifery model makes up for.

There are many implications of not having the proven system of care here in the United States, the most significant being that women within this country are not provided emotional support, educated on all their options, or possess a sense of control, choice, and thus

empowerment, in their own birthing process. Although the concept of midwives has a connotation in our culture as being medieval or archaic, and thus inferior to the care provided by trained surgeons; every patient and physician I spoke with indirectly spoke to the importance, need, and desire for such aspects of care, which midwives provide under the midwifery model. Physicians spoke to the way in which women should have support while in the birthing room in order to make their job easier, while patients had wished to have been better heard by their physicians and better informed on their options in preparation to and during labor.

The ideal solution of already having the proven system in place, in which the majority of births are handled by midwives and only the complicated cases handled by physicians, is simply not the case within this country. It is due to the history of midwifery and our business minded culture that our standard birthing system has become so medicalized; as demonstrated during the period of industrialization within this country, when care provided to women during childbirth became more about creating a new business (the hospital), and fighting for clients rather than providing the most efficient care to these women. Additionally, the replacement of our current standard system of care surrounding birth with that of the proven system is simply inconceivable due to the medicalized society we have come to be. And so I digress from this unrealistic ideal to a more hopeful solution in order to improve the system of care provided within this country in childbirth.

Birthing Centers as the Standard of Care

A birthing center is a medical facility that specializes in childbirth and provides a less restrictive, more homelike, environment in comparison to the hospital setting. Birthing centers are a new and continuing trend throughout the field because they remove birth from the hospital setting and yet possess all the tools, technologies, and medical professionals to provide the same care you would receive in the hospital setting. My recommendation would be to implement birthing centers as the standard system of care for childbirth here in the United States. I regard birthing centers as such an important tool in revolutionizing care provided within this country due to the fact that they are a freestanding facility, meaning they are “separate from acute obstetric/newborn care with autonomy in formulation of policy and management of operation,” as explained by the American Association of Birth Centers.

I more specifically envision the establishment of birthing centers as the standard of care within this country as follows. Physical birthing centers would be built and run by midwives regionally. Women would be assigned to a birthing center based on where she lived and would attend such a facility upon conception or in order to seek education and other resources to better ensure conception. Such a facility would incorporate educational resources, gynecological exams, routine check ups, testing, and ultimately be the location for actual birth in the care provided, surrounding all aspects of pregnancy. It is also my hope that *all* women upon conception would first visit their local birthing center. Because there are many cases in which a woman is considered to have a complicated pregnancy from the beginning, such patients would

then be referred to by the midwives to a local OB/GYN specializes in the care they require. It is with such a standard system of care that quality of care surrounding birth within this country would benefit all those involved in the ways that follow.

The establishment of such a standard system of care within this country would first and foremost aid in reducing fear surrounding childbirth, which I argue is the fundamental force driving all parties to intervene and promote unnecessary interventions. By creating a one-stop-shop in which women can routinely visit for all her needs prior, during and after giving birth, they will gain a sense of familiarity and trust in the individuals providing care to her within such a facility. This system of care additionally makes receiving care and educating oneself on the experience of birth extremely convenient and easily attainable and accessible. In order to experience such convenience and obtain control over their birth, women in the current climate of care try do so through unnecessary interventions, such as planned C-sections. By giving birth within a non-hospital setting, the fear produced by feeling pressured to intervene by providers of care, as well as through the knowledge of such technology and drugs as being readily available, is reduced and women can therefore focus more on their individual needs, desires, and hopes for their own birthing experiences.

Another advantage of instilling such a standard of care is to benefit the actual providers of care. As an ideally midwifery run facility with on-call physicians available should complications arise; midwives would have the ability to practice their approach to care without the constraints and pressure of working in a hospital setting under the medical model, in which it

is easy to become medicalized themselves (recall the term “medwife”). Physicians are trained surgeons; therefore, by remaining in the hospital setting handling the complicated cases of birth, they thus are able to do what they were trained and socialized to do best within their field of work. It is also through such a hopeful system of care that malpractice suits will decrease. The reason being, women under this system are encouraged to take control and thus responsibility over their own birthing experiences by taking educational classes at their local birthing center. In addition, by normalizing birth through such facilities being midwifery run, women within our culture will come to understand that actively *doing* and *using* everything available is not what constitutes good quality care received in birth, but is rather a more holistic approach to care, in which the expecting mother is heard and respected. By creating a sense of familiarity in attending the same location for care, as well as instilling strong relationships built on trust through the integration of birthing centers as the standard care of model, I therefore foresee improvement in the gaps of care I found while conducting my own research, more content providers of care, and fewer malpractice suits against physicians within this country.

Knowledge is Power

Because for so long our country has followed a dominant model in which physicians handle the majority of births, it is ultimately unrealistic to imagine a major shift in the structure of care we provide to expecting mothers. If I learned anything while traveling to the Netherlands,

Canada, and England it is that no one system is perfect in handling birth and yet, we can learn immensely from specific aspects of one another's systems of care in order to improve upon each of our varying dominant models. Realistically, it is my most feasible recommendation to improve upon this country's current system of care by encouraging education and changing the information provided to all concerning the experience of childbirth.

As part of their curriculum, physicians must be educated on completely natural births if they are to remain the dominant provider of care within our standard system of care surrounding birth. Because physicians within this country are educated and socialized during medical school, residency, and on to specialize in handling complicated cases without ever even witnessing an intervention free birth, it is no wonder we find the 32.7% C-section rate within this country (WHO 2015), as opposed to the World Health Organization's recommended 10% (WHO 2016). Rather than focus on implementing the medical model approach to care within the practice of midwifery through the required nursing degree for a CNM, it is time to similarly integrate the midwifery model of care into the education of physicians. Such may be accomplished by requiring a course or period of time during physicians educating process, in which midwives and physicians practice and learn simultaneously. This was shown to be effective for Dr. B, for instance, who spent a period of his residency working directly with midwives and was thus exposed to their distinct approach to childbirth care. Ultimately, this led him to practice in a more holistic manner than had he never been exposed to the midwifery model at the early onset of his professional career. As the saying goes, you can't teach a dog new tricks; however, a

puppy on the other hand (who is still in the process of learning), can be taught a lot. Therefore, I find it most effective to integrate these two models prior to midwives and physicians becoming professionals but while students, and thus as equals. In such a case, both types of providers equally accumulate the knowledge and understanding of each approach to care. They are also provided the opportunity, through such awareness, to utilize aspects of each model in order to administer the best quality of care to their patients and improve upon the standard of care contributed within the field of birth in this country.

