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ORIGINAL RESEARCH – QUALITATIVE

At pains to consent: A narrative inquiry into women's attempts of natural childbirth

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ABSTRACT

Background: With only 1.2% of all annual U.S. births registered as out-of-hospital births, national trends show an increase in medicalised hospital births. Caesarean sections have become the most common surgical procedure in the U.S.; Caesarean section rates have increased from 20.6% in 1997 to 31.5% in 2009. Furthermore, in 2009, 67% of hospital births utilised epidural analgesia and 26% used oxytocin augmentation. In response to the increased medicalisation of childbirth within the U.S., some women resist standardised medical procedures and instead choose to labour and birth without medical intervention.

Aim: The purpose of this study was to understand and contextualise the childbirth experiences of first-time mothers who planned to have a natural childbirth (without medical intervention) in the Midsouthern United States.

Methods: Using narrative inquiry, we collected data from six participants through semi-structured life-story interviews.

Findings: Utilising thematic analysis, four recurring themes emerged: (1) benefits and limitations of pre-labour self-education; (2) labouring women's experiences of relationality; (3) the importance of birth stories and expectations; and (4) the creation of false dilemmas and complexities of "informed choice."

Discussion and conclusion: The women's stories suggest that U.S. medical establishments, the media, and society need to empower pregnant and birthing women by creating new narratives of labour and positive spaces of relationality. Furthermore, health care professionals need to critically examine their usage of the medical model of care while respecting women's choices and agency.

Summary of Relevance

Problem/Issue

- Increased medicalisation in childbirth in the United States; limited birthing options for women.

What is Already Known

- Caesarean sections are the most common surgical procedure in the United States. 67% of hospital births utilise epidural analgesia and 26% use oxytocin augmentation. Only 4.5% of home-birthing women require this type of medical intervention. Much of the literature about childbirth has focussed on quantitative measures.

What this Paper Adds

- Narratives of women who attempted to have an unmedicated labour for the birth of their first child. Experiences of women in the Midsouthern U.S. where birthing options (midwives, doulas, birthing centres) are severely limited.

1. Introduction: purpose and context

The purpose of this study was to understand and contextualise the childbirth experiences of first-time mothers in the Midsouthern

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United States who planned to have a natural childbirth. Within this research, natural childbirth is understood as labour and birth without medical intervention, including the usage of drugs (labour-inducing drugs, epidurals, etc.). Much of the research that has been conducted about natural childbirth in the United States is quantitative.[1–3] This study highlights the narratives of women living in the Midsouth of the United States, who have been traditionally underrepresented in the literature. This paper adds to a rich and growing body of research in this area. Our guiding research question was: How do first-time mothers who decided to attempt labour and birth without medical intervention conceptualise and experience childbirth? We first provide an overview of current trends about labour and birth within the United States, paying particular attention to an intersectional understanding of the medicalisation of childbirth. We then describe various paradigms of understanding pregnancy and childbirth. Finally, we give a brief overview of the historical context of midwifery and the medicalisation of pregnancy and childbirth within the United States.

1.1. Pregnancy and childbirth: United States context

While in 2010 only 1.2% of all annual U. S. births were registered as out-of-hospital, the rates were even less – fewer than 0.5% – in Southern states.[4] Due to the high occurrence of hospital births and a general disconnect between hospital and midwifery services, most births are attended by doctors of medicine and nurses, while only 7.8% of all hospital birth are attended by certified nurse midwives.[5] National trends show an increase in medicalised hospital births.[6] Caesarean sections are the most common surgical procedure; nearly one third of United States births take place by C-section.[7] This number has increased by 60% between 1997 and 2009.[8] In their national report on planned homebirths between 2004 and 2009, Cheyney et al.[9] noted that in 2009, 67% of hospital births utilised epidural analgesia and 26% used oxytocin augmentation. For home-births, only 4.5% of women required these medical interventions. In their longitudinal study on birth-centre births, Stapleton et al.[10] recorded that 93% of labouring women gave birth vaginally while only 6.1% needed Caesarean sections. Part of this discrepancy between in- and out-of-hospital labours can be explained by the fact that women who choose to give birth at home or in birth centres are generally categorised as low-risk with an expected uncomplicated birth. Nonetheless, current evidence does not warrant the inflated rate of medical interventions including inductions, epidurals, and Caesarean sections in the United States[4,6,11] and does not mirror records in most other Western countries.[12] Many critics of the medicalisation of pregnancy and childbirth, including midwives, doulas, obstetricians, and physicians, describe a phenomenon commonly referred to as a cascade of intervention.[13–15] The cascade of intervention refers to the idea that once one intervention is utilised, an additional intervention will be necessary, followed by another, and so on. Medical interventions interrupt the body's natural progression during birth.[13,16] Although medical intervention can be crucial and even life-saving for women with high-risk pregnancies and rare medical complications, in general, for women with low-risk pregnancies, the cascade of intervention is unnecessarily invasive and possibly dangerous to the health of both mother and child.[16,17]

