


5-3-2010

The Places of Birth: Navigating Risk, Control, and Choice

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The Places of Birth: Navigating Risk, Control, and Choice

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May 3, 2010

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Abstract

Through qualitative research in the Twin Cities, Minnesota and a literature review grounded in health and feminist geography, this paper analyzes how women, their families, and health care providers view and navigate places of birth. Over four million births occur annually in the United States, making birth the most common reason for hospitalization of women. Although 99% of women in the U.S. give birth in hospitals, a small but vocal minority seek alternative places to birth – primarily at home. Where to give birth is a contested subject infused with social and political significance. I suggest that place is highly significant to the experiences of birthing women. Specifically, I propose that care providers and patients navigate the perceived risks of birth to make and justify spatial choices about birth. I further suggest that risk management is a strategic framework for negotiating control, choice, and safety when it comes to places to give birth. Additionally, I discuss the interplay between advocates of hospital and homebirth and the use of spatial rhetoric about birth.

Acknowledgements

This project would not have been possible without the support and encouragement of my professors, friends, and family. Thank you to my advisor Prof. Helen Hazen who worked with me every step of the way and was always willing to offer suggestions and repeatedly read drafts. Thank you also to Prof. Holly Barcus and Prof. Dan Trudeau, who both served as readers on my thesis committee and contributed their perspectives and time to this project. Thanks to Birgit Muehlenhaus for much needed encouragement and for helping me with my maps. Also, thank you to Prof. Karin Aguilar San Juan and all of the other professors who supported the work that led me to this project. Additional thank you to the Mellon Curricular Pathways grant which made the research for this project possible. To my informants: your willingness to share your knowledge and stories with me made this experience incredibly rich. To my dearest housemates – NSK, SAS, and EMS – you all deserve a medal for putting up with my antics this past year. Thank you to all my other wonderful friends, especially KAW, ESG, JVH, who made this process bearable, and a very special acknowledgement of the hard work of the other “inhabitants” of Carnegie 110. And finally, thank you to my family for encouraging me to pursue this project from afar.

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Introduction: Putting Birth into Place

Over four million babies are born in the United States annually, or over 11,000 a day. Pregnancy and childbirth are the most common reasons for hospitalization among U.S. women. Though 99% of U.S. births happen in hospital settings, a minority do not. These other 1% of births take place in clinics, freestanding birth centers, and most often at home. Although some homebirths in the U.S. are unplanned, those that *are* planned reveal a great deal about the complexity of birth experiences. Birth is not a uniform event among women. Individuals experience birth in markedly different ways due to the interplay of numerous factors at multiple scales. Even within the confines of the U.S., individual states, counties, cities, and even hospitals report different statistics about who is giving birth and attending it, what outcomes are occurring, and which procedures are being used. Increasingly, research in a variety of disciplines is seeking to elucidate exactly what is so significant about the experience of birth, one that is at once so mundane and everyday and yet so extraordinary. Through qualitative research in the Twin Cities, Minnesota and a literature review grounded in health and feminist geography, this paper analyzes how women, their families, and health care providers view and navigate places of birth. I suggest that place is highly significant to the experiences of birthing women. Specifically, I propose that care providers and patients navigate the perceived risks of birth to make and justify spatial choices about birth. I further suggest that risk management is a strategic framework for negotiating control, choice, and safety when it comes to places to give birth. Additionally, I discuss the interplay between advocates of hospital and homebirth and the use of spatial rhetoric about birth.

The experience of birth is tied intimately to where it occurs, at both the large and small scale. As Sharpe writes, “Childbirth is, of course, not a geographically uniform event but has variations both between and within cultures and at many geographical scales” (Sharpe, 1999, p. 91). Around the world, there is incredible variation in where birth takes place, who attends it, and what degree of risk of injury and death are present. Even within the U.S., rates of Cesarean section, infant and maternal mortality rates, and insurance coverage vary between regions and demographic groups, adding diversity to the experience of birth. Where birth happens matters profoundly in the lived experiences of individuals.

At the most-detailed scale, the very spaces women occupy or inhabit as they actually labor and give birth to their children are numerous and diverse. Birth can physically occur anywhere a pregnant woman finds herself but it is through repetition and “social patterning” that we come to understand birth to happen in specific places (Jordan, 1993, p. 1). Indeed, these “places of birth” are complex entities with historical and social significance. Today, over two-thirds of out-of-hospital births take place at home (MacDorman et. al. 2010, p. 2). “Babies have been born just about everywhere – farm fields, parking lots, traffic-stalled taxicabs, airplanes, subways, and high school bathrooms on prom night” (Cassidy, 2006, p. 50). Although somewhat glib, the mention of these “alternative” places is a reminder that the embodied experience of birth is diverse, particularly due to unequal access to health care resources and whether the birth environment is planned or not.

This paper discusses issues of place that pertain to birth and engages an existing, and sometimes contentious, political conversation. There is a fierce debate at the local, regional, and national level about the relative safety of different places to give birth and the

ramifications of related conclusions on policy. This paper is *not* an effort to tout the merits of one particular setting over another for birth. Notably however, much of the discourse about birth focuses on where it occurs, primarily forming an antagonistic dichotomy between home and hospital.

Birth becomes a topic of political conversation for a variety of reasons. As Jordan notes, “birth is universally treated as a marked life crisis event” (1993, p. 3). For this reason, it is an ideal site for the production of “internally consistent and mutually dependent practices and beliefs,” which in turn forms the basis for a “birthing system” (Jordan, 1993, p. 4). In turn, this system is viewed by its practitioners as “the best way, the right way, indeed *the* way to bring a child into the world” [emphasis in original] (ibid). In the U.S., the birthing practices developed particularly over the past century have been codified in the form of law, hospital protocol, insurance regulation, and even social regulation and individual expectation.

Given the history, diversity and evolving nature of birth in the U.S., this paper seeks to answer the following questions:

1. What meanings are attached to the places where women give birth - either by the women themselves, family members, or care providers?
2. In what ways are the places of birth contested? Why is place significant?
3. What factors motivate women and care providers to favor particular places over others?

These questions can even be summarized further to: how and why does place matter to birth?

The goal of this paper is to contribute to a growing body of knowledge and understanding of the importance of places of birth, rather than to provide a definitive analysis of why birth occurs where it does.

In this paper, I suggest that place is highly significant to the experiences of birthing women. The choices that women make (or are unable to make) regarding birth have an impact on their experiences. I propose that care providers and patients alike navigate the perceived risks of birth to make and justify different spatial choices about birth. I also examine the ways in which spatial rhetoric about birth enforces normative understandings of “natural” birth and simultaneously complicates the apparent dichotomy between home and hospital. Through a place-specific qualitative study of birth, I seek to identify various ways that places of birth are constructed and how experiences differ between these places. Throughout the paper, I emphasize the individuality of experience and perception of lived events.

This paper uses the aforementioned questions as a jumping off point to further inquiry into the spatialities of birth. I came to this research as an undergraduate geographer with a particular interest in exploring issues of maternal and child health. Previous research papers and coursework exploring the complexities of pregnancy and motherhood shaped my interest in pursuing this project. I relied on both geography background as well as my concentration in community and global health to approach this topic. Ultimately, birth is a topic worthy of geographic discussion because of its variability across space and place, as well as its impact on our understandings of the broader constructions of how place mediates experiences.

For this project, I rely on primary qualitative research focused on a sample of Twin Cities-based birth-related care providers of mixed backgrounds and a literature review to develop my points. This paper is divided into six major sections. The following section provides an overview of the methodology used for research and gives details about the data to be used in analysis. The third section provides background information both on the history

of birth in the U.S. and characteristics of birth today. Building on a historical backdrop of birth, the fourth section includes a review of relevant literature, focusing on disciplinary approaches to birth, issues of choice and risk, and understanding the dimensions of “natural” birth. The fifth section proceeds with the analysis, identifying major themes from the research and integrating these with connections to existing literature. Finally, the last section includes conclusions and final thoughts, including identifying areas for subsequent research.

Discussion of Qualitative Methods

Between June 2009 and December 2009, I completed a total of 24 interviews with individuals in birth-related fields. In one case, I interviewed three colleagues together at their request. Additionally, I completed one focus group made up of an additional three individuals who had no birth-related training. This brings my total number of informants to 27. I identified semi-structured interviews as a particularly effective way to answer my research questions, because I was interested in the nuance of individual perspectives and experiences. Using open-ended questions maintained a conversational flow to my interviews and allowed my informants to focus on the points they found most relevant. In many cases, they dictated the course of the conversation, rather than my list of prepared questions.

Funding for the summer research was provided through a Mellon Curricular Pathways grant at Macalester College, in St. Paul, Minnesota. Macalester College’s Social Science Institutional Review Board approved research before its start in May 2009. A majority of the interviews (19) were conducted in a ten week research period in the summer of 2009. The need for more information prompted me to continue scheduling interviews into the fall 2009 semester. Interviews were conducted primarily in public places, such as coffee shops, or at the informants’ place of work. Several others were conducted in informants’

homes. Most interviews lasted between 30 minutes to an hour. Several informants brought young children and babies with them, who were largely content playing or eating during the interview.

Informants were largely identified through convenience and snowball sampling techniques. These methods are particularly appropriate for this type of research, which seeks to explore the particularities of experiences, rather than to generalize about broader trends. Because some of my informants are friends, colleagues, or acquaintances of one another and due to my method of sampling through referrals, I have assigned all of them a pseudonym to maintain confidentiality. Although I had intended to take these measures prior to embarking on my research, the sentiments of some of my informants have confirmed the need for them. I have omitted any mentioned organizational affiliations and will not name any of the hospitals people referred to during interviews. I will however discuss information I gathered from six hospital visits, as this information is presented publicly. For people entrenched in professions, organizations, or communities discussed in this paper, it may be possible in some cases to identify hospitals or organizations even without the inclusion of names, but I have distanced these remarks from personal identifying factors. This makes it less likely for individuals to be connected to organizations and therefore identified. Appendix A lists my informants by pseudonym, along with information about when and where the interviews took place.

Informed consent was obtained verbally and in writing in every case. All but two interviews were tape recorded with the informants' verbal and written permission. The interviews were transcribed word-for-word and returned to the informants for approval and editing. The remaining two interviews were not tape recorded due to malfunctions of the tape

recorder and were instead hand recorded to the best of the researcher's ability. In those instances, I typed up my closest estimate of the interview based on notes and recollection, and returned it to the informants for approval and editing.

Using these transcripts, I was able to identify common themes. In the absence of a software program, I analyzed my data manually, searching for common words or phrases. Therefore, I do not include any statistics about what percentage of women mentioned specific themes. While I did not use a formal system of coding my results, my informal scans of my transcripts were informed by reading I have done regarding qualitative data (see Boyatzis, 1998). This informal coding system allowed me to draw out the most significant themes from my research.

The majority of my informants spoke to me as professionals in a birth-related field, in addition to sharing their own birth experiences. In many cases, this allowed a more nuanced perspective than if I had interviewed people solely in only one of these capacities. All but one of my informants were women, and most of them (but not all) were mothers and had given birth to their children, as opposed to adopting them. The three informants from the focus group spoke solely in their capacity as a woman who had made birth-related decisions and did not have any specific birth-related training. The rest are all involved in a birth-related field in varying capacities. Because some informants have multiple professional titles and in order to protect their identities, I have aggregated these as much as possible.

During the course of my research, I also attended six hospital tours of labor and delivery units that are intended to give prospective parents a sense of the facility they will come to when they give birth. These tours are generally run by a hospital employee or volunteer. On each of the six tours, the tour group met in the hospital lobby and walked

together to the maternity care unit. Because these tours are free and open to the public, I introduced myself to the facilitator and obtained verbal consent to participate on the tour (which I had also obtained prior by scheduling my visit over the phone). Most of the participants on the tour were women alone or women with male partners. On one tour, a woman shared that she was accompanied by her doula. There were a few young children present. Some of the women were visibly pregnant, while others were not. Different facilitators handled the groups differently. In one hospital, the facilitator asked everyone to go around and share their first name, whether they were expecting a first child and whether they had already selected a provider. In this case, I was able to introduce myself to the participants. On other tours, the facilitators began the tour by only introducing themselves and none of the participants interacted with each other. There were common elements to each tour: every facilitator talked about the procedures for intake, issues related to parking, and what might happen in the event of an emergency. All of the facilitators were women and spoke in a generally upbeat tone throughout. They were largely serving as educators, but also as representatives for the hospital, often sharing about specific features of the hospital that might be attractive to prospective parents.

In addition to hospital tours, I attended two public film screening events sponsored by a birth-focused community organization. These events gave me an opportunity to see two birth-related films that otherwise would have been difficult to view. I also had the opportunity to observe proponents of alternative and “natural” childbirth methods interact with one another.

Overview of Informants

My informants came from a variety of educational backgrounds. In an effort to maintain privacy, informants that had multiple titles are grouped with the title that is general enough to conceal their identities. Revealing information about the other degrees, certifications, or job titles my informants hold make individuals more identifiable. The following table summarizes my informants' vocational backgrounds. Following the table, I provide a description of each profession.

Table 1, Job Titles of Informants

Job Title	Number in Sample
Doula	Six
Homebirth Midwife	Six (including two in training)
Certified Nurse Midwife	Four
Medical Doctor	Four (three Family Practice and one OB/GYN)
Registered Nurse (RN)	Two
Childbirth Educator	One
Community Health Worker	One

In the next few pages, I will provide a brief description of the type of work associated with each profession, in the order they are listed here. Doulas are labor support providers who work with pregnant, laboring, and post-partum women to provide physical and emotional support. They are not primary care providers and do not have medical or midwifery training. However, doula training is a prerequisite to becoming a certified professional midwife. Several of the doulas I spoke to saw themselves as advocates for

patients, particularly in hospital settings. Some doulas are certified through national organizations, such as Doulas of North America (DONA), but there is no formal regulation. Several doulas I spoke to remarked that they chose not to be certified and did not feel certification was necessary if they had experience. Doulas are generally independently contracted by parents prior to the birth and are paid a flat fee. There are several volunteer doula programs in the Twin Cities, which aim to provide free doula services to low income or high risk mothers. Several of my informants mentioned volunteering with these types of programs.

The homebirth midwives I interviewed fell into two primary categories: certified professional midwives (CPMs) and direct-entry midwives. CPMs are trained through a variety of routes, such as accredited midwifery schools (which do not include nursing training) or through apprenticeship programs. They are certified by the North American Registry of Midwives (NARM) and are the primary providers of care at homebirths nationally. The national certification they receive is the primary difference between them and the direct-entry midwives. They also receive training through a variety of sources, which may include more self or peer education than formal education. Neither direct-entry nor CPMs have hospital privileges and the legality of their work varies state by state. Working as a CPM in Minnesota is legal, but most insurance companies will not reimburse a family for using one. Only some of my informants identified themselves as one or the other, which is why they are combined into a single category here.