Women also need to be educated in order to normalize birth. Patients receiving such care must be better educated and, therefore better prepared for childbirth within this country, in order to help remove their fears associated with the process of birth, as well as to improve their overall experience of birth. It is through a perception of childbirth as a normal and natural event that women can feel more confident in taking control over their own birthing experiences. According to Dr. A's feedback, patients who take responsibility of their own birthing experience through education and emotional preparation are his favorite kind of patients to work with. More importantly, he said that these are the women who "do more to get the births they want and in the end just have better births." Through acquiring useful and accurate information on the overall experience along with their available options, women can ultimately gain confidence and trust in the overall process. With the lack of classes being utilized as they used to be through programs such as Lamaze or The Bradley Method, I urge to reintegrate such educational courses back into the system of care surrounding childbirth. According to the doula I interviewed, it used to be in

this country that a woman's significant other had to take Lamaze courses with her in order to be present in the birthing room²². This requirement ensured both individuals were prepared for such an experience as birth. I would recommend that such a requirement is reinstated in order to not only get women to begin taking birth classes again, but also to hopefully create a stronger support system within the birthing room through additionally educating anyone who wishes to present at the birth. With proper emotional support (that physicians do not feel is a part of the care they provide to their patients), administered by the individual or individuals who attend such educational classes with the mother-to-be, I am hopeful that the climate of fear surrounding birth for all involved will decrease. As the doula I interviewed puts it well, "Women today need to understand the fear they experience is not just about the pain, it is about learning about the physiology and dealing with your fears, which is so lost today." Therefore, in order to help remove the fear surrounding the idea of childbirth, women in this country must take responsibility of their own births. In doing so, reliance on the provider will lessen, and the fears midwives, physicians, and patients all experience, which lead to unnecessary interventions, will thus be reduced.

In addition to improving upon the education of providers and receivers of care; by more broadly educating our society on the topic of childbirth, I believe that it is very possible to normalize birth without implementing the proven system seen around the world or even birthing

²² Although I was unable to find this explicitly stated in any literature, the doula I interviewed was adamant about this being the case at a point in her career. After contacting her again to confirm she granted permission to quote her directly.

centers as the standard system of care, for that matter. For instance, I recommend we begin to advertise birth as a natural and normal event through sources such as the media. More specifically, there is power in depicting more natural childbirth scenes in movies, TV shows, as well as having celebrities speaking out about their own natural birthing experiences. We as a culture are highly influenced by celebrities and the media; therefore, rather than more readily advertising designer births and planned C-sections celebrities are undergoing; what is more effective in promoting a new trend of de-medicalizing our country's standard system of care is to more frequently acknowledge all the natural and normal birthing experiences celebrities are having around us. As discussed in the Chapter 1, consumers interest in interventions within this country (as well as the UK) surrounding childbirth, was partly due to the status symbol that came along with receiving the newest drugs and modern technological tools and devices. Today, in the technological world we live in, social media is a powerful tool to be used in order to establish natural birthing experiences as the posh thing to do. Such exposure to natural births in the media will also encourage the talk of normal birthing experiences rather than highly medicalized experiences among everyday social interactions. As the consumers of such care with a great deal of control over the current system of care, we as a culture have the potential of shifting the perception of birth, and therefore, reduce the current medicalizing trend in the United States.

The degree of medicalization concerning various conditions within our culture operates on a continuum of sorts, the most severe being.... Childbirth, though not formally regarded as a disorder or illness, has been treated as such for years through the standard system of care

provided to women being that of the medical model approach predominantly over that of the midwifery model approach. As historically demonstrated by a once highly medicalized condition called Onanism (the act of masturbation) throughout the 18th century²³, medicalized conditions have the potential of becoming de-medicalized. To further my argument, it was through normalizing and familiarizing ourselves with the concept of masturbation as a culture that led to it becoming completely de-medicalized. As Dr. B said to me concerning the fear surrounding childbirth in this country, “how do you get rid of the fear? The familiar,” and in a similar way in which numerous previously considered medicalized conditions have become normalized through more exposure and familiarity through media and society, by doing the same with more natural experiences of childbirth, the medicalization of childbirth will be a part of our country’s past.

In Summation

To conclude this four year long passion project of mine, I reiterate the existing trend of medicalizing childbirth within this country due to our dominant model of care seen nowhere else in the world. The continuation of care provided to patients under the medical model approach is due to our country’s history of midwifery in conjunction with our medicalized society.

Ultimately, this has become the standard birthing model of care in which we as a culture continue to normalize. Due to the gaps in care (which I discovered as a result of this standard

²³ Wikipedia. "History of Masturbation." *Wikipedia*. Wikimedia Foundation, 7 May 2016. Web. 18 May 2016.

system of care), in addition to the poor health outcomes we face concerning childbirth; I believe that a period of de-medicalization is essential in order to improve upon the quality of care provided by our current system surrounding childbirth. The way to approach de-medicalizing childbirth within this country may be done in many ways; some of which I have presented three within this section. Ultimately, however, what I wish to be predominantly recognized after reading my work, is the fear that our country's current system of care instills onto all who are involved in the natural process of birth. That is not to say that childbirth is not a scary prospect in its most natural form, however, prior to the elimination of midwifery within this country, birth was treated as a fabric of life supported communally by women who had previously endured such an experience. Through the treatment of birth as a natural and normal event, it was not such a scary thing. With the introduction of drugs and interventions such normalcy has been clouded. In order to see change for the better in respect to the cost of such care, safety of the mother and child, and achieve an overall better birthing experiences in this country, we must acknowledge such fears and address them through normalizing childbirth by any means possible. Re-instilling normalcy into our culture's perception of birth is what I argue has the ability to encourage a powerful shift in our standard system of care provided in childbirth with an improvement of quality, cost efficiency and increased accessibility.

Appendix A

Infant Mortality Rate per 1,000 live births, (2015)

