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Empowerment as a Birthright: Exploring the Power of Informed Choice

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By

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Delaney Elizabeth Reece

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A Thesis
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In Partial Fulfillment
Of the Requirements for the Degree
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Abstract

Discussion of medical practice as a cultural experience is essential in understanding the disparities between biomedicine medical practice and evidentiary reports without medical intervention during childbirth and delivery such as the use of a midwife. Research, such as interviews, done about birth and birth experience may be able to highlight an individual's experience with these disparities. The history of birth care in the United States and the greater capitalist culture at large have greatly influenced the culture of birth today. Capitalist cultures are not consistent in every hospital or birth experience but remain in every hospital. They therefor also impact birth, and remain a stronghold in general in U.S. medical culture. With this history in mind, research is able to focus on individual experience and how this history trickles down into themes of control, trauma, and knowledge as power. Mothers interviewed for this research spoke about their lack of feeling in control, that for most of them, their birth experience was traumatic, and they felt out of control when decisions were made during labor and delivery. Mothers stressed the importance of knowledge as a way to avoid the loss of control and a way to change the course of events to provide a stronger sense of empowerment for themselves. Empowering mothers is therefore a cultural task that can be accomplished by making information readily available; not only through public means but in creating a cultural expectation for providers to share knowledge and birthing options. Addressing the mindset that Midwives are experts on normal birth, and an OBGYN is medically needed for an abnormal birth, we can bring to light a valid question. Is a midwife not better prepared to see the range of normal, and more likely to recognize a truly abnormal moment protecting the birth experience from the medical intervention?

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This research could not have been done without the mothers' support, whose stories are shared on these pages. I am beyond grateful for their time, vulnerability, and support in my goals. This master's thesis was always meant to support mothers, a means of sparking change and leaving more good than there was at the start. This project has taught me how big a goal this was and how essential boots-on-the-ground efforts are to create this good.

Thank you to the mothers, professors, and classmates who have shown me that positive experiences come from positive interaction, not positive writing. These influences are the driving force in my choice to train to become a midwife following my thesis's completion.

Contents

Preface

I came into this research as a young woman without any children of my own, but with a passion for women's empowerment and a deep love for anthropology. In the end, for me, this thesis has become a love letter to this field of work. It is rooted in the history of anthropology and pushes forward without forgetting the roots of what makes it special. Understanding others and their cultural experience is what I love. Doing this research has shown me as a researcher what anthropology is to me. Anthropology can seem messy and confusing, grasping at understanding what is so different from what we know and hold true. Without full understanding of a specific event or the circumstances surrounding it one can make inferences that cloud this true understanding. This research stands firmly in what American culture already views as true and looks out from that window at the world of other possibilities as only anthropology can, through the eyes of the people living it. Modern anthropologists seek to empower all those they work with, and they do so by giving to the communities they work with rather than taking knowledge for themselves. Working on this thesis, I have decided to do just that. Instead of just writing about these experiences mothers have had, I will be working hands on as a midwife to truly see and learn from the difference my research highlights as necessary.

Introduction

In the United States, for the majority of Americans birth happens in a hospital, and is therefore enmeshed in an established system of power. In the United States the long-standing cultural practices regarding independence, production, and scientific knowledge shape the culture of birth. At the same time, birth is a transformative event that ushers in a new phase of life, in which women become mothers for the first time or all over again. Because of its nature, birth is a particularly vulnerable period, and those who assist or control this liminal

transformation hold a great deal of power (Davis-Floyd 1992). Pregnant mothers face surveillance by the medical community, translating to deeper themes such as shame or empowerment (Rothman 2007). The culture of medicalized control on birth creates multiple experiences, and a sense of plurality of these events by drawing on ethnographic interviews with mothers they can be seen together as a whole picture (Mol 2002).

Medical knowledge is part of birth's cultural conceptualization and brings an inherent struggle for control and power due to the culturally authoritative knowledge bestowed upon medical practitioners (Conrad 2007; Dixon 2019; Jordan 1997). Medicalizing human experience generates this authoritative knowledge and grants practitioners social control over bodies. Within this medicalized structure, birth becomes a site for expressing this control over individuals, specifically women. Further, these systems perpetuate colonial thinking, potentially forcing women into care choices through social control and shame. The stories mothers tell shows the landscape they navigate to safeguard their children's health. By telling these stories mothers can support the dehegemonization of medical care and support the agency of women by telling their stories.

Medicalization

Medicalization is a social process by which traditionally non-medical, physiological events enter the medical field and require supervision by a medical institution. Medicalization occurs when a condition is defined in pathological terms and given diagnostic criteria (Conrad 2007). Furthermore, physiological events become conditions treated under epistemologies and domains of practice enforced by the standing institution. Once these events become medicalized, this spreads into the cultural conceptions held by community members, and these everyday

events are perpetuated as medical conditions. In a cultural community where medical knowledge is highly valued, the diagnostic criteria and treatment are also accepted as the norm and become universally recognized. Once the community takes hold of these criteria, the newly christened medical condition becomes detached from what it once was.

In creating a medical standard of diagnosis and treatment of the human body's natural processes, doctors become experts on the condition and hold authority on the subject. Thus, the medical community establishes themselves as the only ones qualified to act on these events, defining them and, in a way, creating them. Medicalizing puberty, for example, allows doctors to prescribe hormone treatments if the process of puberty is not following a "standard" pathway (Conrad 2007, 77-81). The use, then, of medical treatments positions doctors above the "diagnosed" individuals (Conrad 2007, 77-81).

All of this also holds true for birth. In creating a need for biomedical treatment, both the doctor's role and the patient's role exist in standard form (Conrad 2007). In another cultural context, we may have the concept of "trance," hearing or seeing things that are not there. This experience becomes an illness or disease based on its conceptualization. Trance has different names and meanings worldwide, depending on cultural understanding. Trance is an excellent skill in many places, a gift that gives insights (Benedict 1934, 265). In the past of the Catholic Church, individuals who received visions from God were considered divine and saintly; however, in its medicalized form, these events are lumped in with psychosis, or schizophrenia, and shame rather than sainthood (Benedict 1934, 265). These differences create gaps and miscommunications about a disease —medical experience— and an illness—a cultural experience.

When understanding medicine though anthropology the culture of what it means to be ill is important, as that is what medicine is treating. In this sense illness is something culturally constructed, where disease is what may be happening on a scientific or medical level. Illness comes into being by cultural practices alone and therefor has cultural explanations for happening (Brown and Closser 2016, 14). An example of this would be the idea in Chinese medicine that illness comes from exposure to things that are too cold, or too hot not from a virus or bacteria. An illness can only exist with a cultural explanation, and a disease can only exist when there is an evidence-based medical explanation (Mol 2002). Disease and illness exist in tandem rather than as separate actors. “As soon as the new opinion is embraced as customary belief, it will be another trusted bulwark of the good life” medicine has become such a belief (Benedict 1934, 278). "Medical expertise" has systematically changed cultural experience and practice to a negative experience associated with a newly conceptualized disease. Medicalization becomes a tool for political processes, and once life events become a medicalized culture, it sees only the medical condition. In communities where health, economy, and politics are interwoven, an upset in one causes an upset in another. In accepting these standards, individuals may benefit from a greater quality of life, increased

life span, or face the negative implications of shame and ostracization. There is a lengthy history of the adverse effects of medicalization in the United States. During the acceleration of the Enlightenment period through the 20th century. Women who did not fit into the cultural standards of femininity at the time were deemed mentally ill and removed to an asylum, often only with the consent of a father or husband (Mottier 2008). The catch-all medical diagnosis of these unruly women was hysteria: a medically sanctioned diagnosis for any woman who did not conform to conventional feminine standards.

The use of hysteria as a diagnosis has now been de-medicalized, meaning the diagnostic criteria is no longer used or promoted. The process itself still leaves marks that can not be undone by simply removing diagnostic criteria and taking, for example, homosexuality, where average sexual variance turned into a dangerous disease (Foucault 2020). Homosexuality entered the Diagnostic Statistical Manual —the bible for psychologists— as a diagnosable disease. The medicalization of homosexuality wavered in the late 1970s due to cultural pushback. The hard work of activists forced changes in the cultural community resulting in removing homosexuality as a mental illness in 1974, five years after the Stonewall riots (Conrad 2007, 112). In this case, homophobia and the idea that being gay is a choice or an illness persist within society, despite cultural changes. With both examples of hysteria and homosexuality, the medical community has taken normal human variation from society at large and sequestered it away to the hospital's domain. This removal was a means of control, gatekeeping certain behaviors and experiences. It also means a sustained change to cultural understanding and lasting effects on those who fit aging diagnostic standards. Although institutionally, it no longer views it as a disease, the cultural impacts and stigma remain.

Birth Work

Compared to these historical examples, the modern state of birth remains medicalized, mainly under the control of medicine's patriarchal system, and mothers who waver or drift away from this can face the same cultural pushback.

Medicalization works in the U.S. and the industrialized West under a technocratic healthcare system that plays into medicalization. The technocratic model of care follows the idea that the human body is a machine (Davis-Floyd 1992; Walsh 2006). This human machine can break down, and the repair technician —a doctor— must fix it. These ideas seep their way into everyday lives and American culture. The two become synonymous, with medicine as a

miniature of values in the United States, making the individual the object of scientific and technological intervention (Davis-Floyd 1992, 45-47). In a way medical culture in the U.S. has become a prominent feature of life and ideology. By understanding this, the standards and experiences of individuals can be conceptualized through it. For that reason, the power struggle, sexism, racism, and gatekeeping under the technocratic model reflect the shortcomings of medicine and Western culture at its roots. Medicalization is a far-reaching process and, in many cases, leads to the effective treatment of disease. Among the many benefits are pitfalls, one of which is how medicine and uses -isms to disenfranchise and prey upon those it disenfranchises.

