

AGENCY AND EMPOWERMENT IN THE CHILDBIRTH PROCESS:
THE EFFECT OF MEDICALIZATION ON WOMEN'S DECISION MAKING

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ABSTRACT

Over the past decade, rates of caesarean section births and other interventions in childbirth have increased substantially. With increased medicalization of childbirth, it is often viewed as an illness requiring treatment rather than a natural process that women are equipped to handle with little intervention in most cases. A qualitative study was completed that included interviews with nine women participants who had previously given birth to at least one child. The findings elaborate on how women navigated the medical structures of childbirth in order to assert themselves as decision makers in the process, how they related to their bodies during childbirth, and how they educated themselves about childbirth. Seven categories emerged, of which two dominant areas, *power of words* and *provider and nurse/doula relationships*, affected women's empowerment in childbirth. A key finding is the way prenatal appointments were structured and how they began the process of constraint experienced by women.

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CHAPTER ONE: INTRODUCTION

Over the past decade, rates of caesarean section births (C-sections), pain medication used during labor, and other forms of childbirth intervention have increased substantially. The 1980s saw an increase in the United States from “16 to 23.5 percent of all births” (Marsden, 2006, p. 42). In the 1990s, there was a more concerted effort on the part of some obstetricians to formally decrease the rate of cesarean births. However, in spite of those attempts, in the latter part of the year 2000, “the national C-section rate [had] nonetheless risen from 21 percent to more than 30.2 percent” (Marsden, 2006, p. 43). As of 2011, the statistics show an increase from the year 2000. According to data found in the National Vital Statistics Reports, Birth: Final Data for 2011 (2013), the national cesarean delivery rate in the U.S. was 32.8%. Finally, in looking at cesarean rates and how they vary by U.S. state from 2011, it is interesting to see that both North Dakota and Minnesota ranked lower than the national average at 28.7% and 26.8% respectively (www.cesareanrates.com – retrieved 10/1/2013). For me, these overall increases in cesarean rates raise concerns in how decisions are arrived at to undergo surgery to deliver a baby and what discussions are taking place leading up to the point of the procedure during the labor and delivery process.

In addition to the increase in cesarean rates, childbirth is often viewed as an illness, more specifically it has become more medicalized (Conrad, 1992). Using the definition developed by Zola, medicalization is “a process whereby more and more of everyday life has come under medical dominion, influence and supervision” (1992, p. 295). In a study done by the World Health Organization (WHO) in 1992, “at least seven different studies in the United States have shown that the women most likely to receive C-sections are white, married, have private health insurance, and give birth in private hospitals” (Marsden, 2006, p. 41-42). This raises questions about who/what is involved in these decision making processes, as well as how class and race

factor into medical decisions surrounding birth. More importantly, the existing problem is about how involved women actually are in the process, what drives their decisions, and how they feel about those decisions.

Of particular interest to me is women's role in the decision making process not only in relation to cesarean section births, but more specifically the role women play from the construction of their birth plan during pregnancy all the way through to the completion of the labor and delivery event. With the increase in the rates of C-sections over the past few decades, I am particularly interested in how women arrive at the decision to have a C-section and how women assert themselves in the decision to have a cesarean. Instead of asking what women want during their labor and delivery experience, does the patriarchal health/medical system prescribe what it deems necessary for women during labor and delivery? Thinking about the childbirth process beyond C-sections, there is a larger, more general question, about a variety of decisions that shape a woman's birth plan: hospital or home birth, pain medication or not, and vaginal or cesarean delivery. In all the options and issues that women face during their pregnancy and childbirth, an ongoing question in my research is how empowered women feel to make decisions about their bodies. There is a lack of existing research focused on understanding women's empowerment in making decisions throughout the pregnancy and childbirth processes. Therefore, I plan to concentrate on women's involvement in the birth plan and delivery process, regardless of the decision they make regarding their childbirth plan.

Personally, in regard to two of my own childbirth experiences, I did not realize that I lost control of voicing my desired decisions in the process until reflecting on the experience two years after the fact. Looking back, I can pinpoint the actual event related to the construction of my birth plan which changed the course of how decisions were made moving forward from that

point. When I asked my provider when we could work on my birth plan, she simply stated that it was not necessary for me to create one. Further, she did not even provide an explanation as to why I did not need one. Following that event, I did whatever was recommended by my provider and did not question any decision made in regard to the process and I especially did not disagree with anything suggested to me. Thinking about my own experiences, this research will provide a mechanism for better understanding how women navigate the medical system during their pregnancy. I hope to illustrate how the data received from women produces connections in regard to level of empowerment they felt during the childbirth process and where they may have felt they lost or gained more control over how decisions were made.

In order to understand women's experiences with the medical structures, my research utilized the qualitative methodology of institutional ethnography (Smith, 2005), with a focus on interviews in order to gain insight into understanding women's childbirth experiences. I interviewed women who had recently experienced childbirth and drew on supportive documents such as birth plans to develop a more in-depth understanding of how women work with the medical institution during their pregnancy. With a focus on the North Dakota/Minnesota region, I hope to provide depth of understanding of this population. Equally important was determining what women's agency looked like within the childbirth process. I am interested in how women's decision making abilities have been affected by the medicalization of childbirth. Though my focus is on decision making, I will also report on my findings regarding how gender and sex roles of women played out during the childbirth experience. Additionally, my personal experiences with multiple childbirths prompted me to uncover how women's selves are part of the process. To delve deeper into the intimate journeys women travel during pregnancy and childbirth is important, and in doing so, I aimed to understand the ways in which women

function under the overarching medical structure and how they view themselves and their abilities throughout the process. My research questions are:

R1: How do women interact/relate with the medical structures involved in childbirth?

R2: How do women relate to their bodies during pregnancy and the childbirth process?

R3: How do women educate themselves about their pregnancy and the childbirth process?

In doing this research, I hope to raise awareness of women's involvement in decision making in the childbirth process. Additionally, it will be important to develop material and resources for women in regard to making them more aware and empowered in the decision-making process which would perhaps involve discussions with local hospital representatives to determine methods to improve communication between women and providers. The aim was to obtain data that interrogated the reasons behind women's decisions and behavior during the development of their birth plan and the process of childbirth, even if they were not clearly articulated to others. In understanding the process of constructing a birth plan under the overarching medical structure, I hope to contribute to related research by providing data that will fill the void of understanding women's agency and what drives their decision making.

The following chapters will explore the existing literature on childbirth and aspects of the birth plan. In addition to the theoretical approach, the literature review will emphasize the effect of the institution on the childbirth process, women's experiences within the institution, how agency is conceptualized, and finally how gender is incorporated in the childbirth process. Additionally, the methodology section will address using institutional ethnography as the method of inquiry, the sample, interview process and anticipated analysis.

CHAPTER TWO: LITERATURE REVIEW

The existing research regarding the topic of childbirth and women's decision making in their birth plans focuses on varied areas; however, the literature primarily emphasizes a combination of several aspects central to the birth plan. These include the integration of place of birth (i.e. hospital, birthing center, home), type of provider (i.e. obstetrician or midwife), method of birth, and pain medication involvement. In my research, I am focused on all of the various factors involved in the childbirth decision making process, but more critical to me is the role women play in determining these components of the birth plan. Throughout the process, there exists continuous exertion of agency within the institutional structures that surround childbirth. In the literature, there appears to be a gap in determining women's role in the birth plan or lack thereof. The theoretical framework of Dorothy Smith's (2005) standpoint theory and Giddens' (1984) structuration theory shape the emerging themes in the literature on childbirth and its medicalization. Additionally, Peter Conrad's (1992) outline of the four areas of social control within how medicine is practiced reflect the presence of the institution in childbirth decisions, namely that the most prominent example of the area of medical surveillance is childbirth.

Theoretical Framework- Structuration and Standpoint Theory

My theoretical approach to the women's decision making process as they formulate their birth plan started from looking at the connections of Dorothy Smith's standpoint theory (2005) and Anthony Giddens' structuration theory (1993). Looking at the localized position of women's standpoint in their experiences with pregnancy and childbirth and then how they interact within the structures of gender and the medical institution are of importance. Additionally, Jordan's (1997) definition of authoritative knowledge defines nicely the connections between structuration and standpoint theory. Jordan states that authoritative knowledge is "the knowledge that participants agree counts in a particular situation, that *they* see as consequential, on the basis

of which *they* made decisions and provide justifications for their courses of action” (1997, p. 58). Decisions are made by women; however, those decisions are based on the formation of women’s reality through various overarching social institutions. Authoritative knowledge is “the knowledge that within a community is considered legitimate, consequential, official, worth of discussion, and appropriate for justifying particular actions by people” (Sargent & Davis-Floyd, 1997, p. 58). Authoritative knowledge shows how socially prominent knowledge, in combination with the structures shaping it, serve as what steers women’s decisions. Giddens (1993) affirms that structure “is not to be conceptualized as a barrier to action, but as essentially involved in its production” (p.123). By focusing on women’s localized standpoint of experience, the question of how women assert themselves inside the sphere of institutional knowledge becomes a key point of focus.

Through a deeper examination of Giddens’ (1984) structuration theory, one can see how it can be applied to the framework of women’s agency during the childbirth process. Giddens defines three major concepts that make up the center of structuration theory: structure, system and duality of structure. He states that “‘structure’ is regarded as rules and resources recursively implicated in social reproduction; institutionalized features of social systems have structural properties in the sense that relationships are stabilized across time and space” (Giddens, 1984, p. xxxi). The structure(s) which exist in and surround the childbirth process are essentially socially acceptable and institutional rules of which some are easier to see than others such as those in written form and other tangible resources while others lie beneath the surface and must be teased out. The duality of structure “is both enabling and constraining [for agents] and it is one of the specific tasks of social theory to study the conditions in the organisation of social systems that govern the interconnections between the two” (Giddens, 1993 p. 122). The healthcare system, as

a structure, both enables and constrains women preparing for childbirth through various tangible and intangible structures. While the structure provides an avenue for women to take in the shaping of their birth plan, it also sets up constraints in terms of the options and choices women have in the development of their birth plan. Giddens' theory of structuration provides the groundwork upon which to start asking questions about ways in which women are enabled and constrained within healthcare structures. In order to support a more localized approach in my research, I turn my discussion to Dorothy Smith's standpoint theory (1992).

In looking at women's standpoint theory, Dorothy Smith (1992) emphasizes that the "notion of standpoint doesn't privilege a knower" but rather "shifts the ground of knowing, the place where inquiry begins" (p. 91). The theoretical approach of standpoint theory is when one arrives at the place where women create knowledge through their localized experiences. In looking at how Smith (2005) refers to standpoint she states:

the embodied knower begins in her experience. Here she is an expert. I mean by this simply that when it comes to knowing her way around it, how things get done, where the bus stop for the B-line bus is, at which supermarket she can pick up both organic vegetables and lactate-reduced milk, and all the unspecifiabes of her daily doings and the local conditions on which she relies – when it comes to knowing these matters, she is an expert (p. 24).

The example Smith sets up enables me to ground my focus on the localized experiences of women going through pregnancy and childbirth. It is important to understand the reality of her location in her life and how that relates to the medical care she receives, her expectations and her social relationship to the process. To access these experiences and how women relate to the healthcare system, it is important to speak directly to women who have gone through the

experience of childbirth. In Parry's (2008) research of midwifery, she approaches her research from feminist standpoint theory. Using Woliver's definition, Parry states that it is "focused on uncovering assumptions about power differentials within a patriarchal society" (Parry, 2008, p. 791). Interviewing women who had gone through childbirth as my starting point for research allowed me to develop greater understanding of how women navigate the power systems that shape healthcare structures.

To do this, Smith (2005) relies on the concept of the ruling relations. Ruling relations are defined by Smith (2005) as

that extraordinary yet ordinary complex of relations that are textually mediated, that connect us across space and time and organize our everyday lives-the corporations, government bureaucracies, academic and professional discourses, mass media, and the complex of relations that interconnect them (p. 10).

The ruling relations produce an allowable framework within which women interact and make decisions. Ruling relations organize people within institutions. In the case of women's decision making in childbirth, the ruling relations refer to the medical institution and the guidelines provided to women that shape their navigation throughout the childbirth process. For example, hospital protocol, specific philosophies held by physicians as they are shaped by the medical institution, and information provided to hospitals by an even larger overarching organization all play a role in the ruling relations within which women exert agency. Smith (2005) states that "we are ruled by people who are at work in corporations, government, professional settings and organizations, universities, public schools, hospitals and clinics, and so on and so on. Though they are, of course, individuals, their capacities to act derive from the organizations and social relations that they both produce and are produced by" (p. 18). Additionally, this harkens back to

Giddens' (1993) structuration model where structures are seen as both enabling and constraining. The institutional structures are a direct connection to the ruling relations and how they enable and constrain choices and behavior. The connection of these areas as well as will be an important consideration as the data received from women is analyzed.

Through standpoint theory, in combination with her institutional ethnographic approach to research, Dorothy Smith (2001) seeks to understand the happenings in the everyday lives of women. She defines institutional ethnography as “a stance in people’s experience in the local sites of their bodily being and seeks to discover what can’t be grasped from within that experience” (Smith, 2001, p. 161). Through this approach one needs to seek to understand what is happening within the experiences of women and how women’s decision making is affected by the social in their everyday lives. “Institutional ethnography works from the local of people’s experience to discover how the ruling relations both rely on and determine their everyday activities” (Smith, 2005, 44). Also important to Smith is the idea of textual reality in the area of relations of ruling. She states that “the practice of obstetrics, the organization of delivery and labor rooms, the ward, nursing practice, and so forth, all provide the settings, contingencies, and administrative procedures” (Smith, 1990, p. 87). There is a system to be followed and hospitals enforce these procedures in their everyday practice. These practices affect women’s ability to determine what they want out of birth, making childbirth “a complex organization of power mediated by texts” (Smith, 1990, p. 88). This power exerts itself through the legalization and medicalization procedures that childbirth has undergone.

Additionally, another approach to standpoint theory as described by Sandra Harding (2009) is “to set out to explain what oppressed groups need” and in the case of childbirth it is to determine how to provide the empowerment women need to assert and develop their own voices

in the decision making process (p. 195). Harding also asserts that standpoint theory is about understanding the working of oppressed groups in conjunction with the patriarchal institutions in society. She states that standpoint projects “are focused on critically examining what’s wrong and what’s still useful or otherwise valuable in the dominant institutions in society, their cultures and practices” (2009, p. 195). With this in mind, I shift to the literature on the medicalization of pregnancy and women’s role in their childbirth procedures and processes.