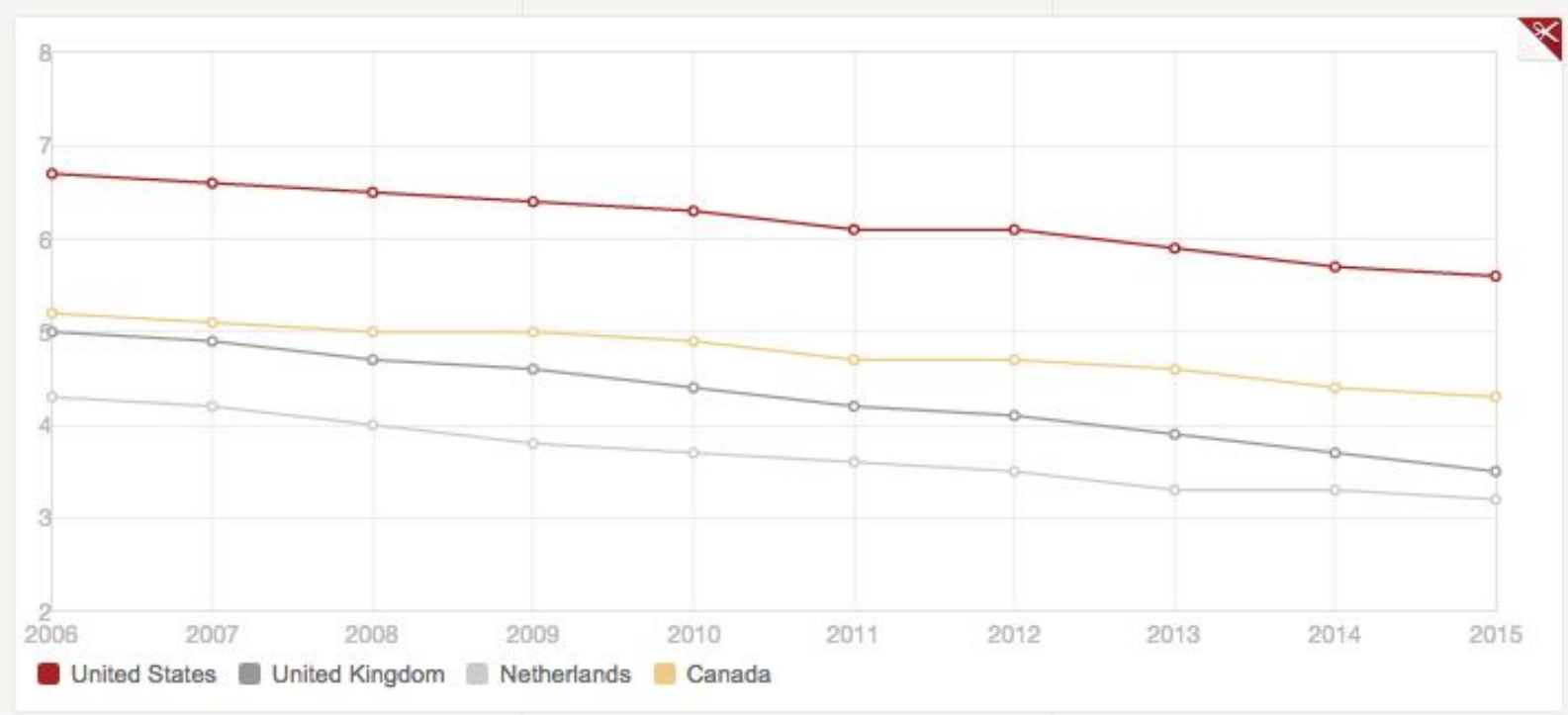


Image 1

Source: The World Bank; Infant Mortality Rates Per Country, 2016; Web; 29 Mar. 2016.

Fetal Mortality Ratio: Birth-Registration States, (1922-1932) and United States, (1933-1960), Rates per 1,000 live births

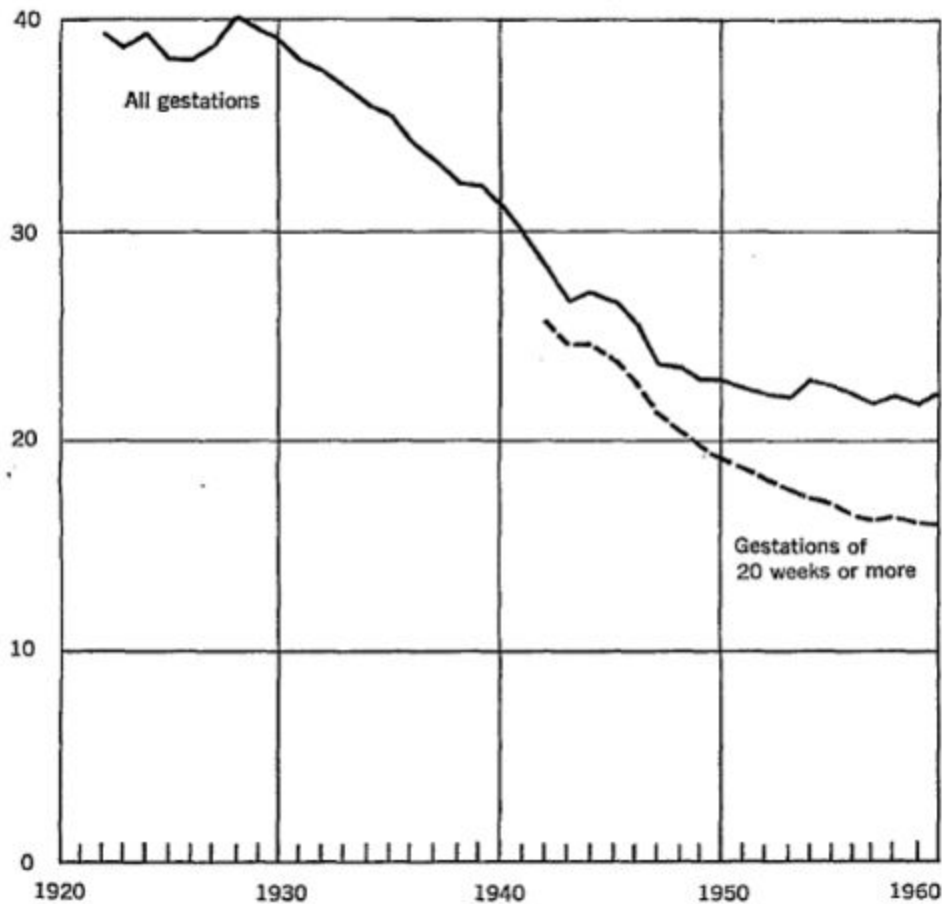


Image 2

Source: Grove, Robert D, and Alice M. Hetzel; *Vital Statistics Rates in the United States 1940-1960*; U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics, 1968; Web; 5 May 2016.

Maternal Mortality Rate Per 100,000 live births, by Year, United States (1900-1997)

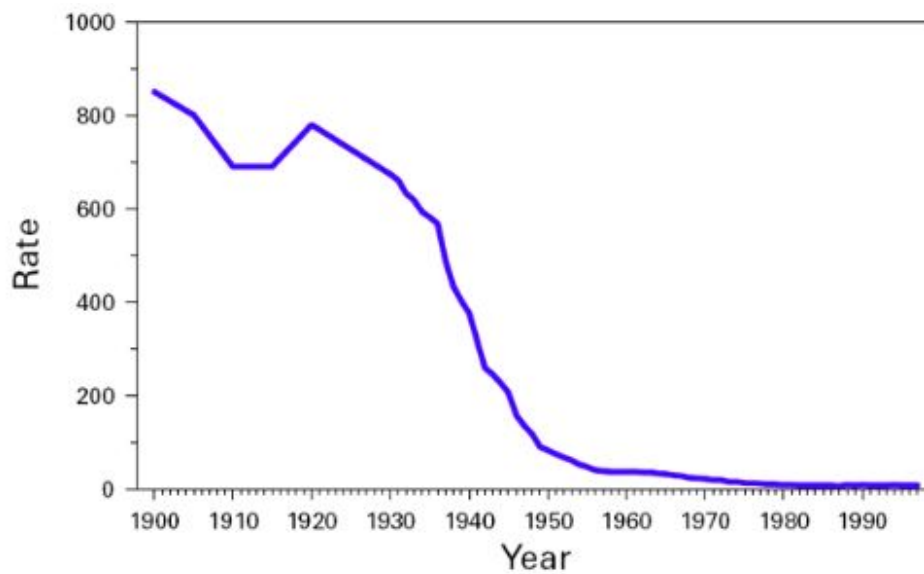


Image 3

Source: Center for Disease Control and Prevention; *Healthier Mothers and Babies--1900-1999*; The Journal of the American Medical Association, 1999; Web; 29 Mar. 2016.