MacDorman et al.[4] reported that, though out-of-hospital births in the United States have slightly increased in the past decade, this is mainly connected to the increase of non-Hispanic white women birthing at home or in birth centres. While this population of women gave birth out-of-hospital in 1.75% of the cases, the number for Asian/Pacific Islanders and non-Hispanic black women lay at .48%, for American Indian and Alaska native women at .7%, and for Hispanic women at .41% (pp. 495–497). Stapleton et al.[10] found a similar racial discrepancy between labouring women in birth centres. In their study, of the 15,574 women who chose a birth-centre birth at onset of labour, 77% were non-Hispanic white women.

Social-economic status and level of education also influences the decision of women on their birthing preference. Stewart[18] reported that higher numbers of college-educated women choose midwife-assisted birth than high school-educated women. She noted, though, that a lower socioeconomic status among non-Hispanic white women may lead them to choose birth with a midwife because of the lower medical costs due to reduced medical intervention and shortened hospitalisation. An additional factor that influences the place and manner of birth is whether midwife services and birth centres are available in the area. MacDorman et al.[4] reported that 248 birth centres were present in the United States in 2010, while 13 of 50 states did not record a single facility.

While in-hospital births are consistently high throughout the country, findings in studies on planned home births suggest a multitude of benefits for birthing mothers, such as feelings of involvement in decision-making[19] and higher rates of overall satisfaction during birth.[20] Conversely, women's feelings of control, security, and reassurance can be diminished when healthcare professionals treat pregnancy and labour as a naturally hazardous endeavour.[21–23]

1.2. Paradigms of childbirth

Davis-Floyd[24] described three paradigms of childbirth; the technocratic, the humanistic and the holistic. According to Davis-Floyd, the Western health care system is technocratic in that it is "strongly oriented toward science, high technology, economic profit, and patriarchally-governed institutions" (p. S5). In the technocratic paradigm, success equates to medicalisation and technological innovation in health care. In this paradigm, childbirth is viewed as hazardous and the experiences of birthing mothers are rendered irrelevant because labour and birth are conceptualised as mechanical processes which require intervention for efficiency and safety. The humanistic paradigm described by Davis Floyd, includes a "relational, partnership-oriented, individually responsive and compassionate" (p. S10) approach while the holistic paradigm embraces "mind, body, emotions, spirit and environment" (p. S16) of the mother. Davis-Floyd suggested that it is in women's best interest to combine the best qualities of all three models. In her words, "If we could apply appropriate technologies, in combination with the values of humanism and the spontaneous openness to individuality and energy chartered by holism, we could in fact, create the best obstetrical system the world has ever known" (p. S22).

Mansfield[21] contends that the attempts of Western medical care of childbearing women to make labour and birth more predictable and controllable implies that women are "deemed out of control and in need of improvement" (p. 1085), because technology is superior to nature. Consequently, if women resist medical intervention and opt for natural childbirth, they could be regarded as irresponsible, erratic, and selfish for placing their own preferences above the assumed needs of their child.[20,23,25] The overwhelming preference of the medicalised model of childbirth by professional medical associations, physicians, and nurses within the United States can be better understood through a historical contextualisation.

1.3. Historical context of pregnancy and childbirth in the United States

The early 1900s saw an increase in medical specialists in hospitals and the advancement of medical technology in the United States.[26] Midwives and their well-established practices came under increasing criticism for lack of medical knowledge and