Existing Research on the Process of Childbirth

The existing literature surrounding the topic of childbirth has emerged primarily over the past thirty years; however, the increased interest in childbirth over the past decade has placed women’s decision making under a microscope. However, with more academic articles and mainstream media/social networking attention given to childbirth and recommended ways for women to play an active role in the process of childbirth, the medicalization of childbirth remains a dominant presence in the delivery room. The literature I am using is a combination of data gathered by obstetricians, academic articles reporting on qualitative data obtained through research involving women who gave birth, and theoretical concepts within sociology that reflect on the social and cultural push and pull in the childbirth process. Within this medicalization, it is important to look at how women’s agency is shaped through their actions throughout their pregnancies. What is lacking in the literature is a focus on women’s voices in the childbirth process in order to understand the interplay of women’s agency within the overarching institutional structures.

Research on Childbirth – The Effect of the Institution

When looking at labor and delivery, there exists many ways in which maternity care in the United States and other parts of the world have morphed into an industry, which has

exercised power over women and their experience with labor and childbirth. For example, according to a true story of childbirth gone awry, Marsden (2006) states that “Mrs. S is aware that something has been inserted, but the obstetrician does not tell her what or even that his goal is to induce labor” (p. 70-71). While there are a multitude of issues involved in childbirth, ranging from giving birth in hospitals or at home, vaginal or cesarean birth, the use of midwives versus obstetricians, and other areas including medical intervention, a primary concern that is surfacing is a birth prescription often excluding the primary person involved – the pregnant woman.

In focusing specifically on women’s decision making abilities and how that impacts what they can and cannot determine for their bodies, it is important to define informed consent. In looking at the general definition of informed consent, author/journalist Jennifer Block (2007) defines it as adults having the “right to receive treatment and the right to refuse treatment, and they have the right to know the risks and benefits of each treatment option, including the option of no treatment at all” (p. 253). She continues to talk about the exceptions for requiring informed consent of which category pregnant women do not fall; however, pregnant women are grouped into that list of exceptions. Marsden Wagner, M.D., M.S. (2006) a physician who avidly supports women in their decision making role, also refers to the importance of informed consent under the guidelines of the American Medical Association (AMA) and American College of Obstetricians and Gynecologists (ACOG). There is specific reference to patient rights including “the right to make medical decisions free from coercion or undue influence from physicians” (Wagner, 2006, p. 174). Various research shows that institutional power is reinforced by the medical system and the information provided by the system leads women to believe that giving up control to let the professionals do their job will result in the best outcome of childbirth (Lazarus 1994;

VandeVusse; 1999). There is a growing concern that women are undergoing childbirth, simply following the instructions of their physician/primary care provider, rather than playing an active role in understanding and determining the plan of action.

Women's passive role in their childbirth experience can be understood within Peter Conrad's (1992) three areas of medical social control, which include "medical ideology, collaboration, and technology" to which he adds a fourth category based on Foucault's influence he titles "medical surveillance" and that "physicians may legitimately lay claim to all activities concerning the condition" (p. 216). Conrad describes in more detail the areas of social control beginning with medical ideology which

imposes a medical model primarily because of accrued social and ideological benefits; in medical collaboration doctors assist (usually in an organizational context) as information providers, gatekeepers, institutional agents and technicians; medical technology suggests the use for social control of medical technological means, especially drugs, surgery, and genetic or other types of screening (p. 216).

Looking at the various areas where the institution provides a framework under which information is provided shapes the decisions of those seeking care.

Another area that affects decision making of women in childbirth relates to how the material in childbirth education classes that prepare women is presented. This area can be viewed as an extension of how structures provide a knowledge base within which women make decisions during their pregnancies and childbirth processes. Hospital-based classes and private classes differed on the focus taken in the information they provided (Sargent & Stark; 1989). An example of how the hospital-based classes focused on interventions was given by an instructor

who explained that “the most important goal was to prepare the couple in case cesarean happens – the possibilities, medications, incisions” (Sargent & Stark, 1989, p. 40). The other type of course was through a private organization not affiliated with a particular hospital of any kind. Rather than prepare women for the “necessary and unavoidable” medical interventions during childbirth, the private class goals were the “provision of information concerning options available in childbirth, promotion of questioning by parents, increased understanding of psychological and physiological processes involved in birth, and enhanced parental confidence in controlling birth events” (Sargent & Stark, 1989, p. 41). The type of information given to expectant parents and women in particular appears to be open and upfront; however, in delving deeper into how information is given clearly has an agenda attached to it. I would argue that the power is present in the language used, while seeming to “lay the options on the table” the hospital classes are actually presenting the interventions as a necessary part of birth and that preparing women to expect them is providing a false sense of what really is necessary.

In looking at childbirth education classes, it is important to view the overarching structure serving as the umbrella over the information circulated. How are women using this information to exert their agency in decision making in childbirth? Anthony Giddens’ theory of structuration serves as an important focus to uncover how women utilize their agency within structure and how it can both serve as a reinforcement of the structure and work to their advantage to deviate from the rules within the structure. According to Giddens (1993), “structure is both enabling and constraining, and it is one of the specific tasks of social theory to study the conditions in the organisation of social systems that govern the interconnections between the two” (p. 122). Within the institutional structure of the medicalization of childbirth, women both are shaped by the structure as well as have the ability to use their agency to make decisions. Agency, according

to Giddens (1984), is “to be able ‘to act otherwise’ means being able to intervene in the world, or to refrain from such intervention, with the effect of influencing a specific process or state of affairs” (p. 14). This will be important in terms of my research in order to determine what agency looks like and how women’s agency perpetuates the social system of the patriarchal medical system and its function in childbirth.

Women’s Childbirth Experiences within the Institution

One way to make sense of Conrad’s work is the ways in which technologies in the birth process have become an increasingly normalized part of the birthing process. The increase in medication interventions during childbirth are now viewed as a normalized part of the childbirth process (Wagner, 2006, p. 53). One of Lazarus’ (1994) interviewees explained her decision to have a cesarean section based on the fact that the pregnancy “was their only chance to have a baby, and fearful that something would go wrong if left to the natural course of events” (p. 37). This was in response to the woman’s obstetrician telling her that “the baby was high and large – perhaps a difficult delivery” (Lazarus, 1994, p. 37). As one can see, instead of presenting the options to let the woman decide, in this case, the obstetrician used fear to persuade her into complying. This particular woman explained that the obstetrician declared that “patients and doctors both see C-sections as no big deal...they don’t see C-sections as surgery” (Lazarus, 1994, p.37).

Pertaining to Conrad’s fourth category of social control, he specifically refers to childbirth as an example of medical surveillance where the process still is under the control of the medical body (Conrad, 1992, p. 216). He references Arney (1982) in how this medical surveillance extends to “prenatal lifestyles, infertility and postnatal interaction with babies” (p. 216). Further, more specifically to the childbirth process itself, medical surveillance is reflected

in the increase of monitoring during the process by the hospital. Jennifer Block (2007), in reference to electronic fetal monitoring (EFT), explains how even with lack of statistics showing improved birth outcomes through use of EFT, it has become increasingly common for hospitals to use this type of approach to monitor women and keep them under surveillance. She writes in detail about how closely women are monitored during the process of childbirth stating that

in spite of the evidence , women continue to be told they must wear a monitor, and therefore that they must stay in bed. In 2005, nearly all women giving birth in a U.S. hospital had the sensor bands strapped around their bellies – the Mothers survey counted 93%. Most respondents to the survey were in fact bound several times over: 83% had an IV line in their arm, 56% had a urine catheter, and 76% had epidural or spinal anesthesia (p. 35).

This type of monitoring shows the level of surveillance and control an institution can have on women and their experience in childbirth.

In exploring how women’s decision making unfolds within the realm of being under the eye of a medical team, my goal is to uncover the pressures felt due to that surveillance and to be aware of that in hearing about the birth stories of women. Moving even further past the area of medical control found in previous research is women’s agency and how control is defined and perceived by women during the process. Revealing how women exert agency is sought in this research to fill some of those gaps. The web of interconnectedness of social control under the medical umbrella is important to understand as data is obtained and analyzed.

Young (2001) addresses the issue of control in relation to how power is exercised (cited in Parry 2008). He argues that “physicians develop and control knowledge in three ways: (1) by defining pregnancy as a medical disorder, (2) by using medical instruments to understand

internal processes, and (3) through employing a medical setting, which discounts a woman's control and expertise over her own pregnancy" (Parry, 2008, p. 786). Young's third point is of particular interest as previous qualitative research done by Leona VandeVusse (1999) outlined how control occurred and the way it affected women's decision making. The four types of control were "unilateral but contested, unilateral and uncontested, suspended: waiting, and shared (joint)" (VandeVusse, 1999, p. 45). What is of great importance in VandeVusse's (1999) findings of how control was exercised is that what really reflected a positive, empowering experience was that they had control to make decisions. In a specific example of a physician performing an international examination versus a midwife performing the same examination was that "the lay midwife offered the choice of an examination" and the woman "knew she could stop the examination at any time" (VandeVusse, 1999, p. 48). Therefore, it is not strictly about whether medical intervention is necessary or not, but more about whether a woman has the ability to decide at any given time what she wants to have happen during the childbirth process. In a large quantitative study done by Waldenstrom (1999), it was found that "being involved in the birth process, feeling free to express feelings during labor, and being supported by the midwife or by the partner were associated with a positive experience" (p. 474). This also provides evidence that feeling involved in the process is a huge factor for women to have a good experience.

Conceptualizing Agency in Relation to Childbirth

The development of their birth plan is an important space where women can insert themselves into the decision making processes of their pregnancy. Giddens (1984) speaks to the issue of power as a required part of playing the role of an agent. He states that "action depends upon the capability of the individual to 'make a difference' to a pre-existing state of affairs or

course of events. An agent ceases to be such if he or she loses the capability to ‘make a difference’, that is, to exercise some sort of power” (Giddens, 1984, p. 14). Miller & Shriver (2012) noted that the majority of women in the United States see the norm of childbirth as a highly medicalized process. However, in reference to Giddens’ view of exerting power, even within the medical institution, “in their [women’s] reliance on physicians, they felt they were exercising agency because they made the choice as a result of their effort to do “everything possible” to ensure the well-being of their child” (Miller & Shriver, 2012, p. 712). In this case, women do feel that “power” in choosing to trust their doctor. Looking at Foucault’s (2003) analysis of power relations, he states that “power is exercised only over free subjects, and only insofar as they are ‘free’” (p. 139). Women are essentially able to make decisions, but that freedom must be defined in more detail in relation to the differences of what that means within the concept of agency. Barker (2008) states that “culturally generated agency is enabled by differentially distributed social resources” (p. 234). This is important as one thinks about the difference of opinion in terms of how a woman would define the level of empowerment she felt and the latitude given to exert herself as an agent within the process. In referring to agency, “because it is socially and differentially produced, some actors have more domains of action than others” (Barker, 2008, p. 235). These areas of choice and power through discourse can be applied to looking at women’s decision making in childbirth as they technically are presented with options and have the decision making ability given to them. Further, Giddens (1984) states that “agency concerns events of which an individual is the perpetrator, in the sense that the individual could, at any phase in a given sequence of conduct, have acted differently” (p. 9). From this, individuals do have the freedom to make decisions within an institutional structure, but one must look at how agency is socially constructed as well to understand why various

decisions are made. For example, “pregnant women who chose alternatives to the medical birth, such as midwifery, may be resisting medicalization” (Parry, 2008, p. 787). Medicalization has changed shape and form historically and is an important area of focus of women’s decision making. According to Miller & Shriver (2012), whether U.S. women are choosing to deliver their babies with a midwife or in a traditional hospital setting, they wish to participate in the experience. However, “scant research examines the preferences women have and how those preferences interface with the larger structural environment as women seek to exert agency over their childbirth experiences” (Miller & Shriver, 2012, p. 710).

Demedicalization is another term Conrad (1992) brings up and even though over the past two decades the “childbirth, feminist, and consumer movements have challenged medicine’s monopoly of birthing” childbirth is still highly medicalized and controlled (p. 225). In spite of this medicalization, looking at how women assert themselves as actors within the medical structure is important.

Gender and Women’s Bodies in Childbirth

Gender plays a large role in the medicalization of women’s bodies and affects many areas of their lives, but particularly “reproductive issues including childbirth, birth control, infertility, abortion, menopause and PMS” (Conrad, 1992, p. 222). The issues plaguing women are under the microscope of medicine when reflects the importance of the role gender plays in the empowerment they feel in terms of decision making in childbirth. Coupled with gender is the idea of femininity as discourse described by Smith (1990). She explains how women are viewed through texts and media as “soft” creatures, which feeds into the ideas that women take on as their role in different areas in their lives. According to Smith, “softness’ in the discourse of femininity expresses a tenet of its doctrines – the feminine woman is yielding, pliant, and

compliant” (p. 176-177). This role of gender is performed repeatedly in a delivery room as women give birth. It is expected at both the structural level as well as the level of the agent. In Martin’s (2003) “Giving Birth Like a Girl,” she refers to gender as being an “internalized part of who we are” and that “it is powerful because we cannot escape such culturally constructed gendered identities” (p. 57). She is interested in how gender affects our performance in daily activities “even during natural experiences like birth” (Martin, 2003, p. 57). Even though one could argue that if birth is a natural process, why would gender matter, the point is that gender is embedded in our consciousness and it isn’t possible to separate how gender affects the way in which we act or respond to each social situation we face. As cited in Martin (2003), Foucault’s “notion of technologies of the self allows us a sharper understanding of these gendered ways of being by showing us how they discipline and control from the inside” (p. 57). The social idea of what femininity is played out in this in that during birth, women are still placing their socialized gender role as primary in the way they make decisions during childbirth. Martin’s (2003) research argues that this makes birth less of a process that women can call theirs. She states that the internalized technologies “cause them [women] not to put themselves at the center of the birth experience, something many feminists argue is essential for control over the experience and empowerment from it” (Martin, 2003, p. 59). In letting go of the external self, Parratt & Fahy (2003) state that she [the woman] is then able to focus entirely on the internal features of her experience” (p. 21). The patriarchy of the hospital exhibits control over women in childbirth, however, the social controls over women’s birth experiences – often less visible – are no less powerful in the construction of women’s choices” (McAra-Couper, Jones & Smythe, 2011, p. 89). It is equally important to view how women’s social spheres of influence combine with hospital protocols to challenge the leverage they have in making decisions during childbirth.