Infant Mortality Rate per 1000 live births, by year, United States (1915-1997)

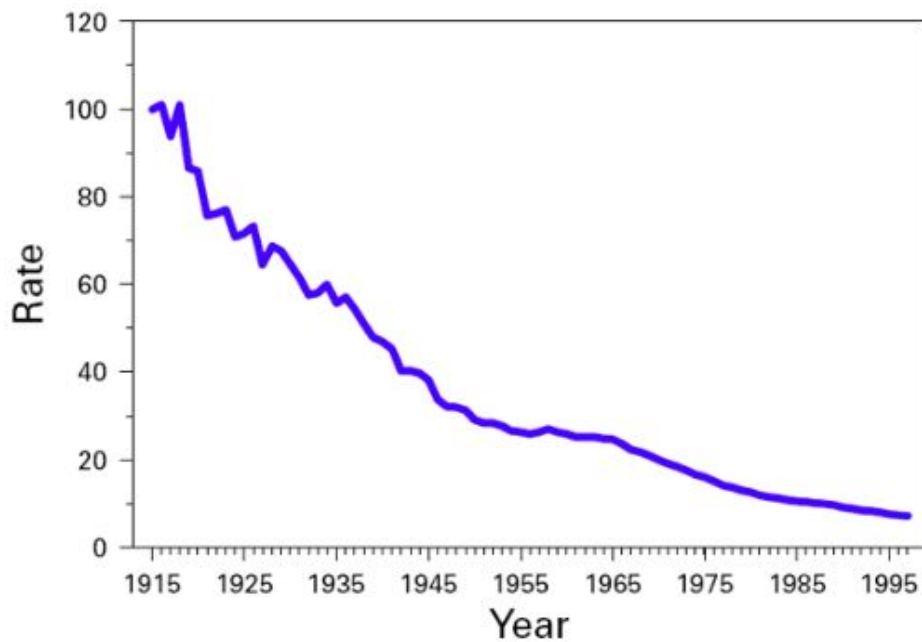


Image 4

Source: Center for Disease Control and Prevention; *Healthier Mothers and Babies--1900-1999*; The Journal of the American Medical Association, 1999; Web; 29 Mar. 2016.

U.S. Maternal Mortality Rates per 100,000 live births, (1987-2012)

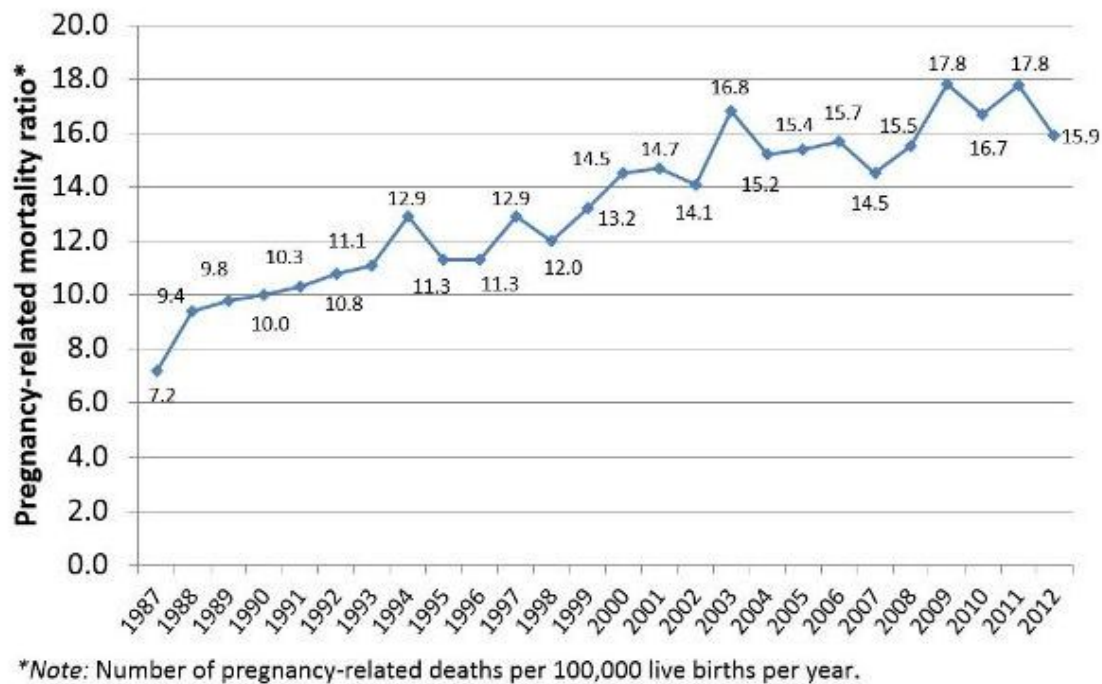


Image 5

Center for Disease Control and Prevention; *Pregnancy Mortality Surveillance System*;
Centers for Disease Control and Prevention, 21 Jan. 2016; Web; 10 May 2016.

Newspaper Clipping From the New England Journal of Medicine, (1911)



Image 6

Source: Wordpress.com; *Rocking the Birth Dogma Boat*; WordPress, Sept. 2011; Web; 3 Apr. 2016.

Maternal Mortality Rates in Various Countries Around 1920, and the Usual Attendants at Normal Births Rate per 10,000 live births

<i>Country</i>	<i>Maternal mortality rate</i>	<i>Usual attendant at normal births</i>
Denmark (1920)	23.5	Midwives
The Netherlands (1920)	24.2	Midwives
Sweden (1918)	25.8	Midwives
Norway (1919)	29.7	Midwives
England and Wales (1920)	43.3	Midwives and doctors
Australia (1920)	50.1	Midwives and doctors
Ireland (1920)	55.3	Midwives and doctors
Scotland (1920)	61.5	Predominantly doctors
New Zealand (1920)	64.8	Predominantly doctors
France (1920)	66.4	Midwives and doctors
United States (1920)	79.9	Very predominantly doctors

Source: R.M.Woodbury, *Maternal Mortality*, Children's Bureau, US Dept, of Labor, Washington, DC, Publication No. 15, 1926.

Note: Rates are expressed as the number of maternal deaths per 10,000 births

Image 7

Source: Marland, Hilary, and Anne Marie. Rafferty. *Midwives, Society, and Childbirth: Debates and Controversies in the Modern Period*. London: Routledge, 1997. Print.

