

Complications in the Classroom: An Investigation of  
Childbirth Preparation Classes

by

Stephanie Julia Hucker

Class of 2011

A thesis submitted to the  
faculty of Wesleyan University  
in partial fulfillment of the requirements for the  
Degree of Bachelor of Arts  
with Departmental Honors in the Feminist, Gender and Sexuality Studies Program



## TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	iv
INTRODUCTION.....	1
CHAPTER 1: THE MEDICAL AND ALTERNATIVE MODELS OF BIRTH.....	15
CHAPTER 2: DUALISMS.....	44
CHAPTER 3: CREATING A PERSONAL BIRTH EXPERIENCE.....	55
CHAPTER 4: FLEXIBILITY AND SAFETY .....	86
CONCLUSION.....	113
APPENDIX.....	119
WORKS CITED.....	120



## ACKNOWLEDGEMENTS

In taking on this project, I have been fortunate enough to have the full support of many professors, friends and family. First, I would like to thank Professor Sarah Wiliarty for her help and encouragement in the thesis process as well as in my overall exploration of childbirth while at Wesleyan. Thank you to both the Feminist, Gender and Sexuality Studies Program and the Sociology Department faculty for inspiring me throughout my project. I also want to thank my parents for their support and love, as well as my friends, especially Dan, for always being willing to help me think out loud. Finally, I want to thank the Pine Grove Hospital instructors and class participants for letting me share in their childbirth preparation experience.



## INTRODUCTION

In March of 2010, Amnesty International released a staggering report on the state of maternal health care in the United States. Titled *Deadly Delivery*, the report examined the incredibly high rates of maternal mortality in one of the most technologically advanced countries in the world. It traced the prevalence, consequences and social implications of the high number of pregnancy-related complications in the United States and Amnesty International brought to light some chilling information. Most notably, the report found that women in the United States are more likely than women in forty other nations to die from pregnancy-related complications, despite a national health bill that is more costly than healthcare in any other country (Amnesty International, 2010, p. 93). Equally significant is that between 1987 and 2005 the number of maternal deaths per 100,000 live births has nearly doubled<sup>1</sup>. 1.7 million women experienced a long-term health complication relating to their pregnancy and birth (Amnesty International, 2010). In a nation that brags of progress and technological advancement in treatment of illness and disease, why is the state of maternal health on a frightening decline?

While there are a number of explanations for the state of maternal health care in the United States, ranging from social inequities to language barriers to a lack of woman-centered care, it is undeniable that the United States offers a disproportionately medical birthing system (R. G. De Vries, 2001; Jordan & Davis-Floyd, 1993). Unlike many other nations, birth in the United States is largely considered a medical procedure. According to the Center for Disease Control Birth

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<sup>1</sup> In 1987, the rate of maternal deaths per 100,000 live births was 6.6. In 2005, Amnesty International reports a rate of 13.3 (Amnesty International, 2010).

Data for 2007, 99.1% of all births occurred in hospitals and physicians attended 91.4% of hospital births (Martin, 2010, p. 24). Midwives attended 7.9 % of all births, the majority of those also occurring in hospitals<sup>2</sup>. Less than 1% of births occurred outside of hospitals in family homes or birth centers (Martin, 2010, p. 24). As the data makes clear, the overwhelming majority of births in the United States occur in a hospital and are attended by a physician. For this reason, I will refer to the United States birthing system as biomedical<sup>3</sup>.

In *Deadly Delivery*, Amnesty International points out the links between problems with birth in the United States and social elements of health. Amnesty draws attention to the barriers for safe and effective care faced by many mothers and families within the biomedical system. Amnesty points out systemic failures such as inaccessible health insurance, a lack of prenatal care, discrimination in health

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<sup>2</sup> The cost of both physician- and midwife-attended hospital births are staggering. In-hospital vaginal deliveries cost roughly \$8,919 in 2008, yet with the addition of medical and technical interventions, this cost can rise to nearly \$20,074 (Childbirth Connection, 2011). Additionally, as the Amnesty International report points out, this elevated spending is not translating into healthy mothers and children. They note that: "...the USA spends more on health care than any other country and more on pregnancy and childbirth-related hospital costs, \$86 billion, than any other type of hospital care" (Amnesty International, 2010).

<sup>3</sup> Importantly, the rate of hospital births in the United States is disproportionately medical, but not altogether unique. As Jordan (1993) illuminates, birth varies greatly across different geographic and cultural landscapes. For example, the rate of hospital births in the Netherlands neared 70% in 1992, when the hospital birth rate in the United States was close to 99%. In Canada, the hospital birth rate in 1992 was also 99%, demonstrating their comparable biomedical birthing system ("Live births and fetal deaths (stillbirths), by place of birth (hospital and non hospital), Canada, providences and territories, annual," 1992; MacDorman, Menacker, & Declercq, 2010; Wiegers, Van Der Zee, & Keirse, 1998). Additionally, the Netherlands maintains a very high rate of home births. In 1992, the rate of home birth was 35% whereas only 1% of births in the United States and Canada respectively occur out of hospital ("Live births and fetal deaths (stillbirths), by place of birth (hospital and non hospital), Canada, providences and territories, annual," 1992; MacDorman et al., 2010; Wiegers et al., 1998).



practices, as well as the absence of primary care health professionals and care centers as shaping the increase in deaths resulting from pregnancy-related complications

(Amnesty International, 2010). They report:

“The failure [by the United States government] to ensure access to adequate health care before a woman becomes pregnant; to provide adequate family planning services; to ensure that women receive early and adequate prenatal care; to ensure that evidence-based guidelines are in place to address the main causes of maternal death; to respect women’s right to information and informed consent and the barriers to women’s active participation in their care; to provide adequate post-natal care; and to ensure systemic accountability for maternal deaths and injuries – all breach international human rights standards” (Amnesty International, 2010, p. 93).

The Amnesty report is dedicated to drawing attention to the glaring disadvantages in the birthing system, specifically for women of color and women with low incomes.

To illustrate a chilling example, Amnesty points out that the maternal mortality rate for African-American women in the United States is four times greater than the rate for white women, as well as other factors that represent a frightening division of care along racial and classed lines (Amnesty International, 2010, p. 1). While this is one component of Amnesty’s report that is worthy of attention, I seek to highlight another element of Amnesty International’s project.

Along with demonstrating the birthing system’s alignment with race, class, and gendered discriminations, Amnesty International also draws attention to another alarming deficit in the maternal health care system. In the quote above, they name the removal of “women’s right to information and informed consent,” and installment of “barriers to women’s active participation in their care” as shaping the maternal health care crisis. Amnesty points out that, “Many women are not given a say in decisions about their care and the risks of interventions such as inducing labor or cesarean

sections. Cesarean sections make up nearly one-third of all deliveries in the USA – twice as high as recommended by the World Health Organization” (Amnesty International, 2010). If women are not active participants in their care, then others must be making decisions about their births. Given the rate of medical birth in the United States, it is likely that physicians are the primary decision-makers.

Frighteningly, Amnesty points out that this medical tendency is leading to rates of intervention deemed unsafe by the WHO. The problems with women’s lack of choice and participation that Amnesty identifies are two-fold: not only are others making decisions about women’s bodies and births, but they are doing so in a perilous way. As this paper continues, I draw attention to how the biomedical birthing system in the United States limits women’s participation and choice during birth.

In order to examine participation and choice in birthing practices, I turn to childbirth education<sup>4</sup>. In the United States, 56% of first-time mothers enroll in some type of childbirth education, showing the cultural importance of learning about birth (Declercq, 2006). Beginning with Grantly Dick-Read’s development of prepared childbirth, systems of childbirth education have faded in and out of United States’ popular culture since 1915 (“About ICEA: History,” 2011; Cassidy, 2006). The International Childbirth Education Association celebrated its 50<sup>th</sup> anniversary in

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<sup>4</sup> When other systems in the US face such problems, education is often seen as a means to address such issues. Classical theorists such as John Dewey (1938) and Paolo Freire (1970) envision social improvement by means of education. More recent theorists and activists such as Geoffrey Canada promote addressing poverty through increasing access to equal education through programs such as Teach for America. Even public health advocates have taken up education as a tool to increase breast cancer awareness and decrease binge drinking on college campuses. (“Alcohol and Other Drug Concerns,” 2009; “Learn about Cancer,” 2011). Education, undeniably, is seen as a tool for personal and social improvement.

2010, demonstrating the long-standing influence of childbirth education. Because of their ongoing impact, childbirth education classes are important for understanding maternal health in the United States.

Not only are classes influential, but childbirth education also facilitates choice and participation in the maternity care system. Classes teach women and their families about options for their care, and they thus illuminate the ways that families can participate in birth. As classes are usually taken months before birth itself, childbirth preparation serves as the beginning of families' choice and participation in the birthing process. For this reason, studying childbirth education is crucial to understanding the absence of "women's right to information and informed consent" in birth and "barriers to women's active participation in their care" in the United States' maternal health care system (Amnesty International, 2010, p. 1).

While education theorists have long pondered how best to teach students in academia, childbirth education has not received consistent attention. Most recently, De Vries and De Vries (2007) prescribed a reformation of childbirth education, and Morton and Hsu (2007) identified key dilemmas recognized by childbirth educators. In her integrative review of existing literature, Koehn (2002) cites the lack of uniformity among childbirth education studies as a problem for commenting on childbirth education on a national level. While this thesis does not answer Koehn's call to use health outcomes as a mode of measurement for childbirth education success, it does take on the project of better understanding the experience of mothers and families in birth to aid the assessment of childbirth education systems.

## TWO MODELS OF BIRTH

In addition to problems with choice and participation in birth, the United States is also a very confusing place to have a child. There is a battle over health, safety, and women's rights that rages between alternative and medical birth advocates, which makes choosing care and participating in birth perplexing. For the purposes of this paper, the medical model of birth is constituted by the idea that birth is a medical procedure; birth should occur in a hospital and a physician should be the primary birth attendant. In an alternative model of childbirth, birth is seen as a natural process. Medical interventions are viewed as unnecessary for most mothers, and birth often occurs in a home or freestanding birth center. In the alternative model, birth is generally attended by a midwife.<sup>5</sup>

A website entitled "Natural Childbirth-A Much Better Way" sheds light on the character of the debate between alternative and medical birth advocates. The website features articles such as, "Are Men, Machines and Hospitals Necessary for a Healthy Birth?" and "Ulterior Motives of Your Ob/Gyn" ("Natural Childbirth-A Much Better Way," 2009). As these titles show, the dispute is not limited to the risks and benefits of certain procedures, but it also includes vicious attacks on the practices

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<sup>5</sup> Others define beliefs in medical versus alternative birth differently. For example, Davis-Floyd (1992) introduces technocratic and holistic models of care; Rothman (1982) aptly entitles a chapter "Birthing Babies or Delivering Neonates: Two perspectives on birth" and defines a medical model as linked to technology (p. 34); medical and midwifery models of care are used by organizations such as Our Bodies, Our Selves. There are certainly nuances to each definition, and it is important to recognize that many women, health care providers, scholars, and advocates embrace a model of care that falls somewhere between the two camps. In this paper, I chose to define a "medical" and "alternative" as broadly linked to a medical understanding of birth versus a view of birth as a natural process to account for the most glaring differences between the two belief systems, that is their views of biomedicine, medicinal and technical intervention in birth, and where birth should occur.

and people associated with either model. For this reason, pregnant women and their families find themselves in a tug-of-war between the two camps, each advocating for the best and safest way to have a child.

Despite the presence of both alternative and medical models of birth in the United States, in-hospital medical births are most prevalent. As the Center for Disease Control points out, 99% of births in 2007 occurred in a hospital (Martin, 2010). Why is medical birth utilized more frequently? Arguably, the medicalization of childbirth and social conditions which emphasize that birth is a medical procedure have contributed to the formation of medical authority, that is the dominance of doctors, technologies and ideas strongly associated with biomedicine. This medical authority positions the medical model of birth as most advantageous for women and their families.

However, numerous alternative birth activists have condemned medical authority. A series of scholars including Barbara Katz Rothman (1982) and Robbie Davis-Floyd (1992) have traced the role and formation of medical authority in the birthing process. They specifically note that medical authority can compromise a woman's experience of labor and may negatively affect the labor itself. Brigitte Jordan (1997) goes so far as to identify medical authority as present on a systemic level, describing a "system of authoritative knowledge" evident in American hospital births. Popular items such as Jennifer Block's *Pushed* (2007) and films such as *The Business of Being Born* (Epstein et al., 2008) also point to issues with the medicalization of a seemingly "natural" birthing process. They argue that the

medicalization of birth disempowers women during childbirth and contributes to the numerable issues with maternal care in the United States.

Importantly, this disdainful view of a medical birthing process is challenged by supporters of the medical birthing model. Organizations such as the American College of Obstetricians and Gynecologists (ACOG) view birth as best managed through medical monitoring and care, and many medical professionals deem births outside of the medical realm as dangerous to the health of mother and child (*ACOG Statement on Home Births*, 2008). Just this year, Wax et al. (2010) published a study condemning home births in the United States, which was vocally challenged by the alternative birth community (Gyte, Dodwell, & Macfarlane, 2010; Keirse, 2010; Wax et al., 2010).

Pregnant women and their families that are making decisions about birth are thus faced with conflicting information from medical and alternative birth advocates. To understand this information, they frequently turn to childbirth education. Because of the rift between the alternative and medical camps, one would expect childbirth preparation classes to fall along a similar divide. In-hospital classes would seemingly prepare participants for a medical birth, and participants would learn about the alternative birth ideal in classes that occur outside of the hospital.

That being said, even a brief online search for childbirth education classes reveals that classes may not subscribe to the polarized system. Classes are offered in hospitals, at homes, and in birth centers. Some classes emphasize breathing techniques and movement (Lamaze and Bradley Method classes), some offer support and prenatal visits alongside education (Centering Pregnancy), and still others draw

on hypnosis as a means to manage pain (Hypnobirths). Though many types of classes identify birth as a natural process, participants in childbirth education go on to birth in both medical and alternative settings. While childbirth advocates are split into two opposing camps, the range of childbirth education classes in the United States suggests that childbirth preparation offers a more nuanced understanding of birth. For this reason, childbirth education represents an important point of analysis in understanding women and their families' participation and choice in birth.

In this thesis I seek to examine participation and choice through looking at childbirth education classes in the United States. Amnesty International points out the lack of participation and choice in birthing care, and I examine childbirth education in order to understand how women and their partners learn about their options in birth. In addition, I investigate the presence of alternative and medical models of birth in classes as factors that could complicate women and their families' choice and participation. I thus begin with two main questions: First, do childbirth preparation classes align with either a medical or alternative model of childbirth? Second, how do these models interact in childbirth preparation classes, and how do they shape class content and participants' births?

## METHODS

In order to answer these questions, I observed two series of childbirth education classes offered by Pine Grove Hospital<sup>6</sup>. Because the majority of births in the United States occur in hospital, assessing childbirth classes in a hospital setting

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<sup>6</sup> All names of class participants, instructors, and locations have been changed in order to protect participants' privacy.

provides insight into this medical system. Advertised on the hospital's website as "Childbirth Preparation Classes," each series consisted of five classes, and each class lasted approximately two hours<sup>7</sup>. Class Series 1 took place in the hospital itself in a small classroom on the Labor and Delivery floor. It was made up of ten male-female couples, all of which were having their first child. Class Series 2 occurred at a clinic under the hospital's jurisdiction located roughly thirty minutes away. It consisted of seven male-female couples and one mother-daughter partnership. All couples in both classes intended to deliver at Pine Grove Hospital. During classes, I observed the instructors' language, tones, mannerisms, as well as her interaction with class participants. I also took note of topics covered in the classes and materials provided by each instructor. Overall, I drew on the sociological tradition of grounded theory, in which claims emerge from the field<sup>8</sup>.

In order to better understand the role that the presence of each model plays in participants' birthing experiences, I also conducted interviews with individuals who participated in the childbirth preparation classes. I interviewed six class participants and heard four birth stories, meaning that I spoke to at least one mother and one couple from each class. Of these six interviewees, four were women and two were male labor partners. I conducted two interviews with each person/couple, and each conversation lasted approximately thirty minutes. The first interview took place after the completion of the childbirth class series and the second occurred between two and

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<sup>7</sup> I observed a total of nine classes. Laura, the class instructor for Series 1, requested that I not attend class one so that she could have time with her class alone.

<sup>8</sup> In my application of grounded theory, I draw on the work of Glaser and Strauss (1965). In *Awareness of Dying*, they employ a method in which their theory regarding the significance of awareness contexts in death emerges from their field of study.



twelve weeks after the baby was born. The interviews were largely open-ended, though I did have a series of guiding questions. These questions are featured in the Appendix.

In addition to interviewing class participants, I also spoke with class instructors regarding their opinions of the role and content of childbirth preparation classes. My interviews with both instructors took place over the phone approximately eight weeks after class completion, and the questions that guided our conversations are featured in the Appendix. Both my interviews with participants and instructors supplemented my class observations, and they helped to inform my argument about class content and effects.

Though I ask broad questions about the scope and effectiveness of childbirth education classes, my commentary on the significance of the presence of medical and alternative models of birth is limited to the classes I observed and the participants that I interviewed. Observing two series of childbirth education classes and interviewing families from each were crucial components of my research, yet it should be noted that my sample size and scope were limited. Attempting to explain a wide range of experiences is impossible given the number the families that I interviewed. In making statements about the presence of opposing childbirth models and medical authority in childbirth education, as well as their effects on birth, I am speaking most directly to the participants in Class Series 1 and Class Series 2 and the childbirth preparation classes at Pine Grove Hospital. Despite these restrictions, the classes still serve as an interesting and important gateway into understanding childbirth education and the

maternal health care, thus I will use the circumstances in these classes to comment on the system more broadly.

## FINDINGS

After observing classes and conducting interviews with women and their partners who attended childbirth education classes at Pine Grove Hospital, I learned that both the medical and alternative models of childbirth were resoundingly present in class. In Chapter 1, I go on to explore the presence of these models, using Rooks' (1999) definition of each.

Not only were medical and alternative models of birth present in childbirth preparation classes at Pine Grove Hospital, but there was also a positive emphasis on each ideology. The negative repercussions of practices promoted by each model were not discussed in class, and criticisms of each model were also markedly absent.

This positive emphasis on each birthing model resulted in the presence of dualisms in childbirth preparation classes, which serves as the main focus of Chapter 2. By invoking the term dualism, I argue that alternative and medical models were allowed to exist parallel to one another. Classes did not allow for their intersection. For example, classes did not address the impossibility of walking around to labor and receiving epidural anesthesia, a medication used to eliminate feeling in the lower body. In my observations, I noted two dominant dualisms: an ideological dualism in which theoretical claims made by each model ran parallel to one another, and competing choices, in which practical decisions featured by each model were mutually exclusive yet able to coexist in class.

In childbirth preparation classes at Pine Grove Hospital, these dualisms were maintained by the idea that birth should be a personal experience. Class rhetoric emphasized making personal choices during birth, an idea that participants and instructors favored. This emphasis on choice and personal experience prevented recognition of the presence of dualisms in birth; every birth was different, all births were personal, and choices should be made based on participants' individual needs. Through emphasizing personal choice and individual decision-making, classes prevented recognition that not all decisions could be made together. Though both medical and alternative models of birth were present in classes, during labor and birth participants would be unable to exercise both models together.

Furthermore, this emphasis on choice and a personal experience prevented recognition that classes themselves were located in an authoritative birthing system (Jordan, 1997). While classes presented both models of birth and a range of choices, the classes' placement in an authoritative knowledge system and the presence of medical authority in class affected the choices that participants could make. The emphasis on birth as a personal experience prevented recognition of this medical authority. In Chapter 3, I discuss the conflict between choice and authority in classes.