As Shannon Carter (2009) approaches her research regarding gender performance in childbirth, she recognizes that the way gender presents itself will look different depending on class, race, and location of where the childbirth takes place. As I approach my research, I will be focusing on white, middle class women in childbirth and hope to interview women who have had hospital births and home births to distinguish both similarities and differences in how gender is played out.

Dorothy Smith (1992) refers to the standpoint of women as the “knowing subject” and the subject “is always located in a particular spatial and temporal site, a particular configuration of the everyday/everynight world” (p. 91). To uncover the underlying social forces that shape women, Smith argues that researchers must delve into the actualities of the daily lives of women. In terms of inquiry, Smith (1992) states that it is “directed towards exploring and explicating what she does not know—the social relations and organization pervading her world but invisible in it” (p. 91). And, to better understand how women’s agency within gender presents itself, the institutional ethnographic approach will enable me to explore the interconnectedness of gender, in combination with medicalization and social control delivered through the institutional structures affecting the pregnancy and childbirth process.

The existing literature addresses some of the issues of institutional roles in the childbirth process as well as how women felt certain involvement was perhaps more positive or negative in the experience, but there still exists a lack of data expressing how women utilize the resources at their disposal, how they interact within the medical structures and how they feel connected to their bodies during the childbirth process. Overall, the data statistically reflects what types of decisions are made, but does not address processes through which women navigate the healthcare system and what prompts them to feel more or less empowered within the process.

Therefore, in seeking data specifically on how women explore the childbirth process and their options within medical structures, I hope to contribute further understanding to improving and raising awareness and confidence in women, encouraging them to interject their desires and opinions through the entire pregnancy and childbirth process. With these concerns in mind I developed the following research questions:

R1: How do women interact/relate with the medical structures involved in childbirth?

R2: How do women relate to their bodies during pregnancy and childbirth process?

R3: How do women educate themselves about their pregnancy and the childbirth process?

CHAPTER THREE: METHODOLOGY

In this research study I utilized Dorothy Smith's (2005) institutional ethnography. Smith explains that institutional ethnography "begins by locating a standpoint in an institutional order that provides the guiding perspective from which that order will be explored" (p. 32). As part of this methodology, I utilized in-depth interviews with women who had delivered one or more children of which at least one having been born no later than three years prior to the start of my interviews. Of particular interest was the exploration in the development of the birth plan for women and what drove them to either create one or not and how they asserted agency through the development of the plan. The approach of institutional ethnography seeks to "go beyond what people know to find out how what they are doing is connected with others' doings in ways they cannot see" (Smith, 2005, p. 225). In relation to decision making and development of the birth plan, the focus is to uncover social connections and themes in women's agency utilizing this approach.

Data Collection

In order to understand the experiences of women in their childbirth experiences, I engaged in interviews that drew out information about the details of each woman's pregnancy and the childbirth process. My sample consisted of women who had given birth within the last three years from the start of my research. I did not have any further perimeters for my sample. In order to find women to participate in this study, I used snowball and convenience sampling based on my own experiences in childbirth and lactation groups. I sent emails to these women order to ask them to participate. From there, I asked my participants if they knew of other women who would be interested in participating in my research. I interviewed a total of nine women.

I used an interview schedule (see Appendix A) that both organized the interviews and provided the ability for my participants to openly discuss their experiences. I utilized a digital

recorder and transcribed the interviews. I wanted participants to feel comfortable sharing their experiences with me and in as much detail as possible. As a woman who has given birth myself, I anticipated there to be more ease with the participants in my study, making it easier for them to share more detailed, intimate accounts of their pregnancies and childbirth processes. I interviewed participants either at their place of residence or another location of their choice to make each participant as comfortable as possible.

The process of childbirth is one that is laden with details. Martin (2003) offers a couple examples from her research where women describe themselves as feeling bad for vocalizing pain and for lacking attentiveness with a doctor. Her work demonstrates the value that qualitative research brings to understanding the complex ways that agents engage, on a micro-level, with a structure such as the healthcare system. Therefore, in-depth interviews enabled me to access, in greater detail, the processes involved in the women's childbirth experiences. The importance in my approach to this research study was to draw out the ways in which my participants make sense of the healthcare system and how they worked within that system throughout their pregnancy. By focusing on their personal experiences through in-depth interviews, my goal was to gain insight into the how women negotiate the childbirth process.

Additional Textual Data

Smith (2005) emphasizes that "institutional ethnography begins in the local actualities of the everyday world, with the concerns and perspectives of people located distinctively in the institutional process" (p. 34). In order to determine the level of empowerment women felt during their birth plan construction as well as during childbirth I also relied on asking questions about their birth plan construction and asked participants to remember and narrate those experiences. Particularly because institutional ethnography involves the importance of texts, and their

activation through dialogue and conversation, the use of the birth plan allowed for a central document around which the interviews can develop. Smith (2005) states that “as a reader activates a text, she or he engages with its language and is also responding to it” (p. 104). It is my hope that the birth plans will create a greater depth and insight into their past experiences with childbirth.

It is important to understand the idea behind what a “text” refers to and the “text-reader conversation.” Smith (2005) states that texts “produce the stability and replicability of organization or institution” and that institutional ethnography “recognizes texts not as a discrete topic but as they enter into and coordinate people’s doings, and, as activated in the text-reader conversation, they are people’s doings” (p.228). Texts themselves are the same as they are produced in material format whether it be a birth plan or form of information provided by the medical institution, but what is important from the standpoint of institutional ethnography is to capture the importance of the text-reader conversation and that it places women in the local. Smith (2005) defines text-reader conversations as those that “take place in real time, in the actual local setting of their reading, and as moments in sequences of action” and keeping in mind that it is something that is activated enables one to see them [texts] as “embedded in social relations and, hence, as being in action” (p. 228). This type of approach created paths of inquiry that looked different from one to the next based on where each woman placed herself in her world and how that world was socially structured. However, the institutional ethnographical approach that “proposes to enlarge the scope of what becomes visible from that site, mapping the relations that connect one local site to another” (Smith, 2005, p. 29) is critical in the childbirth process as what is occurring at the local site will be brought to light and then connections made with other areas of the women’s lives.

As I outlined the approach to my research, the sample, interview process and coding procedures created a blueprint for answering my research questions. In terms of conducting research, as previously mentioned, I explored standpoint theory. As Dorothy Smith (1987) explains, “a sociology for women preserves the presence of subjects as knowers and as actors. It does not transform subjects into the objects of study or make use of conceptual devices for eliminating the active presence of subjects” (p. 105). I wanted to be sure to retain women in their actual life and to capture them as subjects. I was able to uncover what their agency looked like within the structure of the healthcare/medical institution. Coming from the feminist methodology approach to research, Harding & Norberg (2005), state that “understanding how our lives are not governed primarily by individuals but more powerfully by institutions, conceptual schemes, and their “texts,” which are seemingly far removed from our everyday lives, is crucial for designing effective projects of social transformation” (p. 2011).

Approach to Analysis and Research Process

A total of nine interviews were conducted. Unfortunately, two of the interviews conducted did not record well enough to be deciphered for direct quotes from the interviewees. To fix the issue with the recording malfunction an external microphone designed for maximum quality was purchased and used for the remaining seven interviews. In analyzing the data received, seven interviews were transcribed word for word to gather any subtleties or hesitations from the women during their interview process. This allowed me to focus on the areas of importance and areas construed as “hot button” topics for the women.

During the first round of coding, each of the seven interviews was coded according to any comment made that reflected an idea of something that would contribute to empowerment of the women during their pregnancies and the childbirth process as well as demographic information

which informed me of variance in experience across the interviews. The second round of coding narrowed the categories of focus even further into 10 areas of importance where color coding was used to group comments into those areas. Finally, a third round of analysis resulted in a total of seven categories which contributed to the process of determining level of empowerment felt as well as whether or not the participants ever thought about the idea of choices and their role in the decision making process of childbirth. The codes assigned, were labeled in such a way so as to assist in answering my research questions most effectively, focusing on women's agency within the medical structures surrounding childbirth, how they relate to their physical bodies during that process, and how they educate themselves about the entire process of pregnancy and childbirth. To protect each woman's privacy, it was critical for me to provide a pseudonym for each one. In doing this, it was helpful for me to capture each woman's personality by naming them according to how they approached the process and what seemed most accurately represented their essence. Another approach to analyzing I have found I am particularly interested is in those who have delivered more than one child in order to evaluate differences in the childbirth experience and changes in decision making that occurred for women.

Following approval of my proposed research plan and its objectives by NDSU's Institutional Research Board (IRB), I located the participants in my research study through email announcements and word of mouth, which resulted in creating a snowball sample for my research. I proceeded to conduct in-depth interviews with nine women who had previously given birth to at least one child during the previous three years with some having had additional children as well. In thinking about where interviews would occur, it was critical that the women felt comfortable and in an environment where they could share openly about their pregnancy(ies) and childbirth, a topic that often conjures up emotions and even memories of physical pain,

trauma, joy and excitement. Of the nine interviews, five of them occurred in the individual homes of the women, three were conducted in the women's place of employment in a private office space and one was held in the library in a private study room. Each interview lasted between 20 minutes to one hour.

Research Participants – Demographics of Women

All seven women interviewed were from the Fargo-Moorhead and Grand Forks communities. While the decision making process differed from woman to woman, there were many similarities that surfaced and are worth focusing on to help address the issues in my research questions. Table 1.2. (below) provides an overview of ages and employment status for the participants interviewed. Further, Table 1.3. (below) gives a snapshot of the types of birth, interventions and provider type for the women interviewed in this study.

There was a representation of various types of providers, birth types and interventions to reflect what women's empowerment looked like in the different situations. Because all the births took place in a hospital setting, the study of the decision making process among the women interviewed will focus especially on how the medical structures were involved in shaping the process of events during the pregnancy and birthing experience(s) for each woman. The responses received spoke to how women asserted themselves within the medical structures they found themselves having to navigate as issues arose during pregnancy and childbirth where decisions needed to be made. What the data reflects is how those decisions, while met with choice, were also met with limits and boundaries.

As mentioned above, each woman was assigned a pseudonym according to her personality and individual presentation style during the interview, which also reflected her role in the childbirth process. Additionally, to protect the women's families, when spouses' or

children’s names were mentioned, another name was assigned in the data to protect their privacy.

Table 1.1 shows the names and meanings assigned to the women:

Table 1.1. Pseudonyms and Meanings

Name	Meaning
Lora	Honor and victory
Bridget	Strong
Halle	Heroine
Kaia	Earth
Bella	Beautiful
Azalea	Flower
Audrey	Noble Strength

The responses received spoke to how women asserted themselves within the medical structures they found themselves having to navigate as issues arose during pregnancy and childbirth where decisions needed to be made. What the data reflects is how those decisions, while met with choice, were also met with limits and boundaries. Details about each woman’s experience are reflected in Tables 1.2 and 1.3:

Table 1.2. Information About Women

Woman’s Estimated Age – 20s	-	-	-	Yes	-	Yes	-
Woman’s Estimated Age – 30s	Yes	Yes	Yes	-	Yes	-	Yes
Working Outside Home	Yes	Yes	-	-	Yes	Yes	Yes
Working Inside Home	-	-	Yes	Yes	-	-	-

Table 1.3. Details During the Childbirth Process

	Lora	Bridget	Halle	Kaia	Bella	Azalea	Audrey
Birth in Hospital	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Number of Births	1	1	4	2	2	1	1
Vaginal Birth	1	1	4	0	2	0	1
Cesarean Section Birth	0	0	0	2	0	1	0
Induction	0	0	3	1	1	1	0
Epidural	1	0	0	2	0	1	1
Pain Medication	Yes	No	Yes	Yes	No	Yes	Yes
Provider – Obstetrician	1	1	4	2	1	1	-
Provider – Midwife	-	-	-	2	1	-	1
Provider – Family Practice	-	-	-	-	-	1	-
Sex of Provider – Male	1	-	-	1	1	-	1
Sex of Provider – Female	1	1	4	1	1	1	1

Researcher’s Involvement and Personal Role

While my involvement as the researcher in this study was not as intimate nor as embedded as one would be in a participant observation model, I feel it important to emphasize the importance of my personal experience with childbirth to this research. I have given birth to three children. During the year following the birth of my second child, I saw a documentary about the current state of childbirth in hospitals in the United States. It was during that documentary that I had an awakening which brought me to tears, realizing how little I asserted myself in the decisions made during the birth of my two boys and how I let the medicalization of childbirth take over. I then began to delve into the existing literature on the topic, finding many

areas of interest and I knew I wanted to pursue more research into this area to discover the issues women face and how they navigate pregnancy and childbirth. Therefore, having gone through childbirth and being able to relate to the women in my study created an openness and willingness on their part to share their experiences with me in an honest and detailed manner. This provided a wealth of information in regard to addressing the factors that affect women's decision making in the pregnancy and childbirth process. I was careful to refrain from asking questions that would appear leading in any way. Where appropriate, I did insert comments about my own experience, but it was merely to affirm women's thoughts and feelings about their own birth experience(s). In the following chapters I discuss my findings and results.

CHAPTER FOUR: RESULTS

As the research approach taken was qualitative in nature, a large amount of information was obtained from the interviewees in regard to their pregnancy and childbirth experiences. The results reflect my research focus, paying attention to the ways women interacted and related to their medical structures, how women related to their bodies during the pregnancy process, and how they educated themselves about their pregnancy in preparation for the childbirth process. Throughout the examples in the results, it was evident that women's agency was shaped according to the medical structures surrounding them within each category, sometimes explicitly and other times implicitly. Giddens' structuration theory (1984) presents agency as being "able 'to act otherwise'...being able to intervene in the world, or to refrain from such intervention, with the effect of influencing a specific process or state of affairs" (p. 14). This agency for the women interviewed was reflected in the discussion surrounding the interview questions.