Distribution of Live Births by Place of Delivery and Attendant, United States, (1940-92), *percentages

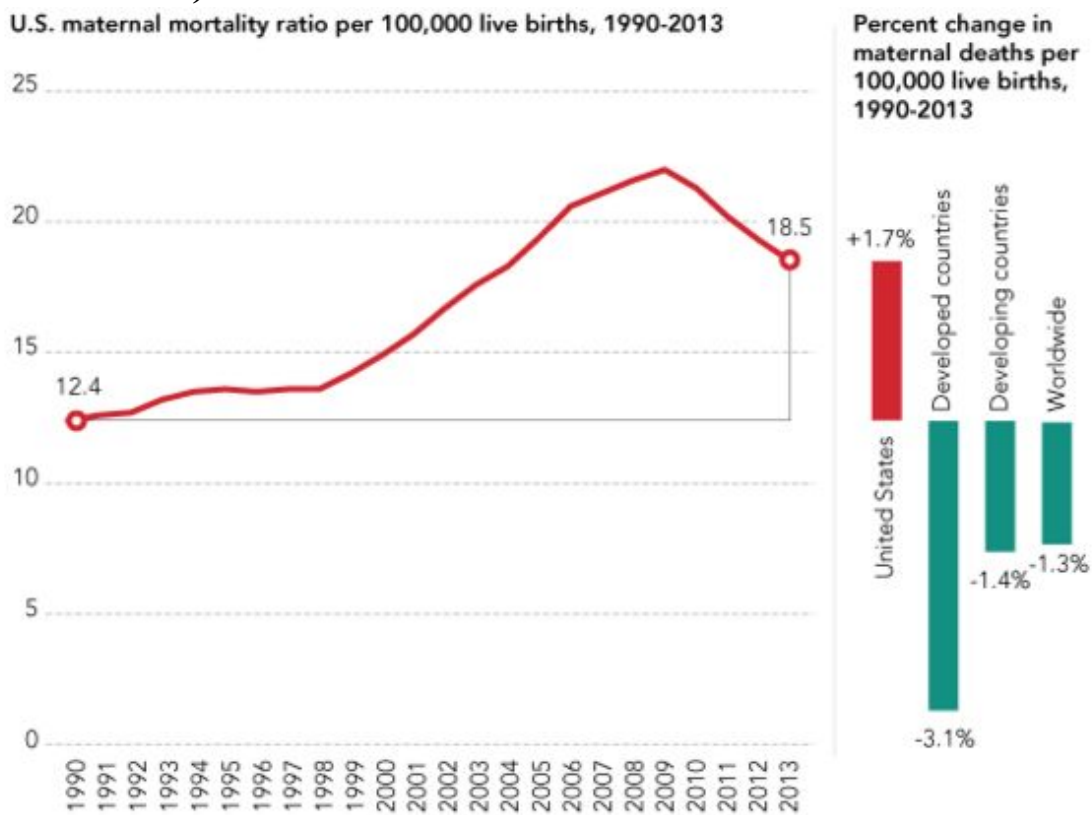
Year	Place of delivery		Physician	Attendant Midwife	Other
	Hospital	Not in hospital*			
1940	55.8	44.2	90.8	8.7	0.6
1945	78.8	21.1	93.5	6.1	0.3
1950	88.0	12.0	95.1	4.5	0.4
1955	94.4	5.6	96.9	2.9	0.3
1960	96.6	3.4	97.8	2.0	0.2
1965	97.4	2.6	98.3	1.5	0.3
1970	99.4	0.6	99.5	0.4	0.1
1975	99.1	0.9	98.8	0.9	0.3
1980	99.0	1.0	97.4	1.7	0.8
1985	99.0	1.0	96.7	2.7	0.6
1990	98.9	1.1	95.3	3.9	0.8
1991	98.9	1.1	94.8	4.4	0.8
1992	98.9	1.1	94.5	4.9	0.6

Sources: US Department of Health and Human Services, *Vital Statistics of the United States, Vol. 1—Natality*, Hyattsville, MD, US Department of Health and Human Services, 1993; National Center for Health Statistics, 'Advance report of final natality statistics, 1990', *Monthly Vital Statistics Report*, 1993, vol. 41, no. 9, supplement; National Center for Health Statistics, 'Advance report of final natality statistics, 1991', *Monthly Vital Statistics Report*, 1993, vol. 42, no. 3, supplement; National Center for Health Statistics, 'Advance report of final natality statistics, 1992', *Monthly Vital Statistics Report*, 1994, vol. 43, no. 5, supplement.
Note: * Includes free-standing birth centers

Image 8

Source: Marland, Hilary, and Anne Marie. Rafferty. *Midwives, Society, and Childbirth: Debates and Controversies in the Modern Period*. London: Routledge, 1997. Print.

U.S Maternal Mortality Ratio per 100,000 live births, (1990-2013)



Source: The Institute for Health Metrics and Evaluation/The Lancet

THE HUFFINGTON POST

Image 9

Source: The Institute for Health Metrics and Evaluation/The Lancet; *The U.S. Is The Only Developed Nation With A Rising Maternal Mortality Rate*; The Huffington Post, May 2014; Web; 20 Aug. 2015.

Percentage of Births Attended by Certified Nurse-Midwives and Certified Midwives, (2005-2014) *percentage

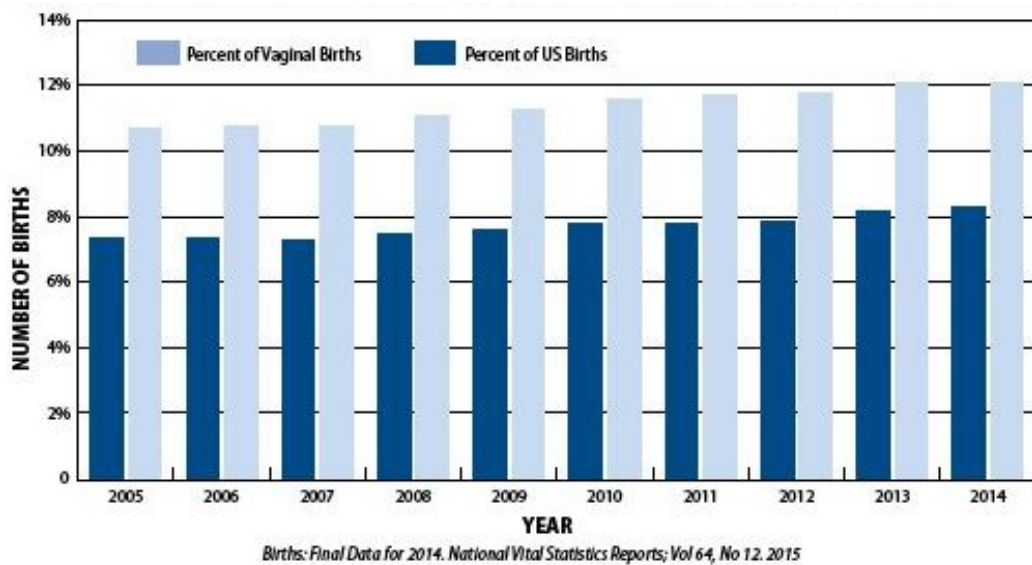


Image 10

American College of Nurse-Midwives; *Essential Facts about Midwives*; American College of Nurse-Midwives, Feb. 2016; Web; 23 Mar. 2016.