Not only did medical authority shape participants' choices, but safety and flexibility, two additional themes of class, also influenced participants' decisions. The rhetoric of choice was intertwined with an emphasis on being flexible and safe; choices are important, but participants should also remain ready for anything in labor, as the hospital would ultimately act to protect their health. Coupled with the idea of medical authority, the promotion of flexibility and safety sets the stage for medical

interventions in birth. Just as medical authority affects participants' choices in birth, ideas of safety and flexibility also impact the selections that participants can make. In Chapter 4, I track classes' emphasis on flexibility and safety, and I points out how this rhetoric, coupled with the presence of medical authority, shapes participants' choices during birth.

Throughout Chapters 3 and 4, I also address questions of class participants' agency and oppression in the birthing process. Along with pointing out medical authority comes the suggestion that participants are subject to the power of the medical institution. Rather than take up this argument, I show how understanding participants as powerless does not fully explain participants' birth experiences. Participants were certainly making choices in birth, but their selections were limited by the presence of medical authority and their placement in the medical system.

In childbirth preparation classes at Pine Grove Hospital, the presence of alternative and medical models of birth, along with the emphasis on choice, suggest that participants can freely make choices in birth. However, restricting factors, such as the presence of medical authority and classes' placement in a medical system, prevented this autonomy. The emphasis on choice also prevented participants' understanding of these systemic components of their birth experience, so they thus were denied a full depiction of their birth. As this thesis moves forward, I aim to show the nuanced and complex ways in which medical and alternative models of birth, a rhetoric of choice, flexibility and safety, and medical authority all interact in childbirth preparation classes and shape class participants' birthing experiences.

## CHAPTER 1: THE MEDICAL AND ALTERNATIVE MODELS OF BIRTH

In ongoing discussions of birth in the United States, birth is often conceptualized as *either* medical *or* natural. As demonstrated in the introduction, popular discourse surrounding birth is divided into two vocal camps; the American College of Obstetricians and Gynecologists and medical enthusiasts fall on one side of this debate, and alternative birth advocates reside on the other. Undeniably, the vast majority of births in the United States occur within a medical model; hospitals and physician-attended births occur far more frequently than births at home. The firm division between alternative and medical birth advocates suggests that those who opt for a hospital birth would fully denounce the alternative model, which would include denying beliefs in the strength of women's bodies. In this chapter, I question this division. If birth is as polarized as discourse suggests, then are women who embrace the medical model denouncing the entirety of alternative ideology? Given the presence of the two models in popular culture, and the question of how far the ideology of medical birth extends, it is fair to wonder if childbirth preparation classes align with an either medical *or* natural understanding of childbirth that exists in birth debates, presuming that childbirth education informs families' understandings of the birthing process.

My research reveals that rather than embracing one model of birth, classes at Pine Grove Hospital contain elements of both the medical and alternative ideologies. Technical interventions are stressed alongside breathing techniques, and just as medicinal interventions are highlighted in class, so too is the belief that women's bodies are strong and capable of labor. In this section of the paper, I detail the

overwhelming presence of both alternative and medical models of childbirth in childbirth education classes at Pine Grove.

Not only were both birthing ideologies present in class, but there was also a notably positive emphasis on each. Repercussions of choices in either model were markedly absent from class discussions, as was attention to instances in which the models are mutually exclusive. Despite the models' ideological oppositions, this positive emphasis allowed them to coexist.

In this chapter, I also include a description of the classes' physical setting at Pine Grove Hospital and a nearby clinic. In order to fully situate the classes, it is helpful to understand their physical locations. If I seek to provide a more thorough account of childbirth preparation classes, then only describing classes as in a hospital would be incomplete. Thus, this section begins with an account of classroom locality.

Following this description, I begin to detail the presence of the medical and alternative models of birth in childbirth preparation classes at Pine Grove Hospital and the positive emphasis on each ideology. I provide examples in which the models were able coexist because of this positive emphasis, and I also note specific instances in which positivism prevented their potential intersection and the proceeding conflicts. Overall, this chapter surveys the presence of alternative and medical models of birth in childbirth preparation at Pine Grove Hospital. It serves as the foundation for understanding the effects of the presence of both models on participants' births, which I will discuss later in this thesis.

PINE GROVE HOSPITAL

Before describing the classes themselves, I seek to situate Pine Grove Hospital in a broader United States context. Pine Grove Hospital is a large non-profit hospital in New England that prides itself on high-quality care and the use of services at the forefront of the country's technological advancement. For example, upon visiting the hospital's website, the viewer is greeted with news that Pine Grove Hospital has successfully administered an innovative cancer screening technique for the first time in the United States. In addition, Pine Grove Hospital is a "community" hospital as opposed to a hospital placed in an urban setting or a teaching-facility. As the hospital website states, "...benefiting the community is at the core of our being" ("Pine Grove & The Community," 2011). On its website, Pine Grove Hospital certainly expresses outright dedication to using the best possible practices to serve the surrounding community.

Presumably for this reason, the hospital itself has received a series of prestigious awards in recent years. Pine Grove is one of 383 hospitals recognized by the American Nurses Credentialing Center (ANCC) as a Magnet Hospital, through an extensive application and training process for nursing staff ("ANCC Magnet Recognition Program®," 2011). It was also a part of the *Thomson Reuters 100 Top Hospitals: Benchmarks for Success* study in 2011, which recognizes superb hospitals in the United States according to their size based on financial stability, operations, and patient care ("Top National Hospitals," 2011). Health Insight 2010, an external review of hospitals, reported that Pine Grove Hospital performed better than 79% of hospitals in the country on items related to quality care ("National Rankings for

Hospitals," 2010). Even more relevant to my study is the hospital's designation as a Baby-Friendly Hospital by Baby Friendly USA:

"The Baby-Friendly Hospital Initiative (BFHI) is a global program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding. The BFHI assists hospitals in giving mothers the information, confidence, and skills needed to successfully initiate and continue breastfeeding their babies or feeding formula safely, and gives special recognition to hospitals that have done so" ("About the Baby-Friendly Health Initiative," 2010).

Pine Grove's designation as baby-friendly shows that it is dedicated to bettering the health of mothers and infants. In order to receive the Baby Friendly Designation, hospitals undertake a ten-step program designed by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). As of January 2011, only 105 hospitals in the United States had achieved this recognition. Not only does Pine Grove focus on mothers and infants, but its numerous awards and sources of recognition also illustrate that the hospital is focused on providing high-quality and innovative care. For this reason, the hospital serves as an interesting site to examine childbirth preparation. Pine Grove Hospital has been awarded for its innovative care practices; will childbirth preparation classes at this hospital have a similarly impressive effect?

In addition to information about Pine Grove Hospital, some background information about Pine Grove County would also be helpful in understanding the hospital's broader context. According to United States Census Data from 2009, Pine Grove County is home to 166,000 people (United States Census Bureau, 2010). The median household income for 2008 was \$75,000 and in the year 2000, roughly 35%



of residents over the age of 25 had received a Bachelor's degree. The county is composed of approximately 88% of persons who identified as White but not Hispanic, approximately 4% of persons who identified as Hispanic, and approximately 5% of persons who identified as Black (United States Census Bureau, 2010). This information serves to situate the hospital as treating a predominantly white population, and the median household income shows that it is likely all participants in the class had an income that exceeds the national median, \$52,000 (United States Census Bureau, 2010). These demographic factors are important because they affected my research considerably. While the target of my project was not to examine individual differences and identities that affect birth experience, it is undeniable that had the classes been in a different setting or contained a more age or racially diverse group, both class and birth experiences would have been different.

Childbirth Preparation Classes at Pine Grove Hospital were advertised on the maternity services section of the hospital website. The description reads:

“Learn what to expect during the labor and birth experience. The mechanics of labor and birth as well as tools for coping with the demands of labor are taught in this 5-week series...” (“Events and Class Calendar,” 2011).

In addition to childbirth preparation classes, the hospital offers courses in breastfeeding, infant massage, sibling relations, as well as newborn care. As described in the methods section, the classes themselves were each two hours long and took place over the course of five weeks.

It is worth noting that these classes included a \$120 fee for the five-week series. At this point, it is important to recognize this fee as a means of social exclusion; without payment, individuals could not enroll in the classes and were

thus excluded from access to hospital-sponsored information about pregnancy, labor and birth. This serves to reflect the broader context that the hospital is situated in, the United States, where quality health education and services often reach already privileged groups of individuals. Childbirth preparation classes at Pine Grove Hospital fit in with this general trend.

### CHILDBIRTH PREPARATION CLASSES

This section of the paper now describes the childbirth preparation classes with particular emphasis on physical setting and class make-up. While I consider thematic elements of childbirth preparation classes as this paper moves on, describing the classes' physical attributes helps the reader to better understand the classroom environment.

Class Series 1 took place in Pine Grove Hospital. The classroom was located on the same floor as the pregnancy and birthing center, though it was attached to the waiting room and thus separated from the actual birthing ward. When participants exited the elevator, they were able to see the waiting room, the nurse's station, and ominous white doors with the ward's title above. These white doors were not opened until the class toured the birth center, and while the class intended to integrate participants into the hospital's birthing system, the doors were rather daunting. They served as a barrier between attending classes and actually giving birth.

The classroom itself was small and square. A cabinet was featured in the back of the classroom where drinks and snacks were placed for class breaks. In

the front of the classroom, there was a podium pushed into one corner, a board for writing messages, and a drop-down screen for showing videos. In the corner opposite the podium was another door, assumedly for a storage closet where Laura, the class instructor, often stored materials such as books, pillows, the CD player, etc. In addition, there was a series of three windows for which the shades were always drawn. On the walls were posters that Laura sometimes referred to in class; one poster featured the benefits of squatting while pushing, and another was an animated depiction of contraction strength, timing, and mother's discomfort during the stages of labor.

When participants entered the room, the lights were often dimmed and music was playing. The music was always soft and instrumental, and it was seemingly designed to have a calming effect. Chairs were arranged in a half-circle along the classroom walls. When there were class handouts, they were placed on a colorful bandana in the center of the room along with class nametags, and participants were encouraged to take both a nametag and handout when they arrived.

Laura, the class instructor, often sat in a chair in the front of the room so that she was facing the half-circle made up of myself and class participants. Below her chair was a box filled with tools used in class; a model pelvic bone, baby doll, books, and pillows were strewn about in the box. Laura herself was always ready when participants arrived and greeted them with a warm smile and "Welcome!" She was a middle-aged woman with short hair who dressed casually for class. Her outfits generally included clogs or hiking shoes, corduroys, and a shirt or fleece vest. She always appeared neat and organized, and she generally began classes on time.

The class itself was composed of ten couples, though not all couples attended every class. Though I did not speak with all couples in the class, it appeared that the majority of class participants were white. Because I did not speak to everyone in class, it is impossible to ascertain whether all couples were married, but everyone came to class in a male-female coupling and often expressed affection during class sessions. Each couple in the class was having their first child, though participants appeared to range significantly in age. I would estimate that the youngest participant was twenty years old and the oldest participant was forty.

Unlike Class Series 1, Series 2 did not take place at Pine Grove Hospital. Rather, Series 2 took place at a clinic owned by the hospital but located thirty minutes away in a nearby town. Unlike the sanitary and new feeling of the hospital, this clinic had a dated and more cramped feeling. The building's decorations, carpeting, and chairs were all dark colored and floral. Past the automatic doors at the clinic's entrance was a folded-up wheelchair, presumably present in case a patient needed to be wheeled from the parking lot into the unit. Once participants entered, they encountered a waiting room and a large desk. White-coat clad physicians, nurses, and security guards were often chatting or working at the desk. In order to reach the childbirth class, they walked past the desk into a large open area with televisions and chairs. After walking through this second waiting room, participants finally turned into the radiology waiting room where classes were held in a room that contained a large desk and multiple computers. Unlike in the hospital setting, there were often people waiting in this room. On more than one occasion, Mel, the class instructor, asked families to move so that she could arrange the chairs in the room for class. Nurses and

physicians were walking throughout the other rooms, and the clinic itself seemed to whirl with activity (unlike in the hospital setting, where activity happened beyond the white doors and the space itself appeared eerily quiet).

For the childbirth preparation classes, the floral-patterned chairs and blue pleather couches were arranged in a full circle. When class was in session, Mel often fluctuated between sitting in an open chair and standing in the middle of the circle. There was a TV in one corner of the open room, and when participants arrived, it was often tuned to children's cartoons. Behind the TV was a wall panel of windows, though unlike in Series 1, the window shades were not drawn because they faced a dark field. However, because of these windows, temperature was a constant discussion in class: Were participants too hot or too cold? Participants frequently switched seats during class so that they could be more comfortable.

The class itself was made up of seven couples. Again, I did not speak to all participants, but six appeared to be married couples, and two participants attended class as a mother-daughter dyad, where the daughter was pregnant and the mother had already been through labor a total of four times. Though I did not speak to every participant, thirteen participants appeared to be white and one participant appeared to be Hispanic. Like Series 1, this group also seemed to range in age, with the youngest participant at an estimated twenty-two years old and the oldest at approximately forty.

The class instructor, Mel, often placed a box and rolled-up posters by the windows, containing a pelvic bone model, dolls, tools for demonstrations, pillows, and markers. She spread out the posters when speaking about them, and would often struggle to hold up the posters and point to their images. Mel herself appeared

middle-aged and she had long, brownish-grey hair that she generally wore in a ponytail. She also wore colorful glasses and a beaded chain, and her clothes included socks with Birkenstock sandals even on the cold winter nights when class was held. She often wore a sweater and pants or a long, flowing floral skirt with a knitted shawl to classes.

I hope that this brief physical description sets the stage for the reader in moving forward to discuss thematic elements of classes. This paper now goes on to discuss the first important element of childbirth preparation classes, namely, the presence and positive emphasis on the medical model of birth. However, in order to understand this association, it is first necessary to further explain the medical model of birth.

#### THE MEDICAL MODEL OF CHILDBIRTH

Rooks (1999) identifies four criteria upon which the midwifery, that is alternative, and medical models of care differ. According to Rooks, the medical model of care “focuses on the pathologic potential of pregnancy and birth” (p. 370). Within this model, birth is usually attended by a physician “...who [sees herself/himself] as the key decision maker” during labor and delivery (p. 372). In this, Rooks suggests that physicians know the safest and healthiest course of action for mother and baby, and that their decisions are crucial to maintaining maternal and infant well being within the medical model. Additionally, Rooks notes that obstetric interventions and technology are frequently used in the medical model of care. Rooks implies that medical care ignores the idea that, “Pregnancy results in a *mother* as well

as a baby” and focuses heavily on the birth of the baby rather than the woman’s transition to motherhood (p. 373, emphasis in original). These four criteria: 1) a focus on birth’s “pathologic potential,” 2) a focus on the physician as the ultimate decision-maker, 3) the frequent use of medicinal and technical interventions and 4) the emphasis on the birth of the baby as opposed to process of becoming a mother, will be used to define the biomedical birthing model throughout my discussion of classes.

### AN EMPHASIS ON INTERVENTIONS

Childbirth preparation classes at Pine Grove Hospital placed positive emphasis on the medical model of birth, which is to say that medical procedures were often discussed without attention to repercussions. For example, the classes featured a clear discussion of the medicinal and technical interventions available to participants in labor. In Series 1, a video entitled “Works of Wonder” was shown which depicted a range of interventions. The video featured epidurals, an anesthetic administered through a tube inserted in a woman’s epidural cavity that eliminates sensation in her lower abdomen and through her legs, fetal monitors, devices used to monitor the baby’s well-being that can be placed externally or internally, as well as Pitocin, a drug administered intravenously and used to induce labor. The video talked in detail about each intervention and featured the risk and benefits of each.

However, while the risks were indeed present, the dominant emphasis was on women being relieved from hours without dilating (Pitocin), being able to check to make sure that their child was safe (fetal monitor) or hours of trying and traumatic pain (epidural). Though a narrator described the risks, the images and videos of the

relief experienced by participants seemed to quell the information put forth about the interventions themselves. For example, the videos did not depict a woman experiencing contractions that are stronger than usual due to the use of Pitocin and instead included a narrator who monotonously highlighted this effect. Likewise, the movie did not show instances in which epidurals only partially worked or produced fever or lasting numbness, and it instead only portrayed mothers' relief from pain. The video's title, "Works of Wonder," most simply suggests that the interventions enabled wondrous relief from pain without regards for complications. While the video featured the pros and cons of interventions, the positive emphasis prevailed because of the visual images; the strength of seeing someone receive these interventions prevails over hearing a narrator blandly describe their effects. The capabilities of the medical interventions to quell pain, provide information on the baby, and begin the labor process were emphasized; the negative attributes of these interventions were only minimally included.

Like Class Series 1, Class Series 2 discussed the risks and benefits of interventions such as Pitocin and episiotomies, though emphasis was also placed on the positive elements. For example, alongside discussions of medication such as Stadol, a drug used to "take the edge off of pain" in labor, classes highlighted Pitocin and episiotomies. In their introduction, Mel placed specific emphasis on practical reasons for their use. According to Mel, Pitocin was used to induce labor when complications such as hypertension, or high blood pressure, arose or when mothers were past their due date. She briefly mentioned that Pitocin can increase the strength of contractions, though she did not associate its use with other interventions.



Similarly, when discussing an episiotomy, an incision made on the woman's perineum during birth, Mel focused on its use when "the mother is very, very tired" or because there is a question of the baby's health. She did not mention its routinization or the debate over its use at all (Lede, Belizán, & Carroli, 1996). While this section moves on to explore other instances of excessive positivism, I take up discussion of the risks and safety associated with medical interventions such as Pitocin and episiotomies later in this thesis.

#### DEFERRING TO DOCTORS

An additional way that the biomedical model of birth was resoundingly present in childbirth preparation classes was in the encouragement of class participants to work closely with their physicians throughout the labor and delivery process. Both class instructors encouraged participants to check in with their doctors regarding their interests in birth, and though instructors put considerable emphasis on participants' abilities to make choices, physicians were seen as the final decision makers, specifically in moments when health or safety was jeopardized. Rooks (1999) points out that within the medical model, "Physicians are more likely to see themselves as the key decision-makers, and most say that they 'deliver babies'", showing the emphasis on physicians in the medical model (p. 372). In the childbirth preparation classes, Mel encouraged participants to call their doctor "whenever and wherever" if they felt inclined, and Laura also began classes with questions about recent doctors' visits and advised participants to share their birth plans and questions with providers. This emphasis on physicians served to connect participants'

classroom experiences to their communication with providers, yet it is worth noting that only the positive elements of this relationship were emphasized.

As this paper moves on, I challenge this seemingly natural and healthy deferral to physicians throughout the pregnancy and labor process. Notably, classes did not cover what happens if the interests of the physician and participants are at odds with one another, nor they did describe the potential this deferral to physicians could create for doctors to proceed unchecked during labor and delivery. In this, important questions arise regarding why physicians make decisions; how do medical training, years of practice and/or risk of malpractice affect physicians' decision making? Laura and Mel's encouragement to rely on doctors in times of need expressed that physicians always act in the best possible way, yet factors such as acting to prevent malpractice, as opposed to treating a patient, or the routinization of certain procedures could also inform providers' decisions. Equally related to this discussion is an understanding of safety used in childbirth preparation classes and at Pine Grove Hospital. Indeed, safety proved to be a major component of the classes, and questions about how safety is defined and understood will be addressed in Chapter 4.

#### “PATHOLOGIC POTENTIAL”

This emphasis on deferring to care providers represents another instance in which classes stressed the positive elements of the medical model of birth, in that classes emphasized providers' ability to curb the “pathologic potential” of childbirth. While classes do not focus entirely on what could go awry in labor, there is

considerable recognition for birth as a physiological process that needs management. Rooks (1999) describes that, “Since an unexpected complication can happen to any woman at any time, the medical management model prepares for the worst. For example, an intravenous induction (IV) or “hep lock” (placement of an IV cannula to ensure rapid access to a vein) are often provided *just in case* the woman needs blood or drugs in an emergency” (p. 371, emphasis in original). In fact, during childbirth preparation classes at Pine Grove, class informed participants that “hep-locks,” short for Heparin locks, would be put in place upon their arrival to the hospital. During class two, Mel notified participants of this reality and Laura addressed Heparin locks as hospital procedure during class three.

