

AN ABSTRACT OF THE THESIS OF

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Abstract approved: _____

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Increasing demand for home birth has created an upheaval in the American medical profession and, is a controversial political and legal issue as well. This research, utilizing ethnographic, historical, and survey data analyzes contemporary home birth.

A review of the so called "medicalization" of childbirth is presented noting that the majority of medical developments which made childbirth safer did not necessitate hospitalization.

In Oregon, the whole spectrum of birthing alternatives are legally available although midwifery statutes have not yet evolved to a stable point.

In order to distinguish the characteristics of those who choose home birth, a survey questionnaire was designed to ascertain important factors influencing the woman's decision about what type of delivery to have. The survey was completed by 83 women who had recently given

birth in a tri-county area of western Oregon where the home birth rate averaged five percent.

The results revealed several factors on which women who chose home birth differed markedly from those who chose hospital delivery. Home birth women did not accept society's definition that childbirth is a medical event at its onset. Rather, they made a distinction between a normal and a complicated delivery that the larger culture did not.

In addition, the majority of the women, regardless of the place of delivery, exhibited a high degree of consumerism, were educated about childbirth, and expressed concern over obstetrical intervention. Thus, it is suggested that elected home birth is part of the current pressure to deinstitutionalize the American health care system.

FACTORS IN THE SELECTION
OF HOME BIRTH:
A COMPARATIVE STUDY OF BIRTHING ALTERNATIVES
IN WESTERN OREGON

by

Susan D. Fuhr-Dunn

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APPROVED:

Redacted for Privacy

Professor of Anthropology in charge of major

Redacted for Privacy

Chairman of Department of Anthropology

Redacted for Privacy

Professor of Sociology

Redacted for Privacy

Professor of Political Science

Redacted for Privacy

Dean of Graduate School

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Typed by Tracy Mitzel for Susan D. Fuhr-Dunn

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CHAPTER I

INTRODUCTION

Home birth in contemporary American society has emerged as a controversial legal and political situation with analysis focused primarily on the three medical practitioners it affects: the private physician, the Certified Nurse Midwife (trained and licensed as a nurse and midwife) and the lay or empirical midwife (with variable, unlegislated training in midwifery techniques). Little is known, however, concerning the motivations of women in the dominant cultural group whose increasing demand for home birth is the cause of the controversy. The issues involved range from legal and moral questions about the rights of parents and home birth attendants to fundamental questions of social change. Thus, the increasing demand for home birth and the resurfacing of the midwife as a prominent figure is a dynamic situation which presents the opportunity to study cultural change in process rather than in retrospect.

The focus of this research is the cultural change (particularly the changing values of women) encompassed in the home birth controversy. This change will be examined utilizing Robert K. Merton's "Paradigm for Functional Analysis" (1968: 104-108). No attempt was made to test Merton's theory of social structure. Rather, the paradigm was used as

an organizational tool for disclosing the functions of elected home birth in America today.

Mertonian functional analysis, stressing the interdependence of elements, is rooted in the logic of biochemical experimentation.

Generally stated, the premise of the biological approach is:

1) Various functional requirements vital to an organism's survival of operation are established; 2) Detailed descriptions are made of the structures and processes through which these requirements are typically met; 3) If mechanisms are destroyed or found to be functioning inadequately, the observer endeavors to detect compensating mechanisms, if any, for meeting the requirements; 4) a detailed account is made of the structure for which the functional requirements hold as well as an account of the arrangements through which the function is fulfilled. (Merton 1968: 103).

Merton (1968: 79) points out that anthropological and sociological attempts to view cultural phenomena as functioning, interrelated units contributing to the maintenance of structural continuity, are fraught with three restrictive and inaccurate assumptions. First, standardized cultural activities or items are functional for the entire social system. Second, all social items fulfill cultural functions. And third, these items, structures, or activities are indispensible. According to Merton (1968: 82), these false assumptions result, in part, from studies of highly integrated aboriginal populations,

but one pays an excessive intellectual penalty for moving this possibly useful assumption from the realm of small non-literate societies to the realm of large, complex and highly differentiated literate societies.

Alternately, Merton believes that a culture's functional needs are permissive, rather than determinant, of specific social structures. A

range of variations in the structures which fulfill the particular function is allowed, within the limits of structural constraints. Merton introduces the concept of functional alternatives, equivalents, or substitutes which he feels are vital in understanding cultural interdependence as a process rather than a static situation (Merton 1968: 88).

Within Merton's paradigm, childbirth is an observable, vital, and universal cultural function. In America the dominant way of fulfilling this function is by giving birth in a hospital, surrounded by technology and highly trained medical practitioners. The value (or validity) of giving birth within the medical structure varies considerably among women expected to utilize it. The range of this variation will be examined demonstrating that for some women bureaucratic hospital delivery is stressful and has, in fact, become dysfunctional (or maladaptive) due to their prevailing values and attitudes.

Home birth and lay midwifery are examined as emergent functional alternatives. The manifest function (or intended consequences) of home birth is the safe delivery of the child within a meaningful and satisfying setting. The latent function (or unintended consequences) is that the values which predispose women toward home birth (questioning the medical model of birth) bear threatening affects on the authority and dominance of the medical profession.

The medical profession's active resistance to this threat is viewed as the structural constraint within which home birth, as a

functional alternative, must operate. However, interdependence of structures (e.g., medical, political) and cultural elements are not seen as a static condition. Rather, interdependence is merely seen as limiting the overall framework within which effective possibilities must function. In the broader sphere, the social implications of changing the preferred place of labor and delivery will be assessed.

As mentioned, the changing values of women and the criteria employed in selecting a satisfying birth experience are regarded as the stimulus for changing the preferred place or type of delivery. Therefore, a comparative survey questionnaire was designed to determine the social/psychological, medical, experiential, and financial factors involved in selecting home birth over conventional hospital delivery. Additionally, the survey was designed to generate biographical data which would answer the question: How do women who choose home birth differ from women who choose hospital birth?

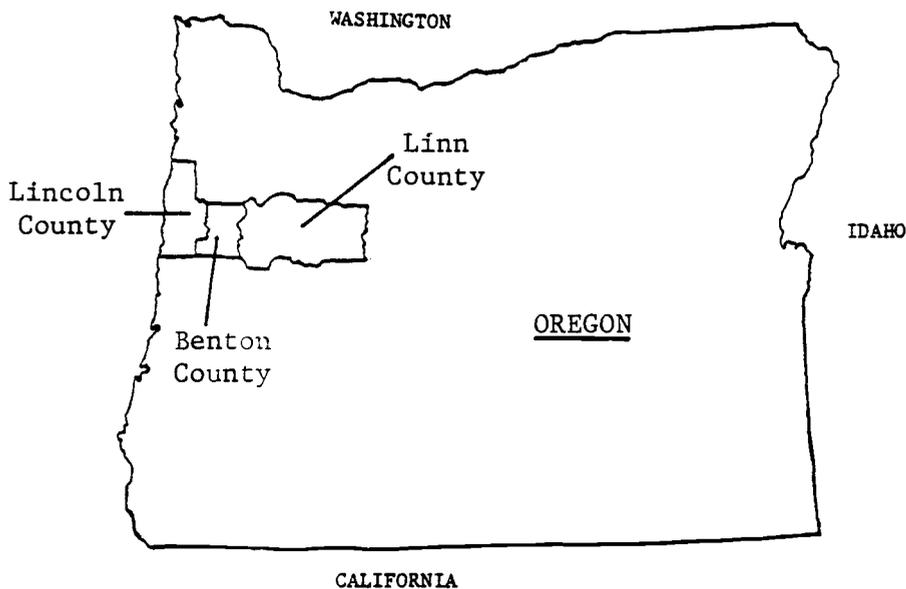
Oregon as the place of study was advantageous because lay midwifery is not illegal, and home birth is practiced at a relatively high rate (4 percent statewide) west of the Cascades. Furthermore, Benton County was considered a valuable area on which to focus for several reasons.

Benton County enjoys a reputation for maintaining excellent obstetrical services. Good Samaritan Hospital of Corvallis (in Benton County) is viewed by many as "progressive" in its outlook and superior in its medical standards. Testimony to this is given by the many women who journey 40 miles from the coastal towns of Lincoln County to give

birth at Good Samaritan, in spite of the fact that there is a hospital in nearby Toledo and in Newport. In Linn County, there is also a hospital which is apparently viewed as a less desirable place to give birth by those who choose to drive 12 miles to Corvallis.

An analagous situation existed for women considering home birth when a well trained, experienced midwife arrived in Corvallis. Educated in a Midwifery Training College in Kumasi, Ghana, she came to the United states having attended 3000 deliveries, including 50 sets of twins. Her reputation became quickly established among childbirth educators, women, and couples desiring home delivery (Redditt-Lyon: 1982).

Figure 1. Location of the study area.



Originally, the plan was to limit the study to one county, facilitating collaboration of the results with state vital statistics

which are collected on a county basis. Upon examination of birth records at the Benton County Health Department, however, it became apparent that the records are compiled by county of birth rather than by county of residence. Owing to the large influx of women from adjacent counties, the study's population was expanded to the boundaries of Linn, Lincoln, and Benton counties which accounted for the majority of births recorded. Thus, the sampling population was women who had recently utilized the obstetrical services offered in Benton County (either the midwife or hospital described above) and who resided in either Linn, Lincoln, or Benton County.

Preparatory field work began with informal interviews conducted with lay midwives, childbirth educators, licensed attendants, and women who had delivered at home as well as those who were opposed to home birth. On the basis of these interviews, a list of criteria was drawn up reflecting factors mentioned as important by both home and hospital birth women. Other factors were added to test the hypotheses that 1) social and psychological factors are most important to enjoyment and satisfaction during normal, uncomplicated deliveries; 2) women choose home birth to control the social and psychological setting of labor and delivery; 3) women who choose home birth are more likely to rate social and psychological factors as important than are women who choose hospital birth.

This research fits broadly into a proposed course of study outlined by Brigitte Jordan. In her book Birth in Four Cultures (1980), Jordan

argues that the studies required to generate and evaluate alternative sets of birthing practices must be system oriented, taking into account the internal logical consistency and mutual dependency of local obstetric practices, cross cultural, "so that we can overcome the restrictive, unexamined assumptions of our ethnocentric medical model", and they should be biosocial, addressing the interface between the panhuman biological function of parturition and the culture-specific production of the event (Jordan 1980: 89).

I have endeavored to utilize the above framework in conjunction with Merton's functional paradigm as a general approach to the home birth problem addressed in this study. Preparing an accurate picture of the home birth demand in western Oregon, the participants involved, and the important issues was the main objective of the research. It is hoped that this will provide useful information to a variety of professionals currently practicing in and legislating childbirth. Thus, the work may contribute in some small way to an understanding of the social restructuring underway to reincorporate home birth and the midwife's role into American culture.

Referring to the restructuring of the medical profession, several authors (Illich: 1967, Rivkin: 1981, and Conrad and Kern: 1981) have described American health care as in a state of crisis. Many elements of this crisis relate to childbirth specifically. Increasing specialization and the decline of solo practice have resulted in impersonal care which lacks continuity for many people. Medical costs,

rising exponentially, have become a factor in the decision to seek medical care. In fact, medical costs have become the leading cause of personal bankruptcy in the U.S. (Conrad and Kern 1981: 3). Although the United States maintains some of the most sophisticated medical technology, it stands behind at least a dozen other countries in life expectancy (the number of years a person can be expected to live) and infant mortality (infant deaths within the first year of life).

Perhaps the element of the health care crisis most pertinent to childbirth is what has been called the "medicalization" of society. This refers to the expansion of medicine's domain; redefining many social problems (e.g., drug addiction, child abuse) and normal life process (e.g., birth, death, sexuality) as medical problems per se (Conrad and Kern 1981: 5). In this regard, home birth may be seen as one step toward the demedicalization of society so that while home birth participants may or may not be aware of the current health care crisis, their behaviors and attitudes cannot be divorced from it and may have far reaching implications.

The thesis is arranged in four major sections. Part I contains a cross-cultural comparison of childbirth. Recognizing that the ethnographic record is generally limited in such information, childbirth customs in four selected cultures are examined. Part II includes an historical overview of the westernization of childbirth, an analysis of the political and legal environment of the home birth trend, and an outline of the current situation in Oregon. In Part III, the focus is

narrowed to the tri-county area of western Oregon where a comparative survey was conducted among women who had recently given birth. Sampling and distribution procedures and the results of the survey are discussed at length. Part IV summarizes the research findings and the implications the results bear on the delivery of maternity services congruent with the wishes and expectations of women today.

CHAPTER II

CROSS-CULTURAL COMPARISON OF CHILDBIRTH

The physiological processes of childbirth are the result of on-going genetic selective forces which operate, in part, to balance female pelvis size and optimal birth size and weight for infants. It has been theorized that the human infant is born more immature than other animals (and thus has a longer period of dependency) to compensate for the infant's large brain size and a substantial layer of subcutaneous fat (McElroy and Townsend 1979: 83).

The average neonate is between six and eight pounds with a head size that strains the dimensions of the birth canal. Although the time required for labor is variable, all births (especially first births) are characterized by tremendous stretching and contracting of musculature in order to expel the comparatively large baby (Wood 1979: 141).

Childbirth is not purely a physiological act, and contrary to some popular theories, it has never been simply "natural". The image of a tribal woman taking but a moment from her work to deliver a child in the garden is largely a myth.¹ Ethnographic studies and archaeological skeletal data support the claim that many primitive women anticipated childbirth with fear, that deliveries were commonly prolonged and painful, and that the threat of death for mother or child was always present (Wood 1979: 125-126). Poor nutrition, parasitic infections, prevalence of acute diseases, and lack of ability to control reproduction all added elements of risk to childbearing.

A thorough study of birth in nonwestern cultures is beyond the scope of this research. The following comparative data were selected to demonstrate that birth, like all fundamentally physical processes, occurs within the larger context of a culture's beliefs and practices.

American culture is no exception. America's scientific orientation has greatly contributed to the technological developments which accompany the majority of births in the United States today. It will be demonstrated that elected home birth in America is neither a rejection of science per se nor a return to "primitive" childbirth customs. For example, in contrast to many of the following cultures, exclusion of the father from the place of delivery, depriving the newborn of colostrum, and a supernatural explanation for complications are not characteristics of contemporary home birth practices.²

Unfortunately, ethnographic studies are seriously deficient when it comes to providing details on gynecological and obstetrical practices. Women have generally been reluctant to talk about such intimate subjects with male anthropologists, let alone have them witness a birth. L.S.B. Leakey (1930: 186) encountered this problem when attempting to record birth customs among the Masai of Africa. Midwives carefully guarded their instrument for cutting the umbilical cord from Leakey's view, and although he guessed it was an obsidian or bone knife with considerable supernatural power, he was never able to ascertain its symbolic meaning. Nearly two-thirds of the cultures

included in the Human Relations Area Files contain no description of normal childbirth practices (Jordan 1980: 5).

Kitzinger (1980: 83) points out that male anthropologists have written extensively about disposal of the placenta:

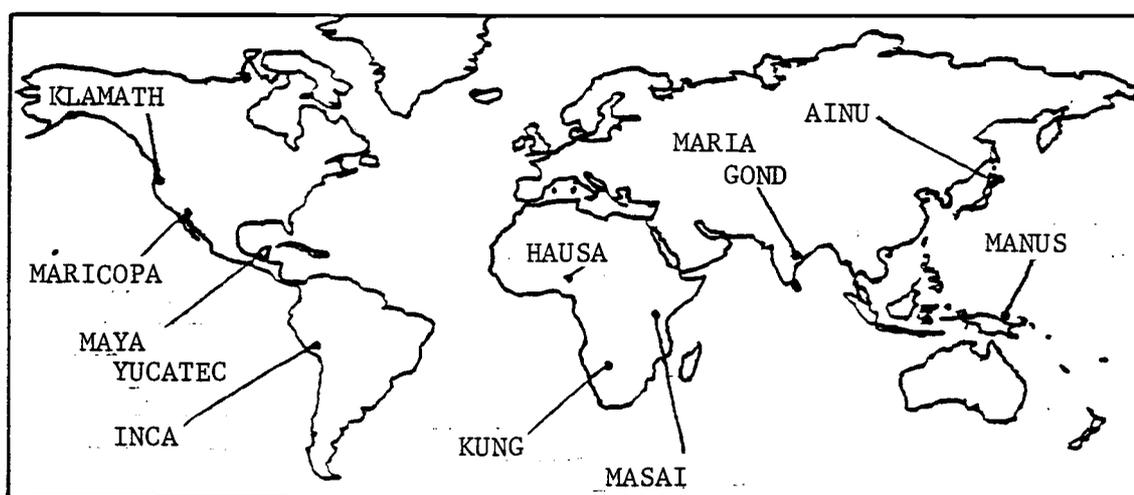
One suspects that male anthropologists, not allowed to witness the birth, wait outside the birth hut for the moment when someone emerges bearing the placenta and he can at last make some useful additions to his notes.

Being a female anthropologist, however, in no way guarantees access to childbirth information. Some cultures have very strict rules pertaining to who may be present or involved in the birth process. Margaret Mead, a pioneer in studies about childbearing, was excluded from Manus births in 1928 because she had not yet borne a child herself. When she returned to New Guinea in 1953 having fulfilled this criterion, it was no longer a requirement. She was allowed to witness a birth, and since her account is one of the few based on first hand observation, it is included here.

Although there is increased recognition of the need for research concerned with the intricacies of childbirth and some women anthropologists are pursuing this, many cultures have long since perished and so the information along with it. The following accounts should be read bearing in mind the limitations faced by the authors. Synthesizing all information from the "ethnographic present" sometimes necessitates the use of data that are actually separated by many years. Some researchers have relied on one informant while others received conflicting

information from many sources. The following accounts demonstrate that all cultures allow for a certain amount of individualization where birth practices are concerned.

Figure 2. Location of cultures discussed in comparative childbirth chapter.



The Manus of New Guinea

The Manus occupy the Admiralty Islands, north of New Guinea, living in vaulted, thatched houses set on stilts over calm lagoons. The marine environment is exploited for a variety of sea foods, especially fish. Taro, yams, and sago are cultivated. Coconuts and betel nuts are collected and traded. The culture, largely egalitarian, is held together by intricate bonds of kinship. Villages are politically autonomous, although united through mutual economic

dependence maintained by an extensive system of trade throughout the Admiralty Islands. Margaret Mead studied the Manus extensively, once in 1928 and then again in 1953.

As mentioned previously, when Mead first inquired about birth customs she was informed that only women who had borne children were allowed to be present at the delivery. However, when she returned in 1953, men and even children were present at births.

Among the Manus, the pregnant woman is subjected to a few taboos, but she must not cut fish or wood with a knife or axe for fear she will cut off one of the limbs of the child (Mead 1930: 320).

