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INTERPRETATION AND CRITIQUE OF THE CHOICE AND EXPERIENCE OF HOME BIRTH: POSITIVE HOME BIRTH EXPERIENCES OF NEW YORK WOMEN

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# INTERPRETATION AND CRITIQUE OF THE CHOICE AND EXPERIENCE OF HOME BIRTH: POSITIVE HOME BIRTH EXPERIENCES OF NEW YORK WOMEN

by

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Abstract

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Adviser: Professor Maxine Wolfe

A methodology informed by the principles of philosophical hermeneutics and critical theory was applied to the study of home birth. The women in the study were living in the New York Metropolitan area and were white, mostly college-educated, and predominantly middle-class. The majority of births were attended by Certified Nurse Midwives, and the experiences were overwhelmingly positive. A group of women who had home births prior to nineteen-sixty were also included in the study to provide a contrast of experiences. The purpose of the research was to understand the women's choice and experience of home birth within its historical, social, physical, economic and political context. The four aspects of the hermeneutic circle provided the levels of analysis: (1) childbirth in the New York Metropolitan area and childbirth in the United States, (2) the women's past and present attitudes, beliefs and experiences relating to childbirth, (3) relationships with practitioners, prenatal care, birth setting, support persons, etc., and (4) the birth itself: characteristics of labor, birth positions, perception of pain, actions of birth attendants, etc.

To George, for his love and support,
to Adam and Joshua, who bring joy to my life,
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# Chapter One.

## Introduction.

This thesis represents an attempt to derive a social science methodology based on the principles of philosophical hermeneutics, and is the first example of the application of hermeneutics to the study of childbirth. A few social scientists have used similar methodologies based upon critical interpretation (Sullivan, 1984) to study human behavior. The study will provide a detailed account of the experience of home birth for the birthing women, and will enable others to understand their reasons for choosing out-of-hospital birth. The study will also provide a systematic examination of the ways in which the hospital and home birth experience differs for those women who have experienced both, and will document the perceived safety and benefits of alternatives to traditional hospital birth.

The purpose of the proposed research was to examine the experience of out-of-hospital birth from the perspective of the women who have chosen such a birth setting. This was done through the use of in-depth interviews of women who have had home births. The individual's choice and experience of out-of-hospital birth was analysed within its social, political, historical, physical and economic context in order to determine its origin and meaning.

Such an analysis provides the groundwork for the

achievement of a deeper understanding of the experience of out-of-hospital birth. The meaning that the experience holds for the women who birth at home is revealed through the interpretation of the birth experience within its contexts. The interpretation of the home birth experiences of the women who participated in this study is bounded by the particular social, political, economic, physical and historical contexts of their lives. The interpretive methodology applied to this study was derived from the principles of philosophical hermeneutics.

The history of birth in the U.S.

Prior to 1914, the majority of births took place at home, with female midwives in attendance. The proportion of hospital births increased from 36.9% in 1935, to 88% in 1950, to 96% in 1960 (Devitt, 1977). Anesthesia and hospital based obstetrics were seen by obstetricians as tools to slow the sharp decline in the birth rates of the upper classes (Guttmacher, 1943; Letourneau, 1953; The Week, 1931).

Today, the vast majority of births take place in a hospital under the care of an obstetrician. The change of venue and personnel has been attributed to a political struggle between male physicians and female midwives (Ehrenreich & English, 1973a); the desire of medical men to free women from the horrors of childbirth through the employment of new technology, often requested by the women themselves (Wertz & Wertz, 1977; Devitt, 1979; Hubbard, 1984) and the discovery of

the fetus as a patient in its own right (Shorter, 1982; Hubbard, 1984). The resultant hospital birth takes place under the auspices of medical men and is a product of the new obstetrical technology.

Technological birth.

Hospital birth is seen by many researchers as a highly technological event in which one technology leads to another, rendering the woman a passive participant (Haire, 1972; Arms, 1975; Brackbill, Rice & Young, 1984). The shaving of pubic hair, enemas, intravenous infusion, electronic fetal monitoring, Pitocin to induce or augment labor and Demerol for pain relief are routine accompaniments to hospital birth. This influences women's perception of birth in the direction of viewing it as a medical procedure requiring technological intervention (Haire, 1972; Shaw, 1974; Arms, 1975; Brackbill, Rice & Young, 1984). A result of this is the restriction of choices available to a birthing woman when told that certain technological interventions are necessary to insure the health of her baby (Hubbard, 1982; Rothman, 1984). Rothman (1982) contrasts this model of childbirth with that of midwives, who view birth as a natural process in the transition from pregnancy to motherhood.

The major concern over the use of technology in pregnancy, labor and birth management is that many interventive procedures used routinely in many hospitals have never been demonstrated in properly controlled, scientific investigations

to adequately benefit healthy women and their babies (Kerr, 1975; Young, 1982; Brackbill, Rice & Young, 1984). The benefits of innovations in obstetric management with regard to fetal mortality (death) and morbidity (complications or disability due to a procedure) need to be documented in adequately controlled trials in scientifically valid studies (Chalmers & Richards, 1977; Young, 1982).

Many routine obstetric procedures have been shown to have minimal benefits for low risk mothers (Banta & Thacker, 1979; Lumley, 1982; Banta & Thacker, 1982). The long term effects of ultrasound, used in fetal monitoring and as a diagnostic tool, is unknown (Edwards & Waldorf, 1984). The cesarean section rate in the United States quadrupled from 1970 to 1980 (Marieskind, 1980) and reached a national rate of 18 percent in 1982 (Placek, Taffel & Moein, 1983). The increase has been attributed to obstetric policies, interventionist procedures, the nature of residency training programs, changes in the subjective judgments of obstetricians as to what constitutes an indication for surgical delivery, and the fear of malpractice suits (Brackbill, Rice & Young, 1984). The risks of cesarean delivery include increased mortality and morbidity for both infant (Niswander & Gordon, 1972; Marieskind, 1980) and mother (Evrard & Gold, 1977; Cohen & Estner, 1983).

Safety: Hospital versus home.

The increase in technological innovations in birth

management during the last two decades corresponds to a reduction in neonatal mortality during that period. However, the relationship is deceptive. Three-fourths of the recent decrease in neonatal mortality rates has been attributed to a lower incidence of low birth weight, rather than changes in obstetric care (Lee, et al, 1977). Low birth weight is more a function of social factors than medical care, and correlates highly with poverty and high number of previous pregnancies (Rider, et al, 1955).

Despite the multitude of technological interventions available for the management of labor and birth, the United States continues to have a high neonatal mortality rate compared to other industrialized nations (Brackbill, Rice & Young, 1984). The same procedures that are designed to reduce mortality and morbidity rates may actually contribute to its high level (Pettiti, 1981; Pettiti, et al, 1982; Brackbill, Rice & Young, 1984). The use of one procedure often necessitates the use of another procedure to alleviate or complement the effects of the first (Marieskind, 1979), a phenomenon described as the daisy chain of technological intervention (Brackbill, Rice & Young, 1984).

Studies of the safety of home versus hospital birth during the period of 1930 to 1960 do not show that women benefitted from hospital obstetric care (Devitt, 1977). Despite the fact that many women who birthed at home during this period were frequently poor and of poor health, had

attendants who were poorly trained, had unsanitary homes, and had little possibility of hospital emergency care, the maternal and perinatal mortality and morbidity rates were often lower than those for hospital births (Devitt, 1977). If home births were as safe or safer than hospital births under those conditions, then it can be concluded that the technological care available in hospitals is not necessarily safer or of lower risk.

Recent studies of the safety of home birth have found lower neonatal mortality rates (Burnett, et al, 1980; Brackbill, Rice & Young, 1984; Stewart, 1981) and morbidity rates (Mehl, Shaw & Creevy, 1975; Mehl, 1977) when compared to hospital births. Problems with home and hospital birth comparisons include the underreport of neonatal deaths and misrepresentation of the cause of some maternal deaths (Rubin, et al, 1981) and the unknown number of healthy babies whose home births are never registered (Brackbill, Rice & Young, 1984).

Why in-hospital birth?

Since 1960, the vast majority of births have occurred within the hospital (Devitt, 1977). Why do women continue to give birth in hospitals despite the availability of evidence questioning the benefits of in-hospital birth? One reason is that the medical establishment is strongly in favor of in-hospital birth (Rothman, 1982), and physicians have the power to influence their female patients (Ehrenreich & English,

1973b; Notman & Nadelson, 1978; Scully, 1980).

The majority of women of childbearing age were born in the hospital, and the majority of births today take place in the hospital. Thus, many women only know of others who are having hospital births and are unaware of the existence of birthing alternatives (Lipkowitz & Cook, 1983; Lipkowitz, 1985). When they become pregnant, many women remain with the practitioner they had been using for routine gynecological care and use the affiliated hospital for the birth (Lipkowitz, 1985).

One group of researchers examined why women chose to have hospital births and submit themselves to high tech deliveries. They found that the women did not deliberate the risks and benefits of hospital births, but instead relied on their doctors' beliefs (Brackbill, Woodward, McManus & Ireson, 1984). The women believed that the hospital was safer and would insure that their babies were born healthy. Many were unaware of the existence of alternatives. Another group of women gave their reasons for choosing hospital births as wanting to feel in control and have the utmost safety (Sacks & Donnenfeld, 1984). The majority of the women included in both these studies were white, middle-class, and college educated.

Why out-of-hospital birth?

Reasons given by women for choosing an alternative to hospital birth are the desire to avoid intervention in the birth process, to maintain control over their births, to avoid

separation from family, to remain in a secure environment, economic considerations, and the belief that hospitals are for illness and are therefore psychologically and physiologically dangerous for healthy mothers and babies (Hazell, 1975; Devitt, 1977; Petty, 1979; Kitzinger, 1980; Stewart, 1981; Brackbill, Woodward, McManus & Ireson, 1984; Sacks & Donnenfeld, 1984). According to several recent studies, approximately 80 percent of women who had both hospital and home births preferred birth at home (Pathak, 1960; Goldthorpe, & Richman, 1974; Lee & Glasser, 1974).

People known to be choosing home birth and whose experiences have been studied in most research are almost entirely white, middle-class, well nourished and often college educated (Hazell, 1974; Mehl, Peterson, Shaw & Creevy, 1975; Sacks & Donnenfeld, 1984). In some regions, particularly the west and southwest, home births are becoming very popular, and may be the norm for some social groups, although documentation of this does not exist. Women who do not fit the description of the "typical home birther" are difficult to locate, possibly because they may not use known home birth attendants. The majority of home birth attendants carefully screen clients to insure that only healthy, low risk women are allowed to birth at home (Epstein, et al, 1976; Ettner, 1976). This is to insure that those women who are more likely to develop complications during labor or birth are in a facility equipped to handle any problems that might arise.

In summary, hospital birth in the last fifty years has become increasingly technological and almost soley the domain of physicians, changes that have been attributed to social, political and economic as well as medical factors. Women who choose alternatives to traditional hospital birth do so for many reasons having to do with control over the birth and avoidance of intervention, but their choice is also a function of the broader context in which childbirth is defined and takes place.

The aim of this study is to question the ways in which birth is defined by its broader context and the ways in which its context influences the choice and experience of out-of-hospital birth. The broad context in which childbirth takes place includes economic, political, social, physical and historical frameworks that must be addressed. To do so requires conceptualizing the problem within its broader context and utilizing a methodology designed to incorporate the contextual framework into the analysis.

Chapter Two.

Conceptual and methodological framework.

In the literature previously cited, pregnancy and childbirth have been examined by historians (Wertz & Wertz, 1977; Shorter, 1982); sociologists (Shaw, 1984; Oakley, 1980, 1985; Rothman, 1982), anthropologists (Kitzinger, 1962, 1972, 1977, 1980; Newson & Newson, 1963; Jordan, 1983), photojournalists (Arms, 1975) and feminist scholars (Frankfort, 1972; Corea, 1977; Ehrenreich & English, 1978; Arditti, Klein & Minden (1984). Many of these studies provide rich descriptions of the nature of hospital birth and the factors responsible for its character. Studies done on home birth are similarly descriptive (Sousa, 1976; Gilgoff, 1978; Petty, 1979). For example, Kitzinger (1962, 1972, 1977, 1980) has taken written accounts of women's descriptions of their experiences of birthing and has superimposed thematic frameworks derived from the characteristics of the responses. The present research builds upon the earlier approaches, using hermeneutic interpretation and critique to supplement the descriptions provided by the previous works.

The purpose of the present research is to understand women's experience of out-of-hospital birth within its historical, social, physical, economic and political context. To do so it utilizes a conceptual approach which integrates individual experience with interpretive understanding, critique

of ideology and an historically oriented analysis of social systems (Habermas, 1970, 1979). The methodology which was applied to the study of the experience of home birth in this research was informed by and derived from the epistemological principles of hermeneutics and critical theory. This particular conceptual and methodological approach to the study of childbirth has not been undertaken previously.

Hermeneutic or interpretive understanding is the revealment of the meaning a phenomenon holds for the members of a particular society at a particular time (Gadamer, 1978). A hermeneutic approach is historical; understanding is the result of the interplay between preunderstanding (foreknowledge of the phenomenon), the movement of tradition, and the movement of the interpreter within the circle of understanding (Gadamer, 1978). Gadamer distinguishes between the dominant socially shared meanings or beliefs of a society with respect to a phenomenon and the meaning the phenomenon holds for the individual members of that society. The experiences of the individual members of the society are shaped by the dominant beliefs and by the prejudments held by the individuals themselves. The dominant belief system is shared in varying degrees by the members of the society, ranging from little or no consensus to complete agreement. There exists a constant tension between the individual and the larger society that varies as a function of the degree to which the social meaning is shared.

According to my interpretation of Gadamer's philosophical position, a hermeneutic understanding of childbirth must incorporate whatever beliefs are brought to the experience by the members of a society, the history of the phenomenon within that society, and the interaction of the researcher with both the beliefs and the tradition of the phenomenon. In other words, the researcher must place birth within its context and analyze the beliefs held towards childbirth by members of a given society in relation to the context in which it occurs. The researcher provides the bridge between the historicity of birth within its previous contexts and the beliefs that surround birth as a function of its present contexts.

Kockelmans (1975, 1978) proposes that the human sciences must select and justify their theoretical frameworks by means of two corollary a priori components to the usual empirical component, the descriptive and the interpretive. The formal framework of meaning, the predetermined theoretical framework, is to be constituted by the descriptive component. The interpretive component tries to provide a scientifically and critically acceptable account of the meaning which the social agents themselves attach to their own social actions in the life world. This meaning is shared to some degree among members of a society and is intersubjectively accessible. The achievement of intersubjective validity can be assured by the adherence to the canons for inquiry (Kockelmans, 1975).

The canons of hermeneutics are not directives for a methodology; they stipulate what must be taken into account in order to reach an intersubjectively valid account of the meaning of a phenomenon. The application of these canons to the research problem is based upon my interpretation of Kockelmans' writings. However, the canons themselves are taken directly from Kockelmans' work (1975).

The first canon for inquiry is the autonomy of the object. The legitimacy of the interpretation is derived from and tested against the phenomenon itself. This does not mean that the phenomenon must be removed from its context. Rather, the interpreter must be aware that phenomena may become imbued with meanings derived from philosophical prejudices of the interpreter rather than from the phenomena themselves.

Secondly, one must search for an interpretation which makes the phenomenon maximally reasonable. A phenomenon may be so complex and so deeply rooted in the tradition of a society that its genuine meaning may be inaccessible to the members of that society (including the researcher). In order to understand such a phenomenon, the interpreter must complement the phenomenon with suitable assumptions in order to make it maximally reasonable, or human. In other words, the interpreter distances him or herself from the phenomenon by employing assumptions about the secondary and tertiary layers of meaning superimposed in that society.

One way of checking the legitimacy of such assumptions

is through historical research. In addition, it is necessary to validate the legitimacy of these assumptions in terms of their intersubjective meaning among the persons being studied. The approach of this research addresses the issue of intersubjective meaning by presenting the interpretations to the persons being studied for critique. This will enable the researcher to check the relevance of the assumptions to the actual experiences. The influence of the researcher's prejudments in the application of the assumptions will be clarified by the critique. In addition, someone other than the researcher or the participants can critique the validity of the assumptions by listening to or reading transcripts of the interviews and questioning the prejudgments of the interviewer and the accuracy of these assumptions.

The third canon states that the interpreter must attempt to achieve the greatest possible familiarity with the phenomenon, in terms of its historical origin and the layers of meaning which have evolved, and the traditions in which the phenomenon originated and developed. The social, political, economic and historical contexts of the phenomenon, past and present, must be taken into account in order to reach an interpretive understanding of the phenomenon.

The fourth canon describes the hermeneutic circle. There are four aspects of the hermeneutic circle, all parts-whole relationships. The first aspect is the relationship of the phenomenon taken as a whole and its

constituent parts. The second is the relationship between the phenomenon itself and all other related phenomena which contribute to its meaning. The third aspect is the relationship between the social agents and their life world, and the fourth, the relationship between the phenomenon as it exists in our society as representative of Western civilization and Western civilization as a whole. The diagram below demonstrates the application of the four aspects of the hermeneutic circle to the phenomenon of out-of-hospital birth.

| ASPECT OF HERMENEUTIC CIRCLE | APPLICATION TO CHILDBIRTH |
|---|---|
| PHENOMENON AS A WHOLE AND ITS CONSTITUENT PARTS | THE BIRTH ITSELF: LABOR, BIRTH POSITION, DISCOMFORT, ACTIONS OF BIRTH ATTENDANT, ETC. |
| PHENOMENON AS A WHOLE AND OTHER RELATED PHENOMENA | RELATIONSHIP WITH PRACTITIONER, PRENATAL CARE, BIRTH SETTING, SUPPORT PERSONS, ETC. |
| SOCIAL AGENTS AND THEIR LIFEWORLD | THE WOMEN'S PAST AND PRESENT BELIEFS, ATTITUDES AND EXPERIENCES RELATING TO CHILDBIRTH |
| PHENOMENON AND THE LARGER SOCIETY | BIRTH IN NEW YORK CITY AND BIRTH IN THE UNITED STATES |

The hermeneutic circle represents the circular relationship between the whole and the parts of a phenomenon. Every movement through the circle reveals greater meaning of the phenomenon. The meaning emerges as a result of the movements between the parts and the whole. A definitive interpretation can never be reached due to the spiral relationships in the process of understanding. At some point,

a level of meaning will be reached that the researcher/ interpreter determines is adequate with regard to the particular phenomenon at that particular time.

Sullivan (1984) proposes four conditions for an adequate critical interpretation. An adequate account is negotiated. The interpreted must be able to identify themselves in the account given. If identification is not possible, it may be that the account reveals to the interpreted something that they do not want themselves or others to realize. It may be that the research itself is wrong. However, Sullivan proposes that a critical approach to research decreases that likelihood. An adequate account presents itself as an argument. A valid argument is a form of advocacy for a particular interpretation. There may exist more than one interpretation, provided that each of them meet the conditions for adequacy. An adequate account expresses an emanicipatory praxis. An emancipatory account will reveal to the participants that their world is constructed historically. An adequate account is critical. A critical account consists not of reiteration but of resymbolizations, in which the experience is interpreted for the persons being studied.

In a hermeneutic analysis all meaning is recursive. Meaning at any one point of analysis both depends upon and calls into question what has preceded it (Dyer, 1979). Interpretation is a relational act, involving a dialectic between analysis and synthesis, and must result in the

resymbolization of the experiences (Sullivan, 1984). In other words, the meaning the experiences hold for the participants is derived from both the experiences themselves and the interpretation of the experiences within its framework of meaning.

A hermeneutic approach to the understanding of the experience of home birth is carried out within the hermeneutic circle, and is revealed through the interplay between the parts and the whole of the experience. Birth is a complex phenomenon that consists of numerous constituent parts. The experience of birth can be examined within the four aspects of the hermeneutic circle. The nature of the birth experience is influenced by the different aspects of the birth process, such as the characteristics of the pregnancy, the length and intensity of labor, and the management of birth. The experience is also influenced by related phenomena, such as the relationship with the practitioner, choices in the management of birth, knowledge about the birth process, emotional support of significant others during birth, and the characteristics of the birth setting. The birth experience is also influenced by the history of a woman in her family and her society, including her past and present relationships, experiences, beliefs and fears. Lastly, the relationship between the experience of birth as it occurs in our society and the characteristics of the larger Western civilization influences the characteristics of the birth experience. For instance, birth in a commune in

Northern California may differ from most other births in larger society in terms of the differences between the smaller and larger societies.

All of the associatied physical, emotional, historical, political and societal components contribute to the resultant understanding of the meaning the experience holds for birthing women. Deeper understanding of the meaning of birth is achieved as each aspect of the birth experience is examined within its context. Deeper understanding of the constituent parts of the birth experience leads to deeper understanding of the phenomenon of birth, which in turn leads to an even deeper understanding of the different aspects of the birth experience.

The fifth canon of inquiry states that in all of the previous steps, the researcher must attempt to show the meaning of a phenomenon for his or her own situation. In doing so, the interpreter brings forth his or her own prejudgments about the phenomenon and his or her own tradition with this phenomenon. Essential to hermeneutic interpretation is the stipulation and critical examination of these prejudgments for their own meaning.

It has been argued that hermeneutic understanding rests on the sublimation of social processes entirely into subjectively intended or culturally transmitted meanings, which is problematic in that these meanings may conceal and distort as well as reveal and express the social, economic and

political conditions of life (Habermas, 1970, 1979). Hermeneutic interpretation alone is limited in scope because it ignores the role of authority and power in meaning constitution (Habermas, 1970). An adequate social methodology must take into account the contextual framework of social action and the empirical conditions under which traditions historically change. An historically oriented analysis of social systems must be integrated with interpretive understanding and critique of ideology, and must incorporate an emancipatory intent (Habermas, 1972). A critical interpretive psychology must incorporate the fact that human action is not solely under conscious control but is embedded in social conditions outside human awareness (Sullivan, 1984).

Chapter Three.

What's different about a hermeneutic approach to research?

It is necessary to examine the ways in which a hermeneutic approach to the study of the experience of home birth differs from other social science approaches, particularly empirical approaches and the clinical case study method. This will be followed by a discussion of the ways in which the canons of hermeneutics can be applied to the issue under consideration.

A hermeneutic approach differs from empirical approaches in several ways. A formal, predetermined theoretical framework is an a priori condition of most empirical approaches. From this framework, hypotheses are derived and tested. Usually, the methodology that is selected is the one that will best provide the data necessary to test the hypothesis. When questionnaires are used, they are designed to elicit responses to questions or issues the researcher deems as most salient to the problem. Aspects of the experience that are overlooked or not considered important will be unexplored. A hermeneutic approach does not begin with an a priori formal, predetermined theoretical framework. Rather, the framework is formulated as the meaning of the phenomenon under consideration is revealed through interpretation. The researcher must constantly question the evolving framework as it relates to his or her own prejudgments

and to the various aspects of the phenomenon. In essence, the formulation of the framework takes place within the hermeneutic circle.

This thesis represents an attempt to formulate a methodology based upon my interpretation and application of philosophical hermeneutics. Thus, the methodology is not a well-developed one. Empirical approaches are premised on the existence of a priori theoretical frameworks, whereas a hermeneutic approach is not. The differences between the proposed methodology and the methodologies used by most empirical approaches reflects the differences in the frameworks.

In a methodology informed by hermeneutics, no rigid, predetermined interview is used. Rather than having to fit her experience into the categories predetermined by the interviewer, the respondent tells her story in her own words. This is similar to a focused interview, with the characteristics of the particular woman's experience determining the focus and direction the interview is to take. A hermeneutic approach focuses on the dialogue between the interviewer and the participant. The participants are encouraged to discuss whichever aspects of the birth experience are most salient to them, and to ask questions of the interviewer. The interviewer can ask the participants questions in order to clarify aspects of the experience that are unclear and to address issues of interest to the

interviewer that have not been discussed. This dialogue provides the text for interpretation, from which the meaning of the phenomenon of out-of-hospital birth emerges.

Empirical approaches frequently attempt to control for individual differences by categorizing the experience into various compartments. The hermeneutic approach described above deals with individual differences by incorporating the range of experiences into the methodology. Two subsets of the participants have been brought together for discussion groups about their various birth experiences. The discourse among the participants and the interpreter will act as another method for obtaining intersubjective validity. Rather than taking the viewpoint or experience of others as providing an individual's account of meaning, in the hermeneutic approach it is used to clarify the range of different experiences as well as the socially shared meaning. The group format facilitates the check on intersubjective validilty among the participants and provides a method for assessing the accuracy of the researcher's interpetation of the birth experience.

In empirical research, the researcher is often in a privileged position which may be exercised as one of dominance over the participants. The relationship between researcher and participant in a hermeneutic approach is interactive and depends upon the establishment of a dialogue between the parties. The researcher does not seek to predict or control the behavior of the respondent. What is sought is bilateral

communication, with both researcher and respondent asking and answering questions. The researcher has a responsibility to the respondents to make his or her own experience accessible.

A hermeneutic approach, based upon my interpretation of the methodological implications of hermeneutics, has many similarities with the case study method used in clinical approaches. In both approaches, the focus is placed upon the researcher or therapist / participant dyad, and the dialogue between the parties provides the text for interpretation The experiences of the participants are interpreted within the context of the persons' lives. However, most clinical approaches focus only on the experience of each individual, whereas a hermeneutic approach is concerned with the social meaning of an experience or phenomenon. The goals of most clinical approaches are helping the participants and spurring them onto change or action. In a hermeneutic approach, the participants are helping the researcher to achieve the goal of understanding the phenomenon.

In most anthropological research, the responses and behaviors of a community to a particular event is of interest. In these accounts of childbirth, the participation of the birthing women and the members of the society are described. Yet although it is possible to derive some limited sense of the experience of the women from the descriptions, the focus is on the society's experience of the event and not on the meaning the experience holds for the birthing women. A hermeneutic

approach, by contrast, is concerned with the meaning childbirth holds for birthing women within a particular culture, and the tension between the individual meaning and the social meaning of the phenomenon. Kitzinger's (1962, 1972, 1977, 1980) anthropological studies are an exception to the usual anthropological focus since she examined women's individual experiences, but her method cannot be considered hermeneutic for three reasons. A hermeneutic approach, as I have interpreted from philosophical hermeneutics, relies on the dialogue between researcher and participant to provide the text for interpretation. In Kitzinger's research she interprets the birth experience from written accounts provided by birthing women. There's no dialogue nor an attempt to ascertain intersubjective validity. Secondly, Kitzinger's method does not explicitly take into account the prejudgments of the interpreter and the participants, nor does it provide a means for the researcher to check the legitimacy of assumptions that may be attached to the phenomenon in the research process. Most importantly, Kitzinger's work does not place the experience of birth within the hermeneutic circle. The birth experiences are not examined as they relate to the four aspects of the hermeneutic circle, from the relationship between the birth process and its constituent parts through the relationship between birth as it is experienced in a given society and Western civilization as a whole.

Application of the canons of hermeneutics to social science

research.

The canons of hermeneutics suggest guidelines for approaching a research problem in a way that will yield a high level of intersubjective validity. The canons emphasize what must be taken into account in the research process. They do not, however, stipulate how a researcher might apply the canons to a particular study. The application of the canons to social science research presented below is derived from my interpretation of Kockelmans' (1979) work.

