



Navigating Risk in Minnesota's Birth Landscape: Care Providers' Perspectives

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Abstract

Over 99 percent of US births occur in hospitals, but a small minority of women actively seek out-of-hospital deliveries—primarily at home. Through a qualitative study with maternity care providers in the Twin Cities, Minnesota, we examine the role of the healthcare industry in constructing places of birth in the US. We argue that healthcare structures have reinforced a medicalized notion of risk that defines the birthing landscape, significantly influencing broader understandings of what birth looks like in different places. Specifically, hospital birth is defined as the normative 'safe' option, juxtaposed against the 'riskier' feminine site of the home. These understandings of the birth landscape are used to



make and justify spatial choices about where birth is most desirable, with implications for birth experiences.

Introduction

“Birth is universally treated as a marked life crisis event,” with the event itself and the immediate post-partum period considered as particularly vulnerable times for mother and child (Jordan, 1993, 3). As such, assessments of risk are central to understandings of the birth landscape. Ritual prescriptions for coping with the peri-partum period are common within societies and often aggressively enforced and reproduced (Jordan, 1993; Davis-Floyd, 1992). Place is critical in this context through empowered groups defining what can, or cannot, occur in particular spaces and who should or should not be in those spaces; healthcare providers represent one especially influential group in this respect. Efforts to upturn dominant understandings of how birth should look—where birth should occur, who should be present, how the birth should proceed—are therefore often radical.

We use qualitative research with maternity care providers in the Twin Cities, Minnesota to consider how healthcare providers construct understandings of places of birth. We view healthcare providers as uniquely situated to comment on current constructions of the birthing landscape in their position as both insiders to the healthcare industry and consumers of care. Specifically, this study explores ways in which place can reinforce normative birth experiences, as well as ways in which place can be used radically to subvert dominant understandings of the birth process. Minnesota is currently at a critical turning point with respect to out-of-hospital birth: the topic of licensing birth centers has been on the legislative agenda over the past five years and there is currently a groundswell of interest in alternative birthing practices. Minnesota therefore provides a key case study for understanding how the birth landscape is negotiated and renegotiated.

Putting Birth into Place: The Significance of Place to Birth Experiences

Birth is both a physiological and cultural process (Fannin, 2009; Jordan, 1993), with “bodies, gender, place and culture” inextricably interwoven (Longhurst, 2008, 2). Geographers and others have conceptualized place at a variety of different scales in exploring birth as simultaneously a cultural and embodied phenomenon. At the finest scale, feminist scholars have argued that the female body is a significant site of repression and struggle (Rose, 1993), although the pregnant body has received remarkably little attention in this respect, despite its inherently gendered nature (Longhurst, 2008). Of greatest relevance here is the use of the male body as a normative standard. In contrast to an idealized and stable male body, the changes that female bodies undergo associated with reproduction have traditionally been defined as disease (Young, 1984). Although modern healthcare providers are unlikely to define birth in overtly pathological terms, the legacy of this understanding lives on in many dominant ideas: that hospitals and doctors are an integral part of the birth experience, that ‘symptoms’ of pregnancy

need 'treatment,' or that mothers need pharmacological pain management to cope with labor, for example (see Young, 1984).

Place is also significant in terms of where a woman delivers her baby, with place critical to the history of birth and at the center of its politicized nature (Sharpe, 1999). Birth can physically occur wherever a pregnant woman finds herself, but it is through repetition and "social patterning" that we come to understand birth happening in specific places (Jordan, 1993, 1). Many qualitative analyses have explored the significance of place to women's birth experiences, often focusing on distinctions between hospital and home, and sometimes also birth centers,² as sites for labor and delivery (e.g., Cheyney, 2011; Kornelsen et al., 2010; Longhurst, 2008).

While hospital and home are commonly presented as dichotomous, with characteristics such as feminine, natural, and autonomous associated with home, and masculine, medicalized, and paternalistic associated with hospital (see Sharpe, 1999), it is important not to over-simplify meanings attributed to places of birth (Longhurst, 2008; Sharpe, 1999; Michie, 1998). McDowell (1999, 4) argues, "that places are contested, fluid and uncertain," and it is important to appreciate that maternities are played out in different ways in different places (Manderson, 1998). Nonetheless, spatial structures, and particularly institutionalized spatial segregation, typically reinforce pre-existing male advantages (Rose, 1993; Spain, 1992), and so many feminist accounts of birth have argued that the masculinized site of the hospital is a particularly disempowering place for women, with (male) doctors' cultural authority seen as overruling mothers' preferences and undermining the traditional (female) role of the midwife. However, feminist readings of the transition of birth from home to hospital are not straightforward, and should not imply that women have little agency in determining the course of their births (Beckett, 2005). For instance, many first-wave feminists actively claimed medicated, hospital-based births in the early twentieth century in the pursuit of safe, pain-free childbirth. Similarly, the recent turn back towards out-of-hospital deliveries has been interpreted by home birth advocates as a spatial mechanism for women to reclaim control of the birthing experience, both as mothers and as care providers. Yet, for many women the space of home may represent a site of work or even abuse—far from the place of empowerment and autonomy that the home birth movement enthusiastically touts (Longhurst, 2008; Michie, 1998).