Food feasts are common for rites-of-passage, birth being no exception. An important male relative arranges the food feasts which require the distribution of many coconuts to villagers before and after the birth. A "brother" (one of the woman's male relatives) divines the proper place of delivery as the date approaches. This determines whether the husband will move out of his home for the birth and let his brother-in-law and wife move in, or whether the pregnant woman will go to her brother's house (Mead 1930: 322).³

At the onset of labor, the parents shake hands to symbolize that there are no ill feelings between them--for it is feared that anger will interfere with the normal birth process (Mead 1930: 325).

The mother is placed on a small, log-framed square on the floor with woven mats under her. Mats are also hung to screen her from the rest of the house. A fire is made beside her, and her personal cooking

vessels, in which only her food can be cooked, are placed beside her (Mead 1930: 322).

Three women assist the laboring woman. An extra post or board is arranged on the wall so she will have something to push against with her feet. One woman sits on each side of her and one behind. The pregnant woman hooks one leg over the midwife beside her and presses the other leg against the wall board. The three women support her and relax with her between contraction pains. From time to time, the midwife may have the woman change positions (sides), even up to 20 or 30 times during labor. The three women back her emotionally as well as physically. At the moment of birth, the helpers sit forming a hollow square with their bodies into which the child (whose mother's body completes the square) is born. A woman may also squat and support herself by a bamboo rope suspended from the ceiling at the moment of delivery. The infant is held facing the mother, cord uncut (Mead 1956: 344).

After the child is born, the mother is encouraged to bear down and expel the placenta while an attendant holds the infant and sings a "lullaby" in time with its wail. As the child's cry increases, so the midwives' voices rise into a "crescendo" (Mead 1956: 345). Once the afterbirth is delivered, the umbilical cord is cut. The cord, considered to be a lucky object, is cut into small pieces. One piece is wrapped with the placenta (considered to be an unlucky object) for disposal. The rest are preserved for good luck, and some may be smoked (Mead 1930: 322).

Immediately after the delivery, there is a flurry of visiting as the child is bathed in sea water and tended to by the older women of both the father's and mother's kin. The mother is given a hot mixture of coconut milk and taro. Heat is applied to her abdomen. The infant is settled into a bed made from an old grass skirt. Whenever it cries, there is a "lullaby" echoing its cry.

The new baby is not fed until it "cries for food" which can be several hours after birth (Mead 1956: 345). In 1928, Mead was told by her informant that the child is not fed until 20-24 hours after birth, and then it is fed by other nursing mothers. The mother herself will not nurse the child for 2-4 days. If the mother is ill and/or other women nurse it for a long period of time, the mother is expected to return milk to the wet nurses' child when she is able (Mead 1930: 323). An infant is also given a bit of taro chewed fine by its mother from time to time.

When a delivery is difficult, the husband is now constrained to be present although he usually keeps his distance. The older women at the birth instruct the couple to confess any anger they might hold against each other. On and on the women's voices probe for events which may have caused resentment or anger, pausing when the woman has a contraction. If a child is born dead or malformed, the couple is similarly pressured to confess ill feelings so as to insure the safety of future children and the parents themselves (Mead 1930: 325-326).

The father is not permitted to be in the same house nor to have sex with his wife for a period of one month following the birth (Mead 1930: 321).

The Ainu of Japan

The Ainu were one of the aboriginal peoples occupying Japan. Early explorers and missionaries often noted their "hairiness" and the facial tatoos of Ainu women. When they were studied in the early 1900's, the Ainu lived in the southern half of Saghalien and Hokkaido Islands although they once inhabited the whole of Japan.

Ainu villages are permanent settlements located along rivers known to be spawning grounds of dog salmon. Fish are plentiful; turtles and fish eggs are also exploited. Small game, when available, is hunted. The islands produce an abundance of berries and grapes which are collected along with other wild vegetal foods. Millet is a staple.

Among the Ainu, the willow tree is of great importance, for it is believed that the backbone of original man was formed from it. It is often used for making fetishes, among them the willow fetish when a child is born (Batchelor 1971: 183).

The fire hearth is also important because Kamui Fuchi, the Supreme Ancestress, resides in and never leaves the fire. When, as in child-birth, there is an impurity in the house, a second fire is built at the lower end of the hearth, and a substitute for Kamui Fuchi takes charge there.

A pregnant Ainu woman is told to move around frequently so that the fetus will remain small and the birth will proceed quickly without excess pain. The closer the moment of delivery, the more exercise the woman is advised to take. If she sits around too much during her pregnancy, the fetus becomes large and the mother suffers a prolonged birth (Pilsudski 1910: 763).

The birth of the first child takes place in the mother's natal home. Subsequent births take place in her husband's home. It is desirable, though not vital, to have her matrikin (mother's mother and mother's sister) serve as midwives. Several women may assist at the birth including the father's female relatives (Sugiura and Befu: 1962). An "experienced woman", usually the mother or an aunt, stands beside the woman in labor and does not leave her from the moment of the first labor contractions (Pilsudski 1910: 764).

During labor the woman remains by the fire. Children, and sometimes all the men, are asked to leave, for it is believed that a large number of spectators will increase the woman's pain. Quiet is desirable. The husband may take the place of the midwife if she does not arrive on time or if the labor is long. Otherwise, he and other men may help the woman by placing a stick carving in the fire when she moans. This is believed to alleviate pain. If this doesn't help, then another sacrifice is made to the deity Kamui Fuchi by the elders of the house who whisper a soft prayer (improvised for the occasion) as the carving is consumed by the flames (Pilsudski 1910: 765).

The midwife is expected to control her feelings, alleviate the woman's physical pain, and offer emotional support. If it is a first birth, the midwife tells the woman to be patient and reminds her that soon she will have a child to help her with her work (Pilsudski 1910: 765).

The spot where the woman is to give birth is covered with twigs of fir and pine. The woman lies on either her right or left side with a belt clasped lightly around her abdomen (Pilsudski 1910: 763). To speed up the birth and lessen pains, the attendants massage the woman. The midwife moistens a piece of marine plant (laminaria), warms it until it is slimy, and then rubs the woman's back, chest, and abdomen. She prays to the spirits of deceased ancestors (who are generally considered to be protectors) to help the laboring woman (Pilsudski 1910: 767).

The umbilical cord is tied with a string of plant fiber and then cut with an obsidian knife (Landor 1893: 267). The wound is sprinkled with a powder obtained by rubbing river shells together and bandaged with a piece of cloth (Pilsudski 1910: 767).

To speed up delivery of the placenta, a narrow strip of silk is wound around the abdomen. If the delivery is delayed, the woman will put her finger down her throat to induce vomiting which is usually successful in separating the placenta. It is then wrapped in a mat with all other excretions and placed outside, away from the house (Pilsudski 1910: 766).

The newborn is washed with warm, clear water on its first day of life. A boy is given a colder bath than a girl. As soon as the child is wrapped in diapers, it is nursed. Usually, another nursing woman feeds the newborn. If there is none available, the mother will nurse her child (Pilsudski 1910: 767). The head of the infant is massaged several times a day; otherwise, it may become misshapen.

To alleviate discomfort after the birth, massages are continued and warm stones wrapped in wood chips may be placed on the woman's abdomen. If she experience pain in her sacral region, heated sand bags are applied to the area (Pilsudski 1910: 766). According to Pilsudski (1910: 767), the Ainu have never heard of a vagina tearing during childbirth, and they do not know of any artificial means to help extract the child.

If a birth becomes difficult, there are several ways to aid the laboring woman. However, a labor is not considered "difficult" unless delivery has not taken place after the fifth day from the first pains. A midwife sensing problems wears two necklaces of twisted willow shavings. These are usually worn by women wearing them as bracelets when performing the ritual of "brushing away evil" from the sick. They are not usually worn by the woman in labor, but one is placed under her pillow (Munto and Seligman 1963: 37).

A dried bat wrapped in wood shavings or hairs from the belly of a dog are used for massaging the woman experiencing a difficult labor (Pilsudski 1910: 765). If these methods fail, Kamui Fuchi is summoned

and a sacred mortar and pestle are used to drive away evil spirits. The mortar is rhythmically beaten by the side of the woman and over her head and body. If this also fails to produce results then the spirit of the fresh water crab is summoned to save the mother's life by extracting the baby with it's large, hard claw, even if the infant must die. A last resort is to give the woman some of her husband's urine to drink or some diluted human excrement which an elder prepares. This makes her vomit and so ejects the evil spirit (Munto and Seligman 1963: 111).⁴

After the birth, a rite of removing the ashes from the hearth is performed to avoid contaminating the purity of the fire (Munto and Seligman 1963: 60).

On the first day after birth, the parents arrange a feast for all the neighbors who come quietly so as not to disturb the resting, new mother. Wild garlic, considered to be a favorite food of the kamui, is thrown into the fire. The new mother is served the best and most easily digested foods. She is given rice and fish but no berries. All food is served to her at a tepid temperature (Pilsudski 1910: 765-766).

Batchelor (1971: 189) states that for two days the woman is expected to "go gently" and eat nothing at all except thin millet gruel, and she may not even drink water until the second day.

Soon after the child is born, the father or grandfather goes to the bank of a river to pray and cut a green stick of willow. This is

whittled into a doll-shaped fetish and carefully placed in the sleeping area. It is treated reverently as the tutelary god of the new child (Batchelor 1971: 183).

The woman and her husband (who resides temporarily in another dwelling) are expected to rest for five to six days. It is believed that during this period, the father transmits the spirit and intellect to the child, for the mother has already given it its body. On the seventh day, the woman goes to a spring or river for a bath and, thus purified, gradually resumes her normal tasks. This private ceremony is called "moving back to the hearth" (Batchelor 1971: 190-192).

The parents abstain from sex for 30-40 days (Pilsudski 1910: 767).

It is uncommon for women to not have enough milk for their child. Landor (1893: 267) states that children were nursed for seven to eight months while Hitchcock (1891: 267) reports they were nursed until they were four to five years old. It is probable that infants were given supplemental foods at seven to eight months but were still nursed, sometimes along with older siblings, until they were four to five years old.

The Klamath of Southern Oregon, U.S.A.

Although the Klamath live near and exploit the resources of Klamath Lake and Marsh, they are primarily an inland riverine culture. They live in semi-permanent settlements of earthen (pit house) dwellings but build conical mat huts during the summer months.

Taken as a whole, the material culture of the Klamath is similar to Plateau types, although many social habits are the result of Northwest Coast contact. No formal social stratification exists, however, wealth and personal merits are markers of prestige (Minor et al. 1979: 102-117).

The Klamath subsistence is that of hunters and gatherers utilizing seasonally available food resources. In the spring and fall, fish runs are exploited by a variety of fishing methods. Small game, deer, and antelope are continually hunted. Waterfowl and their eggs are also eaten. In the late spring and summer, the Klamath move to flat meadows and various digging grounds to obtain vegetal products. Root crops such as camas, epos, and arrowroot are collected. Seeds (primarily wokus) and berries are also gathered. During the winter the Klamath rely on dried foods (Minor et al. 1979: 102-117).

Supernatural power in the form of vision quests, is deliberately sought by most members. A vision quest consists of isolation in the mountains, fasting, chanting, long distance running or other strenuous physical exertion, and swimming in cold rivers or special pools.

Birth among the Klamath must always take place outside the usual dwelling. A dome-shaped lodge is prepared for the event by the expectant woman's mother (Spier 1930: 55). The arrival of a first child holds special significance. At the time of delivery, it is believed there will be strong winds and thunder. This is also an appropriate time for the father to seek supernatural power in the mountains (Pearsall 1950: 340a).

A woman's first delivery is attended by four or five older women well known for their skill as midwives; thus, they are not necessarily her relatives. Men are excluded from the birth lodge (Spier 1930: 55).

A special bed of grass with a soft cover of coyote or raccoon skin or duck feathers is made to receive the infant. As labor progresses, the attendants press on the woman's abdomen and lift her repeatedly to hasten delivery. Otherwise, she may lie on her back on her bed of grass (Spier 1930: 55). No reference is given to her position during the actual delivery.

After the child is born, the umbilical cord is tied with the mother's hair and cut with an obsidian, bone, or cane blade. If anything besides the mother's hair is used to tie the cord, the child will continually cry (Spier 1930: 55). The naval is annointed with squirrel grease, and a round piece of rabbitskin may be used as a bandage. When the cord drops off, it is buried or sometimes kept and worn by the child for good luck (Pearsall 1950: 340).

Generally, the afterbirth is disposed of quickly by burial. If it is turned over, this will assure a child of the opposite sex for the next pregnancy. Occasionally, a woman throws the placenta away carelessly to prevent future pregnancies (Pearsall 1950: 340).

If labor becomes prolonged or difficult, a shaman may be called into the place of delivery to aid the woman. No medicines are given; rather, singing or coaxing the infant out is common. If a breech presentation is suspected, the woman is held suspended upside down prior to delivery (Voegelin 1942: 213).

The newborn infant is sponged off immediately with water, and the face and body are massaged and molded. The mother is seated in the birth lodge on a bed of hot stones covered with leaves. She remains on this warm blanket, covered, with her child beside her in seclusion for four to five days (Spier 1930: 55).

According to Pearsall (1950: 340), the infant is put to the breast a few hours after birth. The mother's nipples are squeezed and hair is worked in them to start the flow of milk. Thereafter, the child is nursed whenever it cries. But Voegelin's informants reported that the newborn is not allowed to nurse until a day after birth or sometimes longer, and that the child is never given colostrum. Instead, colostrum (called "water milk") is expressed into a small basket and poured onto a hot rock to make the "white milk" flow quickly (Voegelin 1942: 215). If the mother is unable to nurse, a wet nurse, usually a relative, is called in.

During her period of seclusion, the woman drinks warm water freely. Both she and her husband must use a drinking stick (Spier 1930: 55). Voegelin (1942: 213) reports that after delivery the woman is given sugar pine sugar.

Presents are brought to the newborn. A boy is given a tiny bow and arrows or perhaps a small quiver. A girl is given a tiny digging stick or basket. Later, these may be hung on the cradleboard (Pearsall 1950: 340).

The infant, padded with soft tule bark, remains in a cradleboard tightly secured for the first year of life. Otherwise, its body might not grow properly, or it might become humpbacked. Flattening of the forehead while the child is in the cradleboard is desirable. A stuffed buckskin sack is tied across the child's head and fastened to the cradleboard (Spier: 1930; Voegelin: 1942). The child is never left alone for more than a few minutes, and then only when it is sound asleep.

The Hausa of Northern Nigeria

Hausa culture is a blend of Moslem law and Hausa customs. Rural agriculturists living in northern Nigeria, their chief crops are millet and sorghum. Beans, maize, and manioc are also grown. Domestic animals such as goats, sheep, and chickens are the major sources of meat. Thick walled mud or brick houses with conical thatched roofs provide relief from the sun. Dwellings are grouped in compounds with the patrilocal extended family as the normal unit of residence.

In accordance with Moslem law, a limit of four wives is imposed; polygyny is widely practiced and marriage involves a bride price. Purdah (segregation of the sexes) is practiced and women are political minors. Divorce is easy and frequent.

During the seventh to ninth month of a woman's pregnancy, her husband collects extra wood which will be needed for a fire to warm her after delivery and during her period of bathing and purification (Smith 1954: 249).

The woman's mother or other kinswomen act as midwives at the birth. Occasionally a woman returns to her natal home for the birth, but generally it occurs at her own residence.

If a woman suspects labor is near, she may make a tea from leaves which are known for their laxative effect (Hassan and Shuaibu 1952: 59). As labor progresses, the woman lies on her bed and turns frequently from side to side. When she feels birth is eminent, she gets up and kneels over a shallow hollow which has been made in the dirt floor and gives birth in this position. If the baby does not emerge, she returns to her bed. In the case of prolonged labor, she may be given a laxative mixture of kalkashi leaves to eat, which are like okra but more oily (Smith 1954: 249).

Soon after delivery, the umbilical cord is cut in the middle and treated with warm sheanut oil until it heals and falls off. The placenta is immediately buried behind the hut and the place covered with a stone. When the cord falls off, it is buried in the same hole (Smith 1954: 126). Hassan and Shuaibu (1952: 59) report that after the umbilical cord falls off, it may be sewn into a leather pouch and hung around the child's neck. When the child shows signs of colic or stomach distress, this pouch is put into water in a small calabash. The child is given this water to drink which cures his ailment.

The newborn is washed by the acting midwife seven times with soap and water immediately after the birth. Antimony is put in his eyes (Smith 1954: 125). If it is a first birth, the mother covers her

head and eyes and ritually refuses to handle and nurse the child. Being very modest, she is embarrassed by the experience. Finally, the new mother's kinswomen implore her to behave sensibly, and she accepts her child (Smith 1954: 189).

After the delivery, the midwife washes the woman very thoroughly with soap and water, massages her abdomen and binds it with cloth. Oil is rubbed all over her body and she is given "warm" foods to eat. She drinks gruel mixed with honey and eats porridge prepared with hot spices (Smith 1954: 126).

She is washed morning and evening with hot water splashed on her body with leaves. Water is poured into her vagina "so it will heal". Only the outside of her body is washed after seven days. Ritual bathing with hot water may continue for up to five months (Smith 1954: 126).

The new mother lies on her bed and turns from side to side so that heat from the fire beneath it warms her. After seven days, she is "thoroughly warmed," the blood (lochia discharge) has stopped and her uterus has returned to its proper place (size). She no longer needs to wear a cloth bound around her abdomen. If she drinks plenty of hot water, eats spicy foods, and has a fire under her bed, she will heal properly (Smith 1954: 126).

The new mother puts antimony on her eyes. She is allowed to chew kola nuts and rub tobacco flowers on her teeth.

The infant drinks only water the first three days (for a boy) and four days (for a girl) of life. Then they are given the family mark (a

cut on the face performed by the barber) and their Muslim name. Children are breast fed for approximately two years during which time the mother is expected to abstain from sexual intercourse with her husband. If the child refuses to be weaned, the mother places bitter herbs on her nipple, which work quite effectively (Smith 1954: 189).

On the "naming day", the father's mother prepares a delicious meal for the occasion. The new mother is given meat stew and other rich foods. The midwife grinds up peppers (kimba) for her.

Rattray (1913: 186) states that the naming ceremony takes place on the seventh day after the birth. On that day a ram or chicken is killed for the festive meal. The woman is given the choicest food "till all the after birth has come away". The husband sets out kola nuts and they are distributed throughout the town.

The naming ceremony of the first child is more a rite-of-passage for the new mother than child. She has now fulfilled her feminine role successfully. Thus considered to be a "woman," she is well accepted into her husband's household. A woman who has just borne a child is complimented by her husband and given many gifts (Faulkingham 1971: 166).

Patterns of Childbirth

It can be seen that birth in most nonwestern societies does not simply occur "naturally," acknowledging that there are a few cultures where women are reported to give birth unassisted. The !Kung

(Kalahari Bushmen) of Africa reportedly go into the bush, remain quiet, and give birth unassisted and unceremoniously. An exception, however, is sometimes made for a woman delivering her first child: she may be attended by her mother. It may be significant that children among the !Kung can create a tremendous strain on the delicate balance of food resources and infanticide is widely practiced (cf., McElroy and Townsend 1979: 181). Thus, a sacred view of children and ceremonious birth customs would sharply contradict actual practices.