The certified nurse midwives (CNMs) I spoke with are registered nurses who have gone on to get a Masters of Science in Nursing degree, complete with specific training in

midwifery. They do not perform surgery, and often work in partnership with or underneath a supervisory obstetrician in the event of complications. In addition to labor, delivery, and post-partum care, they may also provide well-woman care. CNMs are responsible for the majority of midwife-assisted births in the U.S. and work primarily in hospital settings, often with lower risk patients. RNs typically provide the bulk of the hands-on patient care in maternity care hospital facilities.

The doctors I spoke with fell into two categories: obstetricians and family practice doctors. Three of the four doctors were actively attending births, while one (a family practice doctor) was not. Obstetricians are surgeons trained in the specialty of labor and delivery. Family practice doctors who attend births have more generalized training and often see their patients for well-woman care outside of pregnancy and birth. Because of their higher degree of specialty, OBs tend to handle patients in a higher-risk category. Family practice doctors do not generally perform C-sections, but often work in conjunction with OBs in more complicated cases.

Registered nurses (RNs) work in hospital settings in a position of active patient care. They generally work in conjunction with and under the jurisdiction of doctors. The two RNs I spoke with both had experience as labor and delivery nurses, who provide the bulk of the hands-on patient care during labor and birth. Their primary responsibilities were to monitor the progress of labor, provide comfort and pain relief, and to identify any possible risks that would require the attention of a physician.

Childbirth educators are not care providers or medical professionals. Instead, they work with women and families prior to birth to educate them about the process of labor and

birth. They may work independently or through larger certifying organizations, such as Lamaze International. Different methods of childbirth education stress different techniques of managing pain and preparing for birth. Many of the doulas I spoke with worked as childbirth educators in addition to their doula work.

Community health workers are best described as “lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve” (U.S. Department of Health and Human Services, 2007). They are not unique to the U.S. and often work with populations that experience barriers to accessing care. The hope is that their position within the community increases their effectiveness. The community health worker I spoke with fit this description. As a member of the Somali community, she was well-equipped to meet the language and cultural needs of other Somali people and provide education and referrals to appropriate services.

Strengths and Limitations

Because I did not collect demographic or survey-style data, I am unable to draw firm conclusions about the age, race, and income levels of my informants. However, since many of these pieces of information were revealed casually in the course of the interview, I can say that a sizable majority of my participants were white and middle-class. Approximate ages of informants ranged from 25 to 70. This contributed a degree of diversity to their responses that I did not originally anticipate. Because informants spoke about their own personal

experiences as well as the historical trends that had defined their work, this span of ages allowed for a deeper understanding of the shifting landscape of birth.

Efforts to interview a racially and socioeconomically diverse group were only marginally successful. This lack of diversity is due to several significant factors: 1) my own sampling bias, 2) the nature of the existing relationships my informants had with others, and 3) the demographics of people seeking out a particular type of birth. Statistics for the year 2000 show that almost 90% of women planning a homebirth were white, while 58% of hospital births were to white women (Johnson and Daviss, 2005, p. 3). Like VandeVusse, I intentionally oversampled women who had professional or personal experiences with non-physician care providers and homebirths to “maximize the range of experiences [...] among a relatively small sample [...] while keeping the data set manageable” (1999, p. 44). Similarly, achieving a representative sample was not one of my goals, because I did not seek to generalize my research to a broader population. Instead, I sought to understand the complexities of different individuals’ choices and negotiations with birth as a way to reveal the significance of place in the experiences of individuals. Ultimately, more research would be an important way to discern the way race influences this issue.

In conducting this research, I was forced to reckon with my own position as researcher and to sift through ways in which my own identity might influence the interviews I was doing. As a young, white woman representing an undergraduate institution, I made an effort to present myself professionally but informally with the goal of minimizing any possible perception of threat that researchers might elicit. Also, because of my young age in comparison to my informants, people were more willing to explain details of basic concepts from the field to me, since knowledge about birth and pregnancy is culturally situated as

something that one learns about with age as well as through personal and/or professional experience. This allowed me to learn more about the nuances of the topic than I might have otherwise. Additionally, because I was interviewing primarily other women, I was frequently able to emphasize “commonalities of experience” that became “part of a mutual exchange of views” (McDowell, 1992, p. 405). Although it is fallacious and even potentially dangerous to suggest that these commonalities exist simply by virtue of a shared gender identity, I nevertheless found that an exchange of views was an important part of conducting interviews. Many informants were eager to hear my opinions on various topics or were interested in what other informants had shared with me. This made it challenging at times to maintain both my own neutrality and confidentiality for other informants.

I want to make it clear that I am not trying to suggest that a shared gender identity is necessary to conducting this type of research. As McDowell recognizes, “We may no longer assume a coincidence of interests based on our femaleness in all situations, but must build theories appropriate to particular circumstances and political alliances around specific issues” (1992, p. 412). She goes on to explain the ways our multiple identities interact in ways that significantly impact our communication, goals and priorities. For example, she includes an acknowledgement of how race, sexuality, and geography influence and complicate our gender identities. She writes,

White feminists have had to come to terms with a similar question from women of colour, as have straight women from lesbians, northern women from southern women and so on. Thus there is no longer (if there ever was) a single unproblematized concept of patriarchy to uncover in our research, but rather a complex set of intercutting gender relations, specific to time and place (ibid).

Although she does not use the word, McDowell describes a concept well explored in queer and feminist theory – that of intersectionality. Intersectionality is a recognition and understanding that an individual's identity is multiplicitous, with shifting loyalties, concerns and interests that are all contingent on time, space and place. I experienced the challenges of maintaining this perspective through my own experiences conducting this research.

With this in mind, and despite the fact that the people I interviewed either knew or (correctly) assumed that I am childless, we often were able to find points of relation, often due to a shared interest in birth-related topics. In most cases, my informants spoke to me from a position of authority on the subject of birth, due to their personal and professional experience. Frequently, their status as experts in their respective fields also contributed to this dynamic. For the most part, my age, gender and position as a student mitigated most of the potential challenges due to a power imbalance.

A major challenge that qualitative researchers face is in establishing rigor out of findings. Baxter and Eyles examine the work of over thirty qualitative social geographers and find that while these scholars are keen to establish rigor, they often fail to be explicit about how this is accomplished through their work. They define rigor as the satisfaction of certain criteria, namely “validity, reliability and objectivity” (Baxter and Eyles, 1997, p. 506). I made conscious efforts throughout my research to utilize several of the strategies they identify as effective in this endeavor, for example, by being transparent about my methods and the limitations of my data. I also aim to strengthen my credibility by demonstrating the ways in which multiple informants and other sources reported similar information.

Evolution and History of Birth in the U.S.

In this section, I will take a look at how birth has historically looked in the U.S. in an effort to provide better context to what we find today. What is significant about human childbirth that has generated such a lively debate both in the public and academic sphere? Average fertility in the U.S. is approximately two children per woman and over 80% of women ages 40-44 are mothers (CIA, 2009; U.S. Census Bureau, 2009). In other words, a sizable majority of U.S. women become mothers, but they are likely to experience birth only a couple of times. As Rutherford and Gallo-Cruz note, “even as birth has become less frequent, it has become all the more invested with emotional weight” (Rutherford and Gallo-Cruz, 2008, p. 94). Furthermore, birth experiences may have a lifelong impact on women. VandeVusse, citing Simkin and Githens, notes that women retain accurate memories of the events of their children’s births for decades (1999, p. 43). This suggests that the experience of birth carries a great deal of significance for many women.

Childbirth is a biological, social, cultural, economic, and political phenomenon. In evolutionary and biological terms, humans have possibly the most challenging birth experience of all primates, due to fetal brain and skull size, skeletal structure, and pelvic shape (Cassidy, 2006). Human strategies for dealing with these physical challenges are varied and numerous, differing across cultures and among individuals. Characteristics of birth in the U.S. have changed rapidly – especially in the past 100 years. Maternal mortality in the U.S. was 607.9 deaths per 100,000 live births in 1915. By 1987, the rate had fallen to 6.6 deaths per 100,000, but in the past two decades the rates have risen again to 13.3 deaths per 100,000 live births in 2006 (CDC, 2003, p. 1; Amnesty International, 2010, p. 3). This recent rise after such a long period of steady decline is particularly worrisome given that the

United States spends more money per capita on health care overall than any other country (Amnesty International, 2010, p. 3). The U.S. also spends more money on maternal health than any other type of hospital care, yet women in the U.S. have a higher risk of dying from childbirth-related issues than women in 40 other countries worldwide (ibid). A woman's lifetime risk of maternal death in the U.S. is one out of 4,800, compared to one out of 8,200 in the United Kingdom, a country with comparative wealth and levels of development (WHO, 2007, p. 27).

The practices surrounding and experiences of childbirth in the United States have undergone dramatic and rapid changes over the past 100 years, in particular. As Fannin writes, "childbirth is both an embodied and symbolic process, and the home and the hospital have been the shifting and contested sites of childbirth in contemporary discourses of birth in the United States" (Fannin, 2009, p. 513). In early colonial America, self-taught or apprentice-trained midwives attended the majority of births in women's homes. (There is notably little information in the literature that looks outside the Euro-American experience with birth). Midwives of this era ultimately lost their "professional edge" as men practicing medicine began to claim childbirth under their jurisdiction (Cassidy, 2006, p. 35). Racism, xenophobia, classism, and sexism all contributed to the degradation of the midwifery profession, as predominantly educated, white males entered the growing medical profession. By 1910, midwives and doctors were evenly split in the number of births they attended, although the births midwives attended were increasingly to low income, immigrant, or African-American women (Cassidy, 2006, p. 31).

The growth of hospitals and solidification of the medical profession contributed to a demise of "traditional" midwifery. Women who could not afford doctors or midwives to

attend them at home would come to these facilities for help with their labors, although the outcomes were often somewhat poor. For instance, in 1883, women coming to the Boston Lying-In Hospital had a 50% chance of contracting puerperal sepsis, which often proved fatal (Cassidy, 2006, p. 56). The disease was spread easily between patients due to the doctors' practices of moving back and forth between autopsies and examinations of live patients without hand washing (ibid). Midwives working in women's homes could certainly spread the disease too since they did not yet know about the importance of hand washing either, but their slower pace and greater time in between patients meant outbreaks were less likely. Even into the 1920s, the disease still accounted for up to 40% of maternal deaths in the U.S. and parts of Europe. Not until the advent of antibiotics in the 1940s did this risk dissipate (Cassidy, 2006, p. 61). This legacy of risk, disease, and death has had an impact on the contemporary birth experience, because it informs collective perceptions of birth as a risky event.

There are discrepancies in the literature about how and why the transition from majority home birth to majority hospital birth took place. On the one hand, "feminist accounts of the relocation of childbirth from the home to the hospital emphasize the political machinations of the emerging medical profession" (Beckett, 2005, p. 253). Additionally, as the (male) doctors' cultural authority increased, they were able to effectively put traditional (female) midwives out of business (ibid). As Beckett notes, "women had long expressed a great deal of fear and trepidation about the potential pain (and danger) of childbirth" (ibid). Therefore, the pursuit of pain-free childbirth became a top priority of first-wave feminists in the early 20th century. First-wave feminists were primarily white, upper and middle class women interested in suffrage and gaining rights equivalent to those that men of their race and

class position had at the time. When these wealthy, white women learned of medical interventions being developed in Europe that could help them manage the pain of birth, they leapt at the opportunity to spread these innovations to the U.S. (Cassidy, 2006).

Women were eager to minimize the risks to themselves and their children that were so common at homebirths¹ at the time. Unfortunately for women of this era, the transition to hospital births did not always minimize these risks. Women were trying to avoid the risks that homebirth created, but new risks were introduced in the hospital which, over the mid twentieth century, spawned a small subset of the population to avoid the hospital and seek alternatives – often by returning to the home.

In 1940, 40% of white women and 73% of nonwhite women in the U.S. were still giving birth at home (Boucher, et. al. 2009, p. 119). In the next twenty years, these figures plummeted further: by 1960, fewer than 1% of births took place outside of hospitals. Although there have been slight fluctuations, this remains largely true today. Statistics for 2005 show that 37,402 infants were born out of hospitals that year in the U.S., representing a mere 0.9% of the over four million births (ibid). This figure includes births at home, in freestanding birth centers, in clinics and other locations. Significantly, the vast majority of these out-of-hospital births were to white mothers, a stark reversal of the racial breakdown of homebirths in the 1940s.

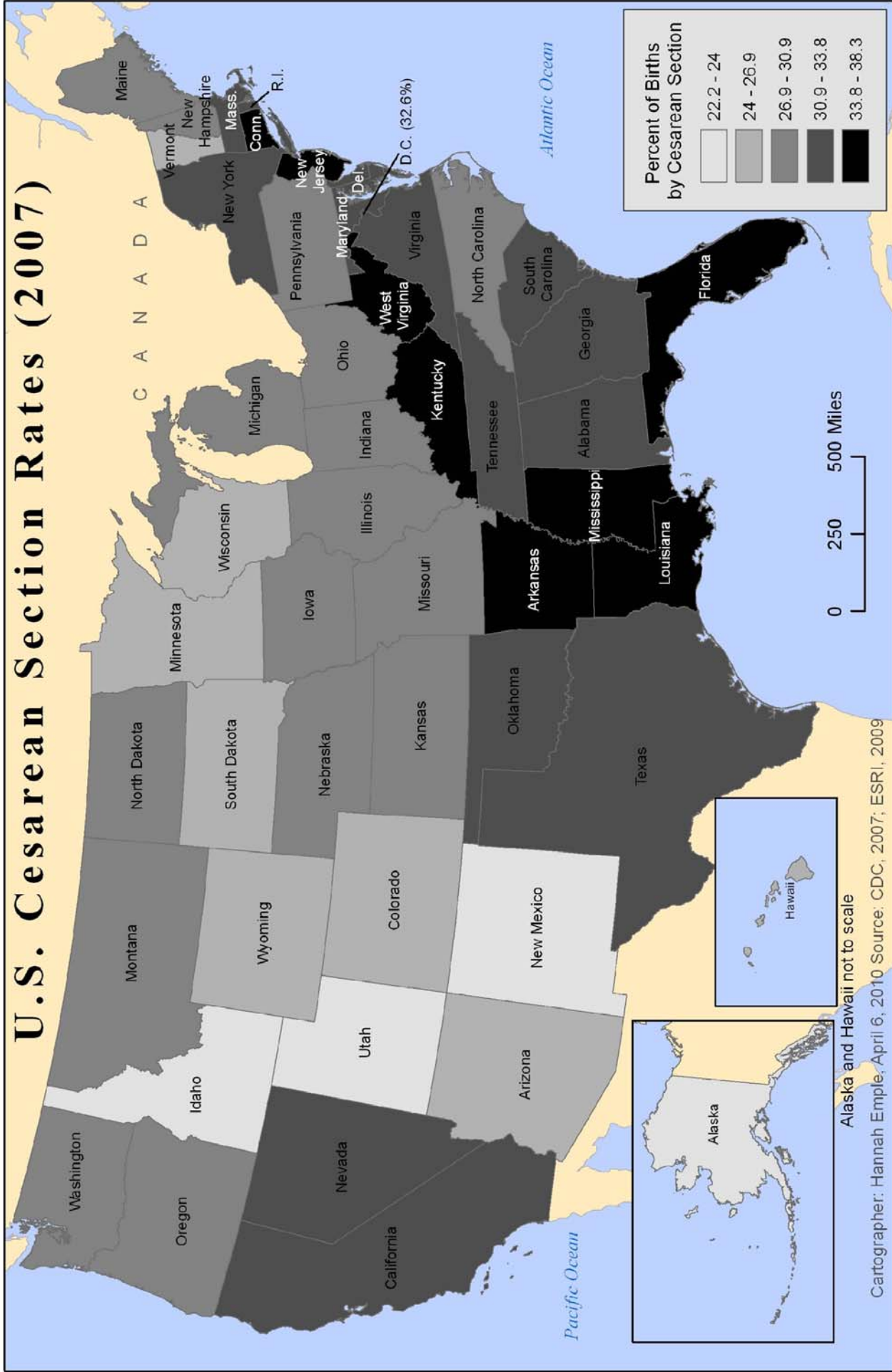
U.S. Birth Today

The average birth today in the United States takes place in a hospital, under the care of a physician. In the United States, about half of births are covered by private insurance,

