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Birth, Choices

By Melissa Wilkins

> To change the experience of childbirth means to change women's relationship to fear and powerlessness, to our bodies, to our children; it has far-reaching psychic and political implications.
>
> -- Adrienne Rich, *Of Woman Born,* 1976

The contractions are still intermittent, irregular. My 2-year-old son studies me intently during these, solemn and quiet. At one point, he squats beside me; other times he strokes my hair or pats my shoulder. At his own birth, my daughter, almost 3, had darted back and forth between my body and her father's lap. Now she dances in and out of the room exuberantly, snapping digital photos of the midwives and chattering excitedly.

I read Adrienne Rich's *Of Woman Born* years before having my first baby, in a college class studying cultural representations of motherhood. Perhaps because I could better comprehend the singular event of giving birth than the long haul of mothering, what I continued to reflect on later was Rich's conclusion that "as long as birth -- metaphorically or literally -- remains an experience of passively handing over our minds and our bodies to male authority and technology, other kinds of social change can only minimally change our relationship to ourselves, to power, and to the world outside our bodies." Not yet a mother myself, my concept of birth consisted of ER-style emergencies and other

managed deliveries (PUSH! One, two, three, four . . . KEEP PUSHING!). The idea of mothers choosing to reclaim authority over their births from medical professionals seemed radical and perhaps even a bit dangerous. Yet it appealed to me as a practical act of protest available to any pregnant woman willing to insist that she maintain authority over her own body and responsibility for her own choices, and willing to require that her caregivers respect both.

I reread parts of the book when pregnant with my daughter, this time imagining how I would resist the unnecessarily confining, frustrating norms of motherhood Rich describes. I fully understood Rich's point that motherhood would change my life "in the most profound and also the most trivial ways," but ultimately decided I couldn't plan for this extreme and unknowable transformation. Instead, I focused on the transition to motherhood, and began to search out a birth plan that would serve my own physical, emotional, and spiritual needs. I knew I could not embrace "the expected female fate of passive female suffering"; I knew I could not be comfortable without being in "real command of the experience"; I knew I would have to confront the "male medical technology"[1] of modern Western medicine on my own terms.

I took Rich's approach as my own, exploring my childbirth options through both personal testimony and research studies. I began reading about the safety and necessity of common birth practices in books like Diana Korte's *A Good Birth, A Safe Birth* and Henci Goer's *The Thinking Woman's Guide to a Better Birth*, while also reading dozens of personal accounts of labor and birth experiences, mostly from Web sites like childbirth.org. Having a background in research, I wanted to make decisions based on evidence. I wanted facts and figures. I wanted to know what advantages technology could offer me, and in which circumstances interventions would be useful. But I also wanted to know what to expect, how other women processed their birth experiences, and which procedures, caregivers, and birth places other women were satisfied with. I wanted a healthy baby, of course, and was reassured to learn that most labors are "normal" and will result in a healthy mother and baby without any intervention or assistance. I understood that not every labor can proceed naturally, but I wanted to be sure that medical interventions were used only in times of actual need, and with my informed consent; for me, that would define an empowering birth experience.

Throughout this pregnancy, my daughter has insisted that she would like to be one of

our midwives. Perhaps the adults could be her assistants, she suggests. Our midwives tell her this is a fine plan. They help her feel along my belly for the baby's position, and teach her to listen for the baby's heartbeat with the fetoscope. My son also puts his little hands on my belly, though he is far less impressed by these new-baby preparations.

In 1986, Adrienne Rich described the movement to demedicalize childbirth as a national one whose feminist origins had been mostly forgotten as alternative birthing practices became slowly re-medicalized. She noted that "birth centers have not necessarily remained as originally envisioned; nurse-midwives have been replaced by obstetricians who refuse to accept clients on welfare; expensive 'obstetrical beds' have replaced simple furnishings,"[2] which seemed a fair description of the state of childbirth in the United States as I read it years later. It seemed to me that the laboring woman, like women in the workforce, "had only been integrated into the same structures which had made liberation movements necessary"[3] -- though Twilight Sleep wouldn't be pushed on me, I would still have to overcome the attitude that a laboring woman's body needs outside management.

My midwives rub my shoulders and massage the pressure points in my feet. They offer me tea and snacks, ask if I want a bath drawn, and leave me alone with my husband. I remember my first labor, when my midwife barely had time to come in and say hello before the baby was born. My husband and I joke after every birth that it's a good thing we didn't intend to go to a hospital; we'd never have made it in time.

Some might suggest that there are many choices for childbirth in my general vicinity. Within driving distance, there is a teaching hospital, a private hospital, and an in-hospital birth center. As I more closely examined these options, however, I found that, in practice, they looked very much the same; Rich's comment some twenty years earlier, that in childbirth a "relentless consistency of method is pursued without regard to individual aspects of a particular labor,"[4] certainly seemed to be the case in my town. Each location put a slightly different veneer on the same birth experience—but what if that wasn't the experience I wanted? I began to suspect I wouldn't be well-served by a medical birth, even if the furnishings were lovely. Instead of choosing between the pink rooms with obvious equipment and the mauve rooms with disguised equipment, I decided to keep looking for a different kind of care.