In the majority of cases, however, childbirth is a recognized event accompanied by varying degrees of ritual and elaboration.

The woman is often physically separated from society by screens, going to her natal residence, or constructing a special birth hut (cf., Jordan: 1980). The actual spot for delivery may be prepared by digging a hole, blessing the spot, or making a special mat onto which the child is delivered.

Generally, the woman is attended by her female relatives. Although ethnographies may mention midwives attending the birth, scrutiny is advised as most nonwestern cultures lack "professional" midwives. Rather, kinswomen become "acting midwives" when they attend a birth. Some women naturally will become proficient at midwifery skills and may be asked to assist, particularly at a first birth or when a delivery becomes difficult, but birthing practices and knowledge are not restricted to certain individuals. Thus, the "midwife" in nonwestern cultures knows the expectant mother intimately, is in a

position to give advice (on transgression of norms and taboos) if difficulties arise, and will keep the woman's secrets once confessed. In societies where a premium is placed on modesty and purdah is practiced, as among the Hausa, the woman will be more relaxed among her kinswomen.

Men are almost universally excluded from the immediate scene of delivery although their behavior is seen as having a definite and direct impact on the process. The husband is given specific tasks to carry out aimed at facilitating the delivery. The custom of couvade, where the father acts out the birth as though he were delivering the child, may be practiced. Many cultures call for the husband to be present if the delivery becomes complicated because both parents are considered responsible for the child, and either may be at fault for the unusual occurrence. Ill feelings between parents may be blamed for difficult deliveries as in the case of the Manus. In some cultures, women are instructed to confess extramarital affairs, or even name lovers taken before marriage, if the delivery is to be successful (Ford 1964: 62). In these cases, men are excluded and the woman is generally safe confiding in her most trusted attendants.

In extreme cases, a shaman may be called in for difficult deliveries. Deities may be summoned, evil spirits forced away, and the woman purged. Those present may resort to scaring or shaking the baby out, pushing forcefully on the abdomen, or making the woman vomit (Wood 1979: 150-151).

Surgical and mechanical methods of aiding delivery are unknown although the attendant may try to pull the infant out. It is interesting that among the Manus, when a woman dies in childbirth, the fetus is removed through a longitudinal cut made in the abdomen and buried alongside the mother (Mead: 1928). This technique was never performed prior to the woman's death in an attempt to save her. Surely it would have only prolonged her agony although it may have saved the child. This was not viewed as a desirable outcome by the Manus as some infants, whose mothers died in childbirth, were killed for fear the mother's ghost would return to reclaim her child.

Women give birth in a variety of positions. Most adopt a position such as sitting, squatting, or kneeling on all fours which utilizes the force of gravity. A recline position, common in American hospitals, is very rare. Ford states:

In primitive societies, an attendant generally supports the woman from behind and, in some instances, attempts to assist the delivery by wrapping her arms around the woman's waist and squeezing the fetus downward. The woman gains further support in some societies by pulling upon a rope which hangs from the ceiling or by grasping a stake which has been driven into the earth. The baby either falls upon a soft pad of some native material or into the hands of the attendant women (1964: 59).

Brigitte Jordan (1980) who has written extensively on childbirth in Yucatan, Mexico, reports that Mayan women give birth in native sleeping hammocks.

Both the placenta and the umbilical cord are considered powerful by most nonwestern societies. The Klamath believe that the placenta

may influence the sex of future offspring or, if carelessly treated, cause sterility. The most common method of disposal of the after-birth is burial. Ford (1964: 64) suggests that careful disposal of the afterbirth stems from health considerations, that a decaying placenta is likely to contain gas bacilli and provide a rich source of infection. It may be that the placenta is considered powerful because of its literal connection with the infant or because it is a mass of tissues and blood. The power attributed to blood will be addressed later.

A few societies studied by Ford (1964: 64) believe that the placenta, if carefully cooked and preserved, forms a powerful medicine and keep it for use in magical potions. "This is interesting," he states, "in view of the fact that placental tissue is now known to contain a large amount of sex hormones" (Ford 1964: 64).

While the placenta may be considered an unlucky object or a target for malevolent spirits, the umbilical cord (though largely ignored in western culture) is considered to have a variety of positive powers and is often kept for this purpose. The Manus and Klamath preserve the umbilical cord for good luck. The Hausa may give the cord to the child to wear around his neck and believe it has medicinal qualities for stomach distress. The Inca reportedly preserved a child's umbilical cord with great care and give it to the child to suck or chew whenever he felt ill. Another person's umbilical cord would not work (Garcilaso de la Vega 1871: 31). The Kiwai of New Guinea believe

that a boy's naval cord, preserved from infancy, provides a potent "love charm" which renders him irresistible to the partner of his choice (Ford 1964: 25).

Differential treatment of the sexes immediately after birth appears to be common. Among the Ainu, a boy may expect a colder bath than a girl. Klamath infants are given toy tools which reflect the appropriate division of labor in that culture. Among the Hausa, a boy is nursed one day earlier than a girl. In cultures where infanticide is practiced, the sex of a child may determine whether it lives or dies. If twins of the opposite sex are born, one or both may be killed. This is practiced among the Manus. Ford (1964: 71) believes it is an extension of the incest taboo:

Within the womb these two (opposite sex twins) have experienced much more intimate contact than is deemed permissible and they are therefore punished by death. In other societies, however, twins are considered a blessing and all possible attention is given to insure their welfare.

All infants are nursed for extended periods in preliterate cultures, but it is not known to what extent the custom of having wet nurses feed the child after birth prevails in other cultures. This practice, so evident among the few cultures studied here, deprives the newborn of beneficial colostrum, rich in nutrients and immunities. It may be that a wet nurse is used to permit the new mother to rest. A nursing woman requires extra calories for milk production and, often, the new mother in seclusion is subject to strict food taboos which may deprive her of necessary calories. Some Klamath women consciously refuse to give their newborn colostrum believing it is not "real" milk.

Eventually, the newborn is nursed by the mother and she may provide this nourishment until another sibling is born.

Seclusion of the mother and newborn for a prescribed number of days is nearly universal and is advantageous for many reasons. It promotes bonding and allows the woman having her first child to adjust to and accept her new role. A common belief is that the newborn is particularly vulnerable to evil spirits and thus is kept isolated. Chance of infection or contracting contagious diseases is minimized by seclusion. During the period before the umbilical cord drops off (sometime during the first week), the infant is extremely susceptible to infection through the umbilicus which provides a direct route to the blood stream (Ford 1964: 66).

Bathing, massaging, and in some cases purification of the mother occur during this period. Heat (either indirectly through fires or directly through hot drinks) and heat packs are viewed as beneficial. Natural sugars, such as honey among the Hausa or sugar pine sugar among the Klamath, may be given to the mother.

Besides providing rest and a certain amount of protection, isolation also provides a private place for the woman to heal and be while her lochia discharge is the greatest. Lochia discharge and blood associated with the birth and placenta may be one reason that birth is considered both powerful and polluting. Recognition of menstrual blood as dangerous ranges from sexual prohibitions to isolation in menstrual huts. A menstruating woman, it is believed by some, can ruin a man's physical

capabilities, poison foods, endanger crops if she touches the soil, or kill domestic herds if she comes in contact with them (Wood 1979: 114). McElroy (1979: 134) suggests that erecting a special hut for birth may improve sanitary conditions, but it may well be that the birth hut is an extension of the menstrual hut concept.

During a woman's seclusion for menstruation, she usually follows certain food taboos and must use a scratching and drinking stick. These prescriptions are often imposed on women who have just given birth. Purification rites are common after delivery or before the period of seclusion ends. The Ainu believe the act of birth constitutes such an impurity that a second fire must be built in the sacred fire hearth. The Maria and Maricopa actually give birth in the menstrual hut (Ford 1964: 55). Wood (1979: 113) reports that among the Gururumba it is believed that blood contamination extends to the child in utero. Consequently, bleeding for "purification" during male initiation rites is induced by cutting the boy's nostrils. Related to this subject, Kitzinger (1980: 190-191) has written:

In most societies woman is a paradox. She is dangerous, mysterious and an unclean thing but also, as a mother, the most revered. As a non-mother and erotic object she represents the forces of darkness, of animal nature which draws men away from the spiritual, a polluting agency which threatens to emasculate men's vital powers...As mothers, on the other hand, women are the fount of creation and love, embodiments of charity.

Childbirth in preliterate cultures may be as much a rite-of-passage for the mother as for the child. As demonstrated among the Hausa, the new mother is now fully considered a woman who has fulfilled

her feminine role. Festivities, feasts, or a naming ceremony may be given in the child's honor when the period of seclusion is over and mother and child are reincorporated into society.

Many societies delay according full status to the infant due to high neonatal death rates. Although all are breastfed, the chances of losing a baby before immunization occurs is high, and diseases such as malaria, infant diarrhea, and parasitic infestations also claim lives. Depriving a newborn of colostrum would only contribute to this. Dietary restrictions also appear to be counterselective. Wood (1979: 154-155) reports that infant mortality rates are as high as 50 percent among some cultures and cites Dunn (1968) who shows that life expectancy among hunters and gatherers is consistently lower for females than for males because of maternal deaths during childbirth, the stresses of multiple pregnancies and deliveries, and in some cultures, dietary disparities between males and females.

Summary

In this comparison it has been demonstrated that childbirth occurs within the larger context of cultural beliefs. Each society prescribes acceptable behavior during pregnancy, labor, delivery, and the post-partum period. Each society has its own definition of what constitutes a successful outcome. Sacricy of human life where the newborn is concerned is not a universally held value.

Birthing knowledge and experience is not limited to a specific elite although it is primarily the function of women.

Traditional medical practices are applied to the birth experience; for example, native herbs known for their laxative effect may be used to speed delivery. Native sources of natural sugar (honey, coconut milk, sugar pine sugar) may be given to the new mother to replenish her depleted energy stores.

Traditional religious and spiritual beliefs provide an explanation and course of action for unusual and complicated deliveries. Specialists are called in only when the birth deviates from the norm. These shamans and sorcerers are responsible for doing what they know best--driving away malevolent spirits--not obstetrical mastery. Producing the child and relieving the mother is still left to the attendants who may be forced to resort to desperate and painful practical action.

Since procreation is vital to a culture's survival, the pregnant woman's welfare is not only the concern of her immediate family but of the entire social group. A couple's status, particularly the woman's, is often measured by the number of offspring she produces. Happily then, a woman who has given birth to a healthy, wanted child is generally regarded with high esteem. The culture publicly reincorporates her and the infant by readjusting family ties and giving the child its rightful place among kin.

CHAPTER III

THE WESTERNIZATION OF CHILDBIRTH

Historical Perspectives

While conditions for the primitive woman were far from ideal, the "progress" of medieval western civilization did little to produce substantial improvements for the pregnant woman. In the urban areas of Europe, garbage and sewage were dumped in the streets, water supplies were often contaminated, and dense, inadequate housing contributed to an explicitly unhealthy environment. Rats, lice, fleas, and other insects spread infections and disease (Twaddle and Hessler 1977: 11).

Medical practices during the Middle Ages were dominated by Christian theology, which taught that sickness was the consequence of and punishment for sin. Hospitals were charitable organizations run by monks and nuns who offered spiritual services, salvation, and a place for the poor to either recover or die (Twaddle and Hessler 1977: 235, Conrad and Schneider 1981: 155).

Books and manuals for midwives, who were largely self taught, became wildly circulated during this period. Early drawings from these books show the fetus having the proportions of an adult and standing in a flasket-shaped uterus with no placenta (Radcliffe: 1967).

Difficult labor was attributed to a failure of the pubic bone to separate. In these cases, the midwife was instructed to reach into the womb and pull the infant out (Radcliffe: 1976). Otherwise, folk

medicine and spiritual intervention were utilized. A doctor, if present, waited in the adjoining room to tend the woman after delivery.

In keeping with the prevailing Christian explanations, malformed children were believed to be the result of the mother "entertaining" evil spirits. Also during this time, almost any woman could be accused of being a witch. Midwives were no exception. Kitzinger ,(1980: 100) describes a popular misconception:

It was the custom of medieval midwives to leave the nail of one finger...extra long, and to trim it till it was pointed, in order to rupture the bag of waters when necessary in labor. It is understandable that it might be with this weapon that the witch-midwife could be thought to kill the babies she delivered. (By thrusting it through the fontanelle into the brain.)

Between 1600 and 1700, conditions only worsened in the big cities and slums of Europe. Cross infections, transferred from patient to midwife to patient, were rampant. In the cities especially, syphilis was epidemic and midwives were warned not to deliver prostitutes. Nutrition was grossly inadequate, Calcium deficiency, known today as osteomalacia, was common (Radcliffe: 1967). This condition resulted in deformed pelvises which became worse with each pregnancy. Birth in these instances was dangerous, and craniotomies (crushing the skull of the fetus en utero) were the accepted way of delivering an infant through a contracted pelvis. In addition, crochet hooks and scissors were often employed to extract a dead fetus, often bearing tragic results for the mother as well (Radcliffe: 1967). It is hard to imagine how terribly painful and traumatic such a delivery must have

been. It is incomprehensible in light of the fact that they were done without anesthesia or antiseptics, and lacerations were not sutured. The development of forceps and the Cesarean section operation were a response to these conditions. In 1739, the first "successful" Cesarean section was performed on an English woman who had two inches between her pubis bone and sacrum. The mother died, but the child lived (Radcliffe: 1967).

In the late 1600's, Newton's Principia (1687) initiated application of quantitative reasoning to medical research, but by and large, medicine still lacked a substantial body of usable scientific knowledge (Twaddle and Hessler 1977: 11, Conrad and Schneider 1981: 157). In colonial America, medicine lagged behind European advancements. There were no medical schools until the 1800's and few physicians. Because of the vast frontier and sparse population, most medical care was "self-help" (Conrad and Schneider 1981: 156). Midwives and relatives routinely attended births out of necessity.

In the mid 1700's, hospitals began to emerge in the United States. In 1751 Benjamin Franklin argued for the creation of a privately financed public hospital to serve the poor in Philadelphia. He envisioned many benefits, including relocating diseased and dying people from the streets to a hospital. Franklin believed that serving a hospital instead of individual residences would realize financial savings as well (Twaddle and Hessler 1977: 236).

In the early years of the 19th century, several medical sects existed, including "regular" (meaning regularly educated), homeopathic, and botanical physicians. The medical practices of most doctors were "heroic," consisting of dramatic, violent, ineffective, and often dangerous treatments such as vomiting, blistering, bloodletting, and purging of the bowels (Conrad and Schneider 1981: 157).

These treatments were similarly applied by doctors attending women in labor. Some doctors bled women to unconsciousness to counter labor pains. Leeches were applied in localized regions to reduce back, abdominal, and vaginal pain (Wertz and Wertz 1981: 178). One unfortunate woman living in Boston in 1833 suffered a variety of such innovative treatments. Having experience convulsions before her expected due date, a doctor was alerted of her circumstances. Over a two day period she was bled intermittently, given a purgative, and given emetics to induce vomiting. Ice was applied to her head, and mustard plasters were placed on her feet. She lapsed into a coma and her cervix began to dilate. While she was unconscious, doctors gave her ergot to induce labor, applied ice and mustard plasters again, and repeated the emetic and purgative treatments. Six hours later she delivered a stillborn child. After two days she regained consciousness and recovered.

The doctors considered this a conservative treatment, even though they had removed two-fifths of her blood in a two day period, for they had not artificially dilated her womb or used instruments to expediate delivery.

(Wertz and Wertz 1981: 180)

Fortunately, during this time period the majority of women were not attended by doctors. A small percentage (perhaps 5 percent) gave birth in hospitals. These women were usually poor and unmarried--hospital records indicate a large number of instrumental deliveries and excessive experimentation at such births (Wertz and Wertz 1981: 180).

The public's general dissatisfaction with "heroic" medicine, competition between various medical sects, and the concern among "regular" physicians to professionalize, all contributed to the establishment of the American Medical Association (AMA) in 1847. The AMA, established by a group of "regular" physicians, set out to define and enforce medical standards and ethics (Conrad and Schneider 1981: 156-157). And so, "regular" physicians became effectively organized just prior to the fundamental historical developments which placed medicine on a scientific and exclusive basis.

It was the mid 1800's when Louis Pasteur linked bacteria with the theory of contagion and demonstrated that germs caused anthrax, chicken pox, and cholera. Twaddle and Hessler (1977: 11) have called germ theory "the most powerful single idea in the history of medicine," being responsible for:

1. A massive and effective assault on acute disease through immunization and treatment.
2. A refocusing of attention onto the disease process with an attendant loss of interest on the part of the medical profession in nonbiological aspects of illness.
3. A period of optimism in which it seemed possible to eradicate all illness from human populations, and
4. a fundamental reorganization of medical training resulting in the modern medical school.

Germ theory also led to the development of pharmacology and medications which "cured" a wide range of human ills. This further marked an important shift in medicine from a people-oriented to a disease-oriented profession (Twaddle and Hessler 1977: 12).

Throughout the late 1800's, most cities developed public health departments responsible for epidemic control and other public health measures (Twaddle and Hessler 1977: 13). Because these programs depended on medical expertise, the AMA had considerable input on their design. This increased the AMA's political power and established the validity of physician influence on public policy. This political power proved immensely useful to the AMA which eventually gained control of physician licensing, thereby creating a legally enforced monopoly of practice. Furthermore, the AMA became functionally autonomous, insulated from external evaluation (Conrad and Schneider 1981: 161-162).

While the American medical profession was evolving in the 1800's, many technological developments were occurring in Europe where increased dissection, knowledge of anatomy, and related scientific finds were applied to reproductive processes. Although introduced in 1848, suction traction was not widely used until nearly 100 years later. Different types of forceps were continually being developed (and closely guarded) until several years and many perforated uteruses later, forceps and their use were fairly standardized (Radcliffe: 1967). The use of antiseptics in the 1800's dramatically lessened the

spread of infection which had killed so many women in the postpartum period. Sulphuric ether inhalation was experimented with as an anesthesia. Later, chloric ether was used, which sometimes knocked out the doctors as well as the patients, but surely reduced pain. The use of anesthesia was controversial. Conservative doctors and clergy opposed it, feeling that pain in childbirth was "desirable and a manifestation of life forces" (Radcliffe: 1967). Opposition to the use of anesthesia came to an end in 1853 when Queen Victoria used ether to deliver her eighth child.

The above factors combined to make birth a medical event under the jurisdiction of physicians. The environment of urban Europe gave rise to conditions which altered birth from a normal physiological function to a complicated medical problem.

Two facts should be kept in mind, however, before examining the current conflict over childbirth in the United States. First, medical advances had made delivery, the postpartum period, and the neonate's life easier and safer. Second, in spite of these medical advances, the great majority of births still took place in the home. The technology was portable and doctors considered birth a family event. It was not until the 1940's that hospital births passed the 50 percent mark and by 1972, less than 2 percent of births in the United States were attended by midwives (NAPSAC Fall 1981: 8).