Within these debates, healthcare providers play a significant role in constructing both the image of different places of birth and the birthing women,

² Birth centers are typically midwife-led units that focus on providing births with minimal interventions for women with low risk pregnancies. Although some hospitals call their maternity units 'birth centers,' we reserve the term for units that are independent of hospitals.

and influencing the activities that occur at different sites through the philosophical model of birth that they pursue. Two main models of birth are often recognized in this respect, distinguished largely by their definition of risk. The biomedical model views birth as a medical, even pathological, phenomenon—with maternal and fetal death/injury the paramount concerns. By contrast, the midwifery model frames birth as a family event, with labor and delivery viewed as natural processes that require little interference in most cases, and which benefit from holistic approaches that value connection between mother and caretaker (Katz Rothman, 2006; Davis-Floyd and Davis, 1996). An important element of risk, once again, is maternal and fetal injury, but risk is also defined as the potential threat to the mother-child bond associated with excessive technological intervention or a negative birthing experience. As such, the *process* of birth becomes significant as well as the outcome (Buitendijk, 2011). Although these philosophical approaches to birth cannot be categorically assigned to physicians and midwives respectively, providers diverge in the relative emphasis placed on these two philosophies (Buitendijk, 2011), and the models tend to be associated with hospital and out-of-hospital deliveries respectively.

Studies confirm that rates of intervention in birth tend to be place-specific, tied both to the facilities available and the practitioners who operate in different locations. Although it is to be expected that hospitals will have higher rates of intervention than the home because of their greater proportion of high-risk deliveries, studies suggest that rates of intervention differ significantly by place even among low-risk births. For instance, Johnson and Daviss, in a study of deliveries in North America in 2000, found that 19 percent of low-risk hospital births ended in Cesarean section compared with just 3.7 percent of intended home births. Similarly, episiotomies occurred in 33 percent of low-risk hospital births but in only 2.1 percent of intended home births (2005, 1418).

The question of whether out-of-hospital deliveries carry excess risk in terms of maternal/fetal injury or death remains very contentious (see Chervenak et al., 2013; McLachlan and Forster, 2009). Part of the problem is the relatively small number of women undertaking out-of-hospital deliveries in the Western world, and the significant differences between those individuals selecting home births and those electing hospital deliveries, making statistical analysis challenging (McLachlan and Forster, 2009). While many independent studies have found no evidence of increased physical risk to mother or child associated with home births (e.g., Johnson and Daviss, 2005; Hutton et al., 2009; Wiegers et al., 1996), reports compiling the results of many studies suggest that, overall, out-of-hospital deliveries may carry a slightly increased risk of fetal injury, although even these meta-analyses do not provide a completely clear picture. At one extreme, Wax et al. (2010) report a two- to three-fold increase in risk of neonatal mortality between planned home and hospital deliveries (although no difference in maternal outcomes) and argue that the risk of home deliveries is being underestimated. By contrast, a recent report commissioned by the UK's National Institute for Health

and Clinical Excellence (NICE) that examined the results of a large number of recent studies concludes that, "We do not have enough information about the possible risks to either the woman or her baby relating to planned place of birth," but adds guardedly "that if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care" (NICE, 2007, 7-8).

Overall, the literature is clear that there are significant differences in birth experiences among sites of delivery, but the relative risks of different sites remain highly contested. What is widely accepted is that hospitals are the normative site of birth, and offer the safest outcomes for high-risk births, but at the cost of far higher rates of intervention. Indeed, many potential disadvantages of hospital deliveries are cited, mostly related to the potential for disempowerment of mothers and midwives, and unnecessary interference in the birth process.

Placing Birth in Minnesota: The Structural Context

Place is significant to birth also at the national and local scales where policy decisions and socio-economic frameworks influence birth landscapes. A brief history of birth in the US is instructive in situating the case study presented here.

While the US shared a tradition of midwife-attended births with most other countries in its early years, by the late 1800s the rising power of medicine was beginning to supplant midwifery traditions, largely through undermining female knowledge and precluding midwives from using new obstetric techniques. Male doctors, with access to the power of the state through their professional organizations, were able to leverage power over midwives, who were often portrayed as backward (Katz Rothman, 2006). Indeed, government and medical officials in many US states worked to systematically exclude midwives well into the mid-1900s (Craven, 2005; Fraser, 1998). This transition away from home birth with a midwife was also accompanied by a strong, racialized campaign against traditional midwifery in the South, where it was often associated with the African American community (Fraser, 1998).

Throughout the latter half of the twentieth century, most industrialized nations were experiencing a shift towards hospital birth, associated with the rising significance of hospitals in delivering healthcare and the increasingly dominant view of birth as pathological. These pathological understandings of the birth process implicitly positioned the hospital as the ideal place for delivery. In this way, childbirth in the industrial era has been read as a reflection of society's patriarchal and technocratic biases (see Davis-Floyd 1992).

While the hospitalization of birth in the US paralleled the increasing significance of hospital-based care throughout much of the Western world between the 1930s and 1960s, it was distinctive in being stimulated also by the growth of private health insurance plans and the development of hospital-based technologies

for pain relief (Declercq et al., 2001). Much has also been made of the idea that turf warfare between midwives and physicians continued, particularly as the nascent specialty of obstetrics began to develop a powerful political voice that outranked midwives (Katz Rothman, 2006). As Declercq et al. (2001, 11) describe, “moving birth to hospitals...was...a powerful weapon in the campaign to eliminate midwives. Equally important, midwives, divided by ethnic differences and lacking a sense of profession, failed to work together to protect their own interests.”

