

**A QUESTION OF BIRTHING PHILOSOPHY:
A QUALITATIVE STUDY OF MATERNITY CARE DECISION-MAKING PARADIGMS**

by

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Background: Medicalization has led to the standardization of American maternity care and limited the choices of pregnant women by restricting their access to alternative types of care. While there is evidence that women are dissatisfied with this trend, very little is known about how pregnant women make decisions in the current maternity care environment. **Objective:** To describe the conceptual frameworks women use in making maternity care and birth decisions by exploring the context in which these choices are made. **Methods:** In-depth, semi-structured interviews were conducted with 22 women between March and December of 2010. **Results:** Three major themes emerged from the data. The first theme is that women take an active role in their own maternity care through the formation of goals, some of which were better served by the maternity care system than others. Second, women articulated underlying birth philosophies and discussed the philosophies of their caregivers. Dissonance between a patient's birth philosophy and that of her provider led to tension and mistrust. The final theme is a discussion of choice and barriers in maternity care. The lack of choice that many women experienced led to difficulties in receiving the type and amount of maternity care that was most appropriate for them and resulted in frustration and dissatisfaction with the provision of their care. **Conclusions:** These findings call for expanded access to nonstandard maternity care, the removal of barriers to alternative care, and more vigilant observation of fully informed consent. Quality maternity care must provide support for meaningful choices whether or not those decisions reflect current maternity care norms. **Public Health Significance:** Over four million women become pregnant and give

birth in the United States each year. Pregnancy and birth account for one in every five female hospitalizations and a quarter of all hospital stays. Given its magnitude, the quality of maternity care services is an important measure of overall healthcare quality and thus a critical public health concern.

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PREFACE

An incredible group of women volunteered to collaborate with me on this project. They have opened their homes to me, allowed me to play with their children, and shared the most intimate details of their birth stories. Each interview inspired and astonished me, and every mother reminded me in her own way of the passion and courage that is the human experience. I am honored to be the keeper of so many birth stories.

I am so grateful to my thesis committee for their guidance, encouragement, and incredible depth of knowledge. It is truly a privilege to have learned from you.

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1.0 INTRODUCTION

Over four million women become pregnant and give birth in the United States each year (Maternal and Child Health Bureau [MCHB], 2010b). Pregnancy and birth account for one in every five female hospitalizations and a quarter of all hospital stays (Levit, Wier, Stranges, Ryan, & Elizhauser, 2009). In 2007, six of the ten most frequently performed hospital procedures were associated with giving birth, and cesarean sections were the most frequently performed operating room procedure (Levit, et al., 2009). If taken together, hospital stays related to pregnancy, birth, and the newborn cost the United States over \$34 billion per year, more than any other condition that receives medical care (Levit, et al., 2009).

In addition to the sheer volume and infiltration of maternity-related health care, the quality of a nation's maternity care is important due to its function as a measure of overall health and social progress. In 1929, medical historian H. W. Haggard posited that "the position of woman in any civilization is an index of the advancement of that civilization; the position of woman is gauged best by the care given her at the birth of her child" (as quoted in Caton, 1999, p. 3). This standard holds true today, evidenced by maternal health's inclusion as one of the United Nation's eight Millennium Development goals (United Nations, n.d.). Maternity care is also a focus area in the U.S. Department of Health and Human Services' (U.S. DHHS) Healthy People 2010 report (U.S. DHHS, 2000).

The American Academy of Family Physicians defines quality health care as “the achievement of optimal physical and mental health through accessible, safe, cost-effective care that is based on best evidence, *responsive to the needs and preferences of patients and populations, and respectful of patients’ families, personal values, and beliefs*” [italics added] (American Academy of Family Physicians, 2006, ¶1). Therefore, given the immense utilization of maternity care services, the responsiveness of maternity care to the preferences of pregnant women and the system’s respect for their individual values and beliefs are important measures of overall healthcare quality.

The Social-Ecological Model is an approach to health promotion and research that explores the personal, social, institutional, community and public policy environments in which individual level decisions are made (McLeroy, Bibeau, Steckler, & Glanz, 1988; Ulin, Robinson, & Tolley, 2005). It emphasizes the influence of a person’s environment on his or her physical and psychological health and notes the reciprocal influence that a person’s behavior may have on his or her environment (National Cancer Institute, 2005). Focusing mainly on personal and social factors, the purpose of this study is to describe the conceptual frameworks women use in making maternity care and birth decisions. By exploring the environment in which women make maternity care choices and the values, preferences, and external factors that influence those choices, we begin to understand how women come to decisions regarding the birth of their children. Using in-depth semi-structured interviews, the study adds women’s voices to the ongoing assessment of American maternity care.

This paper examines the circumstances of modern maternity care including its historical context and medicalization. It describes the choices available to pregnant women and acknowledges the psychological aspect of pregnancy and birth. The study’s research

methodology is described in detail and the themes that emerged through the application of grounded theory are presented and discussed. Finally, the study's limitations are offered along with opportunities for future research.

2.0 BACKGROUND

The average American woman gives birth twice and has her first child at the age of 25. Two-thirds of these women initiate prenatal care within the first trimester of their pregnancy (Martin, et al., 2009). The vast majority deliver their babies in a hospital with a physician as their primary care provider, and over 30 percent are delivered by cesarean section (MCHB, 2010b). Their risk of maternity related death is 13.3 per 100,000 births, which has not improved since 1982 and has in fact been rising since 2003 (Hoyert, 2007). One in eight births occur prior to term (MacDorman & Mathews, 2009), and the current risk of infant mortality is 6.8 per 1,000 births (MCHB, 2010a). Following the birth of their child, 75 percent of these women will initiate breastfeeding (MCHB, 2010a). Over 14 percent will develop postpartum depression (Gavin, et al., 2005) and 1.9 percent will meet criteria for post traumatic stress disorder (Soet, Brack, & Dilorio, 2003).

2.1 MEDICALIZATION

2.1.1 Historical Context

In the early 1900s public attention was drawn to the potential hazards of childbirth. Comparisons were made between the female duty to bear children and the obligation of men to

fight the nation's wars, the view at the time being that childbirth was the potentially more perilous responsibility (Caton, 1999; Sandelowski, 1984). A Children's Bureau study in 1917 cited maternity as the second leading cause of death after tuberculosis in women between 15 and 44 years of age (Meigs, 1917). As registries were developed and it became possible to generate statistics like these, average Americans began to view pregnancy and birth as hazardous. Maternity was no longer "as natural as breathing or sleeping" (Sandelowski, 1984, p. 39) but rather a latent crisis that required supervision, management, and treatment.

One discussion in the 1940s was that birth required medical care because civilization had rendered modern women unfit for childbirth (Caton, 1999; Sandelowski, 1984). Medical innovations such as pharmaceutical pain management and surgical birth were thus viewed as necessary to offset the consequences of living in modern society. Birthing women themselves were dedicated promoters of early interventions such as Twilight Sleep, a combination of medications which eliminated the mother's memory of birth or the pain associated with it. These advocates were so successful that providing pain relief during birth came to be widely viewed as the physician's duty and receiving such relief the woman's right. The promotion of Twilight Sleep brought additional attention to the potential hazards of childbirth and further justified the presence of medical doctors at births. It also accelerated the movement of birth from homes and birth centers into hospitals, as physicians insisted that only hospitals could provide the controlled environment necessary for its successful use. Moreover, the popularity of Twilight Sleep "accentuated the idea that women needed special help and protection by virtue of their ability to give birth" (Sandelowski, 1984, p. 19).

The advent of pharmaceutical pain relief meant that birth attendants could no longer rely on women alone to judge the progress of their labor. Women under the influence of these drugs

were also often uncooperative and less informative to the doctors providing their care. These factors inevitably led to the development of alternative means of gathering information, which took the form of medical procedures such as pelvic exams and fetal monitoring (Sandelowski, 1984).

2.1.2 Definition of Medicalization

Medicalization is the term coined to describe the “biomedical tendency to pathologize otherwise normal bodily processes” (Inhorn, 2006, p. 354) and occurs when life events like pregnancy and birth come to be viewed as illnesses. The transformation of birth from a natural process to a medical event both reinforces and requires its conceptualization as a time of danger and uncertainty and brings this assumption of risk to the forefront. Medicalization thus classifies pregnancy as a medical disorder and organizes it in terms of risk (Simmonds, Rothman, & Norman, 2007). It normalizes the employment of a medical setting and justifies the use of medical instruments in place of physical experiences, such as the urge to push, to monitor the internal processes of pregnancy and birth, all of which is done in the name of the safety of mother and child and a doctor’s obligation to reduce the woman’s experience of pain (Durain, 2002; Parry, 2008).

In this way, modern medicine often characterizes a birthing woman’s body in terms of its function. It is a machine and as such may be flawed or faulty, requiring adjustments or repairs. In order to identify and compensate for these flaws, medicalization sets strict quality control guidelines and employs interventions to “fix” any deviation from the standards that have been set (Downe & McCourt, 2004). Consequently, medicalization emphasizes the ability of medical doctors to compensate for women’s flaws and discounts the participation of women themselves

in childbirth (Davis-Floyd, 1994). It also constructs the fetus itself as a patient, often rendering the mother as “little more than a maternal barrier to its care” (Simmonds, et al., 2007, p. xxii). Medicalization has thus altered a woman’s role in reproduction by making conception, gestation, and birth events that scientists monitor, examine and often seek to control rather than something that women innately do (Parry, 2008).

Through defining pregnancy as a medical condition, using medical instruments to monitor internal processes and requiring a medical setting for normal birth, the medical community has near complete control over the development of knowledge about the care of women who are now seen as patients. Transforming birth into a medical process conceptualizes it as a time of danger and risk becomes the central tenet of care. Perhaps as a result, American women often appear willing to give up their decision-making authority due to fear and the belief that birth is a medical event that requires trained experts. This belief simultaneously elevates the power of the medical establishment and diminishes the role of women in their own pregnancies. Women are no longer the natural experts in and about childbirth but are often seen as deficient, lacking proper education and without the intelligence necessary to take an active role in decisions regarding their own pregnancies (Parry, 2008).

2.1.3 Medicalization and the Standardization of Maternity Care

Pregnant women in the United States almost universally give birth in a hospital under the care of a physician, and medicalization ensures that most hospital births are fairly uniform; there is a basic procedure, and almost every woman’s care is dictated by it without regard to individual characteristics or preferences. This care often includes numerous restrictions of dubious value, such as withholding meals or limiting movement, and a number of invasive medical

interventions, like electronic fetal monitoring or episiotomies, which in most cases are not absolutely necessary (Say & Thomson, 2009). In a sense, the creation of clinical protocols and best practices which medicalization demand has precluded differentiation and served to standardize maternity care (Downe & McCourt, 2004).

The Centers for Disease Control and Prevention (CDC) reports that in 2006, the most recent year for which statistics are available, 99 percent of births in the United States occurred in a hospital, and 91.5 percent were overseen by a physician. That same year, more than one in five pregnant women were induced, and nearly a third gave birth by cesarean section (Martin, et al., 2009). Data on the use of other interventions is not routinely reported, but among the 1,573 women surveyed by Childbirth Connection in 2006 (Declercq, Sakala, Corry, & Applebaum, 2006), more than nine in ten were continuously attached to an electronic fetal monitor. Eighty-six percent utilized pharmaceutical pain management and 76 percent obtained an epidural. Women reported that 81 percent were given at least one vaginal exam, 80 percent received fluids through an intravenous catheter, 65 percent had their water artificially broken, 55 percent of labors were augmented with pitocin, and 43 percent had a catheter placed to remove urine. Nearly every hospital birth took place while the mother sat or lay in bed with her feet in stirrups. Other sources estimate that at least 53 percent of all births are not allowed to occur and progress spontaneously (Wagner, 2006). Episiotomy rates, down from their high of 64 percent in the 1980s, still occur in 39 percent of births (Weeks & Kozak, 2001). Despite recommendations against its use, episiotomies are still used at a rate of between 70 and 80 percent among first-time moms (Wagner, 2006).

2.1.4 Medicalization and Health Outcomes

It is not within the scope of this paper to fully evaluate the health outcomes of the various maternity care choices that women may make. However, the implication of medicalized care, which is that standardized practices minimize risk and optimize positive outcomes, necessitates a brief discussion of the safety of specifically nonmedicalized maternity care options.

It is important here to distinguish medicalization from the availability and provision of medical care. As previously noted quality health care allows for the personalization of care and requires evidence-based treatment that is responsive to the recipient's preferences, personal values and beliefs (American Academy of Family Physicians, 2006). As such, high quality health care is, by definition, flexible. It is not inherently confined to one particular method of service delivery or provider type. It is also nearly universally regarded as a positive resource for pregnant women, and advancements in medical technology have undoubtedly enhanced the safety of women and children during pregnancy and birth (U.S. DHHS, 2000; United Nations, n.d.). In comparison, medicalization is a philosophy of maternity care provision that defines pregnancy and birth as illnesses that require medical monitoring and care (Inhorn, 2006). Because it emphasizes the minimization of risk, medicalization does not leave as much room for patient preference or involvement in decision making (Downe & McCourt, 2004; Simmonds, et al., 2007). Medicalization is discussed here due to its widespread practice within the modern maternity care system which, as noted above, has limited the maternity care choices available to women (Downe & McCourt, 2004; Caton, 1999; Sandelowski, 1984).