As previously noted, through the multiple rounds of coding the data, seven dominant categories emerged, each of which is a piece of the puzzle informing women's decisions in relation to childbirth. There are three categories predominantly related to structure: *prenatal appointment structure, provider relationship, nurses, doulas and other support people, and power of words*. Two categories capture the interaction of structure and agency: *childbirth education and birth plans and power of words*. The remaining two categories reflect more agent (individual) based actions: *pain management and other interventions* and *control and decision making*. Within these seven categories exist themes that frame the path of thinking for women in childbirth. While most of the categories lend themselves to fall into a more defined structure-based or individual-based area, there exist many connections between the categories. Equally noteworthy is the fact that the categories work together to either empower women or cause them to feel a lack of control and/or ability to assert themselves during the pregnancy and childbirth

process. In the upcoming discussion chapter I will examine the interactions between these categories in relation to the research questions. However, in this chapter I will provide an in-depth overview of the seven categories that emerged, as well as show connections between categories in order to set-up the interplay examined in Chapter 5.

To help set-up the interconnectedness of the categories and how they work apart and together to contribute to women’s empowerment in decision making, Figure 1.1 provides a visual aid encompassing the complexity of the relationships:

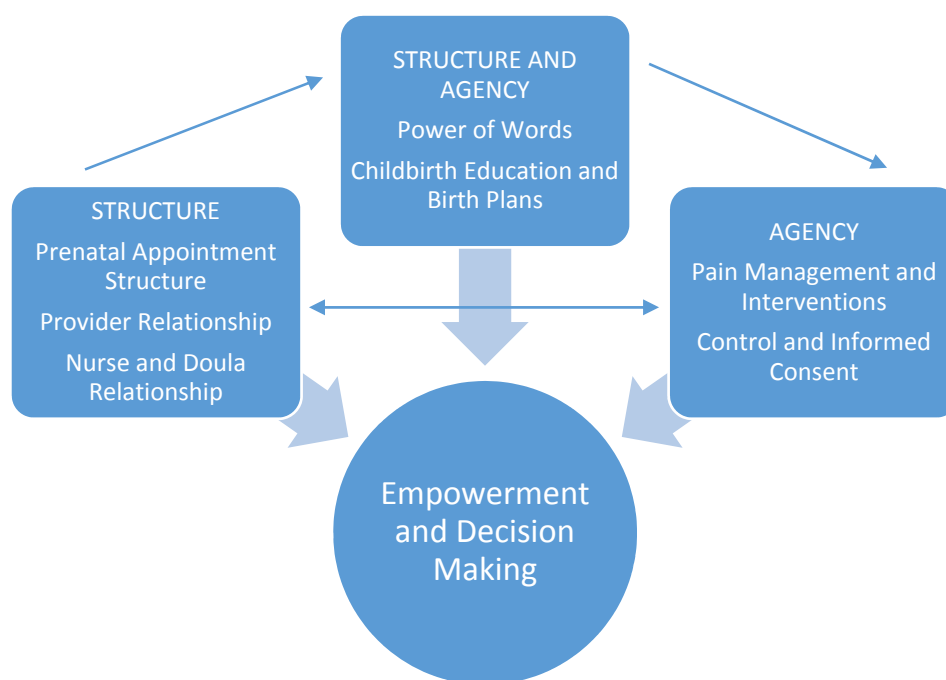


Figure 1.1. Relationships of Categories

Prenatal Appointment Structure: Agents Navigating Medical Structures

The way that the appointment structure is set-up for women during their pregnancy certainly varies by hospital and type of provider among other factors. The three main sub-categories involved time spent in appointments, the structure/rotation of providers for appointments and general treatment during the appointments. In speaking with the women interviewed, it was clear that there was a lack of time spent in appointments with their

provider(s) during the prenatal period. Some women were disappointed and a few expected this as the type of care provided because it is simply assumed that providers are too busy to spend more time with them to answer questions or engage in discussion about expectations. For the appointment structure, all of the sub-categories make up the structure as created by the medical system under which women figure out their role and how they maneuver that system to have their needs met.

Lora commented on how rushed the appointments felt which also affected women's feeling about the questions they might have or wanted to ask.

All of the appointments were scheduled for like 10 minutes, so they would allude to it [options for childbirth] but more like “we have all these classes that you can take and then they'll discuss your options basically in the classes.” Yeah, I would say that he [provider] was on a mission 9 out of 10 visits and so I think that played into the role of asking questions, too, besides like talking down to me was that when I would ask a question I mean like it would be such a simple answer or he would brush it off maybe as like it's not really concerning, but I'm asking about it so clearly it was concerning to me. So, I think that yeah it's good that you brought it up because I think that that played a part of it, feeling really rushed.

The structure of appointments can in and of themselves be restricting for women to ask questions they may have thought of pre-appointment. Additionally, “doctors control conversations by asking closed-ended rather than open-ended questions, thus making it difficult for patients to raise new topics” (Weitz, 2010, p. 300). This type of approach often led the women in my study to obtain information in alternate ways such as through childbirth education classes, through reading books or doing research online.

The prenatal appointment structure varied for the women involved in this study; however, it was clear that the way many of appointments were constructed gave a clear impression that the appointment would have an unspoken time limit. Both Bridget and Kaia indicated that they sought out information and support from individuals and groups aside from their provider due to lack of time available in the prenatal appointments.

Bridget: I talked to them [pregnant women in yoga class] and my husband more than I would talk to my provider and part of that was just that I saw my provider for what, like 15 minutes every appointment?

Kaia: Other than that [childbirth education class] I felt like the appointments were mostly overall impersonal and rushed.

Giddens' (1993) duality of structure is evident as the medical system on one hand gives these monthly appointments to allow for women to see a provider, but on the other hand it limits the amount of time which hinders a woman's ability to ask questions as they are not encouraged or supported with more time to pose questions of importance.

Hospitals vary in terms of their policies and how the prenatal appointment structure works. For example, at one hospital, if a woman sees a family practice doctor, she might always see that one provider for every prenatal visit and even the birth would be that provider no matter what time of day the birth actually happened unless of an emergency or if the provider was out of town on vacation. Another model might include a rotating schedule of midwives who see a woman throughout her pregnancy to familiarize herself with various providers because the time of birth would determine who would be attending the actual delivery. Still, another method may be that a woman sees the same obstetrician throughout, but might very well have another obstetrician attend the actual birth due to how they are scheduled and when they are on call

outside of normal business hours, etc... Throughout my interviews, the women's comments about seeking information on childbirth from their provider(s) alluded to some of the concerns about appointment structure and seeing multiple providers. Additionally, the personal connection was lacking in some cases if multiple providers were involved. This is a perfect example of how the appointment structure bleeds into the strength of the provider relationship.

Bella, who has four children, spoke to her experience about having conversations with her obstetrician about pain management options. She explained,

I think that I had conversations as we got closer [about pain management] with my OB about sort of what is the general approach. I mean how long would a first time mom labor? [question posed to doctor] Before, you're like, this is going on too long. But also it's partly asking your OB that may not matter if you get someone else. So I think it's a different situation if you are working with someone who you knew was going to deliver your baby, or at least supposed to deliver the baby. So you have all those questions in conversation.

Feeling lost in the medical structures, she tried to ask questions of her OB, but still felt uncertain, in part, because of the lack of certainty that she could depend on her OB.

Kaia felt her appointments were very impersonal due to seeing so many providers and the fact that they, both nurses and providers, would look at her chart and speak to her based on her statistics (i.e. previous childbirth, size of baby), rather than speaking to her in a personal, connected way.

But, what each one said to me when they came in the room every time, they would say "Oh, I see you had Macrosomia," which is what they mean George [first birth] was. "Oh, and you had a C-section," and I'd say "Yep!" Then, they would say, "how are you

feeling?” and I would say “fine.” You know what I mean? There was nothing to it. It was the same old crap. Then the nurse would do it and then the doctor would do it every time. They would be like “Big baby – C-section,” I was like they might as well have just named me that.

Feeling more like a body than a person, Kaia was addressed based upon her previous birth experience which caused her to continually think about that label. With the constant reminder of her previous birthing experience with each provider and nurse appointment, she was left to reflect on her body’s ability.

Within the multiple provider structure of appointments, one woman, Audrey, seemed to learn to navigate the system in order to see the midwife she felt most connected to within the medical structure.

I would say the one I saw the most was because I was most comfortable with her. It was because our styles...her communication style fit - made me feel very empowered. [She] made me feel like I could ask anything. And, I certainly did ask questions of the other two, but it felt like it was less of a personal connection with them.

Audrey’s choice to see the provider with whom she felt most comfortable and with whom she was able to express herself freely provides evidence of increased feelings of empowerment in relation to a personal connection during prenatal appointments.

One could look at seeing multiple providers as a way to truly choose a provider one feels most comfortable speaking to about her concerns, plans, and expectations for childbirth; however, it could also be more difficult as a woman may see multiple providers which actually provides for less of a chance to solidify a personal, trusting relationship with a single provider. Audrey’s navigation is a great example of Giddens’ (1993) structuration theory as she

approached the process from a more assertive approach where although the appointment structure had her seeing multiple midwives, she asserted her agency by choosing to schedule appointments with the midwife with whom she felt most connected. Not all women exhibited the same assertion as they were bounced from one provider to another during the process. This leads to the significance of a woman's relationship with her provider.

Provider Relationship: Medically Structured Relationships

The importance of the provider relationship is one that cannot be emphasized enough when looking at how women navigate their appointments as well as how they feel about the decisions they make during the childbirth process. The idea of authoritative knowledge surfaces for Kaia in her descriptions of her predicament with the decision to have a cesarean section (C-section). Authoritative knowledge is “the knowledge that within a community is considered legitimate, consequential, official, worth of discussion, and appropriate for justifying particular actions by people” (Sargent & Davis-Floyd, 1997, p. 58). Kaia's account of what happened with regard to her scheduled cesarean section and the treatment she received by a provider shows how there is this “knowledge” that is considered in determining if an issue is up for discussion or who one can go to with questions based on the system that is set-up for women in relation to their designated provider. As Kaia explains,

I remember going home crying and crying and finally Joe said, “Honey, you need to see someone else. I don't know if this is the person for you.” You know? And, I'm like, it's kind of late. We're scheduled for next week [C-section]. He [husband] said ‘why don't you just make sure that we understand all the choices.’ And, so I ended up calling another midwife who I liked and just said, “I'm so confused.” And, she said, “why didn't you call him [her current midwife]?” And, there's only one guy midwife in town so she

knew who I was talking about. So, she's like "are you not comfortable talking to him?"

And, then it got weird because I felt like they were all friends and are close.

With Kaia, there exists this fear of what the provider would think of them if they switched or sought counsel from another provider.

For Bridget, it was clear that a personal connection was necessary to create that trust and know her provider cared for her. In relation to her diagnosis, she felt as if her provider only gave her a canned response.

I didn't feel like maybe she [provider] was able to deal with the fact that I was really upset about it 'cause it was so, she's like you know, "it's fine, this happens to a good number of people...baby's fine." Maybe there is nothing she could have said that would have made me feel better at that point. The experience that I had with the woman that I have now was different...it's better. I felt like she cared about me more.

Again, at her six week postpartum appointment, Bridget did not get to see her obstetrician, which disappointed her since she was not able to be at the birth.

I know that with my OB, with this pregnancy, my six week follow-up she always outsources to her nurse practitioner, so that kind of hurt my feelings a little bit that I didn't, you know...I had gone through the whole pregnancy...I had him [son]...I went into labor naturally. I was so excited about all of that and then I found out I wasn't even seeing her for like the six week follow-up. It's like I don't matter to you anymore. I don't get it.

It is clear that for Bridget, her feelings and worth needed validation – the desire to feel human and cared for as an individual person as opposed to another completed case. Pregnancy and

childbirth are this sort of rite of passage for a woman and the role of the provider being a cheerleader is critical to the process.

Information, or lack thereof, made available by providers about what to expect during pregnancy and childbirth was noteworthy. The responses I received from my participants reflected their feelings in relation to seeing a single provider or multiple providers, which includes opinions about each type of experience. Four of the women comment below on their impression with lack of information provided by their doctors. Bridget's experience was one of not receiving enough information from her provider in order to make decisions regarding childbirth. She recommends that women take the initiative to obtain information through self-seeking online and in other resources. She asserted, "Educate yourself. I would say you are in a better position to make the decisions if you are doing that research on your own because the doctor's not going to tell you all of this stuff." Bridget's experience reflects a lack of relationship and connection with her provider as she bluntly states that information will not be divulged. Notice that lack of relationship affects the ability to confront the provider with a request for more information. To feel equipped and empowered to make meaningful decisions, she then sought information on her own, separate from her provider.

Halle and Bella provide further nuance to this experience.

Halle: I don't feel like those conversations happened unless it was initiated by me. I think that I had educated myself prior to all my kids about what medications were out there and what was available because I think that...I don't think they tell you. I don't think they do a good job of telling you what the choices are. I think a lot of the assumption is that everybody will get epidurals and then nobody knows what other choices are.

Bella: I wouldn't say I had counsel from any of the doctors. I mean I, if I had questions, they were willing to answer, but it was just a general invitation to ask questions.

Halle's and Bella's accounts reflected a provider's standardized approach of inviting questions without a personal, human touch. Even the way an invitation was presented reflected the lack of a meaningful relationship, which discouraged women from asking questions. Additionally, Bella's feelings are comparable to Giddens' (1993) concept of duality of structure in that the provider is there to allow a woman this opportunity to ask questions, but yet is not freely offering in-depth, thoughtful advice for a woman on an individual basis.

Azalea: No, we didn't really talk about anything. Towards the end, we did talk about it [pain medications] as he reached his due date, we talked about induction and that was really the only thing we discussed in detail and how that would go.

Azalea's experience reflected lack of initiative taken by the provider to ask meaningful questions which could then have drawn out more pointed questions with relation to the childbirth process.