Until the 1800s, female midwives were the primary attendants for births worldwide. In the U.S, midwives and female relatives assisted in more than 90% of births, with less than 5% requiring surgical intervention (Cogburn 2019, 30). Male surgeons did these surgical interventions to save the mother's life, as babies had a much lower chance of survival. This general practice and perception was the case until the late 1800s, when the focus shifted to saving the babies' lives in difficult births. Coupled with the exclusion of women from enrolling in traditional medical schools, men became the birth attendants of the wealthy class. By the 1900s, midwives were in the past, and male obstetricians gained control over birth (Cheyney 2019). It was a short jump into the hospital from home, where male doctors gained even greater control, and birth had transformed into a dangerous and scary version of itself, a perceived danger that has become commonplace (Cheyney 2019,181). Historical events weave together the complicated history of birth and create cultural history. Now, it has become an economic, masculine, medical event rather than being recognized as a cultural event. Fear perpetuated about birth, and the pain has been a motivator for the medical absorption of the experience. Simultaneously, a shift in thinking about the economic value of an unborn life is likely another

contributing factor. Science and colonialism create opportunities for oppression by using the perceived legitimacy of medical practice as a justification for interventions; the more significant the intervention, the greater the degree of control. The scientific community must deem the previous process inadequate or dangerous. From there the new standard spreads to the community, where it adopted as the best, safest, most moral choice, and social pressures do the rest of the work pushing individuals to choose it. The shift toward the economic value coupled with the systematic removal of women as birth care providers created the perfect opportunity for oppressive practice. By removing group members, considered experts, and replacing them with typically doctors, mothers are at the mercy of outsiders. A new interest helped this shift in preserving the baby's life in a difficult birth; a baby with more significant economic potential leads to the birth care we know today as commonplace.

Pregnant women who, for whatever reason, have behaviors that do not line up with medical standards are lazy or careless by cultural standards (Taylor 2008, 116-143). These stigmas are everywhere: continuing to drink caffeine, giving into cravings, and gaining too much or too little weight. Further, mothers' behaviors and birth outcomes directly represent their character, becoming difficult patients and bad mothers based on this alone (Farmer 2010). By denying medical interventions, tests, and observations, women face a similar stigma of being deviant from medical recommendations (Browner, 1996, 153; Brubaker 2009; Donovan, 2006, 401). Making choices that contradict the medical establishment is considered evidence that women make the wrong choice —one that does not produce an economic positive—and are uneducated in their actions (Parry 2008). All of these examples connect back to the profound cultural idea that a mother's "job" is to produce a happy, healthy baby because a healthy baby can produce and consume and thus has value. Further, it is a system that maintains the bias that

women are homemakers, fragile, and in need of coddling (Davis-Floyd 1992; Singer 1998). The root of the dichotomy of "good" and "bad" mothers lies within medical culture; "good" and "bad," however, is often more than moral statements. To begin, before a woman can be "good" or "bad" as a mother, they must first become a "good" or "bad" patient. Their behavior as a patient often heavily influences the determination of a "good" or "bad" mother. Being a "good" patient within the realm of medicine involves relying heavily on scientific knowledge given to them by doctors. Furthermore, "good" patients never argue and rarely question the treatments given. In this way, being a "good" patient means being quiet, passive, and obedient. "Bad" patients, on the other hand, deviate from these expected behaviors in a medical setting (Farmer 2010, 505). Patients considered "difficult" or "selfish," ask too many questions or refuse something the doctor believes to be medically necessary. In other words, they push back against the authority of the doctor (Rothman 2007).

Control of Information: Medical Training and Patriarchy

Within the medical community there is an inherent struggle for control and power due to authoritative knowledge. The hierarchy of power and control exist not just between patient and doctor, but in a pyramid with nurses, family members, and midwives (Decker 2019). Although not necessarily the intention of the practice, medicalization of birth also generates political control over women's bodies (Conrad 2007). Doctors participate in this, perhaps unwilling or unknowingly, by treating the patient's body as a technical problem and closely guarding medical knowledge. The prestigious role that medical professionals hold in society, achieved through years of hard work, seemingly justifies their power. Entering into this influential position is no easy task with four years of college, the MCAT (Medical College Admissions Test), four more years in medical school, two years of residency, and finally achieving licensure. These phases

are long and drawn out to create what culture views as a "good" doctor using this extended liminal phase (Davis-Floyd 2018). This process is similar to how the medical culture creates a “good” mother. Medical school, both in the classroom and the field, creates its own “good” and “bad” students, with similar definitions to the “good” or “bad” patients. “Good” students do not complain, ask too many questions, or argue. “Bad” students are those who argue or let their wishes dictate their treatments. Medical students face the one reality of medicine during their education: bringing their ideas or wishes into their field will be detrimental to achieving their licensure (Davis-Floyd 2018, 110-125).

By creating a historically top-down system where women cannot reach the top, biomedicine encodes a system of control over women’s bodies (Singer 1998). Medicalizing previously nonmedical events allows them to be understood and treated by medical professionals as medical problems. This process leads to a social and cultural transformation around medicine’s importance and role in society. Historical practices remain in these hospitals despite a lack of evidence supporting their benefit, where they cause undue harm as nothing more than symbols of the cultural workings outside the hospital (Davis-Floyd 1992, 305). In the last century, this same process has continued regarding birth, moving from the home to the hospital, and maintaining treatments that no longer have a base in evidence. The authority granted takes more significant control over a narrower population in a private setting away from public opinion and view. Birth in a hospital is then just as safe as home birth, and in the case of some practices, it can be even riskier due to medically caused complications (Davis-Floyd 1992, 177-186; Kobinsky 1999). These practices impact women’s agency and power in a process that can be one of the most empowering moments in their lives. By drawing attention to medicine’s cultural

practices rather than the science of medicine, we can see where they diverge, which gives room to examine outside perspectives.

The domain of medical knowledge and medical shame extends beyond doctors' offices and hospitals. By the time a patient has reached the doctor's office they must already have an understanding of their place in the system, and already be acting in accordance for what is expected from a healthy person in a medical sense. In this system, healthy equals good. This starts in some cases long before women even become pregnant. Women's bodies are under the surveillance of their communities from a young age. Political opinions on women's healthcare affect the general cultural sentiment about women's choices for their lives and body. In particular, this is an issue in reproductive healthcare. With these medicalized structures in place, pregnant women are under surveillance to opt for the proper care at the correct times or face accusations of being bad mothers (Davis-Floyd 1992). Women's behavior is monitored before the prenatal period, birth, and their choices in raising their child. In denying medical interventions, tests, and observations, women face a similar stigma of being deviant from medical recommendations (Browner, 1996, 153; Brubaker 2009) Making choices that contradict the medical establishment shows that women make the wrong choice and are uneducated in their actions (Parry 2008).

Economization of Life

Rather than being qualified, human life has become quantified under a biopolitical frame. Human biology must be managed, maintaining a population with the most significant economic benefit. As a result of this life and death must both be managed to maintain their value. These biological politics spearheaded the shift from midwives to doctors, shifting the value of human life from emotional, religious, or intrinsic to human production's monetary value (Lemm 2014).

In this frame, the value of a person is rooted in their ability to produce an economic positive; and in turn those who are able to do so are seen as morally good. Therefor a mother's value is not her own in this case, but in the potential economic value of the child she carries (Murphy 2017; Rothman 2007). The emergent idea of the individual as the producer of value translates into a biopolitical approach to the management of life and death. As a result of this connection, medical institutions became deeply embedded in the U.S. as individuals became agents in production (Davis-Floyd 1992). Medicine treats the individual and does so by using a narrow view of the individual at the start. In this frame, disease cannot be shared, nor are the deeper reasons why someone became ill necessary for their treatment. In this model, the individual is the largest scale that can be accounted for, take for example COVID and how responsibility is placed on the individual for safety and health. Medicine reduces disease's singularity, treating only physical symptoms, not cultural ones (Brown and Closser 2016). In the current medical model of birth, women entering motherhood risk having their identity outside of their pregnancy stripped away; they become simply pregnant women in need of medical attention to give birth to a healthy, happy baby. While this goal seems unattainable, women's identities are taken and replaced with the title of 'patient". This renaming system is used in slightly different terms by colonists to control and limit the choices of those disenfranchised by society.

Women become a part of a conveyor belt in which they are the creators of a product not yet accounted for in the GDP but still connected to it. A baby who can be a positive number towards the GDP becomes a priority above all others, in the U.S. and abroad. Most women are encouraged to wait to have children until they are economically stable. Economic readiness is not for the mother's benefit, though, it is so the child will have a more significant opportunity to produce for the GDP. Not all births in high GDP countries are positive economic numbers; some

are “better off not born” as the poor or uneducated are unlikely to provide economic benefit (Murphy 2017, 41). The responsibility of avoiding this and producing an economically productive child falls on the mother. Subsequently, a child born who suffers from birth defects or life-limiting conditions is not a useful product in terms of economic output. The social consequences of this fall on the mother, sometimes for failing to prevent a condition, and sometimes for not ending their pregnancy (Murphy 2017, 41).

Counter Cultures

A growing body of research has focused on the natural birth movement, empowering mothers in homebirth’s positive experience. There have always been and always will be different ways of giving birth; these different experiences vary in regularity, acceptance, and the general experience. Although not at the forefront of cultural experience, birth away from hospitals exists as a possibility for experience with growing numbers of women taking notice (Mol 2002; Parry 2008). However, the general public believes birth must occur under medical supervision; and most births continue to occur in hospitals under the supervision of a doctor (Brubaker and Dillaway 2009, Cheyney et al 2019). The technocratic model of birth takes different shapes around the world. Nations lumped into the industrialized West range on a spectrum for care. For example, in the Netherlands and New Zealand, midwives attend nearly half of all births, but in Greece, more than 60% of births are cesarean (Georges and Daellenbach 2019). In Greece this is not for any medical reason, mother opt for c-sections because it is seen as an upper-class option with less pain and damage to the genitals. In the United States, midwives and birth centers have become synonymous with an anti-medicine counter-culture rather than another side to the coin of care. Often, they are the choice of the elite, who desire a specific birthing experience, or those who hold radical ideas about intervention and the medical state. The ability of the elite to choose and influence their birth experience is consistent around

the world; whether that means opting for natural or medical birth varies culturally (Georges and Daellenbach 2019).