Some feminist scholars are quick to attribute the demise of home birth to male psychosexual needs, dominance by doctors, and/or the

medicalization of birth (Wertz and Wertz: 1981, Ruzek: 1978). This is an exaggeration, for until the late 1940's, most doctors carried their medical supplies into women's homes for delivery. Rather, a clear distinction must be made between "medicalization" and "hospitalization," for the decline of home birth more appropriately seems to coincide with the concept and rise of the modern hospital. Around the late 1940's and early 1950's several factors contributed to the hospitalization of birth.

Rapid technological advances produced cumbersome and expensive equipment which, though life-saving in some instances, could not be carried around the countryside. Hospitals became the center of medical care because they housed such technological equipment and supplies (Conrad and Schneider 1981: 163). Eventually, AMA standards, which stress the importance of sophisticated equipment, forced licensed physicians to be affiliated with a hospital.

Another important factor was specialization within the medical profession which resulted in fewer General Practice M.D.s and more OB/GYNs. Trained with a pathological view of birth, OB/GYNs became dependant on medical technology (Jordan: 1980, Corea: 1979, Conrad and Kern: 1981). In 1940, only 20 percent of American physicians were specialists. By 1969, 75 percent were full time specialists and only 20 percent were General Practice M.D.s (Conrad and Schneider 1981: 163).

Using a hospital for delivery allowed a physician to provide services to a larger number of patients which was particularly desirable given the population explosion and migration to the cities characteristic of the times. This arrangement is also clearly advantageous from an economic standpoint in a fee-for-service payment system which encourages the delivery of a large number of services to enhance physician income (Twaddle and Hessler 1977: 226).

Increased American mobility also resulted in fewer stable communities, breaking the networks of families supporting midwives (Wertz and Wertz 1981: 181). In comparison, midwifery remained an important part of medicine in the smaller countries of Europe. In summary, it might be correct to say that, in America, there has been a "hospitalization" of medicine in general. And, given the explosive rate of technological advances and the profit-motivated characteristics of health care institutions, it is doubtful that medicine will be dehospitalized in the near future. There is evidence, however, that many people are demanding that birth (and in fact, death) become dehospitalized--a point to be considered later.

The Home Birth Controversy in the United States

Review of American historical events has demonstrated the way in which the AMA became a powerful social institution. Power as defined by Merton (1968: 378) is the capacity of a group to enforce its collective decisions upon (a) its members, and (b) its social environ-

ment. Once hospital birth became established as "the" way of giving birth, elected home birth necessarily became dysfunctional, straining medical institutions at the structural level.

Home birth in this analysis is not, however, viewed as deviant (generally taken to mean criminal) behavior even though lay midwifery is outlawed in some states. Rather, home birth is considered nonconformist behavior. Merton (1968: 414-415) distinguishes between deviant and nonconformist behavior:

...the nonconformist does not, like the criminal, try to hide his departures from the prevailing norms of the group. Instead, he announces his dissent. The nonconformist challenges the legitimacy of the norms and expectations he rejects or at least challenges their applicability to certain situations; the criminal generally acknowledges their legitimacy. Thirdly, the nonconformist aims to change the norms of the group, to supplant what he takes to be morally illegitimate norms with norms having an alternative moral basis. Finally, the nonconformist is...assumed to depart from prevailing norms for wholly or largely disinterested purposes; the criminal is assumed to deviate from the norms in order to serve his own interests.

Nonconformist behavior activates mechanisms of social control, for public nonconformity can have manifest and latent functions of changing standards of conduct and values which have become dysfunctional for the group (Merton 1968: 415, 420). When mechanisms for controlling dysfunctions are operating effectively, these strains are kept within such bounds as to minimize change of the structure (Merton 1968: 176). These controls are called concessions, compromises, or cooptation in some political theory.

The legal and political position of women desiring home birth will now be examined bearing in mind Merton's query: How are observed dysfunctions contained within a particular structure, so that they do not produce instability? (Merton 1968: 107.)

To briefly reiterate, analysis of the historical and ecological conditions which gave rise to the current American health care system is crucial in understanding the home birth controversy, for if the conditions have changed but the response remains static, it renders itself dysfunctional.

Home birth advocates believe the conditions have changed and that hospital birth is not necessary for the majority of women. They believe that with proper nutrition, prenatal care, and a qualified attendant, home birth today is safe and satisfying in the course of a normal pregnancy. They know that approximately 90 percent of all births are normal and spontaneous and, that with nearly all complications that arise, transfer to the hospital is possible. Most believe that physicians are necessary for dealing with previously diagnosed high risk pregnancies (e.g., multiple births, toxemia and certain blood conditions) and complicated labors when they arise (Jordan: 1980, Hazell: 1978).

Not all physicians oppose home birth, and many feel that the risks would go down with active back-up services from the medical profession. The official position of the American College of Obstetricians and Gynecologists (ACOG), however, is against home birth (JAMA: 1980).

Many physicians who oppose home birth have managed unpredictable emergency situations, such as placenta previa, ruptured uterus, placenta abruption, and cord prolapse. While these complications are rare, they are unpredictable and life threatening, some requiring immediate Cesarean section. For these reasons, the majority of doctors feel the safest place for labor and delivery is the hospital.

Out-of-hospital deliveries can be divided into at least four categories: 1) accidental; 2) religious rejection of hospitalization; 3) poor and/or isolated women denied access to medical care; and 4) elected home birth. It is the latter we are concerned with here because legislation involving home birth is aimed at this growing trend.

Nationally, the legal position of home birth is ambiguous. Many states (including California, Idaho, Utah, North Carolina, Vermont, and Ohio) have made lay midwifery illegal per se. Approximately ten states allow lay midwives to legally practice. These include Arizona, Florida, Tennessee, Texas, and Washington. Some states (including Alabama, Arkansas, Colorado, Hawaii and South Carolina) have laws which permit midwifery but require midwives to register in some way. In many of these states, lay midwifery has been "administratively outlawed" by virtue of the fact that the State Health Departments refuse to register anyone who applies (NAPSAC: Fall 1981). In Alabama and Arkansas, this administrative action has occurred since 1979.

Doctors, Certified Nurse Midwives, and Registered Nurses could lose their licenses for participating in a home delivery in states where it is illegal. Lay midwives and other unlicensed attendants could be charged with a number of violations--including practicing medicine without a license and even murder in the case of tragedy. In some states, parents opting for home birth have been charged with child abuse.

Three home birth couples--in Louisiana, Idaho, and North Carolina --were accused of child abuse in 1978. In the North Carolina case, police, acting on an obstetrician's complaint, forcibly took the woman from her home while she was in labor and transported her to a hospital (Corea 1979: 50).

In 1978, the Marianne Doshi case brought the home birth controversy to national attention. A California lay midwife, Ms. Doshi, faced charges of second degree murder and practicing medicine without a license after the death of a baby whose birth she had attended. The parents opposed the suit. Testimony revealed that the baby's umbilical cord was knotted and that the child quite probably would have died had it been in a hospital (before preparations for a Cesarean section could have been made). A California Superior Court judge dismissed the charges against Doshi admonishing the medical profession to have enough "maturity" to accept different birthing practices (Corea 1979: 106).

In 1979 another California midwife was charged with second degree murder. Rosalie Tarpening administered mouth to mouth resuscitation on an apparently stillborn infant who did not "breathe" until they reached the hospital. Soon after arriving at the hospital the baby was pronounced dead and the doctor initiated charges against Tarpening. Evidence presented at the trial by a pathologist who later performed an autopsy on the baby revealed that the hospital had administered oxygen at a high level and had, in fact, blown the child's lungs out. Tarpening was acquitted of the charges but was later found guilty of practicing medicine without a license (NAPSAC: Fall 1981).

On June 20, 1980 a Grand Jury issued a felony indictment against Jo Ann Ruiz, a California lay midwife. That basis of the accusation (which carried the threat of a prison sentence) was that she had given nutritional counseling to a client, an act which constitutes "the practice of medicine" under California law. The charges were dropped in August 1980 after negotiations with the District Attorney and also after public opinion, including an article in the Sacramento Bee, expressed outrage at the charges (NAPSAC Fall 1981: 4-5).

It can be seen that home birth is a controversial situation affecting several segments of society. Many physicians, while making concessions on their own turf (e.g., homey birthing rooms), are acting quickly to invalidate home birth as a viable birth alternative.

Two questions are central to the legal status of home birth. First, who has the right to decide where a baby will be born? And

second, what constitutes a "qualified" attendant? Home birth advocates argue that the parents-to-be are responsible for the fetus and that it is their right, based on personal and social values, to decide the optimal balance between medical and psychological benefits for each child. Hospital birth advocates argue that since every birth has the potential to develop life threatening complications, the hospital is the appropriate place for labor and delivery. Dr. Edward Hon, developer of the Electric Fetal Heart Monitor, has commented, "The dangers are so great with home birth that one wonders whether a woman has the right to make that decision for an unborn baby...we do not have the right to expose our minor children to undue hazard" (Corea 1979: 106).

The conflict of state/private disputes is embodied in the fourteenth Amendment of the U.S. Constitution which states in part "...no state shall...deprive any person of life, liberty, or property without due process of law." National precedent exists indicating that the state has a legitimate interest in legislation concerning midwifery and home birth.

In terms of the unborn child, the parent's right is not absolute. As illustrated in the landmark abortion decision of Roe v. Wade (410 U.S. 113, 1973), the State's "important and legitimate interest in potential life" becomes "compelling" at the point of "viability". The Supreme Court stated in Roe, "This is so because the fetus then has the capability of meaningful life outside the mother's womb. State

regulation protective of fetal life after viability thus has both logical and biological justifications". Therefore, in a potential Supreme Court case involving home birth, parental responsibility for the infant presumably would not be absolute as the fetus is viable at the time of delivery.

In terms of the woman's rights as addressed in the Roe v. Wade decision, the State's interest in the health of the mother becomes "compelling" at the end of the first trimester when abortion becomes a more complicated procedure. The Supreme Court said, "A State may regulate [abortion] to the extent that the regulation reasonably relates to the preservation and protection of maternal health" [emphasis added].

The basis of the state's interest in maternal and fetal health is encompassed in "police power", a state authority which covers all health and other laws deemed necessary to preserve the "safety, health, peace, good order, and morals of the community." One case which illustrates the extent to which state police power may regulate an individual's life is Jacobson v. Massachusetts (25 S.Ct. 358, 1905). At issue was a Massachusetts law requiring compulsory smallpox vaccination in anticipation of an infectious outbreak. Jacobson contended that the law violated his "personal liberty" guaranteed by the fourteenth Amendment because it was

"unreasonbale, arbitrary, and oppressive and therefore hostile to the inherent right of every freeman to care for his own body and health...and that execution of such a law against one who objects...no matter for what reason, is nothing short of an assault upon his person."

The Supreme Court failed to agree with Jacobson and held that the statute as a health law was "enacted in a reasonable and proper exercise of the police power." Although the case is fairly old, the logic behind the decision (that vaccination was deemed necessary to "secure the general comfort, health and prosperity of the state") still applies.

Several points made by the Court while explaining their decision might apply to a home birth case as well. The Court said,

It is no part of the function of a court or jury to determine which one of two modes [of vaccination] was likely to be the most effective for the protection of the public against disease. That was for the legislative department to determine in the light of all the information it had or could obtain.

While conceding that some laymen and professionals did not believe that vaccination was a preventive measure, the court stated that vaccination "is accepted by the mass of the people, as well as by most members of the medical profession..." It further stated that:

A common belief, like common knowledge, does not require evidence to establish its existence, but may be acted upon without proof by the legislature and courts...for what the people believe is for the common welfare must be accepted as tending to promote the common welfare, whether it does in fact or not.

This logic, no matter how frightening, could easily be used to build a case against home birth today. In presenting evidence to the legislature, one would say that: 1) hospitals and clinics are commonly considered to be the safest place for labor and delivery since approximately 95 percent of all births occur there; 2) that high medical authority (the AMA and ACOG) support the use of hospitals and is opposed to home deliveries; and 3) that legislation against home birth is necessary to preserve the public health.

As demonstrated, the state does have a legitimate, if not compelling, interest in protecting fetal, neonatal, and maternal health. As long as state statute allowed for religious and accidental exceptions, it would probably be upheld.

The argument in favor of home birth would have to rely heavily on medical statistics challenging the assumption that hospital delivery is necessarily the safest. Besides the health advantages associated with home birth, psychological benefits (e.g., bonding) should be recognized and stressed. Testimony in favor of home birth should be presented by a variety of respected experts, particularly physicians, who attend home births.

The issue of safety is pivotal and one on which justification for many legal decisions are made. To date, studies of delivery outcomes and safety factors, riddled with methodological problems, have proven inconclusive. Statistics for home births are particularly hard to compile in states where home birth is illegal because many births are not registered. Recently, Dr. Lewis Mehl, director of research at the Center for Research on Birth and Human Development, has begun a project aimed at collecting data and statistics on 10,000 home births. Jordan (1980: 50-51) lists several studies indicating favorable (comparable with hospital) results for home births. A three year study (1973-1976) of home births and lay midwifery in North Carolina (which included among its authors a physician, a statistician, and U.S. government

representatives) supported the safety and viability of lay midwives in that state and encouraged the promotion of "non-physician birth attendants" (NAPSAC Fall 1981: 10).⁵

In fact, the hospital has never been proven to provide the safest environment for birth, and many studies are beginning to reveal that several factors, including physician intervention during labor, are the cause of serious complications (Corea: 1979, Jordan: 1980, NAPSAC: Fall 1981). In addition, these interventions, coupled with the real threat of malpractice suits, have resulted in a 15 to 20 percent Cesarean section rate and the eighteenth lowest perinatal death rate among nations. In contrast to the United States, the Dutch, who have a 55 percent home birth rate, offer socialized medical services so that every woman has access to prenatal care, routinely have Certified Nurse Midwives do hospital deliveries, and offer no financial incentive for surgery, have a 2.8 percent Cesarean section rate and have the third lowest perinatal death rate among nations. Latest figures indicate that Sweden has the lowest infant mortality rate, followed by Japan, and Holland (Jordan 1980: 94).

Health statistics aside, many advocates contend that home birth is strictly a civil-rights issue. Lay midwife Judith Luce has said, "It's a woman's civil right to give birth where she chooses to give birth. It's a family's right to maintain the privacy of family life" (Corea 1979: 105).

Returning to the second question; if home birth per se is not made illegal, then society must define what constitutes a legally "qualified" home birth attendant? If the medical profession finds itself fighting a losing battle over the place of delivery, it will turn its attentions to control over who may deliver the child. This has already been experienced in many states and is organized at the national level by the American Medical Association and the American College of Obstetricians and Gynecologists. In December of 1979, Donald Price, M.D., addressing a meeting of the Organization of State Medical Association Presidents, warned physicians about extending the scope of practice for nurses, nurse practitioners, and nurse midwives and urged them to oppose any proposed legislation which would do so (NAPSAC Fall 1981: 8).

In May 1980, Warren Pearse, M.D., Executive Director of the ACOG, speaking to a group of family practice M.D.s, described the growing trend toward midwifery as "worrisome" and "a serious problem" (NAPSAC 1981: 8).

The AMA has often spoken out against home birth and midwifery in the official Journal of the American Medical Association and during the annual meeting in June, 1981, "took steps to stifle competition to doctors" by voting "to seek elimination of federal funds for training of physician assistants, nurse practitioners and other mid-level practitioners", CNM's among them (Van: 1981).

Early in 1981 the California Medical Association (CMA) issued a written position on midwives which stated the following recommendations:

- PRIORITY I-
- A. Continue to oppose licensing of lay midwives and the use of home birth practices;
 - B. A multidisciplinary task force be created immediately to develop statistical and other material to support CMA's opposition to 1) lay midwifery as a category of licensed providers, and 2) home birthing; and prepare a comprehensive statement for use in legislative debates and for distribution to legislators and others.
 - C. Obtain an Attorney General's opinion on... Nurse Practice Act, and the specific use of standardized practice by nurses for the practice of midwifery; and, if necessary, seek means by which such practices can be terminated.

(NAPSAC Fall 1981: 8)

The issue of economic competition may be as significant as the safety question issue, practically speaking. Neil Foley, legislative advisor for the Massachusetts Medical Society (MMS), when discussing MMS opposition to a state bill allowing freestanding (independent) birthing clinics, stated, "You have to understand something about Boston and Massachusetts. We have 20,000 physicians and only 5 million people" (Foley: 1982). The bill passed and although the nurse practitioners running the clinic in question were not doing home deliveries, the MMS has drafted two bills it plans to introduce at the next legislative assembly. One would require nurses "practicing in the expanding role" to work with a physician, in a team, in a facility licensed for newborn and maternal care. The other bill would dictate the acceptable geographical proximity for freestanding clinics in relation to the nearest hospital.

As mentioned, home birth activists and lobbyists see obstetricians and their organizations as special-interest groups with economic and political motives for suppressing midwives. George Annas, associate professor of law and medicine at Boston University School of Medicine has said, "The number of children being born has gone down and so has the census in obstetrical beds in hospitals. It costs them money every time somebody has a baby at home. That, I think is the primary motivation behind the campaign against home birth" (Corea 1979: 106).

Declining demand for OB/GYNs has not resulted in rational planning of physician training. Illustrating the interdependence of teaching institutions and the medical profession, Charles Hendricks, M.D., and head of OB/GYN at North Carolina Medical Center has rather bluntly stated, "My job is to flood the State with Obstetricians" (NAPSAC Fall 1981: 10).

To illustrate the economic issue closer to home, using a low average figure of \$1,500.00 for an uncomplicated hospital delivery, the 1,679 out-of-hospital births in Oregon in 1980 cost hospitals and physicians over 2.5 million dollars in lost revenues.

Women, as consumers of birthing services, want qualified attendants. The results of this are two fold: 1) Women are asking Family Practice M.D.s, Certified Nurse Midwives, Chiropractic Doctors, Doctors of Osteopathy, and Naturopathic Doctors to attend their home deliveries. In Oregon in 1980, 62 percent of all home births were attended by licensed medical practitioners. The AMA actively opposes this and

pressures licensed practitioners to cease home deliveries. Many hospitals have policies of revoking obstetric privileges to staff members who participate in non-emergency home births (Corea: 1979, NAPSAC: Fall 1981); 2) Lay midwives are beginning to take steps to form licensing or certification boards. This can be very difficult considering it is necessary for lay midwives to be "underground" in states where they are illegal. Also, there are at least three formal national organizations for lay midwives, none of which has worked together to establish cohesive midwifery standards (NAPSAC Fall 1981: 16). Although some lay midwives oppose licensing, believing it is co-optation, it appears that, in the future, licensing or certification would give lay midwives more power and responsibility.

Summary

A historical overview of the so called "medicalization" of childbirth has been presented with the hope that people today, accustomed to a high standard of health, might understand these developments and appreciate the traumatic risks associated with childbearing for some women in the past. However, as indicated earlier, the medical advances which made even uncomplicated deliveries safer were portable and did not necessitate hospitalization.