In relation to trust and feeling confident that a woman's provider will know her needs and desires are for childbirth, it can be completely turned upside down when a different provider is present. In a study by Hauck, Fenwick, Downie & Butt (2005), they emphasized the importance of provider support to the laboring mother. One of the participants described "how one of the midwives caring for her had stayed beyond her shift to share the actual birth. She believed that the midwife had acted as a true advocate: 'she stood up for me...she knew my birth plan and preferences' (p. 241). This example shows the impact of having a consistent provider there during the labor and birth for women. Even if women understand that there may be a provider present with whom they never met or spoken to, they do not know how that may affect their experience with childbirth. As Bridget explained,

I almost felt like I was being treated by the system, not in a bad way, but like they communicate with one another and I understood that it would be different like the OBs that I would be working with so I don't even remember it being odd to me that I met with someone else like on my due date.

Here, Bridget spoke about her expectation of being treated by the system and structures that shape things, but that it was not "bad." However, earlier, in relation to prenatal appointment structure, she indicated her disappointment and hurt feelings with regard to her primary provider outsourcing her six week postpartum visit to another provider. This indicates that the relationship with a provider certainly does matter. Women do feel alienated by the system. Even in Bridget's case where she seemingly felt ok with seeing multiple providers, she in the end longed for her provider to care enough about her to want to hear the details of the birth she [the provider] did not attend. Similarly, Halle stated

So, I didn't even know her...[whispers] she wasn't very nice either. She was mean. She was yelling at all the nurses. I was like "excuse me, I'm giving birth here and she's yelling in here?" You've had all these conversations about how things are going to go and why you're doing that and the person you've had these conversations with doesn't even show up. They [attending providers at birth] don't know if you're just saying it because it's stressful right then or if it's something you've thought through and that you know you've wanted. They just don't know.

Again, it is evident in Halle's experience that the provider relationship is critical throughout the entire process of pregnancy and childbirth. Halle did have a solid relationship with her provider during the pregnancy and then during the childbirth ended up with a provider she had never met.

The lack of provider relationship created doubts, which affect how women relate to their body as their feeling of trust is diminished.

One of the two scenarios where doctors have the most power according to Freidson (1970a, retrieved from Weitz (2010)), is “when doctors have sufficiently greater cultural authority than their patients so as to argue convincingly that they can most accurately judge patients’ best interests” such as when “that patient is a pregnant woman who refuses a cesarean section” (Weitz, 2010). Although Bridget’s and Halle’s comments were not in regard to the decision to have a cesarean section, the effect of having multiple providers certainly muddies the decision making process for a woman. Where there is a lack of a relationship, there can easily be a distrust of any suggestion made, particularly an intervention like a cesarean section. However, in reference to cultural authority as suggested by Freidson, women feel this pressure to accept the provider’s decision as final due to their position.

For Lora, even though she had encouragement from her friends and family to switch doctors, she did not. She gave reasons that indicated her fear of switching based on the system of how providers are scheduled for delivery.

A bunch of people told me that I should just have switched, but I didn’t really feel comfortable doing that either, so I’m, like, if I switch, I know he’ll be the one there delivering [due to how shifts are scheduled].

The issue of fear is apparent in this situation. Although the system allows women the freedom to choose a provider based on her needs, fear often prevents women from following through. For Lora she had this fear of switching and then ultimately she felt that at the childbirth “he” would be the one to deliver. This shows how women are given a choice of provider, but then the system, and in this case it would be the prenatal appointment structure, also bleeds into how

providers are scheduled, causes the woman to be fearful of being judged for switching providers. With an appointment system that rotates providers, it impacts the relationships women can and cannot develop with providers.

Nurses and Doulas: Finding Humanity/Connection/Value in the Medical System

So much of my focus when starting this research study was looking at the medicalization of childbirth from the perspective of the provider (physician, obstetrician, midwife) however, what emerged from their discussion of the medical system was the value and impact of nurses and other support staff during the women's pregnancy.

Lora stated quite strongly about her satisfaction with her labor nurse. Bridget and Kaia also had excellent support from the nurses as well. As Lora explained,

During the delivery, the labor nurse was like my best friend. She was the one holding my hand. So, we ended up with a nurse for a couple hours and then another nurse for a couple hours and then another nurse and it was just like I got comfortable and then they change, but then that third one stayed with us through the end, so that was helpful.

It is evident by this account that nurses are an integral part of the childbirth process and allow women this support that is critical to her, but also reinforces the challenges with the medical structure that relies on staff rotation, rather than consistency.

As extensions of the provider, other important people who play a support role are not only nurses, but also doulas. Depending on how long a woman is in the hospital for the childbirth process, she may be with a few or many nurses until the actual time of delivery of the baby and even the care received after the birth. The support, or lack thereof, particularly through words of encouragement or discouragement (implied based on word choice or tone) will be discussed

below, but it is an important part of the role nurses and doulas can play in women's childbirth decisions.

Here, Bridget and Kaia emphasize the positive experience they had with their nurses both during the childbirth and the care they received after the baby was born.

Bridget: I had really great nurses, like super amazing people. Yeah, I had really good nurses, so I felt very fortunate for that because I know that sometimes it's the luck of the draw, like who's on shift.

Kaia: In the end, I had unbelievable care once I had the babies. The nurses and the staff were just a dream. Nurses are amazing people and they know all that good stuff.

With nurses present during the childbirth process, there is not the time to develop a relationship. This is why it is so important that the nurses present are supportive of the women and allow for trust to be developed quickly in order for women to stay in touch with their bodies throughout the process, knowing their needs are understood. Organizationally, the nurse rotation and fear of getting a less than ideal nurse can affect how women are able to navigate the process of childbirth.

Another area, aside from nurse support, was the role of doulas. A doula, by definition is "a woman experienced in childbirth who provides advice, information, emotional support, and physical comfort to a mother before, during, and just after childbirth" (<http://www.merriam-webster.com/dictionary/doula> - retrieved 3/27/15). The very first interview I did, which did not record well enough to decipher, was the first woman to mention the huge impact having a doula had on her birthing process. In the field notes I took, she said that a doula should be given to every woman during childbirth. She said doulas cost between \$300 and \$1,000, so quite a range in price, but she said it was critical to providing her with the childbirth she wanted. Halle had a

doula with her first child, but not the other three births. As she explains, “I had a doula for the first one and then I kind of toyed around with having a doula with the others and then I never did, but kind of wish I had in retrospect.” Having had both an experience with a doula and then without a doula in subsequent childbirth experiences, Halle reflected on the importance of the support she had with a doula present for her first childbirth. A doula would provide that consistency of having a support person with whom a relationship was developed prior to the birth experience.

Bella directly discusses the issue of cost as a restriction to having a doula, “Yeah, it would have been great, but financially...if funds weren’t limited, it probably would have been great to do.” The option to have a doula present is really only an option if one has funds to pay for one. This brings up an important area of discussion when looking at possible ways to empower women through the offering of a doula, which would not be cost prohibitive. In the discussion chapter, this will be addressed in more detail.

Audrey had a very important historical perspective on how childbirth used to be attended by many women to supporting the laboring woman, but now the idea has left the delivery room as childbirth has moved to the hospital where medicalization has taken over.

I think every woman deserves it [to have a doula present]. I know there is this resistance.

This idea that I don’t need a stranger there helping me. But, women used to be surrounded by other women at birth because it’s so hard, so why did we take that away and say, “now, do you it yourself and do it in the hospital, but don’t worry, we can shoot you full of pain meds because then you don’t have to experience the whole thing.”

Anybody should have the option to have the birth you want and I think the doula provides you with that. I mean, she did everything from remind me that I have the opportunity to

make a decision to writing down things that we said right after Billy was born that I never would have remembered. It wasn't intrusive, but I was able to be with my husband more because she was there.

Audrey's account shows the benefit to having a doula present to truly support the laboring mother's wishes and desires. The doula served as a means through which Audrey was able to navigate the medical structures surrounding her and allow her to assert her agency inside those structures.

The idea of having a doula only emphasizes the importance of the relationship between a woman and her provider. The doula serves as an additional advocate for the laboring woman to provide that consistent support keeping in mind the woman's desires for how she wants her childbirth to go and what decisions are important to her. This allows for the woman to feel safe in the vulnerable state she finds herself in during the childbirth process.

Power of Words: Structuring Agency and Relationships

The power of words emerged as a significant theme in the women's discussions with me. Throughout the interviews they reflected on how words used by providers and nurses or other support people in the everyday lives of women directed their decision making ability or path. The language used by providers and others within the medical system had the power to encourage or discourage women in various decisions throughout their pregnancy. Words acted as a mechanism to form a structure within which women could exert their agency through asking questions and absorbing information to make informed decisions. In relation to feeling encouraged and respected when asking questions during the prenatal appointments, Lora talked about the tone her provider used and how it made her feel like she wasn't capable of handling complex information.

I guess I may have asked more questions if I would have stuck with my initial provider in Minot. My provider here in Fargo...hmm...I felt like he almost talked down to me and so I didn't. Any kind of question that I had I felt more comfortable doing the research myself or you know kind of talking to my sister or friend who have gone through the birth. I mean, just kind of talked to me at a 4th grade level.

The use of words and language in provider interactions in Lora's case were memorable and changed the way she approached finding out answers to her questions with regard to her pregnancy and childbirth expectations.

Women's dependence on providers and support people such as nurses and doulas places an importance on the how language used by support people encourages or discourages pregnant women as they prepare for childbirth and during the labor and delivery stages. The processing of language can really affect a woman's confidence level. Words are powerful and can easily set the stage for how a woman perceives her abilities. During the early stages of labor for Bella, the nurses alluded to the fact that she hadn't yet even begun to experience pain and to wait and see if she could even handle the upcoming stages of birth without receiving some kind of pain management medication.

I think that with Betty (first birth), I think they didn't have as much confidence in my...I guess maybe the nursing staff specifically, not the doctors or anything. I guess at least one nurse just you know saying a comment. She was like "this is just the beginning!" I can't remember exactly the words, but she made some statement of maybe a little bit of doubt like "we'll see if you can, we'll see if you change your mind [with regard to using pain management drugs]." She also said, "you hardly ever see anybody induced anyway

that does not take medication.” That might impact other women if they are telling you, “oh, nobody does this, why would you do this?”

Bella actually mentions specifically that she didn’t think the nurses had confidence her ability to give birth without medication. The nurses knew she wanted to give birth without medication, yet were not supportive in using encouraging language. In spite of hearing comments about the unlikelihood of accomplishing the birthing experience without medication, Bella had to assert herself in order to stand firm and trust her own ability to make decisions.

For Audrey, she was surprised at how encouraging simple words from her mother were in terms of helping her to gain confidence in her body’s ability to handle the process of childbirth.

And my mom, who I wasn’t particularly close to prior to pregnancy, had some good insight. She’s like, “honey, it hurts, just do it.” You know what? That actually really helped me. It was just more of this it’s going to hurt, but you can do this. Like, this is something you can do. That assumption that I could do it. It was powerful. I was like, “you’re right, I can do this.” So, that was a really great moment.

Audrey’s experience is reflective of how encouraging language was empowering and in a time of doubt, changed Audrey’s outlook of her body and what it was capable of handling. Additionally, what is worth pointing out is the fact that she talks about not having been close to her mom prior to pregnancy. Even though she may have been inclined to brush off advice from her mother, she was actually receptive to it as the words used were encouraging and supportive. This could also applied to support people such as nurses. Even though time does not allow for a relationship to be developed during the actual childbirth process, using positive language does make a difference.

Conversely, a nurse who handled Audrey's initial check-in to the hospital for the birth of her baby spoke words that sucked the confidence from her and affected her outlook.

She [intake nurse] talked about how...she talked about pain management and about Pitocin¹ and epidurals as if they were a given so when she talked about the epidural, she specifically even said about how women come in with an idea. She told me not to get too connected to my birth plan. "Women often times come in and I would say 90% of them get an epidural." You know, with that attitude, of course they did! Of course they do! You just told me that I'm not going to be able to do it.

Similar to what Bella experienced with her nurses not having confidence in her, Audrey also experienced that discouraging language from her intake nurse. What seemed like a simple explanation of options quickly turned into a negative approach to almost encourage Audrey to surrender to the process that was ideal within the medical structure and give up what she desired for childbirth as outlined in her birth plan.

These examples reflect the profound effect of words whether it be from within the medical system (i.e. a nurse or medical doctor/provider) or a social/cultural stance (i.e. a woman's mother). Whether simple and direct or what appears to be an indirect statistic, encouraging or discouraging words can affect a woman's sense of confidence and can create the structure within which she functions and the decisions made.

Not only do words affect women's confidence in their body's abilities, but they can profoundly shape the decisions they make. The approach taken is more of those in authority within the medical structure of the hospital speaking at the women as opposed to engaging women in a discussion about their desires and feelings. In Meyer's (2012) article about control in

¹ A drug administered to assist with the induction of labor.

childbirth, she presents birthing scenarios and the steps involved and it clearly depicts women's feelings of control and how they are treated. In her example of a woman being checked into a hospital, she mentions that "the nurse tells her [laboring woman] that she can only have ice chips because eating or drinking could cause her to aspirate if she has to have a caesarean section and tells the woman to let know when she wants the epidural" (Meyer, 2012, p. 4). This type of approach sets the woman up for what to expect without any questions posed or insinuating in any way that there is a choice in the matter. Women need to have a shared trust with their provider and support people such as nurses or doulas. Lundgren and Berg (2007) in reference to a midwife patient relationship emphasize that "to mediate trust to the woman means that midwives promote a trustful relationship. This includes believing in and support of the normal childbirth process. A trustful relationship can strengthen the woman's self-esteem and give her security" (p. 4).

The power of language not only affects women's beliefs about whether or not they can handle the childbirth process in the way they hope to, but those words can also come across as more aggressive and particularly so when words come from the top-down from a provider or nurse within the medicalization of the process. The words translate into a directive that steers the women into a prepared path of decisions. Kaia underwent complications with both of her pregnancies and birth. She experienced directed decision making both during the pregnancies and during the births. During her first and second pregnancy, she felt pressured in different ways, but both approaches made her feel manipulated and bullied into making her decisions. Kaia explained

[first pregnancy] He [midwife] told me things like, “oh, well if you know, his shoulders get stuck, we’ll just break the clavicle” and all these horrible things and I was so afraid and he said if I just wanted to come in at 39 weeks, we’ll just induce you.