Researchers bring to their projects attitudes and beliefs which affect the ways in which they conceive the problem at hand. The phenomenon under consideration may become imbued with meanings derived from the researcher's own prejudices. Thus, he or she must be aware of the differences between the phenomenon itself and the meanings he or she attaches to it. The researcher's biases or prejudices are not to be "controlled for" nor counterbalanced by the inclusion of another researcher who holds opposite views in the project. Rather, the researcher must be aware of his or her prejudgments during every step of the research process. The existence of philosophical prejudices is accepted as given; awareness of their effects is necessary to preserve the legitimacy of the interpretation.

The historicity of the phenomenon both in relation to a given society and its members influences its meaning. The phenomenon under investigation must be addressed within its

political, economic, social and physical context, past and present. The meaning a phenomenon holds for a society and its individual members evolves as these contexts change over time. Interpretation of the meaning a particular phenomenon holds for the participants of a study must incorporate this historicity. Understanding of the phenomenon in its various contexts can be achieved by placing the analysis and interpretation of the phenomenon within the four levels of the hermeneutic circle.

Intersubjectivity of the interpretations among the participants must be evaluated. This can be accomplished by presenting the study participants with the interpreter's findings and examining the fit between these interpretations and the participants' interpretations of their own experiences. A group of study participants can be brought together for the purpose of initiating a dialogue among them in order to assess the fit between the researcher's interpretation and the individual and collective interpretations held by the members of the group.

The researcher must be aware of the function of the hermeneutic circle. The meaning of a phenomenon will emerge as a result of the movement between the layers of understanding revealed through interpretation and the emerging whole or mosaic of the experience. Each new layer of understanding shapes the mosaic of the meaning of the phenomenon, which in turn influences the interpretation of other aspects of the experience. In essence, interpretation takes place within the

social, political, economic, physical and historical context of the phenomenon. Each aspect of the phenomenon influences the meaning which is revealed, and each aspect is considered in a new light as a function of the emergent meaning.

Critical interpretation.

Interpretative social science research must be accompanied by critique of both the meanings held by the participants in a study and the prejudgments brought to the analysis by the interpreter. Ideological critique involves analysis of the social context of the phenomenon in order to examine the origin and historicity of the meanings that have become attached to the phenomenon by the members of society. Critique is necessary because the meanings held by a society may conceal as well as reveal the social, political, historical, physical and economic context in which the phenomenon exists. Similarly, the prejudments of the interpreter must be taken into consideration.

One method of critiquing the prejudgments of the interpreter and the validity of the interpretations is to have another person or persons listen to or read transcripts of the interviews used in the study. The other persons can point out contradictions and discrepancies in the interviews and interpretations, and raise questions about the prejudgments of the interpreter and the assumptions that are present in the analysis of the interviews.

## Chapter Four.

### Study approach.

The study approach was derived from my interpretation of the methodological implications of philosophical hermeneutics. A hermeneutic approach to the study of out-of-hospital birth set out to examine the phenomenon within its historical, social, and economic context in order to understand the meaning the birth experience holds for the women who choose such a birth setting. The study was archival and relied upon the women's recollections of their experiences. The women's stories were communicated to the researcher by means of a researcher/participant dialogue.

The four aspects of the hermeneutic circle provided the levels of analysis to be applied in the study. The birth experiences were analyzed with respect to the women's communities and the larger society, the women themselves and their own lives, both socially and historically, the birth itself and related phenomena, such as the relationship with the practitioner, and the birth itself and its constituent parts.

### A hermeneutic method applied to the study of birthing experience.

In a study of out-of-hospital birth, a researcher is likely to hold strong attitudes and beliefs about birth and its management both in and out of the hospital. It is necessary that the researcher stipulate his or her prejudgments in order

to adhere to the canons of hermeneutic inquiry. Through personal as well as research experience I have come to perceive birth as a natural function not in need of medical intervention. A strong belief in the need for birthing alternatives may cause a researcher to accentuate the positive aspects of out-of-hospital birth. Therefore, I had to be constantly aware of my prejudice throughout the research process, during data collection and particularly when interpreting the birthing experiences.

The meaning of childbirth is socially defined and is the product of centuries of redefinition according to the customs of each period. The social, political, economic, physical and historical context of childbirth determines its past and present meaning. The study had to take into account the historicity of the meaning of childbirth by carefully researching the societal changes that have influenced both the management and experience of childbirth. Historical changes in the nature of the birth experience were addressed as evolving out of a dialectic between individuals and their society.

The meaning out-of-hospital birth holds for the women in the study was revealed through the function of the hermeneutic circle. The meaning of childbirth emerged as a result of the movement between the layers of understanding revealed through interpretation and the emerging whole or mosaic of the experience. Every reading of an account of home birth led to a deeper understanding of the phenomenon. Every

interview revealed more about the experience. Each new layer of understanding shaped the mosaic of the meaning of home birth, which in turn influenced the interpretation of other aspects of the experience. Interpretation takes place within the social, political, economic, physical and historical context of childbirth.

A hermeneutic approach places birth within its historical context, including the history of the women themselves. The influence of prior birth experience on the choice and experience of out-of-hospital birth was therefore of interest. Several criteria were used for selecting study participants. The range of birth experiences included prior hospital birth, prior out-of-hospital birth and no prior birth experience. For recent home births, preference was given to women whose most recent birth had taken place within the last three years. However, the time limit was flexible in order to obtain participants in every category.

Because childbirth takes place within an historical, social, economic and political context, an effort was made to represent women of diverse socioeconomic, racial and ethnic backgrounds. The trend of choosing alternative birth settings has been associated with white, educated, middle class women. Several midwives known to attend home births in the New York Metropolitan area confirm this belief. The inclusion of a subset of women representing other socioeconomic groups addresses whether this image of women choosing home births is

representative of other women choosing home birth in our society. The women in the study represent a range of ethnic and socioeconomic backgrounds (see Tables 13, 14 and 15). However, all the participants were caucasian, and most had some college background (see Table 16). The characteristics of the participants and the conspicuous absence of women of color from the clientele of several known home birth attendants will be examined in the analysis section of this thesis.

The meaning childbirth holds for a given society varies as a function of the historical, economic, social and political context in which it occurs. For this reason, a small number of women who had home births prior to 1960 were incorporated in this study. The effects of the women's movement and the women's health movement, and the changes in the political, economic, social and technological aspects of birth management on the choice and experience of out-of-hospital birth were of interest.

The findings from the study were presented to each woman in the sample on an individual basis to examine the intersubjective validity of the emergent meaning, in other words, to see whether the interpretation was relevant to the actual birth experience. Interpretation and critique of the reactions of the women to the findings are presented in the discussion section.

Two subsets of the women who have had recent home births were brought together for the purpose of initiating a

dialogue among them about their birth experiences. The results of these group discussions served to check the validity of the assumptions held by the researcher about home birth and the validity of the interpretations. It also allowed the researcher to examine the intersubjective validity of the birth experience among the participants. This provided a double check on the validity of the interpretations by assessing the intersubjective validity among the researcher and each individual participant and among the participants as a group -- the shared meaning.

Without including the group in the methodology, it would be difficult to determine whether the shared meaning of the experience of home birth emerged out of the interpretation of the individual experiences. Attending the group gave some of the women who did not know of others choosing home birth the first opportunity to discuss their birth experiences with other home birthers.

The analysis and interpretation of the individual and group interviews are accompanied by critique of both the meanings held by women choosing out-of-hospital birth and the prejudgments brought to the analysis by myself as interpreter. Ideological critique involves analyzing the social context of childbirth in order to examine the historicity of the meanings that have become attached to it by members of society. As stated earlier, the meanings held by society may conceal as well as reveal the social, political, and economic context in

which a phenomenon exists.

Critique of the prejudments of the interpreter and the validity of the interpretations was provided for by having other persons listen to and read some transcripts of the interviews in order to point out contradictions and discrepancies. Members of the dissertation committee have performed this task.

Procedure.

Acquisition of participants. The geographic location of the study was restricted to the New York metropolitan area. In a city the size of New York, women can choose among several traditional and alternative birth settings within the confines of a hospital. The reasons for choosing out-of-hospital birth when such a large number of birth settings are available will be of interest.

Six women who had home births prior to nineteen-sixty were included in the study. Two of the women I interviewed were the aunts of one of the women who had a recent home birth. Another participant was my grandmother, who gave birth to my mother in the hospital and, four years later, gave birth to my aunt at home. The other three participants were referred to me by friends and acquaintances. I was able to locate several women in their fifties and older who were born at home, but most of their mothers were deceased. I had a good deal of difficulty locating women who either had home births or were born at home in the years between 1940 and 1960, at a time when

most births in the United States took place in the hospital (Devitt, 1977). For this reason, the home births for this group of women took place between 1920 and 1938.

Midwives who are known to attend out-of-hospital births and childbirth educators provided a major source of potential participants for recent home births. Brief descriptions of the research project were mailed or handed to the women by their practitioner, and the women themselves had the option of initiating contact with the researcher by returning a brief questionnaire. Once contact had been made with women who have had home births, their assistance in referrals to others who have birthed at home was requested.

Participants were contacted by telephone and were provided with a brief description of the study. I explained that I would like to discuss with them their birth experiences, both in and out of the hospital, and their reasons for choosing home birth. If they expressed interest in participating in the study, I told them that I would be contacting them shortly to set up a time for the interview. Only one woman declined to be interviewed, saying that she really did not have the time. She offered to answer any questions that I had over the telephone, if it would only take a few minutes. I explained that I really preferred to do an in-depth interview in person.

All but two of the interviews took place at the participants' homes. Two of the women came to my home to be interviewed for reasons pertaining to logistics. About half of

the interviews took place in the living room and about half at the kitchen or dining room table. Virtually all of the women offered me something to eat or drink before or after the interview and I always accepted at least a beverage.

One individual interview was conducted with each respondent. All but two of the interviews with women having recent home births were tape recorded. The two women who felt uncomfortable providing a taped account were both actively involved in the alternative birth movement and requested that I take notes instead. Only one of the interviews with the women who had home births prior to 1960 was tape recorded. The women expressed a preference that I take notes because they were not comfortable speaking with the tape recorder on.

Interview. The interview consisted of an autobiography of each woman's prior and recent birth experiences. The interview format closely resembled a therapeutic interview in that the women were encouraged to express their feelings and beliefs about their experiences. The women were asked to talk about their reasons for choosing home birth and what the births were like. If the women asked me what I wanted to know, they were asked to talk about whatever they felt was relevant to their decision and their experiences, both in hospital and at home. Once the dialogue began, the women's stories unfolded with little need for prompting. The women seemed glad to have the opportunity to discuss their births, and were very candid. Aspects of the experiences that were unclear were questioned by

the interviewer during the course of the interview.

The length of the interviews ranged from one half hour to forty-five minutes with the women who had home births before 1960. For the women who had recent home births, the range was forty-five minutes to one and three-quarter hours, with most interviews lasting about an hour and fifteen minutes. The fact that the earlier home births took place at least forty-eight years ago affected the amount of detail the women retained about their birth experiences, which can explain the shortness of their interviews. Also, the sweeping changes in labor and birth management took place after their births (Shorter, 1982), thereby eliminating a topic of conversation ubiquitous in the interviews with women having recent home births.

Group discussions. I arranged for three groups of women to meet at my home to discuss their birth experiences. Most of the women expressed a preference to have their youngest child present during the discussion, often because they were currently breastfeeding or preferred to have their child remain by their side. One discussion group consisted of three women who had only home births and another consisted of two women who had both hospital and home births. Each group was supposed to consist of five women but there were many cancellations due to sick children, oversleeping, work commitments, naps that arose unexpectedly, and so on. I tried to arrange a discussion for a third group of women, setting up two meetings on two days. I found out minutes before each meeting was to begin that more

than four out of six expected participants had to cancel. The reasons given were the same as for the no-shows in the other two groups. Many of the women scheduled for the third group said that it was likely that they would cancel again at the last minute for similar reasons, so I did not attempt to reschedule a third time.

The two group discussions lasted about one and one half hours a piece, and the format was conversational. I introduced the women to one another and asked them to tell each other a little bit about their birth experiences, and the dialogue flowed from that point. The content of the dialogues and their relationship to the assessment of intersubjective validity is discussed in a later chapter.

Although a hermeneutic approach to the study of childbirth focuses on the shared meaning the phenomenon holds for the women in the study, the data and thematic analysis is derived from the women's individual characteristics and experiences. The following chapter provides the reader with a sense of what the women in the study are like and the characteristics of a "typical" home birth.

Chapter Five.

The interpretation and critique of the choice and experience of out-of-hospital birth for the women in this study is derived both from the experiences themselves and my approach to these experiences as researcher/ interpreter. As a researcher on birthing and as a woman who has experienced childbirth, I hold strong opinions and beliefs about the nature of hospital birth and the need for birthing alternatives. Through previous research I have come to believe that hospital birth is largely under the control of physicians, and birthing women themselves have little or no choice in the management of labor and birth. Labor and birth are treated as processes in need of medical intervention, a practice I have come to believe unnecessary and potentially dangerous.

My own birthing experience took place almost three years ago in a hospital birthing room with a midwife in attendance, and occurred with a minimum of intervention (no IV, monitoring, medications, or episiotomy). My postpartum hospital experience was positive as well, primarily because I had full-time rooming in and was able to go home as soon as I liked. What I learned through my birthing experience was that, in my opinion, hospitalization is not necessary for routine, uncomplicated childbirth. This in turn strengthened my commitment to supporting the need for alternatives to traditional hospital birth.

All of the women who participated in the study inquired about my own birthing experience and my feelings towards home birth. I discussed my own experience with them and told them that I believed that birth was a natural process and that home birth was a safe alternative to hospital birth.

I became pregnant with my second child while in the process of interpreting the women's experiences of home birth. Although I had been considering out-of-hospital birth for some time, my experiences in interviewing the women about their home births and the process of interpretation reinforced my desire to give birth outside of the hospital. The idea of home birth strongly appeals to me, and I have no doubts about its safety. However, I chose to give birth in a freestanding birthing center staffed by Certified Nurse Midwives as opposed to at home, as a compromise between myself and my husband, a physician who is not comfortable with the idea of home birth. My second child was born one week prior to the dissertation defense, with my son, my husband and a good friend present. We came home five hours after the birth. The birth was a wonderful experience, free of intervention, and I am convinced that an out-of-hospital birth was the right choice for me.

The study of home birth had personal implications for my life that went beyond my own births. Several of my friends are health care professionals, and a few have entered into practice in Obstetrics and Gynecology. My husband's colleagues are physicians, as well. I was surprised to find a high level

of interest and support both for the research and for my choice of birth place among a group of persons trained to rely on technology and intervention. They gladly provided medical information and literature when asked and were a constant source of encouragement, even though I was working on a project that might have been construed as anit-medicine or anti-physician.

The following sections of this thesis present my interpretations and critique of the women's experiences of out-of-hospital birth. These interpretations focus on the socially shared meanings the experiences hold for the women in the study. However, the text of the interviews themselves provide the basis for interpretation and critique. For this reason, it will be helpful to the reader to have some idea of what the experiences were like for the women in the study. For that purpose, two transcripts of interviews with women who had recent home births are provided in the Appendix.

The two experiences described in the transcripts are fairly representative of the range of experiences reported by the women in the study. As will be demonstrated in later sections of this thesis, the characteristics of the birth experiences do vary from woman to woman and from birth to birth. These individual experiences provide the subject matter for interpretation and critique because the themes characterizing the experiences are derived from the actual stories of the birthing women.

Chapter Six.

## Characteristics of study participants.

### Home births before 1960.

Demographic characteristics of the participants who had home births prior to 1960 are provided in Tables 1 - 7. All but one of the women are from working-class backgrounds, and all but two emigrated to the United States from Europe. All of the women's home births took place between 1920 and 1939, at a time when fewer than forty percent of births in the United States took place in the hospital (Devitt, 1977). Women who had home births between 1940 and 1959 did so at a time when eighty-eight to ninety-six percent of births in the United States took place in the hospital (Devitt, 1977). Thus, the participants' home birth experiences differ from the experiences of women who had home births in later decades by virtue of the transition of the common place of birth. Many of the participants' home births took place during the Great Depression, at a time when only one of the women had a family income. It is likely that women from middle or upperclass backgrounds, and or those who belonged to families who retained their wealth during the depression had home birth experiences that differed from the women included in the study.

### Recent home births.

Midwives and childbirth educators provided the source of potential participants for the study. I contacted two midwives listed in a directory of alternative

birthing services and asked for their assistance in locating women who had recent home births. One of the midwives agreed to mail out interest questionnaires to her previous clientele, and another agreed to have her receptionist hand out the questionnaires at postpartum checkups. Both midwives are black women trained as Certified Nurse Midwives. The midwife who agreed to mail the questionnaires for me is in her forties, was trained in Great Britain, and is originally from an Island in the West Indies. She has teenaged children and sees her clients for prenatal care in her home. Her approach to childbirth stems from perceivig it as a natural occurrence and she rarely intervenes in the birth process. She insists on seeing her clients for a minimum of two prenatal visits. Additional visits are optional, but will be scheduled at the request of the pregnant women. The other midwife is in her thirties and does not have children of her own. She was trained in the New York Metropolitan area and has an office in Manhattan. Her approach to childbirth is noninterventive. She prefers to see her clients for regularly scheduled prenatal visits, usually on a monthly basis early in pregnancy and more often in later months.

A certified childbirth educator provided me with a major source of participants. I had contacted La Leche League in hopes of locating home birthers among their members. One woman referred me to this childbirth educator in her thirties who had had three home births and has written a book on home

birth. She knew of many women who had had recent home births and agreed to mail questionnaires to them. One of women with whom she had put me in contact was also a childbirth educator in her thirties, and she in turn contacted two prospective participants on my behalf.

The women themselves had the option of contacting me if they were interested in participating. The majority of responses to the interest questionnaires were returned to me within one month of their initial mailing by the midwife and childbirth educator. The other midwife had the questionnaires handed out in her office at postpartum checkups, and it took several months for responses to trickle in. The problems of selection by midwives and self-selection must be addressed. It is possible that the midwives selected women who they perceived were pleased with the outcome of their births, and that women who disliked the experience were avoided. One of the childbirth educators knew many home birthers through organizations supportive of home birth, and it is possible that these women differed from other women choosing home births as a function of their affiliations.

The response rate to the interest questionnaires was very high (above ninety percent) except for those distributed by the second midwife, whose clientele response rate was less than fifty percent according to the number of interest questionnaires handed out by the receptionist. It is likely that the experiences of these respondents differed from that of

the women who chose not to participate in the study. Since the questionnaires were handed out at postpartum checkups, it is possible that some of the women were two busy with their new babies to respond or did not feel up to discussing their experiences, or put the questionnaires aside for the time being and forgot about them. Similarly, it is not possible to know what the experiences were like for the ten percent of nonresponders from the other sources. The women who chose to participate may have felt the need to talk about their births and the reasons for their choices, or may be committed to furthering the alternative birthing movement by assisting in research. It may be that some of the women had such good home birth experiences that they want to share it with others. Some of the responders were dissatisfied with aspects of their home birth experiences, but none of them regretted having chosen home birth. The nonresponders may have had negative experiences with their midwives or their births, or they may regret their choice of birth setting. They may have been too busy to participate, or may feel uncomfortable about discussing something as personal as birth with a stranger.

Obviously, it was not possible to know all the reasons behind self-selection for this study. The interpretation and critique is restricted to those women who chose to participate. Several of the women who responded to the interest questionnaires told me that they welcomed the opportunity to discuss their home births with someone who would listen to

their reasons instead of judging them as crazy. Others stated a desire to contribute to any research that was supportive of birthing alternatives. The participants as a group differed from women represented in other studies on home birth primarily in terms of education and occupation. Most home birth studies have focused on white, middle-class, educated women. The women in this study are more varied in this respect.

Tables 8 - 16 present demographic information about the participants whose home births took place after 1960. Half of the women had prior hospital birth experience and half had only out-of-hospital births. One of the women in the latter category used a freestanding birthing center for her first two births and choose a home birth for the third.

Every effort was made to achieve a balanced sample in terms of socioeconomic, racial and educational background. I contacted most of the practicing home birth midwives in the New York Metropolitan region. When questioned, they characterized their clientele as being predominantly white middle class. My own data indicates that this characterization reflected a lack of class consciousness on behalf of the midwives, since the actual socioeconomic status of referred participants was varied (see Tables 13 - 16), particularly in terms of occupation.

In order to gain an understanding of the reasons for the absence of women of color from the clientele of these midwives, several of whom are themselves black, I asked them specifically about this issue. One argument that was presented

by several of the midwives was economic: Medicaid covers only in-hospital birth, and many insurance companies cover midwife-attended births only when they take place in the hospital or a birthing center. One midwife offered a reduced fee to poor black women in order to allow them to choose a home birth, but received few responses. This can also be looked at from a political standpoint, as pointed out by more than one midwife. When the decision was made as to what type of birthing facility to cover under public assistance, inner city public institutions were chosen. Women were denied a choice of alternative birth settings, unless they were fortunate to live in close proximity to the one city hospital that has an autonomous midwife-run birthing service. According to several obstetric residents who rotate through this unit, the service has a large minority clientele. None of the participants in the study lived in close enough proximity to this setting, and none mentioned interest in its services.

Five of the women in the study who had recent home births reported having no family income at the time of their home births, and no insurance. Several others found that their insurance did not cover home births. However, all of these women were able to pay for their home births out-of-pocket, which would not have been possible unless they had some access to money, either in savings or by borrowing. These women had a choice of where to give birth simply by having access to some means of paying for the home birth. Had they been unable to

pay for the births, it is possible that they would have ended up using a local municipal facility.

Several midwives who have worked in municipal hospitals cited the lack of information about alternatives and money as contributory to the absence of women of color from home birth services. Women who are forced to rely upon the services of municipal hospitals are forced to accept whatever care they are given. Midwives inferred that the issue was more about class differences than racial differences. In New York City, as nationwide, institutionalized racism means incomes for blacks are lower than for whites, and a higher proportion of black households have incomes below the poverty level and are forced to use municipal serices. It is highly unlikely that doctors or other staff in these settings would provide information about alternatives. In addition, the recent alternative birthing movement was begun by white, middle class women who probably did not focus on disseminating information to other groups.

Another argument that has been made is that, to certain ethnic groups, such as West Indians and Latin Americans, the use of hospitals for birth represents a significant step forward, much in the way that it did for immigrants in the early part of this century. The same argument has been offered as to why breastfeeding is largely only popular among the white middle class.

Home birth attended by midwives is reportedly

widespread in the rural south among poor women, regardless of race. This may be due to several factors, including lack of local doctors and hospital facilities and the absence of the widespread conversion to hospital birth that occurred in the northeast. One participant in the study, who is caucasian, had four home births, two of them in rural Tennessee, and another had been using a midwifery service in Texas during a pregnancy that ended in miscarriage. Both reported that there was a much greater acceptance of out-of-hospital birth in these regions, as well an on-going tradition of lay midwifery. Another factor that cannot be ignored is institutional racism and its affect on the availability of health care to southern blacks. Frequently, blacks did not have access to the health care facilities which provided care to whites (Starr, 1982). Many blacks were then rendered choiceless in the decision of where to give birth; the only option available was to give birth at home.

Obviously, the ability and desire to use any particular birthing method will be affected by economics, the available institutions and their perspective, and the availability of information, as well as previous experience, both cultural and personal. While there are undoubtedly some women of color using home home birthing, it was impossible for me to locate them, despite several different avenues of approach. All of these factors seem to have made the use of home birthing in the New York City area at the present time a method used almost

exclusively by white women, and although none were poor, they did vary in class position from working-class through upper middle-class (from household incomes of $10,000 through over $50,000 per year). Thus, these women differ in socioeconomic status from the women whose home births were reported in other studies. The interpretation and critique of the experiences of the participants in this study are grounded in their particular racial and socioeconomic contexts.

Chapter Seven.

The meaning of the experience of home birth is revealed through the interplay between the parts and whole of the birth experience. The components of the birth experience are examined within the four aspects of the hermeneutic circle. The analysis is circular rather than linear; every aspect of the birth experience both influences and is influenced by the other aspects. The four aspects of the hermeneutic circle, as they are applied to the study of home birth, are 1) the relationship between the birth itself and its constituent parts; 2) the relationship between the birth and related phenomenon such as the characteristics of the setting, the practitioner, etc.; 3) the relationship between the birth and the woman's past and present beliefs, fears, relationships and experiences in her family and society; and 4) the relationship between birth as it occurs in our society and Western civilization as a whole.

Because every aspect of the analysis both determines and is a function of every other aspect, the decision of where to begin is arbitrary. It is the choice of this researcher to begin the analysis with the fourth aspect and work backwards. The social meaning of the experience of childbirth is, by definition, a product of the nature of the society in which it occurs. For this reason, I have chosen to begin the analysis with the relationship between the experience of birth in this

society and society as a whole.

Hospital birth in our society.

The experience of birth as it generally occurs in the United States differs considerably from birth in Great Britain and Western Europe (Kitzinger & Davis, 1978; Jordan, 1983). The use of midwives as birth attendants is ubiquitous in Europe, and home birth is much more common, particularly in Holland, where it is the norm. By comparison, only a very small percentage of births in the United States are attended by midwives, and even fewer take place at home. Doctors control birthing, and many insurance companies provide only for hospital delivery.

The use of twilight sleep (scopalamine and morphine) during labor and ether and chloroform at the time of birth in order to render women unconscious gained prevalence in the early nineteen-hundreds, and had reached widespread usage by the nineteen-thirties (Shorter, 1982). The use of spinal anethesia, which enabled women to remain awake but without sensation below the waist and required the use of forceps, began in the nineteen-forties (Shorter, 1982).

Disagreement exists about the reasons behind the growing usage of anesthesia in labor and childbirth. Shorter (1982) attributed the increased usage to women's desire for relief from the horrors of childbirth. Physicians were viewed as giving the women what they themselves were seeking. In contrast, Wertz & Wertz (1977) saw the increased usage of

anesthesia as another way for physicians to maintain control over childbirth. In the first half of the twentieth century, the women's movement focused on the right to use birth control, not on childbirth (Gordon, 1974). Since the eighteen-hundreds, male experts have sought to exercise and maintain control over virtually all aspects of women's lives, from work to childbearing to social behavior (Ehrenreich & English, 1978). It follows then that the use of anesthesia and technology in childbirth was an outgrowth of physicians' desire to control women's bodies. Women's relationships with their physicians represented a microcosm of the larger society.

The natural childbirth movement was introduced in the nineteen-twenties by Read, applied by the Soviets following World War II as a psychoprophylactic method, and brought to the United States by Lamaze in the late nineteen-fifties (Wertz and Wertz, 1977). The natural childbirth movement revolutionized hospital birth by arguing that women should have the opportunity to be awake and aware for the birth and to have a support person present. However, increased acceptance of prepared childbirth by physicians and hospitals coincided with a sharp increase in the use of technology in labor and birth management (Brackbill, Rice & Young, 1984). Originally, the focus of natural childbirth was to educate and prepare women to have drug-free births by relying on relaxation or distraction methods to deal with the discomforts of labor. With the technological explosion of the nineteen-seventies, the focus

shifted to "prepared childbirth" (Brackbill, Rice & Young, 1984), and the use of electronic fetal monitoring to assess fetal well-being during labor (Shorter, 1982). Women could still be awake and aware, but were often hooked up to fetal monitors and instructed to watch the monitor printout to begin breathing at the onset of contractions. Instead of focussing on their bodies, women were told to rely on machines to help them get through labor.