¹ “Homebirth” in this context is an anachronism because the majority of people at the time gave birth at home. Thus the term would have little meaning because it was understood implicitly that birth took place at home.

while 42% are covered by Medicaid (Amnesty International, 2010, p. 5). Nationally, 32% of women have their babies via Cesarean section, which represents a huge increase just in the past few decades (Amnesty International, 2010, p. 9). In 1970, the Cesarean rate was only 5.5% (Gaskin, 1996, p. 297). The World Health Organization (WHO) recommends that Cesarean section rates be between 10 and 15% (WHO, 2007). They conclude that in countries where the rate is lower than that women and infants are potentially at risk to complications that are not being addressed. Meanwhile, countries like the U.S. that exceed this figure may be over-utilizing the surgery in situations that do not warrant it and therefore introducing unnecessary risk. Based on the progression of the Cesarean rate from below this target range to significantly above it, we can speculate that the U.S. has over-shot its goal. Although appropriately-used Cesareans can be life-saving, valuable surgeries, the risk of a U.S. American woman dying following a Cesarean birth is three times greater than with a vaginal birth (Amnesty International, 2010, p. 9). Like other major surgeries, C-sections elevate the risk for infection and blood clots, among other complications. Ironically, C-sections can lead to puerperal fever, the very illness that plagued hospitals in the early twentieth century. The map on the following page (Figure 1) shows the wide variation in Cesarean section rates by state in the U.S. which range from 22.2% in Utah to 38.3% in New Jersey. Some of this variation can be linked to broader health conditions in individual states, insurance coverage, or variable state policies concerning prenatal and maternity care. Nevertheless, women's odds of a Cesarean section can clearly vary state to state.

U.S. Cesarean Section Rates (2007)



Alaska and Hawaii not to scale
 Cartographer: Hannah Emple, April 6, 2010 Source: CDC, 2007; ESRI, 2009

Additionally, technology and medication are integral parts of the experience of hospital birth for most women, even for those delivering vaginally. From the LTM-II² in 2006, we know that 94% of women experienced electronic fetal monitoring, 86% were given medications for pain relief, and 71% had epidurals for vaginal deliveries (Declercq et. al. 2007). Appendix B describes these and other birth-related terms. These rates of intervention are the subject of intense debate, both domestically and globally.

Racial disparity in maternal and fetal mortality is an unfortunate defining feature of birth in the United States. African-American women are nearly four times more likely to die of pregnancy-related complications than white women (Amnesty International, 2010, p. 4). While the Centers for Disease Control (CDC) notes overall improvement in infant mortality within every racial group between 1995 and 2005, black infants remain more than twice as likely to die as white and Asian infants (Matthews & MacDorman, 2008, p. 1). These statistics help to frame the social context of birth and add a backdrop to this research.

Introduction to Homebirth, Its Proponents, and Its Malcontents

A “homebirth” is quite simply a birth that occurs at home. Homebirth is not a monolithic category however, so it is critical to identify the different scenarios in which this type of birth might occur. Michie identifies three types of people seeking homebirth,

with very different relations to medical culture: upper-middle-class college-educated women who plan a home birth because of a feminist or proto-feminist critique of medical ideology; conservative and/or religious women who come from patriarchal family structures that emphasize the privacy of the family and the supervision of the father; and poor and/or extremely young women who have had little prenatal care (1998, p. 263).

² The Listening to Mothers-II (LTM-II) was a national survey of 1,600 women in 2006, which collected quantitative and qualitative data, with the aim of learning more about the particularities of birth experiences. The demographics of the sample population closely mirrored those of the greater U.S.

These distinctions are a reminder of the diversity of experiences, even among those who actively plan for homebirth. Significantly, unplanned or accidental homebirth is not within the scope of this paper. I use the term “homebirth” as a single word throughout this paper to demonstrate the intentionality of these planned births at home.

There are important demographic trends to note regarding homebirth in the U.S. MacDorman et. al. report that non-Hispanic white women are more than three times as likely to have a homebirth than women in any other census category (2010, p. 2). On average, women who plan homebirths are also more likely to be older, married, wealthier, and more educated than women giving birth in hospitals (Johnson and Daviss, 2005, p. 3). This is significant because, as Longhurst notes “mothering is a powerful construct that privileges some (such as ‘white’, heterosexual, able-bodied, middle-class and married women) and oppresses others” (Longhurst, 2008, p. 127). Planned homebirth may be accessible only to relatively privileged members of society.

Proponents of homebirth are often quite vocal in their support. The Twin Cities has several organizations which promote homebirth and aim to garner support. In particular, there is a lively doula community in the area. At the national level, the North American Registry of Midwives (NARM) is a major supporter of homebirth. NARM serves as the main source of certification for homebirth midwives. As the website reads: “NARM affirms a woman's right to choose her birth attendants and place of birth and [...] affirms the safety and viability of planned, midwife-attended birth at home, in hospitals, and in freestanding birth centers” (NARM, 2010). There is also mobilization at the national level to increase political support for out-of-hospital birth. The Big Push for Midwives is an organization

seeking to expand state certification of CPMs and to encourage the implementation of policies supportive of birth at home and in freestanding birth centers (The Big Push, 2010).

Frequently, homebirth is discussed in conjunction with “natural” birth. “Natural childbirth” is a term used widely by birth-related professionals and parents alike but its meaning is not standardized or consistent. As Lazarus writes, quoting a *New York Times* piece, “doctors have changed the definition of natural childbirth ‘to include any birth in which the mother is awake and delivers vaginally’” (Lazarus, 1994, p. 27). Proponents of homebirth typically define “natural” birth as an unmedicated birth, meaning that women do not receive pharmacological pain relief or other interventions like Cesarean sections or vacuum extraction.

In general however, homebirth is not accepted by major medical organizations such as the American Medical Association (AMA). This and other large professional medical groups are often highly critical of homebirth. A 2008 AMA position paper on the issue reads,

Whereas, an apparently uncomplicated pregnancy or delivery can quickly become very complicated in the setting of maternal hemorrhage, shoulder dystocia, eclampsia or other obstetric emergencies, necessitating the need for [...] the availability of emergency care, for the health of both the mother and the baby during a delivery; therefore be it RESOLVED, that our American Medical Association support the recent American College of Obstetricians and Gynecologists (ACOG) statement that “*the safest setting for labor, delivery, and the immediate post-partum period is in the hospital* [emphasis in original] (AMA, 2008).

This stern wording is characteristic of physicians’ groups and other bodies which find homebirth to be too risky. Malcontents of homebirth are frequently in positions of greater political authority than proponents. This is one way in which the places birth occurs are politicized.

Birth in the Twin Cities, MN

This paper focuses on the significance of place, using qualitative research based in the Twin Cities metropolitan area. The findings of this research are not intended to be generalized to the city or even state level. Rather than generalizing about trends, I examine processes and individual experiences of these trends. Nevertheless, it is helpful to provide information about the area to better contextualize these findings. Overall, Minnesota has comparatively health statistics for both women and babies. Minnesota is one of only five states nationwide to successfully reduce maternal mortality to fewer than 4.3 deaths per 100,000 by 2006 (Amnesty International, 2010, p. 7). The Twin Cities in particular have a high percentage of doula-assisted births, which evidence suggests improves birth outcomes (Sakala and Corry, 2008; Dempsey, 2006). Although most parts of the country have seen a decline in the number of births at home and in freestanding birth centers since 1990, recent figures suggest that these numbers may be reversing in some states. Minnesota is among eleven states to report a statistically significant increase in out-of-hospital births between 2003 and 2006 (MacDorman, et. al. 2010, p. 3). Nevertheless, 99.35% of Minnesota births take place in hospitals (ibid).

Minnesota's Cesarean section rate of 26.2% is lower than the national average of 31.8% (CDC, 2007). Rates vary widely, however, between different hospitals. In the Twin Cities, individual hospitals have Cesarean section rates as low as 12% and as high as 36% (Minnesota Hospital Association, 2008) This discrepancy can be explained to a certain extent by the populations served at each because some hospitals cater to higher risk women. For instance, those hospitals that have a Neonatal Intensive Care Unit (NICU) on site are already set up in part for people who know in advance they are delivering a high needs infant.

Women who experience premature labor might also be more likely to seek out these facilities. However, hospital protocol and staff attitudes play an enormous role in the rates of intervention as well. The following table provides details about the types of services offered at various facilities in the Twin Cities.

Table 2, Comparison of Twin Cities Hospitals

Hospital	City	C-section Rate (2008)	Nurse-Midwives?	Waterbirth?	LDRPs?	NICU?	Doula Program?
Abbott Northwestern	Minneapolis	36%	Yes	No	No	Yes	No
United Hospital	St. Paul	34%	No	No	No	Yes	No
Fairview-Southdale	Edina	34%	No	No	No	Yes	No
Fairview-University	Minneapolis	27%	Yes	No	No	Yes	No
Methodist	Saint Louis Park	24%	Yes	No	Yes	No	No
Healtheast-Woodwinds	Woodbury	24%	Yes	Yes	Yes	No	Yes
North Memorial	Robbinsdale	22%	Yes	Yes	No	Yes	No
Hennepin County Medical Center	Minneapolis	21%	Yes	Yes	Some	Yes	Yes
Regions	St. Paul	22%	Yes	No	No	No	No
Healtheast-St. Joseph's	St. Paul	11%	Yes	Yes	Yes	No	No
St. John's	Maplewood	21%	Yes	No	Yes	Yes	No

See Appendix A for definitions and acronyms. Data from: Author participation on hospital tours, 2009; Minnesota Hospital Association, 2008; Hospital websites, Accessed March and April 2010.

Minnesota and the Twin Cities in particular are in the midst of a change when it comes to birth. Two freestanding birth centers are in the process of opening in the greater

Twin Cities metropolitan area. A third is rumored to be planned. A freestanding birth center is a facility which operates completely independent from a hospital. While some hospitals call their maternity care units “birth centers,” these are different because they are still staffed by physicians, CNMs, and nurses, unlike freestanding birth centers which are generally staffed by certified professional midwives. Notably, the MacDorman report’s study period precedes the opening of Minnesota’s two freestanding birth centers in 2009 and 2010. Additionally, there is movement at the state legislative level to change the current policies handling insurance reimbursement. Lack of insurance coverage for births at a birth center posed a fatal problem for Minnesota’s only other birth center which closed in 2004 (Olson, 2010).

State senator Linda Berglin has been working for several years on legislation that would allow for the licensing of freestanding birth centers, provided that they met certain criteria to satisfy the demands of insurance companies and doctors’ professional organizations, such as the AMA. Licensing would allow approved birth centers to submit claims to insurance companies for reimbursement. The bill has been delayed due to controversy surrounding issues related to Medicaid reimbursement. Minnesota does not currently allow Medicaid to reimburse families who have out-of-hospital births with CPMs, which effectively makes this option inaccessible to lower income families. Political change in the coming years may further change the characteristics of birth in Minnesota.

Review of Literature

In this section, I review literature that highlights key concepts that form the theoretical underpinnings of my research and analysis. First, I provide an overview of disciplinary approaches to birth and outline several models or views of birth that pervade the

literature. I then introduce the concept of “cognitive maps” and lay the groundwork to apply this idea to birth and birth choices. I also explore relevant literature which complicates the framework of choice that is often used to discuss birth. Next, I discuss risk and risk management, and identify these as critical ways of framing conversations about birth. I also take a closer look at literature that subscribes to or critiques the discourse of “natural” birth. Finally, I examine spatial rhetoric about birth as a way to understand the spatial dichotomy of home vs. hospital arising out of birth discourse.

Geographers, Place, and Birth: Disciplinary Approaches to Birth

Scholarship on the subject of where birth takes place crosses into disciplines as disparate as geography, psychology, religious studies, feminist theory, disability studies, clinical medicine, and anthropology. By no means exhaustive, this list of diverse disciplines will hopefully add nuance to an understanding of the significance of where birth takes place and the dimensions of risk, control, and choice. Only in recent years have geographers and other social scientists devoted extensive time and thought to subjects such as birth. As Monk and Hanson ask, albeit in the early 1980s, “Why has geography for the most part assiduously avoided research questions that embrace half the human race?” (1982, p. 34). More recently, Longhurst, writing in 2008, notes that “issues of space, place, territories, borders and boundaries in relation to maternities, maternal bodies and mothering have not yet been explored in great depth” (p. 145). Although the past two to three decades have brought considerable change to the academic world and opened new avenues for research, there is still much room for further discussion and work in this field.

There is a fundamental spatial component to birth (Sharpe, 1999). Applying a geographic lens to birth requires us to examine the places of birth critically. Most simply put,

a place is “a unique spot in the universe,” complete with geographic location, material form, and a meaning invested (Gieryn, 2000, p. 464). Places where birth occurs, such as a specific hospital, home, or birth center, are infused with social, political, and economic meaning. As Staeheli and Martin write, “geographers conceive of places as being contested, multiple, layered, subject to shifting and porous boundaries, and constructed in relationship to systems of power, including economic relations, racialization, ethnicity, and gender” (2000, p. 140). The spaces and places where birth happens are indeed centers of lived meaning. Experiences of birth are often articulated through where they occur.

This research can be situated in (at least) two sub-disciplines of geographic thought: feminist geography and health geography. Feminist geography seeks to emphasize people’s agency in creating their own meanings and experiences of place and to examine connections between the construction of place and gender (Staeheli and Martin, 2000). Similarly, it seeks to move beyond essentialist gender constructions of the body, to complicate the gendered nature of the home, and explore the lived experience of motherhood. Feminist geography is also a useful departure point in studying topics related to pregnancy, birth, and motherhood, which have traditionally been either ignored, unrecognized as legitimate areas of serious study, or approached as part of a study of gender which succeeds in cementing women in their essential capacities as “natural nurturers and caregivers.” Feminist geography is a way to explore the social positioning of womanhood and motherhood in a way that destabilizes the supposed universality of experience based on gender. As McDowell notes,

what tended to be termed 'women's issues' were excluded from consideration for many years on one of several of four grounds - that they are trivial; that they are at the wrong spatial scale, for example the domestic; that the methods used to examine these issues are not respectable (not science, inappropriate to

geography); that the work is biased, subjective or, worse, political (1992, p. 404).