Midwives have since regained some agency, however. A resurgence of midwifery in the 1960s led eventually to the reemergence of midwifery as a valued profession, but also led to its division into two almost separate place-based fields. On one hand, the rise of certified nurse midwives (CNMs)—individuals trained in nursing who also provide obstetric care—placed midwives firmly within the biomedical fold, with CNMs part of an obstetric care ‘team’ led by doctors and working in hospitals.³ On the other hand, midwifery developed a counter-cultural home birth movement as some midwives rejected integration into the hospital system in order to preserve the holistic nature of their practice. These ‘traditional’ midwives often used apprenticeships rather than institution-based training programs to learn their skills (so-called ‘direct-entry’ midwives). This divide remains today, although efforts have been made to try to reintegrate the two forms of practice (Bourgeault, 2006).

These changes are reflected in US national statistics. In 1940, 40 percent of white women and 73 percent of women of color in the US gave birth at home (Vital Health Statistics, 1984). By the 1970s, hospital birth had become the norm across socioeconomic and racial groups, with 99 percent of births occurring in hospitals since the 1970s (Curtin et al., 1999; MacDorman et al., 2010; Wax et al., 2010). Today, the average US birth takes place in a hospital, overseen by a doctor; indeed, pregnancy/childbirth is the most common reason for hospitalization of US women. Technology and medication are integral parts of the birth experience for most women, with C-section used for around one-third of all deliveries and well over three-quarters of women receiving pain medication (Hamilton et al., 2009; Declercq et al., 2006).

In spite of this, US hospitals are increasingly offering midwife-based care or even entire midwife-based units, and a vocal community is now advocating the option of home birth or birth center deliveries for women with low-risk deliveries. Between 2004 and 2009, home births increased by 29 percent in the US, putting rates at the highest levels since data collection began in 1989—although the rate was still only 0.72 percent in 2009 (MacDorman et al., 2012, 1, 5).

³ Table 1 provides descriptions of the types of maternity care providers interviewed in this study.

The topic of home birth remains politically charged, however. Indeed, an unusually high degree of antagonism exists towards out-of-hospital births from professional organizations in the US compared with most other Western nations. The powerful private healthcare system of the US has tended to heavily emphasize hospital-based maternity care, with reimbursement of birth expenses often contingent on a hospital delivery. Medical and state representatives in some states continue to try to prevent direct-entry midwives from practicing, and discourage home births as inherently too risky, often focusing on the “‘logical’ and ‘natural’ superiority of biomedical childbirth practices” (Craven, 2005, 194). Physicians’ organizations have furthered the status quo. The American Medical Association (AMA) is highly critical of home birth (although more accepting of birth centers), supporting an American College of Obstetricians and Gynecologists’ (ACOG) statement that “the safest setting for labor, delivery, and the immediate post-partum period is in the hospital or a birthing center within a hospital complex...or in a freestanding birth center...” (AMA, 2008).

In response, home birth advocates have aggressively defended home birth as not only safe but also more ‘natural’ than hospital deliveries. However, this rhetoric has tended to “reify home as an idealized site,” with home “unproblematically portrayed as a positive choice offering benefits such as safety, less intervention than at a hospital, no medication, less infection, familiar environment, no travel, fewer breastfeeding problems, continuity of midwifery care, privacy, emotional bonding with the baby, and the emotional well-being of the mother” (Longhurst, 2008, 92; see also Banks, 2000; Donley, 1986).

Within these debates, the Twin Cities provides an instructive case for investigating the significance of place to birth. Although over 99 percent of Minnesota births occur in hospitals and Minnesota is only in the mid-ranks among states in terms of the number of out-of-hospital births (MacDorman et al., 2010, 3), a number of other trends put the state—and particularly the Twin Cities—at the forefront of movements to promote choice over place of birth in the US. While most parts of the US have seen a decline in the number of births at home and in freestanding birth centers since 1990, Minnesota is among eleven states to report a statistically significant increase in out-of-hospital births between 2003 and 2006, reporting a 25 percent increase in home births over this period (MacDorman et al., 2010, 3). Traditional forms of midwifery are legal in the state and optional licensure is available for traditional midwives (figure 1); the Twin Cities also has a high percentage of doula-assisted births (Dempsey, 2006). Minnesota’s Cesarean rate of 26.2 percent is lower than the national average of 31.8 percent (Menacker and Hamilton, 2010). Finally, in 2010, Minnesota passed into law the licensing of freestanding birth centers, and provision for Medicaid reimbursement for birth center deliveries (*Star Tribune*, 5/24/2010). Three freestanding birth centers opened in 2009, 2010, and 2012 in the Twin Cities; another in 2010 northwest of the Twin Cities.



Figure 1: Legality of Direct Entry Midwifery, 2010
Source: Data from MANA (2010); ESRI (2009)

In these ways, Minnesota contributes a unique case study for analyzing places of birth. Although women ostensibly have choice over place of birth in Minnesota, political, economic, and cultural factors have traditionally combined to emphasize the preeminence of the hospital as *the* place to deliver, and hospital birth remains the norm. We began this study with the intent to explore how healthcare practitioners frame the birthing landscape today in ways that reinforce or contest this status quo.