Giving women the option of being awake during labor and birth did not lessen physicians' control over the process. Although women were no longer rendered unconscious, their labors and births were out of their control and managed by their doctors. A woman can remain awake throughout labor and birth yet be hooked up to IV's and monitors, have her membranes ruptured, be given Pitocin to augment labor and an epidural to anesthetize the lower half of her body, and have the baby removed by forceps. There is a great deal of difference between being awake and aware and having a birth without intervention.

Malpractice premium rates for obstetricians in New York City are among the highest in the country, as are the rates of cesarean section in many of its hospitals (MariesKind, 1980). It is likely that fear of malpractice suits influences the degree to which labor and birth are managed (Brackbill, Rice & Young, 1984). In other words, if one does everything possible to insure a perfect outcome, then the chances of being sued

decrease. Most urban obstetricians do not remain with their patients during labor, particularly in busy labor units or in busy practices. The printout from the electronic fetal monitor provides a record certifying that the labor was monitored throughout its duration (Brackill, Rice & Young, 1984).

Around 1930, fetal indications began to be accepted for obstetric operations, even when the mother was in no danger (Shorter, 1982). Prior to this time, obstetric interventions were done for the convenience of the doctor or to make childbirth easier for the mother. The factors that led to the discovery of the fetus as a patient in its own right are unclear. According to Shorter (1982), the new concern about fetal outcome led to an explosion of intervention on behalf of the fetus. However, it is equally possible that the technological advances themselves gave rise to the focus on fetal well-being. Perhaps the physicians discovered a new way of exercising control over the birth process, by focusing on fetal outcome.

The discovery of the fetus as a patient in its own right paved the way for present-day interventive obstetrics. Obstetricians are very outcome oriented, and technological intervention provides their means of insuring a healthy baby. The quality of the experience for the birthing women becomes of secondary importance. In contrast, midwives remain with their clients during labor and are as process oriented as they are

concerned with the birth resulting in a healthy baby. The physical and psychological well-being of the mother is as important to midwives as the outcome of the birth.

Obstetricians work in "delivery rooms" but midwives work in "birthing centers" or in their clients' "homes." The choice of wording is not arbitrary. Most doctors "deliver babies," with the women a passive participant. Most midwives "attend births," and "assist" the women in the process. The choice of terminology reflects the orientation towards birth. Doctors and hospitals tend to rely on technological intervention and "deliver" babies for their patients. Midwives in birthing centers and at home are oriented away from intervention and assist women in labor and childbirth. Do women choose hospital birth because they believe that it is safer or more preferable to out-of-hospital birth, or do they choose it because it is the only option they perceive as available or appropriate?

Choosing hospital birth before 1960. The two women who chose hospital births for their first births did so at a time (1925, 1937) when the place of birth was in transition from home to hospital (Devitt, 1977). These women were born at home, as were most everyone they knew. Both had older sisters who had recently given birth at home. However, a growing number of women around them were choosing to go to the hospital to give birth. The women's physicians were in favor of hospital birth, so they decided to give it a try. Their

decision to go to the hospital to give birth did not create a problem precisely because the common birth place was in transition. They were viewed by friends and family as doing the modern thing and following their doctors' recommendations. It is important to note that these women lacked knowledge about their own bodies, particularly about labor and childbirth. They did not deliberate whether to go to the hospital or give birth at home. Rather, they adhered to the desires of their physicians.

Choosing hospital birth after 1960. The women in the study who had recent home births were all born in hospitals between 1939 and 1964, and most of their parents were born in hospitals as well. During the women's childhoods and adolescences (1945-1980), going to the hospital to have a baby was routine and rarely questioned. Physicians attended the births, and midwives were unheard of or thought of as "grannies" who attended births long ago, before their role was usurped by medical men beginning around 1915 (Ehrenreich & English, 1973a). When the women themselves were born, their mothers were likely to have been rendered unconscious for the birth, and had little memory of what it was like to birth a baby.

The choice of hospital birth must be examined within the larger context of women's lives. Societal expectations for sex-appropriate roles are handed down from generation to generation. Women have been traditionally encouraged to assume

the roles of wife and mother, and to leave matters beyond the home to their husbands. Similarly, women have been encouraged to rely upon experts for advice on subjects ranging from infant feeding to housecleaning (Ehrenreich & English, 1978). Passive acceptance of society's role prescriptions was the norm, as was following the advice of experts without question.

Half of the women in the study who had recent home births had their first one or two births take place in the hospital in the years between 1969 and 1982. Most of them never considered having the baby anywhere else, or even knew of alternatives. Many of the women said that they knew so little about pregnancy that they really didn't give a lot of thought about the actual birth. For example, one woman said that when she became pregnant for the first time nine years ago that "I didn't even know where my cervix was." In a society where virtually everyone gives birth in the hospital, there is nothing unusual about their selection of birth place. In the context of the women's lives, having a hospital birth was the expected behavior. The few women who were interested in finding out about birthing alternatives either found it very difficult to access information or were told by physicians and lay persons that the hospital was the safest place to be.

The lack of knowledge about birthing and birthing alternatives was perpetuated by physicians who restricted the flow of information to the women and sought to maintain control over birth. Inquiries about natural childbirth or alternatives

were often met with responses such as, "All of my girls get epidurals" or "You're crazy if you go to a midwife." Doubts the women had about standard procedures such as episiotomy were often met with "I only use episiotomies when necessary, but I find them to be necessary 98 percent of the time." For the women who had their hospital births after the mid-nineteen seventies, the use of IV's and fetal monitors was almost universal. Questions often went unanswered, and the women were told by their doctors "not to worry about it, just let me take care of everything and I'll give you a healthy baby."

The physicians maintained control over the women and over the births often by treating the women like children who were told only what it was thought they needed to know. One woman was told by a doctor four years ago when pregnant with her first child to "do me a favor and don't read anything. I'll tell you everything you'll need to know." Another woman was told that her requests to avoid an episiotomy and to nurse on the delivery table were ridiculous. The doctors were in charge of labor and birth and the majority made decisions about intervention without consulting the women.

The characteristics of the hospital birth experiences will be discussed in greater detail the next chapter. What is significant here is that the nature of hospital birth and its management and physician's attitudes shaped the women's experiences and influenced their decision to ultimately give birth at home. Greater knowledge about childbirth gained

experientially and the characteristics of the experience of birth itself also contributed to their decision. As the analysis of the experiences progresses, the various aspects of the experiences and their relationships to each other will become clearer.

Home birth in our society.

Home birth before 1960. Six of the women in the study had home births during the years 1920 - 1938. During these years, the majority of births still took place at home (Devitt, 1977; Wertz & Wertz, 1977). Three of the four women who had home births for their first birth had their first child by 1925, at a time when home birth was very common in urban areas (Wertz & Wertz, 1977). The choice of home birth in that context meant simply following the usual way of doing things, and was not seen as remarkable by friends and family. The women were simply following accepted behavior, adhering to societal expectations.

Home birth after 1960. Since hospital birth is now the overwhelming norm in our society, almost all of the women in the study who had home births after 1960 met resistance from others when they told them about their home birth plans. Many had to convince their partners that it was safe. Often, their partners' fears were assuaged by speaking to the midwife about their concerns. The choice of home birth was surrounded by a veil of secrecy, a result of the attitudes in our society towards birthing altenatives. Many of the women did not tell

their parents about their choice of birth place until after the baby was born. One woman, who was thirty-six when she became pregnant for the first time, said "My husband and I kept the decision to have the baby at home to ourselves. We wanted to avoid arguing about the home birth." The women were often put in the position of having to justify their choice to others. The women themselves were not completely free of doubts or fears about the births, particularly for their first home births. The disapproval of others sometimes served to undermine their confidence. For this reason, many of them were reticent to make their plans well known. For subsequent home births, many women felt that justifying their position strengthened their own convictions. Reactions of others following the birth were typically that of "You got away lucky this time." Since many of the women did not know of others who had also had home births, they often felt isolated among other mothers.

Reactions from doctors, nurses and hospitals were no more positive. Many pediatricians reacted badly when informed about the birth place, and acted as though the women did a very foolish thing. Many of the women have not brought their babies to pediatricians for this reason. A few of the women had to bring their babies to the hospital for jaundice or other ailments not related to the place of birth and were told that it was their fault for having had the baby at home. They were often confronted by hostile hospital staff members who treated

them as though they were from "outer space."

In general, people who were aware of the home birth either thought the women were odd or very brave for making such a choice. Very few of the women received social support for their choice, unless they knew of others who had already had home births or were sympathetic to their reasons. Others tried to make to the women feel that they were different and had done something unusual, although none of them felt that they did anything so strange. Virtually all of the women stressed that home birth was a natural and logical choice when high-tech hospital birth was the alternative. One woman, who had her first baby in the hospital three years ago and a home birth last year said "What's strange to me is going into a hospital full of sick people and medical equipment for something as natural, healthy and normal as having a baby."

Choosing out-of-hospital birth for the first birth after 1960. The women's reasons for choosing out-of-hospital birth for the first birth have to do with prior experiences with doctors and hospitals, beliefs about medical practices and practitioners, professional training and personal approaches to birthing and life processes. These aspects of the birth experience will be discussed within the next level of the hermeneutic circle. What is relevant to this level of analysis are the ways in which the nature of hospital birth in this society influenced the decision to seek an alternative setting, whether at home or in an out-of-hospital birthing center.

When they became pregnant with their first child in the years between 1974 - 1985, all of the women knew others who had recently had hospital births. The women had heard about the high intervention and cesarean section rates and believed from what they had read and heard that there was too much reliance on technology and procedures that negatively affected babies' health and the quality of the birth experience. Many of the women expressed a reluctance to give over control of their births to doctors and institutions. Overall, they were dissatisfied with the characteristics and quality of hospital birth, and did not feel that it would suit their needs nor fit their expectations for the birth. They perceived birth as a normal process not in need of intervention and wanted to avoid the medicalization of childbirth that they believed took place in the hospital.

Unless the women already knew someone who had had a home birth, it was difficult to locate someone to attend the birth. It was often necessary for the women to call several hospitals and nursing schools in order to obtain names of home birth attendants. Interestingly, virtually all of the home birth attendants in the New York Metropolitan area are Certified Nurse Midwives or lay midwives. No physicians are known to attend home births in New York City. The National Association of Parents and Profesionals for Safe Alternatives in Childbirth (NAPSAC) has, for the last decade, kept track of alternative birthing services in the United States. About ten

years ago there were about five local physicians known to attend home births. However, in recent years a number of home birth physicians in the northeast have either lost hospital privileges or their license to practice medicine because they refused to stop attending home births. There was a lot of pressure placed upon physicians to restrict their practices to the hospital, probably because the hospital was losing patients.

Midwives are not immune to political and economic pressure to curtail home birth activities. Recently, insurance companies in several states have raised malpractice insurance premiums for Certified Nurse Midwives to equal that of obstetricians, even though Certified Nurse Midwives have few malpractice suits filed against them and serve only a low-risk clientele (The New York Times, 6-13-85; Daily News, 7-11-85). The rate hike is rumored by midwives to be supported by the American College of Obstetricians and Gynecologists. Only midwives in private practice or those who are not hospital based are affected; midwives hired, paid and supervised by hospitals are not. Hospitals only lose patients if the midwives attend births at home.

In summary, the meaning childbirth holds for a given society at a given time and the characteristics of the usual mode of birthing influences the choice of birthplace. In the first three decades of this century, the common place of birth shifted from the home to the hospital. At the same time, the

management of childbirth became more and more technological. Women who chose home birth fifty years ago did so at a time when home births were common occurrences. Women who choose to birth at home today are influenced by the changes that have taken place in the attitudes surrounding childbirth and the way birth is managed in the hospital. They choose home birth at a time when hospital birth is a nearly universal occurrence.

The factors discussed in this chapter contributed to the choice of out-of-hospital birth, and are interrelated to other factors surrounding the birth. The women in the study have a history of experiences and beliefs that influence and are influenced by their perception of the nature of hospital birth in our society. These beliefs and experiences within the family and society and their relationship with the experience of home birth comprise the next level of analysis.

Chapter Eight.

The choice of birthplace and the experience of birth do not take place apart from the daily realities of women's lives. Rather, the context of the women's life world determines the reasons for her choices and the nature of her experiences. The focus of this next level of analysis is to understand the relationship between past and present attitudes and beliefs, expectations, and experiences and the choice and experience of home birth for the women in the study.

The characteristics of the women's attitudes and prior experiences and the attitudes of those around them were determined by the context in which they originated and exist. The women who had home births prior to 1960 did so at a time when health care delivery took place on a much smaller scale, and family doctors who made home visits were common (Starr, 1982). In addition, these births occurred while the place of birth was in transition and before technological advances revolutionized the management of childbirth (Shorter, 1982; Wertz & Wertz, 1977).

The women in the study who had recent home births have a history of interaction with institutions in general and the medical system and hospitals in particular. These past experiences helped to determine their choice of birth place for first and subsequent births, and influenced expectations they held for the births. Similarly, attitudes held by these women

towards medical care and childbirth influence and have been influenced by their experiences. The experiences and beliefs of others such as family members and friends also influenced expectations and the women's choice of practitioner and birth setting.

Four basic themes are used to examine the historicity of the women's choice and experience of childbirth. The themes are interdependent and have emerged as a function of each other. The first is experiential, the second is attitudinal, the third is personal growth as a function of birth experience and the fourth has to do with control and responsibility.

Prior experience.

Home birth before 1960. None of the women in the study who gave birth before 1960 had experience with hospitals prior to their births. They had relied on a particular family doctor to attend to their needs, and the family doctor made house calls when someone was ill.

The three women who had both hospital and home births preferred their home births because they liked the more personal attention given to them by their doctors at home. Two of the three women recalled being left in a common labor room with several women who appeared to be in a lot of pain. They disliked the lack of privacy and the infrequency with which hospital staff members came to check on them. All of the women were awake during labor and birth, although they each recall being offered ether at the time of birth. The reason given for

declining the offer of ether was that they had already gone through discomfort and didn't feel the need to be "knocked out" for the birth. They also disliked the long hospital stay and preferred to spend the recovery period at home. The women reported that it was standard to be ordered by the doctor to remain in bed for at least a week regardless of whether you gave birth at home or in the hospital.

Home birth after 1960. Half of the women in the study who had recent home births experienced at least one hospital birth. For them, dissatisfaction with the hospital birth experience is perhaps the most compelling reason behind their decision to have a home birth. Most of these women knew little about childbirth prior to becoming pregnant and had little or no knowledge about alternatives to hospital birth. Several of the women had read a number of books on pregnancy and childbirth, but found only passing reference to birthing alternatives. A few of the women had heard about home birth, and one woman had attended the home birth of her sister-in-law's child. These women liked the idea of home birth but either had difficulty obtaining information about it, lacked the support of their partner, or believed that the hospital was the safest place to give birth to their first child. At the time, they viewed home birth as a great alternative for subsequent births only, once their ability to birth normally was proven.

The characteristics of the women's recent hospital

birth experiences are presented in tables 17 - 23. The women's experiences are typical of many women who have given birth in hospitals in the New York Metropolitan area (Lipkowitz & Cook, 1983; Lipkowitz, 1985). However, the hospital birth experiences of women in other areas are likely to differ as a function of the varying context of childbirth. The most common complaints the women had about their hospital birth experiences pertained to being treated by their obstetricians as a child who would be told only what the doctor thought they needed to know, and the rigidity of the protocols for the management of labor and birth, such as routinely doing episiotomies. As one woman said, "Every question I had was treated as though it was ridiculous, and anything I wanted for the birth was laughed off." Those women who had attended hospital clinics for prenatal care were unhappy about the lack of continuity of care that results from being a clinic patient. They saw a different obstetric resident at each visit and had no way of knowing who would be present at the birth. According to one woman, "Some guy could have walked in off the street into the delivery room and I wouldn't have known the difference."

The women perceived childbirth in the hospital as being out of their control and placed completely under the care of the doctors and nurses. They were there to "deliver" their baby, and the doctors were there to do it for them. In-hospital birth was an event in which they were a spectator, a feeling reinforced by the hospital's enforced separation

between mother and baby for most of the stay. Many of the women felt that the hospital acted as though they owned the baby until discharge even when rooming-in was offered, because there were so many regulations affecting the actual amount of time the baby remained in the mother's room. Several of the women had difficulty in arranging their baby's discharge before the baby was three days old because the pediatric department rigidly adhered to their protocol for discharge.

The depersonalization of the hospital itself greatly contributed to the women's dissatisfaction with hospital birth. A common feeling was that no one in the hospital cared about the patient as a person, that they were simply bodies on an assembly line. One woman who had three hospital births said "I felt as though I had been raped. No one cared about me or about what happened to me." Hospital rules about nursing on the delivery table, support persons at the birth, time of discharge, walking during labor, etc., reinforced the feeling of dealing with a rigid institution. Many of the women felt the hospital staff perceived all pregnant women as belonging to a single category such as "can not handle pain" and that these perceptions influenced labor management for every laboring woman. Individual differences were of no import. The fact that the birthing woman was part of a family was virtually ignored by many of the hospitals, and husbands were either reluctantly tolerated or excluded altogether. The women desired a more family-centered approach to birthing,

particularly so that their older child or children could participate in the birth.

The one emotion expressed by the majority of women towards their hospital birth experience was anger. This anger was directed at their practitioner for not providing them with answers to their questions or because of the way their birth was managed, towards the medical system because it treats women patients like helpless children, and often towards themselves because they did not know enough about what hospital birth was like before they gave birth or because they were too afraid to choose an alternative. They were angry about what childbirth has become in this society and because obstetricians perpetuate the lack of information about alternatives among their clientele.

Several of the women who opted for only out-of-hospital births had negative prior experiences with hospitals either as a result of conditions unrelated to pregnancy or when they were going to a doctor or clinic for prenatal care. Again, the depersonalized treatment characteristic of hospitals influenced their decision to have an out-of-hospital birth. Memories of being treated like a diseased entity instead of a person having a disease during a hospital stay remained sharp. The women who first looked into hospital birth were dissatisfied with what they learned. One realization they had was that your obstetrician will not remain with you throughout labor but will check your progress through the report of residents, and may

not even attend the birth if it is not his/her day on-call. The women were unhappy with clinic prenatal care because it precluded the formation of a relationship with the practitioners since the residents rotated in and out of clinic service, and there was no way of knowing who would attend the birth. Many of the women disliked that the pregnant woman was treated as separate from her family unit, with the partner was forced into the role of outside observer.

The women who had only out-of-hospital births did not need to experience hospital birth in order to be convinced to choose an alternative, possibly because their antipathy towards hospital birth emerged as a result of attitudes and beliefs that they held prior to their pregnancies. In contrast, the attitudes and beliefs of the women who had recent hospital births were altered by their hospital experiences. The nature of attitudes and belief systems is determined by the context in which these beliefs originate and evolve.

Attitudes and beliefs.

Home birth before 1960. These women gave birth at home betwen the years 1920 - 1938, at a time when the place of birth was in transition from home to hospital (Devitt, 1977). The women's attitudes towards birth were shaped by their knowledge that they and almost everyone they knew were born at home. Home birth was a common occurrence, and birth itself was seen as a natural process. During the nineteen-twenties, most of the women they knew were giving birth at home. Physicians had

not yet begun to routinely intervene in the birth process (Wertz & Wertz, 1977; Shorter, 1982). Therefore, the women's perception of birth was consistent with that of their birth attendants. The women who gave birth after 1935 became pregnant at a time when hospital birth had become the usual choice among their peers. However, these women had grown up in a time when home birth was typical and they continued to perceive birth as a non-medical, natural process.

Three of the women had planned to have their first births take place in the hospital. One woman was influenced by her cousin, who told her that it would be easier (less painful) in the hospital. The other two women became pregnant after 1935, and their doctor persuaded them to go to the hospital. However, none of the women believed at the time that the hospital was any safer than the home. In fact, one woman who gave birth in 1936 left the hospital after ten hours of labor against her doctor's wishes because she felt that being away from home was inhibiting the progress of her labor. Her doctor drove her home and attended the birth there.

The hospital experiences of these women reinforced their belief that birth was a normal, natural process. They found that the hospital did not provide them with any advantages over their own home and saw no reason to return for subsequent births. The women also did not want to leave an older child at home for the duration of a hospital stay. The only reason one woman had a hospital birth after a home birth

was because her doctor had reason to believe that she would hemorrhage after the birth.

The women's current attitudes towards birth have been shaped by the changes that have taken place in health care and birth management over the last fifty years. House calls by family doctors were replaced by office visits and sophisticated testing in hospitals. When the women were giving birth, hospital birth was first becoming popular. In the intervening years, hospital birth became almost universal, and the use of anesthesia and technological intervention increased. All of the women expressed mixed feelings about the changes that have occurred in health care in general and childbirth management in particular. They believe that health care has become too impersonal and too many tests are being performed. On the other hand, they've witnessed progress in treating illnesses that were, in the recent past, life threatening. All of the women had recent experiences with doctors and hospitals that were unsatisfactory because of the perceived impersonal treatment and the heavy reliance on tests, intervention, and medication that seems to do little to alleviate their ailments.

All of the women have grandchildren who were born in hospitals, and many have greatgrandchildren who were recently born in hospitals. They questioned the necessity of many of the procedures used in childbirth because they still believe that birth is a natural, normal process. However, all but two of the women think that perhaps birth is safer in the hospital

because of the availability of intervention just in case something goes wrong. The women's attitudes are both a function of their experiences with health care delivery over the course of their lives and the sweeping changes that have occurred in medicine and technology over their lifetime.

Home birth after 1960. Both groups of women, those with only home birth or freestanding birthing center experience and those with hospital and home birth experience, shared similar attitudes towards the medical profession and the management of childbirth. However, the origin of these attitudes differ. The women who chose to have only out-of-hospital birth based their decisions upon beliefs about the medical system and pregnancy and childbirth that they held prior to becoming pregnant. The woman who had her first two children in a freestanding birthing center held attitudes similar to those choosing only home births.

The attitudes and beliefs of the women in the study originated and evolved out of the social, political, economic and historical contexts of their daily lives. In other words, their attitudes and beliefs were created and shaped by the society in which they grew up and reside, and their own life histories as persons in that society and within their families. The attitudes and beliefs of others differ from these women as a function of these contexts.

Hospitals were perceived by many of the women as businesses run for profit, and doctors were viewed as being

motivated by money instead of by the desire to give health care. The use of diagnostic testing was perceived as based upon the generation of income for the hospital, the desire to avoid malpractice suits, and the benefits to patients of such testing was questioned. The management of childbirth was viewed in a similar light. Obstetricians were seen as largely out for economic gain, and intervention was viewed as serving to shorten the amount of time the doctor had to remain with a patient in labor. Tests and procedures were perceived as being performed for the purpose of avoiding malpractice suits. The women believed that many doctors characterized all pregnancies as high risk. Others felt that doctors intervened in the birth process because they had to be in control and could not sit by and let nature take its course. Some of the women viewed male doctors as mysogenists who enjoyed dominating women through controlling their reproductive functions. Two of the women were involved in professions that encouraged a natural approach to health care (midwifery and chiropractics).

These women all shared a strong belief that birth was a natural occurrence that did not require intervention. They felt that tests and procedures routinely used by obstetricians were not only unnecessary but often dangerous. They had been told numerous stories by other women about labor and birth and were appalled at the high rates of cesarean section and forceps deliveries for what seemed to them to be questionable indications.

The following quotes represent attitudes towards hospital birth held by the women in the study who have only had recent home births:

> "The trauma of being in a place like a hospital would have a negative effect on something as joyous as birth."
>
> "The medical profession focuses too much on what can go wrong instead of what things can go right."
>
> "Hospitals are for when you need intervention and people to save a life."
>
> "You're going to be prepared for surgery (shave and enema) and all you're going to do is have a baby?"
>
> "The medical profession retains too much control legislatively over childbirth. They should not have such power over women's bodies."
>
> "In the hospital, they are in control. At home, you are in control."
>
> "When there is equipment available, you can be sure the Doctor is going to use it."
>
> "Hospitals are for when you're sick, not for something as natural as having a baby."
>
> "Everything they do to you in the hospital is a way to fear: separating you from your family, hooking you up to IV's and machines."
>
> "The hospital takes a family event and turns it into a medical event."

The decision to choose home birth was well deliberated and based upon much reflection about what the women wanted for their births. The women did a lot of research about safety factors. All of the women who chose only out-of-hospital births did a great deal of reading about hospital birth and alternatives and based their decision upon the belief that they could best achieve the kind of birth experience they wanted by

giving birth at home. They also believed that it was often safer to have the baby in a place where intervention could be avoided. Several of the women expressed fear of having a hospital birth because of all of the things that could be done to them once they were in the hospital.

The women who chose hospital births also did a lot of reading about pregnancy and childbirth, but their choice of reading materials usually gave little mention of birthing alternatives. This is partly due to when these first births took place (see Table 10). Until the late nineteen-seventies, there were not that many books available on alternatives, and those books that were available, such as Immaculate Deception, were probably not recommended by the average obstetrician.

The women who had hospital births before they chose an out-of-hospital setting held many similar attitudes, but these attitudes were usually shaped by their hospital birth experiences and reading they had done subsequent to the births. Some of the women did have doubts about the benefits of intervention in birth but had little access to information in order to clarify their beliefs. As stated earlier, it was their dissatisfaction with their hospital birth experiences that was largely responsible for shaping their attitudes towards childbirth management.

Many of the women, regardless of their prior birth experiences, held very strong beliefs about natural approaches towards raising their babies. Many are vegetarian, and are

raising their children the same way. All but one woman breastfed, and all but one of the women nursed for at least one year. The majority of the women infrequently or rarely use pediatricians for routine care, and several of the women are not immunizing their children, and many of the male children were not circumsized. This natural approach is consistent with the women's belief that intervention is unnecessary in childbirth.

Beliefs and attitudes of others.

Home birth before 1960. For those women who gave birth at home in the nineteen-twenties, their choice of birthplace was accepted without question. There was nothing unusual at the time about choosing home birth. The women who had home births in the late nineteen-thirties encountered different reactions from their peers. Their families thought there was nothing unusual about choosing home birth, but other women of childbearing age did not understand why the women did not want to go to the hospital "to be taken care of" and "to be knocked out if you wanted it." The place of birth was in transition, and hospital birth was seen by many women as the modern way of doing things. According to the women in the study, many of their peers began to see home birth as old fashioned and old-worldly.

Home birth after 1960. The majority of women who had recent home births encountered opposition from friends and family, often to the point of open hostility to the idea. Many

of the women kept their birth plans a secret from their families to avoid confrontation over the issue. The primary concern of both friends and family was safety, and the question most asked by others was "what if...?"

The attitudes of others must be addressed within the context in which they arose. All of the women in the study were born in the hospital, as were most of their partners. Virtually all of their peers were having hospital births. Therefore, the ubiquitous belief was that the hospital was the place to give birth. Very few of the women were able to assuage the doubts of others, regardless of the strength of the arguments for home birth and against high tech hospital birth. The persistent belief held by others was that home birth was not safe, and that hospital birth was the proper avenue to pursue.