My research led me to the midwifery model of care, in which, according to the California Association of Midwives, "the woman maintains power and authority over herself. Responsibility is in the hands of the woman, shared with her partner and midwife."[5] Midwifery Task Force Inc. adds that "the application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section."[6] When I began meeting with local midwives, I knew I had found the option I was looking for: I would invite midwives -- women who were experts of normal, natural birth and who would know me well by the time I went into labor -- into my home to support me. I knew that if my midwife suggested an intervention, or even a transfer to the hospital, it would be because I needed it -- not because it fit her schedule or convenience to do so. I also knew she would explain my options, and that all decisions about my care would be mine to make.

At the moment of her sister's birth, my older daughter presses her face sleepily into my mother's shoulder. My husband holds our son in his arms. The little guy was worried, they tell me later, until I looked over at him and smiled. When the baby is born, I hold her to my chest; my husband comes close and the older children clamber up around us. We all touch her gently, kiss her wrinkly newborn skin, and whisper her name and other welcoming words over and over again.

After the birth, the midwives clean up, remake the bed. They stay long enough to tuck us all in; my mother gives the older kids midnight snacks before she too leaves. The midwives will be back tomorrow, and over the next few days and weeks, to answer our questions, check on our health, and even bring us dinner.

Because "what we bring to childbirth is nothing less than our entire socialization as women,"[7] we need real choices available for labor and birth. The plan that empowers me won't be right for everyone, just as other models of childbirth wouldn't work for me. The National Organization for Women noted in 1999 that "reproductive freedom not only includes the ability to decide whether or when to bear children, but also the right to devise a birth plan with a medical provider of their choice in either a hospital or an alternative setting such as a freestanding birth center or private residence," but that "women's access to midwifery and traditional birthing practices are many times limited by restrictive laws and non-coverage by private insurance companies and state-

subsidized funding."[8] Nurse-midwives practice legally in every state, though the American College of Nurse-Midwives boasted just 6,243 members in 2005,[9] not nearly enough to provide care for the more than 4 million women who deliver babies in the United States each year;[10] direct entry midwives practice legally in only 34 states.[11] Only 54 hospitals and birth centers in 22 states meet World Health Organization guidelines to be designated "Baby Friendly."[12] Thirty years have passed since Rich suggested that women themselves ought to choose the circumstances of their labor "freely and intelligently,"[13] yet women's childbirth practices are still limited by legislators, bureaucrats, hospital administrators, and insurance companies; many doctors still use fear tactics to influence women's decisions; and mothers without insurance or other available funds may find themselves with no options at all.

Have our attitudes changed in the last thirty years such that we, as women and as a society, respect instead of fear life-giving capabilities? Do we, for the most part, actively embrace our birth experiences? Making informed choices -- not achieving a specific outcome -- ought to be our goal. Knowing you made the right decision for your situation, the best choice given your unique circumstances, is empowering. How many of us know that out-of-hospital birth reduces our risk of needing an unplanned cesarean section to under 5%?[14] How many of us know which procedures are likely to be pushed on us for economic, rather than health, reasons?[15] How many of us know which options we aren't even offered? Of course, childbirth is a brief moment in a woman's life: just one day, one event. But that one event often shapes our confidence, our physical health, and our mental wellbeing as we navigate our way into motherhood. Our options should extend far beyond whether to use pain medication in a traditional, high-tech hospital -- like so many of the "choices" offered to mothers today, this one excludes a wealth of other possibilities. An informed mother will make the best choices for her body and her baby every time. Let's make sure we -- and our sisters, our neighbors, our friends -- are armed with information that empowers.

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Notes:

1. Adrienne Rich, *Of Woman Born: Motherhood As Experience and Institution*, 1976, p. 176

2. Ibid., p. xii

3. Ibid., p. xiv

4. Ibid., p. 177

5. California Association of Midwives' Midwifery Model of Care definition, , 6/14/06

6. Midwifery Task Force Inc. definition of Midwifery Model of Care,

7. Rich, Adrienne, *Of Woman Born*, p. 182

8. NOW Resolution: Expansion of Reproductive Freedom to Include Midwives Model of Care, 6/14/06

9. ACNM Annual Report, 2005, 06/15/06

10. 4,115,590 total births in 2004, 4,089,950 in 2003, according to National Vital Statistics Reports Volume 54, Number 8: Births: Preliminary Data for 2004; National Center for Health Statistics, 06/16/06

11. "As of 2003, 21 states recognize and regulate direct entry midwives. . . . Only 9 states and the District of Columbia actually prohibit the practice of direct entry midwives, but in 5 more states licensure is required but unavailable. In the remaining states direct entry midwives practice without any kind of state regulation, and in a few the legal status in not entirely clear. . . . So, direct entry midwives are practicing essentially legally in about 34 states, but are considered unlawful or illegal in 14 states.", 06/15/06

12. Baby Friendly Hospital Initiative, , 6/14/06

13. Rich, *Adrienne, Of Woman Born*, p. 174–175

14. 3% of planned home births ultimately resulted in cesarean, as did 4.4% of planned out of hospital birth center deliveries, compared to 19% of all planned hospital births for low-risk women in 2000. 06/19/06

15. "Effects of Hospital Economics on Maternity Care," Susan Hodges with Henci Goer, , 06/25/06

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