Currently, the reemerging demand for home birth has created an upheaval among the medical profession. The AMA's and ACOG's official position is against home birth; C.N.M.s and R.N.s are divided on the

issue. Legally, there is no national precedent regarding midwifery and home birth, and state laws run the spectrum from making it illegal per se to tacit acceptance. The design of state laws can be influenced by a dominant state medical association, prominent members of the state legislature, District Attorneys, organizations representing midwives or home birth advocates, and the general "progressiveness" of a state's populace. With these factors in mind, the focus will be narrowed to the present situation in Oregon.

Alternatives in Oregon

A pregnant woman in Oregon has the whole spectrum of birthing alternatives legally available to her (see Figure 3). Private physicians work in hospitals, clinics, and birth centers; a few do home births. There are also home-oriented birth centers run by C.N.M.s. A variety of licensed practitioners including C.N.M.s, Doctors of Osteopathy, R.N.s, Chiropractic Doctors, and Naturopathic Doctors are available to attend home births. An intricate system of lay midwives also exists.

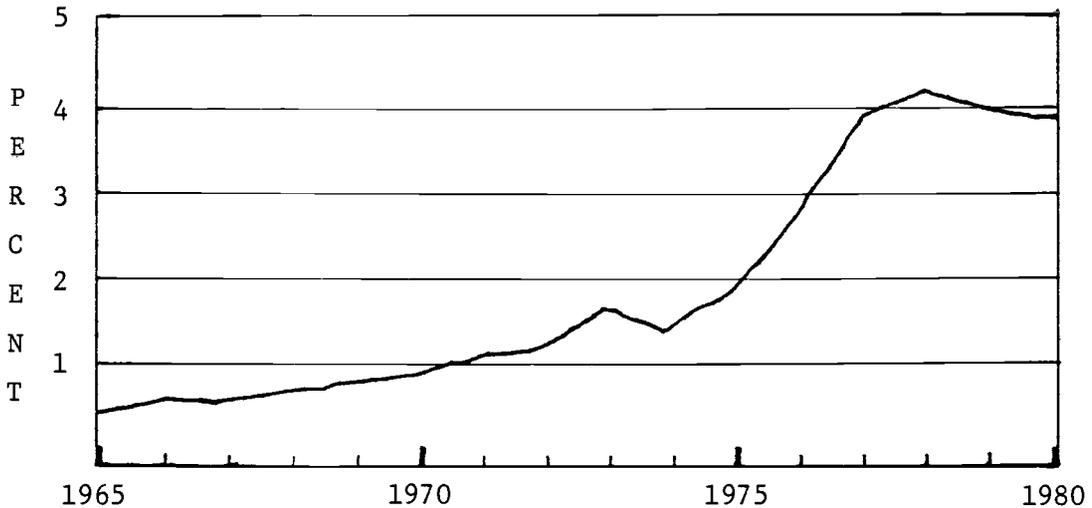
Legally, anyone can assist at a home delivery. The only restrictions placed on lay midwives and other unlicensed attendants are that they cannot administer prescription medications, perform and suture episiotomies, or repair tears of the perineum.

Figure 3. Births by county of occurrence and type of attendant, in the study area, 1980.

COUNTY	HOSPITAL TOTAL	M.D.	D.O.	C.N.M.	R.N.	N.D.	D.C.	LAY MIDWIFE	OTHER
Benton	1,361	1,273	15	71	2	--	--	--	--
Lincoln	237	210	17	--	9	--	--	--	1
Linn	1,180	979	87	91	22	--	--	--	1
<hr/>									
	HOME TOTAL								
Benton	52	4	--	1	--	10	--	31	6
Lincoln	34	5	--	1	1	4	4	11	8
Linn	56	9	--	19	3	--	1	15	9

At four percent, Oregon has a relatively high home birth rate compared to the national estimate of 1.5 percent. Vital Statistics of 1980 show that there were 1,679 out-of-hospital births statewide. Hospital births numbered 42,544.⁶ For the second year in a row, the proportion of births occurring out of hospitals declined slightly, although the actual number of these births has remained stable for the past three years (Oregon State Health Division 1980: 34). While the percentage of home births appears small, the significance becomes apparent when compared to the .05 to .06 percent found throughout the 1960's. Preliminary reports of 1981 Vital Statistics indicate a statewide increase in out-of-hospital births from four percent to 4.4 percent. The increase in the proportion of home births is illustrated in Figure 4.

Figure 4. Increase in the proportion of out-of-hospital births in Oregon, 1965-1980.



A preliminary report by Erma Dingley (1979) suggests that the majority of Oregon women choosing home birth follow the national characteristic of being well educated. In 1977, of mothers giving birth out of hospitals, 43 percent had attended college, 15 percent had graduated from college, and 5 percent had been to graduate school. This is particularly significant given that a portion of Oregon's home births occur in a very conservative community of Russian Old Believers, orthodox Christians who practice home birth based on religious conviction and who generally do not attend school past the secondary level.

Home birth women reside in the more metropolitan counties of Clackamas, Lane, Marion, Jackson, Multnomah, and Washington where hospitals are easily accessible in case of emergency. Statistics show

that most (though certainly not all) fall into the low risk category; some factors considered are age, prenatal care, and no prior obstetric problems or history of stillbirths. Dingley (1979: 247) reports that in 1977 less than 1 percent of Oregon births with licensed attendants (including out-of-hospital births) reported no prenatal care. Unlicensed attendants reported 19 percent of their births received no prenatal care. The religious communities and births with fathers attending accounted for the majority or "no prenatal care" cases. The "lay midwife" differed from other unlicensed attendants, with no cases without prenatal care and with 71 percent of their patients receiving first trimester care.

National concerns are, of course, reflected in Oregon's home birth situation. Dr. Peter Watson, chief of obstetrics and director of the Perinatal Center at Emanuel Hospital in Portland, reiterates the safety issue,

I sympathize with the objectives of home birth advocates, with the idea of making obstetric care more personal; to developing the care of making childbearing the ecstatic, positive experience it is. I can sympathize with enlarging the participation of the father and the siblings. What I am concerned about is the 5 percent of the births that have serious problems. That might not seem like very many, but when it's you, it's suddenly 100 percent.

(Hofferber 1980: C-1)

A Salem obstetrician, Dr. John Alsever, concurs:

If you don't have the emergency equipment and facilities right there and available, you run a much higher risk to the mother and baby. That risk doesn't have to be there. I don't believe a home birth in our area of the country right now is a safe thing to do--some of the problems that come out are ones that never should have happened.

(Reiner 1980: 1E)

Those who attend home births disagree with the premise that home birth is unsafe. Dr. Peter Bours, a family practice physician who attends both home and hospital deliveries has said,

I think what we have is ideal. A trained doctor and trained nurse who have hospital privileges. I take all the equipment to a home birth that I would have in the hospital. I feel we can do almost anything in a home or in the cabin we could in the hospital birthing room, except take X-rays.

(Hofferber 1980: C-1)

Another physician, Dr. Robert Kirchner of Albany, prefers hospital births but attends home births which approximately one-third of his obstetrical patients choose. He says,

I basically see myself as a patient advocate. What I'm trying to promote is safe, family-oriented deliveries in whatever setting the family can agree on. I probably spend the most time talking to patients about how hospitals have changed and how things are safer. But then, if they still want the birth at home, I go along.

(Reiner 1980: 1E)

Dr. Kirchner's comment that hospitals have changed is one quickly pointed out by advocates of hospital delivery. Still, many people remain skeptical, believing that hospital efforts are merely token responses to the pressures for change. Jordan (1980: 87) has commented that hospital birthing rooms, "in spite of a bit of interior decorating ...are no improvement...in regard to the territory issue. The woman still gives birth in an unfamiliar environment...Real decision-making power remains with medical personnel."

In July of 1979, the Oregon Legislature granted hospitals considerable latitude in obstetrical regulations by allowing individual

hospitals to set policies concerning the number of people allowed at a delivery, the necessary attire, and whether or not children can visit the mother. But Pat Schwiebert, perinatal education coordinator at the University of Oregon Health Sciences Center, has stated,

My biggest concern is that if the hospitals don't have the mind to change, they won't. The rules haven't changed; the Legislature has only allowed hospitals to change their rules. The hospitals also have to take the initiative to tell the parents that alternatives are available. I don't think the hospitals are looking at [alternatives] as carefully as they could. Some hospitals have written up changes, but the medical staffs haven't approved them.

(Hofferber 1980: C2)

No successful legal suits have been brought against home birth participants in Oregon. Benton County District Attorney Peter Sandrock has said that he is unaware of any Oregon cases involving home birth and that, in his opinion, it would not be in the public's interest to prosecute such a case unless gross negligence was involved (Sandrock: 1981). A Certified Nurse Midwife cannot be sued if she is acting within her profession's guidelines and has proper physician back up unless the parents refuse to go to the hospital when necessary or the CNM was negligent. Malpractice insurance for Certified Nurse Midwives costs only a fraction of what a physician is charged, due in large part to the lack of suits brought against them.

In Oregon there has been no real effort to make home birth illegal per se. However, Ida Laserson, C.N.M., has reported that a Portland doctor drafted a bill which would forbid anyone except a "licensed

medical practitioner" from doing home deliveries. This action was taken after the unfortunate home delivery of twins by a Portland area lay midwife. One of the babies died and the mother was hospitalized for severe hemorrhaging (Laserson: 1981).

The Oregon Medical Association supports, in essence, the AMA's official position on home birth. In their 1980 policy statements book, "Where We Stand" (OMA: 1980), the OMA states it "strongly supports family-oriented in-hospital births and encourages public education regarding birth alternatives." In April 1980, the OMA House of Delegates directed the Public Policy Committee to "investigate legislation concerning training, licensure and accreditation of all presently unlicensed and non-regulated birth attendants in Oregon" (OMA 1980: 37). In November 1980, however, the OMA voted to take no action on the above policy and adopted, instead, a more "comprehensive" approach to out-of-hospital births. This included the recommendation that:

The conference of Local Health Officials and the State Health Division conduct a statewide study of the causes and reasons for deliveries outside of hospitals. The OMA also encouraged the State to continue monitoring the incidence and complications of out-of-hospital births in relationship to maternal and newborn complications, through development of a telephone notification service, and support legislation requiring the reporting of all births, no matter what the circumstances.

(OMA 1980: 75)

At the same meeting, the House voted to support the media in the development of public education regarding safe birthing practices.

Another strategy of the OMA is that of putting pressure on the licensed attendants who do home births. During the 1981 Legislative

Assembly, Senator Kitzhaber, at the request of the Oregon Medical Association, sponsored SB410 (see Appendix A) which is aimed at curtailing the independence of nurse practitioners (Certified Nurse Midwives included).

According to Paula McNeil, director of the Oregon Nurses Association, the OMA has been debating for a year whether or not to repeal or amend a 1979 law granting nurse practitioners the right to prescribe medications (except experimental or narcotic drugs). The same law grants direct reimbursement to nurse practitioners by insurance companies. Ms. McNeil attributes legislation such as SB410 to a "patient shortage" (American Journal of Nursing 1981: 653).

Currently, nurse practitioners must meet criteria set by the Nurse Practitioner Prescription Advisory Council, an autonomous body whose decision is binding on nurses. Senate Bill 410 would strip the Council of its autonomy and make it advisory to the Board of Medical Examiners (BOME). The BOME would determine standards, control screening, and grant approval. One factor to be considered by the BOME, and mentioned in SB410, is whether or not the nurse practitioner operates in a geographically isolated area. If geographic isolation is conditional, its significance is revealed in light of the fact that home birth demand is highest in the metropolitan areas and, of course, the ability to prescribe medications would enhance the desirability of a nurse practitioner as an attendant. Most of the C.N.M.s working in Oregon reside in the Willamette Valley where the home birth rate reaches 8 percent in some counties.

The Oregon Medical Association feels so strongly about the bill they state it is necessary "for the preservation of public peace, health and safety" and declared "a state of emergency to exist" (see Sec. 10, SB410). The Senate apparently failed to concur in the urgency of the situation and tabled SB410 on May 3, 1981 for procedural rules.

Another vehicle used by the Oregon Medical Association to discourage licensed practitioners from doing home deliveries is denying them independent access to a hospital. Sacred Heart General Hospital of Eugene had such a policy until April of 1982. Certified Nurse Midwives with private home birth practices were allowed to use the facilities for delivery only in the event of an emergency and under the sponsorship of their back-up doctors. Certified Nurse Midwives who did all deliveries in the hospital, within a group of support physicians, were welcome to work there.

The statement behind Sacred Heart's policy was a clear disapproval of home birth and independent Certified Nurse Midwives. The justification given was that: 1) C.N.M.s who do home births are not fully employed by Sacred Heart and, therefore, the hospital is within its bounds to deny them full privileges; and 2) while not stating that C.N.M.s are not qualified to do deliveries, the hospital was opposed to C.N.M.s not working within a health care team (under the supervision of a physician). Independent C.N.M.s would, of course, comply with all hospital rules and retain physician back-up should a doctor be necessary (Laserson: 1981).

The question of whether or not this policy constitutes "restraint of trade" or an "unfair labor practice" is definitely one worth asking. Certified Nurse Midwives in Tennessee recently sued a hospital with similar policies for "restraint of trade" and the case, which as of April 1982 is unresolved, is being reviewed by a higher court.

The type of pressure exerted on Certified Nurse Midwives and others (including doctors) who do home deliveries is not new. An analogous situation is that of doctors who perform abortions and other services at Feminist Women's Health Centers (FWHC). In 1975, in Florida, the Tallahassee Memorial Hospital physicians were so successful at discouraging virtually all doctors and even residents from working at the FWHC that the clinic finally brought suit against six local physicians and a member of the Board of Medical Examiners. They were charged with conspiracy to restrain trade and create a monopoly in violation of the Sherman Anti-Trust Act. In 1976 a judge dismissed the suit with no explanation. The women have filed for a rehearing in federal court, a procedure which could take years (Ruzek: 1978).

In April of 1982, Sacred Heart General Hospital of Eugene, in what constituted a dramatic turn-around in policy, granted independent hospital privileges to the same Certified Nurse Midwives who had previously been denied full privileges. The C.N.M.s still attend home births but are now fully employed by Eugene Hospital and Clinic (which has no obstetrical floor). According to Ida Laserson (1982), one of the C.N.M.s, they were hired in part to directly compete with other

home birth attendants in Lane County, where the home birth rate is currently eight percent and increasing.

No matter what the reason, the acceptance of the C.N.M.s by the obstetricians at Eugene Hospital and Clinic, and the granting of independent hospital privileges is, to date, unprecedented. It is not, however, without its disadvantages in view of the fact that the obstetricians at Eugene Hospital and Clinic now have a policy of denying emergency back-up services to other home birth attendants.

Certified Nurse Midwives are currently in the professionalization process. Oregon C.N.M.s who do home deliveries are now eligible for direct reimbursement from certain insurance companies and welfare agencies. But, C.N.M.s are often divided among themselves as to whether home birth is appropriately their function. According to the bylaws of the American College of Nurse Midwives, it is strictly forbidden for a C.N.M. to practice without formal physician support. Thus, in states where physicians refuse back-up to C.N.M.s, they are forced to operate outside the law or to not operate at all. Policies like those of Eugene Hospital and Clinic, while appearing progressive, may in the long run weaken the effectiveness of midwives as a cohesive group and as advocates for their own independent profession.

Another form of professionalization currently affecting C.N.M.s is upgrading of training requirements. Recently the Oregon Health Sciences University School of Nursing received a three year grant from the federal Department of Human Services, Nursing Division to

assist the first masters level nurse-midwifery program in the Pacific Northwest. It was also announced that by 1986 the state of Oregon will require all newly licensed nurse midwives to have a masters degree (Oregonian: April 11, 1982).

Summary

It is clear that although Oregon women currently have virtually every option available to them legally (though not always practically), legislation to limit or restrict the scope of these options may be imminent. Midwifery statutes in Oregon, as throughout the United States, have not yet evolved to a stable point. The ill fate of SB410 may be a positive indication of the legislature's stand on the legitimacy of alternative medical providers. Policies such as those initiated by Eugene Hospital and Clinic and Sacred Heart General will make Oregon a testing ground for innovative arrangements.

If physicians supporting hospital affiliated C.N.M.s (no matter where the place of delivery) choose to deny back-up services to non-affiliated and/or non-licensed midwives, the policy will negatively affect the options available to prospective parents.

Although physicians and hospitals clearly have a vested economic interest in desiring that all deliveries be doctor attended (at least) and in a hospital (at best), generalizations about home birth should be made with the utmost caution. Not all physicians oppose home birth.

And, not all women insist on having a female attendant. The fact that in Oregon in 1979, 51 M.D.s delivered 285 infants at home births illustrates the point.

Having outlined the cultural, historical, legal, and political aspects of the home birth controversy, the focus will now be narrowed to the minority of women who choose home delivery--who they are, and how they are different from women who choose hospital delivery.

CHAPTER IV
THE CHILDBIRTH SURVEY

Design of the Instrument

To briefly reiterate the rationale for the survey, the changing values of women and the criteria employed in selecting a satisfying birth experience is viewed as the stimulus for changing the preferred place or type of delivery. The survey questionnaire was designed to test the hypotheses that: 1) social and psychological factors are most important to enjoyment and satisfaction during normal, uncomplicated deliveries; 2) women choose home birth to control the social and psychological setting of labor and delivery; 3) women who choose home birth are more likely to rate social and psychological factors as important than are women who choose hospital birth. These hypotheses were neither stated nor tested statistically. Rather, Chi-Square values were used descriptively, in conjunction with all data bases, for hypothesis testing.

The resulting survey was in three parts (see Appendix B). The first part contained descriptive questions pertaining to the characteristics of the pregnancy, labor, and delivery of the child. Type of attendant, number and relation of others present at the birth, and occurrence of complications, if any, were included. The second section was designed to ascertain important factors and values influencing the woman's decision about what type of delivery to have. The degree of

this influence was measured relatively by a modified Likert scaling of 28 factors which were ranked according to a range of Very Important, Important, Neither Important or Unimportant, Unimportant, Not Considered, and Does Not Apply. Satisfaction with the birth attendant and overall birth experience are also included. The third section covered more mundane items, such as insurance coverage and distance to the hospital, and finally ended with simple biographical data.

The ranked factors were designed to assess the predominance of several themes pertaining to American childbirth values. Likert scaling proved useful in evaluating the degree of support given these themes.

Several social/psychological factors related to the hypotheses were included, for example, participation of husband, family and friends. The importance of control was inferred from ratings of factors such as "closeness and contact allowed with newborn" and "fear of interference with the birth process." Factors reflecting attitudes toward the medical profession included "availability of sophisticated medical technology" and "having a licensed attendant." Experiential factors bearing on the woman's decision include "previous difficult delivery" and "previous unsatisfactory hospital experience". Financial factors, such as income, insurance coverage, and importance of delivery costs were included as were health considerations which might predispose a woman toward hospitalization, e.g., "pregnancy specific condition (ie. toxemia, multiple birth)". Figure 5 shows the categorization of ranked factors. Finally, satisfaction and dissatisfaction

were measured to better understand the pressure placed on the medical structure by discontented clients.