A desire to choose is often a result of negative personal experiences with medicine/birth or having heard nonmedical birth praise from a trusted source (Cheyney et al., 2019). Elite, primarily white, upper-middle-class mothers with low-risk pregnancies often reach out for a midwife to have a specific birthing experience. The midwifery care model follows a holistic approach, emphasizing a person's whole experience within its context rather than asking it to fit a mold. Mothers consistently used words such as "natural" or "personal" to describe experiences with midwives. The midwifery model directly contrasts with the medical model, which breaks the person into parts that need treatment and strictly follows hospital protocol. Midwives strive to establish a cooperative dialogue between themselves and the mother to find the correct balance of power (Parry 2008). The midwifery model of care allows mothers to exert additional control over their birthing experience. Small movements often encourage individual mothers to assert themselves, failing to foster connections with others in the same position. This choice favoring midwives is not universal. In other communities, midwives are reserved for the most impoverished populations, while doctors are the choice of the wealthy. For example, in Tanzania, home birth might cost a mother the equivalent of US$5 for the help of a traditional midwife (Davis-Floyd and Melissa Cheyney 2019). In contrast, a hospital birth means financing all the medical equipment needed (Cogburn, Strong, and Wood 2019). Most births occur outside the hospital in Tanzania, leaving poor mothers who require hospital-level care to have to choose to save themselves or their babies when a medical emergency arises. In Greece, the cultural preference for wealthy mothers is for c-sections and doctors. They prefer them for the same reasons; however, there are some mothers who prefer midwives, and continuity of care. Doctors

in Greece are given gifts or extra money to ensure that mothers have the same provider through delivery (Georges and Daellenbach 2019, 140-143). While on the flip side, poor and immigrant mothers deliver in public hospitals on "Gamma" wards with up to eight beds to a room and are attended by whichever midwife is available (Georges and Daellenbach 2019, 160-162).

Furthermore, these are not systemic changes. Davis-Floyd's (1992) ethnography *Birth as an American Rite of Passage* breaks down and discusses the experiences of many mothers who gave birth in hospitals during the 1990s. This ethnography shifted the attention of those inside and outside the hospital system to more significant issues of institution-level problems. The 1990s acted as a turning point for maternal care, and many of the harmful practices described in the book are no longer commonplace. Still, electronic fetal monitoring, drugs such as Pitocin, and episiotomies are widespread, even with little evidence of benefit to support them (Davis-Floyd 1992, 73). Methods such as attempting to speed delivery have been shown to, in fact, create harm (Davis-Floyd 1992). Davis-Floyd shows that their use has minimal medical justification due to the potential risks, and for the harm, their use is then a byproduct of cultural norms. Cultural norms can only be perpetuated and kept up by a cultural system that relies on them to continue. This system maintains the bias that women are homemakers, fragile, and need coddling (Davis-Floyd 1992; Singer 1998). More recently, other authors have written on the medical model and addressed this lack of change (Decker 2019). Unfortunately, because of how knowledge is transferred in medicine, these changes take more than ten years to make their way up the ladder. In some places, these changes are happening, wherein in one city there is a hospital that allows all kinds of birth plans, and in another, that is quite the opposite (Decker 2019).

The World Health Organization reports that only 10-15% of births require hospital-level care. These births include preeclampsia or cord prolapse, which both necessitate cesarean delivery for the safety of the mother and child. (Cogburn, Strong, and Wood 2019, 50). This difference in which births need medical attention versus what culture prescribes has led to the medicalization of birth and the technocratic model of U.S. healthcare. Hospital birth is emphasized as safe in this system, yet in Mexico City, where hospital births are also standard, the maternal mortality ratio reaches over 100 deaths per 1,000 hospital births (Kobinsky and Heichelheim 1999, 401). Although culturally endorsed as the safest option, exceptions to the rule tend to go unaddressed for hospital care. These differing ideas are simply different sides of the same coin, two sides that have the same goal, in the end, a healthy, productive baby. They are, in a way, the same colonial thinking on a women's body as a mechanism for another producer. However, they reach this goal with different means. This is not to say that midwives and home birth benefits do not exist, but these benefits are overruled and overshadowed by more extensive cultural mechanisms. Medicalized birth and natural birth become pitted against one another, each claiming a better outcome and claiming that the mother who chooses it is the "good" mother. A mother is "good" for following staff instructions in a hospital. However, in a non-medical birth, she can be perceived as "good" for refusing medications. In both cases, if reversed, the mother is "bad" for not fitting the schema of her given culture. It does not truly reflect her competency or ability to be a good or a bad mother, but rather her ability to check the boxes of standards set by medical personnel and to maintain level emotions through the process so she is not seen as weak. The history of care for mothers and their babies is far from linear, leaving no right or wrong answers in its wake. Cultural changes in what good care and a good patient look like have changed, from Twilight Sleep, rendering mothers unable to participate in birth to mothers being

in control of themselves throughout labor (Cheyney, 2019 182). The Lamaze method is being used in most US hospitals in conjunction with medical supervision. This care system encourages mothers and partners to be involved in the delivery together and helps to avoid unnecessary medical intervention (Lamaze 2021). Regardless of the kind of care a mother chooses, mothers must still navigate the judgment of making those choices. There are multiple options for care and how someone can be a good mother. This multiplicity allows for many ways to be empowered in their experience; empowerment is not one size fits all but an individual experience (Mol 2002). What stands in the way of achieving this is not the lack of options; instead, it is the inability to choose these options freely because of a lack of access to cultural understanding and the risk of being judged for making those decisions.

Feminine vs. Masculine Knowledge

The harmful practices discussed in *Birth as an American Rite of Passage* and the practices still used above exist due to the current training model for medical professionals. Learning in the U.S. is based on right and wrong answers rather than collaborative solutions (Davis-Floyd 2018, 115-120). These unspoken rules begin in the medical classroom but are carried over into new doctors' hospital training. These disparities exist because there are harsh black and white lines in teaching medicine. During their clinical rotations, up-and-coming doctors learn from current practitioners. This linear passage of skills perpetuates potentially outdated methods of decontextualizing the human patient over time (Davis-Floyd 2018, 116). It is essential to learn from experience, yet new doctors have no choice but to accept their teachers' philosophies (Davis-Floyd 2018, 115). The lineage of knowledge is often passed uninterrupted for over ten years, despite rapid innovation in the field. This system purposely allows for little free time, self-expression, or reinvention of the wheel, leaving upcoming doctors in a state of

forced conformity. During their time learning, they face one reality of medicine: bringing their emotions with them will make them “bad” doctors (Davis-Floyd 1998, 107-140). Overworking these interns and the emotional numbing they describe using to distance themselves from the potentially traumatic events they face daily has consequences. Doctors and doctoral students have an astronomically high suicide rate (Davis-Floyd 1998, 123). This is where we start to see the system of doing and learning medicine as patriarchal. Around 30% of doctors were female within the medical community as of 2010 (Davis-Floyd 1998, 102). The gender discrepancy is a historical one in which women were systematically excluded from the practice. With limited access to education and even fewer jobs in the field, women in the early days of medicine could not shape it to their image. This lack of shape to the feminine image has a two-fold effect: fewer women enter the medical field, and those who do must conform to the masculine expectations to succeed.

The way midwives learn is fundamentally different from doctors. While it follows a similar learning structure, there is a cultural emphasis on community and feminine knowledge. There is the same genealogy of knowledge, the passing of information from teacher to student — the way genes might be passed through a family— but no one is ever just a student, and no one is ever just a teacher as they are learning alongside each other. Midwives must adopt new methods and best practices, and face greater scrutiny from the community and medical system. Doctors with emotional reactions appear dangerous in their systems (Davis-Floyd 1998, 107-140). Without emotion, medicine can seem sterile and cold, reducing patients' statistical risk. With the knowledge and plan for the worst-case scenario, medicine with emotion could be seen as the midwifery model, giving mothers power but in a clinical atmosphere. Where hospitals prioritize intervention for risk management, midwives prioritize prevention; and they do so through

education. A foundation of midwifery care is the education they provide to mothers about the process they are undergoing, and in this, knowledge is power in a medical system.

Midwives practice in multiple capacities in the U.S. depending on the license, in and out of hospitals, in homes, and in birth centers. Certified Nurse-Midwives (CNM) have undergone schooling within the medical frame and practice inside hospital walls under hospital protocol. They are often less invasive than an OBGYN but are still on this same hierarchy, and should the birth not follow hospital standards, doctors are called to make final decisions and take the next steps. Outside of hospitals, Certified Licensed Midwives (CLM) and or Certified Practicing Midwives (CPM) are certified under national standards in different forms of care. The goals of the midwifery model from the National Association of Certified Practicing Midwives are as follows: "to monitor the physical, psychological, and social well-being of the mother throughout the childbearing cycle, provide the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support, minimizing technological interventions, and identifying and referring women who require obstetrical attention" (NACPM 2022). The goal of midwifery today is to carve out a place within the medical model to show the efficacy and safety of birth outside the hospital while still recognizing the place of medical intervention in high-need situations. Unfortunately, the regulations for this kind of care are far from universal. In the United States, there are multiple certifications midwives can have, these being a certified nurse-midwife (CNM), a licensed midwife (LM), or a certified professional midwife (CMP) dependent on the state. An LM and a CMP are comparable, both requiring two or more years of hands-on training in addition to passing a nationally recognized exam. CNMs are nurses first and then undergo training to become a midwife as an additional certification. Only certified nurse-midwives can practice

within a hospital, and there they are under the same umbrella of authoritative knowledge, which places doctors on top. The position of doctors is exemplified by the seven states in which midwifery is illegal; midwives who practice in these states commit the crime of impersonating a doctor.