Comparing the health outcomes of medicalized and nonmedicalized maternity care is problematic due to, among other things, the relative scarcity of nonmedicalized births (Martin, et al., 2009), the small number of adverse outcomes (Springer & Van Weel, 1996; Wax, et al.,

2010) and the difficulty of identifying appropriate points of comparison (Springer & Van Weel, 1996; Wax, et al., 2010). Despite its complexity, numerous attempts have been made, most focusing on midwifery, homebirth or a specific circumstance such as vaginal birth after cesarean (VBAC). Although divergent conclusions have been drawn (Guise, et al., 2004; MacDorman & Singh, 1998; Olsen, 1997; Pang, Heffelfinger, Huang, Benedetti, & Weiss, 2002; Wax, et al., 2010), there is reason to believe that nonstandard care is a safe and appropriate option for some women. In 1998 the *Journal of Epidemiology and Community Health* (MacDorman & Singh) published the first comparison of certified nurse midwife (CNM) and physician birth outcomes to include all CNM deliveries in the United States. Using data from over 800,000 births and adjusting for sociodemographic variables, the authors concluded that the risk of infant mortality was 19 percent lower for CNM attended births. The study also found that women cared for by CNMs delivered fewer low birth weight babies (MacDorman & Singh, 1998). CNMs care for women in many settings including hospitals, birth centers and homes, and each with unique risks and benefits. Planned homebirth, for example, is associated with fewer medical interventions (Caton, 1999; MacDorman & Singh, 1998; Olsen, 1997; Wax, et al., 2010), a lower risk of maternal lacerations, hemorrhage and infection (Olsen, 1997; Wax, et al., 2010), and better psychological outcomes (Baker, Precilla, Choi, & Tree, 2005; Hildingsson, Waldenstrom, & Radestad, 2003). However, there is far less agreement in terms of homebirth's impact on the infant's health; the risk differential for infant mortality between planned homebirths and planned hospital births likely falls somewhere between statistically insignificant (Olsen, 1997) and a contested twofold increased risk for homebirth (Wax, et al., 2010). Both midwives and physicians care for pregnant women who intend to attempt a VBAC. The risks to mother and child associated with a trial labor or vaginal delivery following a previous cesarean section

versus those attributed to a repeat cesarean section are also debated (Guise, et al., 2004). Despite ongoing discussion, the American College of Obstetricians and Gynecologists now supports VBAC as a “safe and appropriate choice for most women” (ACOG release, 2010, ¶ 1) and recommends collaborative decision making and patient autonomy within maternity care.

Although critical to the provision of high quality care, this type of comparison often confuses quality health care with medicalization, equating any increase in risk with substandard care. In this way, risk assessment dominates the discussion of choice within maternity care at the expense of other quality care considerations (Archer, 2006; Davis-Floyd, 2004; Lawrence Beech & Phipps, 2004). It is therefore important to acknowledge that risk is only one of the many factors that women consider in planning the births of their children and certainly not the only determinate of health outcomes (Baker, et al., 2005; Hildingsson, et al., 2003).

2.1.5 Birth as a Rite of Passage

Anthropologists have long noted the rituals that accompany major life transitions like birth, death, and adulthood in most cultures (Archer, 2006; Davis-Floyd, 1994; Jordan, 1980). According to birth expert Robbie Davis-Floyd (1994; 2004), the need for and use of ritual may explain the medicalization and standardization of the American birth experience. Briefly, rituals operate by sending messages in the form of symbols to those who perform or observe them, often communicating about both society’s perceptions and expectations of an individual and also the individual’s perceptions of herself. This is a powerful form of communication because the messages are felt rather than heard.

Davis-Floyd (1994; 2004) posits that American obstetric procedures are in fact rituals that facilitate the internalization of American cultural values, which she believes center around

science, technology and patriarchy. As rituals, “there could be no better transmitter of these core values and beliefs than the hospital procedures so salient in American birth” (Davis-Floyd, 1994,

¶4). She goes on to elaborate:

Routine obstetric procedures are highly symbolic. For example, to be seated in a wheelchair upon entering the hospital, as many laboring women are, is to receive through their bodies the symbolic message that they are disabled; to be put in bed is to receive the symbolic message that they are sick. Although no one pronounces, “You are disabled; you are sick,” such graphic demonstrations of disability and illness can be far more powerful than words. (Davis-Floyd, 1994, ¶11)

Through ritual, hospital procedures may offer women a familiar footing during a time of transition or uncertainty. Women may even experience medical procedures as comforting and calming in the face of the unpredictability that is otherwise normal birth (Archer, 2006; Davis-Floyd, 1994). On the other hand, the use of medical procedures such as fetal monitoring, birth surgeries and epidurals can have a negative impact on the mother’s experience of childbirth, especially if these things are implemented as mindless rituals rather than resources to use or not use as appropriate. Women may feel alienated from their own birth experiences or see themselves as defective when medical technologies are imposed or overvalued. Moreover, since hospitals as institutions “constitute a more significant social unit than an individual or a family” (Davis-Floyd, 1994, ¶20) there is a danger that the rituals surrounding birth in hospitals will “conform more to institutional than personal needs” (Davis-Floyd, 1994, ¶20) and invisibly perpetuate undesirable social beliefs.

2.1.6 Evidence That Women Are Dissatisfied with Medicalized Birth

A growing compilation of evidence indicates that women are dissatisfied with the trend toward medicalized birth and the maternity care options available to them. Every year the National

Center for Health Statistics reports an increase in homebirths attended by midwives (Martin, et al., 2009). Even where alternative births are not supported by established care networks, women are increasingly seeking them out (Wagner, 2006). The number of women seeking midwifery care has risen steadily since its low of less than one percent in the mid-1970s to eight percent in 2006 (Martin, et al., 2009). The percentage of all vaginal births delivered by midwives doubled between 1991 and 2006 when it was reported at 11.3 percent, and the number of midwife-attended homebirths rose by 27 percent between 1996 and 2006 (Martin, et al., 2009). In 2003, a Swedish study (Hildingsson, Waldenstrom, & Radestad) concluded that the homebirth rate in that country would be ten times higher if women were allowed to more freely choose their birth location. Notably, the participants' reasons for choosing a homebirth centered around autonomy, control of the decision making process, and a dissatisfaction with the medicalization of hospital births. Active involvement in care, the ability to control their environment, an aversion to pharmaceutical pain relief, and the ability to include other children and friends in the birth process were all cited as motivations for choosing homebirth (Hildingsson, et al., 2003).

2.1.6.1 The Natural Birth Movement

The use of pharmaceutical intervention in labor was typical by the 1930s, and by 1939 women were publically expressing dissatisfaction with the experience of medicated birth (Caton, 1999; Sandelowski, 1984). In the 1940s and 50s women argued against the “brutal, nightmarish, and cruel” (Sandelowski, 1984, p. 73) experience of hospital birth and expressed disappointment in themselves and their caregivers when childbirth did not meet their expectations. Mothers and some maternity care providers began almost immediately to ask if the battle against maternal pain might have been at the expense of personal pleasure and fulfillment (Sandelowski, 1984). Thus since nearly the advent of medicalized birth, advocates for natural childbirth have been

stressing the enhanced safety of unmedicated birth. These births are perceived to be safer due to factors such as shorter labors, fewer cesarean sections and assisted deliveries, less blood loss, improved maternal recovery and a lower risk of respiratory distress for the baby (Caton, 1999; MacDorman & Singh, 1998; Sandelowski, 1984). The emotional value of childbirth was also stressed by emphasizing the satisfaction, sense of fulfillment and achievement, and enhanced self-esteem that women experienced when they were able to witness and actively participate in the birth of their children (Hildingsson, et al., 2003; Sandelowski, 1984; Simmonds, et al., 2007). In the context of the 1940s and 50s, women who chose natural childbirth were seen as adventurers charting a new course or as heroines. Natural birth, in the face of physician's warnings that it would return women to the maternal dangers of previous generations, inspired awe and "made ordinary women extraordinary" (Sandelowski, 1984, p. 114). It "promised happiness, fulfillment, pride, and a sense of self-esteem to women in an era when maternity was the best and really only acceptable source" (Sandelowski, 1984, p. 114) for female self-realization.

Natural birth advocates continue to stress that the primary goal of maternity care should be maximizing the mother's sense of pleasure and achievement rather than exclusively focusing on the alleviation of pain. They talk about birth as a natural and healthy process, promote the use of minimally invasive support measures such as companionship and birthing tubs, and believe that medical doctors are best suited to attend only medically complicated births (Simmonds, et al., 2007). Also emphasized are the physical and psychological consequences of medicalized birth, which are thought to contribute to elevated rates of maternal and neonatal complications including extended hospitalizations and postpartum mood disorders (Menage, 1993; Simmonds, et al., 2007; Wagner, 2006).

2.2 CHOICE IN CHILDBIRTH

Medicalization in the United States has a tendency to limit the maternity care choices available to women including their access to alternative birth experiences. The movement of birth into hospitals and to the care of physicians has by most accounts served to reduce the number and type of choices available to childbearing women (Caton, 1999; Sandelowski, 1984). For some pregnant women an exclusive focus on risk reduction is warranted and welcome. For others, however, an emphasis on comfort, nonmedical circumstances, or shared decision-making might be preferred and appropriate (Hildingsson, et al., 2003; MacDorman & Singh, 1998). While it is not within the scope of this paper to argue the merits of the above described norms, it is this author's belief that every woman has a right to choose the type and amount of health care that is right for her. For some women that would mean giving birth in a hospital at a scheduled time by cesarean section; others would choose a strictly natural birth in their own homes under the care of a certified nurse midwife. In this sense, the availability of safe and well regulated alternatives to medicalized hospital birth should be viewed as a necessary aspect of quality maternity care.

2.2.1 The Availability of Alternative Care

While modern American women can more or less freely choose a hospital and a physician, and many hospital maternity wards advertise the choices that they offer, it seems that women still have little control over their own care. In the opinion of one author (Wagner, 2006), patients do not have final decision-making authority in hospitals unless they are willing to fight for it. In fact, some obstetricians feel that women should not come to hospitals expecting choices at all: "Don't try to come to the hospital where we're going to take care of you the way that we know

how... and then say ‘I don’t want any of that’” (Simmonds, et al., 2007, p. 216). Therefore, it seems that women must go completely outside of mainstream maternity care in order to exercise their right to choose anything other than a medicalized hospital birth experience. This indicates that the “choices” touted by hospital maternity wards are being used to enhance the value of available maternity care and to “disguise what is often in fact a lack of choice” (Van Wagner, 2004, p. 15) rather than to indicate that any real choices are available to the women seeking care.

While hospital births are nearly universally available to women in the United States, the same is not true of alternative settings. For example, the American Association of Birth Centers, which provides accreditation to birth centers in the United States through the Commission for the Accreditation of Birth Centers, lists only 96 member facilities, and 19 states have no accredited birth center at all (American Association of Birth Centers, 2007). The number of practicing midwives is also thought to be insufficient to serve all interested women. Midwives are scarce: approximately one obstetrician is available for every 100 births but only one midwife per 800 births (Wagner, 2006). Certain laws also restrict the use of and access to alternative birth practices. In some states, out-of-hospital birth centers are not legal, and while homebirth is not against the law in any state, in many parts of the country it is difficult to find a licensed provider who will attend a homebirth (Parry, 2008; Wagner, 2006). Insurance company policies additionally limit choices by declining coverage for midwife care and by charging higher premiums to physicians who provide back-up for midwives (Wagner, 2006).

Significantly, the notion of choice may in some cases be seen by women themselves as at odds with their concern for the health and safety of their unborn child (Kingdon, et al., 2009). Since “any personal preference was viewed as secondary to maintaining the safety of the baby,” (Kingdon, et al., 2009, p. 891) women who participated in a British maternity care study felt that

decision-making should be entrusted to medical professionals. The same study found that some pregnant women felt that expressing a preference for method of birth was undesirable and seen as being inflexible. Over one third of the nearly 90 women interviewed spontaneously stressed the importance of “keeping an open mind” (Kingdon, et al., 2009, p. 890) and acknowledged that the actual birth would be determined by circumstances (for example, the conditions of labor and the baby’s position), not preferences. The authors conclude that in practice the choices available are seen as limited by anatomy, care provision and individual circumstances (Kingdon, et al., 2009).

2.2.2 Problems Regarding Informed Consent

In addition to the limited availability of choices in maternity care, evidence suggests that procedures are done and medications given without the mother’s fully informed consent. A 1996 study published in the *British Journal of Obstetrics and Gynecology* (Mould, Chong, Spencer, & Gallivan) assessed “the extent to which women contribute to the decision for cesarean section” (Mould, et al., 1996, p. 1074) and found that only 69 percent of the 29 women who chose elective surgical deliveries reported a medium or greater contribution to the decision. In 73 cases where cesarean section was done as an emergency surgery, only half reported a medium or greater contribution, and 30 percent felt that they had “no say” in the decision (Mould, et al., 1996). A study of birth experiences in the Netherlands (Rijnders, et al., 2008) found that 25 percent of the 1,309 women who responded to a survey about their birth experiences did not feel that they had sufficient choice in regard to receiving pain relief during labor. This was in turn associated with a threefold increase in their likelihood of recalling their birth experience negatively (Rijnders, et al., 2008). Women in the United Kingdom (Baker, et al., 2005) reported

that they were not given full medical details, information or explanations before procedures were performed and felt bullied into compliance with hospital policies. They elaborated that when they questioned the necessity of a procedure, the hospital staff cited their own expertise and equated the mother's preferences with medical risks rather than providing information (Baker, et al., 2005). In other instances, physicians admitted to using information as a tool to influence the decisions of their patients, guiding them to decisions that the physician feels is best (Lelie, 2000; Say & Thomson, 2009).

