A Comprehensive Literature Review on Childbirth: A Time of Options

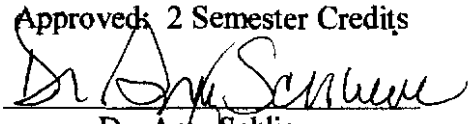
by

Carly J. Rubenzer

A Research Paper
Submitted in Partial Fulfillment of the
Requirements for the
Master of Science Degree
in

Education

Approved: 2 Semester Credits



Dr. Amy Schlieve
Research Advisor

The Graduate School

University of Wisconsin-Stout

May, 2008

The Graduate School
University of Wisconsin-Stout
Menomonie, WI

Author: **Rubenzer, Carly J.**

Title: ***A Comprehensive Literature Review on Childbirth: A Time of Options***

Graduate Degree/ Major: **MS Education**

Research Advisor: **Amy Schlieve, Ph.D**

Month/Year: **May, 2008**

Number of Pages: **38**

Style Manual Used: **American Psychological Association, 5th edition**

ABSTRACT

For centuries, culture has interfered with the process of birth, imposing cultural rituals which ignore the basic physiological needs of mother and newborn. Women are told how to push or how to breathe; they are conditioned to believe that they are unable to give birth by themselves. Pregnant women have always dreaded the pain of childbirth and have done just about anything to avoid feeling it. According to Cassidy (2006), more than 90% of American women ask for an epidural when the pain becomes too intense.

Birth needs to get back to the basics. Delivering a baby should be a birth experience in which a woman feels she has achieved, rather than something that has been done to her. In this literature review three areas are explored which provide useful information for women and their partners in regards to childbirth. The research will explore birthing with a midwife, a doctor, and a doula. Several strategies are discussed which could be used to help women reach their idea of a natural birth.

The Graduate School
University of Wisconsin Stout
Menomonie, WI
Acknowledgments

First and foremost, I would like to thank Dr. Amy Schlieve for taking this project on, despite her busy schedule; it is greatly appreciated. I am especially grateful for Dr. Schlieve's interest in my choice of topic, which gave me the motivation to finish this project. Her candidness and truthfulness allowed me to expand my research to create a better finished product.

Second, I would like to thank my husband Joe, not only for financial support while I committed to graduate school but also for his emotional support. I know my moods were a little unpredictable at times so thank you for being understanding and caring. I could not have completed this without you and I promise I will not live in our office anymore! Love you.

Third, I need to thank my good friend Beth. We went through this process together and I am so happy we did it! Thank you for listening to my frustrations and also to bounce ideas off you; you were a tremendous help. You are the definition of a "life-long" friend and I am thankful for meeting you.

Last, but definitely not least, I need to thank my family and friends who supported me these last two years; especially my mom, dad, and sister who are always there when I needed them most. Thank you for your words of encouragement and for believing that I could do this, when sometimes I wasn't so sure. I love you for that!

TABLE OF CONTENTS

Chapter I

Introduction

An expert in the field of childbirth (Kitzinger, 2000, p. 8) stated, "for many thousands of years, and still in certain cultures across the world, women have given birth among people they know in a place they know well, usually their own home." Knowledge is shared between participants and the act of bringing a baby into the world is a social event. In modern industrial societies today, birth is set apart from the rest of women's lives and accepted as a matter of specialist knowledge. Because our culture of childbirth is intensely medicalised, choices appear to be limited: to have an epidural or manage without painkillers; to agree to electronic fetal monitoring or refuse it; to decide on a Caesarean section or to deliver vaginally; to put complete trust in the obstetrician or to summon up the courage to go it alone; to accept all the interventions that are proposed or to try for natural childbirth (p. 8).

But it does not have to be this way. To make genuine choices it helps to have a wider perspective. A woman can make use of modern obstetric skills and technology if and when she needs them and she can explore everything that has been learned about birth through time and in different cultures so that she can labor using the shared knowledge of countless women. "But throughout most of history, until about a hundred years ago, almost all women gave birth at home, surrounded by midwife, friends and family" (Cassidy, 2006, p. 51). According to Kitzinger (2000), it is easy to ignore the positive aspects of traditional birth practices and the many ways that are known of keeping birth "normal" and allowing it to unfold physiologically rather than under medical control.

Cassidy (2006) stated that although home births continued through the end of the 19th century, the atmosphere began to change as male physicians, rather than midwives, arrived to attend the births. Physicians warned the mother-to-be to limit who would be by her bed supporting her, saying, "many attendants are not only unnecessary but injurious, one lady friend, besides the doctor and the nurse is all that is needed" Dr. P.B. Saur wrote in *Maternity: A Book for Every Wife and Mother* (Cassidy, 2006, p. 52).

In most northern industrialized cultures there is an expected kind of childbirth. It takes place in a hospital, among strangers. Pregnancy and birth are "managed" by caregivers who assume that they know more about what is happening than the woman who is bearing the child. Kitzinger (2000, p. 8) said, "Each woman having a baby in the hospital is transformed into a patient. The admission procedure marks the point at which the institution takes control over her body. So birth becomes a medical, and often a surgical event."

She will be registered, classified, and examined. The fetal heart rate is recorded and mother's blood pressure is measured. In most hospitals, a woman surrenders her own clothing, a symbol of her individuality, and wears the uniform provided by the hospital. She is separated from friends and family, with the exception of a designated birth partner. Kitzinger (2000) states, she becomes, as it were, a child herself, expected to follow instructions, avoid drawing attention to herself and behave nicely.

It has become normal in hospitals for birth to be regulated by artificial hormones and often completed by surgery. The woman is attended to by a team of professionals. She may be hooked up to electronic equipment, be numbed by anesthesia from the waist down and have her uterus artificially stimulated. Next, an episiotomy is performed and she may be delivered by forceps, vacuum extractor, or, ultimately, a Caesarean section.

Alternatively, the decision may be made to avoid labor entirely and to schedule an elective Caesarean section instead. The woman may request a Caesarean because she has been led to believe that this is the easiest, safest and most pain free way to have a baby.

We live in a society where birth is a medical event that usually takes place in hospitals and is thought about almost exclusively in terms of risk. Women who make the decision to give birth at home must usually overcome many obstacles put in place by the medical system.