Methods

We completed 24 semi-structured in-depth interviews with individuals in birth-related fields in the Twin Cities, Minnesota between June and December 2009 (table 1). Interviewees were purposefully selected to provide expert insights into Minnesota's birth landscape. Owing to the integrated nature of the maternity community, informants often referred us to other potential interviewees. We used qualitative methods for data collection, consistent with the goal of exploring

particularities of experiences and attitudes, rather than facilitating generalizations about broader trends.

Table 1: Job Descriptions of Study Participants

Job Title	Job Description	Number in Study
Certified Nurse Midwife	Advanced practice nurses with training in midwifery and nursing. They can be the primary care provider for women during labor and birth and tend to work in hospital settings. They do not perform Cesareans.	4
Childbirth Educator	People knowledgeable about birth who run classes for pregnant women and families. They may be certified by a larger organization or run independent classes.	1
Community Health Worker	Lay health workers who work for the local healthcare system in paid or volunteer positions. Community health workers normally share ethnic and socioeconomic similarities with the community they serve.	1
Doula	Labor support providers who work with pregnant, laboring, and post-partum women to provide physical and emotional support. Doulas are not required to have medical or midwifery degrees.	6
Homebirth Midwife	Two categories: Certified Professional Midwives (CPMs) and direct-entry/other midwives CPMs receive certification through the North American Registry of Midwives (NARM), which involves training from an accredited school and a lengthy exam process. Direct-entry midwives are independent practitioners, trained via self-study, apprenticeship or midwifery school, who tend to practice outside traditional medical settings.	6 (Including 2 in training)
Physician	Two types of physicians deliver babies: Obstetricians and family practice doctors Obstetricians are surgeons specifically trained to deal with labor, delivery, postpartum and well-woman gynecological care, including complicated and high-risk deliveries. Family practice doctors focus on life-span family care but sometimes deliver babies. Family practice doctors tend focus on lower-risk deliveries, typically referring complicated cases, including Cesareans, to obstetricians.	4 (3 family practice, 1 obstetrician)
Registered Nurse (RN)	Registered nurses are trained in a variety of sub-disciplines to provide patient care and support to physicians/nurse-midwives. RNs in labor and delivery are specifically trained to work with laboring women to manage pain and identify problems that require a physician’s attention.	2

We extensively reviewed background literature prior to the study. From this initial reading, we developed interview questions to investigate how healthcare providers perceive the birth landscape in Minnesota. Questions were deliberately open-ended to allow interviewees to direct the conversation towards topics that they deemed to be important and generate their own narratives from their personal experiences and observations. This was consistent with our constructivist approach that aimed to understand how interviewees themselves generated meaning out of the birth landscape of which they are a part.

The study was submitted to the Institutional Review Board's human subjects committee and permission obtained for the study. Interviews were tape recorded with the informants' permission and then transcribed and returned to the interviewees for comment. All informants are referred to by a pseudonym to ensure anonymity. All but one informant were female; most were biological parents with their own personal birth narratives.

We coded the transcripts by seeking common phrases and words using a computer word search function in order to identify key themes. Once the transcripts had been systematically searched for specific themes, the researchers returned to the passages identified and reviewed them for content.

Results

Constructing Landscapes of Birth

Our choices are defined by what we know. In the context of childbirth, respondents frequently emphasized how societal norms combine with personal experience to generate a mental image of what birth looks like in different places. As expected, most respondents described hospital birth as the norm, as exemplified by Donna, a certified nurse midwife,

If they [pregnant women] had all choices available to them, then their choices would be affected by their knowledge base [...] 99 percent of births occur in hospitals so what most people know is that birth happens in hospitals. So a lot of people don't even think about birth centers [...] and fewer than one percent of births in this country occur at home. So there are some people here that give birth at home, but most people don't know people that do that.

Beyond familiarity with particular birth options, several respondents noted how social constructions of the *process* of birth can also push women to make particular place-based choices. In particular, the understanding of birth as pathological and painful was seen as widely infused in popular culture, as Heather, a certified professional midwife, elaborated,

It's also giving that message to women every day, and on TV, in the media, through people that you talk to that, 'I'm not strong enough, my body's not able to do it. So I'm not going to be able to handle the pain

or do it, so that's why I need an epidural.' You know, it's a perception and a little bit of a lack of education.

The construction of birth as an ordeal requiring medical assistance was seen as a key driver of women seeking hospital deliveries, with many forms of pain management only available in hospitals or requiring a certified nurse midwife or physician to administer them, both of whom operate largely from hospital settings.

In many cases, the status quo of hospital delivery is further reinforced by health practitioners, many of whom assume from the outset that a hospital birth is the desired route for their patients. Nora, a certified professional midwife in training, related her own personal experiences in this respect,

I was like, 'Well, if I got pregnant, I would just go to the hospital, that's what you do. You do whatever the doctors tell you and they'll tell you whatever's best for you.' And once I found out there were options for women, at first I was completely outraged because I thought, 'How could I have grown up in this culture and not known that women have all these options to choose from in pregnancy and birth?'

Indeed, even the choice of hospital and healthcare provider may be considered a foregone conclusion, as Michelle, a mother of two, describes, "So I didn't have a choice in the hospital. [The practice] said 'This is where you're going to go.' I said 'OK.'"