Infant Mortality Rates for Various Countries, (1960-2005)

	<i>The Netherlands</i>	<i>Canada</i>	<i>Sweden</i>	<i>United Kingdom</i>	<i>United States</i>
1960	17.9	27.3	16.6	22.5	26
1965	14.4	23.6	13.3	19.6	24.7
1970	12.7	18.8	11	18.5	20
1975	10.6	14.3	8.6	16	16.1
1980	8.6	10.4	6.9	12.1	12.6
1985	8	8	6.8	9.4	10.6
1990	7.1	6.8	6	7.9	9.2
1995	5.5	6	4.1	6	8
2000	5.1	5.3	3.4	5.6	6.9
2001	5.4	5.2	3.7	5.5	6.8
2002	5	5.4	3.3	5.2	7
2003	4.8	5.3	3.1	5.3	6.9
2004	4.4	5.3	3.1	5.0	6.8
2005	4.9	5.4	2.4	5.1	

NOTE: Infant mortality rate is defined as the number of deaths in the first year of life per 1,000 live births.

SOURCE: Eurostat (epp.eurostat.cec.eu.int), StatCan (www.statcan.ca), NCHS (www.cdc.gov/nchs), OECD Health Data.

Image 11

Davis-Floyd, Robbie; *Birth Models That Work*. Berkeley; U of California, 2009. Print.

Maternal Mortality Rates per 100,000 live births, (1990-2013)

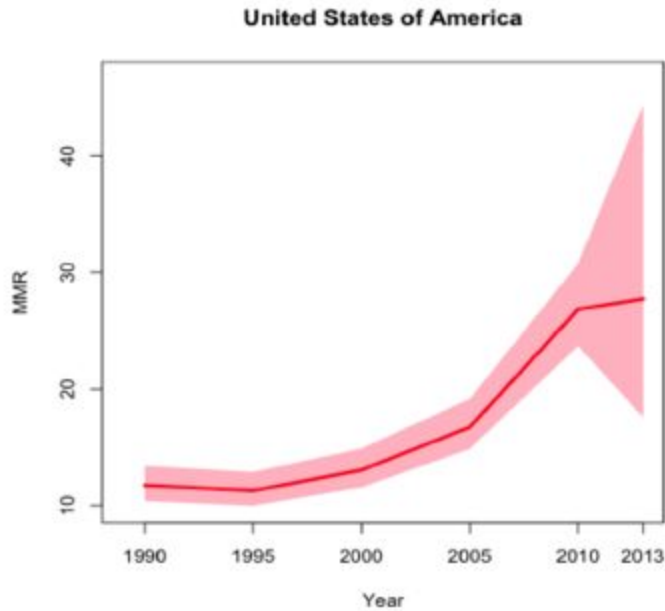


Image 12

Source: WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group; *Trends in Maternal Mortality: 1990-2013*; World Health Organization, Nov. 2015; Web; 3 Nov. 2013.

Maternal Mortality Rates per 100,000 live births, (1990-2013)

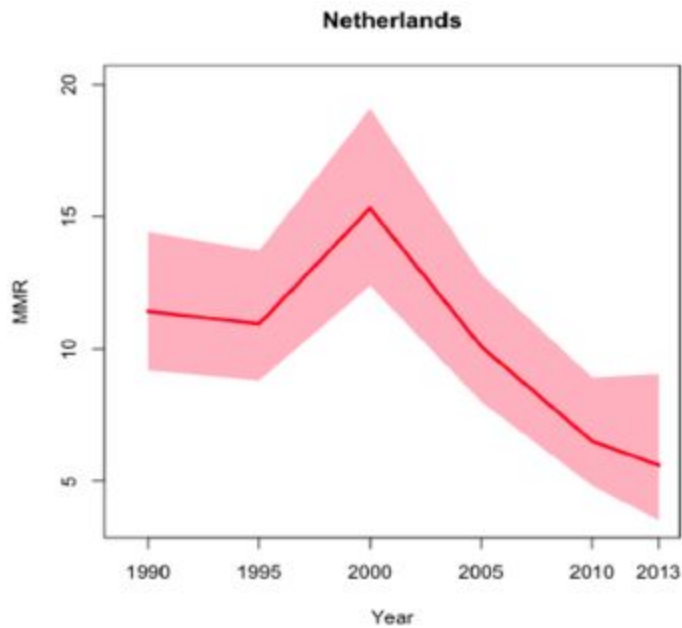


Image 13

Source: WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group; *Trends in Maternal Mortality World Report*; World Health Organization, Nov. 2015; Web; 12 Nov. 2013.

Rates for Total Cesarean Section, Primary Cesarean Section, and Vaginal Birth After Cesarean Section (VBAC), United States, (1989-2014), Rate per 1,000 live births

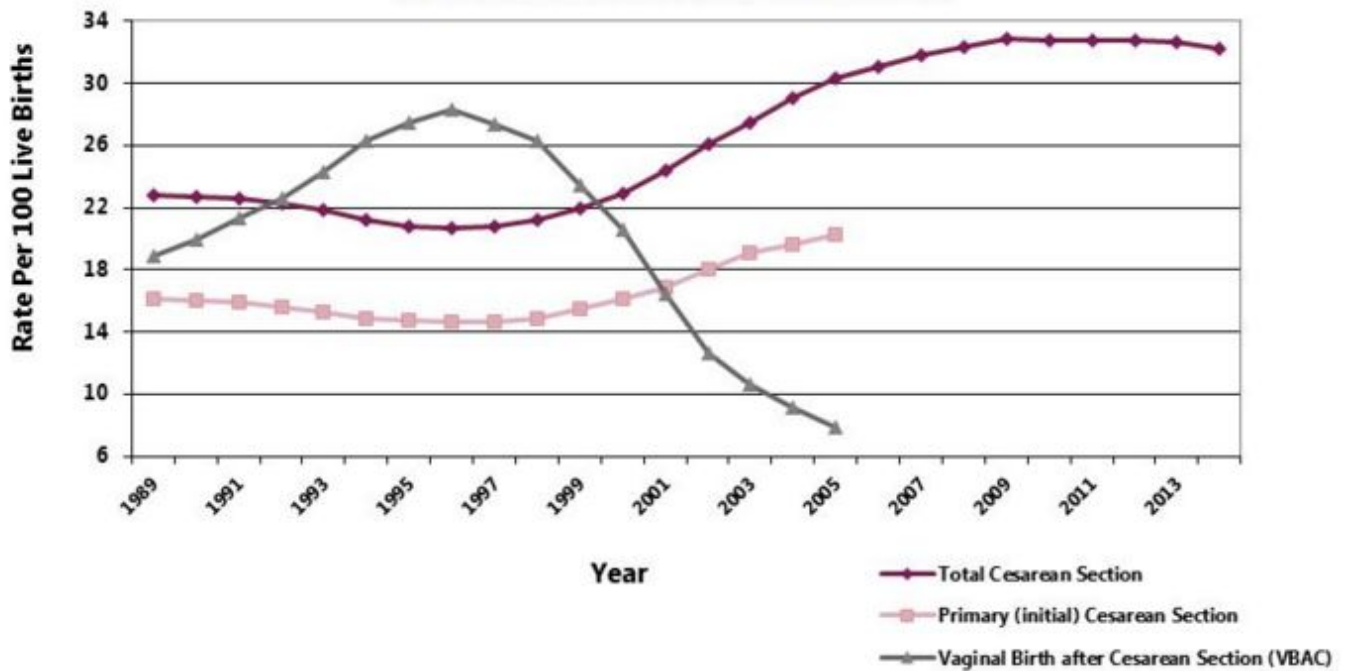


Image 14

Source: Childbirth Connection; U.S.; *Cesarean Section Trends, 1989-2014*; National Center for Health Statistics, 2016; Web; 3 Apr. 2016.