When birth is complicated it is safer to be in a hospital. But today straightforward labors also tend to be treated with all the interventions that are characteristic of high-risk births. Treated as high risk, they often become high risk.

According to Cassidy (2006) the female pelvis has remained narrow, so as to accommodate our walking upright, but it also has evolved in shape to accommodate the newborn head, which has grown in size over hundreds of thousands of years as the brain enlarged. Today the upper opening of the pelvis is wide from side to side, the lower pelvis, however, the baby's exit, is widest from front to back. And therein lies the problem. In order to pass through the birth canal, the baby's head, the largest part of its body, must rotate as it descends in a grinding pirouette.

"The culture of society has unspoken meanings and rules that are so deeply imbedded into our lives that we rarely question them. It is most evident in the great transitions of life: birth, puberty, marriage, and death" (Kitzinger, 2000, p. 11). To begin to understand the patterns of culture, and how they change and impact each other, we have to examine the birth processes in our own past.

Becoming aware of the wide range of possibilities in birth can help us better understand our own culture of birth. We can see what is missing for women today and

can work to enrich our birth culture. This study will attempt to rediscover the power of women's bodies and the support that women can give each other.

Statement of the Problem

Today, the medical world treats pregnancy as an illness. Why not take drugs and medical treatments that are available to help with labor and delivery? Another option would be to have a caesarean section to avoid labor altogether. Rather, you could allow the hormones that have been working for women for thousands of years to fulfill their functions. According to Schwegel (2005), high endorphin levels can produce an altered state of consciousness that helps women flow with the birthing process even when it is long and difficult, leaving them alert, attentive, and even euphoric after birth, thus strengthening the mother-infant relationship. Endorphin levels drop sharply with the use of epidurals and some analgesics such as morphine.

In our culture, people who are not directly involved in birthing care typically do not know much about birth. Things used to be different. Villeneuve (2005) pointed out when a woman went into labor, it was expected that other women in her community would come to her home and help. This was a typical social expectation that had the added benefit of exposing childless women to the experiences of birth.

We are the only mammal species that needs assistance to give birth. Although most animals seek solitude for birth, almost all women in labor ask for help or surround themselves with company. It is as if somewhere, deep inside our brains, we cannot fathom how that baby's big head can make a graceful exit. It is a notion that causes fear, which triggers a cry for help in labor and delivery. According to Kitzinger (2000), this behavior probably developed around two million years ago. Once our brains were advanced enough to know that birth could be dangerous, the onset of labor made us

scared. Fear often leads to the release of the hormone epinephrine, also known as adrenaline, which can stop contractions. To alleviate that fear, to keep labor progressing, women began asking for help from people they felt comfortable with: other women. Around the world, solitary human births are virtually unheard of. The exceptions are those people whose cultures support and value the concept.

Purpose of the Study

The purpose of this research project is to look at the differences among midwifes, doctors, and doulas and the effect they have on the childbearing woman and her baby. This study will be conducted through a comprehensive literature review in the spring of 2008.

Research Objectives

There are three objectives the researcher wishes to address:

1. To determine the differences between birthing a baby with a midwife, a medical doctor, and a doula.
2. To determine the choices a woman has in regards to how her baby will be born.
3. To determine how our society heavily relies on medicated births.

Definition of Terms

For clarity and understanding, the following terms will be defined:

Betadine. A solution used in hospitals to prepare a patient's skin prior to surgery. (Wikipedia, 2008).

Breech. "Abnormal position of the fetus. Buttocks or legs come into the birth canal before the head" (WebMD, 2008a, para. 21).

Caesarean section. A caesarean section or c-section, is a form of childbirth in which a surgical incision is made through a mother's abdomen and uterus to deliver one or more babies. It is usually performed when a vaginal delivery would put the baby's or mother's life or health at risk, although in recent times it has been performed upon request. (England & Horowitz, 1998, p. 149)

Certified Midwife. An individual trained and certified in midwifery. Certified midwives possess at least a bachelor's degree from an accredited institution of higher education and are certified by the American College of Nurse Midwives (Lake, 2008).

Certified Professional Midwife. An individual trained in midwifery and meets practice standards of the North American Registry of Midwives (Lake, 2008).

Doula. A birth doula is a trained labor support person who provides emotional and physical support to a laboring woman and her partner. While she is usually not a medical professional, she can offer a wide range of comfort measures during labor - from massage to aromatherapy to continuous reassurance and coping techniques (Lake, 2008).

Electronic fetal monitoring. An electronic fetal monitor (EFM) is used to monitor a pregnant woman, typically in the third trimester. An EFM measures simultaneously both the fetal heart rate and the uterine contractions, if any, using two separate disc-shaped transducers laid against the woman's abdomen. An ultrasound transducer measures the fetal heartbeat. A pressure-sensitive transducer, called a tocodynamometer (toco), measures the strength and frequency of uterine contractions (Ball, Bindler, London, & Ladewig, 2007).

Endorphins. Neurotransmitters found in the brain that have pain-relieving properties similar to morphine. Endorphins interact with opiate receptor neurons to reduce the intensity of pain. Besides behaving as a pain regulator, endorphins are also

thought to be connected to physiological processes including euphoric feelings, appetite modulation, and the release of sex hormones (The Columbia Encyclopedia, 2001-05).

Epidural. An epidural is an injection that delivers steroids directly into the epidural space in the spine. The epidural space is the space between the dura mater (a membrane) and the vertebral wall and is filled with fat and small blood vessels. It is located just outside the dural sac. The dural sac surrounds the nerve roots and cerebrospinal fluid (the fluid that the nerve roots are bathed in; Lake, 2008)

Episiotomy. Episiotomy is a procedure where the skin between the vagina and the anus (the perineum) is cut. It is done occasionally to enlarge the vaginal opening so that a baby can be more easily delivered (Gartlehner et al., 2005, p. 17).

Induction. "The process of causing or initiating labor by use of medication or artificial rupture of membranes" (WebMD , 2008b, para. 15).

Lithotomy Position. Position in which the patient is on their back with the hips and knees flexed and the thighs apart. The position is often used for vaginal examinations and childbirth. (Medicine Net, 2008).

Oxytocin. "A hormone made in the brain that plays a role in childbirth and lactation by causing muscles to contract in the uterus and the mammary glands in the breast" (WebMD, 2008c, para. 11).