Importantly, both instructors focused on the benefits of this procedure. They highlighted the ability to access a vein in a time of emergency, and further, to ease the administration of medications. The positive emphasis on the medical model is present because classes depicted medical procedures as capable of managing health risks and preventing a decline in health of mother or infant. Neither instructor alluded to the fact that preventative measures such as a Heparin lock could be uncomfortable or a hindrance, demonstrating an adherence to the medical model of birth and the focus on its positive, in this case preventative, capabilities.

At this point in the paper, it would be easy to craft the following sections towards illustrating the negative repercussions of this positive emphasis on the medical model and exposing the harmful components of the medical model itself. As this section shows, the medical narrative of childbirth is

resoundingly present within childbirth preparation classes at Pine Grove Hospital.

While the medical model will certainly be explored as the paper moves on, making the association between the medical model of birth and overwhelming negativity would ignore a major component of classes themselves and misrepresent the class participants' childbirth education experiences. In childbirth preparation classes at Pine Grove Hospital, the alternative model of birth was also present. This paper now moves on to explore the alternative birthing perspectives in the class and ultimately show how these alternative and medical models interact in classroom discourse and impact class participants.

#### THE ALTERNATIVE MODEL OF BIRTH

In this section of the paper, I seek to explore the presence of alternative birthing ideals in childbirth preparation classes at Pine Grove Hospital. Before doing so, it is necessary to consider Rooks' (1999) classifications of the alternative birth model. Contrary to the medical model, which is defined in the previous section, she also takes note to understand a midwifery, or alternative, model of care. For Rooks, an alternative model "...focuses on the normalcy of pregnancy and its potential for health" (p. 370). She goes on to note that, "The possibility of complications is not allowed to preempt all other values associated with the woman's experience of bearing and giving birth to a child" (p. 370). Based on her statement, it can be inferred that unlike within the medical model, the woman is seen as the primary actor

and decision maker in alternative birthing ideals. Rooks also notes that in the alternative model, "...a woman is an active partner in her own care..." and similarly, the woman is seen as the focus of prenatal care (as opposed to the fetus) (p. 371-72). Rooks also finds that the natural physiology of birth is emphasized, and "[providers] avoid interfering with the normal processes; they try to avoid unnecessary use of obstetric interventions" (p. 373). Finally, Rooks describes that in the alternative model of care, "[Providers] value childbirth as an emotionally, socially, culturally and often spiritually meaningful life experience-something to be experienced positively, with potential for making women feels stronger and *be* stronger, and for strengthening bonds between the mother and father..."(p. 373, emphasis in original.) Rooks' notation of birth as a natural process, to which the mother is central decision-maker characterizes the alternative birthing model that I use to examine childbirth preparation at Pine Grove Hospital.

These alternative birth ideals were evident throughout the childbirth preparation classes, and classes presented each idea in a positive form. By suggesting that the ideas were positive, I mean to say that classes did not consider criticisms and negative elements of the alternative birth model. Classes did not focus on repercussions or implications of selections that fall under the alternative model of birth. While I discuss the effects of this positivity in following chapters, this section seeks to emphasize the overwhelming presence of both practical and ideological elements of the alternative birth ideal. In this portion of the paper, I now trace the presence and positive emphasis on an alternative model of birth.

## INTERVENTION-FREE VIDEO

An instance that illustrates the presence of practical components of the alternative birth is the video of a childbirth featured in Class Series 1. In the childbirth preparation classes, only one video of an actual childbirth was provided. This video, though dated, served as the primary visual representation of a birth in the class<sup>9</sup>. For many of the participants, it was their first opportunity to see a birth and it served as an emotional and actualizing depiction of an experience that they would soon share.

That being said, one thing that was particularly interesting about this birthing video was its divergence from a birthing experience that would likely befall the class participants. First of all, the woman in the video did not receive any medical interventions during her labor and delivery. She did not receive medication, intravenously or orally, nor were any technical interventions, such as forceps or an episiotomy, used during her birth. Secondly, her care provider was a midwife, and she stayed with the couple for what seemed like the entirety of the labor. As this paper goes on to discuss, the video depicted a birth, yet the circumstances of birth would likely be very different for class participants due to their placement in the medical birthing system.

Through its alignment with Rooks' (1999) ideals, the video featured in class depicted a birth that can be classified as alternative. Characterized by the absence of medicinal and technical interventions, this birth fits Rooks' description of an alternative birth. Similarly, the provision of care by a midwife is also part of the

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<sup>9</sup> In Class Series 2, the television was broken, thus the class was unable to view birthing videos.

alternative model, and as Rooks emphasizes, continuous care during labor often accompanies alternative birth (Rooks, 1999, p. 372).

What's most interesting is that despite this video's alignment with the alternative birthing model, it differed notably from other aspects of the class. In all likelihood, hospital births at Pine Grove Hospital will have a flutter of nurses in and out of the room. The obstetrician in attendance will probably not stay with the couple throughout their labor, but only appear to perform an internal examination or during pushing.

When this video was shown in class, Laura described that it was dated and that the woman in the video delivers with contractions seven minutes apart. She revealed to participants that this was unusual, yet also used the instance to remind everyone that all births were different. While the recognition that "no two births are the same" proved important for participants, Laura did not specifically mention the lack of interventions or continuous care in labor. Given that this was the sole representation of birth available, this has the potential for couples to form expectations about their birth that align with the alternative model, and it clearly emphasizes the presence of the alternative model in childbirth classes at Pine Grove Hospital.

Furthermore, this representation of birth focused on practical elements of birthing care. The presence of a birth attendant throughout labor, as well as the lack of medicinal or technical interventions are all options that fall under the alternative birth model. Both of these options are decisions that women and their partners can

make during labor which result in the application or forfeit of certain procedures in birth.

Notably, these selections do have consequences; for women who choose to pass over pain medication, their births are certainly painful and tiring. Also, scholars argue that natural birth is “moralistic” and question the political implications of mandating that women experience pain in birth (Beckett, 2005). Arguing that women must feel pain joins them to their capacities as mothers, and they cannot be liberated from the birth experience. Forgoing pain medication during labor thus has practical and ideological repercussions.

However, just as Laura did not separate the birth on the video from class participants’ births, she also did not acknowledge the consequences of choosing these alternative ideals. She did not point out practical or political arguments about the choice to forego medication, such as prolonged labor or mandated pain in birth. Furthermore, Laura did not acknowledge the likely difference between this birth and class members’ births in the lack of medical intervention and continuous care, key components of the alternative model. This choice to avoid discussions of implications and conflicts shows the emphasis on positivism in childbirth preparation classes at Pine Grove Hospital.

## EXPERIENTIAL KNOWLEDGE

In Series 2 in particular, there was also an emphasis on experiential knowledge, as opposed to didactic textbook material as a source of information. This demonstrates the presence of the alternative model because it reflects belief in birth as



a natural process. In Series 2, Mel often used her body to demonstrate breathing and positions while seated in the middle of the classroom circle. During these instances, the classroom rhetoric departed from factual tidbits featured in books, intended to teach class participants, to an emphasis on the experience of the body. There was an explicit understanding that bodies were unpredictable, though what occurred could be seen as natural. Mel herself experienced a hot flash in the middle of demonstrating how to breathe through a contraction and had to discontinue, and having a bowel movement during labor was discussed unabashedly. Mel chose not to emphasize control over the body, but rather the fact that experiences that occur are significant and normal.

In addition, Mel also was incredibly affirming when class participants made suggestions or asked questions in class. In both class series, participation was encouraged, though Mel and Laura did the majority of speaking in each respective class.<sup>10</sup> In Mel's class in particular, she often responded very affirmatively to any answer participants gave in response to a question. For example, if she asked about techniques to manage the pain of labor and a participant responded "moving around," Mel would re-interpret this information as the precise answer she wanted: changing positions and/or walking to help during early labor, without demanding that participants state the textbook technique she had in mind. While this could have been a pedagogical strategy to facilitate participation, it nonetheless suggested that participants in the class knew more than they thought about the labor and birthing

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<sup>10</sup> When I spoke to both instructors, each relayed that the class I observed was quieter than average classes, though neither could determine the reasoning for this.

process. In fact, when participation was slow, Mel would often remind participants that they “knew this stuff” or that they “knew more than they thought.”

Like Series 2 emphasized bodily knowledge, Series 1 also contained information on other experiential birth experiences. In Class Series 1, Laura provided a series of books intended to help couples during pregnancy and birth based on birthing narratives. Though some of these books were written by medical doctors, the books were not medical texts, but instead based on women’s first hand accounts of labor and delivery, doula techniques for preparing for a spiritual birth, and strategies for visualization and infant massage<sup>11</sup>. Compared with a top-down notion that defines medical knowledge as privileged and the only source of accurate information regarding a physiological birthing process, the idea that bodies are capable and individuals already ‘naturally’ possess information about the process can be said to align with the alternative model of birth. This strategy relies on experiential knowledge as opposed to textbook medical information, demonstrating the presence of an alternative model in class.

## BREATHING AND POSITIONS

In addition to the idea of experiential knowledge, other emotional components of alternative birth were also found in classes. Alternative birth advocates often emphasize birth as a natural process for which a woman’s body is equipped, and childbirth classes at Pine Grove Hospital seemed to facilitate that belief as much as possible. Positions were intended to help mothers cope with the pain of labor; they

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<sup>11</sup> Some examples of books provided include: *Pregnancy and Birth*, by Sheila Kitzinger, and *Magical Beginnings-Holistic Guide to Pregnancy and Childbirth* by Deepak Chopra, MD.

were seen as tools to help mothers adapt to their changing bodies, as opposed to exercise control over it. Both instructors encouraged participants to “ride the wave” of contractions and relax themselves, as opposed to demonstrate control through breathing and or positioning. As one participant in Series 2 told me, this mentality was particularly effective during labor:

“When the pain of the contractions came, just like what the teacher talked about... how it was very tempting to fight the contractions... I found it was SO helpful to just remind myself to breathe through it... I think that’s one of the reasons I dilated so fast. I told myself don’t fight the contractions, because then you won’t dilate at the rate that you could.”

Class participants in each series also received handouts with twenty different positions, each depicted in a black and white image. Had the class been entirely aligned with the medical model, it could have focused considerably less on positions intended to help mothers cope with pain, given that medication limits the ability to move in labor. Furthermore, the emphasis on coping and adaptation stresses the idea that women’s bodies are capable of birth, a key component of the alternative model of birth.

Classes also introduced breathing techniques to help manage pain in labor, and they can likewise be viewed as alternative to the medical model. Recalling that the medical model emphasizes the use of medicinal and technical intervention, the breathing techniques and positions can be seen as alternative in their ability to provide a parallel pain management technique. Though there was not a handout that depicted breathing techniques, both Laura and Mel spent considerable class time introducing and practicing breathing strategies. Both breathing techniques and position changes represent an overlap between emotional and practical elements of

alternative birth; they are linked to an emotional idea, namely that women's bodies are capable of birth without intervention, but also represent practical choices that couples must make in labor, in that if medication is selected, breathing techniques often become moot.

While these techniques were introduced, it is important to note that they were not critically discussed in class, demonstrating the class's emphasis on positive elements of each model. As Brubaker and Dillaway (2009) point out, scholars criticize the alternative birth model because of its capacity to essentialize women, meaning tie women to their biological capability to reproduce. Women choosing to experience pain in birth are at times linked to arguments about women's destiny to be mothers, a claim that many women would rebuke. Intervention-free labors are also criticized because the invention of medicinal aids in labor was intended to free women from pain; critics raise the question, why should women endure pain when they can avoid it (Beckett, 2005)? Like classes did not discuss downbeat consequences of the medical model, classes also avoided off-putting associations with the alternative model of birth.

#### “AVOIDING AN EPISIOTOMY-SUGGESTIONS”

Returning to class occurrences, of additional note is a handout passed out in Class Series 1, entitled “Avoiding an Episiotomy-Suggestions.” Written by Penny Simpkin, a noted advocate for natural childbirth, the handout clearly demonstrates an alliance with Rook's (1999) alternative model, as it sees this technical intervention as

avoidable and advises mothers on how to do so<sup>12</sup>. Simpkin's "suggestions" express two values: that episiotomies should be avoided and that the ability to avoid these procedures is in the hands of the mother and her labor partner. As Rooks (1999) declares, the medical model emphasizes the provider as the decision maker; in childbirth preparation classes at Pine Grove, there appears to be some conflated information regarding who is the decision maker and through what process decisions are reached. After I asked one participant in Series 1 if information in the class was helpful during birth, she replied saying:

"I would say...I knew what an episiotomy would be. The doctor, you know he really didn't...the episiotomy, it was just something that he did. It wasn't something where he shouted out "Hey, do you want this?" or "Hey, this is what I'm going to be doing!" It just happened because that's what needed to happen at that time for [the baby] to get out. I'm glad I at least knew that that was a possibility, but it was probably fine that I really didn't you know, have a whole lot of time to sit there and thinking about it or say, "What are you doing down there?" because my doctor just did what he needed to do."<sup>13</sup>

In the statement, the participant shows that her doctor independently made the decision to perform an episiotomy. While "Avoiding An Episiotomy-Suggestions," hints that women will have control over this process, this participants' experience reveals that her physician was the primary actor.

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<sup>12</sup> Penny Simpkin is a world-renowned birthing doula and alternative birth advocate. A physical therapist by training, Simpkin was instrumental in formalizing doula practices through her co-founding of the Doula Organization of North America (DONA).

<sup>13</sup> In including this participants' statement, my goal is not to undermine the doctor's decision, but instead draw attention to the discrepancy between who is the primary decision maker in labor. In this instance, it appears that the doctor made the decision to perform an episiotomy with the woman's inferred input. The episiotomy was arguably performed in the name of "safety," thus the doctor assumes that the woman would be in favor.

Before comparing this participants' experience to a national trend, it is worth noting that data on intervention rates is difficult to access. The hospital reportedly does not keep rates on interventions, yet a consumer-based non-profit dedicated to decreasing hospital intervention rates, a state Worst to First Campaign, lists episiotomy rate as approximately 8% at Pine Grove Hospital ("State Hospital Statistics," 2010)<sup>14</sup>. According to the Listening to Mothers II survey taken by Choices in Childbirth, a non-profit based in New York City, the national episiotomy rate is 25% (Declercq, 2006, p. 33). When I asked a doula that works in the area about this data dilemma, she promptly replied, "That's the 10 million dollar question!! Getting honest accurate information. We all get the same info, who knows what the real numbers are" (Personal communication). As my friend adequately described, finding accurate and reliable hospital information is challenging. If the rate reported by the Worst to First campaign is accurate, then it is worth nothing that Pine Grove Hospital itself has a low rate of episiotomies.

That being said, not all birth practitioners perform episiotomies, and similarly, some providers perform episiotomies far more frequently than others. In 2006, the American College of Obstetrics and Gynecologists recommended that, "The use of episiotomy during labor should be restricted..." (*ACOG Recommends Restricted Use of Episiotomies*, 2006). They go on to note, "Without sufficient data to develop evidence-based criteria for performing episiotomies, clinical judgment remains the best guide to determine when its use is warranted, according to ACOG" (*ACOG*

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<sup>14</sup> Based on the campaign website, it is not clear where this estimate comes from. I contacted the site administrators in order to ask them about their data, but did not receive a response.

*Recommends Restricted Use of Episiotomies*, 2006). The ACOG thus stresses clinical judgment, and some clinicians judge situations differently. While the class did address how to avoid an episiotomy through techniques such as “Kegel or pelvic floor contraction exercises,” and “good nutrition to promote healthy tissues,” it failed to take into account couples’ abilities to select their care provider based on the performance of these procedures. Surely in avoiding an episiotomy as well as other medicinal and technical interventions, the choice of practitioner is a relevant one, yet childbirth classes at Pine Grove did not address this decision<sup>15</sup>.

The fact that classes did not recognize couples’ abilities to choose their care providers further demonstrates the positive focus of Pine Grove Hospital’s childbirth preparation classes. In discussing the episiotomy, Laura suggested that an episiotomy was undesirable (the title implies that avoidance is positive) yet she did not go so far as to discuss why it should be avoided or fully explore how to do so. In discussing restricted use of episiotomies, the ACOG points out “...there was a general underestimation of potential adverse consequences associated with the procedure, including extension to a third- or fourth-degree tear, anal sphincter dysfunction, and painful sex. Data suggest that women who have an episiotomy do not have significantly improved labor, delivery, and recovery compared with those who do not have one” (*ACOG Recommends Restricted Use of Episiotomies*, 2006). Despite likely having access to this information, Laura did not share reasons for avoiding an episiotomy with class participants, and she instead characterized it as able to help a

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<sup>15</sup> It’s possible that this was not discussed because women in the class were far along in pregnancy. While switching providers in pregnancy is sometimes difficult because providers do not want to take on problems associated with mistreatment by another provider, health risks are not associated with the switch itself.

mother when she is tired or performed as a measure of safety. This lack of recognition regarding why episiotomies should be avoided demonstrates the positivism in class.

A similar event occurred in Series 2, during class two, in which Mel was discussing positions for labor. Mel lay on her back in the center of the circle, demonstrating pant-pant-blow birthing breathing. She then transitioned to sitting upright, and she continued to demonstrate the breathing. Next, Mel quizzed the class on how they might feel in each position. Participants associated lying down with feeling “scared,” “uncomfortable,” and even “awful,” and the class unanimously responded that sitting upright seemed “better.” Mel pressed on to describe how sitting upright allowed them to become more in tune with their bodies. While Mel did not explicitly state that lying on one’s back should be avoided, the message that sitting upright could result in a more positive labor experience was clear. Like the “How to Avoid an Episiotomy” handout distributed in Series 1, this instance stresses that the women are the decision makers during labor (as they will assumedly decide to sit upright or lie down) and that a back-lying birthing position, common with medicinal and technical interventions, should be avoided.

However, like the lack of discussion surrounding the ability to choose a care provider, classes did not address the notion that couples themselves would be directly able to control their position in labor. In addition to presenting breathing techniques and positions for pain management, the class also focused on medicinal and technical interventions. However, classes did not make the distinction between receiving an epidural and having access to upright laboring positions. Because an epidural is



administered intravenously through a site in a woman's back, it severely restricts movement in the woman's lower body, and its purpose, that is to prevent feeling so that pain is lessened, eliminates sensations needed to sit upright. Despite this contradiction, classes did not discuss the difficulty of achieving an upright position while on medication. Again, the positive elements of upright birthing positions were featured; the necessary steps to so and the disadvantages of this choice were not.

#### DO CLASSES ALIGN WITH A MEDICAL OR ALTERNATIVE MODEL OF BIRTH?

In conclusion, a positive emphasis on the alternative model of birth was resoundingly present in class. Mel and Laura stressed breathing techniques, experiential knowledge, as well as confidence in the strength of a woman's body, all demonstrations of a positive view of alternative birth. Not only was the alternative model featured in class rhetoric, but so too was a positive emphasis on a medical ideology. Illumination of the medical model can be found in the classes' presentation of medicinal and technical interventions, the belief that birth must be managed, as well as a reliance on doctors' positions. In returning to the question posed at this chapter's initiation, do childbirth preparation classes align with either an alternative or medical understanding of birth, class content reveals that both models are present in classes at Pine Grove. In the following section, I discuss the implications of this pluralism, and I go on to talk about how the models affect participants' birth experiences.

## CHAPTER 2: DUALISMS

In childbirth preparation classes at Pine Grove Hospital, both the medical and alternative models of birth are emphasized. Not only are both models present, but they are each also featured in a positive light. Class did not feature the repercussions of procedures espoused by each model nor did they focus on the models' ideological contradictions. It is thus fair to pose a follow-up question to the plural presences previously described: How can the alternative and medical models of birth be understood together?