The partners of women who had hospital births were often resistant at first to the idea of home birth, primarily for safety reasons. Most of the partners were convinced by the women or the midwives of the safety of home birth and accepted the women's reasons for choosing to have their next child at home. Many of the partners were dissatisfied with the hospital birth experience and wanted to play a greater role in the birth. However, a few of the partners grudgingly went along with the idea of home birth, never really convinced of its safety. Two of the women divorced and acquired new partners prior to their home births. Their original partners were

strongly against the idea of home birth, a factor contributory to the breakup of their marriages. The women's partners for their home births were supportive of the choice of birth setting.

Most of the women who had home births for their first births had partners who shared their views of health care and hospital birth and were completely behind the idea of home birth. Perhaps these shared attitudes towards hospitals or intervention in natural processes were important aspects of their relationships long before the women became pregnant. The choice of home birth was easier for these women from the start because they had their partner's support.

Personal growth.

Many of the women spoke of their births in terms of personal growth (their words) and changes in their perceptions of childbirth. All mentioned having learned lessons from each of their births. For this reason, various instances of "personal growth" are discussed below.

Home birth before 1960. For these women, each birth reinforced their belief in birth as a normal, everyday occurrence. The women who had hospital births learned that hospitalization was unnecessary, and that the recovery period was much more pleasant at home, surrounded by family.

These women did not speak of their births in terms of growth experiences, possibly because personal growth is a concept that is an outgrowth of consciousness raising that

gained popularity in the nineteen-seventies.

Home birth after 1960. Every woman in the study held expectations about their first births. Very often, the women had been told by their mothers, sisters, friends, or others that birth was very painful, and expected difficulties. Others knew that their mothers had easy births and expected to have the same. Still others, perceiving birth as a natural process, expected to have everything go easily. The most common change in expectations occurred in those who expected difficult births, but everyone in the study experienced birth as a learning experience.

All of the women perceived their births as learning experiences. The lessons differed from woman to woman, but each believed that she had been taught something new by each birth. Many of the women had been told by their mothers and their friends that labor and childbirth were very painful, and doubted their ability to get through the ordeal. One woman said that "I really believed that something had to be done to me in order to make me go into labor, and then something had to be done in order to get the baby out," a belief expressed by several women. Birth was viewed as something necessary in order to become a mother, and the idea of the process of birth itself as pleasurable rarely occurred to the women when thinking about giving birth. Their reflections on their births and the reading that they did subsequent to their hospital births shifted their focus from birth as something fearful and

painful to birth as a wonderful process to be appreciated in its own right.

Following their hospital births, the women learned that they had a right to be informed about and participate in decisions about their care. If they had previously wanted to have a home birth but gave in to pressure to use the hospital, they learned to fight for what they themselves wanted for the birth. A few of the women had thought about home birth for their first or second births, but encountered such strong opposition from their partners that they went through with the hospital plan. For those who had second or third hospital births, they learned more about what they wanted and needed from their practitioners and discovered that it was better to remain at home in labor for as long as possible. They fought for their rights to avoid intervention, to nurse on the delivery table or to have early discharge, and their choice of practitioner was influenced by the practitioner's willingness to adhere to the woman's requests. Many of the women recalled that they felt they needed permission during their home birth labors to move during labor, to go to the bathroom, or to change positions. They learned from their home birth experiences that they did not have to ask permission from the midwife to do what they wanted. One woman, discussing her first home birth and third birth, said "I learned to submit to the labor instead of the authority of those around me."

With each birth, the women discovered ways of getting

through the discomfort of labor and the most comfortable positions and methods of pushing. They got to know how their bodies functioned during labor and birth and learned to accommodate their bodies' needs. They also discovered what type of emotional support worked best during labor and birth and knew what to expect both physically and emotionally during transition.

Regardless of whether or not the home birth was for a first birth or followed a hospital birth, each birth reinforced the women's belief in birth as a natural process. Several of the women recalled doubting during labor their body's ability to give birth. The experience of giving birth gave rise to faith in their own bodies and lessened their fears about childbirth. The effects of not being ready emotionally to let go and give into labor became apparent to many of the women. They learned that it was necessary to resolve whatever was holding them back, whether it was the presence of someone at the birth who made them uncomfortable or doubts about their ability to get through the labor that arose unexpectedly. Once they resolved the problem they were able to succomb to the labor. Many of the women reported that their midwives were able to spot when they were holding back and helped them to resolve the issue. One woman was making little progress in labor until her midwife brought her into the bathroom and told her to sit on the toilet. The woman perceived the toilet as a natural place for release and dilated more during the half hour

in the bathroom than she had in the previous six hours spent walking around her apartment.

The experience of childbirth affected the women's approach to birthing. Half of the women first approached birthing from a scientific viewpoint, basing their decisions on what they wanted for their birth upon what they believed was most beneficial healthwise for the baby. With subsequent births, their approach to birth became more spiritual, as they focused more on the experience of birth rather than the outcome. The presence of loved ones at the birth became more important, as did family bonding after the birth. One woman described the change in approach from matter of fact to spiritual. Half of the women first approached birth as something magical and awesome and, with each birth, perceived it as being an ordinary, everyday thing that was not so mysterious.

Five of the women, all but one of whom had hospital births, were motivated by what they had learned through their births and reading about alternatives to help others gain knowledge of and access to birthing alternatives. This gave one woman the impetus to become a midwife, and two became childbirth educators (one of whom is now studying to become a midwife). One woman is working with a childbirth educator to disseminate information about birthing alternatives, and another, who had her only child at home, is working in the office of the midwife who attended her home birth.

Control and responsibility.

Home birth before 1960. The issues of control and responsibility did not appear to be relevant to the women in this group. They all saw their doctors as in control of and responsible for their births, and willingly submitted to the doctors' authority. Perhaps this is due to the status of women at the time of these births. These women never questioned their doctors' right to control their births, just as they probably did not question their second-class status in society. They followed the social norms of the time. The women's movement that was active early in this century focused on voting rights and on the right to reproductive freedom (Gordon, 1974). The women included in this study were not part of this movement.

Home birth after 1960. Central to the choice of out-of-hospital birth for the women in this group are the issues of control and responsibility. These issues were salient for the women in the study precisely as a result of the context of the women's lives. Had the women lived and birthed in an area where hospitals and physicians approached birthing in a noninterventive way, and where the general attitudes about birthing focused less on technology and pathology, it is likely that other issues would have been salient.

The following discussion reflects the women's perceptions of control and responsibility in birthing. In the hospital, the doctors control birth. They decide where it

occurs, and often, through intervention, when and how it occurs. In the hospital, the locus of control belongs to the doctors. At home, the locus of control is negotiated between the woman and her attendant, a point to be discussed in detail in the next chapter. The birthing woman is responsible for deciding what she wants for the birth and takes the ultimate responsibility for its safety. No decisions can be made without her consent, and she doesn't need to ask permission to do what she wants, such as walking around during labor or taking a shower. The baby belongs to her and no one can take it away to the nursery. She can choose the room she wants for the birth as well as the surface on which it is to take place. Unless the woman goes to extraordinary efforts to convince her doctor and the hospital to grant her all her requests, as one woman in the study did for her second birth (a vaginal birth after cesarean section), no where else does a woman maintain such a high level of control over the birth. In out-of-hospital birthing centers the requests of birthing women about nonintervention and following their birth plan are usually adhered to but they run the risk of being transferred to the hospital during labor because of predetermined risk factors that may arise. At home, a woman has the right to refuse transfer if she believes it is unnecessary.

All of the women expressed fear of going to the hospital for the birth precisely because they did not want someone else to control their births. In the hospital you can

rarely be guaranteed that your doctor or midwife will be the one to manage your labor or attend the birth. Women are pressured to sign consent forms stating that they will allow whatever is necessary to be done to insure their health and that of the baby. Only at home did they feel they could retain control over their bodies and their births and insure that only their carefully chosen birth attendant would be present.

Responsibility for the outcome of the home birth was accepted by the birthing women. They knew that there was risk involved with any birth and believed that they were reducing that risk by having the baby at home. Rather than give over responsibility for the birth to a doctor and hospital, the women assumed the responsibility themselves and shared it with their birth attendant. The women accepted that, by taking an active role in decision-making during labor and birth, they were influencing the outcome of the birth. This responsibility did not frighten the women. Rather, it reinforced their feeling that they were in control of their bodies and of their births. The birth attendant was looked upon as someone to assist them in giving birth, and the relationship with the attendant was seen as cooperative rather than submissive.

In summary, the choice and experience of out-of-hospital birth takes place within the context of the women's lives, present and past. Prior experiences influence attitudes and beliefs about home and hospital birth, these attitudes and beliefs in turn affect the experience of

out-of-hospital birth. The issues of personal growth and control and responsibility were of much importance to the women who had recent home births, but held little relevance for the women who had home births before 1960.

Experiences, attitudes and beliefs helped shape the expectations the women held for their home births. The next chapter focuses on the relationship between the birth itself and related phenomena, specifically the relationship between the women and their birth attendants, the characteristics of prenatal care, the presence of support persons and others at the birth, and the importance of the actual place of birth.

Chapter Nine.

The characteristics of the birth experience are determined by more than just what occurs physiologically during labor and birth. The frequency and characteristics of prenatal visits and the relationship between the pregnant woman and her practitioner affect the development of trust a woman has in her birth attendant. Knowledge about the physiological and emotional aspects of labor and birth acquired experientially or through childbirth education classes influence the women's level of preparation for childbirth. The attitudes of friends and family affect the amount of emotional support available to the women for their choice of birthplace. The presence of others at the birth impede or enhance the experience, depending upon the woman's level of comfort with those around her at the time. The actual and perceived length of labor and degree of pain affect the experience, as do the characteristics and meanings attached to the actual place of birth. The focus of this chapter is on the interplay between these related phenomena and the birth experiences of the women in the study.

Prenatal care and relationship with practitioners.

Home birth before 1960. Physicians attended all but one of the home births that took place before 1960 (see Table 26). In the nineteen-twenties, physicians began to usurp the place of midwives in attending births (Ehrenreich & English, 1973a; Wertz & Wertz, 1977). Therefore, it is not surprising

that physicians were in attendance for these births.

Two of the women (sisters) used a physician who was a family friend, and all but one of the other women had used their physician for general health care. With the exception of the first birth of one woman that took place in Europe, each of the women had the same physician in attendance for every birth, regardless of whether the births took place at home or in the hospital. [The women who had recent home births did not have the option of using the practitioner from their hospital births because none of their practitioners attended home births, and few, if any, were supportive of the idea.] The women had a history of interaction with their doctors that continued through subsequent births. They were accustomed to being treated by a familiar family doctor, and desired to incorporate the familiarity into their births.

When these women were pregnant (1920 - 1944), it was still common for physicians to make house calls. As the women recall, the doctor came to their home for prenatal checkups once a month in early pregnancy and more often in the last trimester. Maternal blood pressure and weight were checked, as was the fetal heart rate by use of a stethescope. About half of the women recall having had their blood drawn and taken back to the doctor's office for assessment.

All of the doctors had hospital privileges, and the women were told that they would be transferred to the doctors' affiliated hospital in the event of complications. Because the

doctors had access to the hospital, there was no need for the women to arrange for a backup physician or institution. None of the women expected the need for transfer to arise, particularly since they had grown up in a tradition of home birth with hospital transfer an infrequent occurrence.

According to the women's recollections, pregnancy was treated by the doctors as a natural process rather than a pathological condition. They were not given restrictions on diet or activities, and were encouraged to go on with their daily lives. The women had come of age at a time when pregnancies were incorporated into women's daily lives, and their doctors' positions were consistent with this. The assumption held by both patient and practitioner was that everything was fine and that there was no need to worry. Pregnancy was a normal life event that did not interrupt the usual pattern of socializing, childcare, housework, or any other roles held by the women prior to their pregnancies. None of the women were employed when they became pregnant so it is not possible to determine whether their pregnancies would have caused termination of their employment.

Relationship with practitioners.

Home birth after 1960. Several home birth practitioners were used by the women who had recent home births, as shown in Table 27. One Certified Nurse Midwife, who provided a source of participants, accounted for more than half of the home births in the study. The frequency and

characteristics of prenatal care varied from practitioner to practitioner. Some midwives wanted to see their clients twice during pregnancy, leaving additional visits at the discretion of the pregnant women, and would accept women late in pregnancy. Others, including the one physician who attended a home birth, preferred monthly prenatal visits and wanted the women to begin prenatal care by the end of the first trimester. Most of the practitioners worked out of offices while others worked out of their homes. Some practitioners had a holistic approach to prenatal care, emphasizing the emotional as well as physiological aspects of pregnancy and birth. A few others focused primarily on physiological aspects.

The one physician who attended a home birth in 1973, when there were a few physicians known to attend home births in New York City, and the lay midwives were found by the women to be more relaxed in general than some of the Certified Nurse Midwives about hypertension and anemia during pregnancy and about breech and twin births. The women expressed the belief that the close regulation of Certified Nurse Midwives by New York State caused them to be more careful and rigid in their home birth criteria in order to retain their licenses. Thus, vaginal births after cesarean section (VBAC), and twin and breech births were avoided, and thirty-seven weeks gestation was the early cutoff for home births. Some women felt that their midwives placed too much importance on iron and blood pressure levels for the same reason. Many of the women

expressed annoyance that legislative control over birthing was able to influence their birth experiences by forcing their midwives to be too cautious.

The quality of the women's relationships with their home birth attendant seemed to be determined by the fit between the needs of the women and the practitioners' style of prenatal care and their personalities. Some of the women really enjoyed having a midwife who was very concerned about their emotional well-being, and spent many hours just talking with their midwives at prenatal visits. They felt a friendship with their practitioner that was hard to give up after the birth. Others felt that this type of relationship was too intrusive for their needs. Some women wanted a close, warm relationship but found their practitioner to be too cold and business-like. Some of the women felt strong personality conflicts with their midwives that diminished the quality of their prenatal care. However, none of the women felt that personality conflicts with their attendants adversely affected their births. The attendants were able to adapt their behavior to the needs of the women at the time of labor and birth, so that a midwife who seemed too intrusive during prenatal visits kept her distance at the birth if that's what she perceived the the needs of the woman to be.

One Certified Nurse Midwife never carried a beeper, a situation which caused anxiety among some of her clientele who participated in the study. The women wondered whether they would be able to reach her when they went into labor, and what

they would do if she was not at home. The midwife made an effort to tell her clients who were near term where she would be if she was going to be away from home for some time, and none of the women were unable to locate her when their labors began.

All of the women felt that they had a cooperative relationship with their practitioners, that they had an equal role in decision making during their pregnancies and birth. They were treated with respect and intelligence by their practitioners, something particularly appreciated by those who had been treated like children by obstetricians during previous pregnancies. Trust was a very important element in the women's relationships with their attendants. The women trusted their practitioners' knowledge and skill, and they trusted that their attendant would not intervene in the birth process without their consent.

There were several instances, however, of conflicts between the women and their midwives. These conflicts gave rise to negotiations to find a compromise position. Conflicts arose primarily about conditions under which the midwives would not want to attend the home birth, such as high blood pressure, anemia, or if the women went into labor too early or post-dates. The women feared being "risked out" of their midwife's care for these same reasons. The conflicts were resolved by having the women and their midwives decide upon acceptable and unacceptable levels of blood pressure, anemia,

etc., through negotiation. First, the midwives would suggest ways of remedying the problem, such as through diet. Then, the woman and her midwife would try to agree upon what would constitute a situation where hospital transfer was necessary. Even with the successful negotiation of a compromise position, the fear of transfer remained. All of the women were aware of the possibility of having to go to the hospital, yet the fear was far greater for those women who had these tendencies towards hypertension or anemia. The other women expressed the belief that the odds of a hospital transfer were so low that they did not dwell on the possibility.

The women negotiated with their midwives about what they wanted for the birth, in terms of internal examinations, birth positions and episiotomy. All of the women felt that their attendant was supportive of their requests. One Certified Nurse Midwife required two prenatal visits, but would see her clients more often at their request. Three of the women wanted to avoid monthly prenatal checkups, but their Certified Nurse Midwife would not agree. The women also negotiated about childbirth classes and backup for the birth. One of the midwives required that all of her clients see a specific backup doctor and attend classes with a specific instructor. These requirements were not negotiable, and two of the women were unhappy about that. Other midwives left backup and childbirth classes to the discretion of their clients.

Two of the women reported withholding medical

information from their midwives. They gave as their reasons wanting to avoid being turned down for the home birth. One woman had a premature birth in the hospital, followed by her child's death two months later. She also had a vascular condition that made pregnancy a dangerous condition for her own health. She told the midwife that her baby died but omitted the facts about the prematurity and the vascular condition. She was convinced that no midwife would accept her for a home birth if her history was revealed. One rationalization that she used for the omission was that her second (hospital) birth was full-term and she would go to the hospital if this pregnancy resulted in premature labor. Her desire to have a home birth, particularly to avoid repeating what she felt were terribe hospital birth experiences, led her to lie to the midwife and distort the facts. She developed a very close relationship with her midwife and said that she feels terrible about the deception, but that she had no other choice. Another woman decided not to tell her midwife that there was excessive protein in her urine because she was afraid of being "risked out." It is impossible to know whether any other women withheld information from their midwives, also out of fear of losing the option of home birth. The possibility is likely. Both of these women had prior hospital births. Does the desire for a home birth or the desire to avoid a hospital birth lead to such deception?

All of the home birth practitioners used by the women

encouraged their clients to be well read about pregnancy and childbirth and to express any questions or doubts they had about all aspects of the birth process. Rather than control the flow of information to their clients, the home birth practitioners preferred that their clients become as informed as possible. The midwives and physician were not threatened by their clients' knowledge, but welcomed it. This was very refreshing for the women in the study, particularly those who had experienced encounters with physicians who carefully guarded "the secrets" of pregnancy and childbirth, telling their patients only what they felt was necessary.

Eight of the women had two or more home births, and six of them used the same midwife for every birth (see Table 28). The majority of the women would use the midwife from their last birth for future births (see Table 29). Most of the women who did not or would not use the same midwife again gave as their reasons personality conflicts or a mismatch between their needs and the midwive's style, such as wanting a warmer relationship with a business-like midwife or a cooler relationship with an intrusive one. A few of the women questioned whether they would even use a birth attendant for subsequent births, an issue discussed in the following chapter.

Prenatal care - recent home births. About half of the women began prenatal care early in their pregnancies, and half waited until their second trimester. The women tended to begin prenatal care earlier for first births and first home births,

and later for subsequent home births. Most of the women saw their practitioners by choice three or four times, but a few practitioners required monthly checkups. Monthly visits were viewed by most of the women as unnecessary since they felt well and did not expect to have any problems, but a few women were reassured by frequent prenatal visits.

Few tests were routinely performed during prenatal care (see Table 31). Hemoglobin levels were checked periodically in order to check for anemia, and fetal heart rate checks were done using a fetoscope. The women liked the fact that pregnancy was treated as a healthy state, and few procedures were performed. Their practitioners' approach was consistent with their belief that pregnancy was a normal occurrence, a healthy state of being rather than an illness.

Most of the home birth attendants were concerned with the women's emotional as well as physical well-being during pregnancy. They encouraged the women to be open with them about anything that was troubling them, particularly if it was affecting the way the women felt physically. The practitioners saw their clients as more than just another pregnant body, focusing instead on the total person. All of the women appreciated this holistic approach to prenatal care, although some found their midwives to be too intrusive.

None of the procedures listed in Table 31 were ordered by the home birth attendants. Ultrasound and glucose tolerance tests were ordered by the backup doctor or clinic, and were

seen by the women as unnecessary. However,one women requested ultrasound for each of her four pregnancies because she continued to menstruate throughout pregnancy and wanted to know her approximate due dates. The women who had amniocentesis chose to do so because they were older than thirty-five at the time of their pregnancies and wanted to ascertain that their babies were healthy. Two of the women who were over thirty-five at the time of their pregnancies chose not to have amniocentesis.

In general, the midwives left the arrangement for backup at the discretion of their clients. Only one Certified Nurse Midwife required that her clients see a particular backup. The women's backup plans for the home births are presented in Table 32. Most of the midwives recommended a particular backup physician who practiced in Manhattan, and many of the women saw him once prior to their births. The women found him to be supportive of home birth, but did not feel that it was really necessary to be examined by a doctor to be cleared for the home birth. Backup was harder to find in the outer boroughs and in Nassau County, causing a few of the women to see obstetricians for monthly prenatal visits under the pretense of planning to deliver in the doctors' hospital. A few other women found obstetricians willing to serve as backup provided that the women came in for regular prenatal visits. Regular prenatal visits with the backup were viewed by the women as completely unnecessary, but were often tolerated

in order to maintain backup coverage. Examinations by backup physicians were perceived by the women as doing little more than duplicating care given to them by their midwives, and were often seen as a waste of time and money. The one woman who had a physician for her first home birth did not need to arrange backup since her doctor had hospital privileges.

Several women planned to use an emergency room as backup. Many of these women had negative prior experiences with clinics or with backup doctors who tried to convince them to have diagnostic tests or hospital births and decided to avoid confrontation with backup personnel. Others felt that their choice of backup personnel was irrelevant because the hospital would do the most expedient thing in the event of an emergency.

Childbirth education classes.

Births prior to 1960. Formal childbirth education did not exist as such in the years these women were pregnant (1920 - 1944). Knowledge about childbirth was passed on from woman to woman, and the women in the study attributed any knowledge they had about birthing to what they had been told by others. Traditionally, knowledge was handed down from mother to daughter and sister to sister. Their doctors communicated little to them about labor and birth, and the women did not expect it to be any other way. The women were content to let the doctors do their jobs and keep their information to themselves.

Doctors have historically had a paternalistic attitude towards women (Ehrenreich & English, 1978). The women in the study accepted their doctors' attitude that it was unnecessary for women to be given any more information than the doctor thought they needed to know. They did not question their doctors' authority, nor did they see a reason to do so. They submitted to the authority of experts and followed the norms set forth by the society in which they lived.

Births after 1960. Tables 24 and 25 present the women's childbirth education backgrounds for hospital, birthing center and home births and the type of classes that were taken. Most of the women took childbirth classes for their first hospital births and/or first home births. Lamaze classes were found to be geared toward intervention and many of the women were dissatisfied with the approach. However, the information given about labor and birth was considered useful. Cooperative Childbirth classes were frequently taken for home births. This course, the Bradley course, and the course given by the birthing center focused much more on pregnancy than did the Lamaze program, and were more geared towards nonintervention in the birth process. The majority of women found the classes to be full of information and good preparation for giving birth. However, some women, particularly those who never took a course or only took them for their first hospital birth, found the proposed methods for getting through the pain of labor distracting and unnecessary, and preferred not to rely on

specific techniques.

Social support.

The amount of social support the women received for their choice of home birth influenced their thoughts and behavior during pregnancy. The presence or absence of social support was largely determined by the historical and social context in which the women's pregnancies took place.

Home birth before 1960. Those women who gave birth in the nineteen-twenties received much more social support than did the women who had home births in the late nineteen-thirties. In those two decades, the common place of birth was changing from the home to the hospital (Devitt, 1977). Most of the women and their peers were born at home, and there was still a lot of support for home birth among their parents' generation. According to the women, as more and more young women began to have hospital births, hospital births were accorded higher status. Choosing a hospital birth meant that you had the resources to pay for the hospitalization. In addition, women could have pain-free labors in the hospital by virtue of twilight sleep (scopalamine and morphine). The women who had home births in the latter part of the nineteen-twenties and nineteen-thirties were often viewed by their peers as old-fashioned. Safety issues were not a primary concern. Rather, the women were asked why they would want to have a home birth when they could have a modern, pain-free birth in the hospital.

The women who had home births in the early or middle nineteen-twenties still had plenty of social support from their peers for their choice of birthplace. The women who had later home births had less social support from their peers but were not ostracized for their choice nor thought of as crazy or taking unnecessary risks. They never felt the need to constantly justify their decision to others.

Home births after 1960. By contrast, the women who had recent home births did so at a time when hospital birth was almost universal. Most of them received little social support from others for their choice, unless they had friends or family members who had given birth at home or supported home births. Many of the women were constantly told by others that they were crazy for taking such a risk with their babies' health, and "What if" was the question they were most often asked. Many people seemed to feel that danger was imminent during labor and birth and that home birth was truly unsafe. This can be understood in the current climate of reliance on technology and intervention in the birth process. At a time when so many hospital births occur by cesarean section or forceps, and so many women require pitocin or pain relief, it makes sense that many people question the safety of birth in a setting without drugs or emergency equipment. For many of the people with whom the women in the study have come in contact, the hospital was seen as the necessary place for birth primarily because of the availability of technology and medication. Labor and birth

were viewed as pecarious conditions, disasters waiting to occur.

The attitudes of others towards home birth influenced many of the women to keep their home birth plans a secret from family, friends, acquaintances or neighbors in order to avoid confrontations. They created a pretense of planning for a hospital birth. Others were open about their plans and were constantly put on the defensive. Many of the women felt that any doubts they themselves initially had about the safety of home birth were assuaged by the arguments they found themselves presenting to everyone else.

A few of the women were surrounded by families and friends who were supportive of home birth. They were spared the necessity of having to justifying their position to those close to them, but still frequently encountered opposition from acquaintances and others who learned of their plans. The women found it easier to deal with the hostility of others to the idea of home birth when they had the support of those close to them.

Most of the women had partners who were or became supportive of their choice of home birth, which made it easier to deal with the opinions of others. However, a few of the partners never really felt comfortable with the idea of home birth until after everything went well with the birth. The lack of support or ambivalence of a partner to the idea of home birth often caused a strain on their relationship, and the

women found themselves withdrawing more and more as the birth approached. A partner's ambivalence or unease with the idea of home birth affected the birth itself, as discussed below.

Presence of others at the birth.

Home births before 1960. According to the women, it was custom for only women and the birth attendant to be present at home births. Husbands and children were usually somewhere else in the home while the birth was taking place. Some of the women were attended by only their physician, while others had a sister or close female friend present. The women did not consider having their partners or children in the room for the birth, since that wasn't the traditional thing to do.

Home birth after 1960. All but two of the women who had partners at the time of their birth (see Table 14) had their partner present for their home births. Two of the partners were so uncomfortable with both birth in general and home birth in particular that their absence at the birth was agreed upon beforehand. Most of the time, the partners took an active role in labor and birth, giving emotional and physical support (back rubs, etc.). Partners who were uncomfortable about the home birth sometimes made the women nervous and were asked by the midwife or the women to keep their distance.

Most of the women wanted their older children to be present for the birth, and had prepared the children for labor and birth through books, films, or just talking to them about what it would be like. It was very important for the women to

have their children share in the birth, and they often found that it brought the family closer together. The decision of whether to actually be at the birth was often left to the children themselves. Some of the children were uncomfortable seeing their mothers in discomfort, and wandered in and out of the room. A few of the women felt uncomfortable having their children see them in labor or give birth, or felt that the children were too young. They arranged for the children to be elsewhere in the house.

One woman planned to have her mother-in-law take her thirteen month old son while she was in labor, but her mother-in-law could not be found when labor began. She felt that he was too young to know what was going on and would interfere by wanting her attention. Her labor was over twenty-four hours in length, with little progress, and she found her son to be a huge distraction, to the point of wanting to scream at him. The midwive told her husband that the child had to be removed or the baby would not come, in which case they would have to go to the hospital. In addition, the woman's blood pressure was running high. A neighbor was called to take the son, and the woman gave birth fifteen minutes later, demonstrating that the unwanted presence of someone at the birth can be disruptive to the labor process.