Indications of Cesarean Delivery (CD) and Maternal Death (2010) *percentage

Indication	No. (%)	Maternal deaths
Previous history of CD	5767 (42.3)	12
Nonprogress of labor	2253 (16.5)	4
Nonreassuring fetal heart rate pattern or fetal distress	1987 (14.6)	4
Induction failure	988 (7.3)	1
Malpresentation	704 (5.2)	3
Intrauterine growth restriction	534 (3.9)	0
Elderly primigravida	556 (4.1)	2
Cephalopelvic disproportion	420 (3.1)	1
Bad obstetric history	261 (1.9)	0
Pregnancy following treatment of infertility	160 (1.1)	0

Image 15

Source: Gourisankar Kamilya, Subrata Lall Seal, Joydev Mukherji, Subir Kumar Bhattacharyya, and Avijit Hazra; *Maternal Mortality and Cesarean Delivery: An Analytical Observational Study*; The Journal of Gynaecology and Obstetrics, Apr. 2010; Web; 12 November 2013.

Rates of Planned Versus Total Primary Cesarean Delivery at University of North Carolina Hospital Data, (1996-2005) *percentages

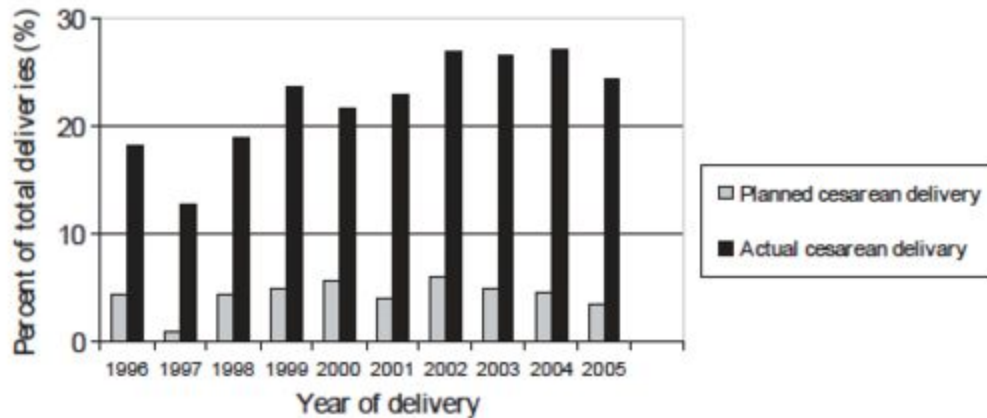


Image 16

Source: Elizabeth J. Geller, M.D., Jennifer M. Wu, M.D., Mary L. Jannelli, M.D., Thao V. Nguyen, M.D., and Anthony G. Visco, M.D; *Cesarean vs. Vaginal Delivery: Whose Risk Whose Benefits? And Maternal Outcomes Associated with Planned C Sections and Planned Vaginal Deliveries*, 2010; Web; 20 Sept. 2011.

Movie Advertisement for Twilight Sleep, (1914)

"TWILIGHT SLEEP"

Motion Pictures At The

Clinton Square Theater

Tuesday, Wednesday and Thursday

(Next Week) Oct. 10, 11 and 12

Most Wonderful Picture in the World
Showing Actual Birth of a Babe

Taken Under the Personal Direction of Dr. Schlossingk, Associate of Drs. Kronig and Gauss, Frauenklinik, Freiburg, Germany, where "Twilight Sleep" was discovered, with

Dr. KURT E. SCHLOSSINGK (himself) in the Pictures

Described in Vivid Detail by Descriptive Talk on the Subject

For years Dr. Kurt E. Schlossingk was associated with Professors Kronig and Gauss, the discoverers of Twilight Sleep, and in June, 1914, he was sent to this country by the Staff of the Frauenklinik, at Freiburg, Germany, for the sole purpose of disseminating the knowledge he had acquired in rendering childbirth painless and to teach the gynecologists and obstetricians of this country the technique of this treatment in maternity cases.

According to some of the most eminent physicians in New York, the most vital question of the day is painless childbirth; better known as Twilight Sleep; or, as the Germans say, Dammerschlaf.

Twilight Sleep is an epochal event in the history of the world's motherhood and it is slowly but surely being adopted by the more prominent physicians and principal hospitals of this country as the established and only method of rendering maternity cases painless.

Nurses of the Albany Hospital to Attend Clinton Square Performances
As Guests of the Management

ONLY WOMEN WILL BE ADMITTED TO THE PERFORMANCES

CLINTON SQUARE THEATER ALBANY, N. Y.

3 DAYS ONLY TUESDAY, OCT. 10

COMMENCING
PERFORMANCES DAILY

Lecture At Each Performance

Image 17

Source: Aria Whitebeam; *How Hospital Births Replaced Home Births*; Renegade Tribune, Mar 2016; Web; 13 Apr. 2016.