In order to answer this question, it is necessary to recognize the ways in which the models contradict one another. The previous section illustrates the presence and positive emphasis on the alternative model of birth, as well as a rhetoric supporting the medical model. As Rooks (1999) suggests, these models are ideological opposites. For example, the belief that birth is a natural process, a staple of the alternative model, opposes a belief that birth is a process that requires management by medical professionals, a key component of the medical ideal. That being said, childbirth preparation classes did not address these oppositions within alternative and medical models of birth. Instead, classes allowed ideological contradictions to persist in classroom discourse. In moving forward, I illustrate these inconsistencies in greater detail, and I seek to understand the presence of both models through recognizing dualisms present in childbirth preparation classes.

### DEFINING DUALISMS

In order to make sense of the presence of both the medical and alternative models of birth, it is necessary to step back from relaying instances in class and describe the presence of dualisms in childbirth preparation classes at Pine Grove Hospital. For the purposes of this paper, the term dualism signifies that elements of the class ran parallel to one another, instead of interacting in classroom discourse<sup>16</sup>. For example, on an ideological level, there is a distinction between alternative and medical models of care, and practical options presented in class were often at odds with one another. Being able to birth in a upright position aided by gravity and having an epidural to eliminate pain are impossible (arguably, incredibly difficult) to achieve together; the view of birth as a physiological experience requiring management is essentially opposed to a belief in birth as a natural process that should be free of medical intervention. Most importantly, these contradictions were not openly discussed in class, which enabled the presence of dualisms.

In the childbirth preparation classes at Pine Grove Hospital, classes often presented two distinct ideologies of birth, yet combining them on a case-by-basis was impossible. Because of both practical and theoretical discrepancies that arise, it is necessary to distinguish between the two groupings. As this paper goes on, the inability to make some choices simultaneously will be referred to as the presence of

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<sup>16</sup> The term “dualism” is present throughout social studies. Feminist scholars, sociologists, economists, and philosophers all utilize the term to signify a divide that is difficult to reconcile. The Merriam-Webster dictionary defines the term “dualism” as “1: a theory that considers reality to consist of two irreducible elements or modes, 2: the quality or state of being dual or of having a dual nature, 3a: a doctrine that the universe is under the dominion of two opposing principles one of which is good and the other evil, b: a view of human beings as constituted of two irreducible elements (as matter and spirit)” (Merriam-Webster, 2011). By invoking the term in this paper, I am drawing on the opposing ideologies of birth in childbirth preparation classes.

competing choices. Ideological dualisms represent the differing sets of ideals present in the class, evident in the presence of alternative and medical models of birth. These definitions provide some clarification as to how dualisms were present in class, in that they show the conflicts between practical options and contradictory theoretical beliefs.

In order to understand why intersection is forgone in class and explain why competing choices are present, it is necessary to look at how each dualism is formed and maintained. In a call for sociologists to revisit analytical categories used to describe medicalization in birth, van Teijlingen (2005) draws attention to analytical discrepancies between what he deems “social” and “medical” models of care. He notes that, “...It is not so much that [social and medical categories] clash with each other, as that neither of them directly addresses the issues that are central to the other. *That is, they present distinctive images of reality*” (no page listed, emphasis mine). Though van Teijlingen is speaking to models of social and medical health care, this is also precisely what occurred in childbirth preparation classes at Pine Grove Hospital. Classes allowed both ideological dualisms and competing choices to proceed unchecked, and each crafted a unique idea of how birth could proceed.

To further illustrate, let us recall two examples from Chapter 1. In Chapter 1, I described how classes featured “pathologic potential” of birth, a component of the medical model. Instances such as the presentation of the Heparin lock illustrate this potential because its preventative insertion suggests that a need would likely arise for medical intervention during birth. Conversely, Chapter 1 also illustrates an emphasis on the belief that birth is a natural process. The introduction of certain movement

techniques suggest that women do not need medication or technical support in labor because birth is a bodily experience that can be managed through breathing and movement. As van Teijlingen suggests, both of these arguments “present distinctive images of reality” (2005, no page listed). The insertion of a Heparin lock and the belief in the “pathologic potential” of birth can be constructed in opposition to the use of movement in labor and belief in birth as a natural bodily function. A Hep-lock suggests that birth should be medically managed, whereas movement suggests that birth can proceed on its own. They each tell a distinct narrative about how birth can proceed.

The presence of these dualisms was facilitated by the positive emphasis on the alternative and medical models of birth. This positivism prevented the aforementioned examples from intersecting in classroom dialogue. Classes showed that Heparin locks were helpful in managing labor, but classes did not focus on their capacity to limit movement. When an intravenous (IV) catheter is inserted into an arm, the administration of the medication and catheter itself limit the use of positions such as being on one’s hands and knees to labor. Therefore, forgoing certain positions comes along with opting for a Heparin lock and later for an IV. Conversely, in order to pursue certain positions during labor, participants must forego medication. Both the use of an intravenous Heparin lock and movement to manage labor come along with a sacrificial repercussion.

Because classes only contained a positive emphasis on each option, they did not feature information on the sacrifices that selecting intravenous medication or specific movements require. Had classes included the sacrifices that come along with

these options, classes would have presented a full picture, the pros and cons, of decisions in birth. However, an ongoing positivism prevented the intersection of these ideas. As van Teijlingen notes, these classroom examples “did not directly address the issues that are central to one another” (2005, no page listed). In neither discussions of Heparin locks nor movement did classes acknowledge the need to forego or accept medication or specific positions, requisites of pursuing each option. This example illustrates how a positive emphasis prohibited the intersection of ideological beliefs and practical components of each model, which lead to the presence of dualisms.

In reviewing my observations, hearing participants’ stories about their preparedness for birth and listening to instructors’ intentions of instilling lifelong skills in participants, it became clear that classes were predominantly drawing on positive components of each ideology. However, challenging repercussions of labor and childbirth were still present in class. There was some discussion of Cesarean section recovery in both classes, and the baby blues and post-partum depression were also topics that classes addressed. That being said, classes mostly focused on the idealistic elements of selections and beliefs associated with the alternative and medical models of birth. While components of each model can be traced in class, criticisms were markedly absent.

#### CESAREAN SECTIONS: ANOTHER EXAMPLE

In order to more fully illustrate the process by which dualisms came to exist in class, I will now focus on another example of class positivism. In the discussion of Cesarean sections, a surgical procedure falling under the medical model of birth,

classes featured the surgery in a predominantly positive light. The instance that I describe below illustrates the process by which the positive emphasis on the medical model of birth produced dualisms in class.

Both Class Series 1 and Class Series 2 featured information on Cesarean sections. In the United States, the Cesarean section rate reached its highest ever in 2007, where 31.8% of mothers gave birth by Cesarean<sup>17</sup> (Martin, 2010). Given that nearly one out of every three women will likely birth this way, Cesarean birth is indeed a relevant topic in preparing women and their partners for birth.

In Class Series 2, Mel addressed Cesarean sections during the final class period. She spoke about the risks and benefits of the procedure, and she acknowledged that the doctors would perform the surgery to preserve mothers' safety. Mel gave the statistical rate of Cesarean sections in the United States in addition to information about what to expect in preparation and during the healing process afterwards. In this discussion, she focused on the ability of C-sections to preserve the safety of mother and child in the case of emergencies. As I discuss shortly, she did not complicate the idea of 'safety' in hospital births or speak about the rate with which surgery is performed.

In Series 1, Laura spoke about Cesarean sections during class four. Unlike Mel, she did not reveal the rate of Cesarean sections in the United States, but rather told participants it was between 20% and 40% depending on the hospital. She did not

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<sup>17</sup> Childbirth Connection, a non-profit based on educating people about evidence-based options in birth, suggests that the high rate of Cesarean Sections in the United States can be attributed to factors such as the side effects of widely used medical interventions, the failure to offer vaginal births after previous Cesarean sections (VBACs), as well as the widespread belief that a Cesarean birth is safer than a vaginal delivery (Childbirth Connection, 2006).

reveal the rate at Pine Grove Hospital, which according to the state Worst to First Campaign, exceeds 35% ("State Hospital Statistics," 2010). In her discussion, Laura stressed that Cesarean sections were predominantly performed for high risk mothers, but that common reasons for their use included placenta previa, in which the placenta blocks the opening to the vaginal canal, the baby in a breech or transverse position, cord prolapse, where the umbilical cord descends before the baby's head, or cephalopelvic disproportion, meaning that the shape of the mothers' pelvis and the shape of the baby's head prevent the baby from descending. Laura moved on to talk about how recovery is difficult, but because she stressed the range of Cesarean section rates in the United States, the reality that almost three couples in the room are likely to have Cesarean sections was significantly cushioned. This begins to demonstrate the positive light in which she depicted Cesarean births.

After her discussion, Laura showed a video entitled "Just in Case" to further discuss Cesarean sections. The video depicted two Cesarean sections, one in which a couple had planned to birth by Cesarean due to the baby's breech, or foot-down, position and another in which the Cesarean section was not planned and decided upon during labor<sup>18</sup>. The video showed the surgical preparation, yet it stopped short of showing the actual surgery. In fact, Laura fast-forwarded through the Cesarean delivery to the women and their partners' testimonies of the success of their birth.

The fast-forwarding can be understood in multiple ways. On one hand, Laura's fast-forwarding can easily be interpreted as a courtesy for class participants.

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<sup>18</sup> In hospital births in the United States, babies are born in vertex, or head down, positions. The breech position is regarded as unsafe, and this perspective will be discussed later in the chapter.



The images in the video undoubtedly depicted tissues, organs, and blood, which are all requisites in surgical procedures. At risk of making class participants ill due to the images, fast-forwarding the video appears logical.

However, fast-forwarding the video also represents classes' continued emphasis on the positive elements of each ideology. A Cesarean section is major abdominal surgery that requires six weeks of recovery, which makes breastfeeding and lifting babies more difficult. Though Laura and Mel briefly discussed the healing process, noting that C-section births require more help from partners and other family members once the baby is home, they placed considerable emphasis on Cesarean sections' potential to enhance births and preserve safety. By fast-forwarding the video, classes allowed the positive elements of the C-section, particularly its ability to decrease harm to mother and infant in high risk or unsafe birth circumstances, to dominate classroom discourse.

Furthermore, the World Health Organization annually calls for a maximum 15% rate of births by Cesarean section, yet this fact was not presented in class (Amnesty International, 2010). The high rate of Cesareans in the United States implies that the surgical procedure is likely overused here, though classes did not discuss this possibility. C-sections were presented as a measure of safety, yet the possibility that families and providers could disagree on when and what was 'safe' was not topic of conversation. In this, the medical model was presented as capable of making birth safer, yet negative consequences such as disagreement over what is safe and the exceedingly high rate of C-sections in the US were hidden.

Finally, an exploration of how safety is defined was also absent from class discourse; class instructors and participants all assumed that vaginal delivery of a breech baby was unsafe. In reality, the practice of birthing breech babies is culturally located. For example, the Canadian Society of Obstetricians and Gynecologists encourages vaginal deliveries for breech babies (Kotaska, Menticoglou, & Gagnon, 2009). The practice of delivering breech babies by Cesarean in the United States is attributed to a 2000 study by Hannah et al that is based on a randomized trial of vaginal and Cesarean breech births, yet other researchers have drawn attention to the study's poor construction and the negative consequences of this practice ("Breaching the Breech Protocol," 2010; Goer, 2010; Hannah et al., 2000). Thus, a Cesarean delivery is not universally recognized as the safest procedure for breech births.

Though these questions regarding the relativity of safety could serve as the basis for another project, it is important to point out these questions' relevance to my own work. Throughout childbirth preparation classes at Pine Grove, safety was not questioned; class participants and instructors assumed that doctors acted in the families' best interests and that the practices of doctors in the United States were universal and safe. Though expecting classes to tackle issues of cultural relativism is demanding, the lack of discussion about how 'safety' is defined and understood, and potential conflicts arising from this understanding, characterizes classes' sole focus on positivity.

Returning to the purpose of this section, that is illustrating the progression of positive emphasis to dualism, let us now recall another component of class. Alongside discussion of C-sections, classes also featured an emphasis on the capability of

women's bodies to give birth. For example, a handout passed around in the class packet entitled "Some Things That May Help a Woman Do the Work of Labor" includes tips such as "Help [the woman] understand that her body is uniquely designed to give birth" and "Be respectful of the rhythm of her labor and her body to birth this baby." The emphasis on Cesarean sections reveal a different understanding of women's bodies and the birthing process, in that medical intervention is needed to produce a healthy baby<sup>19</sup>.

The positive emphasis on both these ideologies facilitates the presence of two distinct narratives about birth; the way C-sections were discussed in class suggest women's bodies cannot do the work of labor (in some instances), whereas class rhetoric also stressed a belief in women's bodies. These two opposing ideologies, and the practices that come along with them, were allowed to proceed simultaneously because of the positive emphasis on each. Had class featured the discussion of the relativity of safety or the high rate of C-sections in the United States, participants would have been given a more comprehensive picture of Cesarean births. Because the belief that women's bodies are capable of labor stands in opposition to the high use of Cesareans, the two narratives would have been able to intersect in class dialogue.

This illustration of a Cesarean birth is an example that falls within the medical model of childbirth. In moving forward, it is important to note that not only did

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<sup>19</sup> In calling attention to the discussion of Cesarean sections in childbirth preparation classes, I seek to draw attention to their overuse. I am not denouncing the fact that Cesarean sections can constitute a life-saving technology. Instead, I seek to point out that the rate of Cesarean births in the United States suggests that medical management is often embraced during the birthing process. Ideas of when Cesarean sections are appropriate have expanded considerably, which espouses the promotion of a medical model of birth.

classes exclude criticisms of the medical model, but they also failed to address critiques of alternative birth. As I discuss earlier in this section, arguments about a controlling rhetoric of “natural” birth and the essentializing capacity of “natural” birth enthusiasts who suggest that mothers *should* experience pain in labor were also not discussed in childbirth preparation classes. Though classes presented the idea that one could use breathing in labor and the belief that birth is a natural process, they did not focus on the criticisms of this ideology. Just as classes failed to discuss the criticisms of the medical model of birth, they also neglected off-putting components of the alternative birth ideal.

## CONCLUSION

In this chapter, I have set out to identify the presence of dualisms in class and show that a positive emphasis on both the alternative and medical models of birth facilitated these dualisms. This positive emphasis allowed classes to harbor “two distinct images of reality,” which did not merge to form a comprehensive picture that includes positives and negatives of each model and procedure (van Teijlingen, 2005). While classes contained both the alternative and medical models of birth, the models were dually present and did not interact in the classes’ foreground.

The following chapter addresses questions regarding how these dualisms were maintained in class. Not only was positive emphasis on the models important, but so too were ideas of flexibility and choice. I go on to discuss the presence of personal experience and choice in childbirth preparation classes, and I show how these ideas maintained dualisms and shaped participants’ births.

### CHAPTER 3: CREATING A PERSONAL BIRTH EXPERIENCE

At this point in the thesis I have addressed two main questions. It is clear that classes feature elements of both alternative and medical models of birth, and thus classes do not align with either model alone. Classes included a discussion of medication alongside an emphasis on breathing techniques and movement, and they promoted Pitocin alongside belief in birth as a natural process. To understand this plural presence, I identify dualisms, parallel ideologies and choices that are mutually exclusive but coexist in class. While a positive emphasis on each ideology supports these dualisms, I now examine more sound support for these ideas in class.

I ask the question, how were dualisms maintained in class? I explore classes' emphasis on birth as a personal experience in order to understand the presence of these parallel ideas and choices. I focus on a 'rhetoric of choice' present in classes as an extension of the focus on personalized birth, and I show that together, these ideas allowed for dualisms to proceed unquestioned<sup>20</sup>. Classes included frequent and strong references to participants' ability to create their own personal birth experience and classes promoted participants' ability to make choices as the means to do so. In this section, I not only explore the presence of this rhetoric but I also go on to question the validity of choice.

While theoretically, a class model that favors informed choice and flexibility in labor is an infallible and empowering strategy, I go on to show some of the

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<sup>20</sup> In her account of choice in her own birthing experience in Britain, Crossley (2007) introduces the phrase 'rhetoric of choice.' Crossley uses this phrase to signify an emphasis on women and their partners making educated and open choices about birth. In classes, I use rhetoric of choice to signify an ongoing emphasis on decision-making during labor and delivery.

complications that arise as a result of this rhetoric. When choice is emphasized alongside the dualisms described in the previous section, couples are likely to focus on having a personal experience, and the discrepancies between choices remain hidden. In fact, the rhetoric surrounding a personalized birth experience prevents the intersection of these dualisms. This rhetoric respects participants' right to choose different options in their birthing experience, to the point that it did not allow instructors to criticize or realistically discuss many of the options in birth. Indeed, this rhetoric poses an interesting problem. On one hand, it is rooted in a respect for participants' wishes and self-advocacy, but on the other, it denies instructors the ability to discuss consequences without seemingly posing a challenge to someone's personal choice.

This emphasis on birth as a personal experience also obstructs participants' recognition of their placement in a dominant system of medical birth. As I go on to show, the rhetoric of personal experience, along with emphasis on safety, choice and flexibility, compromises the autonomy of class participants at Pine Grove Hospital. Alongside the emphasis on choice featured in class was the equally compelling presence of medical authority. Classes can be viewed within an authoritative system and I observed more explicit authority within classes themselves. That being said, a conflict arises. The notion of participants' choice seems to be at odds with receiving authoritative direction. As this chapter goes on, I examine the complicated nature of understanding participants' agency and choice alongside interactions within the medical system.

In addition to discussion of classroom observations, I also explore a more theoretical explanation of what choice and authority together mean for participants' agency and oppression in birth. In this discussion, I draw predominantly on an essay by Deborah Lupton entitled "Foucault and the Medicalisation Critique" (1997). In the essay, Lupton illustrates the debates between scholars who identify medical authority as oppressive and a Foucauldian perspective that finds power in individuals' use of the medical system. With regards to childbirth preparation at Pine Grove, I use the works of Lupton and Michel Foucault, a social theorist and philosopher, to understand classes' promotion choice and medical authority. Using their work, I call attention to the difficulty of understanding choice and authority as linked to either explicit agency or outright oppression. While Lupton talks about medicalisation most generally, I apply her work to childbirth preparation classes at Pine Grove Hospital.

#### BIRTH AS A PERSONAL EXPERIENCE, OR "THERE'S NO WRONG WAY TO HAVE A LABOR"

At Pine Grove Hospital, both series of childbirth preparation classes stressed the significance of crafting one's own experience in pregnancy, labor, and birth. Classes emphasized the idea that birth should be a personal experience and that all births proceed differently. In childbirth preparation classes, personalizing one's birth experience is seen as the end goal, and making choices is the means to bring about this event. Despite this connection, I go on to trace the presence of both the personal experience and rhetoric of choice separately.

In Series 2, Mel often stressed that birth was a personal experience. In classes one and two, throughout class discussions, Mel consistently reminded class participants that birth was different for everyone. Not only did she allude to individual differences, but also drove the point home in response to questions and during discussion. When Mel was describing contractions, she noted that in early, active, and final stages of labor, the uterus progressively becomes as hard as an individual's cheek, nose and forehead. Immediately after this basic generalization, she made sure to say that sometimes contractions proceed and feel differently for all mothers. Similarly, when a participant brought up pain as one of the first things that came to mind about birth, Mel was sure to note that not everyone identifies birth as painful; she described that some women would say, "the word isn't pain." Even when discussing epidurals, Mel refused to give numbers about when was "best" to receive an epidural because she did not want to mislead couples, and she instead focused on their varied desires and interests<sup>21</sup>. These instances illustrate Mel's portrayal of birth as a personal experience.

In Series 1, I observed a similar emphasis on birth as a personal event. In introducing herself to participants during the initial classes, Laura noted that she had attended over one hundred births and that no two were the same. When discussing breathing techniques, Laura demonstrated each technique in a number of ways, including an instance in which she fluctuated between "he-he-ho," "he-he-he-ho," and "he-he-he-he-ho," based on the number of fingers a class participant held up on her

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<sup>21</sup> Because Mel gave specific information in class about how the hospital would proceed, such as where nurses would place a Heparin lock, I assume that she did not skip over this information because she was unaware of hospital proceedings.



hand (For example, two fingers meant “he-he-ho”). Whenever she introduced or practiced a technique, couples were encouraged to do what works best for them in labor. Even when asking couples to practice positions and breathing during class time, she often allowed couples to choose whichever strategy they felt most comfortable with at the time.