Several of the women arranged for friends or family members to be present for the birth, although very few of the women wanted their mothers to be there, usually because they

were concerned that she would panic. Many of the women felt beforehand that the presence of anyone not completely comfortable with the idea of home birth would be disruptive to the birth process. This turned out to be the case. When the midwife felt that the presence of someone at the birth was interfering with the woman's ability to relax and let go, she asked them to go into another room.

Length of labor.

Several nonphysiological factors influenced the length of labor of home births, including the presence of others who made the women uncomfortable. For this reason, the length of labor is discussed in this chapter.

Home births before 1960. Most of the women do not recall the lengths of their labors or anything significant about the duration. However, the one woman who was convinced by her doctor to have a hospital birth labored for what she recalls was a very long time in a busy labor ward, surrounded by other women. She so disliked the experience that she told her doctor she was going home. Although she had not progressed very far in the hospital, she went into active labor while her doctor was driving her home and gave birth very soon after getting into her own bed in her own home. She attributes her failure to progress in the hospital as being due to her discomfort in being in a hospital and her desire to go home. She really wanted to have a home birth and could not submit to the progress of labor while in the hospital.

Recent home births. As stated earlier, the presence of someone who made the laboring woman uncomfortable often impaired the progress of labor. Unresolved conflicts between the women and their partners often slowed labor, regardless of whether or not the conflict was related to the birth. Fears and doubts the women had about their ability to give birth, primarily occurring in those having first births, also interfered with the birth process. Most of the women strongly believed that their emotional state influenced their labor. If the women did not feel psychologically ready to give birth, their labors were affected. Their midwives told them that they had to resolve what ever was bothering them in order to get on with labor. Often, telling the midwives their fears helped them to confront issues that were holding them back. One approach taken by more than one midwife to assist a slow labor was to have the woman spend some time sitting on the toilet, a natural place for release. Many sluggish labors became active as a result of this.

The length of labor was less of an issue at home than in the hospital. The midwives did not have strict criteria for centimeters dilatation after a set number of hours, and usually did not do internals to measure progress. Unless the women had very long labors (the definition of long varied from woman to woman), they did not concentrate on how much time the process was taking. They did not feel the threat of intervention for lack of progress that was present in hospitals and birthing

centers. The home birth attendants generally had much looser criteria than the institutions for what constituted failure to progress. The few women who received internals during labor were aware of their progress, but most of the woman had no idea how many centimeters dilated they were at any given time. Progress was a vaguer concept at home than in the hospital, determined by the activity of labor rather than the extent of dilatation. This took a lot of pressure off of the women to "measure up" to the standard progression or have their labor augmented.

The place of birth appeared to affect the length of labor for second and subsequent births only (see Table 30). However, augmentation of labor by rupture of membranes or pitocin was not uncommon in the hospital (see Table 21), and may be responsible for shortening the length of the women's hospital labors. The use of forceps also hastened a few of the hospital births. The women's subsequent hospital labors were significantly longer than labors for subsequent home births, despite augmentation procedures used in the hospital.

The difference in labor lengths can possibly be attributed to the women's level of comfort and lack of fear at home as opposed to the hospital. The midwives rarely did internals and progess of labor was not measured in degree of dilatation per unit of time. The women were under less pressure to progress and did not feel the threat of pitocin augmentation or transfer for lack of progress. The women

themselves believed that their emotional state affected progress during labor. Tension about making progress in dilatation impeded the progress of their hospital labors. Not having to worry about beating a time clock removed the threat of intervention for failure to progress, and the women were able to be relaxed about the time frame of their labors.

Perception of pain in the birth process.

Home births before 1960. These home births took place so long ago that the women's recollections of pain are somewhat vague. They were aware that they had the option of choosing anesthesia if they wanted to give birth in the hospital, yet none of the women felt the need to be rendered unconscious for their births. Twilight sleep was an option in the hospital if you wanted to avoid the pain of labor. The women came from a long tradition of unmedicated home births. Discomfort was an accepted accompaniment to the birth process, and none of the women felt the need to be spared from the pain. None of them recall having extraordinary pain during labor. They expected discomfort and were able to tolerate it well.

Recent home births. The women who had hospital births generally experienced more pain during their hospital labors than during their labors at home. The women attributed this to several factors. In the hospital, many of them were without the presence of a support person and went through labor alone and afraid. They often felt that their childbirth preparation courses failed to adequately prepare them for the degree of

pain that they experienced. They were in a strange place, surrounded by strangers. Augmentation of labor by pitocin or artificial rupture of membranes increased the frequency and intensity of contractions. Mobility was usually limited, preventing the women from finding an activity or position that might lessen the pain. Many women felt that doctors and hospitals perpetuated the myth that birth was too painful for women to get through without benefit of analgesics or anesthesia. "People think it's painful because of hearsay, having been told that it's necessary to be anesthetized, hospitalized, and prepared for complications to arise."

The women who had both hospital and home births usually found their home births to be less painful, partly because they knew what to expect from their earlier experiences and were less afraid. For the same reason, first home births were usually perceived as being more painful than subsequent home births. However, to a large degree, the perception of pain was influenced by what was done or not done to the women during the birth process.

As will be discussed in greater detail in the following chapter, the women had a lot of freedom at home (and at the birthing center) to do whatever was most helpful to them during labor to minimize discomfort. This included taking baths or showers, walking around, eating, etc. Mobility was not restricted and they had a choice of assuming whatever position or activity was most comfortable for them. The home birth

attendants rarely ruptured membranes early in labor, and pitocin was not given. The women were in their own homes, surrounded by support persons of their own choosing. For most of the births, the attendants were present throughout labor to provide emotional support, which was particularly important for the women who were experiencing long, slow labors.

Home birth labors were hardly perceived as painless, yet the women were able to rely on the support of their partners, friends, and attendants and were free to cater to the needs of their bodies. They were in their own homes, in familiar environments that did not breed fear and isolation. Most of the women did experience pain during the birth process, yet the pain was not perceived as horrendous or intolerable. None of the women felt the need nor desired medication to alleviate their pain. Discomfort was an expected part of birthing, perceived as something the women were capable of handling. They were prepared to get through labor and birth unmedicated, and viewed any pain that might experience as "pain with a purpose." "It's not painless pain, but it's a magical sort of pain because of what you end up with (your baby)."

The meaning of the birth place.

Home births before 1960. For these women, home was the natural place to give birth, following in the tradition of their mothers and grandmothers. The women had little experience with hospitals, thus they felt most comfortable giving birth in the familiarity of their own home. In the

nineteen-twenties and nineteen-thirties, women were commonly ordered by their doctors to remain in bed following childbirth for one to two weeks (Wertz & Wertz, 1977). Hospitalization for birth resulted in very long hospital stays, with the women separated from her family for several days. Women were told to remain in bed for the same length of time regardless of whether the birth took place at home or in the hospital. However, women who had home births were able to convalesce in their own beds in their own homes, surrounded by their families.

Recent home births. The place of birth held many symbolic meanings for the women in the study. For virtually all of the women, hospitals represented disease and intervention, and were viewed as places to go to only when one was ill. Birth was perceived as a natural, healthy life event, and home was "the natural, normal place for a natural, normal process like birth." For this reason alone, the hospital was often seen as an undesirable place to give birth.

In the hospital, personal belongings are stripped away and hospital johnnie gowns are standard attire (Shaw, 1974). Patients spend most of their time attended to by strangers. At home, women in labor are surrounded by their personal belongings and have the choice of wearing their own clothing or nothing at all. They can invite friends and family to be present at the birth. Some women placed a lot of importance on the fact that it was their home, their surroundings, and familiar to them. They were comforted by being in familiar

surroundings and most relaxed at home.

For many of the women, the home represented a place where they had the power to make the rules and did not have to abide by the authority of others. They could decide what to do, what would and would not be done, who to have at the birth, and whether or not they would be transferred to the hospital. "When you're in someone elses' space, you have to abide by their rules." "The birthing center is still an institution, and they have their rules. At home, the midwife is a guest in your home, and you are in charge." "It was going to be my birth, in my home, and I was going to do it the way I wanted to."

Similarly, for many the home represented freedom from unnecessary or routine intervention by others, largely due to control over who would be present at the birth and the absence of technological equipment. For several of the women, the fact that it was their home was not of great importance. What was important was the attitude of those around them, and the avoidance of intervention. They had the power to decide who would be in attendance, and what equipment would be allowed in the setting. The problem with hospital birth was seen by several women as attitudinal. Hospital personnel were viewed as truly believing that intervention was necessary and that all labors and births were high risk. "When birth is viewed as a normal process not in need of intervention, then the place of birth won't matter. Birthing centers aren't the answer, but

changes in attitude."

In summary, the characteristics of the birth experience are influenced by a great deal more than the physical aspects of the birth itself. However, the role of the actual characteristics of labor and birth in determining the experience of birth for the women in the study can not be ignored. Home births differ from hospital births by virtue of the fact that women have more choice in and control over what they do and what is done to them at home. The following chapter presents this issue in greater detail.

Chapter Ten.

The physical characteristics of labor and birth are determined both by physiology and the control exercised by institutions and birth attendants over the management of the birth process. What is of concern in this analysis are the ways in which the women's home births differed from typical hospital births in terms of those aspects of birth that can be affected by external causes: activities and positions for labor and birth, intervention in the birth process, and progress during labor.

Home births before 1960. The women who had home births in the nineteen-twenties and nineteen-thirties did not have very sharp memories about the details of their actual births, such as length of labor. They recalled spending much of labor in bed and giving birth in bed or on the kitchen table, usually on their backs. All of the women received stitches after giving birth, but none of them were sure whether they were cut (episiotomy) or were sutured for tearing. The women's hospital births differed little from their home births in terms of these features. The women remembered following their doctors' recommendations in terms of when to get into bed, when to push, etc.

Recent home births. Table 30 presents labor lengths for recent home births, and Tables 33 - 37 present other characteristics of the births. As demonstrated by the Tables,

the women chose a variety of activities and positions for labor and birth, and had little intervention in the birth process. Internal examinations were usually not performed except for very long, slow labors or at the request of the laboring women, and no episiotomies were performed.

Tables 21 - 23 present characteristics of the women's hospital labors and births. The women had much greater choice in and control over intervention, activities and positions at home. In the huspital, the women had to accomodate to the rules of the hospital or their practitioner. At home, the women were free to assume whatever activities and positions were most comfortable. Intervention in the birth process was a common occurrence in the hospital, yet at home the birth attendants stood by and watched the birth process unfold.

As discussed in the previous chapter, the women generally perceived less pain for their home births. This can be attributed to their having the freedom to decide upon means for getting through labor, whether by walking, standing, or taking a bath. They were able to attempt to lessen their discomfort through activity or by changing positions. Similarly, labor lengths were shorter for all subsequent births that took place at home. Mobility during labor has been associated with faster dilatation and shorter labor time (Cohen & Estner, 1983).

Internal examinations in hospitals are done for the purpose of assessing progress. Usually, women are told when

they are fully dilated and ready to push. They may experience the urge to push but are admonished to wait until they are examined and given the doctor's permission. At home, the women told their attendants when they felt the urge to push, and their birth attendants encouraged them to listen to their bodies. Internals were rarely done to ascertain full dilatation. Several of the midwives told their clients that they were able to tell how far along a woman was in labor by how the woman was breathing and behaving, without the necessity of internals.

The women were encouraged to give birth in whatever position felt most comfortable for them, resulting in a wide variety of birth positions (see Table 36). Many of the women who had more than one home birth chose different positions for each birth. It's interesting to note that only two women, each having had prior hospital births, assumed the lithotomy position (flat on back) ubiquitous in delivery rooms. The women in the study, when given the choice, chose against remaining supine during labor and birth, the usual positions in the hospital. It is likely that women who give birth in hospitals, when given the choice, would also select a wide variety of positions. It has been suggested by several authors that the positions most often used in hospitals are encouraged because it makes it easier for the attendants, more convenient for electronic fetal monitoring, and preserves the dominant position enjoyed by male physicians (Arms, 1975; Corea, 1977;

Ehrenreich & English, 1978; Gilgoff, 1978; Cohen & Estner, 1983; Brackbill, Rice & Young, 1984).

For all of the women, their home births were completely under their control. Their labors were allowed to run their natural course, without benefit of augmentation. They did whatever they felt comfortable doing during labor, gave in to the urge to push, and chose their positions for pushing and giving birth. They had the freedom to listen to their bodies and do whatever made them the most comfortable at the time. Their attendants were present to assist them in the birth process, but the women themselves were actively giving birth. This differed greatly from the women's hospital birth experiences, which were often manipulated by augmentation, analgesics, and episiotomies. Many of the women who had hospital births felt cheated out of giving birth because their babies were delivered for them. Hospital birth often rendered women passive participants, but at home, the women were in charge.

Six of the women gave birth before their attendants arrived at their home (see Table 37), yet in no instance did the absence of a birth attendant cause the women or their partners to panic. The women listened to and trusted their bodies and gave birth on their own. They did not feel the need to have someone there to "deliver their baby," because they felt capable of giving birth. Most of these women would plan to have a midwife present for future births, primarily for

support and to insure the safety of the birth, although a few wanted to do it on their own next time. All of the women in the study held the belief that babies know how to be born without benefit of assistance. Birth attendants were viewed as precautions, reassuring in the event of complications but not necessary in order to give birth.

The women in the study who had recent home births held strong beliefs about allowing birth to occur naturally, without intervention. Home birth provided a means for insuring that the births would take place the way the women wanted. The birth experiences lived up to the women's expectations and desires, free from intervention and according to their needs. These were "natural childbirths," truly proceding according to nature's plan. The women achieved their goal, maintaining control over their births, avoiding intervention, and tailoring their births to fit the needs of themselves and their families.

Chapter Eleven.

Discussion.

The discussion section of this thesis serves two purposes: the first, to address the adequacy of a hermeneutic method as applied to the study, and the second, to integrate the findings into a cohesive summary of the choice and experience of home birth. The first task is to examine the findings in light of the conditions for an adequate interpretative methodology. The first two sections of this chapter focus on the assessment of the validity and adequacy of the interpretations. The third section raises important questions about the adequacy of interpretation and the role of critique in a methodology informed by hermeneutics.

Kockelmans (1978) proposed that an interpretive methodology attempts to provide a scientifically and critically acceptable account of the meaning which social agents themselves attach to their own social actions in the life world. This meaning is shared among the members of a society and is intersubjectively accessible. The canons of hermeneutic inquiry stipulate what must be taken into account in order to reach an intersubjectively valid account of the meaning of a phenomenon (Kockelmans, 1975).

The canons of hermeneutics and their application to social science research have been discussed in detail in Chapters Two and Three. The methodology that was applied to

the study of out-of-hospital birth was derived from the principles of philosophical hermeneutics and formulated according to the guidelines suggested by the canons for hermeneutic inquiry. Adherence to these guidelines should have resulted in an interpretation that was intersubjectively valid for the women who participated in the study. The degree of intersubjective validity was addressed by presenting the findings to the women themselves for comment, and by the incorporation of group discussions in the methodology.

Validity of the interpretations.

The canons for hermeneutic inquiry serve a purpose beyond suggesting guidelines for the formulation of a methodology. The canons themselves provide a means for assessing the validity of the interpretations. The first canon for hermeneutic inquiry is the autonomy of the object. This canon states that the legitimacy of the interpretation is derived from and tested against the phenomenon itself. The interpreter must be aware that phenomena may become imbued with meanings derived from the philosophical prejudices of the interpreter rather than from the phenomena themselves.

The purpose of the research was to examine the choice and experience of out-of-hospital birth for the birthing women. I began the research with the belief that out-of-hospital birth was a safe, acceptable, and preferable alternative to traditional, in-hospital birth. I also believed that women who gave birth at home had a larger degree of control over and

responsibility for their births than did women who had hospital births. However, the type of interview used in the study encouraged the women to tell me their stories in their own words, allowing their experiences to emerge in the process. I did not ask questions that were specifically designed to examine the perception of safety or control. These were aspects that became apparent from the dialogue.

Similarly, I did not approach the transcripts of the interviews with a specific set of themes in mind. Rather, I searched for issues that appeared to be salient to the women in their recollections of their experiences. A conscious effort was made at every level of analysis to be aware of what the women themselves were telling me as opposed to what I expected to hear or how I would have felt in the same situation. I confronted my prejudgments throughout the process of interpretation precisely to uphold the autonomy of the object. As long as I was aware of my own beliefs in the role of interpreter, it was possible to separate my prejudments from the phenomenon of out-of-hospital birth itself.

The second canon states that the researcher should search for an interpretation which makes the phenomenon maximally reasonable, or human. This can be achieved by incorporating the tradition of the phenomenon within a given society and by employing assumptions about the layers of meaning that have been superimposed by that society with regard to the phenomenon. The legitimacy of these assumptions can be

checked through historical research and by assessing intersubjective validity among the persons who have experienced the phenomenon.

I entered into the process of interpreting the experience of out-of-hospital birth with the assumption that birth was an historically and culturally defined phenomenon. Various researchers support this assumption (Wertz & Wertz, 1977; Shorter, 1982; Jordan, 1983; Edwards & Waldorf, 1984). The second basic assumption that I employed was that the meaning birth held for the women in the study was a function of both their history as women and as birthing women within a given society and the socially shared beliefs about birthing held by that society. In other words, I entered into the interpretation with the assumption that the experience of birth did not take place in a vacuum, but was a function of the women's places in their socially and historically construed worlds.

The legitimacy of these assumptions was checked by assessing the intersubjective validity of the interpretations among the women who participated in the study. An overview of the findings was presented verbally to each of the women who had recent home births. This was done on an individual basis. I discussed various points raised in each level of analysis of the hermeneutic circle and asked the women to judge the relevance of these findings to their own experiences. I wanted to avoid having the women agree with me because they felt it

was socially desirable to agree with the researcher. I emphasized to the women the importance of their feedback in assessing the legitimacy of my interpretations and encouraged them to feel free to voice disagreements with any of the findings.

The overall reactions of the women were very positive. Very often, they would tell me the ways in which a finding related to their own experiences. Some of the women found that I brought up issues that they had not thought about, but that represented how they felt. For instance, several of the women related that they hadn't been consciously aware of how much they had been influenced by the stories about childbirth communicated to them by their mothers, other women, and physicians. They realized that they went through a process of unlearning beliefs and attitudes they had held previously in the process of choosing home birth. Others felt that I expressed issues that were salient for them but had been difficult to articulate. A common reaction the women had was that it was wonderful to find out that their feelings were shared by so many others. Many of the women simply told me that my findings were "right on target."

One woman in particular disagreed with just about everything I said, telling me that my findings may apply to everyone else but were the opposite of her own experience. I replayed the tape of her interview and reread the transcript in order to determine whether I had missed something she had been

trying to tell me during the interview or misinterpreted her experience. The tape and transcript supported my recollection that her interview had been full of contradictions, as evidenced by the following quotes:

> "I completely directed the pushing."
>
> "I was running the whole show myself."
>
> "I knew what I wanted to do but I needed permission (from the midwife)."
>
> "Next time I would like someone who would give me more direction (for labor, pushing)."
>
> "My son could have been at the birth if he wanted to."
>
> "I planned to send my son away with my in-laws during the birth."
>
> "No one was opposed to my having a home birth."
>
> "My sister-in-law was violently opposed to home birth."
>
> "My father thought I was crazy."
>
> "The (home) birth was wonderful."
>
> "Pushing was more painful than for my first (hospital) birth."
>
> "It took me a month to recover from the labor and birth."

The question of whether she would have another home birth and/or use the same midwife were twice ignored. My interpretation of her birth experience was based upon my impression that she had many conflicts about her birth experiences. In light of that, it is understandable that she disagreed with virtually all of my findings. I did not confront her with these discrepancies because I did not see

that as appropriate for my role as researcher. She did not participate in the study for the purpose of working through her feelings about the birth; rather, she agreed in order to assist me in my research. Therefore, it is not possible to assess her level of awareness of the conflict.

The woman discussed above believed that home birth in principle was far preferable to hospital birth, yet her hospital birth appeared to be a more positive experience for her than her home birth. My experience with this particular woman's reaction to my interpretations raises an important point concerning intersubjective validity. The women themselves hold prejudments about birthing which may have influenced their readiness to agree with the interpretations. The women were aware that, as a researcher, I was supportive of alternatives to out-of-hospital birth. The women themselves clearly believed that home birth was better, safer or more preferable to hospital birth. Their prejudgments may have made them more willing to agree with interpetations that were not truly representative of their experiences.

The group interviews served as an additional check on intersubjective validity. The women in the two groups discussed their experiences, comparing notes about their midwives, their labors, and the reactions of others. It was clear from the level of communication between the women that the meaning their experiences held for them was intersubjectively accessible. In both groups, the conversation

turned to hospital birth, and how the majority of women have been convinced that all the technology and intervention is necessary. The women expressed similar attitudes about hospital birth management and shared the frustration of not being able to communicate to others that birth is a natural, normal process and that intervention is unnecessary.

The women enjoyed having the opportunity to converse with others who held similar beliefs about birthing. The women also spoke about breastfeeding and the reactions of others to it, particularly in regards to nursing toddlers. The topic turned to questions about pediatricians and immunizations, as well.

The difficulty I encountered in holding the third discussion group raises the question of whether there was a reluctance on the part of the women to come together to discuss their experiences. It is possible that I failed to stress to the women the importance of the group discussions to the study. They may have viewed it simply as an opportunity to get together with others, and their cancellations were not perceived as affecting the research. I did not encounter a single cancellation for the individual interviews, the majority of which were held at the women's homes. This supports the possibility that the women were unaware of the importance of the group interviews to the study. It was also undoubtedly easier for the women to see me in their own homes than for them to come to mine for the group discussion.

The reactions and comments of the women, both individually and in groups, supported the achievement of intersubjective validity of the interpretations. The achievement of intersubjective validity gives legitimacy to the assumptions that were employed in order to make the interpretation of out-of-hospital birth maximally reasonable.

The third canon for hermeneutic inquiry directs the interpreter to achieve the greatest possible familiarity with the phenomenon, in terms of its historical origin, the layers of meaning which have evolved, and the traditions in which the phenomenon originated and developed. The interpretation incorporated this canon by examining the historicity and meaning of out-of-hospital birth within its historical, social, economic, physical and political contexts. The four aspects of the hermeneutic circle guided the interpretations in order to ensure that the experience of out-of-hospital birth was analyzed on several levels, ranging from birth in the larger society to the actual characteristics of the birth itself.

The fourth canon describes the circular relationship between the whole and parts of the phenomenon. The interpretation of out-of-hospital birth emerged out of this circular relationship or mosaic. Each aspect of the interpretation defined and was defined by the experience of out-of-hospital birth. The various aspects of the interpretation were interdependent, and therefore most readily accessible when viewed in the context of the other aspects and

their totality.

The fifth canon states that the researcher must attempt to show the meaning of a phenomenon for his or her own situation. This requires the interpreter to bring forth prejudgments and her own tradition throughout the process of interpretation. The process of interpretation itself affected the way I felt about home birth. Before I began the study, I knew of only one person who had a planned home birth. My reasons for supporting birthing alternatives stemmed from my beliefs about women's roles in society and in the medical system, both as patient and provider of health care, feminism, the use of technology in medicine, and safety and control in the birth process. I had no idea of "what type" of person chose home birth or why, beyond avoiding what takes place in the hospitals. Listening to the stories of the women who participated in the study was a real learning experience. I saw over and over again how the choice of home birth was rooted in the women's lives, and how their lives were affected by that choice. Having a home birth was consistent with the way the women conducted their daily lives. The research affected me personally, as well. I was able to reach a level of rapport and communication with the women that I find lacking with many of the women I meet on a daily basis. In fact, more than a few friendships developed as a result of the research. These friendships did affect the interpretations in two ways. I was able to achieve more insight into the choice and experience of

home birth for the women with whom I became friends. As I got to know them better, I was able to reach a better understanding of the reasons behind their choice of birth place and the ways in which choosing home birth fit into the rest of their lives. On the negative side, it is possible that these friendships prevented me from acknowledging certain aspects of their experiences, although I am not consciously aware of any instances of this.

The five canons for hermeneutic inquiry provided guidelines for the formulation of a methodology derived from philosophical hermeneutics. They also provided a means for assessing the validity of the interpretations that resulted from the application of the methodology to the study of out-of-hospital birth. The validity of the interpretations has been addressed in the preceding pages. The next step in evaluating the success of a hermeneutic approach to out-of-hospital birth is the assessment of the adequacy of the interpretations.

Adequacy of the interpretations.

Social conditions may reveal as well as conceal the meaning a phenomenon holds for the members of a society. For this reason, a critical interpretation must examine a phenomenon within its social context. The methodology used in this study incorporated this critical component. Sullivan (1984) proposes four conditions for an adequate critical interpretation, as discussed in Chapter Two. The adequacy of

the interpretations presented in this paper will be assessed according to these criteria.

The first condition is that an adequate account is negotiated. The interpreted must be able to identify themselves in the accounts given. If this is not possible, it may be that the account reveals to the interpreted something that they do not want themselves or others to realize. A critical approach to research minimizes the possibility that the research itself is wrong. The first condition was met by presenting the women with my interpretations, as discussed in the previous section.

Secondly, an adequate account presents itself as an argument. A valid argument is a form of advocacy for a particular interpretation. To be valid, the account must demonstrate the origin of and basis for the interpretations. The interpretations presented in this thesis were derived from the women's stories of their birth experiences. The experiences themselves were grounded in the contexts in which they occurred, and were backed up, where possible, by quotes and tables.

The third condition states that an adequate account expresses an emancipatory praxis, revealing to the participants that their world is constructed historically. The women's experiences, attitudes and beliefs were examined within their historical context, and this historicity was presented to the women as an integral part of the findings. The women

acknowledged the historicity of their choice of birth place, although many said that they had not looked at it that way before. For the majority of the women, the choice of home birth was an individual action, not seen as explictly connected to social or historical forces. The reasons for choosing home birth had to do with the women's own attitudes, beliefs and prior experiences. Presenting the findings to the women revealed to them the larger context of their choice, both socially and historically.

Finally, an adequate account is critical, consisting not of reiteration but of resymbolizations. Themes were extracted from the women's experiences, and the interpretations were based upon what I inferred from the interview text as well as what was said. The women's stories were not simply taken at face value. Rather, the experiences were analyzed within their social, historical, economic, political and physical contexts. The interpretations were a synthesis of the women's experiences and beliefs within these contexts.

Assessment of interpretation and critique.

The application of philosophical hermeneutics to the study of home birth employed a methodology informed by the canons for hermeneutic inquiry. The methodology itself is not well-developed, and, in fact, evolved out of the process of research. One important question regarding the adequacy of the interpretations is whether one should examine the process or product of interpretation. The canons were used to assess the

validity of the interpretations, and, in doing so, mainly focused on the process of interpretation. The only explicit assessment of the product of interpretation was the presentation of the findings to the women as a check on intersubjective validity. Similarly, Sullivan's conditions for an adequate critical interpretation focus primarily on the process of interpretation.