The Friedman Curve: Phases of Labor

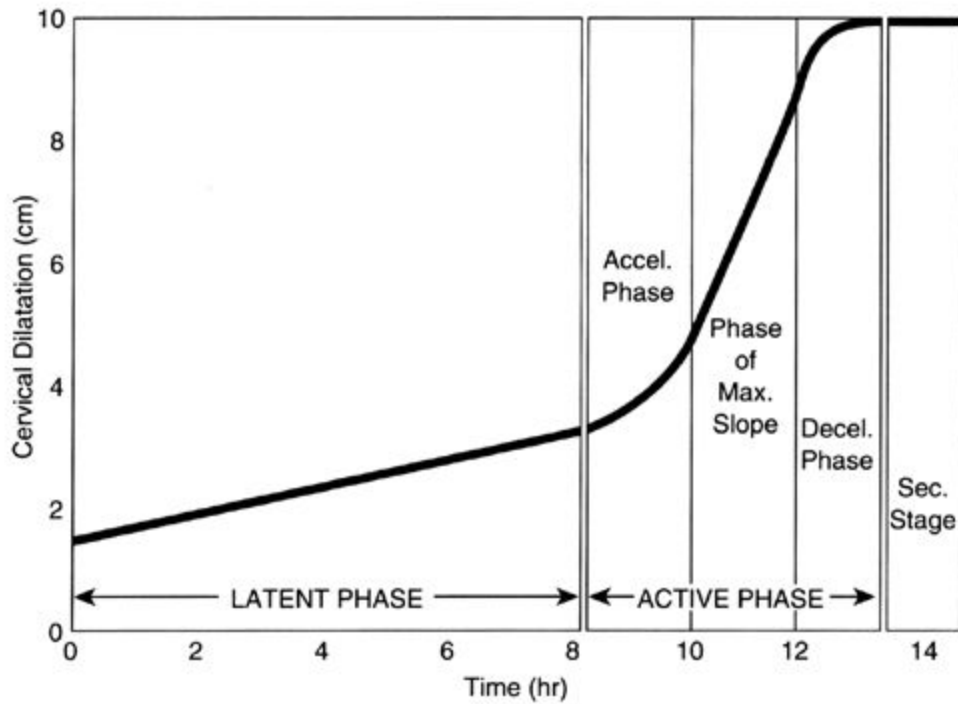


Image 18

Source: Lisa Harrington; *Normal Labor and Delivery*; The Global Library of Women's Medicine, 2016; Web; 16 Mar. 2016.

Site of Births Attended by Certified Nurse-Midwives and Certified Midwives, (2014) *percentage

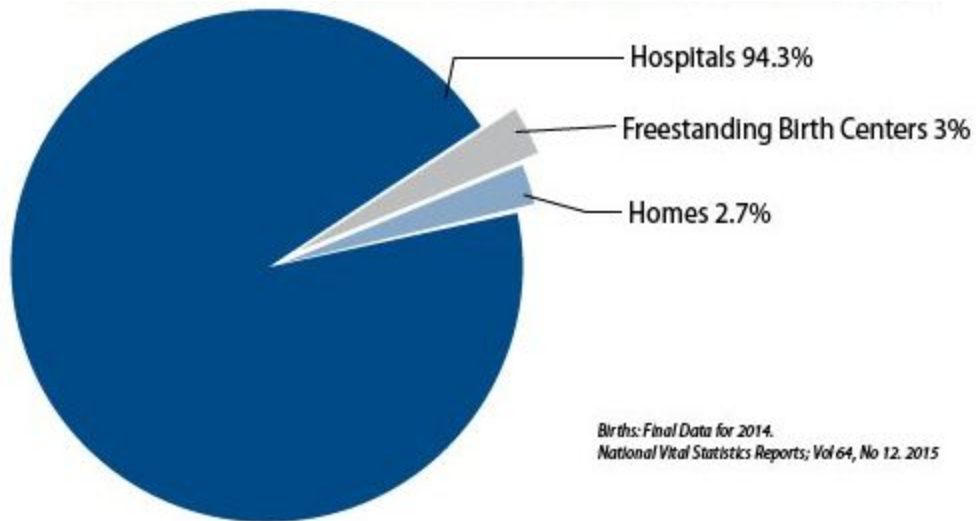


Image 19

Source: Hamilton BE, Martin JA, Osterman MJK, Curtin, SC, Mathews TJ. *Births: Final Data for 2014*. National Vital Statistics Reports; CDC National Center for Health Statistics, 2015; Web; 8 May 2016.

Appendix B

INFORMED CONSENT FORM

My name is Alexandria Gesing, and I am a student at Union College in Schenectady, New York. I am inviting you to participate in a research study for my senior thesis in Science, Technology and Medicine in Culture under the direction of Professor Michelle Osborn (Anthropology) and Professor Melinda Goldner (Sociology). Involvement in the study is voluntary, so you may choose to participate or not. A description of the study is written below.

I am interested in learning about the medicalization of childbirth. You will be asked about your work in a birthing center, as well as your opinion on your country's' healthcare system concerning the birthing process. This will take approximately 15 minutes to an hour. The risks to you of participating in this study are minimal. To maintain confidentiality, pseudonyms will be used and any identifying characteristics will be omitted. If you no longer wish to continue, you have the right to withdraw from the study, without penalty, at any time.

By signing below, you indicate that you understand the information above, and that you wish to participate in this research study.

Participant Signature
Date

Printed Name

You may consent to having your interview recorded (e.g., via tape recorder) or you may decline. Please sign your initials by the appropriate statement below to indicate these wishes.

☐ I consent to being recorded.
☐ I do not consent to being recorded.

Appendix C

INTERVIEW QUESTIONS

Patients

Background:

- How many children do you have?
- Are you married?
- How old are you?
- Where do you live?

The Birth:

- Please take me through your birthing experience.
- What moment during the experience sticks out most prominently in your memory?
- Did you have a birthing plan?
 - If so what was it?
- Ideally what was the kind of birth experience you had hoped for?
- What kind of pain relief methods did you intend to use?
 - If no intention, which were you willing to try?
 - in the end, which did you use
- Did you ever question any intervention done by your physician pre, during, or post the birth?
- Going into your birthing experience had you heard mostly positive or mostly negative childbirth stories (from friends, family, social media)?
 - from which source did you hear most stories from?

The Field:

- What were the strength and weaknesses of your birthing experience?
- What are your opinions of the medicalization of childbirth?
 - Did it affect your birthing plan?
 - Did it affect your overall birthing experience?
- Did you feel the increased use of technology/intervention improved the outcome of your child's birth and both you and your child's health/safety?
- What's the ideal model of birthing to you?
- Are there any aspects of the way you or others experienced birthing that you sometimes question or perhaps disagree with?

OB/GYNs

Background:

- How did you get into this field?
- Please take me through your previous job history
- Generally speaking, how did you get to your current position and organization?
- Take me through a typical day for you

Profession:

- Walk me through a “typical birth” for you
- What are the types of patients you typically work with?
- Why do they come to see you?
- What are their expectations working with you?
- What equipment is readily available to you? Which do you use most often and which none at all?

The Field:

- What are the strength and weaknesses of your approach to birthing?
- What are your opinions of the medicalization of midwifery? Do you feel it even exists?
- What’s the ideal model of birthing to you?
- Are there any aspects of the way you approach birthing that you sometimes question or perhaps even dislike or disagree with?

Midwives

Background:

- How did you get into this field?
- Please take me through your previous job history
- Generally speaking, how did you get to your current position and organization?
- Take me through a typical day for you

Profession:

- Walk me through a “typical birth” for you
- What are the types of patients you typically work with?
- Why do they come to see you?
- What are their expectations working with you?

- What equipment is readily available to you? Which do you use most often and which none at all?

The Field:

- What are the strength and weaknesses of your approach to birthing?
- What are your opinions of the medicalization of midwifery? Do you feel it even exists?
- What's the ideal model of birthing to you?
- Are there any aspects of the way you approach birthing that you sometimes question or perhaps even dislike or disagree with?

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