At issue is a woman's right to receive and discuss complete, unbiased medical information and then to use that information to make autonomous decisions about her own medical care (Say & Thomson, 2009). While information and consent do not amount to choice, they are necessary components of quality care. When these are absent, the result is that "pregnant and birthing women in the United States have limited valid information [and] limited true choices based on full disclosure of risks" (Wagner, 2006, p. 219). In the United States, comments like "I was given an episiotomy after I told them I didn't want one" (Declercq, et al., 2006, p. 61), "I was forced against my will... no one listened to me" (Declercq, Sakala, Corry, & Applebaum, 2008, p. 21), "I had little control" (Declercq, et al., 2006, p. 33), "I wanted to have a more natural birth but..." (Declercq, Corry, Applebaum, Sakala, & Risher, 2002, p. 29), and "I felt undermined in my decision" (Declercq, et al., 2008, p. 26) are found far too frequently in Childbirth Connection's *Listening to Mothers* reports.

2.3 PSYCHOLOGICAL ASPECTS OF MATERNITY CARE

Conception, pregnancy and birth are inherently psychological as well as physical experiences. As complicated natural processes governed by hormones and neurological feedback systems, pregnancy and childbirth do not lend themselves to external control by experts. Such control may in fact disrupt the natural system and render normal labor and birth impossible (Jomeen & Martin, 2008; Wagner, 2006). Still, American society generally fails to acknowledge the importance of the birth experience to women and their families. Instead, the birth of a healthy baby is equated to high quality maternity care (Lawrence Beech & Phipps, 2004). While much is said about the physical safety of the baby at birth, rarely is the spiritual or psychological safety of the mother mentioned, and little is known about how aspects of medicalization may affect these outcomes. The subtle, long-term effects of birth experiences have not been significantly evaluated (Lawrence Beech & Phipps, 2004).

Birth experiences, good or bad, are critical events in women's lives. Childbirth Connection's *Listening to Mothers* reports (Declercq, et al., 2002; Declercq, et al., 2006; Declercq, et al., 2008) consistently find that women value the sense of pride, fulfillment and increased self-esteem that are the result of a positive birth experience. Women interviewed for a 2006 study (Archer, 2006) "saw childbirth as important in creating their own identity and relationship to their child. Childbirth became a project which they learned about and planned for" (Archer, 2006, Conclusion, ¶2). Still, it is difficult to identify or quantify what is lost in the standardized, medicalized American birth experience, which views the mother as a sick person rather than an individual experiencing a profound life-cycle event (Davis-Floyd, 2004; Wagner, 2006).

2.3.1 Diversity Among Women

Women differ in their expectations and preferences regarding childbirth and maternity care (Baker, et al., 2005; Hildingsson, et al., 2003). There is significant disagreement across women about what should be available from the maternity care system and about how birth should occur. The medicalization of birth care is often a central tenet in this debate, with some women seeing medical management as necessary and acceptable and others viewing it as intrusive and avoidable (Van Wagner, 2004). Many factors influence this diversity of opinion, one of which is a woman's own assessment of risk. Risk refers to the probability of injury or damage to a person or to what that person values (Hall & Taylor, 2004) and is thus perceived differently based on individual values.

A labor and delivery textbook published as a guide for hospital staff acknowledged that “women will be from a variety of social, ethnic, and cultural backgrounds, so the circumstances of each individual will be unique” (Marsh, Rennie, & Groves, 2002, p. 1). It defined the “challenge” of providing maternity care as being “to create an environment that is supportive to the woman and her partner and makes them feel that their special circumstances and wishes are respected by those providing their care” (Marsh, et al., 2002, p. 1). It goes on to admonish, “It is important to remember that what may be routine and commonplace for staff may be strange and highly significant for the woman and her partner” (Marsh, et al., 2002, p. 1).

2.3.2 Traumatic Birth, PTSD, and Postpartum Depression

Psychological events or experiences are often overlooked and underreported as birth outcomes, but are relevant in that women attribute “maternity blues” or depression in the first month after

birth to negative feelings about treatment during their hospital stay (Baker, et al., 2005). For example, one mother reported that “being strapped down for the cesarean procedure... is a horrible feeling that left me feeling vulnerable and totally helpless” (Declercq, et al., 2008, p. 22).

Rates of clinical depression following childbirth are generally thought to be between 12 (Segre, O'Hara, Arndt, & Stuart, 2007) and 14 percent (Gavin, et al., 2005). Sixty-three percent of the 1,573 American mothers surveyed for Childbirth Connection's *Listening to Mothers* project (Declercq, et al., 2008) reported symptoms of depression, and 36 percent experienced full depression in the two weeks following birth, indicating that a considerable portion of American mothers are likely to experience depressive symptoms post-birth.

The prevalence of Post Traumatic Stress Disorder (PTSD) in the postpartum period is not well documented but thought to be between 1.9 percent (Soet, et al., 2003) and as high as 5.6 percent (Creedy, Shochet, & Horsfall, 2000). Eighteen percent of the *Listening to Mothers* participants experienced symptoms and nine percent screened positive for full PTSD (Declercq, et al., 2008). It should be noted that among African American women 26 percent reported symptoms (Declercq, et al., 2008).

The experience of birth as traumatic and the subsequent development of PTSD are associated with a woman's feelings of powerlessness during birth and her perception that she did not give consent or have sufficient information about the medical procedures that were performed (Beck, 2004; Menage, 1993; Soet, et al., 2003). Women who reported symptoms of PTSD also had concerns about their care being unsafe and experienced the birth environment as threatening or beyond their control (Allen, Nicholson, & Woollett, 1998; Beck, 2004; Creedy, et al., 2000; Czarnocka & Slade, 2000; Declercq, et al., 2008; Zimmerman, 2008). Czarnocka and

Slade (2000) further conclude that birth trauma lies in the eye of the beholder. They explain that births which mothers perceived as traumatic were often viewed as routine by the clinicians providing their care.

It is important here to note that studies have found that women who chose planned homebirths were more satisfied with their experience than those who delivered in a hospital (Baker, et al., 2005; Hildingsson, et al., 2003). In the Netherlands, a survey of 1,309 women found that four percent of homebirths resulted in negative feelings compared to 23 percent of hospital births (Rijnders, et al., 2008).

2.3.3 Optimization of Health Outcomes

Being able to choose is itself an aspect of quality care but beyond that, choice may improve physical and psychological outcomes of pregnancy and enhance the experiences of women giving birth (Baker, et al., 2005). A great deal of literature addresses the importance of autonomy and freedom of choice in medicine but very little on the health outcomes of patient choice and how choice affects quality of care. Accounting for preference is considered essential since “choosing the right treatment... is rarely either straightforward or entirely a medical decision” (Ziebland, Evans, & McPherson, 2006, p. 367).

Providing at least the perception of control in maternity care is known to reduce uncertainty, enhance coping, and decrease labor pain (Baker, et al., 2005). Similarly, women who did not feel they were consulted about procedures or felt their preferences were not respected reported increased pain associated with medical procedures (Creedy, et al., 2000). Research has also been done about the effects of choice on the outcomes of medical care outside of obstetrics. The *Journal of Behavioral Medicine* published an article in 1991 (Rokke, Absi,

Lall, & Oswald) on the results of giving patients a choice of strategies for coping with pain. Patients who chose a strategy reported greater confidence in the method, felt more in control and had improved pain tolerance compared to those who were assigned a strategy. More recently women with heart disease who were allowed to choose a treatment plan had better psychosocial functioning at four months and better physical outcomes at twelve months than their counterparts who were assigned to a treatment (Clark, et al., 2008). In this study choice appeared to enhance functioning for up to one year. The authors speculated that since different treatment plans had different requirements and demands, allowing patients to choose an intervention ensured that individuals were matched with the plan most acceptable to them.

Care must be taken, however, to provide full information to any patient required to make medical decisions. One study (Jomeen & Martin, 2008) indicates that depictions of childbirth as a risky process may engender concern among women over the appropriateness of their decisions, and thus foster anxiety. Another study (Lantz, et al., 2005) found that surgical patients who felt they had either too little participation or too much participation were equally unsatisfied with their surgeries and the decision making process. Managing medical circumstances successfully requires the active participation of patients since “only the patient knows about his or her experiences of illness, social circumstances, habits and behavior, attitudes to risk, values and preferences” (Coulter, 1999, p. 719).

3.0 METHODOLOGY

The purpose of this study is to describe the conceptual frameworks women use in making maternity care and birth decisions. In accordance with the Social-Ecological Model (McLeroy, et al., 1988), by exploring the environment in which women make maternity care choices and the factors that influence those choices we can begin to understand how women make decisions regarding the birth of their children. This study was conducted between March and December of 2010 using in-depth semi-structured interviews which took place primarily in Allegheny County and the city of Pittsburgh, Pennsylvania. This qualitative study was approved by the University of Pittsburgh's Institutional Review Board on March 30, 2010 (PRO10030429) (see Appendix A).

3.1 SAMPLE

This study drew its sample from the population of women between the ages of 19 and 45 who had given birth at least once and who had experienced maternity care within the past two years.

3.2 RECRUITMENT

Purposive sampling non-randomly selects participants based on their specific characteristics and the nature of the research being conducted (Patton, 2002). It was used in this case to recruit participants who could represent the wide array of maternity care experiences. Since most women in the United States give birth in a hospital under the care of a physician, purposive sampling was necessary to ensure that women who had made a range of choices were included in the study. An effort was made to include women who chose atypical birth locations, sought care from non-physicians, and experienced something other than a normal low-risk pregnancy. This was accomplished by distributing posters and information about the study through informal community networks with the assistance of gatekeepers that included midwives, lactation consultants, social workers, health educators, community organizers, and parents (see Appendices B and C for the Recruitment Script and Poster respectively). Posters were also hung throughout the city of Pittsburgh in restaurants, office buildings and public service agencies and were posted to social networking websites including Craigslist.com and Facebook.com.

3.3 PROCEDURES

Recruitment materials asked women to phone or e-mail the researcher if they were interested in sharing stories about the birth of their children. Upon contact, eligibility criteria were discussed and if met, the study design was explained and an interview was scheduled. In-depth semi-structured interviews were conducted during which participants were invited to recount their experiences with the healthcare system while pregnant and giving birth. Women were asked

about how they planned for birth, what they knew about pregnancy prior to conceiving, where they sought information, and how they felt about their care (see Appendix D for the Interview Guide). All interviews were conducted by the principal investigator, and no identifying information was collected or recorded. Gift cards were purchased from local merchants in the amount of five dollars and given to participants to thank them for their willingness to contribute and for their time.

3.4 DATA ANALYSIS

All interviews were recorded digitally as Windows Media Audio files and transcribed verbatim to text files by professional transcribers. Proper names were replaced with an initial, and other potentially identifying information was removed. Analysis proceeded on an inductive basis in that the process was not initiated with a specific hypothesis in mind. In lieu of asking the data to answer a particular question, analysis focused on listening to the stories as they emerged. Using grounded theory as operationalized by Charmaz (2004), the principal investigator read and re-read the transcripts, coded them, and looked for relationships and comparisons to identify emerging themes. Rather than occurring one step at a time, this method calls for ongoing analysis beginning as preliminary data are collected and then used to shape further interview queries. As the data coalesced, progressively focused codes were created by asking the questions suggested by Charmaz (2004): What is going on? What are people doing? What is the person saying? What do these actions and statements take for granted? How do structure and context serve to support, maintain, impede or change these actions and statements? These codes were

used to organize and frame the data, which facilitated the identification of relationships within it and ultimately the emergence of themes (Hesse-Biber & Leavy, 2006).

4.0 RESULTS

In total, 35 women contacted me regarding participation. Of those, 25 were eligible for inclusion in the study and all but three agreed to participate. In-depth, semi-structured interviews were conducted with 22 women, many of whom had experienced more than one birth and thus more than one maternity care episode. Most interviews were face-to-face and occurred at a location of the subject's choosing, often their home or a local café. Interviews lasted between 45 and 90 minutes. Telephone and web-based interviews were substituted sparingly when face-to-face was not possible due to geographic distance or by participant request.

The sample included mothers who gave birth between a few weeks to a full two years prior to the interview. While the majority resided in Pittsburgh or rural western Pennsylvania at the time of their child's birth, the study also includes women who lived in Texas, Maryland, Virginia, West Virginia, and Philadelphia. Demographic information was not formally collected, but participants self-identified during interviews as African American, Latina, Indian, and Romanian. None reported a sexual orientation other than heterosexual.

These women sought maternity care from an assortment of providers including obstetricians, family practice doctors and midwives and gave birth in large research hospitals, small rural hospitals, independent birthing centers and their own homes. Birth circumstances ranged from spontaneous vaginal delivery without the use of medical intervention to assisted vaginal delivery, preterm delivery, routine cesarean section, emergency cesarean section and

vaginal birth after a cesarean. While all babies were physically healthy and free of major medical concerns at the time of the interview, a number of them had spent time in the NICU. Several mothers also needed significant continuing care post-birth including treatment for postpartum hemorrhage and surgery.

Three major themes emerged and are described here in detail below. The first theme is that women take an active role in their own maternity care through the formation of goals. These goals include giving birth vaginally, birthing without medication, participating in birth decision making, avoiding pain and joining in a collective identity with other women who have given birth. In addition to setting goals for themselves, women articulated underlying birth philosophies that include a belief that birth is designed to go well, requires flexibility and is a natural process that women are capable of completing successfully with or without medical assistance. Women also talked at length about the birth philosophies of their care providers. The third theme is choice in maternity care, which includes the importance of being able to make choices, the strategies that women use for selecting a primary care provider, and the barriers that exist to autonomous decision making.