Pitocin. A synthetic form of oxytocin administered intravenously to induce or augment labor by causing potent and selective stimulation of uterine and mammary gland muscles (Lake, 2008).

Postpartum. The period just after delivery, referring to the mother (WebMD, 2008d).

Vacuum extractor. Vacuum extraction is the use of a vacuum extractor during childbirth. Vacuum extraction is sometimes used when there is no progression during the second stage of labor. Vacuum extraction is an alternative to forceps extraction and caeseraen section. The use of vacuum extraction can have negative effects on both the mother and the child (Pope, 2006).

VBAC. Vaginal Birth After Caesarean (Lake, 2008).

Assumptions and Limitations of the Study

While the researcher attempted to be exhaustive in reviewing the literature available on childbirth, some research may have been overlooked. As such, this review may present a biased view regarding birthing a baby without the use of medication. Further, other complications and interventions that exist when birthing a baby were not discussed in depth.

In addition, this literature review is merely a summarization of previous research. No empirical research was conducted. Therefore, it does not add or contribute new information to the field of childbirth.

Chapter II – Literature Review

Introduction

It is a women's right to birth her baby whichever way she chooses. Should most births be viewed as a natural life process, or should every birth be treated as a potentially catastrophic medical emergency? Different areas and cultures of the world have their own views of what makes a "normal and acceptable" birth. These differing of opinions provide three good reasons to conduct research on the topic of childbirth. The research will explore giving birth using a midwife, using a medical doctor in a hospital, and using a doula.

"In many Third World cultures human pregnancy is believed to be the force that makes the crops grow and animals bear young. There is an interconnection between human fertility and the productivity of nature. They are both part of a great organic whole. The fertility of the land and of the animals and the spoils of hunting depend on human fertility. When women in the village are pregnant all will be well with the harvest and the food supply." (Kitzinger, 2000, p. 17)

According to Kitzinger (2000) the discussion of pregnancy in other cultures is avoided. The woman must disguise her changing shape and carry on with her work just as she did before. In order to have a healthy, beautiful baby, pregnancy had to be hidden. An expectant mother must not "give in" and if she lay around and was thought to be exploiting her pregnant state; she would encounter a great deal of criticism from the other women. The idea was, a real woman gets on with her work without complaint, never draws attention to herself in any way, and gives birth without fuss, unlike other women who moan and cry out.

Kitzinger (2000) states, historically in the industrialized countries, women often delay telling anyone else about a pregnancy before she feels faint fetal movements. In fact, she may not have been at all sure that a baby was on the way until then.

Evolution and the Female Body

Around the world, solitary human births are virtually unheard of. The exceptions are those people whose cultures support and value the concept. According to Cassidy (2006) women of the !Kung San hunter-gatherers living in the Kalahari Desert in northeastern Namibia give birth on their own, for it is a sign of strength and is esteemed in that culture.

In *The Surprising History of How We Were Born*, Cassidy (2006) explains an obstetrical occurrence that may be an adaptation from primitive times: how mammals commonly labor through the night. A female who stops to give birth during the day when they typically hunt for food risks being left behind by her kin. Delivering at night also gives the mother and offspring time to recover without the risk of being discovered by predators. Humans, as well, seem to prefer laboring through the night. But because delivery takes longer for humans, women tend to give birth in the morning. Also, laboring through the quiet of the night may keep the mother relaxed and therefore able to have faster, less complicated births.

Most dilating women today arrive at the hospital during the late shift, when the staff is reduced and the least experienced doctors are working. More senior obstetricians have the privilege of working business hours, while exhausted residents attend to the overnight customers. Babies born late at night have as much as a 16% greater chance of dying than babies born between 7:00 a.m. and 7:00 p.m., a 2005 study found (Cassidy,

2006). This spike in overnight infant deaths may be attributed to the quality and number of doctors and nurses during those dark hours.

There are other ways that life in the developed world has not mixed well with the ancient biological process of birth. Take, for example, modern eating habits. According to Block (2007), easy access to food is yielding bigger babies that, no matter how hard they try, simply cannot fit through the standard sized pelvis. This imbalance is an increasingly common reason for cesarean sections.

Cassidy (2006), an expert in the field, explained that dietary changes affected obstetrics hundreds of years ago, as well, during the period of rapid industrialization and urbanization, which severed populations from fresh milk, green vegetables, and sunlight. Calcium and vitamin D deficiencies led to a bone disease called rickets, which deformed women's already tight pelvises, resulting in countless deaths for mother and baby.

"Although women's pelvises are universally narrow compared with those of other primates, human newborns and their heads are proportionately much larger than what other mammals deliver. Still, anyone who has ever pushed for hours on end only have the experience culminate in a grapefruit-sized head tearing her flesh might be surprised to learn that while human babies' crania are huge by comparison with those of other animals; their brains aren't as large as they should be."(Cassidy, 2006, p. 16)

Kitzinger (2000) says, where mammals have a diet of nuts, berries, and the occasional piece of meat, humans are gorging on cheeseburgers, onion rings, ice cream, chips, and mocha lattes. There is a fatty, salty, fried, or frozen choice for every maternal desire. And moms are not the only ones gaining excessive weight during pregnancy. Babies are getting bigger, much bigger, in countries where food and good pregnancy care are plentiful. While the good news is that the weight increase is likely because women

are healthier during pregnancy, the bad news is that the birth canal is not getting larger. The sudden increase in larger babies has contributed to the tripling of cesareans during the same time period.

"It's clear that survival of mother and child depends on many things, from pelvis shape and head size to the position of the baby and physical abnormalities. And it seems evident that evolution and modern life seem too be increasingly at odds. But the situation is far from hopeless. While a women's labor may be more painful and take longer than a monkey's, human birth does succeed in the vast majority of cases. There are 6.5 billion people on this planet to prove that point." (Kitzinger, 2000, p. 37)

Birth – Then and Now

To appreciate where birthing practices are going, it helps to know where they have been. Many changes have occurred in birthing, some of them for the good, some not.

"Gone is the fear of death for baby and mother in childbirth. Today's mothers nearly always come through childbirth alive, as do most of their babies. Proponents of the new obstetrics boast that at no time in history has a laboring mother been more safely cared for. Opponents counter that with approximately 25 percent of mothers ending up with cesareans, the American way of birth is not as good as it should be." (Sears & Sears, 1996, p. 22) In addition, many parents feel that today's high-tech approach to birth deprives them of a sense of control and interferes with the human experience of birth.