Methods and Research Design

By discussing and addressing the effects of medicalized culture on birth experience this research seeks to emphasize mothers narratives. Participants were sourced from all over the United Sates to look specifically at this cultural community and what these mothers view as important in their own birth stories. To achieve this, the goal was to have mothers share their stories in a group setting, encouraging narrative and story telling rather than interview. By doing this, mothers were at the helm of how these stories unfolded.

This research was done with the approval of the Western Washington University Institutional Review Board. In accordance with confidentiality standards the names, locations, dates, and other identifying information about those who participated in this study have been removed. By maintaining the privacy of those who have shared their stories we can respect not only their honesty but vulnerability.

Individual vs. Group Interviews

An interview is a powerful tool in the pocket of anthropologists by granting a snapshot into the complex lives of those around us. The power of authority is discussed at great length in this research to persuade and disenfranchise. There is a risk that this authoritative power may fall to the interviewer in individual interviews rather than the participant. There is power in numbers, and where the interviewer is in the minority, those sharing their stories have more freedom and

power to do so. Focus groups and group interviews use this sense of camaraderie for a safe place to discuss sensitive topics; the group creates a support network showing safety and building trust through shared experience with other members, rather than the interviewer (Sandelowski 2002).

The group interview is a feminist method that places participants in the driver's seat of research. For this reason, they were a focus and deemed essential in describing experiences and narratives in a social setting rather than in a formal one-on-one interview. To emphasize the agency of participants, Fray and Fontana explain how group interviews emphasize the agency of participants, "ethnographic account be more polyphonic and thus present more of the accounts of the subject studies...that the role of the ethnographer is 'minimized' in the report, to diminish authorial bias and influence" (1991, 175). Members in a group have the opportunity to build off of one another to create a rich narrative about shared and individual experiences. Having a group share narratives, the goal is that the interactions between women would allow for increased recall (Fray and Fontana 1991). These interactions allow the researcher to take "advantage of group dynamics to produce new and additional data" (Fray and Fontana 1991,175)

The interviews follow a semi-structured format, asking women to tell their birth stories. To answer questions about power and control, probing questions derived from an adjusted version of the Childbirth Experience Questionnaire were used (see Appendix B: CEQ; Carquillat 2017; Walker 2020). Hospitals use the CEQ internationally to understand the experience, often as self-reflection and hospital staff assessment. As a result, information from the CEQ in this study can be compared to hospitals worldwide. The interview guide elaborates on the four main domains of the CEQ: Personal Capacity, Professional Support, Perceived Safety, and Participation. Interviews are at the center stage of this research, as the numbers from surveys like the CEQ can only say so much.

Four interviews were conducted in this manner, and a total of 5 individuals were interviewed. Three of the four interviews were done individually with the researcher and participants and closely followed the interview guide (see Appendix D). The fourth interview with two mothers was the longest and strayed farthest from the interview guide. This group interview was the most conversational and allowed for unplanned discussion. As a result, the conversation in this interview informed topics to be brought up in subsequent interviews.

The purpose of these interviews is to emphasize women's stories and women as experts on their own experiences. For that reason, the interviews were transcribed verbatim by the researcher to ensure participant voice continuity and maintenance of essential details (Neergaard et al., 2008). By transcribing these interviews in-house, the researcher can form a closer relationship and understanding of the data. Themes within the interviews were analyzed using grounded theory, allowing them to emerge from the stories of women themselves (Dey 2004; Schwarzburg 2013, 40-44; Seale et al. 2004 80-94). By doing this, those interviewed voices became the driving force for discussion in this thesis rather than topics chosen and pursued by the researcher. The goal of using narratives, group interviews, in-house transcription, and grounded theory is to maintain the agency of these women participating (Seale et al. 2004, 125-140). By using grounded theory to inform the topics of this thesis, participants brought forward three main ideas. Firstly, how medicalization translates to the authoritative knowledge doctors possess over women’s bodies: how birth stories reflect how culturally ingrained and sneaky the process is. Secondly is traumatic birth and how this trauma is pushed aside by the mothers who experience it and society. Finally, how the midwifery model of care navigates these topics and how it is used and perceived by the public and mothers.

2020 and the Covid Pandemic

The research was conducted during the summer and fall of 2020, and as a result, was directly impacted by the COVID-19 Pandemic. Interviews, both group and individual, that would have taken place in person were conducted via Zoom using the same format for recruitment and interview structure. Zoom eliminated the need for individuals to meet in person, reducing risks associated with the virus and reducing the connections made. Based on the described positives of group interviews, the hope was to have them as the principal part of this research. Due to the Covid pandemic and stay-at-home orders, this was no longer the rule but the exception.

Our Mothers

Abby

Abby had her first baby during the start of the COVID pandemic in 2020. Her birth took place in a hospital, and her husband supported her through the process. This was her first pregnancy, and although she was excited to meet her baby, she was nervous about her birth. Her doctors suggested and she made the decision to induce her several days after her due date. Doctors used several medications and a foley catheter —which dilates the cervix manually. The staff explained that first-time mothers often have longer labors, and they wanted to start her induction as early as possible in the morning. Abby was no exception to this commonality; even with her induction, contractions did not get started or established well, and she labored for nearly two days. She spiked a temperature around the 36-hour mark, and her baby's already high heart rate became concerning.

Abby went in for an emergency C-section because of this infection and distress in her baby. During her operation, she lost nearly 2000 ml of blood from both the surgery and a result

of her infection. While in the operating room and immediately after in recovery, Abby was in serious trouble. She received several life-saving interventions, although the way she told her story was bright and happy, skipping over the danger she faced. Abby herself was not able to hold her baby in the OR. After her husband welcomed the baby to this world, the nurses took their daughter to the nursery. Abby and her daughter missed the golden hour of bonding for several reasons. For one, Abby was still very sick. Doctors were also concerned her daughter may be infected due to the uterine infection. Lastly was COVID. In the early days of COVID, there was no universal understanding of what was happening or what was the best course of action. In this story, that means that the obstetric policies in this given hospital and the pediatric policies were different. Once Abby's daughter left obstetrics, she entered the pediatric ward. There she was quarantined as a potential COVID patient at mere hours old. There was no infection, nor did Abby's baby have COVID, but Abby could not see her until tests came back to cross all this red tape. Once all the tests were cleared Abby was able to be with her child for the remainder of her stay in the hospital.

On the other side of this, Abby was grateful for COVID. As she wasn't allowed to have visitors, she would "not have to worry about looking presentable to people" after her surgery and complications. When Abby went home with her new family, they faced the challenge of parenthood head-on, made more difficult by her surgery. Abby spent the first weeks sleeping in a recliner in the living room because it was the only comfortable place she found to rest with her stitches. She and her husband kept a journal about when the baby was fed and changed, and she described how sleep-deprived they both were in those first weeks. Even with scary moments, Abby tells her story as a joyful one, without these events overwhelming the arrival of her daughter. At the time and looking back she sees the choices made as to the right ones. Abby

worked in the healthcare field, and felt as though she knew what to expect, and put her trust in her doctors because of this.

Gwen

Gwen is the mother of three boys, all of whom were born in a hospital via C-sections. She was overdue by two weeks with her first son and started contractions the day of her induction. She and her husband went into the hospital at four in the morning, where she started on Pitocin, a drug used to induce labor. Hours in, with her epidural in place, Pitocin running, and several position changes, her son was not coming into the birth canal. Gwen's doctor informed her on the morning of the second day that "we've done everything we can for you to have him naturally, now it's time to do a c-section." Gwen agreed and said she believed there were more risks in waiting for her son to be born than going through a c-section.

"It was the scariest thing I've ever done in my whole life." When Gwen went in for her surgery, she recalled crying the whole time, completely terrified, which was only made worse by the medication she was given that made her violently ill. She was unsure of what to expect, and because of this, her already poor reaction to the anesthesia was that much more severe. Later when Gwen had her second son, she experienced a repeat of these events and was again sick from the medications. This time, however, she felt as though she knew what to expect, and although uncomfortable and scary, it was no longer the scariest thing she had ever done. Her third son was born in December, with a new provider and a new plan to handle her sickness after the surgery. Not only did she know what to expect, but she was physically comfortable this time and described her provider singing Christmas carols while delivering her son.

When Gwen went home, she was supported by her family members who are leaders of the Le Leche League in her region. The Le Leche League is an international organization that supports and encourages breastfeeding. It is a group for mothers made by mothers for questions, tips, and tricks with breastfeeding. They are often the first step for mothers struggling with breastfeeding before asking questions of a lactation consultant. At the same time, they are also community members that provide emotional support and a sense of community to moms, whether that is a part of their mission statement or not. For Gwen, this was a huge help in her transition home, and to help her the best they could with a rocky start to breastfeeding.

Bella

For Bella, her birth was, in her own words, "horrible." Her daughter was born in a hospital under the care of an OBGYN, and she experienced several serious complications. Bella describes her pain tolerance as low, and when her labor started, she headed to the hospital and jumped on getting pain medication as soon as she could. She had planned that she would get the epidural as soon as nurses offered it, even putting it in her birth plan. Once she got her epidural, however, she and the nurses noticed that it was affecting higher up than it should be, and there was a risk that her lungs were at risk of compromise from more medication. They decided to leave the epidural in place but not administer any more of the new blocking agent. Around the 20-hour mark, after her water broke, a doctor came in and informed her that if the baby were not born in the next four hours, they would need to do an emergency C-section. Without much pain relief, Bella opted for the c-section rather than waiting the four hours, thinking it was already inevitable at that point.