4.1 MATERNITY CARE GOALS

The 22 women interviewed for this study were not content to be passive recipients of maternity services but rather intended to be active participants in their own health care. Confirmation of this active role is found in the goals that women set for themselves and their pregnancies apart from any intention or influence of their providers. In fact, women often chose or changed providers in an attempt to find support for their goals. In addition to the preeminent goal of

remaining healthy and having a healthy baby, many of the women with whom I spoke had secondary goals, which included giving birth vaginally or without medication, fully participating in medical decision making and avoiding pain. In some instances these goals were articulated quite clearly while in other cases they were unspoken, hinted at, or recognized only after the birth took place as feelings of accomplishment or regret. The significance attributed to these subordinate goals varied as did the determination with which women and their families pursued them. Notably, it was not uncommon for a woman to have more than one secondary goal.

Women are often acutely aware of their own goals and make even early maternity care choices with them in mind. For example, one woman sought maternity care from an alternative provider because she did not believe that an OB/GYN would fully support her goal of an unmedicated birth:

I mainly didn't choose an OB because of delivery, not because of the services ahead of time. I wanted to have a natural birth without medication, which is what I did. And I just heard that OBs aren't always very supportive of that. So I wanted to kind of steer clear of an OB. (RB)

Goals also influence the choices that women make regarding medical intervention in the birth process. In one case, an epidural was rejected because the mother's goal was to remain fully in control of her own body:

I like to be in control, so I guess I felt like if I was medicated then I wouldn't be in as much control. Especially, I've had friends, their epidural is too strong when they try to push and then other people are telling them when to push. And I just didn't want any of that going on. I wanted to be fully in control of all of that. (RB)

Goals differ quite dramatically from one woman to the next, and it is important to note that these differences are apparent and notable to the women making maternity care choices:

I had a friend who was six weeks ahead of me within my pregnancy, so she would hit milestones and then tell me about it. You know, but she was in a different... Looking back I recognize that she was in a totally different stage. Like she knew what childbirth was going to be about. She'd tried it naturally and this time around she was planning on doing the epidural. And so her concept was very different than what I wanted. (KN)

I have my sister-in-law for one, she wanted a c-section. And she purposely did it for all three of her pregnancies. She wanted nothing to do with... Me, no, I wanted to try [to deliver vaginally]. Especially if this was going to be my only shot, I definitely wanted to be able to experience that if I could. (MS)

4.1.1 Vaginal Birth

One very commonly cited goal is to experience vaginal birth:

I had two goals. The primary goal: healthy mom, healthy baby. The secondary goal: vaginal birth. (JS)

While each participant's motivation for pursuing a vaginal birth was unique, they can be generalized into two categories: the transformative nature of a vaginal birth experience and the desire to avoid a cesarean section, both of which are discussed further below.

4.1.1.1 Vaginal Birth as a Transformative Experience

Some women consider vaginal birth to be a challenging, empowering and transformative event for which they are uniquely suited and which they do not want to miss:

I wanted the experience of birthing my baby... I think when you talk to women when they are 80 years old and they look back and they talk about their wedding day and the day their babies were born. It is such a profound biological experience, and I think it's something that, once you've done it, it's sort of amazing... The fact that we can force blunt objects through our flesh is pretty amazing. The uterus is a kind of strong and an amazing muscle. (JS)

I saw it as a challenge that I wanted to go through because I, you know, liked to test myself, you know, to see if I can handle certain things. (MP)

That's why it was really empowering to me... I mean, it showed to me that I am very determined. I do feel like, I felt a huge sense of accomplishment, you know, birthing quickly a big child... I looked at it as a big accomplishment... You have to go into this certain place in yourself where you either do it or you don't, you know... I just felt like I tackled it. (MP)

4.1.1.2 Vaginal Birth to Avoid a Cesarean Section

The pursuit of vaginal birth was often intertwined with and described in terms of the avoidance of unnecessary surgical birth. Some women were uncomfortable with the surgical procedure itself while others worried that surgery would inhibit breastfeeding, prolong recovery, cause permanent physical damage or increase the risk of neonatal complications. To some women, a cesarean section is simply not the right way to give birth:

It just didn't feel right to me. To me it just felt so wrong, like that's not how a child is supposed to enter the world. That's their first moment, the beginning of their life. It's a huge transformative and crazy scary experience for a child. And do we really want someone like reaching around and grabbing for their foot and yanking on them? I mean, it just seems a little freaky. (JS)

4.1.1.3 The Special Case of Vaginal Birth After Cesarean

At the intersection of pursuing the experience of vaginal birth and avoiding a cesarean section are women with a history of surgical birth who make vaginal birth, or VBAC, the goal of subsequent pregnancies. This decision is often made without the support of their health care providers and in defiance of conventional maternity care. Nevertheless, these women articulated the most intense desire to experience vaginal birth as well as the greatest determination to avoid a cesarean and put these two goals ahead of nearly every other consideration:

Just to have a VBAC. People would constantly ask me if I wanted drugs or not and I'm like, "I have no idea. I'd never been through labor. We'll see. I just want to not have another surgery. Don't want to have a c-section..." Yeah, I was pretty focused on that. (MP)

My main objective was to have a VBAC... When they go through your birth plan and everything, you know, how I see women have everything, you know, they want this music playing and I honestly, I don't care about any of that. I just want a VBAC. I just want to have this baby come down my birth canal. You know, I said, "I don't care about any of the other stuff." (HM)

These women may go to great lengths to experience vaginal birth. Participants report a scarcity of providers willing to support their intention to attempt a VBAC, and as a result they

talk about traveling unusually long distances to reach those providers, submitting to excessive medical procedures, and adhering strictly to their provider's recommendations for fear that the decision to facilitate a VBAC will be reversed:

We found out that it was going to be a little harder than we thought... I called literally, between me and my husband, we called every single doctor in the area. There are two major medical practices in the area and we called every single doctor that practiced at either one. (HM)

I mean it was like [a] military regime pregnancy, just because I was, like I was almost getting ready for a fight. Because I really felt that was what it was going to be, a fight to have my vaginal birth... I just felt like if I did every single thing [that doctors recommended] no one could change their mind at the last minute because I had done every single thing they asked. (HM)

When questioned further about her perseverance and the value of her VBAC, this woman shared that she wanted to experience what she considered to be normal childbirth because "I was never ever the first person to hold my baby." She went on to say:

I just felt like I was missing something. Like I was always medicated when they would take my baby out. My husband, he would cry every time and I would be sitting on the table strapped down, 'cause you know they strap your arms down, I mean, they strap your whole body down. So you can't hold your baby. All you get to do is see your baby. (HM)

4.1.2 Birth Without Medication

Unmedicated birth, what participants often referred to as natural birth, was the centerpiece of birth planning for many of the women with whom I spoke. Some participants defined this quite rigidly as excluding all pharmaceutical or surgical interventions while others were willing to accept certain exceptions. Oral pain medication, for example, might be acceptable to someone who conceptualized unmedicated birth as birth without an epidural. The unifying intention is to avoid any drastic alteration of the birth process so that birth occurs in as close to the "natural," vaginal, unmedicated state as possible. In describing their goals women used words like

“relaxed” and “as natural as it could be.” Participants explained their intentions in terms of testing their capabilities as women, avoiding the negative effects that interventions can have on health outcomes, and attending to cultural or religious norms.

4.1.2.1 Medication as Unnecessary

Some women pursue unmedicated birth because they believe that women are born able to birth. They see no reason to alter the natural process and are convinced that their bodies are able to accomplish birth successfully without assistance:

I felt like I can do this. In my mind, I didn't need those things. (JK)

Avoiding unnecessary medical interventions or drugs would have been like my goal... I guess I feel like and have faith in the fact that our bodies were designed to give birth. So if I was healthy for it and physically able to do it without harming myself or harming the baby, that's what I wanted. (JK)

I wanted to be able to feel the pain. I wanted to be able to ride through the pain. Again I thought, women all over the world do this without pain medication and I felt that I could do this too. Without pain medication. (KN)

One mother explained that she wanted to try birthing her first child without the assistance of medication because “I wanted to see if I could do without it. And whether that was just a better experience for me” (KA).

4.1.2.2 Safety

The refusal to accept medical intervention can be less about the birth experience itself and more about health outcomes. Some women simply do not see the benefits of intervention as worth the potential risks or side effects that they perceive to be associated with them:

I didn't want to be induced. Because I was worried actually that that would hurt nursing because I've heard that if you speed up the process that it might affect your ability to nurse properly with your baby. So I wanted everything to go naturally. (TF)

No drugs. I mean... They would help you with the pain, but if you use them it could lower his heart beat. So I wouldn't risk that. I wasn't that afraid of the pain. I mean, I was. But, in the minute, you would do anything for him. (DB)

4.1.2.3 Cultural and Religious Reasons

Some participants endorsed religious or cultural reasons for pursuing unmedicated birth.

One woman explained her intention to birth without medication by referring to God's plan for the child and guidance of the birth process:

A lot of it was... about how much better it was for the baby if you let things happen naturally, believing that God will have a plan for the baby, and God will show you and your body what to do to be as safe as possible come time. (AMD)

Another participant saw many benefits to unmedicated birth, one of them being identification with the maternity care practices in her home country of Romania:

From the first time I was pregnant I told her [the OB/GYN] I wanted a natural birth. No epidural, no pitocin... Because... Cultural issues. I knew that in Romania nobody does that. And they don't. Because it's very expensive, and Romania is a poor country. (JF)

4.1.3 Participation in the Birth Process

Women who expressed a desire to participate in their births talked about autonomy and full involvement in the decision-making process. They did not want their providers dictating birth choices but rather providing information and being flexible:

So when we got to the point where I needed to make a decision... what I really wanted was participation in the decision making process. I really stressed with them that it was important to me that I was allowed to change my mind... It's going to be about being able to say, "This is what I want. I changed my mind." (KA)

Some of these women also talked about being fully physically present and in control of their own bodies. To these women participation meant being able to follow their body's cues and allowing their intuition to guide the events of birth. They were concerned that medications would hinder their ability to listen to their bodies:

I wanted to be able to read my body and be able to let my body tell me when I should push and when the baby should come out. (KN)

4.1.4 Avoidance of Pain

The avoidance or elimination of pain is another distinct secondary goal. Some women see very little inherent value in the physical experience of birth and seek to eliminate or reduce pain as much and as soon as possible. They do not think that women should “have to” experience what they see as unnecessary pain and used phrases like “it’s not worth it” (JF) to describe their position:

My whole thing is the pain. I didn’t want to feel anything. So I basically was, you know, I just... I didn’t want to feel anything, and I knew that the epidural would pretty much do that for me. (KCA)

This participant explained that the physical aspects of birth were not significant to her because she had other ways of experiencing the birth of her son:

I didn’t want to feel anything. Because I didn’t need that connection... It wasn’t really a connection point for me. My connection point with my child for me is basically holding him and being there with him and just the whole bonding of holding him and everything. That was a real bonding moment for me. Not the whole birth process. (KCA)

4.1.5 Participation in a Shared Female Identity

Several participants espoused the more abstract goal of joining other women in the common experiences of birth and motherhood. They referred to women on a global scale and referenced their basic biological capacity for birth:

This is what we’re meant to do as women... I feel really fortunate that I’m able to do this. (LW)

This happens multiple times every hour to women across the world. And it’s a beautiful, kind of miraculous experience, and a ton of women do this in a very positive manner. (KN)

4.2 BIRTH PHILOSOPHIES

Women approach birth with their own individual understanding of how the processes of pregnancy and birth work. For the purpose of this paper, I am choosing to call these perspectives birth philosophies. Birth philosophies are distinct from goals in that goals are outcome oriented while philosophies are underlying points of view. A woman's birth philosophy may generate goals and perhaps guide birth decisions, but philosophies are not met or pursued; they simply are. Philosophies also apply to birth in general as opposed to the participant's birth experience in particular; while women did not see their own goals as relevant to the birth experiences of other women, they did tend to view all births through their particular philosophical lens.

Philosophies and goals also have distinct significance for the provision of medical care. Women expect their providers to inform and support their goals but rarely concern themselves with goals that the providers themselves may set. (The only exception to this was in the case of a medically complicated pregnancy where the woman's health care provider set and communicated the goal of reaching a certain gestational age prior to the child's birth.) In the case of birth philosophies, however, providers are sought who hold philosophies that mirror the woman's own. During interviews there was much discussion about the philosophies that providers hold and how women can discern their provider's actual viewpoint.

Birth philosophies may draw on religious or cultural beliefs about what guides the birth process. Some women embrace a position of "hope for the best, prepare for the worst" (MS). More common among the women with whom I spoke were philosophies that normalize the unpredictability of birth, promote flexibility and represent birth as a normal, natural process that is very likely to succeed.