In interviews, participants also stressed the idea of having a personalized birth. For example, when I asked if birth met one Series 2 participant’s expectations, she responded saying, “I think there’s no way that you can really have a grasp on what you’re going to experience until you experience it yourself,” suggesting the uniqueness of each individual birth. She also reported that the class, “[let] you prepare for your own experience, that will be specific and unique to you” and went on to note that “there is no wrong way to have a labor,” clearly reflecting the idea that birth is a personal event. Another participant in Series 1 reported that one of the things that she took away from her class experience was that “[her] experience is going to be like no one else’s.” This idea, that labor is something to be experienced for oneself, demonstrates the demarcation of birth as a personal experience.

When I spoke with class instructors, they both stressed that they did not seek to manage participants’ births. Instead, instructors emphasized the importance of participants’ comforts. This emphasis was based on respect for couples’ own agency in the birthing process, and the ongoing encouragement of choice and crafting one’s own experience can be related to this sentiment. When I asked Laura about the classes’ take-away message, she told me that “I want [participants] to walk away...first of all, that their bodies know how to do this work of labor. I want them to

walk away feeling safe and assured that the birth center is 100% committed to the well being of mother, baby and the supporting partner. We want to make it an experience that is extremely positive and affirming.” Rather than judiciously facilitate participants’ births, Laura wanted class members to feel comfortable, positive and supported. Mel also shared that, “...We want to do whatever we can to make people feel comfortable, and answer their questions to the fullest extent.” These ideas manifested themselves in the consistent emphasis on having a personal experience and making choices for oneself. For class instructors, making participants feel comfortable often meant assuring them that many things could happen in labor, and that they should act on what was best for themselves and their baby.

While the rhetoric of a personal experience appears to be a comforting and supportive way for Pine Grove Hospital to approach births, it is important to recognize that there are major problems with this approach. Recalling the discussion of dualisms from Chapter 2, the emphasis on a personal experience allows for the maintenance of ideologies and practical options that often contradict one another. Participants fail to see the competing choices because they are focused on the idea that their experience will be their own and that they will have the freedom to make certain selections, such as the use of certain positions or medication, as birth proceeds. In addition, instructors stress positivity; as Mel told me, “The class isn’t about all the things that could go wrong in labor.” In this sunny depiction, classes fail to focus on the idea that some choices are mutually exclusive, often leading to surprising revelations during the birthing process.

This focus on a positive, personal experience led participants to encounter oppositional choices during their birth experience. After one participant in Series 2 had given birth, she described, “...I tried to use class positions as much as I could change positions being on Pitocin...It restricts you quite a bit when they have to induce your labor because they do IV drips the whole time,” thus demonstrating her encounter with the difficulties of achieving both ideals during labor. In classes, Pitocin was introduced as a tool for labor induction. Mel briefly mentioned that Pitocin does increase the strength of contractions, but she did not mention its potential to lead to other interventions, such as an epidural to manage pain, or the inability to freely change positions while on the intravenously administered drug<sup>22</sup>. In this same class, she also mentioned time and time again about doing what is most comfortable for you, thereby teaching participants to see birth as a personalized birth experience. Another participant in Series 2 similarly mentioned, “I would say that I really didn’t know that the Pitocin, I didn’t realize that that sort of labor would be so intense...” a topic which she discussed throughout our interview and thus had clearly affected her birth experience. Had the class featured both the positive aspects and negative repercussions of Pitocin, these participants would have understood the realities about Pitocin’s ability to increase contraction strength and restrict movement prior to being on the drug. Ideally, they would have been able to make a decision about receiving the medication based on this knowledge. However, instead of providing the positive

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<sup>22</sup> A common idea among birth advocates is the Cascade of Interventions, meaning simply that once one intervention is introduced in labor, another one will likely follow. For example, if Pitocin is administered to speed up contractions, an epidural or other pain medication will likely be administered to help lessen the pain. This sentiment was markedly absent from Mel’s discussion of Pitocin.

and negative elements, a sunny emphasis on having a personal birth experience and taking things one step at a time resulted in class participants not understanding the downsides their choices.

The preservation of dualisms is not the only side effect of classes' emphasis on a personal birth experience. The emphasis on a personal experience also prevents class participants, specifically women, from seeing their placement in a larger, arguably oppressive system of medical birth. Numerous birth scholars call for recognition of women's mistreatment in the birthing system (Jordan, 1997; Kitzinger et al., 2006; Oakley, 1993; Rothman, 1982). They collectively argue that the system of medical birth in the United States is hegemonic, and it reflects women's oppression in a broader patriarchal social structure. These authors suggest that during birth, women's bodies are subject to the jurisdiction of the medical community, and their needs and interests are secondary to others' authority. These ideas are important in understanding the rhetoric of choice in classes at Pine Grove Hospital, and they will be explored more fully later in this chapter.

Returning to classes at Pine Grove, the emphasis on a personal experience neglects to take into account that across the United States, women are having similar 'personal experiences.' This rhetoric denies participants access to a collective source of understanding, whether that is positive recognition of a birth experience or a solidarity-minded frustration with a particular procedure during birth. For example, if a woman had an issue in labor, such as not knowing that Pitocin would inhibit movement, the classes have ingrained the sense that this issue is personal. Though alternative resources such as the Internet could provide a source of comfort, she might

not think to reach out to this resource because her experience is crafted as ‘personal’<sup>23</sup>.’ In this instance, this woman could access strength and solidarity through recognizing this frustration as a communal experience, and further, change could be made collectively. However, an emphasis on having a unique birthing experience prevents access to this influential channel as well as other resources to help participants share their experience with others.

#### PERSONAL CHOICE AND THE “PAIN MEDICATIONS PREFERENCE SCALE”

Along with the emphasis on birth as a personal experience came the prominence of the rhetoric surrounding personal choice. This section illustrates some of the instances in class where choice is featured in childbirth preparation classes at Pine Grove Hospital and it goes on to explore the complications with this ideal.

To demonstrate the presence of personal choice in the childbirth preparation classes, it is helpful to explore a handout distributed in class Series 1. The handout, titled “Pain Medications Preference Scale,” featured numeric markers in one column,

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<sup>23</sup> In her account, Crossley describes, “Reading Wolf’s 2001 (*Misconceptions*); *Truth, Lies and the Unexpected on the Journey to Motherhood* was also revelatory in terms of its ability to dispel any notion that my own experience was unique. Her account of her own birthing experience almost replicated my own...” (2007, p. 556). Crossley’s encounter with Wolf’s book demonstrates her breaking the emphasis on personal experience through consciousness-raising. For participants in the classes, online forums and resources could likely serve a similar purpose. A thread featured on the Mothering online forum titled “Unsatisfied with Births, longing for more...” represents that other moms have come forward to share disappointing births. The mom who begins this particular thread pointedly ends her post with the question: “Anyway am I the only one who feels this way after being let down about the birth?,” suggesting that identifying birth as a personal experience is a phenomenon that is not limited to Pine Grove Hospital (“Unsatisfied with births...longing for more,” 2006).

alongside descriptions of individuals' state of mind in another column titled "What It Means." The numbers ranged from -10 to +10, and descriptions included emotional state and pain preference in labor, with -10 associated with no medication, and +10 associated with a very high level of pain medication<sup>24</sup>. For example, next to -5, the description read: "Strong preference to avoid pain medications, mainly for benefit to baby and labor progress. Will accept medications for difficult or long labor."

Alongside each numeric indicator and description was another column, titled "How the Partner, Doula and Caregiver Help." A description of activities or the labor partner was also associated with a number. For example, next to -5, it read:

"Prepare for a very active support role. A doula will be most helpful for both the woman and partner. Know how to help her relax and use patterned breathing. Know the comfort measures. DO not suggest medications. If she asks, interpret it as a need for more help and try different comfort measures and more intense emotional support first."

Most notably, the document's directions described:

"A pregnant women and her partner may use this scale to determine their preferences regarding use of pain medications in labor. *To begin, each should choose the number that best matches her or his feelings.* Then compare. If they are not in close agreement, they should discuss why and try to come to an agreement. Her preferences are more important and must prevail if they cannot agree. The right hand column describes what kind of help she needs from her support people" (Emphasis mine.)

When Laura introduced this document, it was intended to help couples share their preferences with each other and help them make decisions about how to manage pain in labor. Indeed, the worksheet was founded on the idea that

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<sup>24</sup> Interestingly, both +10 and -10 were represented at unachievable extremes. The description next to +10 read, "She wants to feel nothing; desires anesthesia before labor begins," and the partner description states, "An impossible extreme..." For -10, the description read, "Wants no medication, even for Cesarean delivery," and the partners' notes likewise began with "An impossible extreme..."

couples, and more specifically women, act as the full decision-makers in pain management and that they will be able to “choose the numbers to match their feelings.” This document simplifies choice to a number that will guide participants’ labors, making birth a unique personal experience. This illustrates an obvious emphasis on personal choice in childbirth preparation classes.

Personal choice was also stressed throughout Class Series 2. Though Series 2 did not contain a physical handout that listed choice, Mel often stressed couples’ ability to choose the course of birth through her respect for couples’ disinterest in practicing breathing and positions in class, her interest in soliciting feedback at the end of class, as well as her consistent emphasis on the fact that different techniques work for different people.<sup>25</sup> For example, Mel only *required* that couples try out a position one time during class. Other times, though she would lead demonstrations, she always stressed that individuals should only participate if they felt comfortable, leading to minimal class participation. Class participants thus always had the choice as to whether or not they wanted to practice breathing techniques and movement. Similarly, after Mel demonstrated a more rapid breathing technique, one class participant raised her hand and shared that she found that swift breathing was more difficult than traditional slow, deep breaths. Mel was incredibly affirming in her response; she praised the woman for sharing that information, and she used the instance to remind all couples that different strategies work for different people,

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<sup>25</sup> It is worth noting that unlike in Series 1, only one handout was presented in Series 2. Thus, the lack of a handout fit in with Mel’s pedagogical strategy and was not an exception.

encouraging everyone to do what was best for them. In this, Mel promoted choices during birth; women and their partners should select different strategies based on what best suits their needs. At the end of every class, Mel also asked the group to share feedback about class content. Even in childbirth preparation classes, participants could choose the topics that they wanted to address. Class Series 2 thus featured an emphasis on personal choice.

While these instances illustrate the presence of choice, they do not demonstrate the problems associated with its ubiquity. Now, I will turn to an instance in Series 1, namely the presentation and continued emphasis on the birth plan, which illustrates the complications relating to personal choice.

#### THE BIRTH PLAN

The birth plan was a major component of class Series 1, and it demonstrates the challenges of understanding and discussing personal choice in classes. The birth plan represents the extent to which class discussions simplified choice. Participants were encouraged to make selections about their birth by marking a series of check boxes, and the plan did not include availability of certain options or systemic perspective on selections.

The birth plan was presented to class participants in class two of Series 1. Laura distributed a birth plan to the couples and assigned “homework,” which was to review the plan and discuss their ideas of what they wanted in birth. The birth plan was revisited in classes three and four, during which couples were first encouraged to share the plan with their providers and later spent time in groups discussing what they wanted during birth. Though the plan itself was only a component of Series 1, a fact



that will be discussed later, it is representative of the challenges that arise based on the emphasis on personal choice and a personalized birth experience.

What, exactly, is a birth plan? The birth plan is traditionally associated with alternative birthing models and is used as a method through which women and their partners can express their interests during birth. It is used most often as a means of communication between partners and with care providers, whether that provider is a midwife, physician or doula, to help couples recognize their birthing interests. Judith Lothian, a birth scholar, describes, “Creating a birth plan provides the opportunity to determine personal expectations, develop relationships with providers, and share in decision making—critical components in achieving a satisfying birth experience” (2006, p. 297). Lothian also points to the standardization of birth plans, as hospitals have plans designed specifically for their use<sup>26</sup>. The three-page birth plan distributed by Laura includes sections describing preferences for “Attendants and Amenities,” “Labor,” “Pain Relief,” “Vaginal Birth,” “C-Section” and “Post Partum. “ It contains options such as: “Once I’m admitted to Birth Center, I’d like to walk and move around as I choose” with a corresponding checkbox for participants to mark if that is their preference.

While the birth plan indeed contained important points of discussion for class participants, such as whether or not the partner would cut the umbilical chord, it also contained misleading elements. Instinctively, many mothers would opt to avoid “stringent time limits” as well as “[put] off any procedures that aren’t urgent.”

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<sup>26</sup> Given that this plan was only distributed in Series 1, I am assuming this was not protocol at Pine Grove Hospital. However, when I Googled certain questions in the birth plan, this plan came up on other websites, including personal blogs and in a downloadable form from parenting and childbirth forums.

Additionally, many participants would likely select “to eat lightly if [they] wish to,” as opposed to eat sparingly or when directed by the hospital, and the ability “to walk and move around as [they] choose” is favorable to being bed-ridden<sup>27</sup>. Though this suggestive language was only featured in some birth plan elements, it provides grounds to call this specific birth plan into question. Was this plan directed at helping couples realize and carry out their preferences in birth, or was it a tool that further emphasized positive components of childbirth without discussing repercussions and realistic choices? The birth plan demonstrates the ambiguity of choices in the childbirth classes.

#### PROBLEMS WITH CHOICE

These questions demonstrate some of the many issues raised by the consistent focus on personal choice in childbirth preparation classes at Pine Grove Hospital. First of all, the birth plan contained options that were not available or limited at the hospital. One item on the plan read, “When it comes time to push, I’d like to do so instinctively,” and classes stressed that participants would be able to push without strict coaching. However, after giving birth at Pine Grove, two participants in Series 2 reported that in fact, when they went to push spontaneously, hospital personnel immediately corrected them, and instead stressed guided pushing. One participant in Series 2 described, “When I was trying to do the breathing that they had talked about

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<sup>27</sup> I am drawing from options such as: “As long as the baby and I are doing fine, I’d like to be allowed to progress free of stringent time limits,” “After birth I’d like to hold my baby right away, putting off any procedures that aren’t urgent,” “Once I’m admitted to the Birth Center, I’d like to eat lightly if I wish to,” and “Once I’m admitted to the Birth Center, I’d like to walk and move around as I choose.”

in the class [during the pushing phase], they were like NO, NO, NO!” and other participant similarly informed me that:

“One thing that...um...our teacher always said was that when you get to that point where you’re going to be pushing, you kind of like bear down a little bit with each contraction, and you know how she said that you don’t push anymore where you like hold your breath and there’s counting?”

SH: “Yeah.”

Participant: “Oh no, no, no, there’s counting!”

In this, pushing “instinctively” represents an item listed on the birth plan but not available at Pine Grove. In addition, options such as the birth ball and the birthing tub were limited because the hospital only had a certain number of each. The unavailability of these selections suggests that the choices were listed simply so that participants could experience the act of choosing, though realistically these options were not available. Based on this analysis, it is clear that the birth plan was designed to facilitate ‘choice,’ though its contents were misleading because the choices themselves were restricted.

That being said, what happens when participants are not able to make choices during their actual birth experience? One participant in Series 2 spoke about this situation in birth. When I asked if there was anything she wished she had known prior to labor, she responded, saying:

“I would say... I wish I would have known that...known to ask for things. I think I was waiting for someone to say, “Do you want an epidural?” and no one ever said that. I think that it would have been helpful to know that at any point, you just need to look out for yourself basically and say this is what I think I need. I guess at thought that the doctors, or my doctor at the time, would come in and say, “Oh, it looks like you’re struggling, would you like that as an option?” And basically, most of the time, your care is done by the nurses...and you

know, I think that...*[calls out to husband, another class participant]* did you get the impression they were really trying to get me through it naturally? *[Returns to conversation]*...Yes, because when it was pretty intense they had me change positions, sit on the exercise ball...they never brought up medication. So I was just kind of waiting for someone to say something, because I was in a lot of pain. I guess I didn't realize that I had to put that out there myself, or be my own advocate, and say this is what I need at this time...and you know, I should have talked to my doctors more about like what to expect or about pain management, I guess now looking back I wish I would have known more about the pain management aspect was going to work. I guess I knew the different possibilities, and I wish they had been presented to me, but finally I just had to say, you know, "Can I get an epidural?!" I wish that option had been given to me hours before I would have asked for it. That's when I really thought that someone was going to keep an eye out and maybe offer it, but that didn't happen."

In this particular instance, the class participant was left feeling helpless because choices were not put forward. In classes, she had been told that she should make decisions and would be able to do so in labor. However, once she arrived at the hospital, her options were not apparent. Feeling like the staff was pushing a certain model of birth, this participant was affected by her inability to act upon the choices stressed in the class<sup>28</sup>. This instance shows that when choice is held as a foundational element of the birthing experience in classes, a lack of choice in the actual birthing process produces dissatisfaction.

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<sup>28</sup> That being said, it is worth pointing out that this participant was not the only one who mentioned that Pine Grove Hospital promoted the alternative model of care. Another class member told me that when speaking with staff during labor, "... "It was very much like, hang in there we're going to do this the normal [vaginal] way. And that made me very, very happy." In fact, while this certainly encourages participants who do identify with practical components of the alternative ideology to act on their beliefs, for participants who seek choice, as the above narrative outlines, this bias becomes problematic.

In contrast to the experience above, which relates to not feeling comfortable asking for medication, other authors have tracked the disadvantage when medication is too heavily emphasized during birth (Block, 2007). It is possible to imagine, therefore, that a woman having taken the classes and wanting a natural birth could have a similar experience had the hospital been overly encouraging of the medical ideology. Say for instance that a participant had been planning on a medication-free birth, yet the nurse mentioned an epidural every time she entered the participant's room. Just as the narrative describes the frustration with an overt emphasis on the alternative model, in the hypothetical situation I described, it is possible to imagine similar frustrations when the medical model is favored.

In addition to the practical concerns with choices featured in the birth plan, there are other issues that arise based on its use as well. Importantly, the plan does not feature the steps necessary to achieve one's preferences, which furthers the dualistic presence of competing choices. When Laura presented the birth plan, she did not discuss the idea that some options may be mutually exclusive. Like other instances in class, the rhetoric failed to incorporate intersections of these choices; they were not discussed in relation to one another or with other ideas put forth in the class. In addition to maintaining the idea of competing choices, the birth plan also represents the ideological dualism featured in class. It both reflects the presence of the alternative model and participants' placement in the medical model of birth.

In addition to furthering the presence of dualisms, the birth plan also simplifies participants' right to choose their own options in birth, regardless of whether this choice is considered within or outside of the medical model. In the birth

plan's checkbox system, it places direct emphasis on elements of personal choice. Marking a box next to a desirable item or strategy in labor verifies the idea that couples could craft their own birthing experience. In fact, when speaking with one participant in Series 1 about the plan, she told me that "Some things in class were personal...like when she wanted us to share our birth plans," and went on to note that disclosure made her uncomfortable. The plan itself stressed participants' abilities to craft their own birth experience through making a series of choices.

It is here that the difficulties with this rhetoric of choice are most evident. Just as a personal experience denies women the right to see the collective presence of birthing, this rhetoric of choice prevents class participants from acknowledging systemic roots of their actions. Because classes encourage participants to make choices that best suit their own needs, it is difficult to acknowledge other factors that might influence their choices.

This next section seeks to explore elements of the system in which the childbirth preparation class at Pine Grove Hospital existed. In doing so, I depart somewhat from class observations relating to choice to track the presence of medical authority in classes. Following the discussion of medical authority, I take up a consideration of choice and a personalized birth experience, in addition to ideas of oppression and agency.

## MEDICAL AUTHORITY AND AN AUTHORITATIVE KNOWLEDGE SYSTEM

As demonstrated in the previous section, positive elements of the medical ideal were stressed throughout childbirth preparation classes. Absent from that

section, however, is an emphasis on the authority that the medical model of birth can possess. Medical authority, that is the dominance of doctors, technologies and ideas strongly associated with biomedicine, can be traced throughout childbirth preparation classes. It is crucial to examine this authority in relation to participants' personal birth experiences and systemic factors in order to fully discuss class content. To demonstrate the presence of medical authority, I first describe the classes' alignment with Brigitte Jordan's (1997) conceptualization of authoritative knowledge, and I demonstrate the classes' placement in an authoritative knowledge system.