In earlier centuries, birth was a social event held in the home. Female friends and family came to help and it was usually a women-only affair. In fact, a 16th-century male physician was burned at the stake for posing as a female midwife (Sears & Sears, 1996). Experienced mothers helped ease the discomfort and steady the progress of the laboring

woman, and after birth these friends continued to lavish their attention on the new mother during her maternal leave. Mothers gave birth in the presence of familiar caregivers and in the comfort of her home.

Midwifery

According to Cassidy (2006) undisturbed birth is exceedingly rare in our culture, which reflects an ignorance of its importance. Two factors that disturb birth in all mammals are firstly being in an unfamiliar place and secondly the presence of an observer. Feelings of safety and privacy thus seem to be fundamental. Yet the entire system of Western obstetrics is devoted to observing pregnant and birthing women, by both people and machines, and when birth is not going smoothly, obstetricians respond with yet more intense observation. It is indeed amazing that any woman can give birth under such conditions.

According to Dr. Buckley (2005), in the United States in 2004, 53% of women reported that they had pitocin administered in labor to strengthen or speed up contractions. "Synthetic oxytocin administered in labor does not act like the body's own oxytocin. First, pitocin-induced contractions are different from natural contractions, and these differences can have significant effects on the baby. For example, waves can occur almost on top of each other when too high a dose of pitocin is given, and it also causes the resting tone of the uterus to increase. Such over-stimulation (hyperstimulation) can deprive the baby from the necessary supplies of blood and oxygen, and so produce abnormal fetal heart rate patterns, fetal distress (leading to caesarean section), and even uterine rupture. (Buckley, 2005)

Giving birth is an act of love, and each birth should be unique to the mother and her baby. "The missing link in all of this modern-day success may be the midwife.

Midwife, from the Old English, literally means 'with woman.'" (Cassidy, 2006, p. 26 & 29). Cassidy went on to say that every culture has had some sort of midwifery assistance, which was usually informal. It could have been the mothers, grandmothers, neighbors, extended family or friends. According to Cassidy (p. 27) "Midwives of old – just like their modern counterparts – would tell the mother when to push, rest or walk. They would use their hands to turn breeches, stimulate the newborn's breathing, or unwind the cord from the baby's neck. They offered mothers encouragement, a massage, or a salve, as well as suggestions for position changes to facilitate the birth."

When a woman feels she is successfully meeting a challenge and that she is the center of loving attention, she may experience a sense of exhilaration and zest even while in great pain. If she feels helpless and unable to cope or that people are not treating her with respect, she will suffer regardless of her pain level. Block (2007) stated that midwives believe they should care for normal births and obstetricians should care for complications.

According to Childbirth Connection (2006) labor pain and labor pain relief play, at best, a minor role in satisfaction ratings, except when expectations go unmet. Women are most likely to feel satisfied with their births when they feel a sense of accomplishment and personal control and when they have a good relationship with caregivers. A good relationship includes such elements as being treated with kindness and respect, getting good information, and being given the opportunity to participate in decisions about care. Davis (2004) stated that it is not a surprise that most women who choose care with a midwife also choose to give birth at home: they instinctively seek the comfort, privacy and opportunity for family participation inherent in their own

environment, with minimal intervention. Research has shown that the more relaxed and at ease a laboring women feels, the more efficiently her body will function.

"The vast majority of professional midwives in the United States are Certified Nurse-Midwives (CNM) and Certified Midwives (CM); according to the American Midwifery Certification Board, there are currently 11,320 CNMs and CMs. The number of CNMs and CMs in the United States has more than doubled in the last 10-15 years. In 2005, the most recent year which data is available from the National Center for Health Statistics, there were 306,377 CNM-attended births in the U.S. Midwife-attended births account for 11.2 percent of all vaginal births that year. The number of CNM-attended births has increased every year since 1975, the first year the NCHS began collecting there data. The majority of midwife-attended births occur in hospitals. In 2005, 98 percent of midwives' deliveries occurred in hospitals, one percent in freestanding birth centers and one percent were homebirths." (Martin et al., 2005)

The philosophy of the American College of Nurse Midwives is as follows: "We affirm the power and strength of women and the importance of their health in the well-being of families, communities and nations. We believe in the basic human rights of all persons, recognizing that women often incur an undue burden of risk when these rights are violated. We value formal education, lifelong individual learning, and the development and application of research to guide ethical and competent midwifery practice. These beliefs and values provide the foundation for commitment to individual and collective leadership at the community, state, national and international level to improve the health of women and their families worldwide. (Martin et al., 2005)

Above all else, midwives advocate choice. "The midwife's most basic task is to do everything she can to promote a mother's relaxation and peace of mind. Her hands

are her most precious tools, as she senses, heals and blesses with her touch" (Davis, 2004, p. 7). "The Midwives Model of Care™, written and trademarked in 1996 by a coalition of organizations, emphasizes two things: that birth is normal and that women need individualized care. The same principle that applies to birth – let it happen in its own time, on its own time, with few exceptions." (Block, 2007, p. 192)

Being pregnant and giving birth are normal life processes for which a woman's body is well designed. Midwifery care has been proven to be a safe and nurturing alternative to physician-attended hospital birth. According to Midwives Alliance of North America (2008), a midwife-attended birth gives a woman a measure of control generally unavailable with a physician—the freedom to move, eat, bathe, or whatever else might help her labor and birth more confidently. "The role of a midwife is to monitor labor, guiding and supporting the birthing woman safely through the birth process. For many women, care with a midwife allows them to birth their way, safely and naturally, supported by the people they love. Many studies show that midwifery care through labor and delivery lowers complication rates and reduces the likelihood of unnecessary cesarean section." (Midwives Alliance of North American, 2008)

The safety and benefits of midwifery care have been proven again and again in countries across the world. "World Health Organization statistics show that births attended by midwives have lower infection rates, lower C-section rates, fewer complications and healthier outcomes—thus, lower overall medical costs—than physician-attended hospital births. In addition, there is no difference in infant mortality between midwife-attended and physician-attended births for low-risk women." (Midwives Alliance of North American, 2008)

"Before midwives fell out flavor, women had the support of other women who knew how and where to touch a laboring woman to ease her pain. But as women began laboring alone in the hospital, birth seemed to get more complicated, requiring more drugs and more interventions." (Cassidy, 2006, p. 196)

Hospitals and Doctors

Until the 1900s, midwives attended nearly all births. These women were noted for their gentle touch, and their skills came, not from universities or books, but through learning from other midwives, from hands on experience, and from a personal knowledge and understanding of birth as the healthy event it usually is. Her tools were her hands, and her focus was on the whole person going through labor, not just on the birth canal. The mother usually gave birth in a vertical position, and the midwife accommodated. The physicians of the time stayed clear of birth; it was women's business.