The notion that professionals know best typically reinforces the choice of a hospital birth, even when those professionals are peers. For instance, Valerie, a labor and delivery nurse, found that her peers (other registered nurses) were alarmed by her desire for a home birth,

[Home birth] is not a very popular decision sometimes among my colleagues [...] when I told them that I was going to have a home birth, they thought I was nuts. They really did [...] 'Cause you know what? We've all seen the risks, nurses, so I think everyone jumps to that worst-case scenario in their mind.

Not all respondents reported that peer influences supported the status quo, however. Rachel, a doula, described how her opinion of home deliveries became more favorable after noticing that there seemed to be some tacit support for home birth among the hospital staff she encountered professionally. Similarly, Cynthia, a family practice doctor, noted support for home birth in her workplace, estimating that in her practice 50 percent of the certified nurse midwives and some of the doctors and doctors' wives had delivered their children at home.

Within certain cultural groups, peer influence may also divert individuals away from broader national-scale norms. For instance, Fadumo, a community health worker within the Twin Cities' Somali community, described the cultural support and encouragement for 'natural' birth among the Somali families that she works with. According to Fadumo, most Somali women prefer to give birth

without medication in order to avoid side effects, unless there is a physical risk to the baby or mother. She reported women telling each other, “Try to have a natural birth. Don’t accept medication when you go to the hospital. Be strong.” Fadumo framed the issue by arguing that Somali women in the Twin Cities draw on culturally-specific guidance and resources to subvert the trend towards pharmacological pain relief that is dominant in the US.

Beyond societal and peer influence, personal experience was reported as significant by several respondents. Indeed, the frequency with which respondents recounted their own experiences in illustrating broader patterns emphasizes the significance of the individual scale in decisions surrounding birth. For example, Megan, a doula who has had two home births, acknowledged that her early experiences of her mother’s home deliveries led her to the understanding that birth takes place at home,

I don't ever remember considering hospital birth [...] From the time that I was a child I knew I was going to have my babies at home [...] I was born at home myself and I have three younger siblings and they were all born at home [...] So I kind of grew up around this ‘birthing thing.’ So I think that's why I didn't really have any conception of a hospital birth [...] because I was already so entrenched in the mindset of having a home birth.

Beyond simple familiarity with a particular *place* of birth, many respondents discussed the significance of place-based *narratives* of birth as significant in influencing decisions over place of birth. Several respondents used narratives of risk to explain their understanding of different places of birth. These narratives generally conformed to the expected division between biomedical and midwifery perspectives on birth. For instance, Jessica, a family practice doctor, highlighted her concerns over the risk of fetal or maternal death, concluding, “I can’t absolutely say, ‘No woman should ever [have a home birth].’ Does it make me nervous? Yes. Would I wish it on a loved one? No.” By contrast, others reported concerns over excessive medical interventions or the risk of losing control of the birth experience, and how these factors argue against hospital deliveries. For instance, Rachel, a doula, emphasized her concerns over the risks associated with epidurals. Most respondents were fully cognizant of the need to balance different types of risk, however. This was most clearly exemplified by Lois, a home birth midwife, who described discussing the balancing of various place-based risks to one worried parent of a home birth client thus,

Your daughter is choosing home birth knowing that there are small risks at home that could come up..., a small chance something could happen that could harm the baby in a significant way. But she knows that if she gives birth in a hospital there's an extremely high risk, a 100 percent risk, that things will happen that will harm the mother-child relationship in a moderate way.

The Impact of Place

Interviewees discussed a number of ways in which the place ultimately chosen to give birth can influence parents' birth experiences, reinforcing the significance of place to decisions about birth. At a basic level, the facilities available in a particular place can influence the likely course of a delivery. As several interviewees noted, the choice of an out-of-hospital delivery precludes the use of a variety of technological interventions, including epidurals and Cesareans. Even within a particular category of facility, there may be wide variations in the services available. For example, four hospitals in the Twin Cities lack a neonatal intensive care unit and only three offer facilities for water birth. Available facilities may, therefore, influence individuals' choice of place of birth, as noted by Rachel, a doula and mother of one,

So I knew from the beginning that I really wanted a water birth and I knew I wanted to be with midwives, and since there's only like three places in the Twin Cities where you can have a water birth that narrowed it down.

The impact of place goes far beyond facilities, however. The atmosphere of a place may also influence the decisions that are made in that context. Respondents emphasized on numerous occasions how care providers' philosophies influence the overall 'sense of place' associated with different sites of birth, emphasizing once again the significance of healthcare providers to birth experiences. For instance, Cynthia, a family practice doctor, suggested that the different professions associated with birth have "completely antagonistic philosophies," resulting in potentially dramatically different experiences. She argued that midwifery and family practice are all about empowering women to choose by informing them of the repercussions of their choices, while "the obstetrician's viewpoint in some practices is basically, 'I know what's best for you.'" Although few informants were quite so overtly critical of obstetricians, informants generally agreed that obstetricians were likely to use the highest level of medical intervention, followed by family practice doctors, and then midwives. The spatial implications of this relate to where different professions tend to operate. As Jessica, a family practice doctor, described, "a lot of times I think [births] get split into: at home with a lay midwife or at the hospital with a surgically-minded OB/GYN." Although she added that there is a middle ground, with family practice doctors and nurse midwives potentially offering a less interventionist approach within the hospital setting.