4.2.1 Confidence in the Birth Process

One birth philosophy is a conviction that pregnancy and birth will go well. This is not a failure to recognize that complications are possible, but rather a confident expectation of success. These women firmly believe that if they remain healthy, pregnancy and birth will naturally progress in an uncomplicated way:

I was really confident that everything was going to be okay. (DB)

I always tell people, you know, “Feel good and take care of yourself, the rest will go well.” (LW)

4.2.2 The Importance of Flexibility

Flexibility is an underlying philosophy that life is unpredictable and that birth does not lend itself to rigid control. Perfection is not seen as a worthwhile pursuit. Rather these women believe that the most satisfying experience will result from limiting their own expectations and adjusting their goals to the events of pregnancy and birth as they occur:

So everything that I was trying to prevent actually ended up coming to fruition [laughing]. Which I was actually fine with. Because my birth plan was really just to be flexible, and whatever you have to do to get the baby out, you do it. And that’s the mindset that I had going in. (KN)

I was probably not clinging to the fact that everything had to be perfect... I just knew that I had to let things happen as they were going to happen, and I think letting go of that control was probably one of the fondest moments of... I thought that was a good way to do it. (LW)

An aspect of this philosophy is delegitimizing the pressure that women may put on themselves to perform or to orchestrate the perfect birth experience. One participant urges women to be confident in the decisions that they make:

I’m like, you’re doing the best that you can. With what you know at this moment, you’re doing the best that you can for your baby. Don’t second-guess it. (MS)

4.2.3 Rejection of Maternity Care that Treats Birth as an Illness

By far the most extensively articulated birth philosophy, alluded to in many of the quotations throughout this paper, is the belief that women's bodies are "designed to give birth" (JK) and to give birth well. Women talk about trusting their bodies and their "faith in how our bodies are supposed to work" (JK). To these women, birth is:

...Something that we are all made to do. Women know how to make babies and birth babies and babies know how to get born, and that is sort of just how things are. (JS)

Integral to the perspective of birth as a natural process facilitated by a woman's body is a rejection of the prevailing norm of treating pregnancy and birth as medical events:

I view birth as a natural process. I don't view it as a medical condition, something that you need to be in a hospital for. (KN)

I guess I was brought up to think of birth as a natural process, not a medical process, not a disease or sickness but part of our natural functioning as human beings... (JS)

In conjunction with this perspective, these women see medical incursions into the natural process as intrusive, unwelcome and potentially harmful:

I have a terrible fear with birth a bit becoming medicalized and of somebody saying to me, "Your body is not doing the right thing and I want to do this to you." Whereas I felt like, I trust my body to have a baby. (JS)

It is not uncommon for these women to avoid standard maternity care options in order to pursue birth in what they see as a less medically orchestrated and thus more natural way:

The birth center kind of way is the normal way to give birth if you are a healthy woman. Just don't go to the hospital unless you have complications... (JF)

One participant reminded me that women were giving birth long before commonly employed medical advances such as pitocin and epidural pain relief were available to them:

You have to remember that hospitals haven't been around forever. Some people were procreating without a lot of things that I have that they didn't, and somehow... No physician, no wet nurse, you know. (MS)

4.2.4 Provider Philosophies as Perceived By Patients

It is not within the scope of this paper to analyze the ways in which maternity care providers approach birth. What is relevant here is how their patients perceive their philosophies and the significance that these philosophies have to women seeking care. The women I interviewed discussed the philosophies of providers with whom they had contact in terms of three general categories: medically oriented philosophies, natural process oriented philosophies, and patient oriented philosophies. Again, these categories are not meant to reflect actual providers' philosophies, but rather to organize the perceptions that women have of their providers. They are also not meant to be read as dividing providers by certification type (such as OB/GYN or CNM). Although women do reference the types of providers that have cared for them, "natural process oriented" should not be read as "midwife."

4.2.4.1 Medically Oriented Providers

Medically oriented providers are perceived as comfortable altering or seeking to improve the natural course of pregnancy through ready use of medical interventions such as labor induction, fetal monitoring and pharmaceutical pain management. They are trained to medically manage complications, and their focus is on identifying what has gone wrong even in the absence of difficulties:

When I asked the question about moving around [during labor], it was a question on birthing philosophy. On how... Like, to the OB this is a medical situation, you need to be constantly watched, the baby needs to be constantly watched, and there is going to be something wrong. And so we need to catch that something wrong whenever it's going to happen. It's much more of a negative mindset, if you will. And I don't think that they believe that something's going to go wrong, but they are constantly aware of what could go wrong. They are always aware of what is going to go wrong. (KN)

The medical approach is one of preempting problems, such as in the case of one woman whose preterm leakage of amniotic fluid prompted her providers to treat her newborn for infection:

They had him on a ton of antibiotics, because if the rupture was due to infection from the leak, they wanted to... They just were like, “We’re assuming he has an infection, and we’re zapping him.” So they had him on oral antibiotics, IV antibiotics... (MS)

Some women expect their healthcare providers to take a medically oriented approach, welcoming it as a necessary part of maternity care, and others see it as a safety net should complications arise. Women who do not share this medically oriented approach to birth may experience care from these providers as disconnected, unreasonably intense or invasive; and the provider is perceived to over-treat the patient:

The doctor... her answer to everything is, “Go take this medicine” or “Go do that test.” If I ever told my OB something that was outside of the mainstream. For example, my sugar kept dropping and I would start shaking because I had low sugar and she would say, “Ooooh, you need to, there is some medicine that you can take.” And I would say “No, no. I’m not telling you because I need a prescription, I’m just telling you so that you know.” I said, “Look, I’m taking glucose when that happens.” And “Oh, that’s a good idea!” So see, why didn’t you tell me so? “Take glucose!” (JF)

4.2.4.2 Natural Process Oriented Providers

Natural process oriented providers were perceived to approach medical alterations of natural pregnancy and birth processes with more caution. They appear to place more trust in the woman’s body and intervene only when medically necessary and always in the least invasive way possible. Although capable of managing complications, their focus is on prevention and support rather than risks and abnormalities:

And their approach was just very cautious. Everyone who is in that practice, I think there are eight midwives, they’re all onboard with the same philosophy of, “We don’t try anything risky, or expensive, or invasive until we try other things first.” If it’s necessary, it’s necessary. But they had the experience to know what other things to try first. So I thought that was a really good idea. (KA)

So with [my providers] it's a little more of a positive spin. And I believe that they do look out for things that are wrong. They are knowledgeable about the things that could go wrong, but they're not necessarily focused on that. (KN)

The natural process oriented provider discourages medical practices that are not evidence-based and instead facilitates birth through more holistic means, such as water therapy and movement. A doula is a professional birthing assistant who stays with the mother for the duration of her labor and is trained in non-pharmaceutical methods of pain relief:

And when I talked to the family medicine doctor, they were really more in line with the midwives in terms of they want you to have a natural birth if possible. They don't believe in episiotomy. They gave me the name of a doula practice, that's how I found the doula. And they were you know, "Have a doula..." (RB)

4.2.4.3 Patient Oriented Providers

The perceived philosophy of patient oriented providers is that patients should influence the level and type of care that is given. The provision of care is guided by the goals and philosophies of the individual patient in such a way that the patient's goals become the provider's goals. These providers see their role as assisting the patient's own coping and decision-making and are subsequently described as "laid back" and "flexible:"

So yeah, that birthing experience was... exactly what I wanted. And that is exactly what they said, "Look, you got the birth you wanted!" And that kind of was their goal, and it was my goal. It was just, how ever I wanted it to happen, that's their goal... They're just all about me having the birth experience that I wanted to have. (MP)

I think that midwives have this profession-wide shared feeling that it is important for people to be involved in their medical care... And that the role of the medical professional is to assist in decision making. (KA)

Their philosophy was very... They were very me centered. They didn't feel that decisions ought to be made by someone other than me so they had a philosophy of informing me to make my own decisions. (KA)

4.2.4.4 The Importance of Determining a Provider's Philosophy

Many of the women with whom I spoke sought out a provider whose approach to birth mirrored their own. Participants felt connected to and trusted providers whom they perceived as having similar birth philosophies or who gave precedence to the woman's own philosophy. Along those lines, women acknowledge that a single provider, no matter how adored by a particular participant, will not address the needs of all women. This situation is attributed to the differing approaches to birth that women take:

My nanny right now, we just found out that she's pregnant, and I joke with her, "How am I going to be able to get you to the midwives so that you can experience the love?" [laughing] but she is not a midwife person. She is very much like, a doctor, "I want to be in a hospital, I want drugs," and all that kind of stuff... And I do think it's a very unique and personal relationship that you form with that person. So for her it would be better with a doctor... She is going to do what's right for her. And what she feels like is right for her body. (KN)

Trust between a pregnant woman and her provider also seems to be a function, at least in part, of compatible birth philosophies:

I had a lot of trust in my doctor because we were always kind of on the same page so I felt like if he thought that [the use of a vacuum] was a last resort then it probably was. (RB)

Furthermore, dissimilar philosophies seem to foster mistrust and suspicion of a provider's intentions and motivations. This is especially true when medically oriented providers are caring for more natural process oriented women:

I was worried that my labor was going too slowly and they were gonna grow weary of me taking up a bed in the [hospital] and would try to intervene or send me home or something. (AMD)

I have quite a few friends who have kids or have recently had children. And just hearing their experiences, it seems like... I'm talking about maybe like six or seven different women... Of those, there's been probably like five or six of them who had medical interventions, I would say, involved with their births. And I'm not a doctor, I wasn't there. I don't know what their specific experiences were, if those things were absolutely necessary or just what the facility or the doctors did with them, but I thought, there's got to be another alternative. I'm a healthy person. Our bodies were designed for this thing,

for giving birth. I didn't really see any reason to have to go through those [medical] things if I didn't need to. (JK)

Assessing the philosophies of potential maternity care providers becomes especially important to women who have felt misled or deceived by past providers. One participant delivered her first child by emergency cesarean and her second by scheduled cesarean when her OB/GYN reversed his support for a trial labor as she approached her due date. When she became pregnant a third time it was important to her to find a provider who would approve a VBAC:

Obviously if you have a 46 percent c-section rate, you're probably not pro vaginal birth, as much as you may have told me at the beginning. So I started thinking like, "Okay I need a doctor that doesn't just tell me that. I need a midwife who doesn't just tell me that, who actually means that." (HM)

I tell everybody... The only thing I like tell every woman I see who is pregnant who wants... I tell them to either be with a midwife or go see a doctor that you know is actually pro vaginal delivery, who doesn't say one thing and do another. (HM)

Her search for such a provider led her eventually to an OB/GYN whose wife had given birth vaginally after a previous cesarean, which she took as proof that his philosophy was really compatible with facilitating her planned vaginal birth:

And when he told us his wife had a VBAC we were like, "Yes. That means he's pro..." No doctor is going to let his wife do something that he doesn't think is, that he thinks is not medically sound... That kind of made me feel like okay. Obviously if he let his wife do this, he believes in it, you know? (HM)

4.3 CHOICE IN MATERNITY CARE

Women are passionate about their ability to make autonomous choices about their own medical care and use those choices to control the type and amount of care they receive. Included in this section are the strategies that participants used to select their primary care providers and a

discussion of the availability of choices. Barriers to choice include a lack of knowledge, rushed decision making, the social stigma of alternative choices, restricted availability of alternative care, unwillingness of standard providers to provide alternative types of care and the cost associated with non-standard services. A final barrier to choice is that occasionally women are given no options at all.

4.3.1 The Importance of Having Choices

This study found near universal agreement among participants that a quality maternity care system would offer women choices. There was of course less agreement on the current availability of adequate choice and on what types of choices should be available, but fundamentally women agree that being able to meaningfully influence the course of their maternity care is important:

I think that every woman should have the choice. Every woman I think should have the choice to have their baby at home, have their baby in a birth center or have their baby in a hospital. I think that's sort of like the American way. So that people can decide what's best for them... (JS)

Somewhere along the way, it's my perception, of course, that the medical community steps in and prescribes these things that aren't completely necessary. But I feel like if you're healthy and you can do it and you want to do it naturally, they should be able to. And I guess from that perspective, I'm very passionate about that you should be able to choose and seek out that level of care... I guess I would say, I would think everyone would have that choice. (JK)

Choice is important in part because women are very different and thus have different needs and preferences. "I do think it's a matter of preference... So I think it depends on what you want" (MP). One participant, for example, cited a lack of family experience and knowledge of birth and her belief that midwives offer more emotionally supportive care as her reason for choosing a midwife as her provider:

I guess it would be different for every person because for me I was very attracted to the more personalized nature of it [midwifery care]... I don't come from a very big family. My mom and I aren't exactly close to talking about pregnancy and things like that... I have a sister but she doesn't have children, you know so... I felt like I needed a little extra support. So that's one thing that attracted me to that too. Whereas some people may think, "Oh it's just natural to do this or go to the hospital. It's just what we do and everyone in the family has done it that way." Some women don't think twice about it. I guess me personally, I told you I was nervous about it. I felt like I needed a little extra support. (JK)

Other women used the existence of options strategically, to assure that they received the type and amount of care that was right for them at the time:

And then I found a group of three midwives and I immediately knew I was going there. It was just more holistic, you do what comes naturally to you, what your body tells you to do, like more trusting of the instinct of the woman and how she feels that she can get through that process. And that's what I wanted. So I ended up with the midwives. (KN)

Friends of mine who have done, staying in the OB/GYN type medical practice, not going to midwives at all, but needed to be on much more... A fight. They needed to say to their doctors, "This is the plan. These are your standard practices which are in contradiction with my desires. And we need to know ahead of time that I am a difficult patient for you in these ways." Just constant vigilance about saying, "No. This is what I want. This is what I want." I didn't want to have to deal with that. So I went with the practice where their standards are a lot closer to what I wanted. (KA)

4.3.2 The Selection of a Provider

One way in which women may exercise choice and influence the course of their medical care is through the selection of their primary care provider. Among the myriad choices that pregnant women make, this decision stands out and is given special attention here for its potential influence on other choices. In many cases the provider chosen will dictate the location where birth takes place. For example, OB/GYNs rarely if ever assist a planned homebirth, and most physicians have treatment privileges in only a limited number of hospitals. The location of birth in turn influences the types of care that are available. Pharmaceutical pain management, for

instance, is available only in a hospital setting. The birth philosophy of a provider, as previously discussed, may also influence the type of care a woman receives.