Kitzinger (2000) stated that as the age of science and reason was developing, birth became a subject of inquiry. This led to a desire to understand the natural process of birth, and, more significant, to control it. It also brought doctors into the picture.

In the early 1800s the all-male medical schools in Europe attracted American men who wanted to become doctors (Cassidy, 2006). Courses in childbirth were only a minor part of medical training. Midwives still controlled normal childbirth. Doctors, scared off by the rituals surrounding birth, felt that anything magical was beneath their professional dignity. Midwives called doctors only when complications arose. Cesarean sections, done by physicians, were performed only to save the life of the baby after the mother had died or was going to die.

Industrialization in Europe and America created conditions that bred disease and injury, forcing governments to open hospitals (Cassidy, 2006). These buildings, and

others devoted solely to helping expectant mothers, were places where only the unmarried pregnant woman checked in. You would not find any self-respecting middle-class woman in these hospitals. They still gave birth at home.

For those who were admitted to these early hospitals, the care was free, but the services came with a price: often, women were used as guinea pigs. According to Cassidy (2006) the first experiments for artificially inducing labor were conducted on charity cases in England. So why were pregnant women, increasingly even middle class ones, still checking in to hospitals? Because delivering at home, at least in many developing countries, had become impractical. Urban families were crammed into small apartments that left little room for a mother to give birth privately. Fewer midwives were practicing, and doctors were mostly seeing women in hospitals. Furthermore, women seeking new pain relief options could receive them only in a maternity ward.

"Birth is a miracle, a rite of passage, a natural part of life. But birth is also a big business. In the United States, giving birth is a billion dollar business" (Lake, 2008). "Delivering at home and in birth centers have been statistically proven to be as safe as those in hospitals, where, not incidentally, one's chances of having a cesarean soar just because you walk through the door." (Cassidy, 2006, p. 75). "More than four million American women give birth each year, with more than 95 percent of them in hospitals" (Wagner, 2006, p. 3). But despite all the apparent options for expectant mothers, they have almost as little choice in where they will deliver, due to limited insurance coverage, cultural norms, and the deep fear many women have about how dangerous birth can be. There are, and always have been, trade-offs in decisions about where a child should be born, especially in terms of comfort, support, and intervention. Women still want to give birth where they feel most safe. And according to Cassidy (2006) for all but a select few

of those pregnant today, that place is on a bed that can, if necessary, be wheeled into the operating room, surrounded by machines, and attached to electrodes and a catheter that drips anesthetic directly to the spine.

"Is it really necessary for women to suffer so in labor? Do they really have to be delivered? Must they lose all human dignity and self-control in labor from the drunken effect of medication given in the vain attempt to make labor pain-free? Does medication really make labor pain-free?" (Bradley, 1996, p. 18) Even today general anesthesia is still being used, as are spinals, epidurals, and cesarean sections.

Dr. Buckley (2005) reported that the first recorded use of an epidural was in 1885, when New York neurologist J. Leonard Corning injected cocaine into the back of a patient suffering from spinal weakness and seminal incontinence. More than a century later, epidurals have become the most popular method of pain relief in U.S. birth rooms. In 2004, almost two-thirds of laboring women reported that they were administered an epidural, including 59% of women who had a vaginal birth.

Spinals and epidurals are two medication choices for when a laboring woman chooses for the pain to stop. Anesthesiologists or nurse anesthetists administer epidurals and spinal epidurals. According to Lyon (2007), these medications are named for the initial location of the medication inside the body. The epidural space is outside of the dura membrane of the spinal cord between two membranes. The dura is the thick membrane that encapsulates our spinal cord and holds the spinal fluid.

"The spinal epidural is when medication (derived from cocaine) is placed in the spinal space through the dura and then withdrawn a bit and the rest of the medication is placed in the epidural space" (Lyon, 2007, p. 133). Depending on the hospital, they may prefer an epidural or a spinal epidural based on their common practice or where the

woman is in labor and how urgent the need is. "The major difference is that with a spinal epidural, because the initial medication placement is in the fluid of the spinal cord, it is more immediate – pain relief starts within three to five minutes so in active labor that's often in one to two contractions. With an epidural the medication is placed outside the spinal space in the epidural space and takes about fifteen to twenty-five minutes to fully kick in." (Lyon, 2007, p. 134) All things considered, it is more ideal to be in an active phase of labor before opting for the epidural.

Once the laboring woman is prepped with an hour of IV fluids (to prevent side effects woman must preload fluids), the anesthesiologist will ask her to curl up in a fetal position lying on her side, or sitting forward. The lower back will be swabbed with Betadine to sterilize it and give the woman a local numbing injection, which is a pinch, so that she does not feel the epidural needle going in. The epidural needle, which is hollow and has a small plastic catheter within it, is then inserted into the epidural or spinal space in the body. The medication is injected first as a small test dose to monitor any adverse reaction and make sure the placement is correct. The rest is given and the needle is withdrawn, leaving the catheter inside the body (Lyon, 2007, p. 137).

"On average, the first stage of labor is 26 minutes longer in women who use an epidural, and the second, pushing stage is 15 minutes longer. Loss of the final oxytocin peak probably also contributes to the doubled risk of an instrumental delivery—vacuum or forceps—for women who use an epidural, although other mechanisms may be involved." (Buckley, 2005)

Buckley (2005) explained that epidurals significantly interfere with some of the major hormones of labor and birth, which may explain their negative effect on the processes of labor. As the World Health Organization commented, "epidural analgesia is

one of the most striking examples of the medicalization of normal birth, transforming a physiological event into a medical procedure."