In each series of classes that I observed, all participants were having their first babies at Pine Grove Hospital, and all class participants were seeing a physician for their prenatal care. For this reason, the medical model of childbirth represents the only birthing option available in the childbirth preparation classes; it was not challenged by giving birth at home or in a birth center, or through the provision of care by a midwife<sup>29</sup>. In describing authoritative knowledge, Jordan names "efficacy" as its first property. She describes that, "some [knowledge systems], by consensus, come to carry more weight than others because...they explain the state of the world better for the purposes at hand (efficacy)" (p. 56). Jordan thus links efficacy with availability; the "state of the world" is better explained by the authoritative knowledge system, and the authoritative knowledge is more readily available than other ideas for this explanation (Jordan, 1997, p. 56).

In both Class Series 1 and Class Series 2, the medical birthing model was the only birthing option available to class participants. Because 100% of couples planned

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<sup>29</sup> Indeed, chapter two traces the presence of the alternative model in class rhetoric, yet the hospital itself was the only place participants were giving birth.

to give birth at Pine Grove Hospital, the knowledge system put forth in the class was neither challenged nor difficult to imagine. In this, the classes association with the hospital demonstrates “efficacy,” which Jordan argues leads to the formation of an authoritative knowledge system.

Additionally, both Mel and Laura often referenced the procedures at the hospital throughout their respective classes, solidifying the “efficacy” through which authoritative knowledge comes to exist. When describing the placement of a Heparin lock, a catheter inserted into a vein to administer fluids or medication during labor, Mel outlined the proceedings at Pine Grove Hospital, which reiterated the singular birthing location available. In Class Series 1, the class took a tour of the birthing ward itself, and the participants in Series 2 were encouraged multiple times to tour the birthing facility at Pine Grove. This consistent emphasis on Pine Grove hospital itself not only served to solidify the singular hospital birthing location, but it also made Pine Grove hospital the most available option for birth.

In addition to greater “efficacy”, Jordan goes on to find that knowledge systems become authoritative because of their “structural superiority,” as they often “[associate] with a stronger power base” (p. 56). In Class Series 1 and Class Series 2, the association with Pine Grove Hospital, and more broadly the connection to a medical understanding of childbirth grounded the classes’ alignment with an already dominant institution. As stated in the introduction, 99% of births in the United States occur in hospitals (Martin, 2010). By volume alone, the medical model of birth can be understood as dominant and “structurally superior” to other knowledge systems.



The association with the medical model of birth was evident in many classes. Primarily, the classes themselves took place in a medical setting. Series 1 took place in Pine Grove Hospital, a room located in the Pregnancy and Birth center. Series 2 took place in the Radiology waiting room of a clinic under the hospital's jurisdiction.<sup>30</sup> In both class series, it was clear that 'medicine' was readily available. Had the classes taken place in, for example, the instructors' living rooms or at an independent location, it can be assumed that the effect would have been different.

Additionally, both classes used technocratic and scientific jargon, which further demonstrates the classes' association with the medical institution. Traditionally, science and biomedicine associate with numeric indicators and quantifiable measures to relay information (Porter, 1992). Particularly in Series 1, numeric markers were used throughout the class. Laura used numbers to describe when couples should go to the hospital (when their contractions are 30 seconds long and 5 minutes apart), the benefits of squatting (increases cervical circumference by up to 25%), and to describe the phases of labor, to indicate the ideal time to have pain medication, etc. This reliance on numbers to measure the phases of labor, as opposed to the ideology that labor is a natural process that is directed by a woman's body,

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<sup>30</sup> While the waiting room was often empty by the class's end, when participants arrived there were sometimes families and individuals waiting for x-rays in the chairs. Waiting individuals often left the class area, yet their presence contributed to the overall feeling of a lack of privacy in the classroom space. In addition, the presence of nurses, administrative staff, and other clinic personnel compromised the privacy of the space, which could have contributed to the groups' unwillingness to try different laboring positions or to vocalize breathing patterns. In one particular instance, a nurse who had taken the class with Mel previously interrupted class to say hello to Mel, and she emphatically announced to the class that "[I] had a C-Section! It was *natural!*" (emphasis mine).

represents another association with the medical institution, thereby denoting the classes' "structural superiority."

The numeric markers indeed served to enforce "structural superiority," but they also define what Rebecca Kukla names as the "public narrative" of pregnancy. Kukla (2005) presents the idea of a "public narrative" of childbirth, which is an ideal birth pattern emphasized by social forces such as the media and the medical institution. For Kukla, this narrative is particularly enforced by a reliance on statistical risk and quantifiable measures of birth. Kukla notes that, "...quantificational measures can be used as tools for implementing techniques of pregnancy in which women mediate their behavior and goals using a canonical pregnant body and pregnancy narrative as the measure of their individual pregnancies" (p. 132). Kukla suggests that numbers allow women to "mediate" and learn about their pregnancies.

The numbers used in the classes not only served to inform women about their pregnancies, but also to help them to align with a specific "pregnancy narrative." The emphasis on numbers and suggestion of the "public narrative," as opposed to recognition of individual circumstances of pregnancy, further enmesh the childbirth preparation classes and the authoritative knowledge system. In fact, this public narrative runs contrary to the ideal of choice presented in class. As Jordan describes, a further consequence of authoritative knowledge system is the "devaluation, often the dismissal, of all other forms of knowing" (p.56). The use of numeric class markers indeed compromises individual bodily knowledge in favor of the pregnancy narrative, and therefore "devalues" mother's own knowledge. Indeed, numeric indicators used

in the class not only reinforce the medical model of birth, but they also contribute to the creation of a singular idea of pregnancy.

It is clear that each class fits in to the models presented by Jordan. Jordan sees “efficacy,” and “structural superiority” as qualities that produce a knowledge system’s authoritative status, and she also notes that the emergence of an authoritative knowledge system is an “interactionally grounded notion.” Jordan describes that, “...people not only accept authoritative knowledge, (which is thereby validated and reinforced) but also are actively and unselfconsciously engaged in its routine production and reproduction” (p. 58). As this paper goes on to show, participants in the classes indeed took the classes to receive “expert” information, and the intricacies and implications of this perspective will be considered in the following section.

At this point, is necessary to point out the contradictions between the presence of choice and medical authority. A rhetoric of choice suggests that participants were in control over their own birth, whereas identifying medical authority, that is the dominance of doctors, technologies and ideas strongly associated with biomedicine, suggests that participants choices were determined by an outside force. The presence of authority complicates the ideals of choice previously established. Choices are not simple, despite the classes’ ongoing emphasis on doing what was best. In order to understand how these contradictory forces existed together, it is necessary to understand the classes as within a system of authoritative knowledge. Because of the emphasis on birth as a personal experience, class participants could not achieve this perspective.

## RETURNING TO PERSONAL CHOICE

In thinking about the ideal of choice, these systemic elements must be considered. How are participants making choices, and why is choice such an esteemed ideal? Based on the idea that the classes were in an authoritative knowledge system, which according to Jordan (1997) “[devalues]...all other forms of knowing,” participants’ choices can surely be understood as within this system (p.56). If the authoritative knowledge undermines other forms of knowing, assuredly participants’ own perceptions of birth were shaped by this ideal. In addition, the “efficacy” and “structural superiority” with which the medical model was presented in classes affirms their placement in the authoritative knowledge system. Jordan herself also identifies that authoritative knowledge is an “interactionally grounded notion.” In that case, participants’ choices can be understood as both forming and furthering the authoritative status of the medical model of birth.

It is important to note that practically, all participants made choices that would place them within the medical birthing system. They used medication to manage pain as opposed to having a birth without interventions, and they all also experienced a hospital birth attended by a physician. These choices are certainly in line with the medical model of care and medical authority. Class rhetoric, which fails to take into account the root of one’s choices and only promotes personal experience, is problematic given that these choices occurred in a broader social system.

In addition to situations previously described, there are other instances where participants were not even given the opportunity to make choices. In instances when health and/or safety of mother and infant were jeopardized, participants’ lost their

right to choose what occurs during birth. This discrepancy raises the questions: Who is making choices in birth, and who is defining when these choices can be made? These issues are of great concern in the following chapter. In this section, I aim to point out some of the issues with the general rhetoric of choice, whereas the connection between choice and safety will be discussed later.

### OPPRESSION AND/OR AGENCY

In examining the choices that participants make during childbirth and the presence of medical authority, we reach one of the major questions in many forms of social theory: Does oppression or agency determine the actions of individuals? This question arises across disciplines, and while there are many definitions and forms of oppression and agency, I take up the perspective of Young (1990)<sup>31</sup>. Young argues

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<sup>31</sup> Stepping back for a moment, perhaps drawing a comparison to another contested topic within feminist literature will illustrate the forces at play in this debate. In discussions surrounding the gendered division of labor, authors and activists often debate whether or not choices to participate in this divide are performing acts of agency. Are women who elect to stay home to mother their children acting of their own resolve or are structural forces backing them into this gendered corner?

In 2003, Lisa Belkin published an article in the *New York Times Magazine* titled “The Opt Out Revolution,” in which she argued that women intentionally choose to leave high-paying and prestigious jobs. She notably declared, “Why don't women run the world? Maybe it's because they don't want to” (Belkin, 2003, p. 3). In the article, she cited groups of women who have elected to stay home with their children, arguing that the lack of women in high-level positions is because women have chosen to mother instead of work.

However, many scholars criticized Belkin’s use of choice (Barnett, 2004; Boushey, 2005). These authors called for recognition of the structural factors that influence “choice,” such as salary, gender norms, and upward career mobility. These decisions, they argued, were facilitated by institutional standards. While Belkin saw women’s decisions to “opt out” of the workforce as purely a “choice”, or act of agency, her critics saw the social structures as oppressive, and as a result, the women who elect to mother can be identified as oppressed.

Though it surely departs from the choices made within childbirth, this example illustrates the complicated nature of debates surrounding oppression and agency. Just as

that because so many different factors affect oppression, oppression does not have a singular definition. For example, the oppression of a Black man is distinct from the oppression of a white childbearing woman because of different racial and gendered histories. In *Justice and the Politics of Difference*, Young identifies five faces of oppression: marginalization, exploitation, powerlessness, cultural imperialism, and violence (1990, pp. 39-65). She finds that the presence of any of these five faces constitutes oppression. In this paper, I take up the particular question of powerlessness with regards to women in childbirth preparation classes at Pine Grove Hospital<sup>32</sup>. Despite examining a collective powerlessness, I acknowledge that there are experiences that vary across these women's backgrounds by age, race and class, and that these experiences inform their sense of power. In looking at oppression, I do not seek to homogenize their experiences. Rather, I ask if the classes informed powerlessness in birth.

Contrary to oppression, I position agency, meaning women and their families' ability to make decisions during birth. If oppression is understood as powerlessness, agency can be defined as the possession of power. Bacchi (2005) argues that agency is the extent to which 'subjects' can employ discourses for their own use or are constituted by them. Taking up this perspective, the 'discourse' is medical authority.

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Belkin's critics raised attention to social forces, I also seek to draw attention to women's oppression within the medical system and the role that social forces play in influencing women's "choices." As Belkin attests to, one could surely argue that these women were making choices of their own accord. However, simply recognizing choices are acts of agency falls short of recognizing systemic factors at play.

<sup>32</sup> Young describes, "The powerless are those who lack authority or power even in this mediated sense, those over whom power is exercised without their exercising it, the powerless are situated so that they must take orders and rarely have the right to give them" (1990, p. 56)

Were childbearing women and their families made powerless by medical authority, or were they able to employ it for their use?

This discussion of oppression or agency bring us to the question: In describing these participants' choices under a medical model of care and informed by medical authority, am I arguing that their agency is eliminated? In childbirth participation classes, the medical model of care shaped participants' opinions. It would thus appear that women themselves were oppressed; their bodies and ideas were secondary to the jurisdiction of medical authority. Conversely, these women and their families were consciously making choices that they saw as healthy and significant, thereby demonstrating agency. A dichotomy seemingly exists between women acting of their own agency in the birth process by making choices that are best for themselves and their family, and women being subject to medical authority in the childbirth preparation and birthing process. In this paper, I challenge this dichotomy. As I go on to show, the debate is more nuanced than identifying actions as either signs of agency *or* oppression.

#### “FOUCAULT AND THE MEDICALISATION CRITIQUE”

In order to illustrate these nuances, I now draw attention to a theorist that challenges the ideas of authority flagged by Jordan (1997). In order to understand the nuances in birth experiences, one cannot embrace either oppression and authority or agency and choice as the only factors that affect birth. In an essay entitled “Foucault and the Medicalisation Critique,” Lupton (1997) points out the shortcomings of what she calls the “orthodox medicalisation critique.” She suggests that agency is found in

specific choices and micro-level power relations, a perspective that I will explore later in this paper.

First, it is necessary to explain Lupton's ideas. Lupton presents the "orthodox medicalisation critique" as the dominant criticism of medical authority in the United States. According to Lupton, central to this critique is the idea that "Medicine, as it is practiced in Western societies, despite its alleged lack of effectiveness in treating a wide range of conditions and its iatrogenic side-effects, has increasingly amassed power and influence..." (p. 95). In other words, medicine in the United States is problematic because of its power and lack of effectiveness. Lupton argues that "orthodox medicalisation" critics also call the practices of medical professionals in the United States into question. According to Lupton, "Proponents of the critique generally take an overwhelmingly negative view of members of the medical profession, seeing doctors as attempting to enhance their position by presenting themselves as possessing the exclusive right to define and treat illness" (p. 96). In addition to defining the "orthodox medicalisation critique," Lupton goes on to criticize its makeup.

Lupton takes issue with various elements of the "orthodox medicalisation critique." According to Lupton, this criticism of US medicine poses a problem for a number of reasons. She takes issue with, first, the "black and white portrayal of Western medicine as largely detracting from rather than improving people's health status;" second, "its depiction of "doctors' intent on increasing their power over patients rather than seeking to help them;" and third, "the portrayal of "patients as largely helpless, passive and disempowered, their agency crushed beneath the might



of the medical profession” (p. 97). Lupton criticizes the polarized and inaccurate depiction of doctors and patients in the “orthodox medicalisation critique.”

To counter the “orthodox medicalisation critique,” Lupton draws on the work of Michel Foucault, a social theorist and philosopher. In Michel Foucault’s *Discipline and Punish* (1977), he presents a useful understanding of power that defines power as a network of relations instead of something that can be possessed. Foucault states, “Power is not something that is acquired, seized or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations” (p. 474). For Foucault, power relations are more complicated than either having or not having authority.

Lupton goes on to use Foucault to present an understanding of power that is distinct from how the “orthodox medicalisation critique” constructs authority. Lupton claims that because power is a network, it can be found in “local techniques and strategies...or the micro –powers that are exercised at the level of everyday life” (p. 103). In the case of medical authority, Lupton identifies that making decisions that go against doctors’ guidance are acts of agency, but she also resists labeling people who heed doctors’ advice as passive. She describes, “...those individuals who go along with medical advice need not necessarily be viewed as passively accepting the orders of the doctor or the medical gaze, but rather could be seen as engaging in practices of the self they consider are crucial to their own well-being and freedom from discomfort or pain” (p. 105). For Lupton, power can be found in making choices that align with medical authority.

What does this mean for understandings of oppression and agency in childbirth preparation classes? Using the logic employed by Lupton, power can certainly be found in families' decisions to birth within the medical system. They used their choices to bring about satisfaction and comfort, practices they see as "crucial to their own well-being" (Lupton, 1997, p.105). Lupton's understanding of power shows that participants in classes are not only subject to medical authority. Rather, their choices and the presence of medical authority must be understood together. This means that Jordan's (1997) understanding of participants as within an "authoritative knowledge system" is not fully equipped to explain their experience. Instead, the power in participants' choices must also be considered.

### THREE MAIN CLAIMS

In this chapter of the paper, I have made three main claims. Primarily, it is clear that childbirth preparation classes at Pine Grove Hospital featured an emphasis on personal choice and having a personal birth experience. This emphasis helped to maintain the dualisms previously described in class. Participants were able to focus on crafting birth as a personal event through freely making choices, thus unaware of contradictions in choices themselves.

This emphasis on birth as a personal event further prevented participants' from recognizing their placement in a broader, medical birthing system. Jordan (1997) shows the classes' placement in an authoritative knowledge system. The second claim in this chapter reflects Jordan's theory; medical authority is present in childbirth preparation classes at Pine Grove Hospital.

In recognizing that authority is present in class, I also take up a discussion of power that is not limited to either/or explanations of oppression and agency. Drawing on the works of Michel Foucault, Lupton (1997) shows that power is found in participants' choices in birth. She argues that by making decisions that suit their own wellness, participants are enacting power. They enact their agency by making choices, despite the fact that medical authority limits their selections. The third major claim I make in this chapter is that in order to understand questions of power in the childbirth preparation classes, it is best to employ an understanding of power that does not position all power with the medical system. Instead, medical authority and choice should be understood together.

## CHAPTER FOUR: FLEXIBILITY AND SAFETY

In the previous section, I discuss some of the issues surrounding the emphases on personal experience and choice featured in childbirth preparation classes at Pine Grove Hospital. This discourse, I argue, supports dualisms because it prevents the recognition of systemic elements of birth. Just as classes stressed choice, classes also fit into a system of authoritative knowledge (Jordan, 1997). While classes pushed participants to craft their own birth experiences, participants are making choices within an authoritative knowledge system.

Based on this restriction, a debate between whether class participants are oppressed or agents in the birthing process arises. Are participants acting freely, or are they subject to medical authority? While Jordan (1997) highlights medical authority, Lupton (1997) introduces another understanding of power that is linked to participant's choice. Based upon Lupton's definition, we can understand class participants as agents, yet it is important to note that their choices are restricted.

In addition to operating within an authoritative knowledge system, what other factors limited participants' choices? In response to this question, I show that ideas of safety and flexibility constrained how participants were able to make decisions during birth. Flexibility encouraged participants to give up their choices, particularly in situations deemed unsafe. In this chapter, I show how safety and flexibility were present in classes, shaped participants' experience in birth, and finally explore what this means for understandings of choice and authority

### THE IMPORTANCE OF BEING FLEXIBLE

Just as the rhetoric of personal choice was featured in classes, so too was the idea of flexibility. By using the term flexibility, I am drawing on an overall sentiment that promoted participants' ability to make decisions, meanwhile keeping an open mind. Though choice was emphasized, being malleable and ready for anything in birth was equally important. Childbirth preparation classes at Pine Grove Hospital contained constant references to the importance of flexibility, and as I go on to show, class participants embraced this idea.

Both Laura and Mel emphasized the idea of flexibility in childbirth preparation classes. Classes consistently promoted keeping an open mind in birth. Laura's presentation of the birth plan, which as the previous section shows is built on the simplification of choices, is a telling example of the extent to which she emphasized flexibility. During one session, Laura addressed the contradiction between having a birth plan and being flexible in labor. She described the plan as "hopeful" and a "wants more than needs" composition of ideas, thereby stressing flexibility alongside the idea of personal choice. In the emphasis on "wants more than needs," Laura also justifies presenting unavailable choices within the plan. By linking the plan to being flexible, Laura cushioned having these supposed choices taken away in birth.

In Class Series 2, Mel also emphasized the importance of having an open mind in labor and delivery. For example, whenever she demonstrated a contraction, she repeated the mantra, "In labor, I will take contractions one at a time." In this repetition, she drew on the idea that participants should maintain flexibility and make decisions as they arose. Very rarely in class did Mel give couples directions, and one

of the sole pointed suggestions she gave was with regards to making decisions. In class three, Mel advised couples to be open-minded about labor during pregnancy and talk to the nurse about how they were feeling once they arrived at the hospital. She said that feelings change, and while couples might expect to feel one way, they could easily end up feeling another. Mel wanted couples to hold off on making their choices and remain flexible until labor began, showing the importance of open-mindedness in classes.