Different facilities' protocols related to risk also influence an individual's likely birth experience by affecting the range of actions open to care providers. Hospitals were reported as having especially rigorous approaches to risk management in order to minimize legal risk. Valerie, a labor and delivery nurse, explained how this can influence hospital-based medical practice,

If you don't respond to something on the fetal monitoring strip and they find that later, you can get sued. So a lot of times I think when there's a question, they'll end up doing a Cesarean just to make sure that the baby comes out OK. [...] It sounds insensitive, but to save ourselves from liability maybe we should just do the surgery.

Similarly, John, an obstetrician, explained that "the fact is we cannot ensure good outcomes for every baby [...] I don't practice with a medical-legal [outlook] but there's no question that a lot of what we do is to err on the side of caution, to bail out if there's a problem." Many of our informants noted that physicians are pushed towards Cesareans by this legal bind.

On the other hand, home births were reported as increasing legal risk for the care provider exactly because of the lack of such rigid protocols, making it harder for midwives to defend their actions should anything go wrong. Nancy, a certified nurse midwife, talked about her decision to work in a hospital setting as partly a consideration of personal legal risk. "Ultimately, I didn't want to expose my family to that kind of liability [associated with overseeing home births]. I think that the midwives who do take that on are tremendously brave. But it wasn't something I thought I could do."

While the selection of a birth site ostensibly offers women the opportunity to direct the course of their birth, many respondents agreed that the degree of choice a woman has over her care provider and place of delivery is often constrained by economic and political contexts. The most commonly mentioned theme was that most insurance companies in Minnesota would not accept a claim to reimburse a midwife who has attended a home birth or pay costs associated with a birth center delivery (although this is now changing). As such, home birth midwives have typically been paid out-of-pocket for their services. The home birth midwives in this study reported charging about \$3,000 for comprehensive prenatal, birth, and postpartum care—out of reach of many low-income women.

Even for women with private health insurance, care may be covered only for certain providers at particular hospitals. For instance, direct-entry midwives are barred from hospitals, and several informants noted how transferring from home to hospital during labor could generate considerable problems related to prejudices towards home birth held by hospital-based healthcare professionals. As Laura, a family practice doctor, stated, "I tell people it's probably a good idea to always have [a doctor] aware that you're doing a home birth, so that when you hit the ER, you're not shunned."

Discussion: Risk and Places of Birth

As expected, our interviewees reported a combination of personal experience and societal norms in defining what birth looks like in different places. While respondents agreed that women have considerable choice over place of birth, societal understandings of the birth landscape were described as dictating the

choices considered reasonable for pregnant women. In other words, women were seen as having choice over place of birth, but from a culturally-dictated 'menu.'

How this 'menu' of appropriate sites of birth was constructed was typically framed around risk. Respondents agreed that a biomedical view of birth is the dominant paradigm in the US, leading to the widespread understanding of birth as inherently risky in terms of maternal and fetal death and injury, and the acceptance of medical intervention in the birth process. This biomedical view clearly supports a hospital-based vision of birth. The authority of these medicalized systems of knowledge, and broader societal acceptance of medicated births, were also seen as encouraging women's utilization of pharmacological pain management, again pushing parents towards hospital deliveries. Many practitioners also noted how medical professionals are charged with the responsibility of actively intervening in deliveries to rectify complications, again furthering the status quo of medicalized deliveries. Indeed, healthcare providers can be held legally responsible if they do not adhere to professionally-defined protocols for managing risk, again reinforcing the biomedical model.

Despite this, alternative attitudes towards places of birth were noted among particular cultural groups, peer groups, and as a result of unique individual experiences, helping to explain why some individuals actively seek out alternative birth experiences. Within the Somali community, for instance, the potential side effects of medication were seen as a significant risk, leading many Somali women to reject pharmacological pain relief. Other respondents noted how tacit support of home birth in their peer groups enabled them to more openly voice their concerns with high rates of medical intervention and in some cases birth their own children at home.

Even practitioners following 'alternative' birth models reported the importance of protocol, however. Indeed practitioners overseeing home births are arguably in an even more vulnerable position than hospital-based providers, as they have already committed the "moral risk" of defying authoritative norms of birth by undertaking an out-of-hospital delivery (see Viisainen, 2000). This concern was typified by Nancy (a certified nurse midwife) who felt unable to assist at home births because of the potential liability she could face if unprotected by hospital protocols. Ironically, part of the value of alternative models of birth is in enabling practitioners to follow their intuition in attending a birth, rather than attempting to rigidly follow medical protocols that may, arguably, limit the effectiveness of the midwife, and yet this very freedom may put midwives at risk of legal recourse (see also Davis-Floyd and Davis, 1996).

While there were many points of agreement among respondents, respondents differed to some degree in the birth-associated risks that they identified. Consistent with previous literature, two different models of birth emerged when respondents reported their understanding of birth-related risks. Commonly, concerns with maternal and fetal injury and the need for medical intervention came from, or were

attributed to, obstetricians, while traditional midwives and doulas additionally emphasized the potentially negative consequences of excessive intervention. Consistent with this division, the very same factors could be interpreted in different ways by different individuals. For instance, for some the presence of highly-qualified individuals and technology in hospitals was seen as minimizing risk; for others these same factors were seen as interfering with a 'natural' event and introducing iatrogenic risk. What was notable, however, was the degree of fluidity between these two perspectives. Although, obstetricians, family practice doctors, certified nurse midwives, and home birth midwives were framed by respondents as representing a gradient of likely intervention in the birth process, respondents themselves often displayed considerable overlap in these perspectives in describing their own personal philosophies. Additionally, many respondents noted their frustration with restrictions that forced them into taking up positions typical of their training but that they were not wholly comfortable with, as exemplified by John's (an obstetrician) concerns over hospital protocols pushing up the C-section rate.