According to Lyon (2007), the medicines used in epidurals and spinal epidurals are a combination of bupivacaine (numbing – similar to Novocain) and a little bit of narcotic (derived from cocaine). Buckley (2005) says the drugs used in labor epidurals are powerful enough to numb, and usually paralyze, the mother's lower body, so it is not surprising that there can be significant side effects for mother and baby. These range from minor to life threatening and depend, to some extent, on the specific drugs used.

The most common side effect of epidurals is a drop in blood pressure. This can cause complications ranging from feeling faint to cardiac arrest and can also affect the baby's blood supply, according to Buckley (2005). The following side effects are taken from Lyon (2007), maternal and therefore baby fever, spinal headache, itching sensation, shivering (temporary), residual numbness postpartum in legs or lower torso, increased chance of incontinence in postpartum time period, increased chance that forceps and vacuum extraction may be needed, increased irritability in newborn for the first few days, changes in the baby's heart rate, slowing of labor, less efficient contractions and increased chance of cesarean birth.

Davis (2004) stated that when the woman's labor stalls or slows down, pitocin, the hormone that causes uterine contractions, is frequently used in hospital births. Unfortunately, pitocin also makes contractions abnormally strong and painful, so many women hoping for natural childbirth end up requesting pain relief. To make matters worse, pain medications may interfere with labor so that more pitocin is needed. But if the uterus is pushed to hard, it will not relax enough between contractions for healthy circulation, fetal distress ensues, and a cesarean becomes necessary. This cascade of

interventions has resulted in a cesarean rate of 26% or more in most hospitals, whereas midwife practices average only 3%.

Childbirth Connection (2006) indicated that although most pregnant women are healthy and have good reason to expect uncomplicated childbirth, the United States cesarean rate is at a record level and rising. The increase is due to many medical, legal, social, and financial factors, including "defensive medicine" and changing attitudes of caregivers and pregnant women.

The c-section is major surgery, and although it saves lives when performed as an emergency intervention, it causes more harm than good when overused. A professional in the field, Block (2007) stated that caesareans are inherently riskier than a normal vaginal birth. They also lead to repeat caesareans and repeat caesareans carry even greater risks. Too many caesareans are literally medical overkill. Yet some United States hospitals are now delivering half of all babies surgically. According to Block (2007), across the nation, 1 in 4 low-risk first-time mothers will give birth via caesarean, and if they have more children, 95% will be born by repeat surgery. In many cases, women have no choice in the matter. Though vaginal birth after caesarean (VBAC) is a low-risk procedure, hundreds of hospitals have banned it, and many doctors will no longer perform it because of malpractice issues. "American maternity wards are fast becoming surgical suites." (Block, 2007).

According to Block (2007) from the Los Angeles Times, "Now there is even more compelling evidence that the United States maternity care system is failing: For the first time in decades, the number of women dying in childbirth has increased. The Center for Disease Control and Prevention released 2004 data showing a rate of 13.1 maternal

deaths per 100,000 live births. For a country that considers itself a leader in medical technology, this figure should be a wake-up call."

"Ninety-nine percent of women give birth in a hospital with access to all the high-tech machines that continuously monitor the baby's heart rate, drugs that can control the speed of contractions like the volume on a stereo, instruments that can coax a reluctant head out of the birth canal, and surgeons at the ready to perform the mother of all interventions, the caesarean section." (Childbirth Connection, 2006)

Childbirth Connection (2006) reported that a new survey unprecedented in scope of women who gave birth in the hospital last year found that women's wishes were not always respected and they were not necessarily asked permission before procedures. *The Listening to Mothers II* report by Childbirth Connection, a New York group founded in 1918 to improve maternity care, revealed that 82 percent of women who experienced an episiotomy said they were not consulted first, and so a doctor went ahead, without warning, and snipped the opening of the birth canal to make it wider. Of the women who wanted a vaginal birth after having had a cesarean, 56 percent said a doctor denied them that option.

Essentially, many of these routine procedures can complicate birth further, initiating dangers or making the experience more difficult for mother and child. According to Cassidy (2006) from the Boston Globe, many other countries also have higher midwifery rates and lower caesarean rates. More than 40 countries also have lower infant mortality rates than America, a country that spends twice as much or more per capita on health care than any other industrialized nation. "Are women, for whatever reason, not going into labor on their own and not progressing fast enough? Or is it our

American tendency to favor speed, control, and technology that has led us to what Robbie Davis Floyd calls this "technocratic" model of birth?" (Block, 2007, p. 6)

Many people believe that hospitals are institutions for sick people. According to Salt (2003), hospitals have improved their image; premiere teaching and learning institutions offer services to paying and nonpaying mothers alike. Hospitals throughout the United States are creating maternity services that are family focused and mother and baby friendly. Nurseries have been abandoned in favor of a mother and her baby staying together in many postpartum floors. Many hospitals though, continue to envision birth as a medical event that needs managing. "Statistically, mothers who give birth in a hospital can expect to undergo a number of procedures as routine protocol. Hospitals strive to deliver babies who are healthy in a timely manner. They achieve this by doing a plethora of medical procedures they consider essential to the birth of a healthy baby." (Salt, 2003, p. 55)

According to the patient's bill of rights adopted by the American Hospital Association as early as 1973, "the patient has the right to considerate and respectful care" and "the right to be informed of hospital procedures and practices that relate to patient care, treatment, and responsibilities" (Salt, 2003, p. 56). Block (2007) stated that today, normal is being redefined: from vaginal birth to surgical birth; from "My water broke," to "Let's break your water;" from "It's time" to "It's time for the induction." Block (2007, p. 5) sums up hospital care precisely, "Hospitals are accustomed to ordering chaos – the lacerated, broken, gasping trauma patient is wheeled into the ER, where staff swiftly open the airway, stop the bleeding, and set the bone. They stabilize. Childbirth, on the other hand, is chaos that the body can resolve itself. If everything goes normally, order will come – a baby will be born, creation will trump destruction."