Bella was taken back for the c-section, and the doctor discovered that her baby and her pelvis were in cephalic disproportion, meaning the baby's head was truly too large for the pelvis

and was stuck. To deliver the baby, she needed to be pulled free from the pelvic inlet. After hours of labor pushing the baby into the pelvis the baby's head was lodged tightly in the pelvis, making it challenging to pull free. Her uterus tore when the doctor pulled the baby free, which Bella says took three or four good tugs. At the time, she didn't know the tear had happened, and neither did her husband, who had taken the baby to the other room while Bella was sutured. Bella described how uneasy she felt while her doctor was suturing her torn uterus, that he was swearing and struggling as he did so. It took more than 30 minutes for the doctor to finish suturing her uterus and then closing her abdomen. All this time, her husband was waiting in the hall with their newborn unaware of what was taking so long and assuming the worst. When he asked the nurses where Bella was, they didn't offer up any information about where she was and did not look into what was taking so long. The three were reunited in the recovery room and spent several days in the hospital for Bella to heal.

After the tear in her uterus, Bella had another c-section with her second child, which she hoped would be easier, having experienced it once before. This time she would not have the swelling and pain of having gone through 20 hours of labor, just the incision. In her first birth, the nurses pushed her to stay up on taking the medications on time, so that she may not feel pain but take it because it could creep up on her. At her second birth, her nurses had a different philosophy, being more careful with opioid medications and trying to stretch the time between doses.

Going home with her first baby was the hardest, as neither Bella nor her husband knew what to expect. After her c-section, she could not get into her bed as it was too high off the ground for her to sleep there, so she spent several weeks on the couch. Her sweet baby didn’t make it any easier, as they struggled with breastfeeding due to a tongue tie and colic. Bella looks

back on her pregnancy and birth through a lens of discomfort. She loves her children but does not love her births.

Kacey

Kacey is a mother of 6; in her life, at the time of our meeting, she had been pregnant five times and had four biological children of her own. One of her pregnancies ended in a miscarriage, and they had adopted two of her children into their family. She had her babies in several states and experienced several different state regulations for her care.

Her first baby was born in a hospital, and she describes this experience very quickly. She made a birth plan in her prenatal exams and followed her OBGYN's recommendations throughout her pregnancy. She went to the hospital well into labor and was admitted to the labor and delivery ward when she arrived. Kacey asked for and received a 'walking' epidural soon after arriving. Her labor went smoothly, and several hours later, after less than an hour of pushing, her baby was born healthy.

In Kacey's second birth, she lived in a state where the regulations integrated midwives into the healthcare system. Because of how easy her labor had gone before, she decided to go with a midwife and pursue a completely natural birth experience. During this pregnancy, she and her husband took Bradly childbirth classes, emphasizing natural pain management methods and encouraging the spouse to act as a birth partner. Kacey's plan was to still deliver in the hospital, under a midwife's care instead of an OBGYN. When labor started, she paid little attention to it, deciding that if she could take her child, who was two at the time to the park, then it wasn't quite enough to go in just yet. Later in the day, she found herself vacuuming the house and doing other chores while generally unbothered by the contractions. In the evening, she laid down to take a

nap and woke up to find that her water had broken. Kacey considered this her signal to go into the hospital finally; and so she called her family to watch her child, had her husband pack a bag, and got in the shower to clean up before they left. This was when the contractions picked up, but she still did not describe them as terrible. She went to use the bathroom -which she sees now as the first sign she should have realized what was happening- and then went down the hall to get in the car. She felt a strong contraction on her way, and she sank to her knees in the hallway. She realized then that her baby was crowning there in the hallway, and with the help of her husband, her baby was born three pushes later "if it had been 5 minutes later, we would have been in the car" Kacey said.

This experience colored Kacey's decisions in the future, and subsequent births were either at home or in a birth center when the choice became available. She recounted how peaceful it was to be able to curl up in her own bed with her new baby; and that because of how everything happened, her husband was listed as the attendant on the birth certificate which they found as a charming bonus. Kacey mentioned that had her baby been born in the car, and gone to the hospital or called EMS, they would have been placed in quarantine at the hospital. Her midwife could not practice outside the hospital but gave them the tools over the phone, so they could stay at home if nothing were going wrong.

Sally

Sally started her birth care with a midwife and during her labor, was transferred to the hospital. Her story is often heard in birth work circles as transfers from care are common. Mothers who risk out of midwifery care often will transfer to a higher level of care to maintain safety and legality. During their care, midwives monitor mothers for conditions that are considered too risky to continue care with a midwife. These conditions will vary based on state,

and midwives' comfortability with conditions. Although Sally never developed any of these conditions —such as gestational diabetes— she transferred care while in labor. Transfers like this are most common for first-time mothers like Sally who are known to labor longer than mothers with previous vaginal births. Her choice to start with a midwife was by chance and by access as it was in a state where they are well integrated into the healthcare system. She described the difference between a doctor and a midwife as the midwife feeling more natural and homey “the office was more comfortable, and the connection was better.”

Sally went through all her care with her midwife, and when it came time to have her baby, she had several support people there with her. Sally was not married at the time, but the father of her baby was there with her. Her labor started earlier in the morning, and by around seven, she was calling her midwife and headed to the birth center. Sally’s baby had yet to make her appearance by nine o'clock that night, and Sally’s labor had been long and hard. She maintained that she trusted her midwife but that her partner was scared, she was in pain, and too tired to keep going, so they transferred to the hospital.

At the hospital, with scans and exams, the doctor determined that her baby was in a malpresentation, meaning it was struggling to go through the turning maneuvers in the pelvis. Sally hoped that there was something they could do, like turn her baby or give her medication to speed things along. What was offered was a c-section if her baby wasn't born within the hour. Sally ended up having the c-section, as she felt like there was no other choice. For Sally, this lack of choice became a theme. For her next birth, she went with an OBGYN, because she had already had a c-section. The doctor then scheduled her for another one without mentioning the possibility of vaginal birth. When it came time for her third child to be born, she was legally required to have a c-section after two with no vaginal births due to state laws.

Sally reflectively tells her story, not negative, and not upset. She emphasized that looking back, she now sees where things went in a direction she had not intended and that if she knew then what she knows now, things could have been very different. In the end, Sally shared that new moms or women who want to be pregnant need to educate themselves not only on what they want but on the unexpected. She had no idea that malpresentation was common and at the time, had no idea that a c-section was not her only option.

Discussion

Although it seems intuitive, the mothers in this study are individuals with deeply complex lives, in which these birth stories are but snapshots. The mothers who participated in this study come at their experiences from different places. Some mothers struggled with infertility, while others experienced unplanned pregnancies. These differences are also a part of their experiences and account for some of the differences personally. Mothers who participated in the survey, but chose not to participate in the interviews may not be represented in full by the stories of those who did, but the similarities of the community where the data came from lends itself to connection. Seventy-eight individuals from all over the United States participated in the Childbirth Experience Questionnaire that was sent out. Of those six mothers continued on to do interviews. While from surveys alone we cannot tell someone's personal story; we can see in some answers that there is more to tell. This is true for the four mothers who reported “some memories of my birth make me feel depressed”, the eighteen mothers who felt “labor and birth did not go as I expected”, and the seven who “did not feel as though they and their partner were treated with warmth and respect.” This research has looked into personal and emotional aspects of care and attempts to connect all the experience’s moving parts. By speaking to those who have experienced these events firsthand, we can imagine a more vivid picture of the occurrence. For

this reason, the stories the mothers share exist in tandem with the ideas they describe; these experiences inform and elaborate on the relevant literature.

The parts of our lives that happen without us noticing are the deeply held cultural aspects of our lives. In this research, these opinions can be understood without mothers needing to address or explain them directly. For example, Abby described the difference between an ultrasound clinic and her OBGYN's office. "At the free ultrasound clinic, it was a very personal experience, I think… Whereas at the OBGYN's office it is more of a clinical setting…". From her description, we can glimpse what she understands as a medical experience. For Abby, in order for something to be clinical or medical, it cannot be personal. This is not just a definition for her, but common in medically dominated communities; personal and medical become mutually exclusive. In this same vein, Bella described her doctors and nurses as using facts rather than suggestions or opinions. Although she did not explain directly how they gave advice, her word choices of "If you haven't given birth in the next two hours we will have to do a c-section" show the lack of options. Furthermore, what Bella did not say, in her lack of argument or line of questioning the word of the doctor, argues the same point. This lack of questioning is a common theme for Sally and Gwen and is just as reflective of the social control doctors have as saying it in plain terms. For some mothers, a negative medical experience is a driving force for discovering alternatives, such as homebirth (Cheyney et al. 2019; Parry 2008). Although Kacey did not have a negative experience with her first delivery in a hospital, the immensely positive experience of delivering at home the second time influenced her to see midwives outside the hospital in the future. Kacey's choice is not an isolated one; in the state she lives in, nearly 10% of all births are attended by midwives of some kind (Vedam et al. 2018). While it is less common to deliver at home, this is becoming more of a reality across the United

States, where the out-of-hospital birth rate is trending up (Vedam et al 2018). As discussed previously, most birth care in the United States is provided by physicians. The kinds of care supplied encompass

examinations, directions for lifestyle changes, possible medications, and the process of labor and or cesarean section. These providers are the experts in this field, making them the only ones able to give and explain a test result. Facilitation of this kind of care creates power imbalances, limits women's agency, and fails to encourage self-confidence by creating a reliance on an individual expert (Rothman 2007, 3-28). Hospital routine and standard procedures, such as wheelchair transfers, routine episiotomies, epidurals, and the hospital gown, can wear away at mothers' confidence in a symbolic effort to place her in this position below the doctor (Burbaker and Dillaway 2009; Davis-Floyd 1997). Mothers differentiate between personal experiences with providers and clinical experiences. Medical providers' focus shifts within hospitals, from the mother's needs to the baby's needs, leaving the mother's agency second (Burbaker and Dillaway 2009, Decker 2019). Studies show women feel and understand the power imbalances and lack of control they experience in the medical field (Brubaker and Dillaway 2009). Mothers in a Canadian study found doctors condescending and disliked the idea of hospital staff they did not know attending to them (Parry 2008). However, a lack of confidence and a dismissive provider is not always the case, and an empowering positive experience can be held in a medical setting where mothers are directly involved in their care.