In light of this, I hope to continue a growing academic tradition that seeks to rework previous understandings of what constitutes “real” or “rigorous” research, not only in geography but a wide variety of disciplines.

A health geography approach is also useful for exploring the experience of birth because of its direct links to the health of individuals and populations. Significantly, health geography expands on medical geography by incorporating a social approach into a traditionally biomedical one, understanding “that diseases, service delivery systems, and health policies are socially produced, constructed, and transmitted” (Kearns and Gesler, 1998, p. 5). The discipline of health geography has evolved out of a more traditional medical geography background and includes a sociocultural approach that was highlighted as missing from medical geography. While medical geography’s study of spatial patterns of disease is highly valuable in a variety of contexts, it may miss the significance of the individual’s self-perceptions and the political dimensions of what is taking place. Traditional medical geography runs the risk of “naturalizing” certain disease/health phenomena by failing to discuss the ways in which the diagnosis, lived experience and treatment of disease are all socially constructed. The experiences and “treatments” of childbirth are similarly constructed.

Models of Birth: Medicine, Midwifery, and Beyond

Three major views, or models, emerge from academic and public discourse on the subject of birth. These views, while general, help contextualize some of the complexity of birth. The medical model views birth as a medical event with inherent risk involved. Emphasis is placed on the role of the doctor (assisted by nurses) to identify and rectify any

complications that occur to ensure a safe delivery for both mother and child. The risk involved is primarily identified as maternal or fetal injury or even death, but may also include an acknowledgement of the legal risk of the physician.

The midwifery model, is frequently characterized in opposition to the medical model, and sees birth not as a medical event, but as a family event. Birth is viewed as a natural, physiological process that requires little interference in the majority of cases. Emphasis is placed on the intuitive knowledge and inherent capabilities of the laboring woman rather than on the authority of an outsider such as the care provider (Gaskin, 1996). Researchers who use this model of birth may devote some time to pointing out the risks of technologically-managed births as a way to counter the discourse of the medical model.

The third view of birth is one that sees birth as a complex biosocial process and integrates social, political, and economic factors into an understanding of the birth process. A biosocial framework incorporates the impact of both physiology and society. Jordan notes that “the distinction between what is biological and what is social is, in many ways, merely analytic” (1993, p. 3). For the purposes of this paper, I will call this broader, multi-faceted view of birth the critical birth model. This model emphasizes the impact of social processes on individual experiences. In a similar vein, Mansfield (2007) characterizes birth as a biosocial process, which hints at the complexity of childbirth, which is both a product of biology, evolution, and “nature,” as well as social conditions, culture, and human agency. Although some literature characterize this third view of birth as a feminist model, I wish to use a different term because there are self-identified feminists who lay claim to each of the above three models (Lee and Kirkman, 2008). Rather than enforcing a single definition of

feminism, I would like to recognize the complexity of the topic and allow space for different and new interpretations of these models.

It is important to note here that even these three models cannot possibly encompass the nuance of cultural variation in views of birth. In Jordan's book *Birth in Four Cultures*, she identifies a different view of birth within each of the four cultures she studies: "a medical procedure (in the United States), or as a stressful but normal part of family life (as in Yucatan), or as a natural process (as in Holland), or as an intensely personal, fulfilling achievement (as is the case in Sweden)" (1993, p. 48). Keeping these nuances in mind is critical because it serves as a constant reminder of the difficulty in generalizing about birth experiences. Furthermore, the four views Jordan discusses cannot describe every single birth in each of those cultures, due to individual preferences and experiences.

Notably, views of birth often borrow from one another and shift over time and space, although not necessarily in an equitable way. Different views may hold greater sway or validity due to political dynamics. For example, Jordan notes that the influence of Western medicine and obstetrics often threatens to subsume the views of "traditional systems" (1993, p. 5). There are also inconsistencies within the models that may be challenging to address. With multiple different classifications of midwives in the United States, for example, the midwifery model is somewhat hazy. Certified nurse midwives in many hospitals seek the same technological solutions to what they see as potential risks in birth as doctors might (O'Connell & Downe, 2009). Meanwhile, homebirth midwives may rely on the selective use of medical technology to ensure safety for mother and baby. Within the medical model, individual doctors have far different thresholds for what they perceive as risky during

childbirth. Since there is no universal understanding of what birth “should” look like, the different models that researchers use reveal information about how the researcher is framing the issue and what assumptions they base their work on.

Cognitive Maps of Birth

Past research indicates that decisions related to birth are fundamentally spatial questions (Sharpe, 1999). Where a woman chooses to give birth does not take place in a vacuum. Her decision is narrowed by her own beliefs and conceptions of the world as well as those held by family, friends, medical professionals, and others around her. This is *not* to suggest that women who choose to give birth in hospitals are somehow blindly forced into institutional birthing settings. Nor is it meant to exalt the women who choose to give birth at home as somehow radical freethinkers, unfettered by the values of society. Wherever women end up giving birth reflects a combination of personal and social determining factors. I suggest that any possible choice for where to give birth carries with it a set of assumptions and expectations.

The influence of our knowledge of particular places is immense when it comes to birth. “For any person or population at any given time, there is an existing *knowledge base*. At the individual level, this knowledge structure is often called a *cognitive representation* or *cognitive map*. For groups it is often called *culture* – that is the shared habits and rules of a society” [emphasis in original] (Golledge and Stimson, 1997, p. 31). A culture that situates birth as a technologically-intensive and hospital-based experience yields affiliate cognitive maps for individuals (Zwelling, 2008, p. 85). These cognitive maps of birth are simply

understandings of what birth looks like and where it occurs. They dictate what a reasonable choice for a pregnant woman is. As Golledge and Stimson write, “Decisions are made under constraints, and they reflect the attitudes, values, and beliefs of people and of society” (1997, p. 1). Women’s choices about birth reflect their cognitive maps of birth and their understandings of where birth should take place and what is safest.

Creating a cognitive map involves processing massive amounts of information, that comes from “not only the observable physical environment, but also memories of environments experienced in the past, and the many and varied social, cultural, political, economic and other environments that have impinged both on those past memories and on our current experiences” Golledge & Stimson, 1997, p. 229). Our collective and individual memories and understandings of place have a major impact on our interpretations of different situations and environments. A pregnant woman (or any individual) likely has a cognitive map of a hospital and possibly of a labor and delivery room. She may have seen popular movies or television shows depicting birth in this setting (“Knocked Up,” “Juno,” and “Father of the Bride” to name a few examples), may have heard family stories about past births, may have been present at or visited the hospital following a relative or friend’s birth. All of these experiences may contribute to a particular cognitive map or conceptualization of birth. By contrast, she may not have seen any images of a homebirth, which means she may not have a cognitive map for what birthing at home might look like. She may be spatially and cognitively removed from any concept of what a homebirth consists of. Cognitive maps become a form of cultural authority which create normative birth experiences.

Complicating Choice

This section complicates the use of “choice” as part of the dominant discourse of contemporary U.S. childbirth. “Choice” suggests unfettered access to any possible option and ignores broader constraints. Lazarus, for example, examines the views of three different groups of women to learn about different birth choices and their limitations: lay middle-class women, health professionals who are also middle-class, and lay low-income women (1994, p. 25). Her findings suggest that socioeconomic class has a major impact on women’s experiences of and perceptions of birth, specifically when it comes to their choices and ability to control situations. Lazarus’ research found that “poor women are constrained by the conditions under which they have their babies and the kind of care open to them, and this affects their ability to acquire knowledge about birth and their ability to act on such knowledge” (1994, p. 26). The implications of this are significant. Individual women will experience birth differently because of variations in access, class, and other social factors.

Similarly, Michie is highly critical of the rhetoric of choice that surrounds the discussion of where to give birth. In her analysis of the “yuppie pregnancy bible” *What to Expect When You’re Expecting*, she notes that the book “largely confines the idea of choice to the last few weeks of pregnancy, to the ‘choice’ of various kinds of labor and delivery” (Michie, 1998, p. 265). Rather than engaging with the imposition of social norms on women, books like *What to Expect* may instead serve to erase women’s agency to make choices about birth or ignore the subsections of the population that lack those choices. Because the intended audience is white, upper-middle-class and heterosexual, the book does not serve as a useful guide to all women. This “rhetorical insistence on choice” is a limiting framework because it implies that everyone has equal access to choice (ibid). Instead, women have varying degrees

of access to different birth experiences and places to give birth due to a variety of interwoven social factors.

Klassen goes a step further by noting the complex racial dynamics of homebirth. She comments that while the homebirth movement may consider itself “progressive or even ‘revolutionary’... it has been so for a particular minority of women” (Klassen, 2001, p. 780). Noting that a disproportionate number of homebirths are to white women, she makes a suggestion to explain this phenomenon. African-American women have a different relationship to homebirth than Euro-American women because of inequities in access to quality health care. Specifically, she notes that,

Women giving birth at home who end up being transported to the hospital often experience chastisement by or disrespect from medical authorities as a result of their eschewing of a medicalized birth. But Euro-American women are much more likely to know that they have adequate insurance that will both pay for their hospital stay and grant them access to the health care that they need, and they are much less likely to suffer from racism in the hospital environment. **Choice is often rooted in privilege, and feeling free to choose where, how and with whom to birth is no different** [emphasis added] (Klassen, 2001, p. 780-81).

By connecting choice to privilege, Klassen complicates the use of choice as a framework for birth. This critique of the impact of race and racism is a much needed component of analysis of out-of-hospital birth in the United States.

Beckett also critiques this discourse of choice by explaining the inadequacies of framing high rates of Cesarean section around choice. She argues that,

the alternative birth movement’s essentialist and occasionally moralistic rhetoric is problematic, and the idea that some women’s preference for high-tech obstetrics is the result of a passive “socialization” into “dominant values” is theoretically inadequate. On the other hand, the invocation of women’s choice and appreciation of high-tech childbirth ignores the social and political

processes through which those choices are made and serves as a weak foundation for a feminist perspective on childbirth (Beckett, 2005, p. 252).

Beckett suggests that social, political, and economic inequalities create unequal levels of access to choice, while broader society remains convinced of the promise of equal choice.

Women may be stripped of choice during the birth process in very immediate and tangible ways. The advent of court-ordered Cesarean sections gives credibility to fear. According to the National Advocates for Pregnant Women, hospitals in over a dozen states have been granted permission to perform court-ordered Cesareans (Cool, 2005). Cool cites a 2004 example in which a Pennsylvania woman who had had six previous vaginal births was told her seventh baby was too large to be delivered vaginally, based on a late-term ultrasound. When she refused to consent to the surgery, the hospital sought and was granted an order to perform a “medically necessary” C-section against her will if she returned. The woman later gave birth vaginally to a healthy baby in a different hospital and subsequently filed a law suit (ibid). Cassidy writes that, as of 1987:

[t]here had been at least twenty-one court orders [...] the reasons for the court orders ranged from the mother’s suspected drug use to her being brain dead or having placenta previa. Eighty-one percent of the women at the center of those court orders were black, Asian, or Hispanic; 44 percent were unmarried; and 24 percent did not speak English as their primary language. All the women were treated in teaching-hospital clinics or were receiving public assistance (Cassidy, 2006, p. 122).

These statistics demonstrate the very real possibility that women’s choices may not be granted or listened to depending on a variety of factors. Additionally, the demographic characteristics of these women again suggest that race and class play a significant role in women’s choices of maternity care.

Women living in prison during pregnancy may arguably face the most restrictions when it comes to choice about birth. Approximately 2,000 American prisoners give birth annually (Liptak, 2006). These birthing experiences complicate our understandings of choice, safety, and comfort when it comes to birth. As of 2006, twenty-three U.S. states had laws that explicitly allow for the use of shackles and other restraints during the hospitalization (and therefore labor and birth) of pregnant prisoners (ibid). The extremity of these policies reveals a profound inequality in the choices American women have when it comes to birth.

Understanding Risk and Risk Management in the Context of Birth

Risk is a key concept at the heart of the discussion on birth and its relative safety in different places. However, risk is not easily defined. Moore and Oppong describe risk as “the possibility of loss” (2007, p. 1059). This definition provides only a broad sense of what people mean when they refer to risk related to birth, however. I will use this space to outline different conceptions of risk: physical/medical risk, moral or social risk, and legal risk.

Medical or physical risks are understood as risks to the health or life of mother and baby. Identifying risk in this sense first requires a description of what the absence of risk looks like – in this case, a “normal” or low-risk birth. This is in and of itself a difficult task because there is much discrepancy about what constitutes a normal birth. Using the definition provided by the World Health Organization (WHO), Reibel defines normal birth as one that is a “spontaneous onset, low-risk at the start of labour and remaining so throughout labor and delivery. The infant is born spontaneously in the vertex³ position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition” (Reibel,

³ Vertex positioning means that the baby’s head is down and facing the mother’s back at the start of labor.

2004, p. 333). Anything that deviates would then be characterized as a risky situation. The use of the word “normal” implies that the above experience is normative, or the most common birth experience. In a country such as the United States where almost a third of births end in Cesarean section and a significant percentage of vaginal births are assisted with synthetic hormones or vacuum, defining a “normal” birth may be more complex than the WHO envisions.

Viisainen found that there were risks beyond the physical, which she characterizes as “moral risks.” For example, women that contemplate homebirth are moving against the authoritative knowledge of medicine which suggests the hospital is the safest, least risky place to give birth. These women encounter a “moral risk” when they defy this authority (Viisainen, 2000). McClain identified a strategy that some women use when contemplating various choices for birth. They negotiated various risks by “magnifying the benefits” of whatever they chose, and simultaneously downplaying the risks (McClain, 1983). I will return to these concepts of risk in my discussion of my informants’ attitudes toward risk management.

The Spatial Dichotomy of Home and Hospital

In much of the literature and discourse surrounding homebirth and “natural” birth, there is a clear distinction made between the home and the hospital. The two are seen as oppositional monolithic categories that come with inherent expectations. Several scholars have critiqued this line of thinking, the most notable of whom is Maria Fannin. Her work complicates the binary created when home is positioned opposite hospital and explores ways in which these entities are constructed. Specifically, Fannin describes how an increasingly

neoliberal economic climate has contributed to a rise in “homelike” birthing spaces (Fannin, p. 513).

The dichotomy of hospital and home is reinforced by the discourse of advocates for each type of birth environment. By creating a supposedly “home-like” environment within the hospital, these facilities send messages to parents about the role of the domestic in their birth experiences (Fannin, 2004; Michie, 1998). Michie experienced this message playing out first hand during a tour of a hospital labor and delivery area while she herself was pregnant. She elucidates a paradox that emerges out of these home-like hospital rooms.