Figure 5. Categorization of ranked factors.

Social and Psychological Factors

Contact and closeness with newborn
 Husband's or partner's participation in
 labor and delivery
 Approval of decision by husband
 Relaxed prenatal visits
 Having the birth at your home
 Siblings and/or other family member's
 participation in labor and delivery
 If your attendant was a woman, how impor-
 tant was that?
 Prior good relationship with birth
 attendant
 Recommendation of birth attendant by a
 friend
 Friend's participation in labor and
 delivery
 Fear of interference with the birth
 process
 Approval of decision by parents
 Approval of decision by friends

Medical Factors

Availability of sophisticated medical
 technology
 Help of hospital nurses and staff
 Time to rest before returning home
 Possibility of unforeseen complications
 Having a licensed attendant
 Availability of pain controlling medica-
 tion
 Pregnancy specific condition (ie., toxemia,
 multiple birth)

Experiential Factors

Previous non-pregnancy related illness
 Prior overall good health
 Previous uncomplicated delivery
 Previous difficult delivery
 Previous satisfactory hospital experience,
 (maternity or otherwise)
 Previous unsatisfactory hospital experience,
 (maternity or otherwise)

Financial Factors

Relatively high financial cost of hospital
 delivery
 Relatively low cost of home delivery

The Survey Reserach Center of Oregon State University was consulted about the design of the questionnaire. They advised minor wording revisions of some questions to remove bias and suggested randomizing the list of 28 factors.

Sampling and Distribution Procedures

A pretest of the entire survey was conducted in October, 1981. Women who utilized the services of a home birth clinic run by C.N.M.s in Eugene (Lane County) participated. It was hoped these women would be in a unique position to gauge the "workability" of the survey questions since they had chosen licensed attendants, but home birth.

The pretest was administered in the same manner (mailed; cover letter; and return, stamped envelope) anticipated for the final study. The anonymous, tabulated, typed results were given to the C.N.M.s as requested by them. Thus, the pretest had proven mutually beneficial. The researcher was given the opportunity to "trouble-shoot" the questionnaire while giving the C.N.M.s an opportunity to evaluate their services and learn more about their patients.

In addition, five women who had hospital deliveries evaluated the rough draft of the survey, and their input was included in the final revisions.

The survey was ready for distribution November 1, 1981. Only women who had given birth within the year prior to distribution

(November 1, 1980-November 1, 1981) were considered so that the experience would be fresh and their memory at a premium.

The objective was to contact all home birth women, estimated from prior years and projections to number somewhere around 60, and an equal number of women who had chosen hospital birth. To obtain the hospital birth sample, a random starting place in the Benton County Health Department's alphabetized records was chosen and every 26th person was selected. If the woman had chosen home birth or requested that her name not be released for publication, the next 26th person was selected. This process continued until 70 hospital women were chosen.⁷

Next, the records were searched for all home births. Registered by address of occurrence, the records also include who delivered the child. All except two home birth women asked that their name not be released for publication, rendering the Health Department a useless source for obtaining the addresses of home birth women. This formidable problem necessitated an alternate sampling method.

Contact was made with the midwife herself who, once assured the surveys were confidential, agreed to release the names and addresses of her "patients". All but one were in the designated tri-county area, and she was excluded from the list. Thus, the addresses of forty-four women who had given birth at home in the selected time period were obtained--less than had been expected.

In this summer, a total of 114 women (70 hospital/44 home) were selected. The survey, a cover letter, and stamped, addressed return

envelopes were sent out November 5, 1981. An eight week period was allowed for their return. After three weeks, a follow-up postcard was sent to all of the women, thanking those who had participated and urging those who had not to do so. In addition, several women expressed an interest in receiving the results of the survey. The follow-up postcard provided the opportunity to give them the address where the results could be obtained.

Response Rate

Babbie (1973: 107-108) has stated the main problem with mail questionnaires is that of obtaining an adequate response rate. He estimates that while the typical response rate for a personal interview is about 95 percent, it is between 20 and 40 percent for a mail survey. According to the Survey Research Center at Oregon State University and Babbie (1973: 165), a response rate of 50 percent is considered "adequate", 60 percent is considered "good", and 70 percent and above is considered "very good".

Recognizing that response rates are generally low for mail questionnaires, the researcher felt confident that an adequate response rate would be obtained considering it involved a subject on which most women have definite opinions. A mail questionnaire was also beneficial due to the time and financial constraints characteristic of unfunded, graduate research. Additionally, a survey, compared with a personal interview, reduced intrusion into the lives of the women, some of whom

had given birth only weeks before. It was hoped that the questionnaire would be set aside until a time when it was convenient, as some of the questions required careful consideration and were of a personal nature.

At the end of the eight week period, 83 of the 114 surveys were returned completed. This constitutes an unadjusted response rate of 72 percent. Because there were no return addresses on the surveys, it is impossible to adjust the response rate for undeliverable surveys. The researcher believes that very few surveys were undeliverable considering the recent source of the addresses. It is also known that, in some cases, the surveys were forwarded because they were returned, completed, from as far away as Providence, Rhode Island, and West Beach, Florida.

Figure 6. Summary of the survey response rate.

	<u>Sample</u>	<u>Completed</u>	<u>Percent Returned</u>
Home Birth	44	35	79
Hospital Birth	<u>70</u>	<u>48</u>	<u>68</u>
TOTAL	114	83	72

Incidentally, twelve women sent self-addressed, stamped envelopes to receive the tabulated survey results (see Appendix C). Of these women, ten had home and two had hospital deliveries.

Problems and Considerations

It is unfortunate that different sampling methods were necessary for the two subgroups. Social scientists, however, seldom work under ideal conditions and it was quite apparent that the home birth sample could not have been obtained in any other way. Of greater concern is the possibility of bias in the hospital birth sample due to the deletion of those who asked that their names not be released for publication. It is not known what percent of the hospital sample this constitutes, only that several names were skipped because of this. If these women hold some unknown common values with the home birth women, they may constitute potential intermediary responses not represented. However, to make such an assumption on the basis of one behavioral trait is purely conjectural.

The actual number of home births in the tri-county area turned out to be less than expected. The 1980 Vital Statistics (Oregon State Health Division 1980: 34) released during the course of this study show a slight decrease, for the second year in a row, in the proportion of out-of-hospital births (statewide), although the actual number has remained stable for the past three years.⁸ In addition, the informant-midwife had reduced availability of her services in anticipation of the birth of her own child and their departure from the United States. It is not known what effect, if any, this had on women's decisions concerning home birth.

A word is in order here about why other home birth attendants were not used as resources for enlarging the home birth sample. Originally this was the plan. However, upon contacting other known lay midwives in the area, it was discovered that they had delivered far fewer infants than the "main" midwife, some only two or three. Also, some had assisted at other births which led to double counting in preparatory fieldwork. This contributed to the expectation of more midwife attended home births. Moreover, some midwives had moved from the area, and at least one refused to cooperate.

Approaching M.D.s, N.D.s and C.N.M.s who attended home births was also considered even though it was known that an active N.D. and one C.N.M. were no longer practicing in the area. Preliminary attempts to contact such attendants were hampered by unreturned phone calls. However, the final reason for abandoning this line of action was the realization that such patients were not an enlargement of the midwife/home birth group but an addition of a third group; home births attended by licensed attendants. While acknowledging this as a significant subgroup worthy of study, insufficient resources were available to add a third dimension and the accompanying logistical and statistical problems at this time. Lay midwifery was chosen in preference to licensed midwifery to provide an anticipated greater contrast with hospital birth values.

Finally, one last consideration should be mentioned. Although the survey had a relatively high response rate (72 percent), the

possibility for non-response bias exists. No effort was made to assess non-response bias because none could be made. This can be attributed to a strong concern about confidentiality, whereby the researcher rendered the surveys completely anonymous by assigning them numbers only after they were returned. Thus, no further follow-up other than the postcards was practical.

Limitations

It should not be assumed that the values and behaviors represented in this research are reflective of women nationwide. Several factors may contribute to the uniqueness of the results. First, women in the study area were free of any legal restrictions affecting who could deliver their child. This is clearly not the case in all states, and it is not known to what extent illegality of lay midwifery inhibits the practice of home birth.

Second, demographically, the study area is neither predominately rural nor cosmopolitan in its make up. It is located west of the Cascade Range, however, where Oregon's population is highly concentrated. Racially, the study area is 95 percent Caucasian. Statewide, Blacks account for only 1.4 percent of the population, Indians 1.0 percent, and "others" 3.0 percent (Oregon State Health Division 1980: 24). A large proportion of these minority groups, including an influx of Indochinese refugees, reside in the Portland metropolitan area.

Also, a very high level of education is characteristic of the sample; over 75 percent had attended college and, of those, half had graduated.

Third, although a few home birth women expressed the belief that God intended childbirth to be spiritually fulfilling, none belonged to religious communities which shun medical technology or which practice home birth based on theological doctrine. The values of such communities are expressly non-scientific in their orientation, thereby constituting a subculture distinctly separate from the dominant culture. Thus, they were not considered part of the sample population. While such groups do exist in Oregon, none were known to exist in the study area. To what extent childbirth values in such cultures are similar to contemporary home birth values is a course of further study.

The Survey Results

A code book for computer processing of the survey results was constructed by assigning each response a numerical value conducive to Fortran coding. The responses to open-ended questions (#8. What factors, if any, were very important to you which were not included above?, and #25. Is there anything you would like to say about your childbirth experience or this survey?) were all read, combined, and categorized according to recurrent themes.

Frequency distributions and simple statistical descriptions of the results (minimum, maximum, mean, and mode) were acquired from Oregon State University's Milne Computer Center with the financial aid

of an Un-sponsored Research Grant. Later, a second run was designed to obtain home/hospital cross-tabulation and Chi-Square values for selected variables. A bar graph depicting responses to each ranked question follows discussion of those factors. Information relevant to each cross-tabulation is included below the bar graph; however, Chi-Square values were not accepted for factors where 35 percent or more of the sample responded "Does Not Apply". All Chi-Square values were computed in the same manner. Appendix D contains a 2 x 2 contingency table representative of the computations.

The survey results are presented in four sections. The first describes general characteristics of the birth, including type and number of attendants, length of labor, and occurrence of complications, if any. The second section contains the ranked questions. The list of factors influencing the decision about what kind of delivery to have are divided into either primary factors (those directly affecting the birth) or secondary factors (those not directly affecting the birth but contributing to the overall birth experience). An example of a primary factor would be "husband's participation in labor and delivery," while "approval of decision by husband" would be a secondary factor. Responses to the primary factors are reported first. Relevant comments are included where applicable and available. The third section summarizes brief biographical data on women, such as age, religion, occupation, education, and political views. Degree of satisfaction and answers to the open-ended questions are discussed in the fourth section.

General Characteristics of the Birth

Of the 83 births represented, 47 percent were first births, 15 home births, and 24 hospital births. Only one woman, a hospital birth, had more than four children. She represented the maximum with six children. Home birth women averaged 1.9 children and hospital birth women averaged 1.7 children.

For the 24 hospital birth women with other children, all 35 of these children had been born at a hospital. Of the 20 home birth women with other children, 10 women had delivered all their children at home or a birth home, and 10 women had experienced both home and hospital deliveries, one of whom planned a home birth but transferred to the hospital in the course of labor.

Home birth women lived in closer geographical proximity to the nearest hospital at the time of birth. Only four home birth women lived over 21 minutes from the hospital, with the majority (57 percent) living less than nine minutes away. In contrast, nearly a third (29 percent) of the hospital birth women lived over 21 minutes from the hospital with the greatest number (44 percent) living 10-20 minutes away.

The majority (84 percent, n=70) of the total sample had prepared for labor and delivery by taking childbirth education classes. Some women commented that they had taken classes for a previous delivery but not for this one. Most hospital birth women took LaMaze classes which are recommended by the clinic doctors and taught at the hospital.

Home birth women were more likely to take Bradley classes which stress "natural" rather than "structured" breathing and relaxation techniques.

The majority (91 percent, n=64) of women who took classes also had their husbands or male partner take classes with them. Two home birth women did not have a male partner take classes with them. One was single. The other, a lesbian, stated that her partner ("co-parent") was a woman.

The two hospital birth women that did not have a male partner take classes with them were both married. Two that took classes gave no answer concerning who was with them.

The choice of a birth attendant is one given variable consideration by pregnant women. Some choose to go the clinic OB/GYNs because of their association with the hospital. At least two hospital birth women had shopped around, specifically choosing a Family Practice M.D. because of unsatisfactory experiences with OB/GYNs at prior deliveries. Home birth women must choose whether to have a licensed or unlicensed attendant.

In this sample, the range was from 0-6 professional attendants. Two home birth women had only the father attending. In contrast, an example of six professional attendants is represented by a woman who had a Cesarean section. She had two OB/GYNs, two R.N.s, one anesthesiologist, and one pediatrician present at her delivery. Home birth women considered either a lay midwife (n=33) or the father (n=2) the main attendant. Among hospital birth women, 37 percent (n=18) con-

sidered professionals other than an OB/GYN their main attendant. Most interesting are the seven women who went to an OB/GYN for prenatal care and delivery but considered the labor room R.N. their main attendant. Some women commented:

She R.N. was there most of the time--more than the M.D.

My doctor [OB/GYN] was there all the time, but in and out. The nurse was there the whole time except for about 5 minutes. She even stayed after her shift. She was very helpful along with my husband.

These comments indicate that support throughout labor is very important to some expectant mothers.

The question of who besides the profession attendant will be present at the birth is an area of major difference between home and hospital birth women. The range was from 0-10 family members and friends present. Home births averaged 3.3 people at the birth, not including the mother or attendant, and hospital births averaged 1.1, usually the father. Virtually all doctors encourage the husband (if there is one) or one other person to be with the woman throughout labor and delivery. Research conducted by Norr et al., (1977) revealed that preparation for childbirth and having someone present increased enjoyment and lessened pain during delivery.

Of the 79 women in the sample who were either married or living together, 77 had the father present, one had a grandparent present, and one had no one except the professionals present at her delivery. Of the one separated and three single women, one had a female "co-

parent", and the others had at least one grandparent instead. Five hospital birth women had people other than the father present.

Home birth women did not have shorter labors than hospital birth women. The average number of labor hours for home births was 14 hours, with a range from less than one hour to 72 hours. For hospital birth women the average was 10 hours, with a range from one hour to 48 hours. It is not known to what extent lack of episiotomies, forceps, and vacuum extractors might lengthen the labor at home births. Nor is it known to what extent medication, fetal monitoring, and medical conditions attribute to the use of the above in hospital deliveries.

What constitutes a "complication" during labor and delivery is a very subjective opinion; therefore, only an open-ended question was used soliciting what, if any, complications the woman experienced. No list or categories were provided for reference. The only instruction was to distinguish between minor and major complications. Because of this, it is impossible to know, for example, how many women received aid (forceps, vacuum extractor) during delivery. The surveys only account for the nine women who considered this a complication. Furthermore, seven women considered it a minor complication while two considered it a major complication.

A larger proportion of home birth women reported minor complications (24/35) than did hospital birth women (27/48). In contrast, hospital birth women reported major complication (16/48) in a higher proportion than did home birth women (1/35). Ten (21 percent) of the

hospital birth women had high risk pregnancies (e.g., history of prematurity, toxemia). The one major home birth complication did not require hospitalization. The baby needed resuscitating after birth which was administered by the mouth to mouth method. Interestingly, another home birth woman whose baby did not breathe immediately after delivery considered this a minor complication. Some of the comments are listed below. All are tabulated in Appendix C.

Hospital birth, "Minor Complication":

"Green amniotic fluid [meconium staining] --connected to monitor, picked up baby under stress while laying on one side. Rolled over, relaxed, everything else fine."

"I had quite a few stitches. The second stage [pushing] was quite long."

"Once fully dilated and in the delivery room contractions eased and slowed--required IV Pitocin. After delivery required more medication to control hemorrhaging."

"Small birth size of twins and not very strong contractions. Doctor tried suction to deliver 2nd twin but took it off right away and I was able to push him out."

Hospital birth, "Major Complication":

"Cephalo-pelvic disproportion" [Cesarean section].

"I got pregnant with the IUD in so was very concerned about where it would end up. It was in the placenta and my baby wasn't hurt at all."

"The pain of contractions is a very difficult thing for myself."

"Umbilical cord wrapped around baby's leg, arm and neck. Heart beat decreased quickly, called in another doctor and used forceps to rescue baby. Oxygen given to mom."

"Couldn't deliver placenta myself. It was grown into an old C-section scar. Doctor had to give me a general anesthesia and remove it himself."

Home Birth, "Minor Complications":

"Back pain during first stage, long crowning time--possibly shoulder dislochia."

"Baby was given mouth to mouth resuscitation to get her started breathing."

"Placenta slow to deliver, so slightly more blood loss than expected normally. Also, the membrane had to be ruptured--delivery followed the rupture by 2 hours."

"My cervix stuck at 9½ cm. for about 4 hours so we just had to wait it out. I tore to the side--healed nicely--no long term problem."

Home Birth, "Major Complication":

"Baby was not breathing. After she [the midwife] gave her a couple breaths she started breathing and pinked up immediately."

Discussion of Ranked Factors

Ratings of the primary factors (those directly affecting the birth) are addressed first, followed by the secondary factors (those not directly affecting the birth but contributing to the overall birth experience). This analysis centers primarily on "Very Important" and "Important" ratings of the factors as those are most relevant to the hypotheses. The bar graphs and Chi-Square information aid in reporting the lower rankings. Figure 7 shows the combined "Very Important" and "Important" ratings for each factor.

Figure 7. Combined "Very Important" and "Important" ratings of ranked factors.

Factors rated either "Very Important" or "Important" by 80 percent or more of the total sample.

<u>Factor</u>	<u>Home</u>	<u>Hospital</u>
* Closeness and contact allowed with newborn	100% (VI)	94%
* Husband's or partner's participation in labor and delivery	97%	92%
* Prior overall good health	97%	71%
* Possibility of unforeseen complications	60%	86%
Approval of decision by husband	89%	81%
Relaxed prenatal visits	86%	69%

Factors rated either "Very Important" or "Important" by 60 percent or more, Home Birth.

* Having the birth at your home	94%	4%
* Fear of interference with birth process	89%	42%
* Siblings and/or other family members' participation in labor and delivery	83%	38%
If your birth attendant was a woman, how important was that?	72%	29%
Prior good relationship with birth attendant	69%	15%
Recommendation of birth attendant by a friend	60%	50%

Factors rated either "Very Important" or "Important" by 60 percent or more, Hospital Birth.

* Availability of sophisticated medical technology	37%	88%
Help of hospital nurses and staff	14%	69%
Time to rest before returning home	3%	69%
* Having a licensed attendant	23%	67%

"Very Important" or "Important" ratings for remaining factors.