A positive experience is not always the case outside of hospitals, as there are cases in which hospital-level care is necessary. Communication, setting up reasonable expectations, and compassion in care can all be achieved in hospitals, even in a surgical room. Gwen delivered her third child in a hospital via a cesarean, just as her first two children had been. This time, she

came into the situation knowing not only what to expect but was able to advocate for medication changes to keep her from getting ill. In this case, she described her provider as gentle and accommodating. “He was born in December, so there was Christmas music playing in the operating room, and the doctor was singing Christmas carols when he held him up over the curtain for me to see him.” Providing women-centered care and following the midwifery model are not limited to spaces outside hospitals. Empowerment is not contingent on location; it relies instead, on the actions of those providing care.

Authoritative Knowledge

When doing reflexive interviews, the researcher is unable to hear the tone of voice used in the reported speech of providers, and these events are out of context. In this case, the word choices made by mothers give clues to when providers are using their authoritative tone. In these interviews, a mother may not say that the doctor used a tone of authority; what mothers share are quotations that carry these implications of tone. When a nurse says to Bella, “If you have not given birth in the next four hours, we are going to have to go in with an emergency c-section,” for Bella; it is the word choice and the lack of discussion on the issue that shows social control. In Dixon’s research discussing an individual story of a birth taking place in a birthing center, when the midwife sought a second opinion, "the doctor's authoritative tone left little space for discussion" (2019, 35). The mother's interviews highlighted this feeling of personhood; in the sense of being a number, being a patient was synonymous with hospitals. Promises to ease pain or move labor faster may seem like kindness from the hospital staff’s position, but these potentially undermine mothers’ long-term goals and wishes. The different kinds of support care providers can dramatically affect the emotional aspect of outcomes. Birth plans are made without the intensity of birth. Offering the quick solution of an episiotomy or encouraging perseverance can mean the difference between sticking to the birth plan and verging into regret (Matsuoka and

Williamson 2019). Furthermore, intrinsically shameful messaging delivered by doctors stays in a mother's hands to avoid disappointing or failing. By arguing with doctors, women and their support system can be accused of child endangerment to force compliance. Bella reported that the "second time around, my nurses did not give me the medication, and even when I would request it... the nurse was like 'oh no, no you do not need it and wouldn't give it to me, and I was in so much more pain." Her nursing staff avoided providing her medication because of the societal fear of opioid use and addiction. Bella had no personal or family history of opioid misuse, but the nurse's fear and personal opinions dictated the care she received. The societal stigma of addiction is coupled here with the shame of being an unfit parent. Hospital staff often repeatedly pester their patients with the same suggestions for refusing treatment, leaving no room for debate before beginning treatment. This social control manifests through these overt and covert behaviors, like in Bella's case when nurses refused her the medication. These actions create detrimental emotions of shame and guilt within mothers. Mothers who deliver their babies within hospitals must face and work through these issues, carefully deciding how much to push back and speak out if something diverges from their wishes.

Trauma

"I went in for the C-section, and it was probably the scariest thing I've done in my whole life. I was bawling, and my husband was there, and I ended up getting sick from the anesthesia... that portion was kind of traumatic." - Bella.

Discussion about trauma is evidence of strides in our understanding but still leaves gaps and differences in defining and explaining it. Traumatic events cause and continue to cause emotional or physical distress at the moment of, or in recalling the event. Of the five mothers interviewed in this study, four used language to suggest that at least one of their birth experiences was traumatic. All four of these women had hospital births that ended in c-sections.

For Sally, it was the surgery that was the stressor. “With my children, they wouldn't latch properly; if I was able to give birth naturally without having them surgically taken, then I do not think that process would have happened.” Without saying that the c-section was a source of trauma, it is clear based on Sally's words, choosing to say “surgically taken” when she tells her story. “It was probably one of the scariest things I’d done in my whole life….” Bella shared, “I was bawling… it was that portion that was kind of traumatic.” Several mothers also brought up their experience with hospital staff; Abby shared that “...the nurse the first night was great at her job but was a little impersonal… she was helping me hand express breast milk and not feeling well from the blood loss was a bit traumatic.” Bella’s nurses did not keep her up on pain management, “the actual pain was worse… they were trying to be careful with the opioids… but I was just not impressed with my care in that regard.” After the operation, neither Abby nor Bella could sleep in their beds and spent their first weeks with a newborn on the couch. Bella stated, “I couldn't bend or lay down, so I had to sleep on the couch… it wasn't a great transition… I guess it's always traumatic, probably, having a baby-waking you every few hours.”

In the description above, mothers use the language, “the nurse that first night, she was just doing her job, but...” or “I guess it is always traumatic...”. Qualifiers such as “but” push trauma away from the mother’s individual experience and into the process of birth itself as traumatic. The same is true for justifications, the assumption that “well, it happens to everyone.” There is an unspoken expectation with medicine and birth that the product (i.e. a healthy baby) is worth whatever struggle. Birth can be traumatic, but in these cases, there is a cultural “shoulding.” Mothers “should” feel happy because their baby is safe. They “should” feel lucky because mother and child are both alive, and so rather than appear ungrateful for their life and their child's life, they “should " away from the actual trauma. This ambivalence seeks to

counteract the pain and trauma someone may feel with the joy of having a baby and pushing an idea that one cannot happen without the other, although they contradict so directly. This contradiction is where the medical establishment can step in, claiming to elevate this, while at the same time creating it.

There is a possibility that for mothers who required a C-section, the hospital deliveries are what incited the C-section. Hospitals risk inadvertently creating the pain and fear commonly associated with birth to avoid it. There is a concern that interventions compound on one another and lead to final surgical intervention (Davis-Floyd 1998, 73-133). The thought is that the interventions create a cascade of cause and effect. Although impossible to tell reflexively, an example in Abby's case might have been receiving the epidural, which slows labor to a point deemed medically inactive (Davis-Floyd 1998, 73-133). Pitocin then acts to speed things back up to a medically normal range, at the cost of stronger and longer contractions (Davis-Floyd 1998, 73-133). These stress the baby and constrict the baby's airflow if contractions pinch the umbilical cord (Davis-Floyd 1998, 73-133). The baby is now in distress and requires a C-section to save their life, but it was the medical intervention that put their lives in danger in the first place. Further, the intervention led to Abby's adverse experiences with nursing staff and her transition home.

In this study, two mothers had experience with the midwifery model in at least one of their pregnancies. The two of them participated in a group interview, in which they were able to share their similar experiences with both midwives and OBGYN offices. They described the appointments and experience as more welcoming and warm than an OBGYN's office. Mothers stressed that they not only trusted their midwives but that their midwives trusted them. A trust to

care for their bodies and know themselves, “there was this difference of I am the expert on myself, to the OB and it was like he was the expert.” This trust that mothers are experiencing pregnancy is central, so they have insights into what is happening beyond those assisting them during the birth as they work together is the main pillar of midwifery care.

Conclusion

So what? This is all just information, this is not true action, and pushing past the non-evidence-based practices in hospitals is a step towards that. How will this make a change or correct inadequacies in this field? What can be done to ensure the stakeholders are heard?

In many hospitals, as in many cultures, things do not change overnight. There are some who will accept new information that proves valuable, and others in the community who will resist. How likely someone is to accept new information that challenges their past perceptions deals a lot with personality. Research suggests that it is in communities where the culture is one of resistance, evidence-based practices also take the longest to be put into effect. In these hospitals, mothers face the culture of medicine rather than the evidence of medicine. A negative experience here with the culture can leave mothers feeling left behind by medicine as a whole, and this creates a cultural division on a larger scale. Knowledge is key for new mothers and the medical professionals that help them through pregnancy and birth. These professionals, medical doctors or midwives learn from experience and the research they are exposed to.

What's next? Education for mothers, right to refusal, holding medical providers accountable in all places and all senses. With access to information being at an all-time high, many people are choosing to use the internet to educate themselves about birth. Hospitals are choosing to add more options, and in many states, this includes integrating with midwives. As

awareness of this issue has grown, access to evidence-based care has grown with it. Many hospitals and hospital systems have implemented their own education and support. In many hospitals in the U.S., Lamaze or similar practices are widely used and encouraged as standard practice (Myles 2020, 162-179). The UNICEF has created a baby-friendly initiative that hospitals around the world have begun to adopt. This initiative supports breastfeeding, and in doing so emphasizes the bonding that happens in the golden hour after birth (Marshall 2020, 684). Hospitals that take on these initiatives and methods put more power into the hands of the mothers by offering these choices and by endorsing them (Marshall 2020, 684). Free choice cannot exist when there is only one way of doing things, it is only by having more than one option that mothers are able to make truly free choices.

On the other side of this increasing public knowledge about birth, there are risks of misinformation. While this research was being conducted, a subculture in the United States took center stage in response to the COVID pandemic. The anti-science movement branded the pandemic a hoax, and the doctors and researchers "quacks" along with it. This subculture is one that has existed all along, but was highlighted by this major event, and gained a greater following in the process. This subculture in the U.S. has also long been associated with midwifery. This is a long-standing issue that reputable and competent midwives face every day and in every care decision. Part of this has to do with the way midwives were painted historically as incompetent and dangerous, and part of it has to do with how the rejection of science was viewed in the same way. It is true that those who align themselves with anti-science ideas will often choose midwives. It is also true that for a midwife to maintain their license they must follow the laws in their state, which often require a transfer of care and a call to EMS should something go wrong. A midwife, however, cannot be anti-medicine because a true certified midwife is a scientist. In

the U.S., midwives must have at least a bachelor of science degree to practice legally. They must take classes in biology and chemistry; they must understand pharmacology and must use it to save lives. These practitioners are not on the fringe but are rather a different kind of medical provider. Midwives are the experts on normal birth, whereas an OBGYN in a hospital is the expert on abnormal birth. In this way, a midwife is better prepared to see the range of normal, and more likely to recognize a truly abnormal moment.

In the wake of this misinformation, midwives in their own practices and on an international scale have placed an emphasis on informed refusal. More than informed consent, which requires a person to understand what they are saying yes to; informed refusal means giving people accurate information on interventions so they understand what they are saying no to. In midwifery, there is a culture of refusal, and this is just as dangerous as a culture of constant intervention. By combatting both of these things both midwives and doctors are able to improve outcomes and quality of care.