Several factors emerge as particularly significant from this study. First, our findings reinforce the notion that place of birth is an extremely significant locus at which societal norms are projected and reinforced. Not only do different places of birth carry different *meanings*, but the place a mother chooses to deliver her baby is likely also to have a significant influence on the type of delivery she *experiences*. Second, all respondents agreed that societal structures and norms reinforce the preeminence of the hospital as *the* place that babies are born in the US today, potentially closing off alternative avenues for expectant mothers. Finally, while healthcare providers diverge significantly in their approach to birth dependent on their training and their field of specialization (e.g., obstetricians vs certified nurse midwives, etc.), there was considerable fluidity between different models of birth among practitioners. Furthermore, many respondents contested parts of their training that they saw as limiting their effectiveness as maternity providers. The fact that healthcare providers are actively contesting the birth landscape offers a window for positive change.

Conclusion

In discussing places of birth, maternity care providers clearly reveal that they perceive stark differences between hospital and alternative places of birth. Often, these place-based differences are framed by considering the relative risks, and different types of risk, associated with birth in different places. Risk associated with birth comes in many forms, including the physical risk of injury to mother or child, the emotional risk of damaging the parent-child bond, and the legal risk taken by healthcare professionals in their work. How risk is perceived by different individuals varies according to professional training, personal experience, and norms of the surrounding community. Risk is integral to the construction of places of birth, as mediated by the differing philosophies of the care providers associated with particular places. These expectations of place are significant in influencing the care and advice offered by maternity care providers.

The fact that particular philosophies of birth overlap relatively consistently with specific places of birth suggests the need for careful consideration of place in trying to ensure equality in provision of delivery options. Both care providers and policymakers alike should acknowledge the significance of place to birth experiences, allowing them to reflect on how their decisions and attitudes contribute to expectant parents' experiences. Considering that significant differences exist in birth philosophies and resulting experiences by place, we suggest that there is a strong argument for supporting informed choice in place of birth. Offering women genuine choice over place of birth will necessitate an effort to ensure that women are not only aware of alternative options, but also feel that they can use these various options without risk of social sanction. Since the relative risks associated with different places of birth remain so contested, providing *informed* choice over place of birth is critically important.

References

- [AMA] American Medical Association. 2008. 'Home deliveries' Resolution 205 (A-08). Available at: http://www.aolcdn.com/tmz_documents/0617_ricki_lake_wm.pdf
Accessed: 5/7/2011.
- Banks, M. 2000. *Home Birth Bound: Mending the Broken Weave*. Hamilton, New Zealand: Birthspirit Books.
- Beckett, K. 2005. Choosing cesarean: Feminism and the politics of childbirth in the United States. *Feminist Theory* 6, 251-75.
- Bourgeault, I. 2006. *Push: The Struggle for Midwifery in Ontario*. Quebec City: McGill-Queen's University Press.
- Buitendijk, S. 2011. Gender issues in determining the service and research agenda for pregnancy and birth care: The case of home birth in the Netherlands. *Interdisciplinary Science Reviews* 36(2), 193-202.
- Chervenak, F., L. McCullough, R. Brent, M. Levene, and B. Arabin. 2012. Planned home birth: The professional responsibility response. *American Journal of Obstetricians and Gynecologists* 208(1), 31-8.
- Cheyney, M. 2011. Reinscribing the birthing body: Homebirth as ritual performance. *Medical Anthropology Quarterly* 25(4), 519-42.
- Craven, C. 2005. Claiming respectable American motherhood: Homebirth mothers, medical officials and the state. *Medical Anthropology Quarterly* 19, 194-215.
- Curtin S., and M. Park. 1999. Trends in the attendant, place, and timing of births, and in the use of obstetric interventions: United States, 1989-97. *National Vital Statistics Reports* 47, no 27. Hyattsville, MD: National Center for Health Statistics.
- Davis-Floyd, R., and E. Davis. 1996. Intuition as authoritative knowledge in midwifery and homebirth. *Medical Anthropology Quarterly* 10, 237-69.