The birthing suite and the liberal culture of pregnancy management in which it is embedded offer the promise of safety, domesticity, and control [...] By replicating home in the hospital, the birthing suite keeps terror at bay. The irony of the hospital-as-home is, of course, two-fold. The closets of the birthing suites [...] are, in fact, filled with the gothic apparatus of medicine; the birthing suite only looks like home. More importantly, however, the hospital-as-home depends [...] on an uneasy vision of the home as a safe place; in this respect the gestures of homeliness, whether they succeed or fail in their referentiality, point to the dangers that lurk in and indeed define so many American homes: poverty, abuse, malnutrition, patriarchy (Michie, 1998, p. 261).

What Michie does here is to expose both the charade of hospitals marketing their labor and delivery areas as home-like and simultaneously debunk the idealized vision of home, which is so central to the rhetoric used by homebirth advocates. She continues with an exploration of the use of spatial rhetoric about homebirth and the home-like qualities of hospital births. In literature advancing homebirth, the home is equated with “female autonomy; it becomes the place not only of comfort but of power and freedom [...] Home functions in this enabling fantasy as a place of free choice over one’s body” (Michie, 1998, p. 261). Ultimately, Michie successfully critiques the usage of the spatial home-based rhetoric about birth.

As Sharpe notes, place and geography are critical to the history of birth and at the center of its politicized nature. He situates birth as both a topic worthy of geographic study and as an “intensely political issue” (Sharpe, 1999, p. 91). His research seeks to show how the spaces of birth are constructed, by focusing on a particular birth center in Sydney, Australia. He identifies three significant ways of reading birth centers: 1) as “sites of resistance to patriarchal obstetrics”; 2) as “sites of co-option” rising from the homebirth community; and 3) as a kind of in-between place, “offering the best of both worlds” of home and hospital (Sharpe, 1999, p. 94). Ultimately, he problematizes some of the inherent dualisms found in rhetoric not only about birth centers, but also hospitals and homebirth. These dualisms, or tensions, come about due to the oppositional history of these spaces. Using his work as a point of departure, I seek to similarly complicate understandings of birthing places such as the home or hospital as monolithic experiences.

Analysis of Themes: Introduction

My informants’ responses suggest several themes that build upon the conclusions of other researchers and deepen current understandings of how care providers and parents alike navigate issues related to birth. In this section, I further previous discussions of cognitive maps of birth by suggesting that women’s choices about where to labor and birth are reflective of their existing conceptualizations, as well as the social, political, economic, and geographic constraints that define and limit those choices. Care providers’ choices for their own birth experiences and their perspectives upon patients’ choices are similarly contingent on ingrained cognitive maps of birth. There are spatial outcomes to those choices, for women who can exercise choice over where to give birth.

The care providers I spoke with varied in their training and views of birth, expressing concern about different risks within the birth process. Through the navigation of these risks, they and their patients/clients seek to create the safest place for birth to justify their spatial choices. I suggest that risk management is a strategy that both pregnant and laboring women and care providers utilize as a way to exert control and in turn create a feeling of safety during the birth process. Although the perceived risks of labor and birth may differ for each individual, similar cognitive processes are used to navigate this perception of risk. Additionally, care providers are an interesting population because their conceptualizations of risk may be more nuanced than those of the general population.

Following this discussion of risk, I examine the competing narratives that my informants hold about the relative importance of maintaining and relinquishing control during the birth and labor process. Many of my informants hold negative views of relinquishing control of the birth process, and seek, through their work, to demonstrate sensitivity to the perceived needs of their clients. This contrasts sharply with the rhetoric about the supposed naturalness of birth that a number of my informants rely on to frame and discuss the birth process. My informants emphasized that laboring women should relinquish control in order to experience a “natural” birth. In characterizing a “natural” birth experience, my informants often relied on spatial language that creates a tension between home and hospital. Paradoxically, while many of my informants create verbal dichotomies between hospital and homebirths, they simultaneously try to incorporate practices from both places into the birth process. This suggests that, while the verbalized cognitive maps of my informants appear to be static, in practice they are part of a negotiating process that continuously shifts understandings of spatialized risk.

Framing Birth-Related Choices in a Social Context

Our choices are defined by what we know. Because most women are familiar with hospital birth as the status quo, this forms the basis of their understanding of where birth takes place. As Donna, a certified nurse midwife, explains:

If they [pregnant women] had all choices available to them, then their choices would be affected by their knowledge base, what they know is available. [...] 99% of births occur in hospitals so **what most people know is that birth happens in hospitals**. So a lot of people don't even think about birth centers, there aren't any birth centers in the state of Minnesota so they aren't going to think about that 'cause they don't exist. And then fewer than 1% of births in this country occur at home. So there are some people here that give birth at home, but **most people don't know people that do that**. They're not familiar with it, so in addition to education or knowledge, just what people know, they are influenced by the people around them and what they know and their experiences. [emphasis mine]

Most people do not give a second thought to the idea of birth in a hospital because it is so pervasive and widely accepted as the “best” – and safest – option. This firm establishment of hospital birth creates a social acceptance and expectation of a particular experience of birth.

The general public's lack of awareness of any possible deviation from this normative experience translates into a disinterest. For example, my three informants who lacked birth-related training had all experienced hospital births, two with nurse midwives and one with an obstetrician. Lauren, a mother of one, noted that at the time of her daughter's birth she had never met anyone who had had a homebirth. All three women felt very comfortable going to the hospital for their births and expressed no interest in homebirth. When I asked if it was something that they had considered, Julie, also a mother of one, commented “I don't see any benefit to having birth at home. It's not something that interests me at all.” Lack of exposure

to and interest in homebirth meant that homebirth was not a choice on the table for these women.

The inverse of this can be true – a woman may be more familiar with homebirth than hospital birth, due to her personal background or vocational trajectory. For instance, Megan, a doula who has had two homebirths, acknowledged that due to being raised in a culture supportive of homebirth, she had no concept of birth taking place anywhere but the home. Megan states:

I don't even ever remember considering hospital birth, like from the time that I was little [laughter]. [From] the time that I was a child I knew I was going to have my babies at home [...] I was born at home myself and, I have three younger siblings and they were all born at home also. And so the first birth that I consciously remember, um, was my youngest sister and I was about a month away from being 8 and she was born at home in our living room. And I remember waking up my brother and my sister and being like "The baby's here!" [...] So I kind of grew up around this "birthy thing" so I think that's why **I didn't really have any conception of a hospital birth** [...] because I was already so entrenched in the mindset of having a homebirth. Like some people come to homebirth out of trauma from a first birth or just kind of come to homebirth because that's what feels good for them. **I feel like I kind of came to homebirth because it was what I was used to.** I didn't really feel like I had to do major journeying or research about it to feel good about it. [emphasis mine]

While the details of her story may be unusual, her process of determining a comfortable choice stemmed directly from her knowledge base, in much the same way that women who decide on a hospital delivery are informed by their knowledge base.

Expanding a knowledge base by learning more about birth options, even inadvertently, prompted some of my informants to have massive shifts in their cognitive maps of birth. In

several cases, these shifts influenced my informants to make specific career choices. Nora, a CPM in training, describes her introduction to midwifery.

I thought, “Well, midwives, they're like only in the bible. They're not still around.” [...] I was like, “Well, if I got pregnant, I would just go to the hospital, that's what you do. You do whatever the doctors tell you and they'll tell you whatever's best for you.” And once I found out there was options for women at first I was completely outraged because I thought, “How could I have grown up in this culture and not known that women have all these options to choose from in pregnancy and birth?”

She expresses indignation that her upbringing had only included one specific view of what birth looked like. Cognitive maps are not static, which means that new information is constantly being integrated. By processing new knowledge, we revise our understandings of the world. In this case, learning more about alternatives to hospital birth prompted a cognitive shift.

Support, or lack of support, from one's peers can also make a difference in perceptions of different birthing options. For instance, Valerie, a labor and delivery nurse and mother of three, found that her peers (other RNs) were alarmed by her desire for a homebirth for herself. Valerie explains her work colleagues' attitudes in this way:

[Homebirth] is not a very popular decision sometimes among my colleagues... But when I told... them that I was going to have a homebirth, they thought I was nuts. [laughter] They really did... 'Cause you know what, we've all seen the risks, nurses, so I think everyone jumps to that worst case scenario in their mind. And I kind of wanted to, in my own way, wanted to prove to them a little a bit too, it doesn't have to be this way. That homebirth is a very viable option and a safe option, it can be very safe.

She explains that the nurses she worked with were concerned about the risks involved with a homebirth. Valerie saw her own successful homebirth as a potential way to shift the cognitive maps of her coworkers. Conversely, Cynthia, a family practice doctor, noticed

support for homebirth in her workplace. She estimates that in her practice, 50% of the certified nurse midwives and even some of the doctors and doctors' wives have homebirths for their own children, indicating that there is support for that choice.

Cognitive maps define expectations of the physical process and experience of birth. For example, many women anticipate a need for pharmacological pain-management, even without significant, if any, firsthand experience with birth. The authority of medical systems of knowledge and broader societal acceptance of normalized medicated births encourages women's acceptance and utilization of these techniques (Miller 2009; Davis-Floyd 2003). As Heather, a certified professional midwife, elaborates,

It's also giving that message to women every day, and on TV, in the media, through people that you talk to, that, "I'm not strong enough, my body's not able to do it. So I'm not going to be able to handle the pain or do it, so that's why I need an epidural." You know, it's a perception and a little bit of a lack of education.

She attributes much of women's fear of pain and desire for pain medication to the presence of social influences as well as the absence of education. Several of my informants suggested that women experience pain during labor largely because they expect to: a self-fulfilling prophecy. Michelle, a woman with no birth-related training, received messages early in her pregnancy that match Heather's description:

As soon as my mom knew that I was pregnant, she was like, "Oh, you're going to get an epidural right?" And at that point I was like, you know, just a few weeks along and I was like, "Well, I don't know" and she was like, "Are you kidding me?" And I'm like, "Well, I'll think about it" and she was like, "No, you have to have an epidural. Trust me. I had four kids without. You don't want to do that to yourself."

Michelle ultimately received an epidural for both her births and was pleased with that decision. Barbara, a doula, sees a direct connection between women's cognitive maps, which create a view of birth as a painful, medical event, and the use of medication and other interventions in hospitals. She explains:

If you're really afraid, you produce a lot of adrenaline. Adrenaline blocks the production of oxytocin [the hormone responsible for uterine contractions]. So in a nutshell how do most women in our culture approach childbirth? With fear. And the first contraction that comes, their fear goes up 100% and they start producing adrenaline and their labors take forever and, of course, they need pain medication [...] Until that changes, we will not see a reduction in the negative outcomes in childbirth.

Barbara sees increasing intervention in hospital births as stemming from a cycle of self-perpetuating painful births.

Giving birth without medication certainly has the potential to be an empowering experience, but this idea may skirt around the very real and common difficulties women may face during pregnancy, labor, birth, and the post-partum period. Notably, some of my informants exercised their choice to use pain medication and found empowerment in that choice as well. Paradoxically, my informants who critiqued the widespread usage of pain medication came to reinforce their own normative birth experience, albeit an alternative one. They resist obstetric control, and yet create a new version of the ideal birth, one that is not necessarily appealing to all women. While authors like Wall (2001) might see Michelle's story as exemplifying the "scientific and medical colonization of reproduction and child rearing" (2001, p. 593), I advocate for a more open-ended reading of Michelle's decision, specifically one that recognizes her own agency to make decisions that work best for her.

Framing birth in a social context requires an acknowledgement of women's diverse experiences. For example, rather than reacting to medication and hospitalization as stressful experiences, Jessica, a family practice doctor, who had her two children in hospitals, found pharmacological pain management to be a major contributor to her enjoyment of her second birth. Having also experienced an unmedicated first birth, she is able to reflect on the different experiences she had and in turn better understand her patients' decisions for either approach. She explained her two births this way:

It was nice to have two different experiences. With [the second birth] it was just me and my husband. I kind of wanted a quieter experience. The first one there was a lot of, like, cheering, and encouragement, and "Come on! You can do it!" And probably I needed it because it was so long and we were having a tough time. And the second one was just very, it felt like we were alone in the world. It was like me and him [my husband] and our doctor was literally just sitting on a stool at the end of the bed saying kind of like, "How you doing, how you feeling?" Checking me occasionally. The nurse was in and out, it was very serene. There is beauty in births, even in those that are well-controlled with pain because it gives the couple an opportunity to talk, to anticipate... when I've been in deliveries where there was really good pain control it just was so, like, quiet, kind of peaceful and you could hear, like if they were on the monitor, you were all just sitting there with the baby's heartbeat in the background [...] I just learned to appreciate the beauty in all different kinds... there's also beauty and immense power in watching somebody do it naturally and just like the sheer will and determination. But um, I really loved that we had a varied experience and for me I didn't have the self-hypnosis or meditation skills to feel like I could have a really quiet, calm experience without the pain medicine and it was lovely. I mean, it was just lovely. I could kind of relax and sit up and watch her head coming out and I talked to my husband and I wasn't like sweating, or crying, or exhausted. It was different, it was lovely in that way. I could thank my nurses, you know, I could really be present. Whereas the first one, it's frankly just a big blur of pain and, like, a good experience, I'll never forget it, but you know, different.

Jessica's personal experiences inform her professional work by giving her a broader perspective on the diverse needs and choices of her patients. She found that each experience had beauty and merit and appreciated the opportunity for comparison.

This recognition of diversity of experience was sometimes missing from my informants' discussions of women's choices. As Rachel, a doula, notes, it can be a delicate balancing act to work with patients who have had a birth experience that she herself would have found dissatisfying. Rachel describes this challenge:

I try to be *very* careful about, well, depending on who I'm talking to what I share about my own birth experience, because if someone did not have a good experience I think that gets hard for them to hear about someone else's good experience. And I mean, in the same way, someone might have labored for 15 hours and then had a C-section and I might personally think "Ugh what a bummer" but they don't see it as a bummer. They're like "Thank God. I labored for that long and they finally gave me a C-section and everything was fine, the baby's healthy." So for me, I think you just have to be really careful not to make any assumptions about what someone's experience was like based on how they gave birth because it might have been a great experience for them. [emphasis in original]

Ultimately, the individual perception and experience of birth is contingent on numerous factors, which form the basis for that person's cognitive map. Therefore, generalities about what women want from their birth experiences are likely to fall flat. Failing to be inclusive and accepting of diverse birth experiences, as well as individual readings of similar situations, may diminish the potentially affirming presence birth professionals may be for their patients. Without recognizing the impact of existing knowledge on patients' experiences, needs, and choices, birth professional may inadvertently ignore the cognitive maps and unique voices of each individual. Social context has a significant impact on birth-related choices, and providers of care should maintain this perspective through their work.