Doulas

Woman-to-woman help in childbirth is the norm almost everywhere in the world. Childbirth is considered a normal and healthy condition, not an illness, but a woman asks others to assist if she is especially afraid, if she had a bad experience last time, or if she had problems. "Women work together to help ease the mother's labor, to mark each stage of the journey to life with ritual, and to celebrate the baby's transition to life and the woman's transition to motherhood" (Kitzinger, 2000, p. 101). "Midwives attended birth and were generally the only ones to examine the woman in labor, but other woman from the community, as well as relatives, would arrive to cook and launder, take care of other children, keep the house warm, fetch supplies for the midwife, and help physically support the woman during childbirth itself." (Block, 2007, p. 154)

Having an extra female support person separate from your nurse, doctor or midwife has been clearly documented to improve outcomes. "It has been shown to shorten labor, decrease the chance of a surgical birth and decrease the need for pain medications." (Lyon, 2007, p. 109). Schwegel (2005) stated that it is an understatement to say that women need support, beyond medical support, during the powerful and sometimes overwhelming experience of birth. While at one point this role may have been filled by nurses, extended family, and midwives, these days it is often hired doulas, whose job is professional labor support.

According to Schwegel (2005), having an experienced person offer continuous emotional and physical support to a woman during labor and birth is one of the greatest rediscoveries of modern obstetrics. This experienced person is called a doula, which means woman serving woman. "Doula is a Greek word loosely translated to mean

"women's servant" or "minister to the woman" (Schwegel, 2005, p. 177). A doula is not a doctor, a nurse or a midwife. She is not trained to make any medical decisions.

According to Schwegel (2005), a doula is trained and/or experienced in the emotional, psychological, and physiological processes of birth. The doula's role is to look exclusively for the emotional well being of the mother. A birth doula does not replace a doctor or a midwife and will not do vaginal exams or check blood pressure. Other doulas see themselves as cheerleaders. The experiences of birth can be overwhelming, and having a person who trusts in a woman's capacity to give birth can keep her motivated.

"A doula is trained to provide: explanations of medical procedures, emotional support, advice during pregnancy, exercise and physical suggestions to make pregnancy more comfortable, help with preparation of a birth plan, massage and other nonpharmacological pain relief measures, suggestions for positions during labor and birth, support to the partner so they can love and encourage the laboring woman and alternatives to unnecessary interventions." (Schwegel, 2005, p. 180)

Doulas are needed today more than ever to support the childbearing woman. "With central fetal monitoring and two or three labors per nurse, with endless forms to fill out, and with more and more non clinical duties to complete during shifts, nursing staff have no time for handholding. Now nurses are caring for machines. A doula restores hands-on care." (Block, 2007, p. 16)

Today, doulas end up serving a far different, far more demanding role than simply that of hand holder or cheerleader; they also serve as advocate and witness. Most women do not like the level of intervention in the hospital. Block (2007) states, they want access to it, they want to know it is there if they need it, but they do not want to feel like they are

on an assembly line. "Today's doula is compensating not only for a social deficit in maternity care, but for a power deficit as well. So often, she becomes a shield, a buffer between the competing interests of the woman and of the hospital" (Block, 2007, p. 158).

"In 2005, doulas attended between 120,000 and 200,000 births, and demand for doula training has grown each year for the past decade. Doulas are currently the most highly rated form of labor support in the hospital setting, above doctors, nurses, partners, and even midwives." (Block, 2007, p. 154)

The process of childbirth is explained by Winnicott (as cited in Kennell, Klaus, & Klaus, 2002, p. 73), "The mother is in the grip of natural forces and of a process that is as automatic as ingestion, digestion and elimination, and the more it can be left to nature to get on with it the better it is for the woman and the baby."

People have forgotten that just a few generations ago the only way to birth a baby was naturally; there were no pain medications, surgical or technological interventions. "The only thing a woman could do was believe in her ability, trust her body and the process, and birth through the pain and fear she may have felt" (Schwegel, 2005, p. 15).

Chapter III: Summary and Recommendations

Introduction

This chapter includes a summary and critical analysis of the current literature review's findings. The researcher will conclude with future recommendations for women and their families derived during the current review of literature.

Summary

People have forgotten that just a few generations ago the only way to birth a baby was naturally; there were no pain medications, surgical or technological interventions. "The only thing a woman could do was believe in her ability, trust her body and the process, and birth through the pain and fear she may have felt" (Schwegel, 2005, p. 15).

A physician managed, hospital-based, and technologically dependent birth can include "not being allowed to eat during labor, limiting who and how many family or support persons can be in the room, having an intravenous needle inserted upon admission, electronic fetal monitoring, induction or augmentation of labor, artificial rupture of membranes, narcotic and epidural use, birthing in the lithotomy position, episiotomy, forceps or vacuum extraction, surgical birth and separating mother and baby."(Schwegel, 2005, p. 19) Unfortunately, the United States has become increasingly mechanical, so that today it feels very strongly that if it can take anything out of human hands and put it through a machine, the United States has made technological progress.

There is no doubt that modern medicine has made astounding advances in the area of birth, but this supposedly beneficial medical help usually leads to more unnecessary interventions. The current medical intervention "fads" change with the times and seem to have a cult like following from women looking for a pain free birth.

Labor is what the term implies, hard work. "Natural childbirth, with its humanistic, undrugged approach to parenthood, is the epitome of holistic medicine" (Bradley, 1996, p. 2). Through proper training and classes, mothers and fathers learn to follow nature and, as other mammals do, give birth without the use of drugs.

Critical Analysis

This literature review provided the reader with useful information that could be used to assist women who are expecting a baby or families who want to explore their options regarding childbirth. While the researcher attempted to be exhaustive in reviewing the literature available on childbirth, some research may have been overlooked. As such, this review may present a biased view regarding birthing a baby without the use of medication. Further, other complications and interventions that exist when birthing a baby were not discussed in depth.

In addition, this literature review is merely a summarization of previous research. No empirical research was conducted. Therefore, it does not add or contribute new information to the field of childbirth.

The first research objective the researcher addressed was to determine the differences between birthing a baby with a midwife, a medical doctor and a doula. The major difference found was that a midwife advocates for a natural birth while a doctor advocates for whatever method will free up the hospital bed the quickest. The midwife uses natural techniques to help the woman through labor, while the doctor uses drugs to speed it up. The doula is there to support the woman and her family however she may be needed. She is the cheerleader and constant support for the woman going through childbirth.

The second research objective the researcher addressed was to determine the choices a woman has in regards to how her baby will be born. There are many different options a woman and her birthing partner can choose. The researcher chose to cover birthing with a

midwife, a doctor and a doula. The woman could birth at home, a birth center or the hospital. The possibilities are endless if she chooses to birth with a midwife, if she chooses to birth with a doctor she must have the baby in the hospital. Today there are medicated births, emergency births, scheduled births and natural births. Ultimately, the choice belongs to the woman and whomever she chooses to include.