The methodology employed in this study clearly lacks the means for assessing the product of interpretation, an assessment I consider essential. It is not enough to address the adequacy of the process of interpretation and end there. It is necessary to examine where the process has led, and to examine whether the product of interpretation is adequate as well. The incorporation of intersubjective validity among the women is not enough. In the analysis presented above, agreement on the part of the women is the sole criteria for assessing intersubjective validity. The question arises as to what constitutes sufficient criteria for the assessment of intersubjective validity. At this point, the methodology has not been sufficiently developed to fully determine the answer. Another method of assessing the adequacy of the product of interpretation is required.

This gives rise to another important question: whether it is possible for the person constructing the interpretation to critique it. Perhaps it is not possible for the person who constructed the interpretation to critique its product. The

interpreter places him or herself in the the center of the process of interpretation, and works through the layers of meaning constituted by the hermeneutic circle. It is very difficult to remove oneself from the process of interpretation and look at the product as separate from the process. The interpreter, by definition, is caught up in the circularity of interpretation. Assessment of the product necessitates stepping out of the process. It may be that the true determination of the adequacy of an interpretation requires the assessment of the process by the interpreter and the assessment of the product by someone from outside the research, a person who can assess the adequacy of the product of interpretation apart from the process.

The interpretation of the choice and experience of out-of-hospital birth presented in this paper satisfies the conditions set forth by Sullivan for adequacy, and the existence of intersubjectivity of the interpretations has been shown. The number of women interviewed for the study is small. However, the number was sufficient to reach an adequate interpretation and for intersubjective validity to be achieved. It is likely that other women who have chosen home births will find the interpretations to be accessible to them by virtue of the similar contexts in which their choices and experiences have taken place.

The women in the study had mostly positive home birth experiences. One factor that may have contributed to this has

to do with the women's deliberate selection of birth attendant and birth place. The women set out with the goal of having a noninterventive birth in their home. They sought an attendant who would abide by their desires for the birth. Therefore, they were able to predict beforehand with some certainty the characteristics of their birth, in terms of the attendant's role, intervention, setting, and who would be present. None of the women developed complications during labor that would have necessitated transfer to the hospital. Had that occurred, it is likely that the birth experiences would have been perceived differently.

Self-selection also contributed to the positive nature of the women's experiences, since it is probable that women who were happy with their choice of birth place were more likely to want to participate in the study. The participants were contacted on my behalf by Certified Nurse Midwives and Certified Childbirth Educators. It is possible that the midwives restricted their choice of potential participants to those women who they perceived were satisfied with their birth experiences. The childbirth educators knew most of the potential participants through organizations such as La Leche League or the Metro. New York Childbirth Education Association. It is possible that the women who have joined these organizations had different birth experiences than other women.

The choice and experience of home birth.

The purpose of this study was to examine the choice and experience of home birth from the perspective of the women who have chosen this option. The women's choices and experiences were grounded in the social, economic, political, historical and physical contexts in which they occurred, and these contexts determined the meaning the experiences held for the women who participated in the study. The interpretation of the women's experiences must be bounded by the context of the women's lives. The women's choice and experience of home birth differ from the choice and experience of home birth for other women by virtue of these contextual differences. The women's choice and experience of home birth does not exist in a vacuum. Rather, the grounding of their choice and experience of home birth in the context of their lives, past and present, is what gives the interpretation presented in this thesis its character.

Home births before 1960. The women who gave birth at home in the nineteen-twenties and nineteen-thirties did so at a time when the place of birth was in transition from the home to the hospital (Devitt, 1977). The use of intervention at birth was minimal, and the use of anesthesia was not yet routine (Wertz & Wertz, 1977; Shorter, 1982). The home was the traditional place for birth, and the hospital was first being viewed as a modern alternative. The choice of home birth was not viewed as unusual or dangerous. Rather, it was accepted as a common, everyday occurrence. In the latter part of the

nineteen-thirties, home birth was often construed as old-fashioned, but the women were not seen as taking any unnecessary risks. Choosing a hospital birth often signified to others that one had the financial ability to pay for hospitalization, and thus became a status symbol for some.

Because these women grew up at a time when home birth was common, they perceived birth as a natural, normal part of life. They and their siblings had been born at home, and they were preceded by generations of women who had given birth without benefit of hospitalization. The hospital was an option, there if you wanted it and could afford it. All of the women could have afforded to give birth in the hospital, but it was viewed as an unnecessary expense.

By the time the women became pregnant, male doctors had already replaced midwives as the usual birth attendants (Ehrenreich & English, 1973a). The women who had hospital births were influenced by their doctors to go to the hospital, more a reflection on doctors' control over women than on the women's beliefs about birthing. The doctors were accepted as authority figures who had the right to keep their knowledge about birthing a medical secret. The women were content to acquire information about birthing from their mothers and female friends. The women accepted their doctors' orders that they must remain in bed for more than a week postpartum. Whether the doctors were right or wrong was never questioned.

At the time the women gave birth, the management of

labor and birth did not differ significantly in the home or at the hospital. However, women who had home births had privacy, something lacking in the hospital, where it was common for several women to share a labor room. They did not have to leave their younger children in the care of others for more than a week's duration, something they felt strongly about. They were able to recuperate in their own beds, surrounded by family. It was common for female friends and family members to help out with shopping, cooking and cleaning while the women were regaining their strength.

Recent home births. Unlike the women who had home births long ago, the women who had recent home births did so at a time when hospital birth had become virtually universal. The mothers of many of these women were rendered unconscious for their births, and had acquired the belief that childbirth was too horrible to get through unmedicated. The women themselves had grown up during a time of great technological innovations in medicine. Hospital labors were monitored and interfered with at an increasing rate, and forceps and cesarean deliveries were on the rise.

Doctors perpetuated the belief that intervention was necessary in the birth process in order to assure a healthy outcome. High tech hospital birth became the accepted method of giving birth in the United States. Childbirth education courses flourished. These courses prepared women to go through their hospital births without benefit of analgesics or

anesthesia. However, prepared childbirth did not guarantee childbirth without intervention, and many women were awake and aware for their births, though monitored, hooked up to IV's, given pitocin, episiotomies and forceps.

The women who had recent home births held strong beliefs about the avoidance of intervention in the birth process, beliefs they held before becoming pregnant or that were acquired experientially as a result of their hospital birth experiences. These beliefs often carried over to other aspects of health care. In addition, the women truly believed that birth was a normal, natural process, and that hospitals were places for people who were ill or needed surgery. They rejected the way society had medicalized childbirth.

The women chose home birth for several reasons. They wanted to avoid intervention in the birth process, something difficult to assure in the hospital. Hospitals were for sick people, but the home was seen as the natural place for a natural process like birth to take place. They wanted control over who would be at their births and the freedom to surround themselves with their children, friends or family. They wanted to be able to decide what would and would not be done to them during labor and birth, and the freedom to behave during the birth process according to their needs. They did not want their babies separated from them after the birth, a common occurrence in the hospital, and they wanted the comfort and familiarity of their own home.

Male physicians were seen as controlling childbirth in order to maintain their position of dominance over women. Women were too often rendered passive participants in their pregnancies and births, told only what their doctors wanted them to know. The doctors decided what was done during labor and birth, giving the women little or no say over what was happening to their own bodies.

It was important for the women to find a birth attendant who would respect their intelligence and be supportive of the women's needs for the birth. They wanted a cooperative relationship with their practitioners rather than one of dominance and submission. They wanted an equal say in every aspect of their care, and wanted to share the responsibility for the birth.

Little social support was given to the women for their choice of home birth, even among their own families. Home birth was seen as unsafe and an unnecessary risk. This put the women in the position of having to justify their choice over and over again. For this reason, it was not uncommon for the women to be somewhat surreptitious about their birth plans. At a time when high tech hospital births are accepted as necessary and safer than home birth, it is not surprising that the women encountered so much opposition.

Through their choice of birthplace and practitioner, the women were able to have the type of birth that was so important to them. They gave birth in an environment

supportive of allowing nature to take its course, in the presence of loved ones and with an attendant who respected the women's needs. The women were free to listen to their bodies and adapt their behaviors and activities during the birth process accordingly. Nothing was done to the women or their babies without their approval or consent.

The choice and experience of birth does not take place within a vacuum, but occurs within a mosaic of contexts that influence its character. Women's experiences of their births differ by virtue of the particular contexts in which they occur, yet the meaning of these experiences is intersubjectively accessible provided that there are commonalities of beliefs, attitudes and experiences. The women in the study chose home birth for a variety of reasons, based upon their needs, their beliefs and their prior experiences. Several practitioners attended the births, and the births differed from each other in many ways. However, the women shared many contexts surrounding their choices and experiences, by virtue of living and growing up in a shared time, in a shared culture, and sharing many experiences in the same life world. Because of this, it was possible to reveal the shared meaning the choice and experience of home birth holds for the women in the study.

# APPENDIX

LC - ONE HOME BIRTH

AGE: 29
AGES OF CHILDREN: 4 MONTHS
EMPLOYMENT: CURRENTLY AT HOME, PLANS TO RETURN TO WORK AS COLLEGE INSTRUCTOR, JOB SHARING, WOULD SHARE CHILD CARE WITH HUSBAND
HUSBAND'S OCCUPATION: COLLEGE INSTRUCTOR
HOUSEHOLD INCOME: $10,000-20,000
EDUCATION: M.A.
HUSBAND'S EDUCATION: M.A.
1 PREVIOUS SPONTANEOUS ABORTION
NO AMNIOCENTESIS OR ULTRASOUND
TOOK GENERAL CHILDBIRTH EDUCATION COURSE

STARTED A COUPLE OF YEARS AGO - HAD A MISCARRIAGE
HAD THOUGHT ABOUT HOME BIRTH THEN, HOW BIRTH WOULD BE A POSITIVE THING
HAD NEVER BEEN VERY POSITIVE ABOUT HOSPITALS OR DOCTORS, RESPECTS THEM BUT DOESN'T PUT THEM ON A PEDESTAL
DIDN'T FEEL HOSP BIRTH WOULD BE A VERY HEALTHY EXPERIENCE FOR HER, JUST "THE TRAUMA OF BEING IN A PLACE LIKE A HOSP WOULD HAVE A NEGATIVE EFFECT ON SOMETHING AS JOYOUS AS BIRTH"
READ A LOT OF BOOKS ABOUT ALTERNATIVES IN CHILDBIRTH AND BECAME ABSOLUTELY CONVINCED THAT THE HOSP WAS NOT THE PLACE TO BE
GOT IN TOUCH WITH GROUP OF LAY MIDWIVES (IN TEXAS)
BABY NOT EXPECTED
THEY WERE A SOURCE OF EMOTIONAL SUPPORT AND INFORMATION ABOUT BIRTH AND PARENTING
THEY WERE STILL THERE FOR HER WHEN SHE LOST THE BABY
SHE'S SURE THAT NO OTHER HEALTH CARE PEOPLE WOULD HAVE GIVEN HER THE EMOTIONAL SUPPORT AFTER THE MISCARRIAGE - SURE THAT THIS WAS WHAT SHE WOULD WANT FOR HER BIRTH
ONE MW CAME TO HER HOUSE AND WAS WITH HER WHEN THE (4 MONTH OLD) FETUS WAS EXPELLED - SURE NO DOCTOR WOULD HAVE COME
ANOTHER MW CAME THE DAY AFTER TO GIVE HER A MASSAGE, TOLD HER SHE'D BE ABLE TO HAVE OTHER CHILDREN, ASSUAGED HER FEARS
WHEN SHE BECAME PREG AGAIN, CALLED THEM UP AND SAW THEM FOR HER FIRST 3-4 MONTHS, THEY KNEW SHE WAS MOVING BUT DIDN'T CARE, STILL TREATED HER
MOVED TO NEW YORK, WANTED TO HAVE A HOME BIRTH MORE THAN EVER DUE TO POSITIVE EXPERIENCE SHE HAD WITH THE MW'S IN TEXAS
LOOKED UP MW'S IN PHONE BOOK IN TEXAS, HARDER TO FIND THEM IN NY
DID A LOT OF READING - MOSTLY CHOICE CAME DOWN TO HOSP BIRTH WITH DOCTOR OR BIRTHING CENTER BIRTH WITH MW - THE ONLY OPTIONS SHE SAW AVAILABLE IN NEW YORK
DID NOT WANT TO GO TO A HOSP BIRTHING CENTER WHERE OB'S WOULD

BE PRESENT, FELT THE MOST NATURAL THING WOULD BE TO HAVE THE HOME BIRTH
IN TEXAS, HAD GONE FOR A 2-WAY INTERVIEW TO SEE IF SHE REALLY WANTED HOME BIRTH AND MET THE MW WHO WOULD BE ASSIGNED TO HER TO SEE IF THEY LIKED EACH OTHER (SHE AND HUSBAND WENT)
BOTH FELT GOOD ABOUT CHOICE AFTER THE MEETING
HUSB WAS LESS CONVINCED BEFORE THE MEETING, NOT SURE WHY SHE DISLIKED HOSPITALS BUT WOULD SUPPORT HER
AFTER MEETING, HUSB FELT MORE CONFIDENT ABOUT THE "WHAT IFS"
MW MADE SURE THEY REALLY WANTED HOME BIRTH AND WERE EDUCATED ENOUGH TO MAKE THE DECISION AND HAD THOUGHT IT THROUGH
IN TEXAS MAJORITY OF MW'S ARE LAY MW'S
AT FIRST, PREFERRED LAY MW'S BECAUSE SHE KNEW HER PROFESSOR HAD A BIRTHING CENTER BIRTH WITH A CERTIFIED NURSE MW, AND ALTHOUGH SHE WAS MORE OF AN ADVOCATE OF CNM'S, THE MW WAS TOO "PRECAUTION MINDED"
"MEDICAL PROFESSION FOCUSES TOO MUCH ON WHAT CAN GO WRONG INSTEAD OF WHAT THINGS GO RIGHT AND SINCE MOST THINGS GO RIGHT, I WANTED THAT KIND OF ATTITUDE"
NOW NOT SURE IT MATTERS THAT MUCH IF LAY OR CNM, IN NY THINKS ONLY CNM'S DO HOME BIRTHS
"WHAT IS IMPORTANT IS THE PERSON AND WHAT KIND OF PROCEDURE SHE IS COMFORTABLE WITH" - FOUND NO DIFFERENCE IN COMPETENCY BETWEEN HER LAY MW AND THE CNM, JUST IN ORIENTATION TOWARDS BIRTH
GROUP IN TEXAS MORE ASSERTIVE, RUN BY WOMEN, ENJOY WORKING WITH WOMEN AND WORK WITH THE TOTAL WOMAN
"HAVING THE BABY MEANT MORE THAN JUST CATCHING THE BABY"
THEY WORKED IN PAIRS, MAYBE HAD MORE OPPORTUNITY TO GET INVOLVED WITH PEOPLE, THE INTERPERSONAL RELATIONSHIPS WERE MUCH MORE SATISFACTORY THAN WITH THE MW SHE HAD HERE IN NY
PACKAGE DEAL, INCLUDED HER HUSBAND AND HERSELF AS WELL AS BABY, MASSAGE FOR MOTHER AND BABY, SEND SOMEONE TO HELP YOU WITH THE HOUSE TO INSURE THAT YOU GET SOME REST
MW HERE WAS MUCH MORE OF A BUSINESS WOMAN, SHE HAS A VERY LARGE PRACTICE, SEEMS TO BE FLOURISHING BUT "ALMOST MORE LIKE A DOCTOR, NOT THAT FRIENDLY, NOT THAT INTERESTED IN WHAT YOU WERE FEELING
WENT TO ORIENTATION MEETING, SHE LEFT OFFICE IN TEARS, COMPARING TWO DIFFERENT THINGS, HAD EXPECTATIONS THAT THE MW'S WOULD BE SIMILAR
SO CUT AND DRIED "PART OF IT IS HER PERSONALITY BUT A LOT OF IT IS THE WAY SHE HAS TO OPERATE, INCREDIBLE LEGAL GUIDELINES TO FOLLOW AND MANIPULATE HER, AFFECTS HOW MUCH LEEWAY SHE HAS, HAS ADVERSE AFFECT ON HOW SHE IS"
TOOK TWO MONTHS TO FIND HER, LOOKED IN PHONE BOOK AND FOUND MW'S AFFILATED WITH HOSPS AND ONLY DOING HOSP BIRTHS
GAVE HER TWO NAMES, WENT TO LA LECHE LEAGUE AND ASKED LEADER, GAVE HER PHONE # OF SOMEONE WHO HAD A HOME BIRTH, HUSBAND'S MOTHER KNEW OF SOMEONE NEARBY WHO HAD A HOME BIRTH, WENT AND KNOCKED ON HER DOOR

COULD NOT FIND ANY OTHERS, "I SUPPOSE IT'S UNDERGROUND"
"IT'S A SHAME. THE ISSUE IN CHILDBIRTH IS THAT THE MEDICAL PROFESSION HAS TOO MUCH CONTROL LEGISLATIVELY OVER ALTERNATIVES IN CHILDBIRTH. AS FAR AS I'M CONCERNED THEY HAVE NO RIGHT TO CONTROL THAT."
CAN SET GUIDELINES FOR SAFETY BUT TO MAKE IT GO UNDERGROUND IS TOO MUCH - HER MW (IN NY) HAS VERY STRICT GUIDELINES TO FOLLOW CLIENTS MUST SEE HER OWN CHILDBIRTH EDUCATOR (WHO HAD JUST COME FROM A TRIAL OF A DR IN SUPPORT OF HOME BIRTH)
MW MUST HAVE REGISTERED MD TO BACK THEM UP, HOSPS DON'T WANT ANY OF THEIR OB'S ADVOCATING ANYTHING OUT OF THE HOSPITAL - IT TAKES TOO MUCH MONEY OUT OF THE OB DEPARTMENT - "IT'S AN ECONOMIC AND POWER ISSUE. THEY DON'T WANT TO SHARE POWER - MEN NOT WANTING TO GIVE WOMEN BACK THE CONTROL SO WOMEN GO AND HAVE THEIR BABIES IN INSTITUTIONS"
SEX OF ATTENDANT WAS SECONDARY - WANTED HOME BIRTH WITH MW AND MOST MW'S ARE WOMEN
REAL DIFFERENCE IS WHETHER OR NOT THE PERSON HAS HAD A BABY
HER MW DID NOT HAVE A CHILD OF HER OWN
"ALTHOUGH SHE PROBABLY KNOWS AN AWFUL LOT ABOUT HAVING BABIES, THE EXPERIENCE, AS YOU KNOW, IS VERY DIFFERENT"
"I WOULDN'T GO AROUND ASKING IF YOU'D HAD A BABY BUT IT MAKES A DIFFERENCE AS FAR AS UNDERSTANDING, ANY KIND OF EXPERIENTIAL KNOWLEDGE, A KNOWLEDGE THAT GOES DEEPER" "IT'S NOT A BIG THING, BUT THEY APPROACH IT WITH A DIFFERENT HEAD ONCE THEY'VE HAD A CHILD"
"IT WAS THE MOST INCREDIBLE EXPERIENCE I'VE EVER HAD, BECAUSE I HAD IT AT HOME" - A HELL OF A LOT OF WORK, BUT AMAZING, A VERY HAPPY TIME
A MW WHO HAS HAD THAT EXPERIENCE, THAT FEELING IS IN THE HOUSE
"A DOCTOR LOOKS AT IT AS ANOTHER $2000"
HER SISTER IS GOING TO BE A SINGLE MOTHER THIS SUMMER, GOING TO BIRTHING CENTER WITH MW
SISTER-IN-LAW HAD BABY IN HOSP, CSEC, "WHOLE NINE YARDS" - BABY HAD APGAR OF 2, IN LABOR FOR 36 HRS, HUSB SENT IN AND OUT, REAL BAD EXPERIENCE
"DIDN'T INTEREST ME AT THE TIME, COULD NOT IDENTIFY WITH IT"
WITH SISTER, EXCITED FOR HER BECAUSE IT'S AN EXPERIENCE SHE'S NEVER HAD BEFORE
"I FEEL SORRY FOR WOMEN WHO ARE TOO AFRAID TO MAKE A CHOICE, ARE TOO CONDITIONED INTO BELIEVING THAT THE ONLY POSSIBILITY IS TO GO TO A HOSP, WHEREAS IN MY MIND, IT'S THE LEAST SAFE"
"IT'S FOR SICK PEOPLE, NOT FOR BABIES"
"HOSPITALS ARE FOR WHEN YOU NEED INTERVENTION AND PEOPLE TO SAVE A LIFE, BUT THAT'S THE EXCEPTION (IN CHILDBIRTH), YOU CAN MAKE ARRANGEMENTS FOR THAT"
"WHEN YOU CAN HAVE THE OPPORTUNITY TO NOT HAVE PEOPLE BELTING YOU UP TO A MACHINE, PUTTING YOU IN A POSITION THAT IS UNCOMFORTABLE, STICKING YOU WITH DRUGS, NOT LETTING YOU EAT OR DRINK, IT TAKES ON A WHOLE NEW DIMENSION"
"MOST WOMEN ARE AFRAID OF HAVING A BABY, THEY'VE BEEN

CONDITIONED THAT IT IS A PAINFUL EXPERIENCE. IT'S TOO WONDERFUL FOR THAT"
ONE OF THE REASONS HER SISTER IS GOING TO THE BIRTHING CENTER IS ECONOMIC - SHE HAS NO INSURANCE COVERAGE AND IT'S CHEAPER
HAVING A HOME BIRTH IS A POSSIBILITY BUT DOESN'T KNOW IF HER SISTER WOULD CONSIDER IT
HAS DISCUSSED HER BIRTH WITH HER A LITTLE BIT
HER FAMILY WAS A LITTLE AFRAID OF HAVING A HOME BIRTH, HUSB'S FAMILY USED TO IT, A FEW OF HIS AUNTS HAD THEIR BABIES AT HOME FIFTY YEARS AGO, HER MOTHER-IN-LAW THOUGHT IDEA OF HOME BIRTH WAS CRAZY BECAUSE SHE THOUGHT IT WAS TOO HARD, RECOMMENDED THAT SHE GO TO HOSP TO BE KNOCKED OUT, LIKE SHE HERSELF HAD BEEN
HER OWN MOTHER HAD NATURAL BIRTHS IN THE HOSP, WAS UNSURE OF HER REASONS FOR WANTING A HOME BIRTH, COULDN'T UNDERSTAND IT BUT DIDN'T SAY ANYTHING
DIDN'T TELL ANYONE ABOUT PLANS UNTIL PRETTY NEAR THE END
BABY WAS HOSPITALIZED FOR JAUNDICE AT 5 DAYS, WHICH UNDID SOME OF THE GOOD OF THE HOME BIRTH
PROBLEM WAS NOT DUE TO HOME BIRTH, WAS ABO BLOOD INCOMPATIBILITY, CORD SHOULD BE CUT EARLIER NEXT TIME TO AVOID SAME
PEDIATRICIAN WAS NOT REAL SUPPORTIVE OF HOME BIRTH
TOOK A WHILE TO FIND ONE, ASKED HIM IF THEY WOULD TREAT BABY DIFFERENTLY AND HE DID, "TREATED AS MUCH MORE OF A SPECIMEN"
HOSP STAFF ALSO TREATED HIM LIKE A SPECIMEN, PUT BABY IN ISOLETTE
VERY HARD TO BE SEPARATED FROM HIM
DRS MADE ROUNDS, WOULD COME TO HER ROOM BUT DIDN'T ACKNOWLEDGE HER PRESENCE, TALKED ABOUT "WHAT THE PARENTS DID TO THIS CHILD, BECAUSE THEY DON'T BELIEVE IN DOCTORS AND NURSES" AND WENT ON AND ON
SHE STOOD UP TO BE NOTICED AND THEY STARTED ASKING HER QUESTIONS ABOUT WHY SHE HAD HOME BIRTH
HER FRIEND CAME TO SEE HER (HAD BEEN AT THE BIRTH) AND SHE CRIED TO HER ABOUT THE ALTERCATION
WENT TO THE HEAD OF PUBLIC RELATIONS TO COMPLAIN, WOMAN IN CHARGE HAD BEEN BORN AT HOME, TOLD HER WHAT HAPPENED, BUT NEVER DID GET AN APOLOGY FROM THE DOCTOR, SO SOME PEOPLE DO THREAT BABIES DIFFERENTLY
UNSURE IF THEY WERE THREATENED BY IT OR WHAT
WOULD DO IT AGAIN AND USE SAME MW "SHE WAS VERY GOOD"
LABOR AND BIRTH: DID A LOT OF PREPARING, SHE AND HUSB READ A LOT OF BOOKS, VERY INFORMED
MASSAGED NIPPLES FOR BREASTFEEDING, MASSAGED PERINEUM TO AVOID EPISIOTOMY, READ "NINE MONTHS, NINE LESSONS" AS PREPARATION FOR CHILDBIRTH
GAVE THEM RELAXATION EXERCISES, GOOD PREPARATION
"REALLY IS TRUE THAT YOU ARE FEELING THE CONTRACTIONS AND IS VERY EASY TO LET THEM CONTROL YOU, BUT YOU CAN CONTROL THEM"
IDEA OF BOOK THAT IF YOU PRACTICE YOU CAN SUSTAIN THE CONTROL AND FEAR WON'T OVERTAKE YOU, IF YOU AREN'T AFRAID, YOU CAN

RELAX
"THAT'S ANOTHER REASON WHY HOSPITALS ARE SO BAD. SO FEAR PRODUCING, STRANGE ENVIRONMENT, PEOPLE WON'T LET YOU HAVE ANY KIND OF SAY, YOU'RE IN THEIR HANDS, IN THEIR POWER"
"SEPARATING AND ISOLATING WOMEN FOR SO LONG, SO FRIGHTENED AND NOT KNOWING WHAT'S GOING ON, TO BE ALONE LIKE THAT"
WANTED HUSBAND AND SECOND COACH WITH HER, WANTED PEOPLE WITH HER THAT WERE SUPPORTIVE AND WOULD HELP KEEP HER RELAXED
WOKE UP 5:30 AM WITH CONTRACTIONS, HAD A GOOD NIGHT'S SLEEP, TOOK A SHOWER AND WASHED HER HAIR, WOKE HUSB AT 6 TO TELL HIM IT WAS REAL
HER MOTHER WAS THERE, UNSURE SHE WANTED HER THERE, MOTHER DIDN'T KNOW IF HER DAUGHTER COULD HANDLE IT
PLUG CAME OUT, STAYED IN BACK OF HOUSE, TALKED TO MOTHER TO MAKE SURE SHE WOULDN'T BE A NEGATIVE ENERGY SOURCE, AGREED TO LET HER STAY
PRETTY REGULAR CONTRACTIONS FOR A FEW HOURS, WALKING AROUND, TRIED POSITIONS, LEANED OVER CHAIR OR WINDOW SILL DURING CONTRACTIONS, TRIED TO RELAX
LATER IN LABOR, LAYING ACROSS COUCH, ON FLOOR, IN BATHROOM
MW CAME 11:30 OR NOON, HAD BEEN 2CM DILATED FOR A COUPLE OF WEEKS, WHEN EXAMINED WAS ONLY 4CM, WAS DISAPPOINTED
MW CHECKED HER BLOOD PRESSURE AND THOUGHT IT WAS TOO HIGH SO PUT HER IN BATHTUB TO SIT UP AND USE THE WATER TO FIND POSITIONS AND BRING THE (BABY'S) HEAD DOWN - LEANING BACK, SITTING FOWARD, SQUATTING
MUCH TOO INTENSE, COULD ONLY DO IT FOR A LITTLE WHILE
HAD RECIPE FOR EASIER LABOR, A LOT MORE VITAMINS, STUFF TO LOWER BLOOD PRESSURE, TOTAL PERSON KIND OF THING
MW KEPT CLOSE TABS ON BLOOD PRESSURE, WHEN IT GOES TOO HIGH, MAY NOT BE GETTING ENOUGH PROTEIN, TOLD HER TO EAT MORE PROTEIN AND IT WORKED
IF PRESSURE WENT ABOVE A CERTAIN LEVEL OR ANY OTHER PROBLEM AROSE, WOULD BE TRANSFERRED TO MW'S BACKUP DR AT ST. VINCENT'S
WENT TO SEE HIM - HE WOULD GIVE THE ABSOLUTE OK FOR HOME BIRTH
DIDN'T REALLY LIKE HAVING TO SEE HIM, UNNECESSARY, TOLD SHE HAD TO DO IT SO SHE DID IT
LIKED THAT HUSBAND COULD HEAR HEARTBEAT THROUGH DOPTONE, MW USED ONLY FETOSCOPE
MW ARRIVED DURING LABOR AND DID INTERNALS - LIKED THAT MW'S KNOW WHERE THE BABY IS, WHERE THE HEAD IS, THE POSITION
MW ASKED HUSB IF HE WANTED TO FEEL THE BABY'S HEAD
DIDN'T THINK A DR WOULD DO THAT, SO INTO USING MACHINES
"I WOULD MUCH RATHER BE FELT THAN MACHINED"
ONLY DID 2 INTERNALS DURING LABOR, BOTH DURING CONTRACTIONS
BABY BORN TOWARDS EVENING
2ND INTERNAL - 7CM, BATHTUB FOR MAYBE AN HOUR, LOST TRACK OF TIME BUT NOT LONG ENOUGH TO TURN WRINKLED
DID A LOT OF KNEELING, GOT A HEATING PAD TO PUT AGAINST HER BACK
STILL DID STANDING BUT PREFERRED "ALL FOURS" POSITION