Spatial Choices

Place joins social context as another significant influence on individual experience and choice. Different places are responsible for different birth experiences. For example, studies show that rates of intervention are different for low-risk women who seek out homebirths than low-risk women in hospital settings. Even if low-risk women intending to have a homebirth transfer to a hospital intrapartum, their rates of intervention remain lower than those of a low-risk population who begin in the hospital. Johnson and Daviss found that while 19% of low-risk hospital births ended in Cesarean section, only 3.7% of low-risk intended homebirths ended in Cesarean section (Johnson & Daviss, 2005, p. 2). Table 3 below provides a summary of findings from this report and demonstrates the comparative levels of intervention that hinge on this spatial choice.

Table 3, Rates of Intervention at Low-Risk Births

Procedure	Hospital	Intended Homebirth
Cesarean Section	19%	3.7%
Episiotomy	33%	2.1%
Vacuum Extraction	5.5%	0.6%
Electronic Fetal Monitoring	84.3%	9.6%

Data from: Johnson and Daviss, 2005

This suggests that choices about where to birth have tremendous ramifications for women's experiences. Two women with similar levels of risk who make different spatial choices may experience dramatically different birth outcomes.

Spatial choices are often the byproduct of individual cognitive maps and the imposition of social, economic, and political constraints. As Donna, a CNM, hinted earlier, most women make a decision about where to give birth and who will provide care based on their knowledge base. Michelle, a mother of two, describes the way she found her doctor and chose where to give birth.

So I didn't have a choice in the hospital. They [the practice] said "This is where you're going to go." I said "OK." And as far as the practice I go to I just basically relied on my friend and she told me where she was going and who she was seeing and then I just randomly had a doctor assigned to me and we worked great together and it was fine. And the insurance covered it so that was great [laughter]. It worked all together.

Michelle was content with her decision and subsequently returned to the same obstetric practice and hospital to have her second baby. Nonetheless, her OB only delivered babies at one hospital, so her choice to work with that provider also became a spatial choice.

A woman's choice of care provider could in many ways, my informants acknowledged, dictate her experience. Therefore, the importance of this choice was a common refrain. Cynthia, a family practice doctor, described the different professions associated with birth as having "completely antagonistic philosophies," which could result in dramatically different hospital experiences – even within the same facility. She explains that,

Midwifery and family practice is all about empowering women and giving them their options and empowering them to choose by giving them knowledge

of what the repercussions are of their choices. [...] And the obstetrician's viewpoint in some practices is basically, "I know what's best for you." [...] So there's a dichotomy as far as how patients are perceived, how women are perceived.

Cynthia feels that there are significant ideological differences between providers that profoundly impact women's experiences. Patient treatment is often contingent on the training and background of providers. Therefore, choosing a provider is a significant determining factor in a woman's experience.

The three types of providers of pregnancy, labor, and delivery care in hospitals are obstetrician/gynecologists (OB/GYN), family practice doctors, and certified nurse-midwives (CNM). Depending on geography, not all of these may be available. Several of my informants presented these professionals on a scale of intervention level, with CNMs representing the lowest levels of intervention likely to occur and an OB/GYN representing the highest levels. Family practice doctors fell in the middle. As Jessica, a family practice doctor herself, described it, "a lot of times I think they get split into: at home with a lay midwife or at the hospital with a surgically-minded OB/GYN. But there's an in-between which is much more acceptable and that would be family practice doctors [and] nurse midwives." For women with private health insurance, their care may only be covered by certain groups of providers at specific hospitals. Therefore, they may not actually have a choice in provider or location. Furthermore, because providers are linked to places this becomes another spatial constraint that has implications for women's experiences. The political dimensions of who can provide what type of care in which settings draw legal and geographic distinctions between hospital, home, and freestanding birth center. Direct-entry midwives and CPMs are barred from hospital-based practices and only work at home or in

freestanding birth centers. Any possible primary care provider of birth-related care is therefore linked to a place.

These distinctions can blur somewhat in instances of intended homebirths that end up in hospital settings. Because CPMs or direct-entry midwives are generally not welcome to practice in hospital settings, this may pose challenges for women pursuing a homebirth. Also, because of perceptions of risk, these women may be met with skepticism or hostility if they do go to the hospital during an attempted homebirth. As Laura, a family practice doctor, notes,

I tell people it's probably a good idea to always have somebody [a doctor] aware that you're doing a homebirth, so that when you hit the ER [emergency room], you're not shunned, you know what I mean? If I knew someone was doing a homebirth and I get a call that says, "Baby's not doing well. We're heading to the ER," I could call them myself and be like, as a physician, "This is my patient and I'm going to meet you guys there," and I think it would just go smoother for everybody.

Laura's position as a doctor enabled her to ease the transition from home to hospital in those cases. Her words, however, point to a general lack of acceptance among hospital staff for homebirth. Other informants expressed a similar potential for judgment by health care professionals in the case of a homebirth requiring a transfer to the hospital, even in a non-emergency situation. The potential for non-hospital practitioners to bridge that gap may be limited, particularly in light of the limitations on who may legally practice in hospital settings.

Rachel's story about her intended homebirth that transferred to a hospital hints at the potential for informal integration of CPMs in particular hospital settings and the willingness of some doctors to establish informal relationships with CPMs. After she decided to go to the hospital, she recalls:

The doctor was letting my homebirth midwives continue checking my cervix and still being in the lead, even though they don't have hospital privileges and technically, while they could be with me, they really shouldn't have had any hands on care anymore. But the doctor just, I think she understood that those are the women I felt most comfortable with and that they had been with me already for 13 hours so they knew what the progression of the labor was leading up to the point of coming to the hospital. So they were all involved but she let the midwives be really involved.

Rachel was careful to note that much of her experience in the hospital was due to chance.

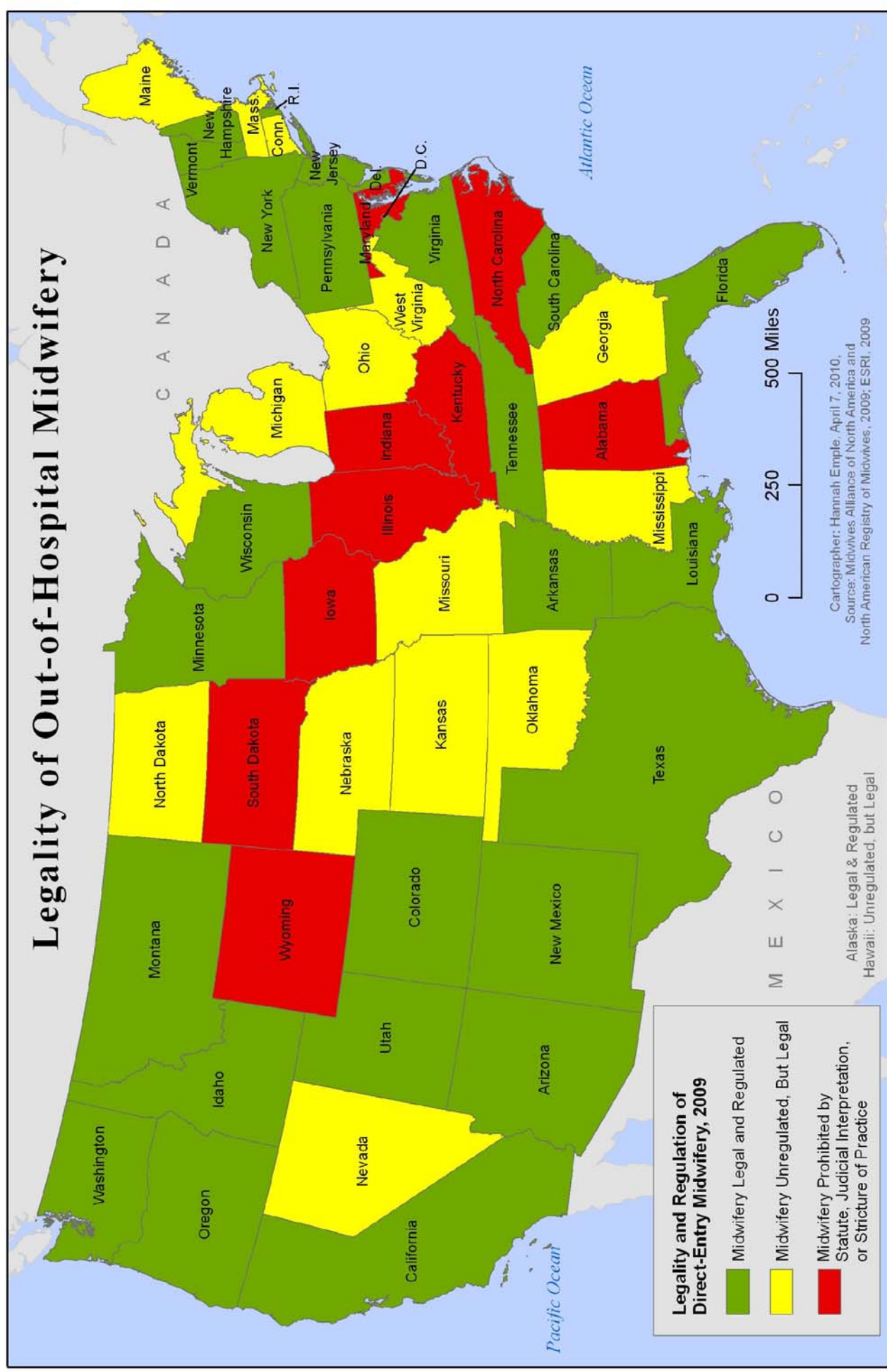
The doctor had no obligation to allow the midwives to remain involved with her care, but did so to ensure a positive experience for Rachel. She comments, "I basically feel like I got a homebirth in the hospital, because everybody was so supportive." The support of her providers, rather than her physical location during the birth, made her feel at home.

Ultimately though, her hospital experience was specific to both that facility and her care provider's particular flexibility.

Individual hospitals have different characteristics, which makes the choice of a specific hospital significant. In many cases, a woman's choice of hospital is limited by accessibility, as well as by highly variable insurance policies regarding maternity care. The choice of a hospital may therefore have significant implications for the birth a woman ultimately experiences. For example, Table 2, on page 31, shows that only three hospitals in the area have the option of waterbirth. Therefore, an interest in waterbirth might prompt a particular spatial choice. Factors like the rate of Cesarean section or the presence or absence of nurse-midwives can also have a dramatic impact on women's experiences. When women and families choose a hospital, they may not be aware of these options, or may be limited by their insurance as to which hospitals they can birth at.

As discussed earlier, it is important to acknowledge that choices related to birth come primarily from privilege. Not all women are in a position to seriously consider a homebirth even if they are attracted to the idea. Only women in certain economic brackets or with particular insurance policies are able to exercise any choice or control when it comes to where they birth. Although hospitalization for pregnancy and birth-related issues is incredibly expensive, it is generally covered to some point by insurance. Most insurance companies in Minnesota, however, will not accept a claim to reimburse a midwife who has attended a homebirth. Therefore, homebirth midwives must be paid out-of-pocket for their services. Homebirth midwives I spoke to charged about \$3,000 for comprehensive prenatal, birth, and postpartum care, compared to \$8,000 to \$12,000 for an uncomplicated vaginal delivery in a hospital (personal communication with the author, 2009; Sakala and Corry, 2008). The key difference is that hospital costs are covered, at least in part, by insurance plans. This means that few lower-income women have the financial option to have a homebirth, even if they were aware of or interested in the possibility. Heather, a CPM, explained that other states have different policies, which allow for the reimbursement of homebirth under Medicaid. She explained that most of the women she sees in Minnesota are financially secure, unlike her experience working in another part of the country. According to the North American Registry of Midwives, there are only nine states allowing reimbursement to direct entry midwives through Medicaid (MANA, NARM, 2006). Furthermore, out-of-hospital midwifery is not legal or regulated in all states. The following map (Figure 2) highlights this national variation. In states that prohibit out-of-hospital midwifery, women pursuing homebirth must use informal networks to locate providers. The providers themselves run a great personal legal risk in continuing their work.

Legality of Out-of-Hospital Midwifery



Risk Management and Safety

My research suggests that using a strategy of risk management is not solely an obstetric or medical tactic. Traditionally it has been a medical approach that “results in women being confined, subject to the gaze of medical technology and, of course, to medical procedures if complications arise” (Sharpe, 1999, p. 94). By identifying and prioritizing various risks and finding ways to mitigate or offset those risks, both providers and parents are finding ways to justify and feel comfortable with their decisions. Their perceived risks may be different but individuals utilize a similar cognitive process. This risk management has a key spatial component to it, as creating a feeling of safety in a place is identified by many of my informants as a key part of a “successful” birth, and in generating positive feelings about the experience.

A risk management strategy can be used as a way of creating a sense of control. It is employed in diverse ways by providers from various backgrounds, mothers, and other labor support people, as well as a way to better control outcomes and justify certain courses of action. It can be both a defensive and offensive strategy. Women who have had or planned homebirths defend themselves against critics of their birthing choices by offering up information that either seeks to demonstrate risks of hospital births or the comparative safety of homebirths.

Decisions about childbirth contain varying degrees of risk management. Professionals and parents make decisions about risk and safety. Despite having different philosophies and educational backgrounds, all care providers are working from a position that seeks to minimize risk. Given this perspective, and the understanding that birth is a socially constructed phenomenon, we come to see that “people make informed decisions based upon

the situation they are in and the risk that they have to take” (Moore & Oppong, 2007, p. 1060). Namely, our familiarity with a particular narrative or cognitive map of birth influences the different types of risk we perceive.

The most serious risk of pregnancy and birth is arguably fetal or maternal death. However, my informants and the literature supports that this is not necessarily the most significant risk factor under consideration, particularly for healthy, well-educated, and higher income women who consider themselves low-risk. The risk of medical intervention, damage to the mother-child bond, or the risk of losing control of the birth experience may loom larger in the minds of some individuals. Lois, a homebirth midwife, described the balance of these various risks to one worried parent of a client pursuing a homebirth in this way:

Your daughter is choosing homebirth knowing that there are small risks at home that could come up [...], a small chance something could happen that could harm the baby in a significant way. But she knows that if she gives birth in a hospital there's an extremely high risk, a 100% risk that things will happen that will harm the mother-child relationship in a moderate way.

Lois feels strongly that there are risks inherent in any hospital birth that, for her, are serious enough to avoid the hospital altogether. Lois identified iatrogenic risks, or risks that stem from the action or inaction of medical professionals, as more likely than the risk of injury to the baby from homebirth. She acknowledges a small risk to homebirth, but ultimately finds it less significant than the impact a hospital birth may have on the mother and child relationship. Nevertheless, individuals who prioritize this type of risk are likely to come from a demographic for which mortality is a very small risk⁴. Therefore, if proponents of homebirth

⁴ As a reminder of the diversity of experience worldwide, there are over ten countries in Africa alone where a woman's lifetime risk of dying from pregnancy or childbirth related causes is one in 20. In Niger, for example, the risk is 1 in 7 (WHO, Atlas of Birth, 2005).

in the U.S. were facing a higher risk of death, they might frame their critiques of hospital birth differently. Risk is a relative concept.