- Davis-Floyd, R. 1992. *Birth as an American Rite of Passage*. Berkeley: University of California Press.
- Declercq E., C. Sakala, M. Corry, and S. Applebaum. 2006. Listening to mothers II: Report of the second national U.S. survey of women's childbearing experiences. New York: Childbirth Connection. Available at: www.childbirthconnection.org/listeningtomothers/. Accessed: 4/2/2011.
- Declercq, E., R. De Vries, K. Viisainen, H. Salvesen, and S. Wrede. 2001. Where to give birth? Politics and the place of birth. In R. De Vries, C. Benoit, E. van Teijlingen, and S. Wrede (eds.), *Birth by Design*. New York: Routledge, pp.7-27.
- Dempsey, R. 2006. Benefits advisory committee meeting minutes. University of Minnesota. July 2006. Available at: <http://conservancy.umn.edu/bitstream/45555/1/060615BAC.pdf>. Accessed: 2/26/2011.
- Donley, J. 1986. *Birthrites: Natural vs Unnatural Childbirth in New Zealand*. Auckland: The Full Court Press.
- ESRI. 2009. ESRI Data & Maps [CD-ROM]. Redlands, CA: Environmental Systems Research Institute.
- Fannin, M. 2004. Domesticating birth in the hospital: Family-centered birth and the emergence of homelike birthing rooms. In K. Mitchell, S. Marston, and C. Katz (eds.), *Life's Work: Geographies of Social Reproduction*. Malden MA: Blackwell Publishing, pp. 513-35.
- Fraser, G. 1998. *African-American Midwifery in the South: Dialogues of Birth, Race and Memory*. Cambridge, MA: Harvard University Press.
- Hamilton B., J. Martin, and S. Ventura. 2009. Births: Preliminary data for 2007. *National Vital Statistics Reports* 57, no 12. Hyattsville, MD: National Center for Health Statistics.
- Hutton, E., A. Reitsma, K. Kaufman. 2009. Outcomes associated with planned home and planned hospital births in low-risk women attended by midwives in Ontario, Canada, 2003-2005: A retrospective cohort study. *BIRTH* 36(3), 180-9.
- Johnson, K., and B. Daviss. 2005. Outcomes of planned home births with certified professional midwives: Large prospective study in North America. *British Medical Journal*, 1-7.
- Jordan, B. 1993. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. 4th ed. Waveland Press.

- Katz Rothman, B. 2006. *Laboring then*. In W. Simonds, B. Katz Rothman and B. Meltzer Norman (eds.), *Laboring On: Birth in Transition in the United States*. New York: Routledge.
- Kornelsen, J., A. Kotaska, P. Waterfall, L. Willie, and D. Wilson. 2010. The geography of belonging: The experience of birthing at home for First Nations women. *Social Science and Medicine* 16, 638-45.
- Longhurst, R. 2008. *Maternities: Gender, Bodies and Space*. New York: Routledge.
- MacDorman, M., T. Matthews, and E. Declercq. 2012. Home births in the United States, 1990-2009. *NCHS Data Brief* 84. Hyattsville, MD: National Center for Health Statistics. Available at: <http://www.cdc.gov/nchs/data/databriefs/db84.pdf>. Accessed: 3/10/13.
- MacDorman, M., F. Menacker, and E. Declercq. 2010. Trends and characteristics of home and other out-of-hospital births in the United States, 1990-2006. *National Vital Statistics Reports*, 58, no. 11 (2/3/2010).
- [MANA] Midwives Alliance of North America. 2010. Direct entry midwifery state-by-state legal status. Available at: <http://mana.org/statechart.html>. Accessed: 5/29/2011.
- Manderson, L. 1998. Shaping reproduction: Maternity in early twentieth century Malaya. In: K. Ram and M. Jolly (eds.), *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific*, Cambridge: Cambridge University Press, pp. 26-49.
- McClain, C. 1983. Perceived risk and choice of childbirth service. *Social Science and Medicine* 17, 1857-65.
- McDowell, L. 1999. *Gender, Identity, and Place*. Minneapolis, MN: University of Minnesota Press.
- McLachlan, H., and D. Forster. 2009. The safety of home birth: Is the evidence good enough? *Canadian Medical Association Journal* 181(6-7), 359-60.
- Menacker F., and B. Hamilton. 2010. Recent trends in cesarean delivery in the United States. *NCHS Data Brief* 35. Hyattsville, MD: National Center for Health Statistics. Available at: <http://www.cdc.gov/nchs/data/databriefs/db35.htm>. Accessed: 5/26/2011.
- Michie, H. 1998. Confinements: The domestic in the discourses of upper-middle-class pregnancy. In S. Hardy Aiken, A. Brigham, S. Marston, and P. Waterstone (eds.), *Making Worlds: Gender, Metaphor, Materiality*. Tucson: University of Arizona Press.
- [NICE] National Institute for Health and Clinical Excellence. 2007. Intrapartum care: Care of healthy women and their babies during childbirth. Available at:

- <http://www.nice.org.uk/nicemedia/pdf/PCNICEGuidance.pdf>. Accessed: 3/10/2013.
- Rose, G. 1993. *Feminism and Geography*. Minneapolis, MN: University of Minnesota Press.
- Sharpe, S. 1999. Bodily speaking: Spaces and experiences of childbirth. In E. Teather (ed.), *Embodied Geographies: Space, Bodies and Rites of Passage*. NY: Routledge, 91-101.
- Spain, D. 1992. *Gendered Spaces*. Chapel Hill: University of North Carolina Press.
- Star Tribune* (May 24, 2010) 'Birthing a new option.'
- Viisainen, K. 2000. The moral dangers of home birth: Parents' perceptions of risks in home birth in Finland. *Sociology of Health & Illness* 22, 792-814.
- Vital Health Statistics. 1984. Midwife and out-of-hospital deliveries. *United States Vital Health Statistics* 21, 40, 1-43.
- Wax, J., M. Pinette, and A. Cartin. 2010. Home versus hospital birth: Process and outcome. *Obstetrical and Gynecological Survey* 65(2), 132-40.
- Wiegers, T., M. Keirse, J. van der Zee, and G. Berghs. 1996. Outcome of planned home and planned hospital births in low risk pregnancies: Prospective study in midwifery practices in the Netherlands. *British Medical Journal* 313, 1309-13.
- Young, I. 1984. Pregnant embodiment: Subjectivity and alienation. *The Journal of Medicine and Philosophy* 9, 45-62.