ALL OVER HOUSE DURING LABOR EXCEPT THEIR BEDROOM, TOO SMALL
NOT MUCH TIME IN BIRTHROOM UNTIL BIRTH
HAD CAMPING MATS ON FLOOR, ROOM TO BE GOTTEN READY FOR BABY
TOWARDS END SPENT MORE TIME LEANING AGAINST COUCH WITH KNEES ON FLOOR, ALL HAPPENED SO FAST TOWARDS END, REQUIRED SO MUCH CONCENTRATION, CONSTANT CONTRACTIONS
WENT BACK INTO BATH, THEN LAID DOWN ON FLOOR, ON SIDE, ALL FOURS, FED HER ICE CHIPS
HER FRIEND TOLD HER SHE WAS CALM, ALMOST ASLEEP AT END OF CONTRACTIONS, THEN WOULD START TO CHOMP ON ICE CHIP AT BEGINNING OF NEXT CONTRACTION TO GET RID OF ICE
TOLD HER SHE HAD FARAWAY, CALM AND RELAXED LOOK, THEY WERE IMPRESSED
MOTHER STAYED OUT OF THE WAY, WAS SUPPORT FOR THE COACHES, HAD NOTHING MUCH TO DO WITH HER LABOR
BOTHERED HER AT FIRST THAT HER MOTHER WAS PRESENT FOR THE LABOR BUT REALIZED VERY SOON THAT "YOUR LABOR IS YOUR OWN"
WOULD HAVE BEEN A PROBLEM IF HER FRIEND WASN'T THERE AND MOTHER HAD TO COACH, TAKES A LOT OF ENERGY
FRIEND HAD COACHED A HOME LABOR OF A HOSP BIRTH, HER FIRST HOME BIRTH COACHING, THOUGHT IT WAS MUCH NICER
MW TOLD HER HER MEMBRANES WERE BULGING, TOLD HER TO PUSH OVER TOILET, GREAT FEELING, TOLD HER IF SHE HAD ANY FEELINGS TO PUSH, DO SO - BUT SHE DIDN'T SO SHE LAY DOWN ON SIDE FOR 10 MINUTES AND THEN HAD URGE TO PUSH, HAPPENED SO FAST, MW YELLED TO WAIT, BECAUSE HEAD WAS COMING OUT, MOST INCREDIBLE PHYSICAL SENSATION, HAPPENED TOO FAST TO SEE
SPENT A LOT OF LABOR IN BATHROOM
EVERYONE CAME IN TO SEE BIRTH, MOTHER ON SIDELINE
WHEN SHE ASKED FRIEND TO COME, REQUESTED REFERENCE BOOKS SO GOT HER SOME, SHOWED HER THE BOOK ON LABOR PRACTICES
FRIEND NEVER THOUGHT ABOUT HOME BIRTH BEFORE, DOESN'T REMEMBER HER REACTION
DIDN'T TELL THEIR MOTHERS RIGHT AWAY, AFRAID OF REACTIONS
"THEY NEVER TOLD US WHAT IF SOMETHING GOES WRONG, JUST THOUGHT IT WOULD BE (PHYSICALLY) TOO HARD"
HAD BEEN HOME BIRTHS IN PARENTS' AND GRANDPARENTS' GENERATIONS ON HUSBAND'S SIDE OF FAMILY BUT ONLY HOSPITAL BIRTHS ON HER SIDE
NEVER REALLY HAD TO JUSTIFY THEIR CHOICE, BUT A LOT OF PEOPLE THOUGHT IT WAS RADICAL - "IN BROOKLYN, THEY THINK I'M NUTS"
GOOD FRIENDS ALL OVER COUNTRY THINK IT'S NATURAL
LOCAL PEOPLE HAVE VERY DIFFERENT IDEAS ABOUT PARENTING AND BREASTFEEDING - "TO BREASTFEED, THEY THINK THAT'S WILD, TO HAVE THE BABY AT HOME, THAT SORT OF WRITES ME OFF AS OFF THE WALL AND THERE GOES ANY KIND OF COMMUNICATION"
VERY DIFFERENT KINDS OF PEOPLE IN TEXAS, UNIVERSITY SETTING, COLLEGE TOWN, HAVEN FOR MORE LIBERAL TEXANS, MORE OPEN TO ALTERNATIVES
"PEOPLE WHO WANT TO BE PARENTS HAVE DONE MORE RESEARCH AND WILLING TO GO THE LENGTHS OR BE MORE WILLING TO LET OTHERS DO

SO"
"IN NY, MORE DONE ON TRADITION, WHICH STEMS NOT FROM THE AGE WHEN WOMEN WERE HAVING THEIR BABIES WHERE BUT WERE TOLD TO HAVE THEIR BABIES IN HOSPITALS AND LET'S FEED THEM THIS FORMULA AND FROM THAT THERE COMES A TRADITION"
"I'VE GOTTEN MORE QUESTIONS ABOUT BREASTFEEDING THAN ABOUT HAVING BABIES AT HOME" - BIRTH ANNOUNCEMENTS NOTE BIRTH AT HOME HER GIRLFRIENDS WRITE AND ASK ABOUT THE BIRTH
"HAVING THE HOME BIRTH DOESN'T SEEM TO ME ANYTHING STRANGE, RADICAL OR ALTERNATIVE, JUST SEEMS RIGHT, SO NATURAL"
MOST OF THE PEOPLE THEY KNOW DON'T HAVE CHILDREN YET
IF LIVING IN NEW YORK, WOULD USE SAME MW
IF LIVING ELSEWHERE, WOULD LOOK FOR WHAT SHE HAD IN TEXAS
WOULD MAKE SURE SHE COULD GET ALONG WITH THEM, WERE FRIENDLY
LACKING IN MW HERE, "SHE WASN'T REAL INTERESTED IN WHAT I WAS FEELING, BUT WOULD ENTERTAIN QUESTIONS, WASN'T BUBBLY"
MW WAS COMPETENT
WOULD LOOK FOR EXPERIENCE, GOES A LOT BY GUT FEELING, WOULD LOOK AT BACKUP SYSTEM, EQUIPMENT BROUGHT TO THE BIRTH, PHILOSOPHY ON INTERVENTION, HOW THEY HANDLE EMERGENCIES
USUALLY MW'S VOLUNTEER THAT, WHICH MAKES A DIFFERENCE
MW GAVE OUT 3 PAGE PAPER LISTING HER PHILOSOPHY AND REQUIREMENTS (TO ENROLL IN HER PROGRAM)
DIDN'T WANT EPISIOTOMY IF IT WASN'T NECESSARY AND MW AGREED
TORE SLIGHTLY, LONG BUT NOT DEEP, NOT STITCHED
HAD VERY PRACTICAL ATTITUDE ABOUT THE POSSIBLITY OF THAT
WENT OVER PAPER ABOUT THINGS IN EVENT OF HOSPITALIZATION
WANTED HER TO VISIT THE HOSP BUT SHE COULDN'T - "JUST THE IDEA OF GOING TO THE HOSPITAL RAISED MY BLOOD PRESSURE ABOUT 20 POINTS"
SHE AND HUSB TALKED ABOUT WHAT SHE WOULD REFUSE TO HAVE DONE AND THOSE SHE WOULD CONSIDER UNDER CERTAIN CIRCUMSTANCES:
NO DRUGS, NO MONITOR UNLESS THERE WAS SOME DANGER TO THE BABY, NO CESAREAN SECTION - BIG FEAR OF CSEC, "MIGHT BE MY ORIGINAL REASON FOR LOOKING FOR ALTERNATIVES"
CSEC RATE SO HIGH IN U.S., WANTED TO WALK IN LABOR, HUSBAND WITH HER AT ALL TIMES, BABY WITH HER AT ALL TIMES, TO BREASTFEED IMMEDIATELY
NO SUPINE POSITION DURING LABOR, TO GO HOME RIGHT AWAY, NO IV
"WHEN I BEGAN TO READ AND BECOME MORE AWARE FOR THE FIRST TIME OF WHAT WENT ON IN THE HOSPITAL AND IN LABOR, THE MORE I READ, THE MORE I DECIDED THE STATUS QUO WAS NOT FOR ME: ROUTINE SHAVE, ENEMA, MONITOR, IV, NO FOOD OR LIQUIDS, WHICH IS SURGICAL PREPARATION, A WAY TO FEAR"
"YOU'RE GOING TO BE PREPARED FOR SURGERY AND ALL YOU'RE GOING TO DO IS HAVE A BABY? I DIDN'T LIKE THAT IDEA"
GOT ENRAGED, READ ABOUT HISTORICAL PERSPECTIVES, BIRTHING CENTERS, HOME BIRTHS, DECIDED HOME BIRTH WAS BETTER
"I WANTED TO KNOW I WOULD HAVE CONTROL IN THJE EVENT I WENT TO THE HOSPITAL"
ALSO DISLIKES ABOUT HOSP - "IF YOUR OB IS NOT ON CALL THAT

NIGHT, IT CAN GO TO WHOEVER, AND THEY DON'T KNOW WHAT YOU WANT OR DON'T WANT, YOU CAN GET SADDLED WITH ANYTHING"
"TO ME, IT SEEMED TOO DANGEROUS, TO LEAVE MY LIFE AND THE LIFE OF MY CHILD IN THE HANDS OF SOME STRANGER"
"I WANTED TO MAKE SURE THAT I HAD THE BEST...LOOK AT HIM (BABY)"

EE - 3 HOSPITAL BIRTHS, 1 HOME BIRTH

AGE: 30
AGES OF CHILDREN: 8.5, 7, 4.5, 3, 7 MONTHS
EMPLOYMENT: P/T NURSE CONSULTANT EDUCATION: B.A.
CHILDCARE: HUSBAND, IN-LAWS
HUSBAND'S OCCUPATION: MORTGAGE CONSULTANT EDUCATION: M.A.
HOUSEHOLD INCOME: $20,000-30,000
NO AMNIOCENTESIS OR ULTRASOUND
TOOK HOME BIRTH CHILDBIRTH EDUCATION COURSE

REGISTERED NURSE, WORKED IN MATERNITY WARD AS A STUDENT AND REALLY ENJOYED IT - NEVER THOUGHT ABOUT HAVING BABY AT HOME
FIRST TWO BIRTHS AT LARGE UNIVERSITY HOSPITAL, EXPERIENCE WAS OKAY, "EVERYTHING WAS WHAT I EXPECTED EXCEPT I WAS GIVEN PITOCIN FOR THE FIRST BIRTH FOR FAILURE TO PROGRESS"
"I COULDN'T COMPLAIN, THE NURSES WERE WONDERFUL"
"I HAD THE PROBLEMS WITH THE DOCTORS, DIDN'T FEEL THAT THEY WERE THERE FOR ME, DIDN'T FEEL THE CONNECTION OF HUMAN EMOTION WITH THEM"
VERY SUPERFICIAL, FAKE, PHONY, DRS IN MANHASSET NOT INTERESTED IN PLEASING HER BEYOND HAVING HER COME BACK FOR THE NEXT PREGNANCY
RECOMMENDED BY HER NURSING PROFESSOR'S DAUGHTER
"THEY JUST CAUGHT THE BABY AND REALLY DIDN'T DO MUCH ELSE"
DURING 2ND PREGNANCY, ASKED DR IF SHE COULD TRY NO EPISIOTOMY, ENEMA OR IV, HE SAID IT WAS RIDICULOUS, SHE FELT THAT HE WASN'T WITH HER
HAD FETAL MONITOR FOR FIRST TWO LABORS, CAME IN TOO EARLY "LIKE I ALWAYS DO"
THEY RUPTURED MEMBRANES, WANTED TO AVOID THAT FOR 3RD BIRTH, "WANTED TO DO IT THE MOST NATURAL WAY" - STARTED THINKING ABOUT HOME BIRTH THEN
SOME PEOPLE IN NEIGHBORHOOD SAID THEIR PRACTICE WAS VERY NON-INTERVENTIVE SO WENT TO SEE THEM
ONE OF THE MD'S TOLD HER HE HAD DONE HOME BIRTHS IN CHICAGO AND IT WAS DISASTROUS, TOLD HER HORROR STORIES, "BUT I USED HIM ANYWAY"
HAD CALLED HOME BIRTH MW'S BUT MOST WOULD NOT TRAVEL TO WHERE SHE LIVED, THE MW SHE USED FOR 4TH AND 5TH BIRTHS WOULD BE AWAY WHEN SHE WAS DUE
AFTER TWO KIDS, DID NOT WANT TO GO INTO THE CITY FOR PRENATAL CARE, SO ENDED UP WITH THIS PRACTICE "DISASTROUS ALL AROUND"
NOT AT ALL CONFIDENT WITH THE MD WHO WAS WITH HER IN LABOR
HOSP 2 MINUTES AWAY, WENT INTO DR'S OFFICE WHEN LABOR BEGAN, SENT HER HOME, CALLED HIM THAT NIGHT, AFTER 12 HRS, TOLD HER TO GO INTO HOSP TO BE CHECKED, HE HAD TOLD NURSES TO CALL HIM IF SHE WOULD DELIVER SOON, BUT SHE WAS 3-4 CM AND LABOR HAD STOPPED
DR SAID HE COULD COME IN TO GIVE HER SOMETHING BUT "I SAID I'D RATHER GO HOME," RELAXED AND LABOR PICKED UP, WATER BROKE

AROUND 11:30PM, WENT BACK TO HOSP
LABOR HEAVY, NURSES REALLY NASTY, WANTED TO SEE LAMAZE CERTIFICATE, WANTED HUSBAND TO FILL OUT PAPERS "WHEN I NEEDED HIM WITH ME"
NURSES WANTED TO HOOK HER UP TO THE FETAL MONITOR, SAID NO, SAID "DON'T YOU DARE"
NURSES VERY ANTAGONISTIC, INSISTED HUSB LEAVE DURING EXAMS, KEPT ASKING HER GENERAL QUESTIONS DURING TRANSITION
RUSHED HER TO DELIVERY ROOM, GAVE HUSB A HARD TIME BECAUSE SHE WOULD NOT GET UP OFF OF LABOR BED, HE TOLD THEM "LEAVE HER ALONE"
NURSES KEPT ARGUING WITH THE DR, NURSES DID NOT HELP HER ONE BIT
TORE VERY BADLY, DUE TO POSITION (SUPINE)
DR ATTEMPTED TO LIFT LABIA OVER BABY'S HEAD - IN A LOT OF PAIN, TOOK A LONG TIME TO STITCH HER UP, NOVACAINE NO HELP
WAS LEFT IN A ROOM OUTSIDE OF A NURSING STATION
FELT LIKE CRYING, "MOST HORRIBLE EXPERIENCE OF MY LIFE, I WANTED SOMETHING SO PLEASANT AND THEY GAVE ME SOMETHING SO HORRIBLE"
"I REALLY FELT LIKE I WAS RAPED, NO ONE CARED ABOUT ME, NO ONE WAS LISTENING TO WHAT I WAS SAYING"
"NO ONE KNEW WHAT I WANTED AND NO ONE COULD CARE LESS"
NURSES GAVE HER ERGOTRATE EVEN THOUGH SHE WAS NURSING, TOLD THEM TO STOP IT
WHEN SHE GOT PREGNANT WITH 4TH, "I DECIDED I WAS NOT HAVING ANY MORE CHILDREN IN THE HOSPITAL"
AFTER FIRST TWO BIRTHS, FELT LACK OF HUMAN EMOTION, BUT HUSB WAS VERY IMPRESSED WITH DRS, THEY WERE VERY CALM
SHE WANTED THEM TO GIVE HER THE ATTENTION
THEY TOLD HER BABY WOULDN'T NURSE ON THE TABLE, "TREATED ALL OF MY REQUESTS AS THOUGH IT WERE NONSENSE, LIKE I WAS A BABY"
THEY WEREN'T WITH HER DURING LABOR
"HUSB ISN'T GREATEST COACH IN LABOR, BUT I LIKE HIM WITH ME"
DRS JUST WALKED IN AND OUT
THOUGHT ABOUT MW'S, WANTED TO KNOW HOW THEY WOULD BE WITH HER
MET SOMEONE AFTER 1ST BIRTH WHO WAS VERY INTERESTED IN NATURAL THINGS AND HAD A HOME BIRTH, GAVE HER MW'S NAMES
MET A LABOR COACH AND CHILDBIRTH EDUCATOR, TOOK HER COURSE, HER MIND WAS SET ABOUT HAVING A HOME BIRTH
CALLED MW, WHO SAID SHE WAS AVAILABLE , TOLD HER HER HUSB WAS AGAINST IT, HE CAME TO MEET MW
"HE WAS MORE AFRAID OF SOMETHING HAPPENING TO ME THAN TO THE BABY, AND THE MW UNDERSTOOD THAT"
MW SAID TO HIM, "COULD YOU LIVE WITH YOURSELF KNOWING YOUR WIFE WOULD BE TOTALLY ANGRY WITH YOU IF YOU DON'T GO ALONG WITH THE HOME BIRTH?"
"MY NEED TO HAVE THE HOME BIRTH REALLY CONVINCED HIM, IT WASN'T JUST A WHIM"
MW WAS SO CONCERNED AND UNDERSTANDING
VERY GOOD PRENATAL CARE, NUTRITION, BLOOD WORK, "VERY CONCERNED

WITH WHAT I NEEDED AND WANTED FOR PRENATAL CARE"
SO CONFIDENT IN MW THAT SHE DIDN'T WORRY ABOUT BACKUP, KNEW MW WOULD BE THERE NO MATTER WHAT, VERY SOOTHING TO FEEL SO CONFIDENT
"SHE MET ALL MY NEEDS IN TERMS OF REASONS WHY I WANTED A HOME BIRTH" "MY NURSING EXPERIENCES AND EDUCATION PREPARED ME FOR WANTING A HOME BIRTH, VERY PRO BEING WITH PATIENTS IN THE LABOR ROOM, EVEN DURING SEDATION, TAUGHT THAT WAY" "WE LEARNED AN APPROACH TO CHILDBEARING"
PROFESSOR WOULD COME ONTO LABOR FLOOR, WOULD ANALYZE THE DATA AND THEN TRY TO HELP THE WOMEN
UNHAPPY ABOUT THE WAY THAT THE HOSP LEFT PATIENTS ALONE, SEDATED, WITHOUT HUSBANDS, DRS IN AND OUT
A LOT OF EXPERIMENTATION WITH INTERNAL AND EXTERNAL MONITORS, "AT THE TIME I SAW IT AS INTERESTING, NOT AS WHAT IN THE WORLD ARE THEY DOING TO THESE PEOPLE"
BROKE WATER TO INSERT MONITOR JUST TO SEE WHAT IT WAS LIKE, RESIDENTS CONSTANTLY DOING INTERNALS, "I REALIZED LATER HOW THAT WAS WRONG, I WOULD NOT WANT THAT FOR MY BIRTHS"
4TH LABOR WAS SAME AS OTHERS, LONG, ON AND OFF, "BUT I WAS AT HOME AND COULD DO WHATEVER I WANTED" - HUSB AND KIDS THERE
LABOR STARTED 8PM, WENT TO SLEEP, WOKE UP AROUND 11PM, KEPT IN CLOSE CONTACT WITH MW, SPOKE TO HER AT 2AM, TOLD HER TO CALL IF CONTRACTIONS CAME MORE QUICKLY AND STRONGER
DAY BEFORE, HAD FALSE LABOR
HUSB HAD FRIEND WHO WAS A RESIDENT, CALLED HIM, HUSB WAS VERY NERVOUS
CALLED HER FRIEND WHO IS AN RN AND INTO NATURAL CHILDBIRTH, CALLED THE LABOR COACH, SENT ALL OF THEM HOME, FALSE ALARM
NEXT NIGHT, WAS TRUE LABOR
MW CAME, FREEZING IN LIVING ROOM, ALL WENT INTO BEDROOM WITH HEATER AND WENT TO SLEEP
MW DID ONE INTERNAL AT EE'S REQUEST, 4CM, VERY DISAPPOINTED, KNEW SHE JUST HAD TO WAIT, MW CALLS IT PRODROMAL LABOR, ON AND OFF, ON AND OFF UNTIL ITS REALLY READY - "ALL MY LABORS ARE ABOUT 12 HRS IN LENGTH"
WOKE UP AND "FELT LIKE I WAS IN TRANSITION"
BED ALL READY, STERILIZED THINGS, MW SET UP INSTRUMENTS, HAD BEEN DOING BREATHING TO GET THROUGH CONTRACTIONS
HUSB CALLED MOTHER-IN-LAW TO TAKE KIDS TO SCHOOL, FRIEND TOOK BABY, HUSB VERY HELPFUL
"I NEEDED HIM TO ORGANIZE THINGS, NOT TO COACH ME, NOT A COACH BY NATURE" - GOT 3 KIDS FED, DRESSED AND OUT
HER FRIEND THE RN ARRIVED, THE COACH ARRIVED, AROUND 9AM
"MAGNIFICENT EXPERIENCE"
SEMI-SITTING, SUPPORTED BY PILLOWS, HOLDING HER KNEES
IN HOSP, LITHOTOMY FOR 1 AND 2, SUPINE FOR 3 (IN LABOR BED), NO FORCE OF GRAVITY
TORE SLIGHTLY, BABY NURSED RIGHT AWAY
"WARM EXPERIENCE, EVERYONE WAS THERE WHO REALLY MATTERED"
WEIGHED AND CLEANED UP BABY IN FRONT OF THEM

IN HOSP, HAD BABY BRIEFLY, ROOMING-IN AFTER
FOR THE HOSP, "THE FIRST TWO WERE THE BEST EXPERIENCES, BUT IT WASN'T THE TOTAL EXPERIENCE, LIKE AT HOME"
"THE 5TH WAS EVEN BETTER"
WATER BROKE THURSDAY MORNING, RELIGIOUS HOLIDAY BUT CALLED MW, WHO WAS OUT, HUSB GOT NERVOUS, SAID TO THINK OF WHERE SHE COULD BE, FOUND HER THERE
TOLD HER SHE'D LEAVE FOR HOME, CALL HER IN 1 HOUR
GOT EVERYTHING READY, COOKED, NO CONTRACTIONS, JUST LEAKING FLUID, GOT COMFORTABLE, "AS COMFORTABLE AS A WOMAN IN THE NINTH MONTH COULD BE"
IN-LAWS CAME FOR THE WEEKEND, THOUGHT IT WOULD BE NICE TO HAVE THEM IN THE OTHER ROOM WITH THE KIDS AND COME IN RIGHT AWAY
FRIEND THE RN CAME OVER, WALKED AROUND TOGETHER, WENT HOME
MW CAME 10PM, RN WENT HOME (HAS 8 KIDS BORN IN HOSP, TOO AFRAID TO HAVE THEM AT HOME, HOSP LETS HER WALK AROUND, LIKES THE ENEMA)
ALL WENT TO SLEEP, SHE WOKE UP ON AND OFF, VERY UNCOMFORTABLE, HAD BACK PAIN - THROUGHOUT PREGNANCY, HAD NERVE PAIN, SITTING WAS UNCOMFORTABLE
WALKED AROUND, MW WOULD WAKE UP AND ASK HOW SHE WAS DOING, IF SHE WANTED MW TO BE WITH HER, TOLD HER IT WAS FINE IF SHE WANTED TO BE ALONE
MW LEFT HER ALONE, CONCENTRATING ON HERSELF, NEEDED TO GET IT OVER WITH, MW TOLD HER COULD GIVE HER PITOCIN TO GET OVER THE HURDLE, BUT CONTRACTIONS PICKED UP
MW SAID SHE DIDN'T NEED PITOCIN, ALTHOUGH SHE WAS READY TO AGREE, PAIN IN HER LEG, "I WANTED IT TO END ALREADY"
STAYED IN BED A LONG TIME, HUSB WENT TO GET RN, THEN IN TRANSITION, GOT OUT OF BED, PAPER ON FLOOR TO CATCH DRIPPING BLOOD, IN A LOT OF PAIN
"SHE LET ME DO WHAT MY BODY TOLD ME TO DO"
DECIDED TO PUSH, MW KNEW BY THE WAY SHE WAS LABORING THAT IT WAS TIME, DID NOT EXAMINE HER
MW SAW HEAD COMING OUT, HER FRIEND COACHED THE PUSHING, TOUCHED THE PERINEUM WHERE SHE WANTED HER TO DIRECT HER PUSHING
TOOK 24 HRS FROM RUPTURE OF MEMBRANES TO BIRTH
HUSB IN AND OUT, SO QUIET IN THE ROOM "MY IN-LAWS FORGOT WHAT WAS GOING ON," CALLED THEM IN WHILE NURSING BABY, KIDS CAME OVER TO BED
"THE MOST WONDERFUL EXPERIENCE, FANTASTIC"
MOTHER-IN-LAW HELD BABY FOR A WHILE
AFTER AN HOUR, GOT UP TO TAKE A SHOWER, FELT WEAK BUT EXHUBERANT
GAVE BIRTH SEMI-SITTING, PUSHING MORE CONTROLLED SO TORE LESS
"I HAVE A PROBLEM WITH THE SENSATION OF PUSHING, I NEEDED TO OVERCOME THE FEAR OF THAT PAIN" "I READ A BOOK THAT DESCRIBED A WAY OF RELAXING THE PERINEUM"
"I VOWED THAT I WOULD NOT SCREAM, WOULD PUSH THE AIR OUT OF MY BODY"
"I FELT PRESSURE INSTEAD OF PAIN, I WAS SO PROUD OF MYSELF, I