Risk is ultimately a relative and individually determined constraint. Not all people perceive the same risks. Jessica, a family practice doctor, finds homebirth too risky to personally consider. As she explains, “I can’t absolutely say, ‘No woman should ever [have a homebirth].’ Does it make me nervous? Yes. Would I wish it on a loved one? No.” However, her willingness to withhold a blanket statement about what all women should do reveals her appreciation for the individuality of risk perception. While Lois and Jessica clearly disagree about the risk of homebirth, their opinions reveal the need for an appreciation of the diversity of feelings toward risk.

Risk management was identified by some informants as a strategy to justify one’s choice of a place to birth. Rachel, a doula, noticed that when she assisted women at hospital births, there seemed to be some tacit support amongst the hospital staff for homebirth “They [hospital staff] would tell me that they had had homebirths and I just started thinking like, ‘OK, if there’s a labor and delivery nurse and hospital midwives and hospital OBs who are having homebirths, like what?’ They know something. They know that it’s OK, as long as there’s no, you know, as long as you’re a low-risk mom.” She judged herself to be low-risk and used the example of health care professionals whose opinions she respected to justify her decision to try for a homebirth.

For many of my informants, navigating risk was part of the process of creating a safe birthing environment. For women giving birth in hospitals, getting an epidural is a common method of pain relief. For women who perceive the physical pain of birth to be a great risk, getting an epidural is a highly logical choice. However, women who are concerned about

risks *inherent* to the epidural may utilize strategies to avoid having one at all. Megan, a doula who had two homebirths herself, explains that she does not think giving birth in a hospital is “evil” or that having an epidural is “bad.” She cautions, however, “As long as you know what the risks are going into it and you feel like the benefits outweigh the risks then go for it, get an epidural. But don’t, like, go into it feeling like there aren’t any risks.” Balancing relative risks was something many of my informants acknowledged they did. The challenge is that there is tremendously conflicting information about what the relative risks of birth and related procedures are.

One method of managing risk that some informants used was to actively take precautions during pregnancy to promote a low-risk birth. As a labor and delivery nurse, Valerie’s process of risk management included active management of her pregnancy through her prenatal care. She explains, “I actually had full prenatal care with doctors [...] ‘cause I had health insurance for it, so I thought, ‘Well, I might as well get all the care and, uh, appointments and blood tests and all that.’” She used a variety of technologies during the pregnancy but had had two unmedicated hospital births. The combination of prenatal risk management with her previous birth experiences bolstered her confidence in having an unmedicated homebirth. By relying on the screening and testing available to her, Valerie navigated the risk of homebirth in a way that allowed her to feel safe at home.

Rachel, a doula and mother of one, used a similar strategy when she was faced with a potential health risk during her pregnancy. Her own concept of risk clashed with her doctor’s strategy of risk management, which prompted her to change from planning for a hospital birth to planning for a homebirth.

The OB that was overseeing the midwives, he just kind of got involved really fast and started talking about all of these interventions just even in my pregnancy, wanting to monitor, doing late ultrasounds and, um, just being much, much more hands-on. And I started doing a lot of research about gestational diabetes and basically came to the conclusion that I was going to refuse – they made me go through the three hour test. So I went to the three hour follow up test and [...] they said, “You are so on the border that we think you're still going to develop gestational diabetes. So we want you to take it again”. And it's this awful three hour test and you feel terrible and the baby, because they pump you full of all this sugar, he was moving around and I just felt like I was going to throw up and pass out and I didn't want to do it again. So I decided I'm going to monitor my blood sugars on my own, which meant I was poking my finger four times a day and doing everything with diet to make sure I was keeping my blood sugar stable. And I didn't want to do a late ultrasound, like at 36 weeks, because they're considered notoriously wrong. They overestimate the size of the baby and that can often cause more interventions, like induction. They want to induce you before the baby gets too big [...] Suddenly my entire upcoming labor and birth just became all about fear and really close monitoring and I didn't want it to be that. I mean, I didn't want to be stupid so that's why I decided to still monitor my own blood sugars and make sure they were ok.

Rachel was interested in maintaining more control over her pregnancy and decided to manage the risks that came up on her own. In part, her work as a doula gave her knowledge about birth-related risks that enabled her to make a more informed choice about where her birth would be and who would attend it. She navigated her risk as a way to exert a great deal of control over the situation.

Some informants acknowledged that providers who tell patients that they are at risk can be highly influential, and even potentially manipulative of patient decisions about birth. Fadumo, a community health worker within the Somali community in the Twin Cities and a mother of three, described the cultural support and encouragement for “natural” birth among the Somali women and families that she works with. According to her, most Somali people

prefer to give birth without medication in an effort to avoid side effects. Women will tell each other, “Try to have natural birth. Don’t accept medication when you go to the hospital. Be strong.” Fadumo noted that the only time medication would be accepted would be if medical staff say, ““Oh, you are risking your baby and yourself” [and] after that they accept it.” The threat of risk could be a powerful motivator. Interestingly, Jessica, a family practice doctor, states that “I know that any sort of guilt-based tactics are not appropriate, professional, or effective. If you start saying things like, ‘You’re putting your baby at risk. Why would you do that?’ I think that’s a very quick way to get a woman to shut down.” Primary care providers may use their knowledge and position of authority strategically to encourage or even coerce patients into making particular choices. Women’s existing knowledge and ability to advocate for themselves in these situations may also affect the outcome of these interactions.

Different providers have varying approaches to risk management and different thresholds for tolerating specific risks. Some patients may base decisions about whether to work with a specific care provider on that provider’s approach to risk. Laura, a family practice doctor, is willing to work with patients to reduce or mitigate their risk factors, which has made her an attractive doctor for women seeking this type of approach. She explains how she frequently works in conjunction with nurse-midwives to manage patient risk. “They [CNMs] often will refer people to me, just saying, ‘Look, I had this woman come in. She wants a waterbirth. Her blood pressure’s a little high.’ [...] So a lot of times I would get them and do the assessment and say ‘Hey, blood pressure’s a little high but still OK for waterbirth but I’m willing to work with you on that.’” This flexibility and tolerance for some level of risk makes her attractive to patients seeking a particular approach. Additionally, she notes

that many of her patients seek her out specifically because they hear about her support for waterbirth and other unmedicated birth. However, if Laura is not available when one of her patients goes into labor, two of her three colleagues do not allow waterbirth, which means that patient will not be able to try that method.

Risk management may also be a strategy on the part of the care provider to minimize legal risk to the hospital or the staff. For instance, Valerie, a labor and delivery nurse, explains how the use of electronic fetal monitoring can create a challenging legal scenario for health professionals. “If you don’t respond to something on the fetal monitoring strip and they can find that later, you can get sued. So a lot of times I think when there’s a question, they’ll end up doing a Cesarean just to make sure that the baby comes out ok [...] It sounds insensitive, but to save ourselves from liability maybe we should just do the surgery.”

Doctors, RNs, and CNMs working in this type of medical-legal climate may face constraints as to how to balance the risks of legal action with the desires of some parents for as little intervention as possible. John, an OB/GYN and father of two, explained that “the fact is we cannot ensure good outcomes for every baby [...] I don’t practice with a medical-legal [outlook] but there’s no question that a lot of what we do is to err on the side of caution, to bail out if there’s a problem.” “Bailing out” frequently means intervening, perhaps in the form of a Cesarean section. Many of my informants noted that physicians are pushed toward more Cesareans by this legal bind. Indeed, obstetricians have some of the highest malpractice insurance premiums of any subspecialty of physician, because of the litigious nature of their work. More succinctly in John’s words, “a bad baby is going to cost millions in lawsuits.”

Hospitals typically utilize a variety of technology that aim to manage risk, both legal and physical. For example, continuous monitoring of fetal heart tones, checking maternal blood pressure, and the routine use of antibiotics to decrease incidence of Group B strep are all examples of procedures that attempt to both improve safety but also to decrease the risk of lawsuits. Unfortunately, since introducing many of these techniques throughout the past couple of decades, there has been little improvement in outcomes. Nevertheless, the medical-legal system favors proactive measures on the part of staff, regardless of how evidence-based the measures are (Sakala and Corry, 2008). On the other hand, homebirths, which lack many of these protocols and procedures, can be seen as increasing the legal risk for the care provider. Nancy, a certified nurse midwife, talks about her decision to work in a hospital setting as partly a consideration of personal legal risk. “Ultimately, I didn’t want to expose my family to that kind of liability. Um, I think that the midwives who do take that on, I think they’re tremendously brave. But it wasn’t something I thought I could do.” Because the history of direct-entry midwives has been so tenuous, Nancy was concerned that entering midwifery without a nursing degree was taking too large a legal risk.

Letting Go: The Limits of Control

Many of my informants held conflicting opinions on the need for and importance of control. Some characterized a lack of control as a bad thing. Women who do not have bodily control or an active voice in what happens during their labors and births run the risk of someone else dictating their experience. Paradoxically, some of my informants, particularly those who were proponents of homebirth, suggested that women must “let go” of control if they want to experience a “true natural birth experience.” By exerting or relinquishing

control in different scenarios, women and providers found they could make a birthing place more or less conducive to birthing in the way they desired.

Many of my informants lamented that they saw most people relinquishing their control over decision-making and the birth process. Jennifer, a childbirth educator, doula, and mother of three babies born in hospitals, described what she found to be the normative experience, “There are plenty of people who just do whatever their doctor tells them, you know.” Many of my informants saw this as potentially dangerous. Doctors, nurses, midwives and doulas alike all agreed that giving women control and encouraging them to utilize it was an important way to create a feeling of safety for the woman wherever she had chosen to be during the birth.

Some women place great value of control over their birth experiences. Rachel, a doula who had hoped to have a homebirth for her first baby, found that staying in control of the situation even when the course of events was not what she had anticipated contributed immensely to her positive feelings afterwards.

After laboring at home for 12 or 13 hours, um, I decided, the midwives had sort of talked amongst themselves that maybe we should do a hospital transfer, not because of an emergency but just to get some IV fluids, to help me get hydrated again because that would kind of kick-start the labor back up again. And um, possibly Pitocin to get my contractions to be stronger. **So they let me come to the conclusion myself though.** I kept saying "I need help, I need help" [laughter]. And one of the midwives said, ‘Well when you say you need help, what do you mean?’ And so I said, “I think I might need to go the hospital.” So they let me come to the conclusion myself, which is such a huge difference than birthing in the hospital where they are more just telling you what is going to happen or what is about to happen, or sometimes they don't tell you at all what's about to happen. Um, so it helped to go through all of that at home, because it felt like, **even though it wasn't going to be going the**

way that I wanted it to go, I still felt sort of in control of my options and therefore I felt ok with it. You know, it was like, this is ok. 'Cause I felt like I was being respected and trusted for my own birthing instincts. [emphasis mine]

Rachel reached a point in her labor where she decided she needed more help than what her providers could give her at home. By allowing her to make this decision on her own, her midwives contributed to her feelings of control and autonomy.

Bargaining and strategic negotiation with providers were also reported as ways to exert control over situations. Laboring women, doulas, RNs, and CNMs all conveyed situations in which they had utilized or witnessed bargaining. Debbie, a childbirth educator and mother of four children, explained that she thought laboring women and their families should bargain to maintain control of their experiences. Frequently, an unequal power dynamic made women feel they could not make requests of hospital staff. This could in turn result in a loss of a sense of control on the part of the women.

Well, it's reasonable to assume your doctors will know more about what's going on because they have a lot of studying and experience behind this that new families don't. But I think that families really need to be empowered to just say, "I need to buy time". [...] If it's an emergency there isn't a lot of time to sit down and so people just kind of go, "Ok, whatever." So but I wish families felt more empowered to ask questions and to delay things. "What if we wait? Can I take a shower before we do this? Can I take a nap? Can I walk the hallways once and see what happens then? Can I buy ten contractions and see what happens then?" I don't think families feel like they can. There's no give and take. It's just all taking. It's kind of a, it's a very passive relationship, I think.

From Debbie's perspective, being able to ask questions about procedures in a hospital setting is a way for parents to maintain a sense of control. Instead of acquiescing to the instructions

or demands of the staff, educating oneself about procedures and bargaining are ways to maintain control. “Buying time” and delaying procedures could give patients a sense of control, but could also be frustrating for hospital staff. At least one informant, a certified nurse midwife, joked about how annoying this could be when patients made demands or did not take the advice of hospital staff. Bargaining is a strategy available only to educated women who feel able to advocate for themselves in the midst of labor.

Conversely, several informants talked about the need to let go of control as a way to experience a truly “natural” birth. As Maya, a doula, explained, “[I tell people to] let yourself go there instead of trying to control it. With birth, you have no control.” There is a common refrain within the “natural” childbirth movement about this animalistic, uncontrollable side to birth, which women must embrace in order to give birth without medication or intervention. One homebirth midwife, Lois, described it in this way:

Birth takes a woman underneath her culture. She has to give up certain expectations of the culture and open up in order to give birth. She can't be in such control that she's trying to avoid body fluids, for instance. She has to be able to let her sounds free [and] get out of her logical mind and let her body carry her. It's a very midbrain-run process. And so each religion or geographical area will have its culture and [...] to give birth naturally you have to get out of that culture.

In this description, Lois sees control as a potential hindrance to a woman who is seeking to have a “natural” birth. The informants that used this line of thinking drew a distinction between “nature” and “culture.” They believed “natural” birth was a way of transcending culture, rather than recognizing that all birth is socially constructed. This discussion illustrates Mansfield’s point about the ways in which proponents of natural childbirth

negotiate “nature-society relationships” (Mansfield, 2007, p. 1084). I suggest that these views demand closer examination through a feminist critique of essentialist understandings of women as somehow inherently connected to nature through “their reproductive capacities” (Mansfield, 2007, p. 1085; Beckett, 2005; Longhurst, 2008). Control in this context then refers to a woman’s relationship to the labor process, and has less to do with her control over the place. However, because different places have such different ways of managing the labor process they are difficult concepts to unlink.

Due in part to conflicting messages about the importance of maintaining and relinquishing control, some women may struggle with this issue. Several of my informants described a particular population of women that they viewed as having rigid expectations of birth that could interfere with the progression of their labors. As Cassidy writes, “Some believe that women who are used to being in charge of every aspect of their lives just can’t give in to the natural process that is birth and unconsciously fight it until labor stalls or the pushing phase goes on way too long” (Cassidy, 2006, p. 125). Like Cassidy, Jessica, a family practice doctor, explained that she thinks some highly educated women attempt to retain such a degree of control over their births that they end up unable to have a vaginal delivery.

I hated seeing women who came in with this very specific birth plan [because] as soon as you see a really specific birth plan, you say, “Shit she's going to end up with a C-section.” [...] And there's no evidence to support that but you're just like the very ones who don't want it the most and who are most adamant about it and most upset. I don't know maybe there is research about it. That sort of tension and rigidity and idealism, does that affect how well they're able to push a baby out?

In this scenario, control could hinder women’s physical ability to give birth the way they desired.