This research is not alone in its emphasis, other work focusing on the importance of birth care is an essential piece to this story. Data in this study comes from a small sample size, but the information reflected in it not only corroborates itself but similar research being done. This study is backed by those done before, and gives backing to them. To expand research like this, future studies may look at specific hospitals, and work with specific hospitals to measure change. A hospital planning to integrate midwives for example, may do a study on experience before and after their integration. Studies like this one are valuable for the birth stories mothers share, not only told from a research perspective but as wisdom that can be passed on to other women. As a final interview question, mothers were asked to share something they felt was important,

something funny or scary, leaving the question vague for personal interpretation. Three mothers choose to share advice.

"My advice… for other people would be just to not feel bad calling out doctors, just being more assertive. Because again for me I was nervous and I didn't have my voice that I wish I had the first time around."

Bella

"I tell new moms, you know newly pregnant women. Learn about the options you know, and if you're interested in doing the whole natural unmedicated thing, learn about it, because you can always go the other way. You're not tied into it, you know. But if you don't learn about your options, then you are stuck"

Kacey

"Make sure to educate yourself because you can take the childbirth classes, and not learn things that you learn when it's happening in terms of delivery… To plan for those things you don't expect to happen. I never expected the baby to be facing my pelvis, I didn't even know that was a thing… I had no idea that this thing that happened to me, could have happened…"

Sally

Mothers can use their experiences and their voices to push for change. Without these experiences being shared on a large scale, these issues are largely hidden behind the walls of the hospital. Education about many facets of childbirth – open conversation and

informed decision making is the key to progress towards informed decision making, and informed choice is the key to empowering experience.

Works Cited

Oakley. "The Sociology of Childbirth: An Autobiographical Journey through Four Decades of Research." *Sociology of Health & Illness*, U.S. National Library of Medicine, https://pubmed.ncbi.nlm.nih.gov/26857343/.

Bendict, Ruth (Fulton). *Patterns of Culture*. New American Library, 1934.

Brown, Peter J. and Svea Closser. "Understanding and Applying Medical Anthropology." *Taylor & Francis*, Taylor & Francis, 14 June 2016, https://www.taylorfrancis.com/books/mono/10.4324/9781315416175/understanding-applying-medical-anthropology-peter-brown-svea-closser.

Browner, C. H., and Nancy Press. "The Production of Authoritative Knowledge in American Prenatal Care." *Medical Anthropology Quarterly* 10, no. 2 (1996): 141–56. https://doi.org/10.1525/maq.1996.10.2.02a00030.

Brubaker, Sarah Jane, and Heather E. Dillaway. 2009. "Medicalization, Natural Childbirth, and Birthing Experiences." Sociology Compass 3 (1): 31–48. https://doi.org/10.1111/j.17519020.2008.00183.x.

Carquillat, Pierre, Françoise Vendittelli, Thomas Perneger, and Marie Julia Guittier. 2017.

"Development of a Questionnaire for Assessing the Childbirth Experience (QACE)." BMC Pregnancy and Childbirth 17 (1). https://doi.org/10.1186/s12884-017-1462-x.

Cheyney, Melissa, Bahareh Goodarzi, Therese Wiegers, Robbie Davis-Floyd, and Saraswathi Vedam. 2019. "Giving Birth in the United States and the Netherlands: Midwifery Care as Integrated Option or Contested Privilege." In Birth in Eight Cultures, edited by Robbie

Cline, Meagan. "Birth Injury Statistics." *Birth Injury Guide*, 20 Aug. 2021, https://www.birthinjuryguide.org/statistics/?msclkid=7beb7febd07911ec942089b977e38e46.

Cogburn, Megan, Adrienne Strong, and Summer Wood. 2019. "Choiceless Choice in Tanzania: Homebirth, Hospital Birth, and Birth Registration." In Birth in Eight Cultures, edited by Robbie David-Floyd and Melissa Cheyney, 49–88. Long Grove: Waveland Press.

Conrad, Peter. 2007. The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders. The John Hopkins University Press.

Creswell, John W., and J. David Creswell. 2018. Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. 5th ed. Los Angeles: SAGE.

Davidson, Valerie, and Jay C Butler. n.d. “Bill Walker Governor State of Alaska Alaska Vital Statistics 2016 Annual Report PREFACE PURPOSE OF THIS REPORT.” http://dhss.alaska.gov/dph/VitalStats/Pages/data/.

Davis-Floyd and Melissa Cheyney, 165–202. Long Grove: Waveland Press.

Davis-Floyd, Robbie E. 1992. Birth as an American Right of Passage. Berkeley: University of California Press.

Dekker, Rebecca. *Babies Are Not Pizzas: They're Born, Not Delivered!* Evidence Based Birth, 2019.

Dey. “(PDF) Informed Grounded Theory.” *ResearchGate*, 2020, https://www.researchgate.net/publication/235327775_Informed_Grounded_Theory.

Dixon, Lydia Zacher, Vania Smith-Oka, and Mounia El Kotni. 2019. “Teaching about Childbirth in Mexico: Working Across Birth Models.” In Birth in Eight Cultures, edited by Robbie Davis-Floyd and Melissa Cheyney, 17–48. Long Grove: Waveland Press.

Farmer, Paul. 2005. Pathologies of Power: Health, Human Rights, and the New War on the Poor. University of California Press.

Foucault, Michel. *The History of Sexuality*. Penguin Classics, 2020.

Frey, James H., and Andrea Fontana. 1991. “THE GROUP INTERVIEW IN SOCIAL RESEARCH.” Social Science Journal 28 (2).

Georges, Eugenia, and Rea Daellenbach. 2019. “Divergent Meanings and Practices of Childbirth in Greece and New Zealand.” In Birth in Eight Cultures, edited by Robbie Davis-Floyd and Melissa Cheyney, 129–63. Long Grove: Waveland Press.

Jordan, Robin G., and Patricia Aikins Murphy. 2009. “Risk Assessment and Risk Distortion: Finding the Balance.” Journal of Midwifery and Women’s Health 54 (3): 191–200. https://doi.org/10.1016/j.jmwh.2009.02.001.

Kaufert, Patricia A, and John D O’neil. 1990. “Cooptation and Control: The Reconstruction of Inuit Birth.” Source: Medical Anthropology Quarterly. Vol. 4.

Kennedy, Brian. 2006. “Healthcare’s Hidden Risks: Identifying Vulnerability in Healthcare Systems.” In Risk and Choice in Maternity Care, edited by Andrew Symon, 13–22.

Koblinsky, M A, O Campbell, and & J Heichelheim. 1999. n.d. “Policy and Practice Organizing Delivery Care: What Works for Safe Motherhood?”

Lane, Sandra. 2008. Why Are Our Babies Dying? Pregnancy, Birth, and Death in America. Paradigm Publishers.

Mol, Annemarie. 2002. The Body Multiple: Ontology in Medical Practice. London: Duke University Press.

Myles, Margaret F. Marshall, Jayne. Raynor, Maureen. *Textbook for Midwives.. Myles Textbook for Midwives*. Elsevier, 2020.

Neergaard, M.A., Olesen, F., Jensen, A.B. and Sondergaard, J., 2008. "Palliative care for cancer patients in a primary health care setting: Bereaved relatives' experience, a qualitative group interview study." *BMC Palliative Care*, *7*(1), pp.1-8.

NACPM, https://www.nacpm.org/.

Parry, Diana C. 2008. "'We Wanted a Birth Experience, Not a Medical Experience': Exploring Canadian Women's Use of Midwifery." Health Care for Women International 29 (8–9): 784–806. https://doi.org/10.1080/07399330802269451.

Raymond, Janice. 1993. Women as Wombs: Reproductive Technologies and the Battle Over Women's Freedom. New York: Harper Collins.

Rothman, Barbara Katz. 1996 "Women, Providers, and Control." *Journal of Obstetric, Gynecologic & Neonatal Nursing* 25, no. 3: 253–56. https://doi.org/10.1111/j.1552-6909.1996.tb02433.x.

Salhi, Bisan. 2016. "Beyond the Doctor's White Coat: Science, Ritual, and Healing in American Biomedicine." In Understanding and Applying Medical Anthropology, edited by Peter J. Brown and Svea Closser, 3rd ed., 204–12. Routledge.

Sandelowski, Margarete. 2000. "Focus on Research Methods Whatever Happened to Qualitative Description?" Research in Nursing & Health. Vol. 23. John Wiley & Sons. Sawyer, Alexandra, Susan Ayers, Jane Abbott, Gillian Gyte, Heike Rabe, and Lelia Duley. 2013. "Measures of Satisfaction with Care during Labour and Birth: A Comparative Review." BMC Pregnancy and Childbirth 13 (May). https://doi.org/10.1186/1471-2393-13-108.

Schwarzburg, Lisa Llewellyn. n.d. "ARCTIC PASSAGES: MATERNAL TRANSPORT, RNUPIAT MOTHERS, AND NORTHWEST ALASKA COMMUNITIES IN TRANSITION."

Schwarzburg, Lisa Llewellyn. 2013. "Arctic Passages: Liminality, Iñupiat Eskimo Mothers and NW Alaska Communities in Transition." International Journal of Circumpolar Health

72 (SUPPL.1). https://doi.org/10.3402/ijch.v72i0.21199.

Seale, Clive, et al. "(PDF) Introduction: Inside Qualitative Research." *ResearchGate*, https://www.researchgate.net/publication/253047776_Introduction_Inside_Qualitative_Research.

Sherry, Paul. 2004. "Health Care Delivery for Alaska Natives: A Brief Overview."

International Journal of Circumpolar Health. https://doi.org/10.3402/ijch.v63i0.17786.