The idea of flexibility also came up throughout my conversations with class participants. One male participant in Series 1 said that, “The biggest benefit of the class is that you need to be prepare of things to go differently than what you prepared for...” which indeed recognizes the importance of the ideal. Another participant in Series 2 described that the classes’ take away message was:

“Being okay with being flexible, no concrete plan or concrete idea, no right or wrong way to experience a labor...My sister had solid plan, none of it went according to plan, some of that was very disappointing because ultimately she had to adjust. I don’t feel that way; whatever is going to happen, happens. I’m very at peace with that...I feel open-minded,”

again demonstrating her commitment to flexibility. Another participant from Series 1 shared that, “One thing that kept on ringing in my head was, from those classes that I took, is that you have to be flexible...and totally you do.” During Class Series 1, one female participant even raised her hand and shared that she had began the class anticipating a “hardcore” birth without medicinal or technical intervention, but she now realized that flexibility was the most important value to take into labor. These instances illustrate how flexibility resonated with class participants.

In classes themselves, the rhetoric of choice and this idea of flexibility often faced each other in discussions of risks and benefits of certain procedures. In fact, flexibility was often used to reconcile participants' interests and the hospital's dedication to promoting patients' safety, specifically in instances where choice could be compromised. The idea of flexibility prevents the maintenance of participants' choice during birth. In situations deemed unsafe, it became a vector for allowing physicians to act unchecked to preserve the health of mother and infant. The following section explores the conflict between choice and flexibility in greater detail.

#### FLEXIBILITY IN THE FACE OF RISKS AND BENEFITS

In addition to an overall presence in class discourse, class instructors used flexibility to bring together potential conflicts of interests; what happens when a class participant's choice is compromised in the name of safety? In each class series, a participant brought up the relationship between risks and benefits of certain procedures in birth, and the idea of flexibility was used to deflect this tricky question. Below, I explore these occurrences and their significance.

First of all, it is necessary to ask the question: why are questions of risks and benefits difficult? Because classes were committed to honoring participants' own desires, discussing universal risk and benefits becomes tricky. What could benefit one participant might be risky for another. In speaking with both instructors, it was clear that they also sought to present unbiased information regarding proceedings in birth. Laura described the role of classes for couples, noting: "This is my own personal philosophy, but it's to help...if the characteristic isn't already within

[participants], it's to help them really become a health advocate for themselves and their child, their baby." Had Laura or Mel responded too strongly to a question about risks and benefits, they seemingly jeopardized their neutral presence in class. Furthermore, a guided response could have compromised "self-advocacy;" their directive could influence the participants' confidence and ideas about themselves. In our interview after the classes' completion, Mel directly noted that: "It's not for me to decide how somebody is going to manage their labor."

When questions of risks and benefits about certain procedures arose in class, Laura and Mel both used the idea of being flexible during childbirth to navigate this terrain. In Series 1, after watching the video that depicted different medicinal and technical interventions, one class participant raised his hand and asked how couples should weigh the risks and benefits of procedures. He asked where the "fine line" was between choosing to have and forego an epidural: When is the procedure beneficial? When is it risky? Laura responded by talking about how different circumstances call for different actions. She noted that the hospital was committed to safety first, and that when there was a question of maternal or infant safety, the hospital would do what was necessary to preserve their health. In this, she alluded to the idea that while couples should make choices for themselves in birth, their choices would be put aside in the name of safety. Class participants should therefore be flexible and prepared for anything in labor, including being prepared for the hospital to take away their ability to make choices.

In Series 2, Mel also directly answered a question regarding the risks and benefits certain procedures using the notion of flexibility. In class 1, a participant



whose partner was planning to birth by Cesarean because they were having twins raised his hand and asked what the advantages and disadvantages were to this procedure. Mel quickly acknowledged the importance of his question and went on to describe how this was a decision couples should make with their doctor. She alluded to the idea of flexibility in that doctors would ultimately do what was best for the family. By remaining flexible, Participants were preparing themselves for doctors to act in this way, as it is unknown what the preservations of health and safety might entail. By extension, participants should be flexible and trust their providers to do what is deemed necessary protect their health. She said that in birth, people must weigh the risks and benefits of certain decisions and work with their care providers to determine what was best for them.

In their responses, both Mel and Laura directly allude to where flexibility fits into the class through the emphasis placed on working with care providers during birth. Couples are to make personal choices throughout pregnancy, but also lean heavily on their physician and retain an open and flexible mindset. This enables the physician to make decisions in times of safety, and the participants' personal choice becomes buried in the rhetoric of flexibility. If providers and participants want different things in birth, participants have learned the importance of flexibility, and will thus likely yield their choices to the medical professional. Flexibility was used to buffer a potential conflict between participants' interests and what is considered 'safe.' In instances of safety, participants were to trust their providers and their choices would assumedly be set aside; the flexibility highlighted in class prepares participants for this experience.

Mel highlighted the relationship with physicians at one point during our conversation. She described, “We try to promote collaboration that begins during prenatal visits...and all along the way,” and went on to mention the “leap of faith” that couples must make to trust their care providers. While she chose to highlight this “collaboration,” it is necessary to explore some factors that might influence how participants and providers work together. As this section has shown, flexibility is certainly stressed in class, and this open-mindedness could allow participants to yield decision-making during birth to their providers. Below, I set out to explore what happens to the idea of personal choice when this concession occurs.

#### PERSONAL CHOICE MEETS SAFETY

In the instances described above, both Mel and Laura hinted that if risky situations arose, participants’ choices would be disregarded in the name of safety. It is notable that these situations arose during participants’ labors, and class participants voiced little dissatisfaction when medical professionals acted in the name of safety. Presumably, had safety not been a factor, participants would have been uncomfortable with their lack of decision-making during the birthing process. However, in situations deemed unsafe, the idea of flexibility prepares participants to sacrifice their choice. In the following examples, it becomes clear that choice was disregarded when situations were seemed risky, and it is presumed that flexibility, which prepared participants to be open-minded in birth, facilitated this concession.

In the previous section, I describe one participant in Series 2 who voiced her frustrations with not feeling able to opt for an epidural during labor (See p. 72). This participant also received an episiotomy without consultation during the pushing phase

of birth as well as induction by Pitocin. Unlike when her personal choice was prevented in labor, the removal of choice in the name of safety did not produce discomfort. She described:

“The doctor who was on call, he came in the morning and checked me...he said, I’ll check you at three in the afternoon. Well he came back at one in the afternoon and said, really, you know there wasn’t more progress there. So he said, you know, “I’m going to start Pitocin and go ahead and get things moving.” Because their concern was that my water had broken, and then there was the meconium that I guess when you hit the sixteen hour point there’s really concern about infection, so they said, “Okay, we’re going to go ahead and do this.” So they started that...”

In this instance, the doctor decided Pitocin was necessary because of the risk of infection. As expected, the mother did not object, as her safety and the health of her child were seemingly in danger. However, it is worth noting that the doctor checked this mother two hours before planned, and that there is contested information regarding whether or not broken waters lead to infection at sixteen hours. While twenty-four hours is more commonly used as a guideline, an evidence-based study of maternity care advises, “Deviation from this arbitrarily defined ‘normal’ rate of dilation should be indication for evaluation rather than intervention” (Enkin, 2000, p. 333). They go on to note that the rate and performance of vaginal exams during labor are contested (Enkin, 2000, p. 285). Thus, both the performance of the vaginal exam and its result to administer Pitocin are not outright indicators of safety. However, this participants’ reliance on her doctor to identify danger results in her concession of choice at these suggestions<sup>33</sup>.

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<sup>33</sup> It is worth noting that Pitocin also increases the predictability of labor, giving the medical professionals control over its start. With the administration of Pitocin, it is sure that contractions will begin, thus possibly shortening labor. Without Pitocin,

Likewise, another participant did not question the decision to have a Cesarean section in the name of safety. In her birth story, she describes:

“They walk me down to the operating room, and begin to do the spinal anesthetic. Sitting in the very cold operating room, bending my back “like a cat” while a nurse hugs me, and the anesthesiologist asks me a series of confusing questions, I start to cry. This is not at all what I imagined. I knew a C-section was possible if there was an emergency, but it never crossed my mind that the baby was breech. After a minute, I pull myself together and they lay me down on my back.”

This participant had been planning for a birth without medical interventions, yet when she found out the baby was breech, a Cesarean was her only option. Despite her discomfort because the C-section was, “not at all what [she] imagined,” she did not defend her right to choose whether or not the surgery would be performed. Another participant in Series 1 who had an emergency C-section described: “Was I disappointed to have a C-section? Yes, but ultimately you know it’s whatever’s best, you have to do what you have to do.” These instances reveal that participants did not question the procedure being done and the superscription of choice that occurs when the safety is jeopardized. Unlike when choice is expected, if the safety of mother and infant is seemingly compromised, participants cast aside their ability to choose how birth proceeds.

Stepping back from classes at Pine Grove Hospital for a moment, in an article entitled, “Childbirth, Complications, and the Illusion of Choice,” Crossley (2007) discusses how safety and choice were defined during her own birth. In a reflective account that describes choice in her own birthing experience, Crossley openly recalls

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contractions are unpredictable. This decision to begin Pitocin demonstrates alignment with a medical model of birth. Through inducing labor, birth is medically managed and predictable, whereas the alternative model respects the indefinite timing of birth as part of the natural process.

how her choices were limited by ideals of safety. She describes being subject to medical interventions, and then questions her own concession. She notes, “Unlike the health professionals who were treating me, I did not have the authority to proclaim whether or not various medical interventions were necessary, or whether my case actually did constitute a medical emergency” (p. 558). She links her inability to make choices to the discussion of safety: “I was not given a choice in any real sense of the term. I ‘had’ to be admitted because of concerns about blood pressure and preeclampsia. I ‘had’ to be induced because of concerns about placenta degradation. I ‘had’ to have Pethidine because both I and the baby could become exhausted by the induction...” etc. (p. 558). Crossley pays particular attention to the role of safety in compromising her choices. In moving forward, I seek to explore a similar relationship between choice, safety, and the medical institution in the childbirth preparation classes at Pine Grove.

Like Crossley (2007) conceded choice during her own birth experience, the instances described above demonstrate class participants’ alliance with actions the hospital deemed appropriate. As Crossley alludes to, however, the physicians’ ability to make these decisions was intertwined with their authority. I now move on to explore what this medical authority means, and how it affects the ideas of choice, flexibility, and safety in the childbirth preparation classes.

## MEDICAL AUTHORITY

In the previous chapter, I show how classes align with Jordan’s (1997) notion of authoritative knowledge, thus demonstrating the classes’ placement in an

authoritative knowledge system. While the previous chapter explores the classes' placement in a certain system, here I show the presence of medical authority, that is the dominance of actors, practices and ideas associated with the biomedical institution, within the classes themselves. In *The Social Transformation of American Medicine* (1982), Paul Starr identifies three levels of authority that work together to create "legitimacy" and "conditions of dependence," the two foundational elements of authority overall. According to Starr, "authority...incorporates two sources of effective control; legitimacy and dependence. The former rests on the subordinates' acceptance of the claim that they should obey; the latter on their estimate of the foul consequences that will befall them if they do not" (pp. 9-10). In his historical assessment of the rise of medical authority in the United States, he identifies three distinct types of authority, cultural, social and professional, that shape "legitimacy and dependence." In childbirth preparation classes, it becomes clear that safety and flexibility relate to these ideas.

The primary category that Starr identifies is cultural authority. Starr describes that cultural authority "...refers to the probability that particular definitions of reality and judgments of meaning and value will prevail as valid and true", and he goes on to note that, "cultural authority entails the construction of reality through definitions of fact and value" (p. 13)<sup>34</sup>. As this paper goes on to show, the notion of cultural

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<sup>34</sup> Importantly, this was not the only ideal of cultural authority present in class. Starr also described that, "cultural authority...may reside in cultural objects," and that "authority in this particular form can be used without being exercised; typically, it is consulted...often in the hope of resolving ambiguities" (p. 13). In each series, medical instruments were passed around during class meetings. Items such as the amniotomy tool, used to break a woman's waters to move along labor, an internal fetal monitor, as well as an external fetal monitor were presented to class participants, and the

authority is prevalent within interactions in childbirth preparation classes at Pine Grove Hospital. Starr himself refers to physicians as the dominant social actors, yet as the actions of the childbirth preparation instructors make clear, other professionals can enact cultural authority as well.

In Class Series 1 and Class Series 2, cultural authority was present in the interactions between participants and instructors, and the implications these interactions would have during birth. Most notably, the instructors “created conditions under which [the advice of physicians] seems appropriate,” which allowed them to indirectly “construct a reality” of birth (p. 14, 13). Both Mel and Laura often referred class participants to physicians through each class series, as demonstrated in discussions of risks and benefits. As described above, they stressed participants’ flexibility and named the physicians as dedicated to preserving participants’ safety.

When Laura and Mel stressed flexibility and safety, this created a condition of dependence upon the doctors’ knowledge and position, as all class participants surely wanted to be safe. Recalling discrepancies between when participants were able to make choices about their birth, and when those choices were made for them, Starr (1982) illuminates how physicians were able to define situations as harmful and then

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instructor passed each object around the room to each couple. In this exposure to the instruments used in labor, “ambiguity” was resolved, and their presence in the classroom suggests their authoritative status, and the broader culture of medical authority. In fact, the sentiment that actions are performed “[i]n the hope of resolving ambiguities” can be directly linked to the flexibility described earlier. Objects and elements of the medical model were indeed seen as capable of providing the safest birth. Participants’ exposure to these objects certainly facilitated choices within the medical system, a key component of the previous chapter.

act to prevent this harm. Cultural authority allows instructors and physicians to define when situations are unsafe, leading to the concession of participants' choice.

Both class instructors and physicians indeed embody the cultural authority that Starr defines. Though neither class instructor was a physician, their emphasis on safety and flexibility furthers the idea that safety is contingent on the physician's opinion. This then gives physicians the ability to define when it is appropriate for patients/participants to make certain choices in treatment. When safety was questioned, participants did not voice any difficulty with their lack of choice. Most directly, the classes "[constructed] reality through definitions of fact and value," which Starr sees as enabled by cultural authority (Starr, 1982, p.13). When situations arose, they were determined to be unsafe, and this "fact" was not challenged because participants were not equipped to question the physician's jurisdiction. Similarly, safety is a universal "value" as well; how could participants jeopardize their own health and the health of their child? By naming flexibility as an important component of childbirth and the hospital's orientation towards health as the overall goal, the classes enabled a reliance on physicians' judgment, thus producing instances which compromised participants' choices in the name of safety.

As demonstrated in the previous section, classes stress that participants will be able to make certain selections during the birthing process. Tangible items such as the Birth Plan and the "Pain Medication Preference Scale" as well as the overall classroom rhetoric, point to an ongoing emphasis on choice and birth as a personal experience. However, equally prevalent are a rhetoric of flexibility and this idea of medical authority. In other words, when the going gets tough, participants must be



flexible because the hospital is dedicated to doing what is safe and has the authority to do so.

Recalling the discussion of oppression and agency, Lupton's (1997) definition of power as a network shows that participants are enacting agency in their decisions to rely on the medical professionals. Bacchi (2005) understands agency as employing a 'discourse' for one's benefit. In instances provided, participants utilized medical authority to ensure their safety. However, social forces that influence how safety is defined at Pine Grove Hospital are nonetheless worthy of examination. Safety is a relative concept, and practices that doctors adhere to are not always regarded as safe. For example, though Cesarean Sections are practiced frequently, health benefits are not associated with their unnecessary use in low-risk births (Childbirth Connection, 2006). For this reason, the agency of participants needs further consideration. How can participants' agency be understood in light of factors such as flexibility and medical authority? How is safety defined? While this exploration will continue later in this chapter, it is first wise to point out another element of medical authority featured in class, that of professional authority.

#### PROFESSIONAL AUTHORITY: COMMUNITY AND VALUES

In drawing on the relationship between safety and cultural authority, it is important to point out that this notion of safety itself draws the classes further into line with Starr's understanding of medical authority. While cultural authority draws on the definition and construction of reality, Starr's idea of professional authority

sheds light onto the importance of safety as the endmost goal for medical professionals. Starr defines professional authority, stating:

“Professional authority can be defined, in part, by a distinctive type of dependency condition- the dependence on the professional’ superior competence...the legitimization of professional authority involves three distinct claims: first, that the knowledge and competence of the professional have been validated by a community of his or her peers; second, that this consensually validated knowledge and competence rest on rational, scientific grounds and third, that the professional’s judgment and advice are oriented toward set of substantive values, such as health” (Starr, 1982, p. 14)

In this section, I move on to briefly comment on how professional authority was likewise present in class and discuss in greater detail the orientation towards the promotion of health and safety at Pine Grove Hospital.

In Class Series 1, it was immediately clear that Laura was part of a knowledgeable birthing community, and that couples enrolled in the class so that they could hear information that she possessed. Demonstratively, one participant in Series 1 told me that, “to hear from experts is really what [she] really wanted,” and was her primary reason for enrolling in the classes. She expressed frustration with horror stories from peers and indecipherable information on the Internet, and turned to the “expert” authority in the institutional childbirth preparation classes to attain correct information. In this transition, Laura (and presumably Mel) took on an expert status.

The understanding of Laura as a birthing “expert” demonstrates the conception of her “superior competence,” one of Starr’s criteria for the attainment of professional authority. This competence is indeed associated with professional authority: most basically, individuals are inclined to believe an “expert.” However, where is this competence derived from?

Laura's association with the medical community directly flags her professional authority. Most notably, Laura also used the word "We" when referring to Pine Grove Hospital (Ex: When you arrive at the hospital in labor, "we" will ask you to fill out some forms.), thus reiterating her status as part of the medical community. Considering Starr's criteria, this statement shows that the information is "validated by a community of her peers," where "peers" represent the hospital itself.

Laura not only demonstrated the association with the medical community, but she also referenced her birthing experience throughout the class. Laura shared her experience in prenatal fitness and massage, her attendance at over one hundred births, as well as her knowledge of birthing literature through passing out books at the beginning of each class. Laura was indeed associated with the birthing community, which further validated her position and the knowledge she possessed.

In a similar way, Mel was also viewed as the beholder and sharer of birthing knowledge. While Mel used "they" when talking about hospital procedures, she demonstrated her connection to the community by offering to pass along questions to the nurse-manager and through referencing her position as a hospital employee in another department. Both instructors thus showed that their knowledge and competence "[had] been validated by a community of [their] peers" (Starr, 1982, p. 14).

Secondly, the information that was put forth in both classes class "[rested] on rational, scientific grounds," another one of Starr's criteria for the

achievement of professional authority (Starr, 1982, p.14). In Series 1, Laura consistently included information that was justified in quantifiable, rational, measures. For example, when discussing squatting, she was sure to remind the class that squatting has the potential to increase the width of your pelvis by 25% due to the forces of gravity. The fact that a 25% increase served as the justification for squatting during labor and delivery shows the need for a numeric, or a rational, justification.

In addition, the book used in both classes entitled *The Gift of Motherhood* included a glossary of terms containing scientific language such as bilirubin<sup>35</sup>, chloasma<sup>36</sup> and peristalsis<sup>37</sup> and the related layperson definitions (Moran & Kallam, 1997). In classes themselves, both and Mel Laura often introduced a scientific word such as "collustrum," then followed with a layperson description such as "the liquid that first comes out of the breasts after birth and is filled with nutrients." The notable shift between scientific and layperson information demonstrates the fact that the class rests on scientific ground.

Finally, the idea "that the professional's judgment and advice are oriented towards a set of substantive values, such as health" was another component of Starr's professional authority (Starr, 1982, p.14). As class instructors made clear on multiple occasions, safety was the ultimate goal for Pine Grove Hospital births. In discussions

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<sup>35</sup> Defined as: "A yellowish substance formed during the normal breakdown of old red blood cells in the body" (Moran & Kallam, 1997, p. 122)

<sup>36</sup> Defined as: "The patchy, darkening of the skin or the face due to hormonal changes during pregnancy" (Moran and Kallam, 1997, p. 122).