On the other hand, controlling one's mind could also be a strategy to feel calmer about birth and therefore promote a progression of labor. Valerie, a labor and delivery nurse who had her third child at home after two hospital births felt it was important to be present in her thoughts during labor and to exert control over her own mind. She balanced the potential risks of having a homebirth against her own belief that it was the best place for her to give birth:

If something were to happen, I would have had to get in the car or call an ambulance and go [to the hospital] anyway. So there was still that kind of in the back of my mind but [...] I just tried to stay as positive as I could and not think about the things that could happen. **Mind over matter, you know** [...] If you have any issues in your mind about homebirth, [...] I think that can stop you as well, if you have any reservations about the process. That's what I tried to do when I was giving birth to [my daughter] was not have [...] any negative thoughts. 'Cause that can hold you back just as much as your environment, I think, giving birth. [emphasis added]

Ultimately, her ability to control her thinking made it possible for her to feel safe in the place she had chosen. Valerie connected her choice in birth environment to her thoughts and recognized that each could potentially impede what she viewed as a natural, physiological process.

Indeed, many women were angry about situations in which they felt control had been denied. The story Kimberly, a certified professional midwife, tells of her own hospital birth reveals the depth of her feeling about having been denied control over her body and birth process.

I negotiated to hold off till 41 weeks. At 41 weeks, I went to the hospital, got my IV hookup for Pitocin. My admission to the hospital started to include everything that I'd already discussed with my doctor I didn't want. The nurse

came in with an enema and a razor and I said, "I'm not doing that, my doctor said I didn't have to." What I quickly learned, um, was that it doesn't matter what your doctor said; the nurses on staff and their philosophy is what you get. And you don't really ever see your doctor, just very briefly during labor and that's the typical hospital experience [...] But I managed to give birth without a C-section and without an epidural and it was fulfilling only in that regard. Despite all the odds, despite people wanting to do all kinds of things to me, I still managed to push her out and feel it and that's what I wanted. But it was such an empty experience. It was so frightening and so lonely and so hollow [...] and then my baby was separated from me for 8 hours for no reason and no one was there to advocate for me.

Along the way, Kimberly felt that her desires were not being listened to. She felt she had been proactive with her doctor, but when it came time for the labor and birth, her wishes were secondary to the actions of the medical and nursing staff on duty. Kimberly's birth experience was so personally challenging that it prompted her to go on and become a CPM. She saw giving women control over their births as very important work.

Megan, a doula who has had two homebirths, describes a scenario that she interpreted as one in which a woman was similarly without control.

I have a friend who for her first baby she had a Cesarean at [a hospital] and I was her doula for her second baby, which she decided to have at [a different hospital] with some VBAC-supportive midwives. And in the process of getting to know what she wanted in interviews getting ready for her birth, I asked her to tell me the story of her first birth. And, um, I just remember, like, listening to her tell me about her first birth and seeing how she had been set up for a Cesarean from, like, four days before she had the baby. You know, like, they set her up, they knew she was going to have a Cesarean and so she did and I just remember thinking to myself, "When is she going to get angry about this?" And she got angry about it about two months after her second baby, who was bigger [...] she had a successful VBAC. Like two months after she was like "I can't believe they did that to me. Why did they do that to me? I was cut for no reason." [...] I feel a little bit like "God they just set people up at those places."

The anger that Megan's friend experienced came from a realization that her Cesarean birth may not have been necessary. Megan concluded that her friend had been "set up" for a Cesarean by the doctors at the first hospital she had gone to. Changing which hospital she was at and the type of provider (doctor to certified nurse midwives) allowed her second experience to give the perspective she lacked about the first experience. Once she could contrast the two experiences, she was frustrated with the first.

In conclusion, some of my informants contradicted themselves about the limits of control. In order to have a successful birth experience, control must be actively maintained, and yet one must relinquish control in order to allow "nature" to take its course. Control was needed and used selectively, suggesting that there are multiple ways of interpreting its place in the birth experience.

Conclusion

There is little, if anything at all, that is universal when it comes to the experience of birth. However, this paper is one among many attempts to identify ways in which political and social trends related to birth influence, and are influenced by, individual preferences and expectations. While readers may find certain themes from this paper applicable to a broader population or context, this research is not designed to be generalized to a larger unit of analysis. What this research *can* do is to broaden our understandings of how individuals navigate the complexity of the spatialities of birth. My informants' responses highlight the individuality of birth that exists wherever it happens. Actively choosing to give birth at home or in a hospital does not yield a clear-cut outcome. Additionally, choices of place are infused with different meanings. While choice stems from a position of access and privilege, it is

frequently applied in a universal way to frame birth. Women have hugely variable access to choices related to their pregnancy, birth, and postpartum care, due to an intersection of different forms of oppression. An increased awareness of this dynamic on the part of care providers, families, and the general public is critical.

This paper framed the rhetoric of choice about birth in a way that complicates our understandings of who ultimately has choice and control. Although choice may be a limiting and problematic framework for understanding birth, it is still one which defines the popular literature about birth. Ultimately, I was still reliant on this phrasing in my own paper. Choice is highly significant to birth, yet remains a problematic term. Creating and maintaining an awareness of this dynamic can allow academics, health care professionals, and lay people to reflect more intentionally on how this framing affects access to services and care. More broadly, research would be useful to understanding the intersections of this tendency to frame birth around choice and the rise of a liberal consumer market in general.

Significantly, by focusing on predominantly white, educated, and upper middle class informants with a great deal of knowledge about birth, this paper could not begin to address the influence that race, class, and other identity-based oppression may have on birth experiences. Further research is needed to understand and critique the influence of social mechanisms on perceptions of birth, risk, choice, and place. Ultimately, this research does contribute a useful perspective to the conversation on the significance of where birth happens. By interviewing providers from varying educational backgrounds, and integrating a spatial, geographic perspective with other perspectives from diverse disciplines, this research expands on work about place and birth.

Care providers in general are uniquely situated to critique the social positioning of normative birth experiences. Their greater awareness of trends on where and how women give birth provides them with a useful perspective on how to approach these issues. Rather than universally advocating for a new normative model of birth, however, they should avoid imposing a new value system on birthing women and families. Although care providers may be pressed for time when meeting with their patients, they should aim to understand their patients' understandings and feelings towards birth in an effort to provide more individualistic care. Both care providers and policy makers should acknowledge the significance of place and space on birth outcomes and experiences. Care providers can also reflect more deeply on their own views of birth and how these contribute to patient experiences.

Another important connection for future research to engage is the relationship between the "natural" birth movement and the feminist movement. These movements are in some ways parallel and compatible, and yet in other ways they are highly antagonistic and divergent. Researchers like Klassen, Mansfield, Michie, and Miller have engaged with some of these issues but there is room for more discussion and research on the places where these movements converge and diverge. In general, feminist theory provides an important lens to contribute to discussions of birth, as an embodied, gendered experience. Specifically, as Beckett notes, "while the essentializing and moralistic rhetoric of the alternative birth movement should be abandoned, its critique of contemporary obstetrics, commitment to women's and children's health, and thoughtful use of health care resources are essential to the reconstruction of a feminist politics of and theoretical approach to birth" (Beckett, 2005,

p. 270). I would encourage more feminist theorists from diverse disciplines to combine feminist methods and approaches with other disciplinary lenses to approach this topic.

Ultimately, deconstructing birth and the places of birth is a major undertaking. This paper advances a qualitative understanding of how care providers in a particular setting navigate this issue through their work and personal experiences. Their voices and stories provide an intimate picture of just how significant these experiences are to women and their families. I have argued that applying the work of geographers from multiple sub-disciplines (health and feminist geography in particular), along with the work of other social scientists, natural scientists, health practitioners, and policy makers can contribute to a broad-based understanding of birth as a significant social, political, economic, biological experience with important ramifications for the individual.

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Appendix A: Summary of Interviews, including Pseudonyms and Job Titles

Lois (Homebirth Midwife). Interview by Author. Bloomington, MN. 6/16/09.

Barbara (Doula and Childbirth Educator). Interview by Author. St. Paul, MN. 6/17/09.

Kimberly (Certified Professional Midwife). Interview by Author. Edina, MN. 6/22/09.

Diana (Certified Nurse Midwife). Interview by Author. St. Paul, MN. 6/24/09.

Sharon (Certified Professional Midwife). Interview by Author. St. Paul, MN. 6/25/09.

Megan (Doula). Interview by Author. St. Paul, MN. 6/25/09.

Louise (Certified Nurse Midwife). Interview by Author. Minneapolis, MN. 7/1/09.

Carol (Doula). Interview by Author. St. Paul, MN. 7/2/09.

Fadumo (Community Health Worker). Interview by Author. St. Paul, MN. 7/9/09.

Donna (Certified Nurse Midwife). Interview by Author. Minneapolis, MN. 7/9/09.

Rachel (Doula). Interview by Author. St. Paul, MN. 7/24/09.

Debbie (Childbirth Educator). Interview by Author. St. Paul, MN. 8/3/09.

Ellen (Labor & Delivery Nurse). Interview by Author. St. Paul, MN. 8/5/09.

Jennifer (Doula). Interview by Author. St. Paul, MN. 8/12/09.

Nancy (Certified Nurse Midwife). Interview by Author. St. Paul, MN. 8/13/09.

Valerie (Labor & Delivery Nurse). Interview by Author. St. Paul, MN. 8/14/09.

Heather (Certified Professional Midwife). Interview by Author. St. Paul, MN. 10/14/09.

Nora (Certified Professional Midwife). Interview by Author. St. Paul, MN. 10/14/09.

Anna (Certified Professional Midwife). Interview by Author. St. Paul, MN. 10/14/09.

Laura (Family Practice Doctor). Interview by Author. St. Paul, MN. 10/23/09.

Maya (Doula). Interview by Author. Minneapolis, MN. 10/28/09.

Jessica (Family Practice Doctor). Interview by Author. St. Paul, MN. 12/1/09.

John. (Obstetrician/Gynecologist). Interview by Author. St. Paul, MN. 12/17/09.

Cynthia (Family Practice Doctor). Interview by Author. St. Paul, MN. 12/18/09.

Appendix B: Key Birth-Related Terminology

Apgar Score – A number between 0 and 10 assigned at one and five minutes after a baby is born that is designed to measure the infant's relative health. Infants are quickly evaluated in five criteria, Appearance, Pulse, Grimace, Activity, Respiration, to ascertain their relative health. The system was created by an anesthesiologist to determine the impact labor anesthetic was having on infants.

Birthing Ball – A device that facilitates the movement of a laboring woman in ways that promote shifts in the baby's position or pain relief.

Breech Positioning – Standard or vertex positioning for a term fetus is head down, facing the mother's back. Babies that are positioned feet or buttocks first are considered to be breech. Ultrasounds are a helpful tool for determining the positioning of a baby prior to labor's start but are not 100% accurate. Breech babies can be born vaginally and even at home, but the risk to both mother and baby is greater than that of a vertex positioned baby. Some doctors will only do Cesarean sections for babies they know are breech.

Cesarean Section – A surgical birth in which a trained surgeon cuts through the abdomen and the walls of the uterus and removes the baby. C-sections can be planned and scheduled or emergency events. They can be performed under general or epidural anesthesia. Epidural anesthesia allows the woman to remain awake and see her baby after it is removed from her uterus.

Electronic Fetal Monitoring – Electronic Fetal Monitoring is a practice of tracking the fetus' heart rate during labor. Monitoring can happen internally (by applying a node to the baby's head) or externally by strapping a monitor onto the abdomen of the laboring woman. Monitoring can be intermittent or continuous.

Epidural – A form of analgesic and anesthetic medication used to numb laboring women from the waist down. An epidural is put in through the spine and can be used once a woman's cervix has dilated to about 4 centimeters.

Episiotomy – A surgical cut made in the perineum to facilitate the birth of the baby's head. Episiotomies were once thought to reduce tearing to the area, but are now thought to actually increase it in many cases. They are used less frequently, although still relatively prevalent.

Gestational Diabetes – Some women develop diabetes, or problems regulating blood sugar, during pregnancy. This poses some risk to both mother and baby and is often manifested in excess weight gain which can make birth more difficult if the baby grows quite large.

Group B Strep – Short for Group B Streptococcus is an infection that mothers may pass to their newborns around the time of birth. About a quarter of women have GBS in the vagina or rectum at any given time. Some hospitals prevent it by routinely giving mothers antibiotics.

HBAC – Home Birth After Cesarean Section – See VBAC. A vaginal birth at home that follows a C-section.

Intrathecal Narcotic – Form of pain control used during labor that is more temporary and has a lesser impact on mobility than an epidural.

LDRP – Labor, Delivery, Recovery and Postpartum – LDRP is a designation that some hospitals use for their units which indicates that a woman and baby’s entire stay in the hospital will happen in a single room. These types of rooms are on the rise, although far from ubiquitous. In the absence of LDRPs, hospitals have separate rooms for each part of the process.

NICU – Neonatal Intensive Care Unit – Unit within a hospital designed for the intensive care of neonates. Babies admitted here are often premature or low birth weight, or have other noticeable health problems at the time of delivery or shortly thereafter.

Perineum – The area of tissue between the vaginal opening and the rectum. The perineum can be a site of tearing during birth and is also the area that is surgically cut during an episiotomy with the goal of making the baby’s entrance easier and faster.

Pitocin – A synthetic form of oxytocin, which is the hormone that causes uterine contractions. The drug is given for a variety of reasons: to speed up or intensify contractions during labor or to help expel the placenta after the baby has been born.

Rooming-In – A practice of keeping babies in their mothers’ rooms rather than in a separate nursery facility. This policy came about in response to consumer demand as well as part of efforts to increase rates of breastfeeding.

Vacuum Extraction – A method of assisting with the vaginal delivery of a baby. A vacuum device is applied to the baby’s head once it is low in the birth canal in an effort to suction it out. Vacuum extraction has largely replaced the use of forceps in the past couple of decades.

VBAC – Vaginal Birth After Cesarean Section – Following a Cesarean birth, women may want to attempt a vaginal birth for a subsequent birth. Some hospitals in the U.S. will not allow women to attempt this, citing potential liability. The saying “Once a C-section, always a C-section” emerged from the observation that women laboring had a higher risk of uterine rupture if they had had a previous C-section birth. With the increase in surgical skill over the last few decades, this is no longer a hard and fast medical rule, but many hospital establishments still fear legal action.

Waterbirth – A birth in which the laboring woman pushes the baby out into a body of water, often a birthing tub. The baby is born into water and then pulled up to the surface where it will take its first breath of air.

Appendix C: Schedule of Interview Questions for Key Informants

These questions were intended for health care providers and other birth professionals. Due to the semi-structured nature of the interviews, other questions were asked where appropriate. Additionally, questions were tailored for different types of care providers.

What do you perceive to be important in a place of birth?

What is your policy regarding balancing health care concerns with comfort of expectant parents?

What facilities/classes does your organization offer to expectant and recent parents?

What trends do you see in parents' decisions regarding where to give birth?

Have you noticed any changes regarding parents' expectations of a place to give birth?

What is your opinion of birthing occurring outside of a hospital setting, e.g., homebirths?

What is your opinion of the relative merits of a midwife vs. doctor attending a delivery?

What is your opinion of the role of a doula?