The language used by Kaia’s provider was intentional and delivered in a way that coerced her into making a decision to be induced or her baby would likely face injury during the birth. The provider led with a dramatic outcome and then followed up with a “safe solution” where she could just come in for an induction at 39 weeks. Had the risks been presented in a less threatening way, Kaia could have still made a decision without feeling such pressure.

[second pregnancy] No one said [until the end of the pregnancy] “oh the worst case you know and the baby is without oxygen until a C-section can be performed.” The idea of going through and loving a baby and finishing a pregnancy and then having brain damage, so I just scheduled it. I just said I couldn’t make up my mind and I don’t want to put the baby at risk.

For Kaia’s second birth experience, her desire was to have a vaginal birth. She was not informed of the possible risks of having a vaginal birth after a cesarean section until closer to the end of her pregnancy which then took her by surprise as the language used insinuated that she could choose, but if she chose to go through with it, the baby would be without oxygen.

Then, during Kaia’s actual birthing process with her second child, she felt pressure to perform from the medical staff present.

They said it’s just going to be a couple of minutes while they get ready. You need to keep pushing. And, I didn’t want to push. I was like, “can I just feel a few of these [contractions]?” I just wanted for everyone to shut-up and let me get myself together. They were like, “you need to push.” I’m like “can I push when I’m ready?” I mean no

one would let me get composed. I'm at the very front and center and I'm sitting there with my ankles in the air, strangers holding my thighs out, no husband, poop on the bed, strangers walking by and staring at me. It was horrible.

Kaia was told to keep pushing rather than being asked if she could keep pushing. Already in a vulnerable position being in a physical location where privacy was not respected and then commands given affected her ability to listen to her body.

Childbirth Education and Birth Plans: Seeking Information Beyond Medical Structures

The first three categories of prenatal appointment structure, provider relationship, nurse/doula support, and power of words portray the medical structures and not only how women are affected by them, but also how the women exist and define themselves within those structures. As institutional ethnography emphasizes the importance of texts, the birth plan is an important piece. Smith (2005) states that "as a reader activates a text, she or he engages with its language and is also responding to it" (p. 104). The process of creating a birth plan and the expectation to engage with it is important. The area of childbirth education and birth plans combine this structural area of classes such as Lamaze courses as encouraged by hospitals and providers while also looking at the agent generated approach to educating oneself about the process and creating a birth plan. This would also include online research, books, and support groups. Kaia and Audrey address the direction they went with regard to reading information about childbirth. Kaia explained,

I read *What to Expect When You're Expecting* and I read a little bit about it [pregnancy and childbirth]. I used it as a reference for a little while, so I would use it, but it was really depressing. So, it was the Mayo Clinic guide to pregnancy and I read the entire thing front to back.

In looking at the way Kaia researched various books to find one that met her needs and spoke to her in the most effective way, one can see how she navigated the structure outlined in books to locate a personal connection where she found information that met her needs. Similarly, Audrey told me,

My classes conflicted with all of the birthing classes and we couldn't do that so I relied heavily on books and on my doula. We met several times and she gave me lots of reading information. Every time I had a question I would just shoot her an email and she is very research driven. She would send me articles to read. She never gave me an opinion. She sent me very reputable articles...a summary she had done she provided to me so that I could make an informed decision on my own and feel very empowered in that way.

Audrey found value and empowerment in her doula's approach in providing her with information and then letting her digest it and inform her decision making with regard to the childbirth process.

Each response reflected the importance of feeling connected and engaged with the resources from which they gathered information, whether through articles, books or online research. For each woman, her reality dictated where she sought the most reassuring and empowering resources to equip her for the childbirth process.

With relation to the structure of resources and childbirth classes, the participants used the information made available to educate themselves in areas they felt were important. They could choose what they needed based on what was provided to them. Halle explained,

I did Lamaze before my first one and then we did Lamaze before...I was married before...my oldest daughter has a different dad. For his first daughter, but my second, we did Lamaze again. Yeah, they were through the hospital and then we read that book, that

childbirth book thing they give you at the hospital when you're pregnant, so a lot of my information came from that book. I think the main parts out of it that I read were like the stages, like the stages of labor. That's kind of what I paid attention to in that book because nobody really tells you about that either.

Similarly, Bella stated that,

For the first one we took a birthing class and that helped a lot just because I had never learned about the stages of labor. I just went to a refresher that was just one evening (with second pregnancy). You forget things, so providers should never assume or should take each pregnancy as an individual.

Just as each woman is an individual and should be treated as such in terms of pregnancy and childbirth, each pregnancy for a particular woman varies and should therefore be treated individually. Bella emphasized the importance of needing to hear the information again even for a second birth experience. Azalea expressed a similar experience.

We were supposed to do classes but we did not. So, basically just had my previous knowledge of childbirth. We just kind of went on that. We didn't really access too much other information. Sanford did give us a book, *What to Expect with the Pregnancy and Delivery*, and that stuff. I did skim that a little bit but didn't reference it too much.

Azalea's lack of seeking out information was an interesting discovery. Even though she was provided with resources to research on her own, she didn't seem to connect with the information and thus did not proactively gather the information. This reflects the importance of having resources that women feel connected to in order to make sure information is understood.

The women's comments largely indicated the necessity of Lamaze classes as a source of information, primarily due to the lack of information provided by their provider(s). Those who

attended Lamaze classes appreciated the instruction and advice provided, but three of the women made it a point to acknowledge that their provider(s) did not provide that information to them. Here a direct relationship back to the structure of the prenatal appointment surfaces examining that it is limited and thus sets up this expectation and need to seek out additional information from other sources. The structure of the appointments is constraining in terms of information provided in the actual appointments, yet enables women by providing information about childbirth education classes such as Lamaze classes or binders/books with information about childbirth.

In addition to classes and other research about the process, a product of these types of research is the creation of a birth plan in preparation for child birth. In the interview discussions, I inquired about whether or not a birth plan was developed. Not all of the women interviewed decided to create a written birth plan. Additionally, some verbally addressed their desires for how they wanted decisions to be made. For Bridget, she had this expectation of confrontation in regard to what she wanted for her birth. She stated,

I did kind of have this sense that I would have to fight with doctors and nurses to do it in a less medical way. I was kind of afraid that I didn't know how that [gestational diabetes] was going to factor into the labor and delivery and people in that room were going to be like "oh you had – you're diabetic, so you can't do this...she can't do this, she can't do this" which is a different situation than what other people would be in.

For Bridget, her birth plan was verbal and not written. She expected conflict with her wishes for childbirth. It is evident that even though the birth plan should allow for women to assert their individual desires for childbirth, they are left with having to navigate the constraints of the medical structures surrounding them.

Bella compares her first and her second childbirth experiences in relation to the birth plan. She developed a written birth plan for her first childbirth in attempt to navigate the structure to attain “success” in her eyes after meeting her goals, but didn’t with her second birth experience.

I guess with Betty [first birth] I did do a birth plan, but they didn’t really follow it I guess. I mean, I wasn’t super angry about it just because she was healthy and they were taking care of her and I didn’t have any bad feelings about it after it. But, I did make a simple birth plan for my first delivery. No, I didn’t formally write a birth plan this time [second birth] and so I really didn’t have...I guess I felt good about the providers that I had seen in the office so I didn’t feel the need as much to write something out, partly because I felt like they were supportive in the office and I had good visits in person and I guess I didn’t really expect everybody to look at it and follow it anyway.

For Bella, to some extent, her need for a birth plan was not as critical when she felt confident in her providers knowing her vision for the birth experience she desired. This reiterates that the birth plan acts as a tool to reflect women’s ideas for the birthing experience.

The birth plan provides a different type of structure as it is created by the woman with her desires and expectations in mind regarding how she would like the various phases of birth treated and how her baby should be treated. The birth plan surfaced as an outlet for the women to assert themselves as the decision-maker. However, they seemed to think, particularly for those going through their second birth, that the birth plan would not be accepted or considered by the medical staff based on the birth experience with their first child. What is important to understand is that the birth plan is a document that reflection of a woman’s desires for how she wants the birth plan to be executed during the child birth process. Based on Belle’s comment, she didn’t make a birth

plan for her second childbirth because she felt comfortable with her providers understanding her needs. This again connects back to the importance of the provider relationship and also the nurse/doula relationship. However, for those women who don't feel they have an established relationship with their provider(s), a birth plan is important as it provides a security for women as they assert their voice in what they want for their childbirth experience. This is even more important due to the structure and how it is often set-up in such a way that the odds of a woman's primary provider being present during the delivery are often quite low. Most of them women interviewed were very aware of the fact that a birth plan is often not able to be followed word for word, but they really needed to feel that their desires were heard and seen as important to those providing care whether it was a nurse or physician.

Most of the women participated in some sort of active research about the childbirth process whether through Lamaze classes, reading books or articles, or their own online research. Initially, I had also planned to ask my research participants to provide me with a copy of their child birth plan so that I could read them and compare what they wanted for their birth and then how the actual birth matched those desires. However, as I began my first interview, I felt that it was too intimate a document to ask for so I instead asked questions about the birth plan to get an idea of what they included and how that was utilized in the childbirth process.

Regarding books and online research, three of the women commented that books and online research was the primary method of obtaining information. Wu Song, Ellis West, & Lundy, et.al. (2012) discuss online research that women do during their pregnancy. Some of their findings reflect similar feelings to Lora in my study. In talking about Karen, one of the participants in that study, it was clear she was lacking a connection and because she "sought meaningful engagement, she went online, read books, took Lamaze classes, hired a doula, and

researched natural childbirth on her own” (Wu Song, Ellis West, & Lundy, et. al, 2012, p. 787).

The search for information is not simply to gain knowledge, but rather to engage with others in addition to doing one’s own research. Lora stated,

I did a ton of research online. Like I said, especially not feeling comfortable asking my provider like any little thing um I would just use...and then we had our health sciences library.

The remaining four women talked about their experiences with going to Lamaze classes in preparation for childbirth. Interestingly, three out of the four alluded to the importance of Lamaze to fill the gap of information not given to them by their primary provider. Bridget expressed that,

The processes came through the class rather than through the regular...because those appointments are so fast right? I mean they come in and listen to the heartbeat and then if you have questions, that is what keeps them in the room. If you don’t then they are on to the next appointment, so I think most of the information that I got about the process was through the Lamaze class.

In relation to discussion about the birth plan, I was really interested in hearing from the women about what the birth plan represented for them, if it was written or verbal and what their expectations were in terms of having the plan followed by the hospital staff. The responses received were mixed in that some developed the expectation that they would have to fight for their desires to be heard and respected, that it wouldn’t be followed for their second birth for example, or that in the end it didn’t matter because the baby was healthy. As Kaia explained,

I did do it with her [second birth]. I just didn’t hand it in. So, with both of them I did it, but with George when I tried to give it to the staff, they were kind of like, “oh, this was

just a worksheet from your birth class. This isn't real." And, in a way I understand that it's not going to go like that way. I'm not foolish that way. But, there were certain things I felt very strongly about like don't take the baby to the nursery or just those things that when I'm all foggy, I want those on paper.

The birth plan provides an outlet for women to create a document that encompasses how they would like to see the childbirth happen and what they would like done if various unexpected issues arose during the process.

Pain Management and Other Interventions: Women Finding Agency

There are many of the categories that influence and inform the decisions women make with regard to pain management and other interventions such as induction or cesarean section. The primary connection has to do with the lack of information offered by the provider. This leaves women to learn about pain management and interventions on their own or through childbirth education classes, for example. Often times, options for pain management or interventions are not discussed until closer to the due date, so women are presented with options for the first time, required to make decisions based on the advice of the provider. Additionally, the approach used by providers, nurses and doulas in terms of language directly affects women's bodies and performance during child birth. Here, Halle and Kaia made decisions based on their providers' advice.

Halle: I was 42 weeks so I was overdue and my doctor felt like the baby was getting pretty big and she was almost 9 lbs so she just didn't feel like it was safe to wait any longer, so I got induced. I didn't want to be. I got induced because my doctor highly, highly recommended it.

Kaia: With my first, I had a scheduled induction at the advice of a nurse midwife which I regret completely.

These experiences reflect the issue of regret in choosing to have an induction. The medical structures here enable women to choose and assert agency, but the recommendation made by the provider is constraining as made available as an option.

For Bridget, Halle and Kaia their providers presented them with options using different approaches, seemingly putting the decision making power into the women's hands. However, with Bridget, for example, she was given a particular timeframe within which she needed to deliver before an induction would be scheduled. Therefore, her choice in regard to interventions had specific date parameters placed on her decision making ability. So, technically, her ability to decide was shaped and given a set of rules to follow under the structure of the medical institution. Similarly for Halle, she was induced in spite of not wanting to be, at the recommendation of her doctor. The use of the baby's projected weight as well as voicing her concern for the baby's safety, her doctor urged the intervention of induction and thus directed the mother's decision to accept/choose the induction option even though she did not want to be. As Belle commented,

We had to be induced [first birth], so that was much more...it was a longer labor and more intense and so it was better this time around [second birth] also being a second labor it was a little bit easier and I knew what to expect. So, I felt a little more in control. I think really minimally [talked about pain management options in appointments]. I think probably because I was pretty clear that I didn't really want them so I might have kind of stopped any conversation that they really would have maybe done otherwise.

As Bella explained early on in her prenatal appointments that she didn't want any pain management drugs, that decision seemed to inform the provider with regard to her wishes for the childbirth process. Azalea discussed her experiences this way:

I was the one who kind of pushed for it I guess. That wasn't something that she really brought up to me, but I was...it's probably bad to say....I was just so uncomfortable and so ready to be done that I just said "ok, we've gotten to the due date and this is kind of what I want to do." Actually, with my primary, we didn't really discuss that but I kind of went in knowing that I would want an epidural so I discussed that with the nurse the day I went in for the induction and they were pretty good about and just said "let me know when you want that."

For Azalea, she was able to negotiate within the structure to make her individual decision to undergo the process of induction. For Audrey, asserting herself in the situation she was in for her birth proved more difficult as actual deadlines were in place before she would be put on Pitocin, a medication that speeds up labor.