<sup>37</sup> Defined as: "The waves of contractions and relaxation of the intestinal muscles needed to move its contents" (Moran and Kallam, 1997, p. 122).

of risks and benefits, health and safety were emphasized- both Laura and Mel chose to emphasize Pine Grove's commitment to participants' well being when faced with questions of risks and benefits. Recalling Laura's ideas of take away messages from class, she described "I want them to walk away feeling safe and assured that the birth center is 100% committed to the well being of mother, baby and the supporting partner." Instructors stressed safety as the ultimate goal in birth.

Class participants also adopted safety as the primary goal in birth. In discussing their perception of ideas of natural and medical births during our interviews, multiple participants referenced their concern for the baby's well being. One participant in Series 2 described, "People have strong feelings about being medically induced and whatever...but the baby came out and she was fine. She wasn't affected at all by the epidural; she wasn't affected at all by the Stadol. It had been long out of the system." In this response, the participant stressed that the baby was "fine" demonstrating a preoccupation with her child's health and safety. In describing some of her desires for an emotionally satisfying labor, another participant in Series 2 noted, "Because you're going through this whole thing, and in the end all you really want is a healthy baby and you're thinking oh my gosh is everything going to be okay?" again showing the focus on well being. Finally, a participant in Series 1 for whom a C-section became a last minute reality relayed, "So that was just a huge shock, but you know, [the baby] was totally fine and not in distress or anything, but they had to do a C-section because it was just too dangerous to do a vaginal delivery in breech." Even when faced with having an unexpected Cesarean, this participant was able to turn towards her infant's safety. In these various mentions of the baby

being “fine” and wanting a “healthy baby,” it becomes clear that safety was the utmost goal for childbirth preparation class participants. Now, I move on to discuss how safety is defined.

#### HOW CAN WE UNDERSTAND SAFETY?

While participants’ willingness to act towards preserving the health of themselves and their families appears to be a responsible and safe decision, it also begs the question of who is able to define when a situation is safe. In the instances described above, the hospital personnel informed participants that their health was jeopardized: sixteen hours in meconium could harm the baby, and breech births are too great a risk to carry out. In both of these situations, the medical professionals determined when safety was compromised.

Furthermore, Starr’s (1982) ideas of professional and cultural authority help to shed light on the conflict that could possibly arise when the medical professional possesses the authority to define when a situation is deemed safe. Earlier in this section, I pointed out that participants are certainly enacting agency in their decision to rely on the medical professionals’ authority, but I also question social forces that enable medical professionals to define when a risky situation arises.

In this questioning, it is important to recognize that procedures deemed as safe at Pine Grove Hospital are culturally, socially and historically rooted. Starr’s book itself is a testament to factors that produced the authority of medical professionals in the United States; items such as the Flexner Report served as a means to link the

medical profession and practices to privileged, exclusive and enviable information<sup>38</sup>. The practices at Pine Grove, therefore, are not universally recognized as ‘safe.’

In fact, countries across the world have a range of birthing practices that are different from procedures in the United States, and the countries have corresponding lower rates of maternal mortality. As Amnesty International points out, women in the United States are more likely than women in forty other nations to die from pregnancy related complications, with a rate of 13 deaths per 100,000 live births (Amnesty International, 2010). The US rate of maternal mortality is higher than rates in France, Sweden, Spain, and Denmark, as well as many other nations across the globe. These nations all have distinct rates of hospital births and various care providers who attend births. For example, births in Denmark are attended by midwives, have low rates of C-sections, and they have also have a lower rate of maternal and infant mortality, only 8 deaths per 100,000 live births (*Maternal Mortality in 2005*, 2007). While there are certainly many factors that affect maternal and infant mortality, these examples point to other understandings of safety that could, in fact, be *safer* than birthing practices in the US.

Even in the United States, it is impossible to find a practice that is universally identified as ‘safe.’ There are advocates against induction, use of medication, and hospital births; equally, home births and births without medical intervention face

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<sup>38</sup> According to Starr (1982), the Flexner Report served as a keystone of the reform of the medical profession. Published as in 1910, the Flexner Report limited the number of medical school in the United States for economic reasons. This significant raised the cost of attending medical school, which limited those who could attend. As Starr points out, this report also limited the number of Black people and women able to enroll in medical school, thus marking the medicine as a privileged profession and homogenizing its education system (Starr, 1982, pp 116-127).

opponents. Thus, in the hospital's subscription to safe practices in the United States, it is important to acknowledge that even those practices are contested nationally.

In moving forward, therefore, it is important to recognize that the when choices of class participants are compromised in the name of safety, the practices being enacted may not be universally seen as safe. As instances such as the Flexner report and contested procedures show, birthing practices are culturally, historically and socially rooted, and therefore not universal. The class rhetoric of flexibility that promotes the concession of choice in the name of safety does not take this into account.

In even further exploration of participants' agency through conceding choices, it is necessary to note the uniqueness of this practice, even in the health care arena. In the stories relayed by class participants, their choices came to rely on the actions of medical professionals; the physicians at their births determined when an intervention such as Pitocin or an episiotomy was necessary.

These physician-led actions flag the idea of consent in the birthing process. Participants themselves did not have a chance to review and examine the procedures and compare them to other options; the classes' focused on the positive prevented them from that information. Even though participants likely signed consent forms upon their entrance to the hospital, it is possible to question how much participants knew about the risks, benefits of procedures, as well as other options. Most likely, an intervention was presented moments before it happened in a situation already deemed dangerous by the health professional. Recalling Starr's (1982) notion that those with cultural authority are able to define reality using "fact and value," the situation



became factually unsafe by physician's definition. In order to challenge this fact, participants would have needed to seemingly risk their own life and the life of the child, thus disputing 'safety, a universal value.

What's more is in other 'dangerous' health care situations, such as when a patient is diagnosed with cancer, different options for the course of their treatment are presented to them and they are then expected to make a decision. Chemotherapy would never start because it "had" to based on the physician's opinion; patients often seek another physician's advice and are able to discuss choices with their families. In birth, as Crossley (2007) points out, treatment occurs because it "had" to. There is little discussion of opinions, alternatives, risks, and benefits in classes (and presumably in birth because the situation is already deemed unsafe).

In a foundational text of medical ethnography, Charles Bosk (1995) reviewed the work of genetic counselors in a Pediatric Hospital. His work shows that even though counselors might color the options with their own opinions, the pros and cons of each options was presented to parents in time sensitive situations. During birth, doctors assume the woman's consent. That assumption is unique in American medicine. Because both assumed consent is unique to birthing in the United States and the practices themselves are contested, the agency based on understanding participants as decision-makers in the birthing process can be questioned.

At this point, it is clear that understanding childbirth preparation classes is complicated based on the classes' presentation of conflicting models, choices, the presence of authority, and how these factors interact. This section specifically explores a rhetoric of flexibility and safety, and I move on to highlight medical

authority and some of the complications that define when a situation might be deemed safe. With regards to participants' oppression and agency, this further suggests that while there may be agency in the ability to make decisions, systemic factors also weigh in on an argument for class participants' oppression in childbirth. In this final section, I comment on the relationship between power and childbirth preparation at Pine Grove Hospital.

#### POWER, OPPRESSION AND AGENCY; UNDERSTANDING PARTICIPANTS' PERSPECTIVES AND MOVING FORWARD

In order to better understand the relations of power that are of importance, I now turn to participants who voiced their understanding of power throughout our conversations. I have so far accounted for class content by drawing on theoretical discussions of authority and power. How did participants experience choice, authority, flexibility and safety in class?

In light of the agency versus oppression debate, participants certainly did not seem to feel "oppressed," thus categorizing their experience as exclusively oppressive becomes difficult. Evidently, participants from the classes feel empowered and prepared for labor. During our conversation, one participant from Series 1 and one participant from Series 2 referenced the idea that "knowledge is power" and further discussed the benefit of preparedness derived from classes. In my conversation with one class participant in Series 2, she stated "I am so, so glad that we did the class. We would suggest it to anybody that is a first time parent...It just makes you feel so much more empowered. You don't feel helpless like you're going through a guessing game,

like anytime they came into talk to us about something it was like, oh, uh we've heard about that, okay, you know? So...yeah, that was really good." This participant was confident and prepared for labor: She saw herself as "empowered" and able to make choices. Interestingly, her choice was to receive an epidural to lessen pain during labor. She notes, "This is something, when I went in there I had every intention of getting an epidural, I think that's the one expectation that I had, I didn't want to mess with a natural childbirth." Though she elects for an epidural and separates herself from a "natural childbirth", there is no doubt that this participant saw herself as an empowered decision maker. In fact, in our initial interview, she described that as a result of the classes, *"I will be empowered through the whole [birthing] process instead of a victim of it."*

Furthermore, in this participant's choice to have an epidural, she was not consciously conceding to an oppressive birthing system. Rather she was making a choice, as class encouraged, which would enable her to be more comfortable. She was not selecting an epidural because she was oppressed by the medical system, but instead to facilitate her own comfort. In this, this participant saw the system she was placed in and acted to bring about her own satisfaction.

Returning to the understanding of agency and oppression, Lupton (1997) argues that this decision-making is an act of agency. Lupton argues that power can be found in "local techniques and strategies...or the micro -powers that are exercised at the level of everyday life..." (p. 105). Drawing on this idea, just as medical authority influenced participants, their decisions to "[engage] in practices of the self they consider are crucial to their own well-being and freedom from discomfort or pain"

demonstrate that they are not merely passive subjects of medical oppression (Lupton, 1997, p. 105). I take up a similar perspective to Lupton; participants shared that they felt prepared for labor, and they utilized the medical model to suit their needs. For these reasons, they must be understood as agents.

This participant, and other members of the childbirth preparation classes, demonstrated agency in their own decision making, yet it is the decision she made and its placement in the larger system that can be questioned. While this participant saw her decision as an act that brought about her own empowerment, from a structural level, this power is restricted. The choice to have an epidural lies within the medical system of birth. The presence of medical authority and classes' placement in the authoritative knowledge system thus limits the choices participants can make. The emphasis on personal experience and choice also enforces these restrictions, as the participant was unable to access a narrative outside of her personal experience in class. While the participant utilized the medical model to suit her needs, she did not have complete access to a range and realistic depiction of birth possibilities. Rather than seeking to take part in a shared history or a broader "agency" that challenges the medical model, this participant described, "I'm not a failure if my labor doesn't progress the ways that student's a, b, and c does. It's my own chapter in my personal history." This participant did not indicate an understanding of the authority, despite making decisions within the system.

While participants' decision-making within the medical model represents agency, participants are also oppressed in birth as a result of their class experience. Agency can be identified in their decision-making, but their decisions are limited by

the construction of birth as personal. The placement in a medical system and the presence of medical authority were not made apparent to participants, and participants thus received only a partial view of their position and birthing options. Though the alternative model was presented in classes, it paled in comparison to medical authority, safety, and flexibility. While agency can be identified in participants' decision-making, oppression can be found in the limits of their decisions imposed by medical authority and incomplete information about options in birth.

For this reason, a debate over whether participants were agents or oppressed is not sufficient to account for the complexities in class. Lupton (1997) shows the potential towards understanding power as a network of relations, and I employ her network argument to show the complexity of understanding agency and oppression in childbirth preparation. While participants made choices in birth, medical authority limited their decisions. Participants were conditioned to act flexibly to preserve safety, but safety itself is a cultural construct. There are not absolute nor infallible practices recognized in the United States, and the fact that participants are often unaware of this relativism further supports their oppression. Classes prevented participants from realizing a full narrative of their birth; systemic perspective was prevented, and medical authority often superceded their own choice.

These chapters will be summarized in the following conclusion and the overall effect of classes will be explored in hopes that the paper's research questions regarding how medical and alternative models interact in childbirth preparation classes, and how they shape class content and participants' births, can be answered. I

will also explore the effects in relationship to power and make recommendations for improving childbirth preparation classes at Pine Grove Hospital.

## CONCLUSION

Childbirth preparation classes at Pine Grove Hospital present a complicated and important set of observations from which to understand choice and participation in maternal health. Based on the Amnesty International report that calls the state of maternal health in the United States into question and the presence of heated debates that rage between medical and alternative birth advocates regarding the correctness of certain birthing practices, I began this paper with the following questions: do childbirth preparation classes align with either a medical or alternative model of childbirth? How do these models interact in childbirth preparation classes, and how do they shape class content and participants' births? In this conclusion, I move to answer those questions and offer suggestions for bettering childbirth education, in hopes of improving a broader system of maternal health.

In Chapter 1, it becomes clear that childbirth preparation classes align with both an alternative and medical model of birth. Classes contained information on medical and technical interventions, presented birth as a process needing management, and demonstrated an association with Pine Grove Hospital, and thus the medical community, that aligns with a medical model of birth. However, the alternative model of birth was also present in classes. Instructors stressed breathing and movements in addition to a belief in birth as a natural process. In response to the first question that guides this paper, classes did not fully align with either model but rather contained elements of both.

As classes featured components of both models, it is important to note that they presented these choices and ideologies with a positive spin. Classes only

minimally discussed consequences of birthing choices, and there was an overt absence of criticism of either model. As a result, dualisms were also present in class. They included ideological dualisms, the parallel presence of both alternative and medical models of birth, and competing choices, birthing options that are mutually exclusive. Because of a positive emphasis on each model and choices, contradictory ideas did not intersect in class.

Childbirth classes' emphasis on birth as a personal experience supported the presence of these dualisms. Throughout class discussions, participants were encouraged to make a series of choices to create their own birth experience. Instructors emphasized that all births were different and participants should make choices to best suit their own needs. As a result, classes prevented participants from recognizing the impossibility of making some choices together, such as receiving an Epidural and walking around during labor. Classes encouraged participants to make choices without being informed about the limitations of their selections.

The emphasis on birth as a personal experience also prevented participants from accessing the systemic perspective of their in-hospital births. Because birth was constructed as personal, it was difficult for participants to recognize their placement in the broader system of medical maternity care. Drawing on Jordan (1997) and Starr (1982), I show that classes are both placed in an authoritative system and contain medical authority. Because of the emphasis on birth as a personal experience, participants had little access to this systemic perspective. While choice was a beacon held out to class participants, medical authority also shaped their births.



In noting the presence of medical authority, I am not arguing that women and their families in classes experienced outright oppression or powerlessness in birth. Rather, I introduce the work of Lupton (1997), who shows that power is relational, and not only something that dominant groups possess. Lupton shows that the choices participants make can also be identified as powerful. In their decision-making, participants are forming the authority of the medical institution itself and using the medical model of birth to suit their needs.

Though Lupton (1997) provides a way to understand choices as acts of agency, two other themes in classes, safety and flexibility, show the extent to which participants' selections were limited. Not only were criticisms hidden by a positive emphasis on each model and by the emphasis on birth as a personal experience, but flexibility and safety also worked together to limit participants' choices. Classes encouraged participants to give up their choice and be flexible in situations that their physicians deemed unsafe. However, the medical professionals were able to define safety, and flexibility often led participants to sacrifice their choice. The definition of safety that physician employed is not an absolute understanding. Rather, it is informed by specific cultural practices. Though Lupton provides a potential understanding for participants' agency in the birthing process, and these participants undeniably saw themselves as prepared and powerful parents, factors such as an incomplete portrayal of safety, the positive emphasis on values of each model, and promotion of flexibility suggest that participants were blinded from understanding the entirety of their birth experience, including criticisms and arguments about the medical system of birth.

Due to the presence of system factors and personal choice, participants' experiences cannot be understood as simply acts of agency *or* oppression. In response to the second set of questions I posed to begin this thesis, how do these models interact in childbirth preparation classes and how do they shape class content and participants' births, the positive emphasis on each model informed a dualism present in class, and the negative aspects of each model's ideology and choices were hidden. An emphasis on personal experience furthered these dualisms, and it also prevented participants' recognition of their placement in a broader medical system that contained medical authority. While medical authority was present, participants can still be seen as agents in the birthing process, though the emphasis on personal experience, flexibility and safety also shows that they were subject to oppressive forces. Just as classes contain both medical and alternative models of birth, participant's birthing experiences must be understood as acts of agency in an oppressive system. Participants made decisions, but their decisions and perceptions of the system itself were limited.

It is in this absence of a full account that childbirth preparation classes at Pine Grove, and classes more broadly, provide means to improve the maternal health care system. If classes are intended to prepare participants for their birth experience as the Pine Grove website states, then classes should do just that: fully prepare participants for birth. Including the pros and cons of each birthing model as well as choices that these models constitute would allow participants to make better-informed decisions. Even if options are still within the medical model, participants will more truly be able to employ the model to their own advantage. If the goal is for participants to be seen

as agents and have satisfying, healthy births, providing a more comprehensive perspective on birth in the United States, thorough discussion of each model as well as interventions and choice, will help to bring about this goal. Not only will it work towards healthier births, but it will also enable participants to make more informed decisions, thus dispersing medical authority.

Instead of the rhetoric of flexibility currently featured in classes, this would call for the ideals of planning as well as, more specifically, *inflexibility*. Even in a hospital as supportive as Pine Grove, achieving a birth free of medicinal and technical interventions in a hospital setting is no easy feat. Metaphorically, the birth plan in class would need to be presented with greater emphasis-if pain medications are to be avoided; here are the sacrifices that you will need to take to avoid them. Likewise, if an epidural is what you want, here are the sacrifices (i.e. to forego a vertical birthing position) that you will need to make once the medication is administered. In addition to providing more thorough information, classes could replace ideas of flexibility in the name of safety with ideals of inflexibility. That is not to say that classes should not acknowledge emergency circumstances, but that promoting an inflexible attitude to prevent unwanted interventions and/or fully realize an interest in them is favorable to ‘flexibility’ replacing participants’ choices and promoting unnecessary medical interventions, even in the emergency situation when the choices cannot occur.

If the maternal health care system in the United States is to be improved, education provides a compelling starting point for this improvement. Through addressing the broader picture of birth in the United States, class participants would be able to better understand the maternal health system, better understand options

available to them in birth, and better understand what it takes to bring about those options. Through empowering participants and providing comprehensive information, this shift towards a more expansive and accountable model of childbirth education offers to drastically improve participation and choice in maternal health in the United States and eliminate the complications in the classroom.

## APPENDIX

### Interview Questions for Participants (Before Birth)

1. Why did you take the classes?
2. Were the classes what you were expecting?
3. Did the classes match up with info you were receiving from your doctor?
4. What did you think about how the class was structured?
5. Did you find the breathing and position demonstrations helpful? How about the breathing? Birth plan? Why/Why not?
6. Was the class what you were expecting? How did the class fit in with/differ from what you were expecting?
7. Do you have a plan for birth? How did the class shape what you are expecting in birth?
8. Was that how you were feeling before starting the class?
  - a. (If it changed) Can you put your finger on why that changed?
  - b. (If it doesn't change), So it's safe to say that the class was in line with what you thought?
9. How do you expect the class to be most helpful in labor?

### Interview Questions for Participants (After birth)

1. Tell me your birth story.
2. Was birth what you were expecting?
3. How did you feel the class helped you in labor?
4. After giving birth, anything you wish someone had told you (or is there something you wish you had known) beforehand?
5. One thing we talked about last was the idea that “knowledge was power” and that the info you received in the class would help you be prepared for labor. How do you feel about this topic having given birth? Would you recommend the class to others?
6. One of the things I'm also interested in is the debate about medical and natural birth; I'm hoping to be a midwife and it's something that I have thought about a lot. After having attended class and given birth, any thoughts on that discussion?

### Interview Questions for Instructors

1. Was the class I observed a typical class?
2. What do you see as the role of the classes in the hospital?
3. What is the message that you want participants to take away from the classes?
4. For what during labor do you see the classes as particularly helpful?
5. Is there anything you wish you could change about the classes?
6. How do you see the classes fitting into the natural birth-medical birth spectrum?

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