Singer, Merrill. 1998. "The Development of Critical Medical Anthropology: Implications for Biological Anthropology." In Building a New Bio-Cultural Synthesis: Political-Economic Perspectives on Human Biology, edited by Alan H. Goodman and Thomas L. Leatherman, 93–123. University of Michigan.

Symon, Andrew. 2006. "The Risk-Choice Paradox." In Risk and Choice in Maternity Care, edited by Andrew Symon, 1–11. Churchill Livingstone Elsevier.

Vedam S, Stoll K, MacDorman M, Declercq E, Cramer R, et al. (2018) Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. PLOS ONE 13(2): e0192523. https://doi.org/10.1371/journal.pone.0192523

Walker, Bill, Davidson, Valerie, and Jay C Butler. 2016. State of Alaska Vital Statistics 2016 Annual Report. http://dhss.alaska.gov/dph/VitalStats/Pages/data/.

Walker, K.F., Dencker, A. and Thornton, J.G., 2020. Childbirth experience questionnaire 2: validating its use in the United Kingdom. European Journal of Obstetrics & Gynecology and Reproductive Biology: X, 5, p.100097.

Walsh, Denis. 2006. "Risk and Normality in Maternity Care: Revisioning Risk for Normal Childbirth." In Risk and Choice in Maternity Care, edited by Andrew Symon, 89–99.

Etsuko Matsuoka and Williamson, K. Eliza, 2019. "Comparing Childbirth in Brazil and Japan: Social Hierarchies, Cultural Values, and the Meaning of Place." In Birth in Eight Cultures (edited by Robbie Davis-Floyd and Melissa Cheney), pp. 89-128. Waveland Press.

Appendix

Appendix A: Childbirth Experience Survey Informed Consent

Informed Consent

This research is part of a graduate research study into the experiences of women in pregnancy and childbirth. You are invited to take this survey to help us learn more. Your decision to participate is voluntary. You are free to say yes or no. If you agree to participate, you will complete a survey that asks questions about you (age, ethnicity, etc.), and your birth experience.

This survey will not ask your name, so there is no way for us to connect your identity to the survey results. The information you share will be pooled with responses from all participants. We anticipate very minimal risk to you in taking this survey.

At the end of the survey, you will be directed to information to contact our study team to participate in an in-person interview to tell us more.

Taking the survey does not obligate you in any way to schedule an interview. You can participate in the survey only, which will take less than 10 minutes.

The study team will keep records of the information we collect for at least 5 years. Records will be stored on a secure password-protected server. We intend to share our study findings through presentations, reports, articles, and a final masters thesis. No participant names will be used in anything we report about the study.

If you have any questions, please contact researcher Delaney Reece at (907) 978-0864 or reeced@wwu.edu. The Western Washington University Institutional Review Board (IRB) is a group that examines research projects involving people. This review is done to protect the rights and welfare of the people involved in the research. If you have questions or concerns about your rights as a research participant, you can contact the WWU Research Compliance Office at (360) 650-2146 or compliance@wwu.edu.

o I Consent to Participating (1)

Appendix B: Childbirth Experience Online Survey

Q5 Where Did You Deliver?

o A Hospital (1)

o A Birth Center (2)

o My Home (3)

o Other (4) _____

Q6 How old where you when you had your first child?

_____

Q8 How would you identify your ethnicity?

o White (1)

o Black or African American (2)

o American Indian or Alaska Native (3)

o Asian (4)

o Native Hawaiian or Pacific Islander (5)

o Other (6) _____

Q1 About You Personally

	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)

Labor and birth went as I had expected (1)	o	o	o	o	o
I felt strong during labor and birth (2)	o	o	o	o	o
I felt capable during labor and birth (3)	o	o	o	o	o
I was tired during labor and birth (4)	o	o	o	o	o
I felt happy during labor and birth (5)	o	o	o	o	o
I felt that I handled the situation well (6)	o	o	o	o	o
As a whole childbirth was painful (7)	o	o	o	o	o
As a whole I had control during childbirth (8)	o	o	o	o	o

Q2 About Your Care Team

	Strongly agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly disagree (5)

Both my partner and I were treated with warmth and respect (1)	o	o	o	o	o
I would have preferred the staff to be more present during labor and birth (2)	o	o	o	o	o
I would have preferred more encouragement from staff (3)	o	o	o	o	o
The staff conveyed an atmosphere of calm (4)	o	o	o	o	o
The staff helped me to feel strong (5)	o	o	o	o	o

Q3 About Your Safety

	Clearly describes my feelings (1)	Mostly describes my feelings (2)	Moderately describes my feelings (3)	Slightly describes my feelings (4)	Does not describe my feelings (5)
I felt scared during labor and birth (1)	o	o	o	o	o

My impression of the team's medical skills made me feel secure (2)	o	o	o	o	o
I have many positive memories from childbirth (3)	o	o	o	o	o
I have many negative memories from childbirth (4)	o	o	o	o	o
Some of my memories from childbirth make me feel depressed (5)	o	o	o	o	o
As a whole, I felt secure during childbirth (6)	o	o	o	o	o

Q4 Input and Ideas

	Strongly agree (1)	Agree (2)	Neither agree nor disagree (3)	Disagree (4)	Strongly disagree (5)

I wish the staff had listened to me more during labor and birth (1)	o	o	o	o	o
I took part in decisions regarding my care and treatment as much as I wanted (2)	o	o	o	o	o
I received the information I needed during labor and birth (3)	o	o	o	o	o

Appendix C: Interview Informed Consent

Maternal Participant- Informed Consent Form

Principal Investigator: Delaney Reece

Graduate Student, Department of Anthropology, Western Washington University

Phone: 907-978-0864, reeced@wwu.edu

We are asking you to be in a research study. The purpose of this form is to give you the information you will need to help you decide whether to participate. Please read the form carefully. You may ask questions about anything that is not clear. When we have answered all of your questions, you can decide if you want to be in the study or not. This process is called "informed consent." Please keep this copy form for your records. [

Why are we asking you to take part in this study?

You are being invited to participate in this study as a mother who has navigated the world around them in order to deliver their child. This research is part of a graduate research study into the experiences of women in pregnancy and childbirth.

Do I have to be in this study?

Your decision to take part in this study is voluntary. You are free to say yes or no. Even if you join this study now, you do not have to stay or complete the interview, you may skip any question, and stop at any point.

What will happen if I agree to participate? Will I be paid?

You have the option to participate in a group interview and an individual interview. If you agree to participate in an interview, I will audio record our conversation so that we can transcribe the recording into words. This is only so I have an accurate account of any of the things you tell me. Because of this, the recording will be erased as soon as the transcription is finished. Any names mentioned will be removed, as well as your own name from the record. In the interview, I will ask you questions about your pregnancy, delivery, and postpartum experience. The compensation for each interview is a $50 Amazon gift card.

How long will I be in the study?

The group interview will take between 1 and 2 hours. The individual interview will take no more than an hour.

What risks or problems can I expect from the study?

I anticipate minimal risk to you by taking part in this interview. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. A potential risk may be a loss of confidentiality. Every effort will be made to keep your study records confidential but I cannot guarantee it. For group interviews, participants will be asked not to share what we discuss. I will encode your information with a number so that no one can trace what you tell us to your name. I will properly dispose of study documents and securely store all research records. Your name will not be used in any reports, presentations, or publications. Your data, with identifying information removed, could be used for future research studies or distributed to another investigator for future research studies without your additional informed consent.

Are there any benefits to taking part in the study?

This study may not benefit you directly, but I hope that this study's findings will empower the choices and voices of mothers through their stories.

What will you do with the information you collect for this study?

Information from this study will be used in producing a graduate thesis. The information will be stored on password-protected computers and kept for at least 5 years. Findings may be published additionally in other media, presentations, reports, and articles. No participant names will be used in any publications or presentations.

Who can answer questions about the study?

If you have questions now, feel free to ask me now. If you have questions later, you may also contact myself at (907)978-0864, or research chair Dr. Josh Fisher at fisherj5@wwu.edu

The Western Washington University (WWU) Institutional Review Board (IRB) is a group that examines research projects involving people. This review is done to protect the rights and welfare of people involved in the research. If you have questions or concerns about your rights as a research participant, you can contact the WWU Office of Research Compliance at (360) 650-2146 or at compliance@wwu.edu.

Statement of Informed Consent:

By giving your verbal consent, you confirm the following:

- You have read (or had read to me) this entire consent document. All of your questions have been answered to your satisfaction.
- You voluntarily agree to participate in this research study. You agree to follow the study procedures as explained above
- The study's purpose, procedures, risks, and benefits have been explained to you.
- You agree to let the study team use and share the information gathered for this study.
- You understand that your name will not be used in any reporting related to this study.
- You understand that your information will be pooled with the information gathered from other women who participate in this study
- You are 18 years old or older.

Please say one of the following:

☐ I AGREE [Begin the interview]

☐ I do NOT AGREE [End]

Researchers present: _____

Appendix D: Interview Questions

Group and Individual Interview Questions

My name is Delaney Reece, this interview is taking place as a part of an investigation into maternal choice. I am joined today on (DDMMYYYY) by Participant number(s) ___.

Before we start, have you received your copy of the informed consent and do you consent to participating in this study including having audio recorded?

No (STOP HERE)

Yes (go on to question one)

1. When did you become pregnant with your first child?

2. What can you tell me about the day you found out you were pregnant?
    0. What was your reaction to the news?
    1. Who were the first people you told?
3. Did you go to a clinic or doctor for prenatal care?
    0. How soon after you found out you were pregnant did you make an appointment?
    1. How soon were you able to be seen?
    2. What did that first appointment look like?
        0. About how long were the appointments?
        1. About how many appointments did you have?

What risk level was your pregnancy considered?
What can you tell me about your care team?
Please tell me the story of your delivery

. Did you go into labor? Was labor induced? Was it a scheduled C-section?
a. Did you receive medications? Do you know what they were?
b. How long were you in labor?
c. Tell me about the nurses and doctors
d. How soon did you get to hold your baby?
e. What happened in the next days before returning home?

Is there anything else you want to share about the experience?