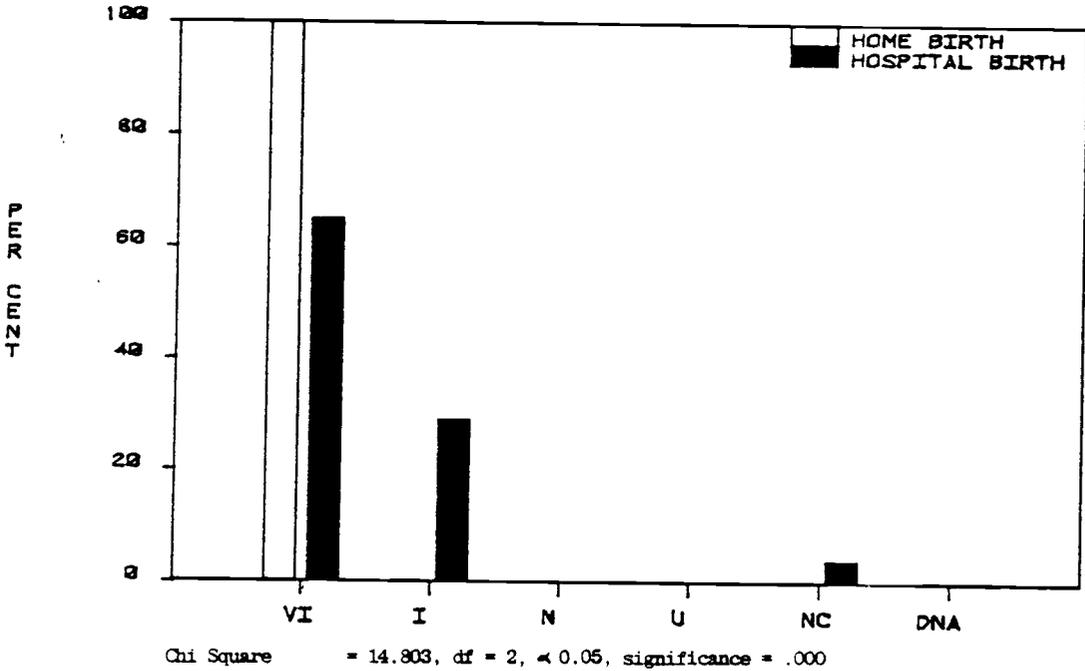
* Friend's participation in labor and delivery	43%	13%
Previously uncomplicated delivery	46%	21%
* Availability of pain controlling medication	3%	44%
* Pregnancy specific condition (ie. toxemia, multiple birth)	11%	27%
Previous difficult delivery	6%	19%
Previous non-pregnancy related illness	11%	13%
Relatively high financial cost of hospital delivery	43%	29%
Relatively low cost of home delivery	49%	4%
Previous satisfactory hospital experience, (maternity or otherwise)	6%	40%
Previous unsatisfactory hospital experience, (maternity or otherwise)	34%	21%
Approval of decision by parents	17%	17%
Approval of decision by friends	14% (I)	10% (I)

* Primary Factor, factors directly affecting the birth.

Primary Factors

Contact and closeness with newborn.

Figure 8.



"Contact and closeness with newborn" received the highest overall ranking of importance. All home birth women responded "Very Important" (n=35), some checking it twice, adding stars, or other symbols of embellishment. Among hospital birth women, the responses were divided mostly between "Very Important" (n=31) and "Important" (n=14). The two hospital birth women that checked "Not Considered" did not have compelling medical reasons influencing their opinions. Of these two women, one, experiencing her first delivery, stressed the importance of medical technology. The other, having her second child, commented that "the entire process made her ill" and that she "wished there was some other way to have a child." She checked only the following

factors as "Very Important": availability of pain controlling medication, time to rest before returning home, help of hospital nurses and staff, having a licensed attendant and availability of sophisticated medical technology.

The overwhelming importance attached to closeness with the newborn has great implications for hospitals incorporating "family-oriented" care into their maternity programs. Obviously, women want to be with their infants after they are born. This may be due in part to a resurgence of breast feeding and recognition of the importance of bonding. Hospitals can expect requests for "rooming-in" to increase, and perhaps one day the neonatal nursery will be considered the proper place only for infants requiring medical attention or infants of mothers requiring special care.

Home birth comment:

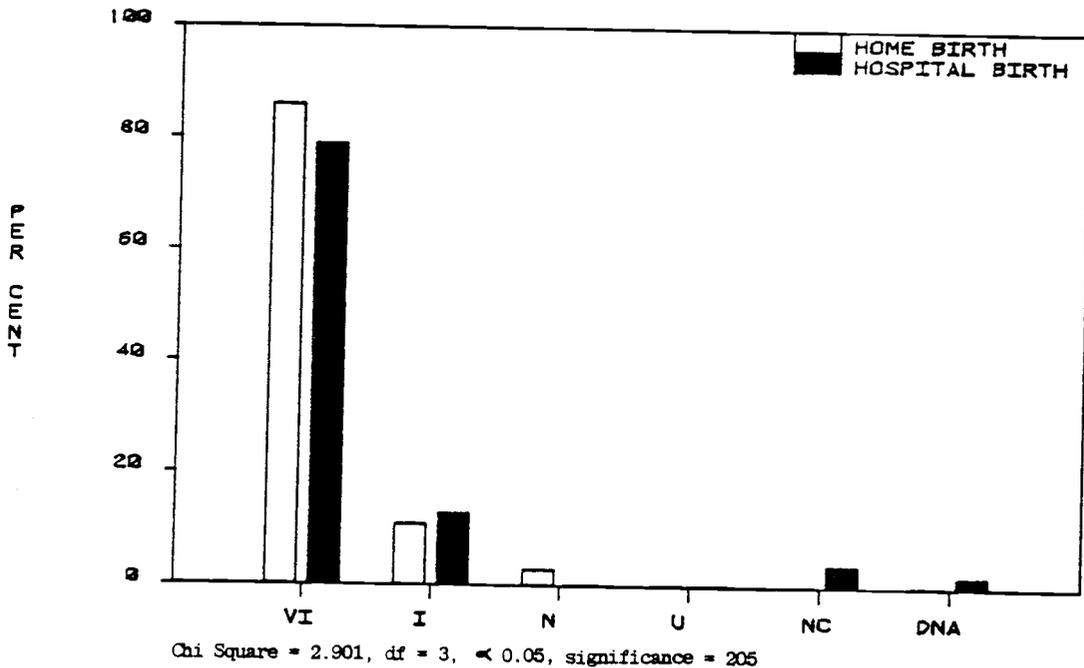
"The infant is born in comfortable, safe surroundings where family can be present and interferences are minimal. Bonding is easily expressed. There are no restrictions."

Hospital birth comment:

"We feel that immediate and prolonged contact between the parents and child is of paramount importance."

Husband's or partner's participation in labor and delivery.

Figure 9.



With 94 percent of the total sample responding either "Very Important" (n=68) or "Important" (n=10), husband's or partner's participation was the second highest rated factor. Home and hospital birth women did not respond significantly differently. That women want their husbands to share in the birth of their child is practically undisputed, a fact which has caused dramatic changes in the hospital policies of ten years ago. The remaining responses can be attributed to the 5 percent of the sample who were either single or separated, and one no answer.

Home birth comment:

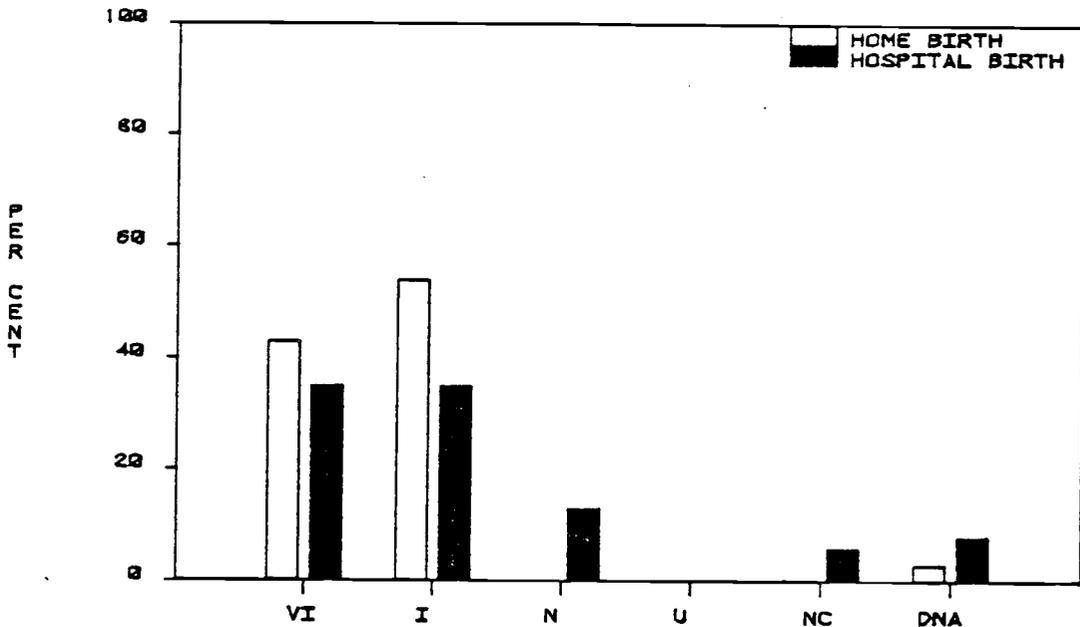
"My husband applied counter pressure on my back for hours until he finally exhausted himself and fell asleep."

Hospital birth comment:

"Having my husband present at the birth and seeing my daughter being born was the most beautiful thing that ever happened to me." (Cesarean section)

Prior overall good health.

Figure 10.



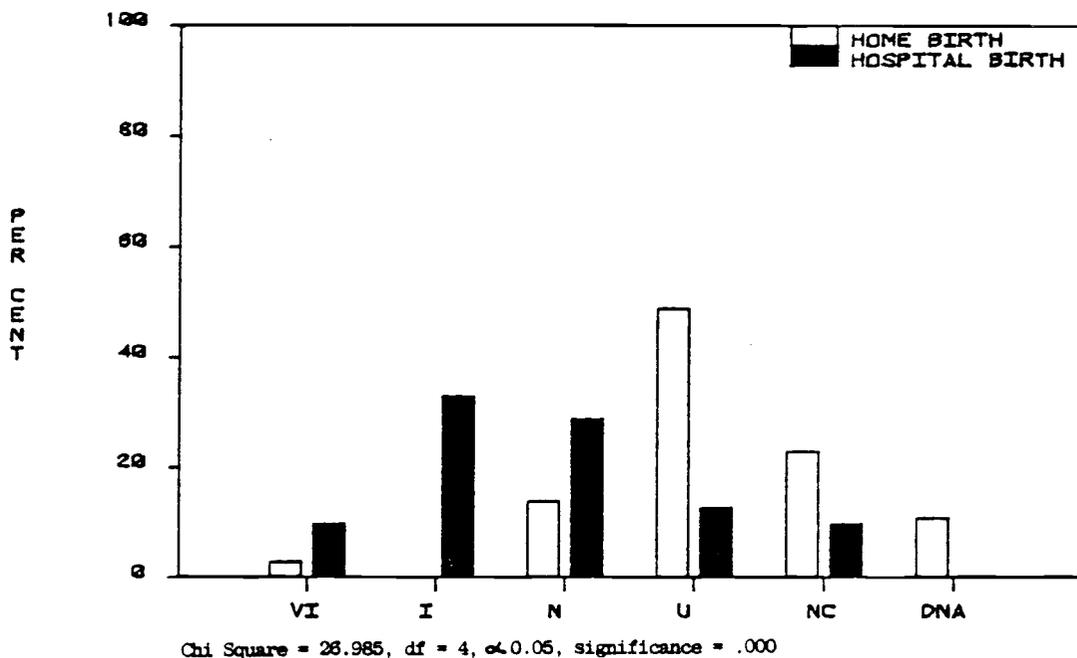
Chi Square = 8.298, df = 3, $\alpha < 0.05$, significance = .040

Generally, prior overall good health was important to both groups, although home birth women ranked it as more important. Of the total sample, 82 percent responded either "Very Important" (n=32) or "Important" (n=36). All home birth women (except one who checked "Does Not Apply"), responded either "Very Important" (n=15) or "Important" (n=19). The woman who checked "Does Not Apply" did not specifically state any health problems but checked "Important" on "pregnancy specific condition". Unfortunately, it is not known what, if any, correlation exists between the two. Perhaps the woman's age, 36-40 years, had some effect on her condition, although this is also not known.

Among hospital birth women, 71 percent responded either "Very Important" (n=17) or "Important" (n=17), and four women (8 percent) responded "Does Not Apply".

Availability of pain controlling medication.

Figure 11.



"Availability of pain controlling medication" is significant because of the lack of importance attributed to it. Of the entire sample, 71 percent stated pain medication was not an important factor. One would expect this to be more important to the hospital birth sample, and 44 percent responded either "Very Important" (n=5) or "Important" (n=16). That over 50 percent of the hospital women didn't consider it important should be taken into account by those in a position to influence women during labor and delivery. Emotional support rather than medication may be just as effective at the crux of pain. Some women feel that doctors take advantage of their vulnerability during labor and offer medication to quiet them, make them cooperative, and to speed up the process.

Among home birth women, only three percent responded either "Very Important" (n=1) or "Important". The woman who responded "Very Important" experienced an unplanned precipitous home birth.

By law, an unlicensed attendant cannot distribute prescription drugs. Most home birth women neither want, expect, or receive pain medication. Certainly, the "naturalization" of birth and the popularity of childbirth education classes have played a role in de-emphasizing the pain aspect. Information about the negative side-effects of medication on the newborn's health, bonding, and successful lactation have also affected women's attitudes towards drugs.

Home birth comments:

"Not having medication being pushed on us or even suggested [was very important]."

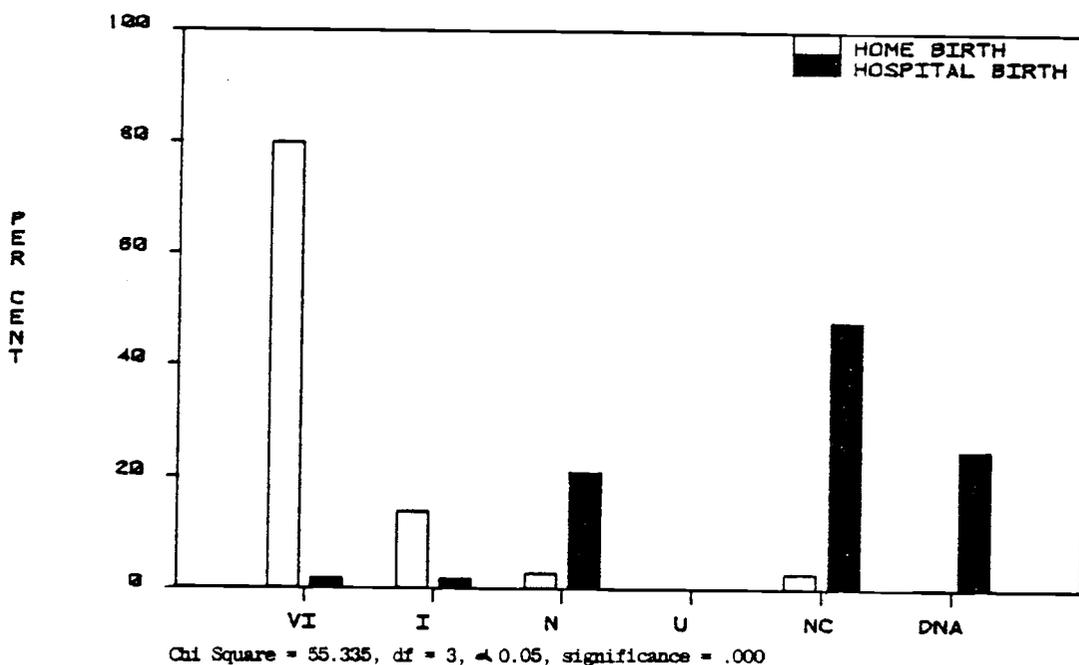
"I was surprised to find out that women (in the hospital, two friends of mine) were given medication after transition. It seems that's the crux of pain there and during the pushing stage one would not want to be drugged up--it's not as painful."

Hospital birth comment:

"We very strongly believe in un-medicated births."

Having the birth at your home.

Figure 12.



"Having the birth at your home" was significantly more important to home birth women, only six percent of whom responded it was "Neither Important or Unimportant" (n=1) or "Not Considered" (n=1). The remaining 33 home birth women responded either "Very Important" (n=28) or "Important" (n=5).

The largest proportion of hospital birth women, 50 percent, responded "Not Considered" (n=24), although four percent responded either "Very Important" (n=1) or "Important" (n=1). One hospital birth woman who responded "Not Considered" volunteered the comment that she had considered a birth-home delivery but "was talked out of it."

Home birth comments:

"Your home environment is predictable without hassles to confront such as the routines and procedures of hospitals and their birth attendants."

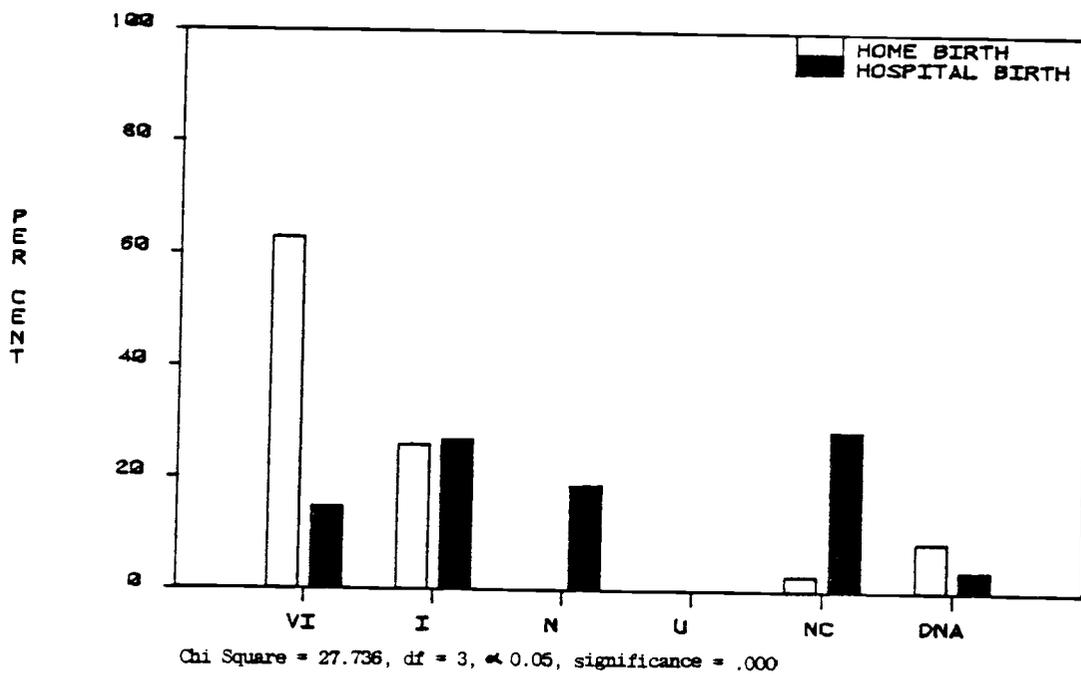
"I never considered going somewhere to have my baby. We made her at home and we accepted her into our lives at home and we welcomed her birth at home. I can think of no better way to start a baby's life than in the home of those who love and plan to care for her."