The third and final research objective addressed was to determine how the society heavily relies on medicated births. You will see from the statistics from Dr. Buckley (2005) that in 2004 almost two-thirds of laboring women reported that they were administered an epidural, including 59 percent of women who had a vaginal birth in the United States. Women are relying on medication because of the fear that their body cannot perform childbirth without intervention. Most women want a pain free childbirth experience and with the use of an epidural they can achieve it.

Recommendations

Based on the review of literature, it is suggested that a woman's body is physically able to give birth without unnecessary medical interventions. However, before a woman chooses to have a natural birth, she should consider several things. First, each person must make her own decisions, in collaboration with her healthcare provider and parenting partner. Second, "the decisions a woman makes about birthing her child are inherently, intensely personal, and what is right for one woman would not fit for many others" (Menelli, 2005, p. xvii). Third, "women dramatically increase their chances of having a satisfying birth experience when they take responsibility for educating themselves and creating a supportive team and environment before labor begins" (Menelli, 2005, p. xvii). Lastly, it is recommended that further research be done on important topics that affect women and giving birth. This would include topics regarding the impact that culture,

ethnicity, social status and the environment may have on women and the choices they make about birthing a baby.

"If, through fear or ignorance, we neglect our heritage and allow technocracy to take over, woman-centered childbirth may be lost forever" (Kitzinger, 2000, p. 250).

References

Ball, J., Bindler, R., London, M., & Ladewig, P. (2007). *Maternal & child nursing care.* Upper Saddle River, NJ: Prentice Hall.

Block, J. (2007a). *Pushed; the painful truth about childbirth and modern maternity care.* Cambridge, MA: De Capo Press.

Block, J. (2007b). The c-section epidemic. Los Angeles Times.

Bradley, R. (1996). *Husband coached childbirth.* New York: Bantam Books.

Buckley, S. (2005, March & April). Ecstatic birth – nature's hormonal blueprint for labor. *Mothering Magazine,* 111.

Buckley, S. (2005, November & December). The hidden risks of epidurals. *Mothering Magazine, 133.*

Cassidy, T. (2006, December 8). Infant mortality rates. *Boston Globe Newspaper Company.*

Cassidy, T. (2006). *The surprising history of how we are born: Birth.* New York: Atlantic Monthly Press.

Childbirth Connection. (2006). *Labor pain.* Retrieved April 18, 2008, from http://www.childbirthconnection.org/article.asp?ClickedLink=262&ck=10191&area=27

Columbia Encyclopedia. (2001-2005).

Davis, E. (2004). *Heart and hands: A midwife's guide to pregnancy and birth.* Berkley, CA: Celestial Arts.

Davis-Floyd, R. E. (2004). *Birth as an American rite of passage.* Los Angeles, California: University of California Press.

England, P., & Horowitz, R. (1998). *Birthing from within: An extraordinary guide to*

childbirth preparation. Albuquerque, New Mexico): Partera Press.

Gartlehner, G., Hartmann, K., Lohr, KN., Palmieri, R., Thorp, J. Jr., & Viswanathan, M. (2005). *Outcomes of routine episiotomy: a systematic review. JAMA* p. 17.

Kennell, J., Klaus, M., & Klaus, P. (2002). *The doula book.* Cambridge, MA: Perseus Publishing.

Kitzinger, S. (2000). *Rediscovering birth.* New York: Pocket Books.

Lake, R. (Executive Producer). (2008). *The business of being born* [Film]. United States: New Line Home Entertainment, a Time Warner Company.

Lyon, E. (2007). *The big book of birth.* New York: Penguin Group.

Martin J., Hamilton B., Sutton P., Ventura S., Menacker F., Kirmeyer S. et al. (2005). *Essential facts about midwives.* American college of nurse midwives. Retrieved April 29, 2008 from http://www.acnm.org/siteFiles/news/Essential_Facts_about_Midwives.pdf

Maternal and infant health: Pregnancy related deaths. (2004). *Center for disease control and prevention.* Atlanta, GA. Retrieved April 19, 2008 from www.cdc.gov

Medicine Net. (2008). *Definition of lithotomy position.* Retrieved May 4, 2008 from http://www.medterms.com/script/main/art.asp?articlekey=25628

Menelli, S. L. (2005). *Journey into motherhood, inspiration stories of natural birth.* Encintas, CA: White Heart Publishing.

Midwives Alliance of North America. (2008). *What is MANA?* Retrieved April 29, 2008 from http://www.mana.org/about.html

Pope, C. S. (2000). *Vacuum extraction.* Retrieved June 27, 2007 from http://www.emedicine.com/med

Salt, K. (2003). *A holistic guide to embracing pregnancy, childbirth, and motherhood; Wisdom and advice from a doula.* Cambridge, MA: Perseus Publishing.

Schwegel, J. (2005). *Adventures in natural childbirth.* New York: Marlow & Company.

Sears, W., & Sears, M. (1994). *The birth book: Everything you need to know to have a safe and satisfying birth.* New York: Little, Brown and Company.

The Columbia Encyclopedia, Sixth Edition (2001-05). *Columbia encyclopedia online.* Retrieved June 27, 2007 from http://www.encyclopedia.com

Wagner, M. (2006). *Creating your birth plan.* New York: The Berkley Publishing Group.

WebMD medical reference. (2008a). *Breech.* Retrieved April 29, 2008 from http://www.webmd.com/baby/glossary-pregnancy-related-terms?page=2

WebMD medical reference. (2008b). *Induction.* Retrieved April 29, 2008 from http://www.webmd.com/baby/glossary-pregnancy-related-terms?page=6

WebMD medical reference. (2008c). *Oxytocin.* Retrieved April 29, 2008 from http://www.webmd.com/baby/glossary-pregnancy-related-terms?page=8

WebMD medical reference. (2008d). *Postpartum.* Retrieved April 29, 2008 from http://www.webmd.com/baby/glossary-pregnancy-related-terms?page=8

What every pregnant woman needs to know about cesarean sections. (2006). Retrieved April 18, 2008 from www.childbirthconnection.org

Wikipedia. (2008). *Betadine.* Retrieved April 29, 2008, from http://en.wikipedia.org/wiki/Betadin