The significance of provider selection was not lost on participants. Women knew that their choice of provider would influence the options available to them throughout the pregnancy and birth:

Even though you're in your second month, you need to think about how do you want your birth to be at the end. Right? And you need to make sure that how you want it at the end, that you're setting up for it right now... By having the right practitioner, by asking all the right questions now because if you need to change you need to change early. (KN)

Women come to their maternity care providers in innumerable ways. Some choose based on the convenience of a particular office or a reputation for exceptional care. Participants commonly cited previous contact with a provider, the recommendation of a friend, disagreement with an OB/GYN, the amount of experience that a provider has or an interest in a particular type of care as reasons for their choice. A few participants were not able to choose a provider directly but rather chose an office and received care from the provider on duty at any given time.

4.3.2.1 Current Provider

At least six participants made their initial prenatal care appointments with providers who were already familiar to them. Often they had previously received annual gynecological care from a provider, and initiating pregnancy care from the same provider was very comfortable:

I had a great doctor, who I already had a relationship with, and I knew that she would take my questions and concerns seriously and respect any decisions I made. (BM)

I saw the midwives... and I have been seeing them ever since I moved to Pittsburgh. You know, so I saw them for maybe a full year before I got pregnant with my son. (MP)

At least one woman had a more extensive history with the practice from which she sought care: "He delivered me and my siblings" (MS).

4.3.2.2 Disagreement with an OB/GYN

While for the most part women were happy with the maternity care they received from providers who were known to them, a few established care with their OB/GYN and then sought alternative providers after some type of discord. For example, one mother was happy with her provider until she became pregnant and needed more care than the office was able to accommodate. She subsequently established care with a group of midwives:

I had a regular gynecologist that I saw and that's who I made my first set of appointments with. And they were overbooked or something. There were other problems but it was just really clear that they didn't have time to devote to me and my questions. (KA)

Another woman sought midwifery care only after finding that her physician would not support movement and use of "the gravity situation" during labor:

When I got pregnant with my first child I was actually going to a traditional OB at the time... It wasn't until probably about my 10th week when I started... asking a lot of questions about delivery. And my big question was, am I going to be able to walk around? Can I get up? Can I walk around? And the doctor plainly said no. She said, "You will be attached to a fetal monitor, you will most likely have an IV, and you will be in bed throughout the whole entire labor and delivery." She's like, "You might be able to get up, but you aren't going to be able to walk." She was almost, it was almost comical to her. That I would want to. That I would envision myself walking around during the whole labor process. And... it was important to me to be up and around and moving. (KN)

When the doctor said that I was going to have very little movement within my delivery I immediately knew I was switching to midwives and I needed to find them. (KN)

4.3.2.3 The Recommendation of Friends

Participants without a previously established relationship with a maternity care provider often went to family and friends for references. Women reported feeling more confident in seeking care from providers who had been recommended by a trusted peer:

I really trusted her. And our friend that had twins also with the midwives... She had twins there and she also told me that it was a great experience for her. So that made me confident that it was good. So I had all of my prenatal care there and it was good. (DB)

I called a couple of places and nobody could get me in right away... So I ended up looking around through some friends... I have friends who are doctors and one who had a baby, or was pregnant, I guess, before me. But she said, "You have to go to this practice. They're really wonderful and they deliver all the residents." Like, all the nurses go there. Like, it's the place, by word of mouth, that is the place to go, this one practice. I was like, "Sweet." (LW)

4.3.2.4 The Provider's Level of Experience

The provider's amount of experience and reputation for handling emergencies were both considerations when women sought maternity care providers. Participants "wanted medical professionals who knew enough about the process of labor and delivery to know when to intervene" (KA). Even women who planned to avoid medical interventions were interested in receiving care from a provider who could be counted on to offer exceptional care should the need for interventions arise. One participant was upset when the practice she was with took on a third provider:

I didn't want to have someone to deliver my baby who didn't have as much experience as the other obstetricians that I was seeing. I know that she's a physician, and I know she has training in the area, but if something goes wrong... That's the whole purpose of why I went to those two physicians, because they're known to do really well in emergency situations. So I was just preparing myself ahead. (TF)

The type of care available from a given provider was also a factor in making decisions. Not being certain ahead of time what she would want or need during labor, one participant chose a practice with a wide variety of choices available in house:

I actually decided on the midwives at [the hospital] because they were immediately in the hospital should I need surgery. They were also able to give epidurals if I wanted or needed, and it wasn't going to be difficult. I was just, wait ten minutes for the anesthesiologist to come. It wasn't wait for an ambulance and then be transferred to the hospital. And I didn't know what I would ultimately want... I wanted whatever options were available to be really good. (KA)

4.3.2.5 The Intention to Avoid a Certain Type of Care

Often when women seek out alternative care providers it is with the intention of avoiding a certain type of care. What exactly is being avoided differs, but there is a sense that vigilance is required to avert cold, medicalized, intrusive care. One participant summed it up nicely by explaining her position that physicians are not optimally suited for providing care to low risk women. She felt that unnecessary interventions and medicalized care could be avoided by choosing an appropriate provider:

Obstetricians aren't trained to be there for low risk deliveries. That's just not what their training is in. Midwives are experts in low intervention births and low risk births. That's what they know how to do really well. And a good midwife, if they need to bring a doctor in, is going to know when to do that. So you don't have to worry about that really. You've chosen the right kind of professional. (JS)

Other women took similar positions, choosing alternative providers thinking that they could avoid unnecessary interventions and maintain their own autonomy by doing so:

I figured I would... end up with a doctor that would say, "You need an episiotomy. You need this. You need that. You're getting the epidural." Things that I would feel like I wouldn't have any control over rejecting or putting my foot down about. So that's what made me want to go and check out the midwives. (JK)

Standard providers can be perceived as excessively cold and judgmental, which some women found to be counter to successful maternity care. One woman had just "never really been a doctor's person" and was thus "very intimidated and very nervous about the whole process" (JK). Another participant shared:

Because every other kind of OB/GYN I'd ever gone to in my life, he was just, nothing traumatic, but just an unpleasant experience for the kind of things that you have to do with this person. They are just so disconnected. And I thought, "Well, you know, I'd like to see a midwife..." Just because I hear that they are a bit more attentive to, I don't know, your feelings maybe... Because you know, dealing with my lady bits, I'm very sensitive, very private. I just want to, in a health care setting I want to feel as comfortable as possible and for a few years now, I have been, you know, overweight, and I've felt a lot of judgment from regular doctors, and I knew that I would want to feel as comfortable as I possibly could, especially getting pregnant. (MP)

4.3.3 Barriers to Choice

Participants found the pervasiveness of standard maternity care practices to be a barrier to alternative choices. Time factors, social stigma, the availability of alternative providers and birth locations, the unwillingness of standard providers to provide alternative types of care and the cost of non-standard care were also reported as barriers to choice.

4.3.3.1 Knowledge of Alternatives

One barrier to alternative care is a lack of knowledge or familiarity with possibilities outside of the standard maternity care practices of giving birth in a hospital under the care of a physician and managing pain with an epidural. Women feel that these practices are “ingrained” (JS) into society to the extent that they are not questioned or seen as options at all. Many participants had never known anyone who chose a midwife or gave birth outside of a hospital, and others discovered the existence of midwives only after they were pregnant:

I don't know anybody. I haven't known anybody who had their baby at the birth center. And I haven't met anybody else who had their baby at home. (JF)

Every single one of my friends except for one used an OB. (KN)

Busy schedules and social messaging were also cited as barriers to pursuing alternative types of care. Television shows, for example, were criticized by a number of participants for dramatizing birth and depicting only standard birthing options:

I also think that people just don't know. I think that in all of our culture it's always doctor doctor doctor, hospital hospital hospital. Like if you look at those shows that are on TV, I think that there was maybe one that focused on a midwife... But all the other ones, you're in the hospital right? You are with a doctor... In this very medical hospital setting. And so you know, when you're bombarded with images and information like that you kind of just assume that that's the way it should be. You should deliver on your back. That's how it's supposed to be... We're stuck with that image. (KN)

4.3.3.2 Pressure to Establish Care Early

Along those lines, women often feel rushed in their maternity care decision making. They have busy schedules and hectic lives and also feel pressure to establish prenatal care as early as possible:

Well, I guess I was seeing an OB... And then when I got pregnant you know a couple of months later I was just like, "Okay, well, I guess she'll help me with that." And she said no. And I kind of panicked and they referred me to other doctors and I thought, "I guess I better hurry up because I don't want to go too long without prenatal care." (AMD)

That's one thing I was thinking, I was working full time... To even think about going to different appointments to meet different doctors... That was the thing. How do you pick a doctor? I don't have time really. I would be like, "Who do you go to? Sign me up." (JK)

The time that it would take to research alternatives, locate a provider and establish care with that provider often seemed like insurmountable hurdles given the other demands of pregnancy and everyday life:

Sometimes I feel like our lives are very busy, that people don't have the time to step back and think about what's going on. It's just like they go with the flow. If they go through a hospital, then that's normal and that's what you do to have a baby. (JK)

We somewhat considered a doula, but I think partly what deterred me from even looking into it was the time factor... Feeling like I was working full time and was away from home for like 11, 12 hours a day... Going to like, say, my appointment and get ready for the baby, and throw in a doula on top of it. I'm sure you'd have to meet with them or you would want to meet with them, get to know them if they are going to be at your birth. And that takes time. So I think the time factor was the deterrent from all that. (JK)

4.3.3.3 Social Stigma

Some women who sought alternative types of care felt that they had to defend their choices due to inaccurate or prejudiced ideas about those choices:

I do think that there are lots of misconceptions about the midwives... I think that people think that they're either for lower income, or they think that it is something that is going to be medically risky, that they don't have all of the medical information that they are going to need. That there's going to be more emergency situations, or accidents, or a

higher death rate or whatever. I do think that there are lots of misconceptions out there. (KN)

In describing the social climate of her community, one participant associates the rejection of midwives with ultraconservatism and racial prejudice:

I live in a very rural county in South Texas, about 20 miles outside a city of about 65,000. It is not a wealthy area, except for a select few families, all of them white, and it is not a very accepting area... Racism against both blacks and Hispanics is alive and well... The Tea Party has lots of followers, and Fox News is the preferred network here. Midwives, doulas, etcetera are things that most people in this area consider to be weird and alternative... You should see some of the reactions when I talk about my cloth diapers or wear [my son] out in public in a sling! (BM)

4.3.3.4 Availability of Alternative Providers and Birth Locations

Many participants spoke about difficulty in locating and receiving care from alternative health care providers. They reported waiting lists, limited numbers of providers within a reasonable geographic distance and a complete lack of certain options such as giving birth at home. Midwives, doulas and birthing centers were not available to one participant in rural Texas:

The problem... just lack of alternatives. There are no midwives, no doulas, no birthing centers, no birthing classes, nothing other than the “traditional” medical doctors and hospitals in my town. There isn’t even a lactation consultant within a 90 minute drive. You have to go to Houston, San Antonio, Corpus Christi or Austin to get anything different. (BM)

And in Virginia, only one midwife practiced in the midsized city where this participant believes there is a market for midwifery care:

So I found what I believe to be the only midwife in this area. She works at a practice of OBs at the birthing center at my local hospital. Well, I looked online and... in the yellow pages and whatever, there was one midwife... I think that a lot of people in this area would want a midwife! (AMD)

Other women agreed that more mothers would choose alternative types of care if only they were more readily available. Several participants were interested in the possibility of giving

birth at home but found that the availability of providers to assist a homebirth is especially restricted:

I would have loved to do a homebirth! But the only midwives in the area... The only certified midwives didn't do them. Yeah, I would want to do that next time maybe. (AMD)

Unfortunately, you know, in Pittsburgh there's really no option for having a baby at home. (JS)

In our society a lot of people don't get to make that choice [to have a homebirth]. I think if it was more available, lots more people would do it. (JS)

Where alternative providers and birth locations do exist, they may be unavailable due to the number of women seeking their care:

First I looked into a CPM, and she was booked, and I was sort of feeling really anxious and almost like despairing because I didn't know what to do and I didn't feel comfortable where I was. (JS)

The one thing I kind of picked up on is, they said that there are some months that currently are closed [at the birth center]. Like say, if you... called there and said, "Hey, I'm due in November." They might say, "Oh, we're full for November. We can't take you." So there might be a situation like that. (JK)

Perhaps most illustrative of this dilemma is one participant who delayed the conception of her first child, "as funny as it sounds," by six months or more until her preferred birth location became available. She did not want to conceive until she was established with the practice of her choice, so "we waited trying until after that appointment." She described the process this way:

Even getting in with the midwife center took some time. My initial call there was in February like last year. At that time I just wanted to... I read on their website that they did well-woman care. So I thought, "I'll just go for my regular annual check-up to see if I even like it there before we even try to have kids." My initial call was in February and they said, "Well, there is a waiting list for new clients, for new well-woman clients." I think that's what she called them... At first I was very discouraged... because I was kinda getting antsy to want to try and have kids. I was like, "Oh, no. I'm on the waiting list." So like two months went by... I think it was like six weeks, and we still hadn't gotten a phone call. And I had, seriously, just about given up on the idea of trying to go through the midwife center. "Maybe this just wasn't meant to be." Honestly. Then one day I got home from work and there was a message saying that they had availability if I wanted to schedule an appointment. So I was so excited. I called back and they said, I think that

was April, they said, “We can see you in August.” I thought to myself, “What? That's four more months.” But I went with August. (JK)

4.3.3.5 Hesitancy of Standard Providers to Provide Alternative Care

An additional restriction on the maternity care choices available to women is the apparent unwillingness of standard providers to provide alternative types of care. That is, OB/GYNs are reluctant to care for women who want to experience pregnancy and birth in ways other than what is standard. Birth, for example, is expected to happen while the mother is on her back in bed and most likely receiving pain medication. One participant was surprised when she found that her doctor would not support movement during labor:

At the time I thought there was more flexibility in how... Because I think at the time I was thinking, I'm going to be able to develop a birth plan and the OB would be able to be flexible with that birth plan. You know, I've heard of people giving birth in water, being able to labor on a ball, and I was a little surprised that I wasn't able to get up and walk around. Which to me just seems like such an easy and normal thing to do. And when she said no, I started questioning a lot of what was going to happen, and I didn't like what I was hearing. (KN)

This rigidity is perhaps most striking in the case of women who pursue a vaginal birth after a cesarean. Many providers flatly refuse to take on patients who are interested in a VBAC and have policies to that effect. One participant in particular described this circumstance:

I called my original OB/GYN and he didn't even come on the phone to talk to me... His nurse practitioner came on the phone, and I knew her. She had helped me before and she said, “No, after two [cesareans] we won't even discuss it [vaginal birth].” And I said, “Okay. Thank you very much,” and just hung up. (HM)

We have two major medical hospitals like literally within 15 to 20 minutes from us and I still could not find a doctor who would allow [a VBAC]. (HM)

The same women reported that providers restrict the availability of VBACs by imposing limitations such as requiring birth by a certain gestational age or allowing a trial labor only in the presence of a history of successful vaginal birth:

Apparently the tested pelvis, that was one of the things that I got told once, “If you don't have a tested pelvis you can't VBAC.” Well, how do you get one of these tested pelvises if nobody lets you VBAC? If nobody will let you try you're never going to have a tested pelvis... They kept saying, “No tested pelvis, no delivery. No tested pelvis, no delivery.” I was like, “Well you're never going to get a tested pelvis if you keep telling people no.” (HM)

There was one doctor who would meet with me for a consultation... They tried to dissuade me from [a VBAC] and then they said... “If you go into labor before 38 weeks.” I was like, “You're not even letting me get to my due date?” (HM)

I mean, it just seemed awful that I couldn't find one doctor who would just see me and let this pregnancy take its natural course. (HM)

Further limiting the availability of a VBAC is the additional monitoring that some providers feel is necessary:

It was kind of a stressful, the actual prenatal part was kind of stressful because I felt like if I didn't do everything the doctor said, that was it, I couldn't do a VBAC. So it was probably my most stressful pregnancy. This perinatal doctor had a lot of very... I was a relatively low risk in comparison to people they were used to. And because they are used to all these high risk women, they gave me the same treatment almost... I was just to the point where I was overwhelmed by medical stuff, where I was like, “Look, I'm just pregnant. I'm not dying.” (HM)

4.3.3.6 Cost

While it should be noted that more or less equal numbers of participants reported satisfaction with the cost of their care and their insurance company's coverage, some women reported costs and a lack of coverage as prohibitive of alternative care. Not all insurance providers cover births that occur outside of a hospital, which means that even where birth centers or assisted homebirths are available many women will not have access to them:

The midwife center doesn't take our insurance... They're in a different healthcare system. Yeah, so unfortunately I would have gone there for sure but it wasn't an option. (RB)

The problem was that the insurance doesn't pay and it [the birth center] was \$4000 in San Antonio. So I was bummed out about that. Because I could have afforded the \$4000 but it would have been a big sacrifice. There are two freestanding birth centers in San Antonio and there is an OB practice that has three CNMs working for them, which is tied

to the hospital. The three CNMs are covered by insurance, the free standing birth centers are not. (JF)

Women who found doulas helpful also acknowledged that they are expensive, thus not everyone will have access to them:

I mean, I tell all my friends that if you can afford to get a doula then get a doula because that's really, it made a big difference. She was there to show my husband how to help me through the contractions... That's a lot of work! And nobody is going to do that for you if you don't have... And she always seemed to say the right thing. So I encourage friends to get doulas. I don't think many people want a doula. I don't think they know what a doula is, I think they feel like it's expensive. 'Cause it is expensive because insurance doesn't pay for it. (RB)

4.3.4 Violation of Informed Consent

In addition to discussing the barriers to alternative maternity care choices, women described circumstances in which they were not able to make choices at all. Participants frequently felt as if their decisions, especially during the course of their labor, were rushed or distracted and made without their true consent. Several women reported feeling that they had no other choice but to comply with an intervention of dubious necessity, and at least five women were forced in some way into procedures they did not want.

During labor women are routinely required to make decisions or to give their consent for medical procedures. This is reportedly often done without providing an environment conducive to information sharing or decision making, and the result is that women feel rushed, distracted, pressured or uninformed. In addition to labor itself, women are physically exhausted and deprived of nourishment while making medical decisions:

Because I was so focused on the pain and getting it to stop, I wasn't thinking about what they were doing. By the time we actually saw a doctor, we'd been in the hospital for over eight hours already and I was exhausted... I would have said no to breaking my water and said no to the pitocin... The doctors are in and out so quickly that it's hard to remember everything you wanted to discuss. (BM)

When the doctor decided to break my water, it was more a “Let's get this show on the road” than a “Do you want us to break your water, here are the risks, here's why we want to do this, etcetera...” Plus, at the time the decision was made, there were several nurses, the doctor and the anesthesiologist all in my room doing various things. I didn't have the time or energy to actually have a discussion about it, since I was busy getting fully admitted and getting an epidural all at once. (BM)

My mind wasn't really with me. I had no strength to argue. I was just, um, just trying to listen to people and you know, focus on what they were asking me to do and what my body was telling me to do. (AMD)

One participant reported being given paperwork about the epidural during her labor, which she was unable to read and understand due to the pain she was experiencing and because she had no reading glasses with her. No assistance was offered, and she signed without full knowledge of what she was agreeing to:

When they made me sign the papers for the epidural... They gave me like six pages of paperwork and... I always want to read everything before I sign it. If people don't want to wait for me I just tell them, “Then I won't sign it...” I'll take it home and read it and come back. But at that time because I was in pain I couldn't read it. So I was trying to read it and my eyes were like... Plus, I wear glasses and I didn't have my glasses. I just remember I went to the side effects and I remember I saw death on there. And I said, “Oh well, if I'm going to die, I guess that's it.” Probably I won't die, so I just signed it and gave it back to them... (JF)

Even more problematic than inadequately informed consent are reports that women feel forced into procedures that they do not want. For numerous reasons, women often do not feel that medical decisions are theirs to make and are surprised at how little input they have in the decision-making process:

Because you don't. I mean when the doctor says, “Hey, we're taking this via c-section” what are you going to say? No? You can't.” (KN)

Ultimately, women feel that “other people, being the doctors and also the baby, were way more in control” (KN) over the mother's own body than she was. Some of these situations are a matter of hospital policies that severely restrict choice; others are a product of the woman's uncertainty about how to disagree with her provider. Women may not always realize that they

have other choices, and they may be afraid of being rejected or punished by their providers for noncompliance. In some cases, women insist that they would have done things differently if the choice were left to them:

I really don't think [being induced] was my decision. If it had been my decision, I would have waited for my water to break. But that's just me. I would have understood if they wanted to induce me when I was overdue by like two weeks... I totally understand that... But I really think they took him earlier than, you know, what they should have. (KCA)

After an epidural placement mistake that caused this same mother pain immediately and for months after delivery, her providers proposed correctional procedures that she felt she had no control over:

The anesthesiologist came in and said, "Well, I'm going to go ahead and take out the epidural. If we have to put in a blood patch then we will redo the epidural and put it in." I'm like, "What?" Like, that doesn't sound like a great idea to me, but he did it anyway. I didn't have much choice. (KCA)

Artificially breaking a woman's water was frequently reported as a means of accelerating the labor process. In many cases, this was presented by providers as "necessary" and done without the mother's true and informed agreement:

The birth was nothing like I was expecting. The contractions were much, much more painful, and labor didn't progress nearly as quickly as I was expecting... I didn't want my water to be artificially ruptured, but since it was going so slow, the doctor broke it at 8:30am. (BM)

I was only four centimeters. In six hours. And at that point the doctor said, "You're going too slow, we're going to break your water." (JF)

Hospital policies are also a source of restricted autonomy. Participants reported that hospitals require everything from bed rest to internal monitoring of the fetus during labor, again leaving women with no choices and the feeling of being forced:

I had briefly discussed breaking my water with the doctor and asked about not having internal monitoring, but left it open, just in case there was medical necessity. I was told the hospital required internal monitoring and since I'd be stuck in a bed anyway, it wouldn't matter. (BM)

Some of the required monitoring equipment causes women problems that are never addressed due to assumptions about their necessity:

There is nothing that they could do about this, but the one thing that really bothered me is that they keep this thing on your thumb or your finger to keep your pulse. And I wish that there was a way that they could put it somewhere else because you have to grip on something, to uh, you have to grip on these handle bars whenever you're pushing. And every time I tried to grip, this stupid thing got in the way, and it made me so mad because I felt like I could have gripped better or pushed better, but I felt like I was focusing more of my attention on keeping this stupid thing on my finger... I guess I just assumed that they couldn't do anything about it. (TF)

One woman was expected to use a bed pan rather than the restroom for no other reason than she was hooked up to monitoring equipment:

They forced me to lay in the bed. I asked to go to the restroom and they wouldn't let me. They wanted to bring me a bed pan. And I said, "No, I'm going to the restroom..." Because they have to monitor my blood pressure and because I was getting an IV. I was hooked up to that and I was hooked up to the baby monitors. So because of all of this they said, "It's better to just get a bed pan." (JF)

In telling the story of her first pregnancy, one participant related how a visit with her provider to address bleeding turned into an induction. She was made to feel that she could not leave the hospital and that she had no choice but to accept the induction:

The nurse told me that "You're not going home without the baby." I don't know why. She just said that. She said, "Oh, you're here. You're staying. You're going to have your baby today..." I just wanted the baby to be fine. And I didn't know that I could go home. I thought that I had to stay there because, I'm telling you, I was totally ignorant about this... It wasn't anything... No contractions. So it was just another pregnant day. There was nothing changed except that the bleeding had happened. So because I was scared and they made me believe that I had to stay there and this has to happen, they told me that they would give me just a little pitocin to get the contractions started again so I said, "Fine." (JF)

When women yield to these pressures and restrictions it is often because they feel that there is no other option. In some cases they are concerned about negative retribution from their provider if they do not comply:

My original intention was to have a vaginal delivery with my daughter. And I went to the same OB/GYN, and he said, "Oh, yes" the whole time through my pregnancy. He said,

“Oh yes. We will definitely try a vaginal birth after cesarean.” But when I hit my due date he said, although I was showing signs of going into labor... He apparently changed his mind... Like literally... I was 40 weeks and I went in for my regular scheduled appointment. And he said, “Well, you're dilated to two and your cervix is completely effaced... But I think we should go ahead and schedule you for a c-section tomorrow.” And that's literally how it happened. And I felt at that time I didn't know any other options. So I kind of felt like I had to do it because my doctor was telling me, you know. And I was scared that if I didn't that I wouldn't have a doctor, and then what was I going to do? So I was just... I didn't know what to do. I was so close to delivery... So it was like, “Okay...” When I asked him, “Well I really wanted to try a vaginal,” he said, “Well, being that you're 40 weeks and you haven't gone into labor yet, I think we should just do a c-section.” (HM)

At least two women were given episiotomies, surgically enlarging the vaginal opening, not only without their consent but without their prior knowledge:

The episiotomy, that was just, it just happened. She said it was going to happen. I didn't even have a chance to say yes or no... She just said, “This is what I'm doing.” (TF)

And then what she did, she took her scissors, without any warning, without asking anybody, without telling anybody, she did, it's called a fourth degree episiotomy. Which is the worst. It's the biggest. I don't know why she feels she needs to do a big one... But that's what she did. And that is... That pain is the only thing that I can still recall in my mind. Like, you know how people can recall feelings? Like, you just close your eyes and you can feel like almost the same as at that moment. That was just... It was so bad. It was worse than anything. (JF)

5.0 DISCUSSION

Three major themes emerged from the data collected for this study. First, women set maternity care goals beyond the requisite intention to remain healthy and give birth to a healthy child. These goals influence the pregnant woman's maternity care choices and establish her as an active participant in the maternity care process. Second, women adhere to birth philosophies, approaching pregnancy and birth with their own unique understanding of the processes involved and individualized expectations of how maternity care should be delivered. Finally, women believe that choice is a critical component of quality maternity care. Having choices allows expectant mothers to tailor the maternity care that they receive to their own specific needs.

5.1 MATERNITY CARE GOALS

The goals that women set for themselves and their pregnancies are a reflection of the diversity that exists among childbearing women, which is consistent with what we already know about the variety of preferences and expectations that women of maternity care (Baker, et al., 2005; Hildingsson, et al., 2003; Van Wagner, 2004). Goals are also evidence of planning, preparation, and self-reflection. Participants learned about themselves, explored their maternity care options, and set goals that were consistent with their own perceived abilities and needs. This is in agreement with suggestions in the literature that women approach childbirth as a project (Archer,

2006) and see it as an opportunity for developing their own identities as women and mothers (Declercq, et al., 2008).

Participants set goals for themselves that included giving birth vaginally or without medication, participating meaningfully in the birth process, avoiding pain, and joining other women in their shared identity as mothers. The goals that women set influence their interactions with the maternity care system in that choices, when available, are made with the fulfillment of specific goals in mind. The type and amount of care that women prefer are also a function of the goals that they have set. In this way, acknowledging and accommodating the goals that individual women have is an important aspect of providing quality maternity care that meets the needs of pregnant women.

This accommodation becomes especially critical when women have goals that are at odds with established maternity care norms. Participants with goals such as vaginal birth (especially after a previous cesarean section), unmedicated birth, and full participation in the birth process felt that their intentions were not reliably supported within standard, medicalized maternity care. It is therefore critical that these women have access to alternative types of care.