It was leaking early on, so you know standard medical procedures after 12 hours if you haven't progressed far enough by their metric, they put you on Pitocin which for me was a complication for my labor because then for 10 more hours under Pitocin because after 26 hours of labor total, I was no longer able to cope with it and had been awake for 40 hours so I ended up having an epidural which for me was also a complication because I feel like with every additional intervention, I felt like I had less control over my birth, so that was for me was what the complication was. Yeah, the midwife helped. The midwife – he helped me come to a point where I could accept getting an epidural in the brief

conversation in a way that I was utterly against it up until that point, so I guess that was a support in some ways because it did allow my body to relax enough to dilate.

Audrey's account of her decision to accept the administration of Pitocin is a solid example of the tension between structure and agency women face as they approach decision making. There is this medical structure placing parameters on when an intervention is necessary, while at the same time women still have the ability to act agents with regarding to making a decision. Therefore, women can easily become confused with regard to what decisions they are able to make.

Azalea's decision for wanting an induction was accepted and respected by her provider which at first seems positive as it is empowering; however, she said "it's probably bad to say...I was just so uncomfortable and so ready to be done that I just said ok, we've gotten to the due date and this is kind of what I want to do," so that implies some guilt in her decision to choose induction if she had not given birth by her due date. Azalea's freedom to decide and the respect shown to her actually is just a layer of her agency. She actually seemed slightly ashamed of her choice in the sense that she may be looked upon as a disappointment to other women. She prefaced her response in the way she did based on the structure of gender defining what acceptable mothering behavior looks like. She was taking into account her assumption of what other women may have thought of her decision to be induced. Smith (1992) states that it [a researcher's role] is "directed towards exploring and explicating what she does not know—the social relations and organization pervading her world but invisible in it" (p. 91). For Audrey, the parameters placed on her made the decision for her, basically. After her water had been leaking for more than 12 hours, she was required to be put on Pitocin which in turn continued to send her down a path of decisions she had to make which continued with yet another intervention.

Control and Informed Consent: Negotiating Self-Determination and Disempowerment

The area of pain management and intervention overlaps with the control felt by women, as well as how informed consent comes impacts their childbirth experience. During the childbirth experience, as with other medical procedures, informed consent is supposed to be received prior to any action taken. However, the experiences of the participants in my study reflected lack of feeling in control with regard to giving consent for any procedure or intervention. Here are a couple of examples of how women felt regarding how much of a say they had in deciding about interventions. Kaia stated, “I felt like I had no control over anything.” This statement is bold and direct, but one that paints a picture of what consent looks like for many women during the childbirth experience. For Azalea, she experienced some attempts at obtaining consent, but for other procedures, she indicated that the staff performed them without receiving actual consent.

I think they kind of just said “this is what we're doing” and I was just so tired and like “whatever...whatever you have to do is fine.” I guess for the epidural part they did go through...the CNA went through in detail and they did consent for that part of it, but for everything else they were just like, “this is what we're doing.”

For Azalea, as she was physically exhausted, she just gave a blanket “ok” to everything, so she arguably gave consent to the interventions.

Particularly moving to me as the researcher was the account Audrey gave in regard to when she was getting put on Pitocin and how that made her feel, particularly in relation to her loss of control and feeling of being alone in her laboring experience. The research done by Namey and Lyerly (2010) took the concept of control and developed sub-themes, the most popular being self-determination. Self-determination in this manner is defined as “the ability to have a birth that is shaped and guided by one’s own inclinations and values rather than those of

others” (Namey & Lyerly, 2010, p. 3). Here, Audrey recalls her recollection of a decision consenting to the administration of Pitocin. Audrey explained,

So, my philosophy was ‘provide me with the support I need, but I don’t want your interventions.’ And, then it felt like I didn’t have a choice. I expected to feel out of control in regards to pain. I didn’t expect to feel out of control in regards to my own decisions about my body and my baby. So, when it came time to put me on it [Pitocin], I started crying and I just felt like...I’m going to cry now. It was really hard for me. [Crying in the interview] I didn’t want it and I remember her telling me...the midwife asked her if I was going to refuse it and I felt like I was wrong. To refuse it was like I was endangering him and I remember thinking, “they are talking about me.” Like, you know they’re “Oh god, it’s this argumentative woman who thinks she knows what’s best. She doesn’t know. We know what’s best. We’re the providers.” I felt like and I even remember saying it. “I don’t feel like I have the option to say no.” And, Bonnie [doula] told me, “you do!” I said, “but I don’t because then I’m taking this culpability on myself.” And, that if something goes wrong whether or not if it would have gone wrong with Pitocin, but if something goes wrong and it’s my fault and so I just felt so completely out of control and I was just so distraught. And from that point forward, but from that point forward, I felt...I don’t know how to say this, but I was more alone during the birthing process. I just felt less surrounded and supported and more told. They were trying to get me to sign the paperwork for the epidural right away. I said, “that feels like kind of resigning myself if I sign this paperwork right now and I don’t want to.” And, they said “ok.”

In Audrey's comment above, she references what she imagined to be floating through the heads of the nurses thinking she was an "argumentative woman" which harkens back to the idea of gender and women are expected to be more compliant and polite. According to Smith (1990), "softness' in the discourse of femininity expresses a tenet of its doctrines – the feminine woman is yielding, pliant, and compliant" (p. 176-177). Also, more specifically within the realm of informed consent, it is crucial to address the effect of both the medical environment on women's decision making as well as how it affects women's bodies ability to labor without added stress or pressure of guidelines, policies, or timed goals. For two of the women especially, the restraints and schedules placed on them created a pressure for them in terms of what decisions they could or could not make in addition to the stress the medical environment placed on their physical bodies causing their labor to stall.

Kaia and Audrey comment on how the medical environment affected their decisions or lack there-of. Here Kaia told me,

We got in the other room and they are those big, beautiful birthing rooms and I had a huge sigh. I turned to my husband and he said, "you can't, they won't let you" [in reference to getting off of the bed]. I didn't realize that I don't even have a choice at that point to get off the bed, so I feel like a prisoner. All I wanted to do was stand for a minute or lay on a ball...anything. I hadn't had an epidural or drugs. There was no reason. They kept me prisoner. All I really wanted was an environment that wasn't so convenient for the doctors and nurses, you know being up and that whole man-invented table birth thing. So the doctor, let the doctor see what's going on best. How about you let the woman work together with her body and her hips and try to find her zone? Maybe we'd have a lot less C-sections.

Kaia just wanted to experience some focus and relate to her body during the childbirth process, but was unable to do so based on the restrictions of the physical medical structures in place to move her through the birth. She lost her decision making ability and remained constrained by the structure surrounding her.

Audrey experienced the physical constraint of the hospital and how it affected her ability to make decisions or at least her perception of losing control in the childbirth process. Audrey explained,

She [the nurse] missed my vein and blew the vein so I had this huge bruise covering my arm and all of sudden and I felt like something was wrong with me and I started crying and I was like...and we hadn't yet called Bonnie, my doula, at that point because we thought "we're in such early labor. We don't need help coping yet." And, I looked at Al. "We need to call Bonnie," because all of a sudden I felt out of control and up until that point I felt fine. I had been in labor since 8 o'clock the night before and I felt like I could do it. And, I immediately started doubting myself as soon as that happened. I still feel like it was still a fairly supportive environment to a certain degree, but there is just this VERY powerful piece about being in a hospital which makes me want to have my next baby at home.

Kaia and Audrey also address more specifically how being in a hospital environment affected their bodies' ability to continue to labor as they were unable to relax during the process.

Kaia further stated:

And, I was told by her [the nurse] that I couldn't have a C-section. She said it's too late. So, she let me go through that for almost two hours before she said "I don't know." Can I please have something for the pain? Can I please have an epidural? She said "it's too

late for that, but we've got something coming. Just hang in there." That was she had been telling me since she admitted me. And, it was a lie. Finally, I said to this one nurse, "there's nothing coming is there?" And, she said, "no, honey." So, one of the nurses confessed that the other woman had been lying the entire time to try and calm me. How could I ever let my body get ready if I was expecting help? You know what I mean? So, I was lied to and it was just...it was an absolute nightmare.

There is a direct relationship here with Kaia's expectation of receiving help with how she connected to her body. An additional complication arose when she attempted to navigate the medical structure surrounding her as there were untruths told about what she could expect, so the lack of control and ability to make decisions diminished significantly.

Audrey: I was Group B positive so they said, "oh, you gotta come in the moment you think, if you even suspect your water has broken or is leaking, you have to come in." And, that's when they put you on this clock and then you're under this pressure, this pressure to dilate and that so much of that work is in your body's ability to let go and so they...I had this very artificial constraint placed on me when I'm supposed to have been dilated to 5 centimeters and I'm at a centimeter and a half. And, they go, "we're going to put you on Pitocin." And, then all of a sudden you have these artificial contractions that are so intense that coping with them became the only thing I could do. I tried to prepare myself that this is going to hurt and this is going to feel like there is nothing I can do about it, so I have to figure out how I can let go of the thought and that I should be doing something about it. And, that became harder and harder the closer I came to these deadlines – feeling like I'm supposed to be doing something.

As mentioned in the introduction to this research study, the increase in interventions in childbirth including an increase in caesarean section births first brought to the light the concern of the direction childbirth has been going over the past decade. The issue of control is woven throughout the categories of importance when looking at how women navigate the system. Lazarus (1994) addresses control and the definition for middle-class women and states that “for some it [control] meant involvement in decision making, asserting oneself, exercising power over what happened” (p. 34). Lazarus continues to give examples of control in that it meant “few or no interventions” (p. 34). While it is most important for the woman to feel she has control over the decision making involved in childbirth, it is also key that women know about the interventions and risks involved with each of them. From there, they can then make informed decisions based on knowing the side effects pain management drugs and other interventions. In many cases, induction of labor was directed at the women in my study as the next step rather than given as an option or asking for the women’s opinions. Bridget explained,

It wasn’t an option [to delay or not have an induction]. Basically, you can go until this point. And they said that I could if I wanted to schedule the induction earlier that was an option. It didn’t have to be on that particular day, but that was the hard stop.

There exists this fine line separating a woman’s choice to have a particular intervention and a requirement to have the intervention because while there are medical risks presented based on prior experience and medical research, not every case looks the same or may not require an intervention.

The procedures performed at a hospital ideally should require informed consent from the patient being treated. This should also apply to women in their childbirth experience. While for some of the women in my study, they felt as if informed consent was received prior to any

intervention or procedure, there were also some who felt coerced into making decisions they weren't comfortable making as is seen in Audrey's account above with regard to feeling like she didn't really have a "choice" with regard to saying 'no' to Pitocin. Additionally, the decisions women were asked to make and consent to were discussed during a vulnerable time for many of the women as they were in active labor. The combination of questions asked and the timing of those questions bleeds over into the area of control for women. The process of asking women to make decisions on interventions and unexpected procedures quickly led women to feeling less in control in some cases. Namey and Lyerly (2010) found "Americans use of control corresponds to five different domains positively linked to birth: self-determination, respect, personal security, attachment, and/or knowledge" (p. 6). The following comments from some of the women interviewed reflect both the feelings linked to one of more of the domains of control which led to a positive experience as well as a lack of one or more of the domains which resulted in an "out of control" experience. Lora stated,

She's [doctor] like "Baby's just not liking these hard contractions and um so we're going to go ahead and give you a little oxygen if that's ok." They asked that and I was like anything we can do. Of course I was like anything to help the baby.

In this case, Lora consented to receiving oxygen to protect her baby, the force driving her decision being the baby's welfare. Additionally, the language used directed her decision making to lean in the direction of consent.

Bridget discussed how another aspect of consent that involved whether she want to have tubal ligation (tubes tied) during the childbirth process.

I had one weird nurse who at the beginning was like when they were doing paperwork with you asked if I wanted to have my tubes tied afterwards. Isn't it weird to ask someone

who is in labor whether they want to have their tubes tied? It doesn't feel like informed consent.

Both Bridget and Lora express uncertainty in the process of being asked for consent during a vulnerable time. For Lora, she was asked to approve oxygen being given to her to help the baby and she was given a reason. However, for Bridget, while asked a question to which she had the ability to say yes or no to, she felt as if she was not in a position to truly give informed consent due to the fact that she was in active labor.

As these categories emerged, it was clear that there were multiple connections between categories and how they all serve as a piece of the decision making process for women in the pregnancy and childbirth process. In the next chapter, the results will be analyzed in relation to providing discussion and answers to the research questions in this study.

CHAPTER FIVE: ANALYSIS AND DISCUSSION

In the previous chapter, the results reflect women's experiences during pregnancy and childbirth with regard to the seven categories that emerged. In this chapter I explain how those results helped me address my research questions. The primary focus and explanation for each research question will entail emphasizing Giddens' (1993) structuration theory, particularly the duality of structure as well as the value of utilizing Smith's (2005) standpoint theory approach to this research topic. The duality of structure "is both enabling and constraining [for agents] and it is one of the specific tasks of social theory to study the conditions in the organisation of social systems that govern the interconnections between the two" (Giddens, 1993 p. 122). The fact that there are multiple connections between categories indicates the ever present tension that exists in the relationship between structure and agency. While there were seven categories of importance that emerged, the two most dominant areas of having the greatest influence across categories were power of words and the relational aspects between women and their provider(s), nurses or doulas. In revisiting the initial research questions of this study, I provide a discussion that addresses how the data begins to answer those questions.

RI: How do women interact/relate with the medical structures involved in childbirth?

As the results indicate, while there are categories that lean more toward structure (prenatal appointment structure, provider relationship, and nurses and doulas) and others that are more individually focused (control and informed consent and pain management and other interventions), there exists a steady intermingling of structure and agency as the women in the study navigated the process of pregnancy and childbirth.

Of particular importance is looking at how the rotation of nurses' scheduled to attend to women in childbirth provide a framework under which women are required to quickly establish a connection of some sort with a nurse only to have to change nurses and start the process over.

The data from my participants shows that having supportive nurses was a positive experience and undergoing a change in the nursing staff had a profound effect if one nurse provided excellent support and the replacement nurse provided poor support or vice versa. Due to time constraints in childbirth, in spite of the challenges in securing one nurse for an entire laboring and childbirth cycle, it appears that a nurse's or multiple nurses' approach(es) in speaking to women in a positive way can overcome some of the institutional constraints preventing only one nurse being in attendance at a birth.