DID IT THE RIGHT WAY"
PRENATAL CARE - TOOK WEIGHT AND BLOOD PRESSURE, FUNDAL HEIGHT, DIET, HOW SHE FELT
"I WAS DOING A LOT OF WORK, CONSULTING, MW SAID I SHOULD EXAMINE MY PRIORITIES, TOO OVERWHELMING" - REDUCED WORK LOAD, SPENT MORE TIME AT HOME
MW VERY SUPPORTIVE, ESPECIALLY PSYCHOLOGICALLY
TOLD HER ABOUT FEAR OF PUSHING, MW TOLD HER THEY'D GET THROUGH IT TOGETHER
THEY WOULD SIT AND TALK "SHE KNEW ME AND I KNEW HER, SHE KNEW WHAT I WANTED AND WHAT I NEEDED"
DRS OFFICE - NURSE WEIGHS YOU, DR MEASURES FUNDUS AND THAT'S IT
WENT TO BACKUP DR IN BROOKLYN, SAW HIM 6TH AND 9TH MONTHS, GAVE HIS BLESSING, SUPPORTIVE OF IT
A NEIGHBOR USED HIM FOR 8 DIFFICULT DELIVERIES AND "HE WAS ABLE TO GIVE HER ALL NATURAL CHILDBIRTH," DID A BREECH VAGINALLY
FRIEND HAD BEEN AFRAID THAT SHE WOULD HAVE A CSEC AND NOT BE ABLE TO HAVE AS MANY KIDS AS SHE WANTED
IF E.E. HAD TO USE A DR, WOULD HAVE USED HIM - "HE DID PREFER THAT I HAVE THE BABY WITH HIM IN THE HOSP BECAUSE IT WAS MY 5TH"
HUSB NOT AGAINST IT BUT WANTED HER TO THINK IT THROUGH, NOT JUST DO IT BECAUSE SHE HAD THE LAST BIRTH AT HOME
HER FRIENDS TRIED TO TALK HER OUT OF IT, ONE FRIEND TOLD HER SHE WAS CRAZY BUT SHE SHOULD DO WHAT SHE WANTED
"MANY FRIENDS WERE SO FRIGHTENED BY THE WHAT IFS THAT THEY WEREN'T LOOKING AT THE NATURAL PROCESS OF BIRTH"
"THEY DON'T HAVE THE UNDERSTANDING OF WHAT HAPPENS, THEY DON'T NEED THE MEDICAL BACKROUND TO KNOW WHAT GOES ON IN THE HOSP"
"THEY THOUGHT I WAS DOING A VERY SILLY, DANGEROUS THING, TAKING A CALCULATED RISK, BECAUSE OF THEIR OWN EXPERIENCES IN THE HOSP"
"THEY WONDERED HOW THE MW COULD KNOW THAT SOMETHING WAS WRONG"
LAST BIRTH USED BACKUP DR FROM LOCAL HOSP, GAVE HER HIS HOME #
DR VERY HAPPY WITH IDEA OF MW, HE WAS NOT AMERICAN
HER IN-LAWS VERY FOR IT, BUT DID NOT TELL THEM UNTIL THE WEEK BEFORE THE FIRST HOME BIRTH! - AFRAID OF NEGATIVE REACTION
VERY SYMPATHETIC, UNDERSTANDING, MOTHER-IN-LAW HAD FAITH IN HER TO DO WHAT WAS RIGHT, IMMEDIATE REACTION WAS THAT IT WAS GREAT
HER MOTHER WAS HAPPY, HAD 5 HOSPITAL BIRTHS THAT WERE NOT THAT GREAT, HAD BEEN TOLD TO CLOSE HER LEGS AND SHUT UP DURING ONE BIRTH
"VERY SAD THAT PEOPLE HAVE TO GO THROUGH EXPERIENCES LIKE THAT"
"MY FRIENDS HAVE BEEN ENRICHED BY MY EXPERIENCES, KNOW WHAT NOT TO DO IN THE HOSPITAL, ABOUT THE INTERVENTIONS"
"THEY ALL TEASE ME ABOUT WHAT I CAN DO NEXT"
A FRIEND JUST GAVE BIRTH IN THE CAR, ASK HER IF THAT'S NEXT
OVERALL, FRIENDS WERE EXCITED, EVERYONE KNEW ABOUT IT
LAST BABY BORN ON RELIGIOUS HOLIDAY, EVERYONE IN SYNAGOGUE KNEW SHE WS IN LABOR - "THEY SAW THE BABY AN HOUR AFTER THE BIRTH, A STRANGE EXPERIENCE FOR THEM, TO SEE THE BABY AT HOME IN A

STRETCHIE, TO SEE ME AT HOME SO SOON"
VERY THRILLED FOR HER, "THE TALK OF THE NEIGHBORHOOD"
"PEOPLE KNEW OF THE CRAZY LADY WHO HAD HOME BIRTHS"
MET TWO WOMEN WHEN PREGNANT WITH 5TH AND TOLD THEM SHE WAS HAVING BABY AT HOME - "SO YOU'RE THE CRAZY LADY"
PEDIATRICIAN - USED SAME FOR ALL 5 KIDS
TOLD HIM BEFOREHAND, KNOWS HER AS A REBEL CONCERNING MEDICAL CARE, ONE OF HIS FIRST MOTHERS WHO NURSED COMPLETELY, HAD CONFIDENCE IN HER THE SAME WAY AS HER FRIENDS DID
"I COME TO HIM WHEN I REALLY NEED HIM, I DISAGREE WITH HIM, USE MY OWN MIND"
CAME OVER TO HER HOUSE AFTER THE BIRTH, IN A FEW HOURS
"HE BEHAVES LIKE A FRIEND, DOESN'T CONDEMN OR CONDONE"
FOR 5TH, HE EXPECTED ANOTHER HOME BIRTH
CAME TO HOUSE, MET MW, NOT NASTY OR ACCUSATORY, REALLY OPEN-MINDED
"I HAD CONFIDENCE THAT THE MW WOULDN'T TAKE CHANCES"
BABY WAS TRANSVERSE AT END OF PREG AND MW HAD CONFIDENCE THAT BABY WOULD TURN AND IT DID
3RD BIRTH, SAME PED. WAS CONCERNED THAT SHE LEFT HOSP AFTER 24 HRS, WANTED HER TO LEAVE BABY FOR ANOTHER 12 HRS, SHE WENT HOME AND CAME BACK
"HE'S CAUTIOUS TO PROTECT HIMSELF"
WOULD USE MW, HAS RECOMMENDED HER TO OTHERS, HAS HAD CALLS FOR INFORMATION
MW IS CAUTIOUS, KNEW SOMEONE ELSE WHO NEEDED TO BE TRANSFERRED TO HOSP AND ENDED UP WITH CSEC
1ST HOME BIRTH COVERED BY INSURANCE, 2ND WAS NOT (HUSB UNEMPLOYED AT THE TIME), "BUT STILL LESS EXPENSIVE OUT-OF-POCKET THAN IF I WENT TO A MEDICAL PRACTICE"
"BEFORE YOU DELIVER, THE DRS WANT THEIR MONEY"
HUSB OUT-OF-WORK, WOULD HAVE TO PUT UP $1500, WAS WORTH IT TO PAY MW DIRECT, "I GOT ALL THE OTHER ADVANTAGES OUT OF IT"

# T A B L E S

TABLE 1 PRIOR BIRTH EXPERIENCE (BEFORE 1960) N=6

| HOSP THEN HOME (1 HOME BIRTH) | HOME THEN HOSP (1 HOME BIRTH | HOME ONLY (2 OR MORE BIRTHS) |
|---|---|---|
| 2 | 1 | 3 |

TABLE 2 YEARS OF HOSP BIRTHS (BEFORE 1960) N=3

| | 1925 | 1937 | 1944 | n |
|---|---|---|---|---|
| HOSP THEN HOME | 1 | 1 | | 2 |
| HOME THEN HOSP | | | 1 | 1 |

TABLE 3 YEARS OF HOME BIRTHS (BEFORE 1960)

| | 1920 | '23 | '25 | '27 | '29 | '32 | '34 | '35 | '36 | '38 | n |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HOSP THEN HOME | | | | | 1 | | | | 1 | | 2 |
| HOME THEN HOSP | | | | | | | | | | 1 | 1 |
| HOME ONLY | 1* | 1 | 2 | 1 | 2 | 1 | 1 | 1 | | | 3 |

* born in Europe

TABLE 4 AGE AT FIRST BIRTH (BEFORE 1960)

| | HOSP THEN HOME | HOME THEN HOSP | HOME ONLY |
|---|---|---|---|
| MEAN | 22.5 (n=2) | 27 (n=1) | 23.3 (n=3) |
| RANGE | 18-27 | | 20-25 |

TABLE 5 MATERNAL PLACE OF BIRTH (BEFORE 1960)

| | U.S. | AUSTRIA | POLAND | n |
|---|---|---|---|---|
| HOSP THEN HOME | 1 | 1 | | 2 |
| HOME THEN HOSP | 1 | | | 1 |
| HOME ONLY | | 2 | 1 | 3 |

TABLE 6 PARTNER'S OCCUPATION AT TIME OF HOME BIRTH (BEFORE 1960)

| | TRADES (GARMENT, CARPENTRY, ETC.) | CLERICAL | n |
|---|---|---|---|
| HOSP THEN HOME | 2 | | 2 |
| HOME THEN HOSP | | 1 | 1 |
| HOME ONLY | 3 | | 3 |

TABLE 7 EDUCATION (BIRTHS BEFORE 1960)

| | HOSP THEN HOME | HOME THEN HOSP | HOME ONLY |
|---|---|---|---|
| MATERNAL | | | |
| SOME SECONDARY SCHOOL | 1* | | 3* |
| SECONDARY SCHOOL GRADUATE | 1 | 1 | |
| | - | - | - |
| n= | 2 | 1 | 3 |
| PARTNER | | | |
| SOME SECONDARY SCHOOL | 1* | | 3* |
| SECONDARY SCHOOL GRADUATE | 1 | 1 | |
| | - | - | - |
| n= | 2 | 1 | 3 |

* schooled in Europe

TABLE 8 PRIOR BIRTH EXPERIENCE (RECENT BIRTHS) N=20

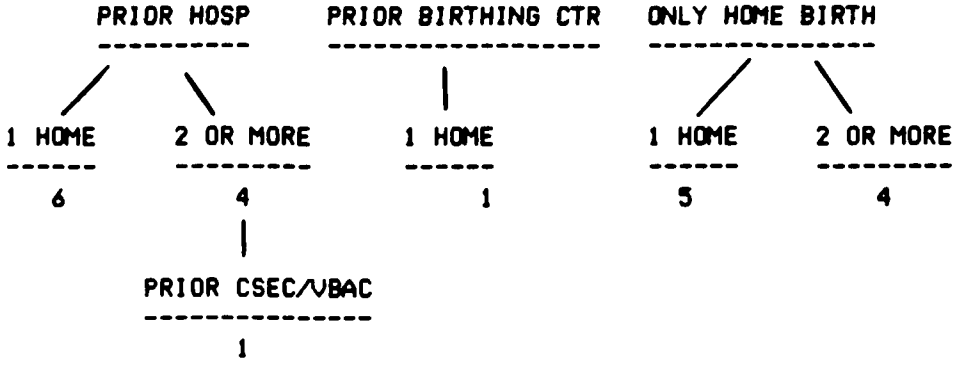

TABLE 9 MEAN, RANGE NUMBER OF BIRTHS (RECENT BIRTHS)

| | HOSP/HOME | BIRTHING CTR | HOME ONLY |
|---|---|---|---|
| ALL BIRTHS | | | |
| # | 33 (n=10) | 3 (n=1) | 15 (n=9) |
| MEAN | 3.3 | | 1.67 |
| RANGE | 2-5 | | 1-4 |
| HOSP BIRTHS | | | |
| # | 17 (n=10) | | |
| MEAN | 1.7 | N/A | N/A |
| RANGE | 1-3 | | |
| BIRTHING CENTER BIRTHS | | | |
| # | | 1 (n=1) | |
| MEAN | N/A | | N/A |
| HOME BIRTHS | | | |
| # | 16 (n=10) | 1 (n=1) | 15 (n=9) |
| MEAN | 1.6 | | 1.67 |
| RANGE | 1-3 | | 1-4 |

TABLE 10 YEARS OF HOSPITAL/ BIRTHING CENTER BIRTHS (RECENT BIRTHS)

| | 1969 | '71 | '73 | '75 | '76 | '77 | '78 | '79 | '80 | '81 | '82 | # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HOSP (n=10) | 1 | 1 | 1 | 2 | 2 | 2 | 2 | - | 3 | 2 | 1 | 17 |
| BIRTHING CENTER (n=1) | | | | | | | | 1 | | | 1 | 2 |

TABLE 11 YEARS OF HOME BIRTHS (RECENT BIRTHS)

| | 1973 | '76 | '78 | '79 | '80 | '81 | '82 | '83 | '84 | '85 | # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HOSP/HOME (n=10) | | 1 | 1 | | 2 | 1 | 3 | 4 | 3 | 1 | 16 |
| BIRTHING CENTER (n=1) | | | | | | | | | | 1 | 1 |
| HOME ONLY (n=9) | 1 | | | 2 | 1 | 1 | 1 | 2 | 4 | 3 | 15 |

TABLE 12 MATERNAL AGE (RECENT BIRTHS)

| | HOSP/HOME | BIRTHING CTR | HOME ONLY |
|---|---|---|---|
| AT FIRST BIRTH | | | |
| MEAN | 24.0 | 28.0 | 26.8 |
| RANGE | 18-30 | | 19-35 |
| AT FIRST HOME BIRTH | | | |
| MEAN | 28.8 | 34 | 26.8 |
| RANGE | 20-35 | | 19-35 |
| AT INTERVIEW | | | |
| MEAN | 32.0 | 34 | 29.6 |
| RANGE | 22-38 | | 21-46 |
| AGE AT INTERVIEW OF YOUNGEST CHILD BORN AT HOME | | | |
| MEAN | 1YR, 7MO. | 3MO. | 1YR, 5MO. |
| RANGE | 3MO-3.5YRS | | 4MO. - 5.5 YRS |
| n= | 10 | 1 | 9 |

TABLE 13 OCCUPATION (RECENT BIRTHS)

| | HOSP/HOME | BIRTHING CTR | ONLY HOME |
|---|---|---|---|
| MATERNAL | | | |
| WAITING/BARTENDING | | | 1 |
| CHILDBIRTH EDUCATOR | 2 * | | |
| CLERICAL | 1 * | | 2 * |
| TEACHING (COLLEGE) | | | 1 * |
| HEALTH PROFESSIONAL | 2 | | 2 * |
| SOCIAL WORKER | 1 | | |
| NOT WORKING | 4 | 1 | 3 |
| | -- | - | - |
| n= | 10 | 1 | 9 |

* part-time

| | | | |
|---|---|---|---|
| PARTNER | | | |
| TRADES* | 3 | 1 | 3 |
| WAITING/BARTENDING | | | 1 |
| CLERICAL | 1 | | |
| TEACHING (COLLEGE) | 1 | | 1 |
| CHIROPRACTOR | 1 | | 1 |
| OTHER PROFESSIONAL | 1 | | 2 |
| BUSINESS | 3 | | |
| | -- | - | - |
| n= | 10 | 1 | 8 |

*construction, manufacturing plants, etc.

TABLE 14 MARITAL/EMPLOYMENT STATUS (RECENT BIRTHS)

| | HOSP/HOME | BIRTHING CTR | ONLY HOME |
|---|---|---|---|
| SINGLE PARENT AT TIME OF HOME BIRTH | 1 | | |
| SINGLE PARENT AT PRESENT | | | 1 |
| NO INCOME AT TIME OF HOME BIRTH | 2 | | 2 |
| | -- | - | - |
| n= | 10 | 1 | 9 |

TABLE 15 ANNUAL INCOME IN THOUSANDS (RECENT BIRTHS)

| | HOSP/HOME | BIRTHING CTR | HOME ONLY |
|---|---|---|---|
| 10-20 | 1 | | 3 |
| 20-30 | 3 | | 1 |
| 30-40 | 2 | | 3 |
| 40-50 | 4 | 1 | 2 |
| | -- | - | - |
| n= | 10 | 1 | 9 |

TABLE 16 EDUCATION (RECENT BIRTHS)

| | HOSP/HOME | BIRTHING CTR | HOME ONLY |
|---|---|---|---|
| MATERNAL | | | |
| 11th GRADE | 1 | | |
| HIGH SCHOOL | | | 1 |
| SOME COLLEGE | 5 | 1 | 4 |
| BACHELORS | 4 | | 1 |
| MASTERS | | | 2 |
| DOCTORATE | | | 1 |
| n= | 10 | 1 | 9 |
| PARTNER | | | |
| HIGH SCHOOL | 2 | | 1 |
| SOME COLLEGE | 1 | 1 | 3 |
| BACHELORS | 4 | | |
| MASTERS | 2 | | 1 |
| DOCTORATE | 1 | | 3 |
| n= | 10 | 1 | 8 |

TABLE 17 TYPE OF BIRTH (RECENT HOSPITAL BIRTHS) N=10

| | 1ST BIRTH | 2ND BIRTH | 3RD BIRTH |
|---|---|---|---|
| VAGINAL | 9 | 5 | 1 |
| CESAREAN SECTION | 1 | | |
| VAGINAL BIRTH AFTER CESAREAN SECTION | | 1 | |
| # BIRTHS | 10 | 6 | 1 |

TABLE 18 TYPE OF BIRTH (RECENT BIRTHING CENTER BIRTH) N=1

| | 1ST BIRTH | 2ND BIRTH |
|---|---|---|
| VAGINAL* | 1 | 1 |

*attended by midwife

TABLE 19 PRACTITIONER (RECENT HOSPITAL BIRTHS) N=10

| | 1ST BIRTH | 2ND BIRTH | 3RD BIRTH |
|---|---|---|---|
| PHYSICIAN | 9 | 6 | 1 |
| MIDWIFE | 1 | | |
| # BIRTHS | 10 | 6 | 1 |

TABLE 20 DIAGNOSTIC TESTING (RECENT HOSPITAL BIRTHS)

| | 1ST BIRTH | 2ND BIRTH | 3RD BIRTH |
|---|---|---|---|
| ULTRASOUND | 2 | 2 | |
| GLUCOSE TOLERANCE TEST | 1 | 2 | |
| N= | 10 | 6 | 1 |

TABLE 21 LABOR PROCEDURES (RECENT HOSPITAL BIRTHS)

| | 1ST BIRTH | 2ND BIRTH | 3RD BIRTH |
|---|---|---|---|
| PITOCIN INDUCTION | 1 | | |
| MEMBRANES RUPTURED BY BIRTH ATTENDANT | 4 | 1 | |
| ENEMA | 2 | 2 | |
| SHAVE | 1 | | |
| IV | 5 | 5 | 1 |
| MOVEMENT RESTRICTED | 6 | 5 | |
| INTERNAL FETAL MONITOR | 1 | 1 | |
| EXTERNAL FETAL MONITOR | 5 | 3 | |
| PITOCIN TO AUGMENT LABOR | 2 | 3 | |
| PAIN MEDICATION: | | | |
| DEMEROL | 2 | | |
| VISTEROL | 1 | | |
| N= | 10 | 6 | 1 |

TABLE 22 LABOR LENGTH (RECENT HOSPITAL BIRTHS)

| | 1ST BIRTHS | SUBSEQUENT BIRTHS |
|---|---|---|
| MEAN | 12.7 HOURS | 15.9 HOURS |
| RANGE | 2-36 HOURS | 8-26 HOURS |

TABLE 23 CHARACTERISTICS OF BIRTH (RECENT HOSPITAL BIRTHS)

| | 1ST BIRTH | 2ND BIRTH | 3RD BIRTH |
|---|---|---|---|
| OXYGEN | 3 | 1 | |
| LITHOTOMY POSITION | 5 | 4 | |
| SEMI-SITTING | 4 | 2 | 1 |
| FORCEPS DELIVERY | 3 | | |
| EPIDURAL FOR FORCEPS | 1 | | |
| CERVICAL BLOCK FOR FORCEPS | 2 | | |
| CESAREAN SECTION | 1 | | |
| EPIDURAL FOR CSEC | 1 | | |
| EPISIOTOMY | 8 | 3 | |
| MANUAL EXTRACTION OF PLACENTA | | 1 | |
| N= | 10 | 6 | 1 |

TABLE 24 CHILDBIRTH PREPARATION (RECENT BIRTHS)

| PRIOR BIRTH EXPERIENCE: | HOSP/HOME | HOME ONLY | BIRTHING CTR |
|---|---|---|---|
| CLASSES FOR HOSP BIRTH ONLY | 4 (n=10) | N/A | N/A |
| FOR HOSP AND HOME BIRTHS | 3 (n=10) | | |
| CLASSES FOR BIRTHING CENTER AND HOME BIRTHS | N/A | N/A | 1 (n=1) |
| CLASSES FOR HOME BIRTHS ONLY | 2 (n=10) | 7 (n=9) | 0 (n=1) |
| NO CLASSES TAKEN | 1 (n=10) | 2 (n=9) | 0 (n=1) |

TABLE 25 TYPE OF CHILDBIRTH CLASS (RECENT BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY |
|---|---|---|---|
| FOR HOSP BIRTHS (n=10) | | | |
| LAMAZE | 6 | | |
| BRADLEY | 1 | | |
| NONE | 3 | | |
| FOR BIRTHING CENTER BIRTHS (n=1) | | | |
| COMBINATION/ECLECTIC | | 1 | |
| FOR HOME BIRTHS | | | |
| COOP. CHILDBIRTH | 5 (n=10) | 1 (n=1) | 4 (n=9) |
| LAMAZE | 0 | | 2 (n=9) |
| BRADLEY | 0 | | 1 (n=9) |
| NONE | 5 (n=10) | | 2 (n=9) |

TABLE 26 HOME BIRTH ATTENDANT (HOME BIRTH BEFORE 1960) N=6

| | 1ST BIRTH | 2ND | 3RD | 4TH | 5TH |
|---|---|---|---|---|---|
| MIDWIFE* | 1 (n=5) | | | | |
| PHYSICIAN | 4 (n=5) | 5 (n=5) | 2 (n=2) | 1 (n=1) | 1 (n=1) |

* birth took place in Europe

TABLE 27 HOME BIRTH ATTENDANT (RECENT BIRTHS) N=20

| | 1ST BIRTH | 2ND | 3RD | 4TH | 5TH |
|---|---|---|---|---|---|
| CERTIFIED NURSE MIDWIFE #1 | 3 | 5 | 4 | 4 | 2 |
| CNM #2 | 3 | 1 | | 1 | |
| CNM #3 | | 1 | 1 | | |
| CNM #4 | | | 1 | | |
| CNM #5 | 1 | | | | |
| CNM #6 | | | 1 | | |
| LAY MIDWIFE #1 | 1 | 1 | | | |
| LAY MIDWIFE #2 | | | 1 | | |
| PHYSICIAN | 1 | | | | |
| # BIRTHS | 9 | 8 | 8 | 5 | 2 |

TABLE 28 USED SAME MIDWIFE FOR 2 OR MORE BIRTHS (RECENT HOME BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY |
|---|---|---|---|
| YES | 3 (n=4) | N/A | 3 (n=4) |

TABLE 29 WOULD USE MIDWIFE FROM LAST HOME BIRTH AGAIN (RECENT BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY |
|---|---|---|---|
| YES | 5 | 1 | 6 |
| NO | 2 | 0 | 1 |
| UNSURE | 3 | 0 | 2 |
| | -- | - | - |
| n= | 10 | 1 | 9 |

TABLE 30 LABOR LENGTH IN HOURS (RECENT BIRTHS)

| | HOSP 1ST BIRTH | HOSP 2+ | B.C. 1ST BIRTH | B.C. 2+ | HOME ONLY 1ST BIRTH | HOME ONLY 2+ BIRTHS |
|---|---|---|---|---|---|---|
| HOSP/ B.C BIRTHS | | | | | | |
| MEAN | 12.7 | 15.9 | 16.5 | 1.5 | N/A | N/A |
| RANGE | 2-36 | 8-26 | | | | |
| # BIRTHS | 10 | 7 | 1 | 1 | | |
| HOME BIRTHS | | | | | | |
| MEAN | N/A | 12.1 | N/A | 5.5 | 13.3 | 6.29 |
| RANGE | | 6-24 | | | 3-36 | .25-24 |
| # BIRTHS | | 16 | | 1 | 9 | 6 |

TABLE 31 DIAGNOSTIC TESTING (RECENT HOME BIRTHS)

| | 1ST BIRTH | 2ND | 3RD | 4TH | 5TH |
|---|---|---|---|---|---|
| ULTRASOUND | 3 | 1 | 1 | 1 | |
| AMNIOCENTESIS WITH ULTRASOUND | 1 | 2 | | | |
| GLUCOSE TOLERANCE TEST | 1 | | | | |
| # BIRTHS | 9 | 8 | 8 | 5 | 2 |

TABLE 32 HOME BIRTH BACKUP (RECENT HOME BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY |
|---|---|---|---|
| PHYSICIAN | 10 | 1 | 7 |
| CLINIC | 0 | 0 | 2 |
| EMERGENCY ROOM | 6 | 0 | 6 |
| # BIRTHS | 16 | 1 | 15 |

TABLE 33 LABOR ACTIVITY (RECENT HOME BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY |
|---|---|---|---|
| BATHTUB/SHOWER | 2 | 0 | 1 |
| WALKING AROUND | 9 | 0 | 13 |
| STANDING | 2 | 0 | 1 |
| LAYING ON SIDE | 3 | 1 | 0 |
| # BIRTHS | 16 | 1 | 15 |

TABLE 34 INTERNAL EXAMINATIONS DURING LABOR (RECENT HOME BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY |
|---|---|---|---|
| YES | 6 | 0 | 4 |
| NO | 10 | 1 | 11 |
| # BIRTHS | 16 | 1 | 15 |

TABLE 35 BIRTH SETTING (RECENT HOME BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY |
|---|---|---|---|
| BEDROOM | 13 | 1 | 11 |
| LIVING ROOM (SOFABED) | 2 | | |
| KITCHEN | | | 3 |
| BATHROOM | 1 | | 1 |
| # BIRTHS | 16 | 1 | 15 |

TABLE 36 BIRTH POSITION (RECENT HOME BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY |
|---|---|---|---|
| SEMI-SITTING | 5 | | 6 |
| HANDS & KNEES | 2 | | 4 |
| ON SIDE | 4 | 1 | 1 |
| SQUATTING | 1 | | 3 |
| STANDING | 1 | | 1 |
| ON BACK | 3 | | |
| # BIRTHS | 16 | 1 | 15 |

TABLE 37 MIDWIFE ARRIVED AFTER THE BIRTH (RECENT HOME BIRTHS)

| | HOSP/HOME | BIRTHING CENTER | HOME ONLY 1ST BIRTH | HOME ONLY 2+ BIRTHS |
|---|---|---|---|---|
| MIDWIFE ABSENT | 2 | 0 | 1 | 3 |
| # BIRTHS | 16 | 1 | 9 | 6 |

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