5.2 BIRTH PHILOSOPHIES

Birth philosophies again illustrate the diversity among women seeking maternity care. Some women believed that birth would naturally progress in a positive manner. Others emphasized the need for flexibility, felt that their bodies were well suited for pregnancy and birth, and rejected the characterization of birth as a medical event. These essential values and beliefs underlie a woman's approach to pregnancy and birth, grounding her expectations and influencing her sense

of the necessity and risk of medical intervention. Participants expressed dissatisfaction and mistrust when the provision of medical care did not echo their beliefs about pregnancy and birth.

One factor in the experience of dissonant care as intrusive and potentially harmful is a woman's own assessment of risk. Risk is defined in the literature as the probability of injury or damage to a person or to what that person values (Hall & Taylor, 2004). Given that women have different perspectives and values, it is not surprising that their assessment of the safety and risk inherent in birth care would also be unique. Therefore, birth in a medicalized hospital environment may be regarded as more or less risky based on a woman's own perception of how medicalized care may encroach upon what she values about the birth of her child. To develop that further, since women have unique values and expectations, it is not possible for identical birth environments to serve all women. Rather, in order for care to take place in an environment where the mother feels safe, more than one maternity care circumstance must be available. If a woman regards the medicalized environment of a hospital as the safest and most supportive location for birth, then she is psychologically suited to a hospital birth. On the other hand, if she views medical procedures and monitoring as invasive, or potentially risky, or sees them as detracting from her emotional experience of the birth, then a nonmedicalized environment where those things are minimally present may be preferable.

In addition to leading to negative patient-provider relationships, the perception of risk may foster conditions associated with poor psychological outcomes. A woman's perception of her care as invasive, unsafe or beyond her control is associated in the literature with postpartum mood disorders and the development of PTSD (Allen, et al., 1998; Beck, 2004; Creedy, et al., 2000; Czarnocka & Slade, 2000; Declercq, et al., 2008; Zimmerman, 2008). At least one study has attributed "maternity blues" or depression following birth specifically to a woman's negative

feelings about her maternity care (Baker, et al., 2005). Respondents to Childbirth Connection's *Listening to Mothers* surveys concurred, associating adverse psychological outcomes with the type of care experienced during pregnancy and birth (Declercq, et al., 2008).

The women with whom I spoke corroborated these findings in that they recognized the importance of identifying providers whose philosophies were compatible with their own. This was especially true of natural process oriented mothers who received care from more medically oriented providers and of mothers who had given birth more than once and had negative feelings about their previous birth experiences. Additionally, several participants clarified their own philosophies by acknowledging that a particular type of care, no matter how ideal for them, would not be equally well received by all women.

Birth philosophies further demonstrate the necessity for variety within the maternity care system. To foster trust, protect against poor psychological outcomes and ensure the provision of quality maternity care, women must be able to locate and receive services from providers whose approach to pregnancy and birth is compatible with their own.

5.3 CHOICE IN MATERNITY CARE

Women who participated in this study passionately expressed near universal agreement that maternity care should offer women choices that allow them to meaningfully influence the type and amount of care they receive. Choice is seen as important because women approach maternity care from an array of circumstances and with a variety of preferences and thus have different care needs. While consistent with previous findings regarding the diversity among childbearing women (Baker, et al., 2005; Hildingsson, et al., 2003), this is in stark contrast to the

standardized maternity care that is presently most readily available (Downe & McCourt, 2004; Sandelowski, 1984; Say & Thomson, 2009; Simmonds, et al., 2007; Wagner, 2006).

From a Social-Ecological perspective (McLeroy, et al., 1988), women discussed the need for choice based on intrapersonal characteristics such as attitudes and preferences. The barriers that participants encountered, however, occurred across the environmental levels of analysis suggested by the model. These barriers included a lack of familiarity with nonstandard forms of care, time restraints, the social stigma surrounding alternative care, limited availability of alternative providers and cost. Women felt that their maternity care decisions were restricted, and several reported feeling forced to accept a particular type of care. These findings echo literature that suggests that access to alternative maternity care is limited (American Association of Birth Centers, 2007; Parry, 2008; Wagner, 2006) and that women may not have significant influence over the course of their care (Baker, et al., 2005; Mould, et al., 1996; Rijnders, et al., 2008; Wagner, 2006).

This lack of choice means that individual American women will not reliably receive the type and amount of maternity care that is most appropriate for them. The results of this, as many participants attest, is frustration and dissatisfaction with the provision of their care. It may also mean less than optimal psychological (Baker, et al., 2005) and physical health outcomes (Clark, et al., 2008; Creedy, et al., 2000; Rokke, et al., 1991).

Reports that procedures are done without the woman's fully informed consent occur both in this study and in the literature (Declercq, et al., 2002; Declercq, et al., 2006; Declercq, et al., 2008; Baker, et al., 2005; Mould, et al., 1996). These incidences represent a special circumstance in that it is not acceptable in the provision of any type of maternity care that a woman be subjected to interventions that she does not understand or accept.

6.0 CONCLUSION

6.1 LIMITATIONS

This study has a number of limitations, the most important of which is its small sample. Although the purpose of this qualitative study was not to generate generalizable data, it should be noted that the sample is not representative of the population as a whole. The experiences of the women represented here are unique to them and therefore cannot be generalized outside of this sample.

A second limitation is that women volunteered to participate after viewing recruitment posters that stated, “I would like to interview you about how you planned for your child’s birth” (see Appendix C). Therefore, women who did not plan for their child’s birth, or who did not see their preparations as “planning,” may have been excluded from the sample.

Women were interviewed only once and only after the termination of maternity care. The study therefore only represents the attitudes, expectations, and recollections of women after their experience with care, and cannot speak directly to the participants’ feelings during or prior to receiving care.

The study is also limited by its failure to collect certain types of data. Demographic information, for example, was not collected from participants unless specifically volunteered in the course of the interview. There was also no attempt made to screen participants for

postpartum psychological disturbances such as Major Depression or Post Traumatic Stress Disorder, which makes it impossible to draw conclusions about the occurrence of such events as related to a participant's experience of maternity care.

Finally, the research is limited by its inclusion of only one perspective. Interviewing care providers, fathers, and birth assistants in addition to mothers might generate richer and more complete data. Accessing additional data sources, such as medical records, would also facilitate the development of a more comprehensive description of the environment in which maternity care decisions are made.

6.2 RECOMMENDATIONS FOR FURTHER RESEARCH

Future research should attempt to link the maternity care choices available to women with the psychological and physical outcomes of pregnancy and birth. Factors that may facilitate positive birth experiences within the current maternity care system, such as partner support and written birth plans, should be described. The effect of demographic characteristics, such as income level and geographic location, on the availability of alternative care should be examined and institutional, community and public policy factors examined more closely. Perhaps most critically, a thorough assessment is needed of the use of fully informed consent within maternity care in the United States.

6.3 CONCLUSION

The perception of childbirth as perilous and the view in the 1940s that modern women were unfit for the “primitive” act of birth paved the way for the acceptance of medical monitoring and intervention in pregnancy and birth care (Sandelowski, 1984). Medicalization further emphasized the risks inherent in maternity and sought to reduce the threat of harm by eliminating any deviation from what was accepted as the “correct” course of pregnancy and birth. This effectively standardized maternity care in the United States, limiting and in some cases eliminating the availability of alternative types of care.

Virtually since its inception, medicalized birth care has had its detractors (Caton, 1999; Sandelowski, 1984). Women and some men have argued that altering the natural processes of pregnancy and birth is itself risky and that treating natural variation as pathological does not serve the needs of all women. This view seems to have gained traction recently, as more women are seeking midwifery care and giving birth in birth centers and at home, receiving support completely outside of standard maternity care.

This study was undertaken to assess the environment in which modern American women make decisions regarding their maternity care and to begin to describe the conceptual frameworks that women use in making these choices. Twenty-two women were interviewed and three major themes emerged from the data. The first theme focused on the active role that women play in their maternity care through the establishment of goals. Beyond the intention to remain healthy and deliver a healthy baby, these goals included giving birth vaginally, birthing without medication, fully participating in medical decision making, avoiding pain, and joining other women in the shared experience of giving birth. The existence of goals illustrates the diversity among childbearing women, underscores the important role that birth plays in the lives

of women, and emphasizes the participatory role that many women want to have in their care. Since certain goals were better served by the mainstream maternity care system than others, they also highlight the need for broad access to alternative maternity care.

The second theme highlights the underlying beliefs and values that constitute a woman's birth philosophy. These philosophies included the understanding that birth is designed to go well, requires flexibility, and is a natural, not inherently medical, process. In discussing their fundamental beliefs about birth, women also spoke about the philosophies held by maternity care providers. Providers were perceived to be medically oriented, natural process oriented, or patient oriented; the women with whom I spoke emphasized the importance of establishing care with a provider whose philosophy was consistent with their own beliefs. Dissonance between a woman's birth philosophy and that of her provider leads to tension and mistrust. It may also be a contributing factor to a woman's experience of her birth as traumatic and to adverse psychological outcomes in the postpartum period. It is therefore critical that women are able to locate and receive care from a provider whose philosophies are compatible with their own.

Finally, participants discussed the importance of being able to make choices regarding their care. Women used these choices, including the selection of a provider, strategically, to influence the type and amount of care they received. However, women also encountered barriers to choice. These barriers included a lack of background knowledge about alternative care, rushed decision making, social stigmatization, the limited availability of nonstandard care, the unwillingness of standard providers to provide alternative care and cost. Some women felt that their decisions, especially during labor and deliver, were rushed and distracted and made without their fully informed consent. Several women felt that they had no choice but to comply with hospital and provider recommendations, and a few women reported being forced into procedures

that they did not want. These barriers restrict a woman's ability to access the type and amount of care that is most appropriate for her, violate her right to consent to medical care and may also negatively impact psychological and physical health outcomes.

Taken together these findings call for expanded access to nonstandard maternity care, the removal of barriers to alternative care, and more vigilant observation of fully informed consent. In order to meet the diverse needs of the four million American women who give birth each year, quality maternity care must provide support for meaningful choices whether or not those decisions reflect current maternity care norms. Public health professionals should advocate for a system that offers safe and effective medical management to women who prefer it, while also respecting the choice of birth without unnecessary medical intervention.

Appendix A

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER



University of Pittsburgh
Institutional Review Board

3500 Fifth Avenue
Pittsburgh, PA 15213
(412) 383-1480
(412) 383-1508 (fax)
<http://www.irb.pitt.edu>

Memorandum

To: Kristyn Felman
From: Sue Beers, Ph.D., Vice Chair
Date: 3/30/2010
IRB#: [PRO10030429](#)
Subject: A Look at Maternity Care Decision Making Paradigms

The above-referenced project has been reviewed by the Institutional Review Board. Based on the information provided, this project meets all the necessary criteria for an exemption, and is hereby designated as "exempt" under section 45 CFR 46.101(b)(2) Tests, surveys, interviews, observations of public behavior

Please note the following information:

- If any modifications are made to this project, use the " **Send Comments to IRB Staff**" process from the project workspace to request a review to ensure it continues to meet the exempt category.
- Upon completion of your project, be sure to finalize the project by submitting a "**Study Completed**" report from the project workspace.

Please be advised that your research study may be audited periodically by the University of Pittsburgh Research Conduct and Compliance Office.

Appendix B

INFORMED CONSENT SCRIPT

Thank you so much for meeting with me. I am really excited to hear about your experiences.

The purpose of this research study is to learn more about how women navigate the maternity care system and make decisions regarding the birth of their children. Over the next few months I will be talking with women like you about their experiences and learning from them about how women approach the social and medical aspects of childbirth.

All of the information that you share with me is confidential (unless it pertains to harming yourself or others) and your identity will be kept anonymous; I will not record your name or any other identifying information for the purpose of this study. If you are willing to participate the interview will take about 90 minutes and upon completion you will receive a \$5 Panera or Starbucks gift card. There are no foreseeable risks associated with this project, nor are there any direct benefits to you. Your participation is completely voluntary and you may withdraw at any time.

My name is Kristyn Felman and I can be reached by phone at (412) 600-7206 or by e-mail at kristynfelman@gmail.com. Please contact me if you would like to participate or if you have any questions or concerns.

Appendix C

RECRUITMENT POSTER



WILL YOU TELL ME YOUR
BIRTH STORY?

I am a student at the University of Pittsburgh and I am doing research to find out how women make their birth choices. I would like to interview you about how you planned for your child's birth!

If you would like to share your story please contact
Kristyn Felman
kristynfelman@gmail.com
(412) 600-7206

Appendix D

INTERVIEW GUIDE

Will you tell me briefly about your experience with the health care system while pregnant?

What were your expectations regarding maternity care?

What did you think that your birth would be like?

Now let's talk about your plans for the birth. What sorts of things did you think about ahead of time?

Where did you get information about pregnancy and birth?

What kinds of questions did you ask?

What made you ask that?

What options did you consider?

How did you weigh your options?

What influenced your choices?

Did your family have any influence? Friends?

Did you consider any options that felt unusual?

How did you choose your care provider?

How do you feel about the care that you received during your labor and/or delivery?

How did the birth compare with your expectations?

Did anything happen that you had not planned or did not prefer?

If yes, how did that make you feel?

Did you ever feel pressured to accept any treatment?

How did you communicate with your healthcare providers about your preferences?

How well did your care providers support the choices that you had made?

How did you feel about your care immediately after the birth?

Have those feelings changed?

How might you plan differently if you have another child?

Given your experiences, what advice would you give to pregnant friends and their healthcare choices?

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