One of the most significant findings in this study was the profound effect of language on women's ability to interact with the medical structures involved in childbirth. Words used by a woman's provider, nurse or even family member had a direct effect on her perception of the childbirth process and her ability to be able to undergo the process in a way desirable to her. What is seen in the results is how words used by a provider that are perceived as belittling to a woman can easily diminish the trust between provider and pregnant woman. When this occurred, the women began to interact differently with their provider and educated themselves in other ways – through books, online research or childbirth education classes, for example. The way Lora's provider talked to her pushed her to seek out information in other ways. She stated,

besides like talking down to me was that when I would ask a question I mean like it would be such a simple answer or he would brush it off maybe as like it's not really concerning, but I'm asking about it so clearly it was concerning to me.

This experience urged Lora to figure out other ways to gather information to be able to make informed decisions. The other most significant finding of the research was the provider and nurse/doula relationship. The relationship, whether good or bad, definitely informed the direction women took with regard to their functionality within the medical structures surrounding

childbirth. For Bella, her relationship with her provider(s) during the second pregnancy was strong; therefore, she did not feel it necessary to write a birth plan outlining her wishes as her she felt confident in that her provider(s) knew what was important for her in the childbirth experience (no pain management interventions). Both examples reflect how the power of words and relational aspects directed the decision making for women in other areas such as how information was gathered and the decision to write a birth plan.

The difference in that Bella felt supported by her provider and did not feel the need to write a birth plan and that Lora lacked reassurance from her provider due to negative language emphasizes the need to approach the study using Smith's (2005) standpoint theory. Smith (2001) also defines institutional ethnography as "a stance in people's experience in the local sites of their bodily being and seeks to discover what can't be grasped from within that experience" (p. 161). Each woman interacts with the medical structures differently based on her location, the structures she experiences, and how she asserts herself based on how the structures enable her to act. Hearing their stories illustrated the avenues women took in order to feel in empowered under the umbrella of structures out of their control. For example, the actions of a provider or nurse is out of one's control, but writing and/or implementing birth plan to indicate a woman's wishes is a response that allows her to express herself and empowers her to make decisions.

R2: How do women relate to their bodies during pregnancy and the childbirth process?

Here, as with the first research question on navigation of medical structures, the comments made by the women indicated a strong influence placed on words/language used by providers, support people such as nurses and doulas as well as individuals in a woman's social sphere relating to how they related to their physical bodies during childbirth. Hearing from each woman from her localized position reflected on her personal experience of confidence in her

ability to perform during childbirth. Reflecting on two different comments experienced by Audrey, the belief in her body's ability to handle the childbirth experience was embedded in the words used by her mother and a nurse during her hospital check-in process. With regard to her mother's comment, Audrey stated,

And my mom, who I wasn't particularly close to prior to pregnancy, had some good insight. She's like, "honey, it hurts, just do it." You know what? That actually really helped me. It was just more of this it's going to hurt, but you can do this. Like, this is something you can do. That assumption that I could do it. It was powerful. I was like, "you're right, I can do this." So, that was a really great moment.

However, the discouraging language used by the intake nurse planted seeds of disbelief in her body to handle what she had previously believed fully she could do. Audrey recounted the experience,

She told me not to get too connected to my birth plan. "Women often times come in and I would say 90% of them get an epidural." You know, with that attitude, of course they did! Of course they do! You just told me that I'm not going to be able to do it.

In Audrey's experience there were two very different messages coming at her with regard to giving birth and the approach to meeting the needs set forth in her birth plan. While the comment from her mother was encouraging and served as an enabling mechanism, she faced a very opposite message from her intake nurse which placed constraints on her approach to having the birth she desired in her birth plan. She was then faced with revisiting her abilities based on the language used, one encouraging her to do it without reservation and another basically letting her know of her limitations.

Overall, women knew that things cannot always go as planned and that they could not control all aspects of their childbirth experience, but it was important for them to feel supported in their decisions, particularly where time does not allow for a relationship to be built. In Audrey's case, even though she did not have a strong relationship with her mother, the positive, encouraging words were effective which only emphasizes the importance of language used in the level of confidence felt by women preparing for and during childbirth.

R3: How do women educate themselves about their pregnancy and the childbirth process?

The category of childbirth education and birth plans which emerged out of the data largely answers this research question. This category in particular involved an aspect of structure and agency as the childbirth education classes served as a structure for preparing women for childbirth while the development of a birth plan reflected women's agency as she presented her desired plan for childbirth. Women educated themselves about pregnancy and the childbirth process in varied ways largely steered by the structure of appointments and provider relationship, their position in the everyday and what was available, or a combination of both. What one can see from the data is that lack of a good provider relationship resulted in women seeking advice and information elsewhere in preparation for what to expect both in pregnancy and childbirth. In addition to educating oneself, the birth plan document is critical to note in relation to women's agency in pregnancy and the childbirth process.

The birth plan serves as a document where women can truly express themselves as to how they want the process to unfold even with the knowledge that it may not be followed. The act of creating a birth plan provides a sense of empowerment with regard to decision making. Conversely, if women felt that their provider knew their desires and supported them, they may have decided to not develop a birth plan. The varied approaches only emphasizes the overlapping

of categories and that the decision to create a birth plan is based on the structures driving women's actions. The tensions that exist between structure and agency with relation to how women educate themselves is evident in that the provider relationship and appointment structure should allow for much of the education to be directed by the "system" yet the organizational structure actually drives women to assert their agency by educating themselves.

CHAPTER SIX: CONCLUSIONS

From the results of my interviews and categories that emerged, I have begun to fill the gap in the research of representing women's voices in their navigation of the pregnancy and childbirth process as well as the what their decision making is based upon. Each of them has a story to tell. Regardless of the decisions that were made, it was evident that women wanted to be part of the decision making process in the capacity of learning about to expect of childbirth and being heard for what they thought was best for them, their bodies and their babies.

In learning about the process, the women faced difficulties with the medical system and the structures created by the system. Giddens' theory of structuration and Smith's standpoint theory were clearly seen in the data with regard to the value that women's voices bring to understanding how women navigate the medical institution in the areas of pregnancy and childbirth. The way prenatal appointments were structured almost instantaneously began the process of constraint experienced by women. The organizational approach and duration of appointments provided a conditioning that prevented women from asking questions outside of basic information as thought necessary by the provider acting who represented the medical structure. The appointment structure then directly affected provider relationships. As was discovered, the dominant areas of power of words and provider and nurse/doula relationships affected level of empowerment with regard to how women obtained information, whether they felt the need to write a birth plan or attend childbirth education classes and making decisions about interventions during the childbirth experience. What is noteworthy is that if women had a good relationship with their providers, they felt confident or if they ended up with supportive, encouraging nurses during the childbirth experience, they felt more in control. This seemed to be the case even though they did not have a prior relationship with the nurses. Where relationships are not established, positive language and encouragement from nurses can overcome some of

those barriers to still provide great care and make women feel confident. The problems arise when provider and nurse/doula relationships are lacking in addition to women hearing discouraging or negative language. These findings are a small first step in uncovering what empowers women's decision making during pregnancy and childbirth. Similar studies should be conducted to expand upon the findings within which interviews focus on commonalities as well as draw out additional data that could be useful in developing solutions for expectant mothers.

Future Research and Recommendations

I think there is a need to add to the literature on the topic of women's decision making and empowerment in childbirth by exploring the focus group approach. Undoubtedly, there would be a different dynamic among women speaking and sharing their experiences in a focus group, as opposed to a one-on-one interview environment. It would be interesting to watch the interactions and hear the discussion to see if more or less would be shared depending on the security level felt from the other women present (those who wanted a natural birth versus a birth with pain management; women grounded in academia and research versus women in other areas of life such as stay at home moms, etc...). During the interviews, women made known their preferences, but were often careful and intentional about the fact that women should be respected for their choices as long as they were fully informed of any risks surrounding interventions for example or the use of pain management drugs. I am not sure how that respect would translate in a group setting. I would anticipate that even more in-depth information would be shared as women felt encouraged by the others in the group.

In addition to sharing more amongst a group of women, more focused discussion could be had with regard to suggesting measurable solutions to help women navigate the process of pregnancy and childbirth in terms of being in control of their bodies. It would be advised to

encourage providers to start a program where doulas were discussed and perhaps offered as a way for women to have that personal advocate. Also, it would be worth exploring a pilot project where women would have the opportunity to develop a birth plan in a class setting with support from other women, including providers and nurses. I think it will be critical moving forward in the research to begin to think of actual areas of collaboration between women and doctors during pregnancy and childbirth. Structure is important and needed from the perspective of the medical system, but women need to be given more support where they can freely assert their agency, which I think can be attained through more intentional education.

As doulas appear to be a support person who could function as a support person for women preparing for and going through childbirth, it would be worth exploring in terms of the need and probability of women using doulas. This may be a common ground approach as a doula should not appear as a threat to the structure of the medical system, but could actually alleviate some of the pressure for providers. Working with doulas could open up opportunities for better outreach and preparation to occur.

This is only the beginning in terms of looking at what people or processes could be incorporated to offer personalized support to women in pregnancy and childbirth. As outreach and future research is conducted, the hope is that more ways will be uncovered to assist in empowering women during pregnancy and childbirth.

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APPENDIX A: INTERVIEW QUESTIONS

Childbirth History

1. When did you have your last child?
2. Do you have any other children?
 - a. If so, in what year(s) did you give birth?

Childbirth Details

3. For your most recent child:
 - a. Where did you give birth?
 - b. What type of provider performed your delivery?
 - c. Was your provider a male or female?
 - d. What type of delivery did you have?
 - e. Were there any complications?
 - i. If yes, can you describe what they were and how they came about?
 - ii. Would you have changed anything about the delivery or childbirth process?
4. If she has multiple children:
 - a. Was this childbirth different from your previous births?
 - i. If so, how?
5. For each subsequent child:
 - a. Where did you give birth?
 - b. What type of provider performed your delivery or deliveries?
 - c. Was your provider a male or female?
 - d. What type of delivery did you have?
 - e. Were there any complications?
 - i. If yes, can you describe what they were and how they came about?
 - f. Would you have changed anything about the delivery or childbirth process?
 - i. Why or why not?

Childbirth Plan & Expectations

6. Did you have a childbirth plan for your most recent child?
If yes:
 - a. Can you tell me about your plan?
7. What were your expectations leading up to childbirth in relation to how the delivery would happen and the childbirth plan?
 - a. How did this vary if you experienced multiple deliveries?
8. Did your primary care provider present you with options for childbirth?
 - a. If yes, what were those options?
9. Did your doctor follow the plan?
10. Did the plan change over the pregnancy?

- a. If so, how?
 - b. Follow-Up: If induced, tell me about how it was presented as an option and the role you played in deciding about it.
 - c. Follow-Up: If a Cesarean section, what were the reasons leading up to that?
11. What types of information/details were important for you to have in the plan?
- a. Were you able to convey these to the doctor? Why/why not?
12. If you had questions during the pregnancy, how did you convey these to your primary care provider?
- a. If so, how did your primary care provider respond to these questions?
 - b. If not, why were you unable to ask?

If no:

13. Are you familiar with birth plans?
- a. If yes, why did you choose not to have a plan?
14. What were your expectations leading up to childbirth in relation to how the delivery would happen and the childbirth plan?
- a. How did this vary if you experienced multiple deliveries?
15. Did your primary care provider present you with options for childbirth?
- a. If yes, what were those options?

Induction and Cesarean Birth

16. Was your childbirth induced?
- a. If so, tell me about how it was presented as an option and the role you played in deciding about it.
17. What your childbirth a Cesarean section?
- a. What were the reasons leading up to that?
18. What types of questions did you have throughout your pregnancy?
- a. Were you able to convey these to the doctor? Why/why not?

**If there are additional children, ask the above questions for each child if details have not been discussed.

Further Details on Childbirth Experience

19. Describe the information provided by your physician in terms of pain management options for your upcoming childbirth.
20. In terms of interventions, can you talk about what decisions you were asked to make during the process?
- a. Follow-Up: What role did you play in those decisions?
21. How prepared did you feel for the childbirth experience?

22. Aside from your doctor, who else did you rely on for support/advice in making decisions about your delivery?
 - a. Depending on response, why did you seek him/her out for support?
23. What other materials did you rely on for support/advice in making decisions about your delivery?
 - a. Books, classes and material, etc.
24. What were your feelings towards your primary care provider before, during and after the birth process?
 - a. Follow-Up: What kinds of occurrences or issues contributed to those feelings?
25. When reflecting on your childbirth experiences, what would you recommend to other pregnant women as they prepare to experience childbirth for themselves?
 - a. Follow-Up: What tools could help them to feel like they were involved in the decision making process?
26. Are there any other details that you think are important to tell me about your childbirth experience?

APPENDIX B: IRB APPROVAL LETTER



May 22, 2014

FederalWide Assurance FWA00002439

Christina Weber
Department of Sociology & Anthropology
Minard Hall 428D4

IRB Approval of Protocol #HS14275, "Agency and Empowerment in the Childbirth Process: The Effect of Medicalization on Women's Decision-Making"

Co-investigator(s) and research team: Alicia Kauffman

Approval period: 5/22/14 to 5/21/15

Continuing Review Report Due: 4/1/15

Research site(s): varied

Funding agency: n/a

Review Type: Expedited category # 6, 7

IRB approval is based on original submission, with revised: original protocol submission (received 5/12/14).

Additional approval is required:

- o prior to implementation of any proposed changes to the protocol (*Protocol Amendment Request Form*).
- o for continuation of the project beyond the approval period (*Continuing Review/Completion Report Form*). A reminder is typically sent two months prior to the expiration date; timely submission of the report is your responsibility. To avoid a lapse in approval, suspension of recruitment, and/or data collection, a report must be received, and the protocol reviewed and approved prior to the expiration date.

A report is required for:

- o any research-related injuries, adverse events, or other unanticipated problems involving risks to participants or others within 72 hours of known occurrence (*Report of Unanticipated Problem or Serious Adverse Event Form*).
- o any significant new findings that may affect risks to participants.
- o closure of the project (*Continuing Review/Completion Report Form*).

Research records are subject to random or directed audits at any time to verify compliance with IRB regulations and NDSU policies.

Thank you for cooperating with NDSU IRB procedures, and best wishes for a successful study.

Sincerely,

Kristy Shirley, CIP
Research Compliance Administrator

INSTITUTIONAL REVIEW BOARD

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