Hospital birth comment:

"I did seriously considered a birth home delivery. I was talked out of it by nurses in a health department."

Fear of interference with birth process.

Figure 13.



Over 40 percent of the women who went to the hospital to deliver their children did so fearing their attendant might interfere with the normal course of delivery. Some had changed attendants for this reason. Among hospital birth women, 42 percent responded either "Very Important" (n=7) or "Important" (n=13). Horror stories and tragic consequences of obstetrical intervention are well documented in home birth advocacy literature. However, it is not probable that many hospital birth women were acquainted with this literature. Instead, first hand experience, stories of friend's deliveries, childbirth classes, and the high Cesarean section rate at Good Samaritan may have contributed to an awareness (in fact, fear) of such a possibility.

Among home birth women, fear of interference figured significantly in their decision to choose home delivery. It was ranked "Very Important" by 63 percent (n=22) and "Important" by 26 percent (n=9). Fear of interference with the birth process reflects an element of personal control and was undoubtedly important to all home birth women. The 9 percent who responded "Does Not Apply" (n=3) had experienced only other home births; one commented, "chose carefully my attendant so felt no fear."

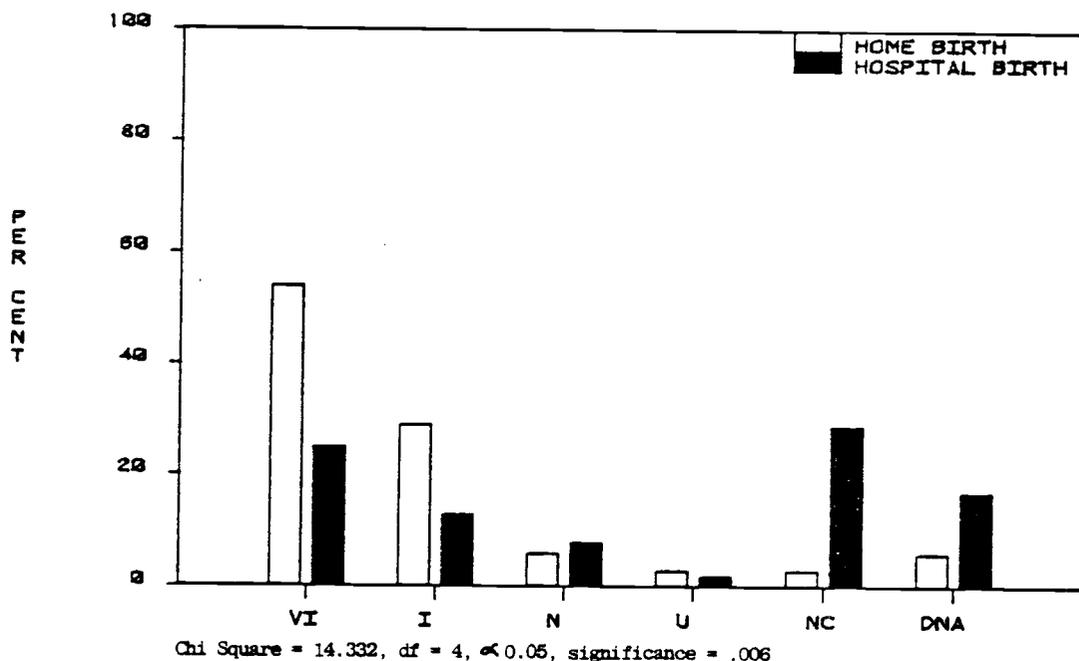
Home birth comments:

"Home birth can be a very safe alternative. Too much medical interference from the doctors in Albany."

"I had a very bad hospital birth causing baby and me much pain and danger."

Siblings and/or other family members'
participation in labor and delivery.

Figure 14.



Home birth women attached significantly greater importance to family participation in the birth process compared to hospital birth women. Although in some cases children are taken to a neighbor's house when labor progresses, 83 percent of the home birth women responded either "Very Important" (n=19) or "Important" (n=10). Some said their children were a source of comfort, others felt they should be present because birth was a family event, and others wanted to teach their children about birth. One mother, who has given birth to four daughters at home, stated, "Having my girls see and experience their sisters being born was very special to me. I know they'll have a healthy attitude about childbearing."

Among women with hospital deliveries, 38 percent responded either "Very Important" (n=12) or "Important" (n=6) although, as indicated by their surveys, none had other children with them. Some had a grandmother present.

Hospitals are becoming more flexible by allowing children to visit after the birth, a practice strictly forbidden in the past. Main concerns are communicable diseases, and the unpredictableness and excitability of children. Some children are simply not interested in birth while others, although interested, don't have the discipline to remain calm and content within the confines of a labor room. While birth homes and clinics are more accomodating to children, the inclusion of siblings at hospital births does not appear imminent. A helpful friend or grandparent could alleviate the problem by accepting responsibility for the child. Given the amount of importance sibling participation was accorded, especially in view of the fact that one third of the population were first births, a push by expectant parents to include children may be anticipated. It is worth noting that many of the arguments to exclude children (aren't interested, carry germs, don't want to see pain or blood) were also applied to the exclusion of fathers at one time.

Home birth comment:

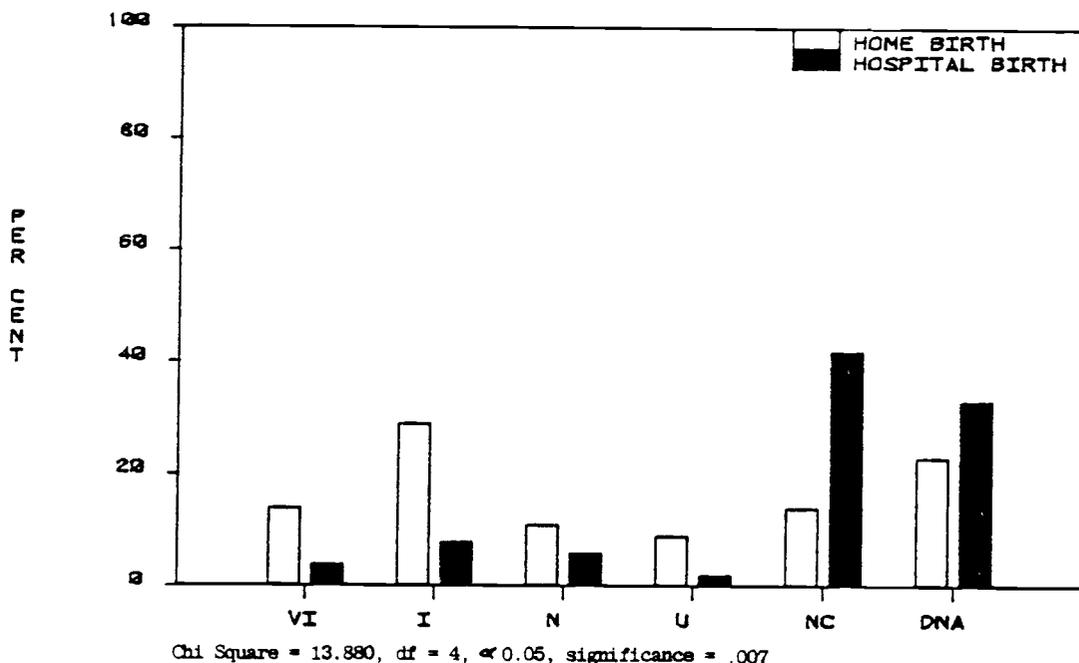
"Having my girls see and experience their sisters being born was very special to me. I know they'll have a healthy attitude about child bearing...My toddler was never separated from us and she suffered no ill affects from being shifted into the "older sister" role."

Hospital birth comment:

"I was pleased with the hospital's plan to make childbirth individualized to my wishes and to include my family."

Friends' participation in labor and delivery.

Figure 15.



Overall friends' participation was considered important by only 25 percent of the total sample. Home birth women ranked it significantly higher than hospital birth women.

Of the home birth women, 43 percent responded either "Very Important" (n=5) or "Important" (n=10). Among hospital women, 13 percent responded either "Very Important" (n=2) or "Important" (n=4).

Female friends (total of 28 represented) are more likely to be at the birth than male friends (total of 9 represented).

Home birth comments:

"controlled visitors--private"

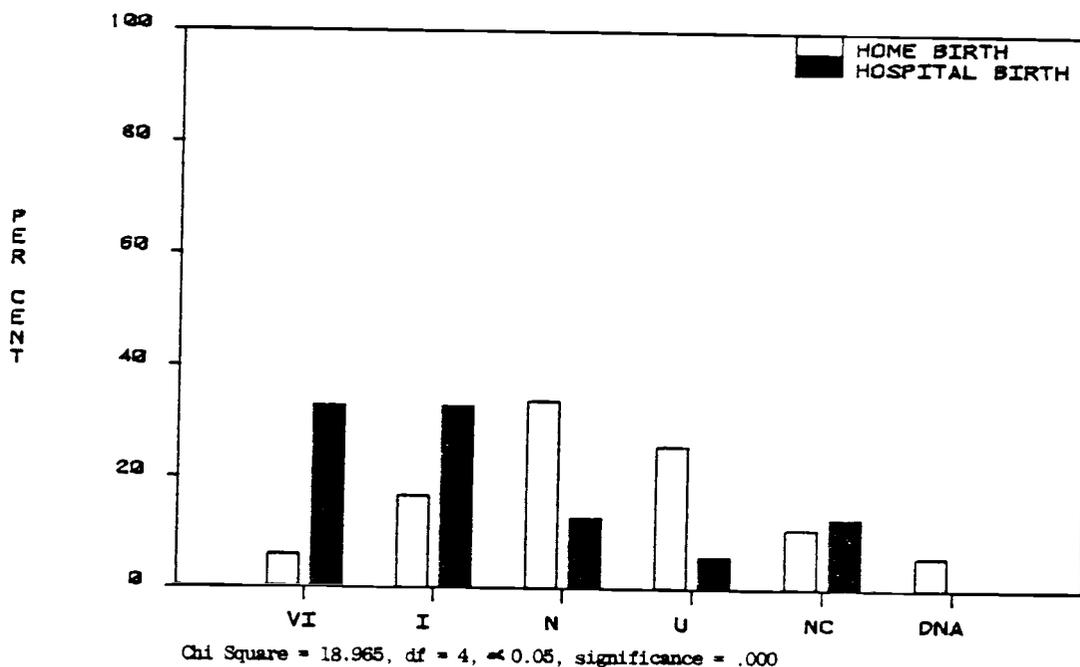
"Help from neighbors with cleaning, meals and other children for days after the birth."

Hospital birth comment:

"She [the R.N.] was a friend that we called in."

Having a licensed attendant.

Figure 16.



"Having a licensed attendant" was more important to hospital women, 67 percent responded either "Very Important" (n=16) or "Important" (n=16), than to home birth women, 23 percent responded either "Very Important" (n=2) or "Important" (n=6). Unfortunately, no comments were volunteered by the 15 hospital birth women who did not check "Very Important" or "Important", and particularly perplexing were the three women who responded "Unimportant".

This item may afford some insight into values concerning medical credibility among home birth women. It is interesting that 23 percent responded "Very Important" (n=2) or "Important" (n=6) considering that their attendant was not licensed in the United States. She was,

however, certified in her home country of Ghana, and many women noted this stating that they considered her a Certified Nurse Midwife even if the medical profession did not recognize her as such. The largest portion of home birth women responded that having a licensed attendant was "Neither Important or Unimportant" (n=12). As one woman stated, "competence was my concern, not necessarily licensing."

Overall indications are that most home birth women do want an experienced person who is accountable for his/her practice. In Oregon in 1980, 62 percent of all home births were attended by various licensed practitioners (Oregon State Health Division 1980: 44-45). The pretest, conducted on women who had home births attended by C.N.M.s, showed that 20 out of 21 women responded either "Very Important" or "Important" to this item.

The "professionalism" demanded by home birth women has definite implications for the future of lay midwifery. Certification would not only be beneficial in terms of political power and responsibility, but would also be helpful in establishing rapport with prospective parents.

Home birth comment:

"Having a professional midwife with a lot of education and background experience is far superior to the less credentialed midwives in practice."

Hospital birth comments:

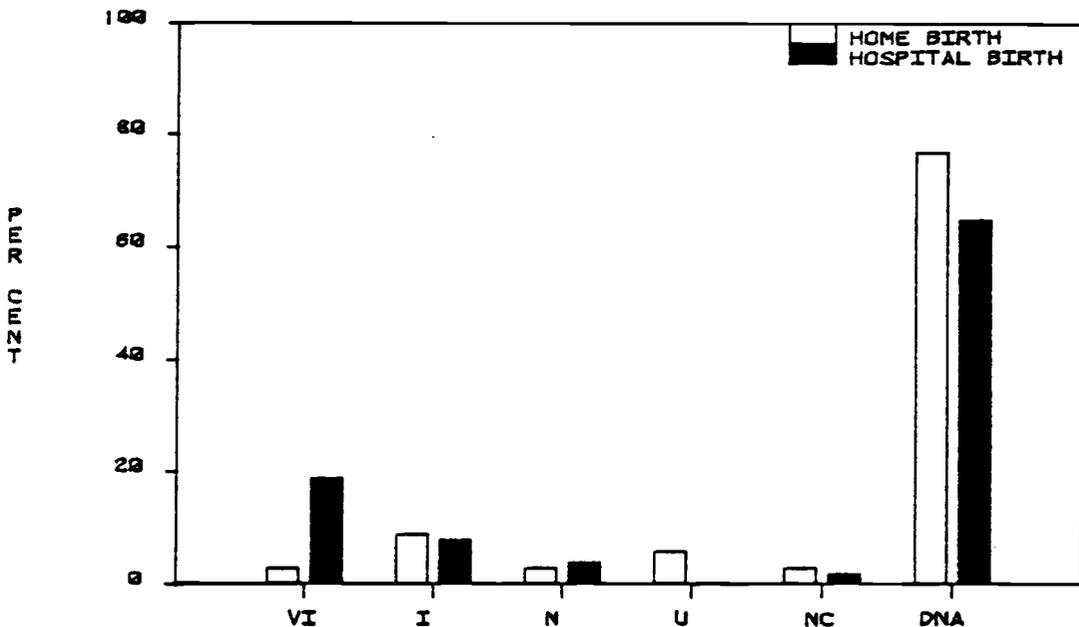
"I liked having my baby in a hospital where there were professionals, but also where the father could be involved in labor and delivery."

"Confidence in experienced staff."

"Doctors keep up with medication."

Pregnancy specific condition (i.e., toxemia, multiple birth).

Figure 17.



Some women have pregnancy-specific medical conditions which dictate hospitalization to insure safe delivery. Overall, this was ranked as either "Very Important" (n=10) or "Important" (n=7) by only 20 percent of the total sample. Conditions such as toxemia (temporary high blood pressure), IUD pregnancy, multiple birth, planned Cesarean section, and Shirdokah Stitch were mentioned by hospital birth women, 27 percent of whom responded either "Very Important" (n=9) or "Important" (n=4).

For home birth women, responses generally fell in the "Does Not Apply" (77 percent, n=27) category. For one woman with a history of fast deliveries, it was marked "Important". She commented she could not have gotten to the hospital in time even if she had wanted to. For

another it was "Important" that she didn't have a pregnancy specific condition, and she commented, "most are ruled out in prenatal screening". As mentioned before, most home birth women are considered low risk, and if a complication arises, the midwife generally refers the woman to a doctor. However, both breech babies and twins have been delivered at home in the study area, births which most attendants automatically consider higher risks. Licensed attendants are prohibited by professional standards from delivering such children at home. Among home birth women, one noted that her child was breech, but responded this was "Neither Important or Unimportant". The child was born after three hours of labor and no complications were noted.

Home birth comment:

"I had pneumonia at five months but recovered enough to have a home birth."

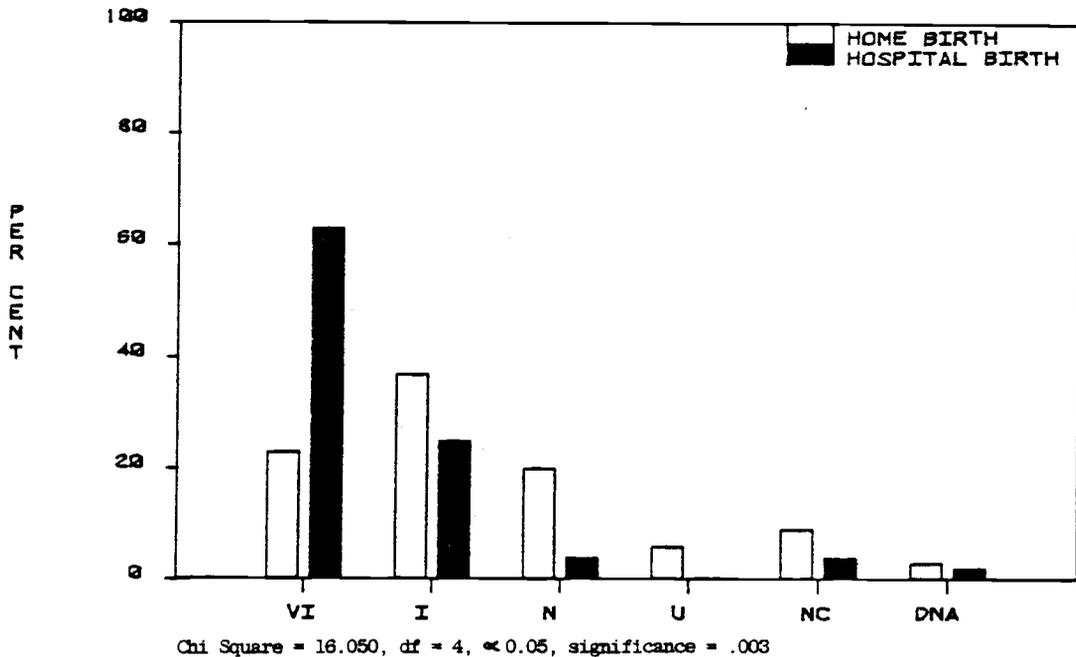
Hospital birth comments:

"Extremely hard pregnancy. Early labor (premature), so were fighting to stop it but came anyway, so was extremely uncomfortable. Nausea from medication that was given to stop labor..."

"I have an Incompetent cervix for which I lost one baby at 5 months. At 4 months into pregnancy a Shirodkar Stitch is put into my cervix (a surgical procedure). I also went into labor early many times during the last three months of last pregnancy needing IV's to stop it and needing to take Ritodrine continuously. Also Shirodkar Stitch needs to be removed at onset of labor or before."

Possibility of unforeseen complications.

Figure 18.



Overall, the possibility of unforeseen complications was of concern to both groups. Of the hospital birth women, 86 percent responded either "Very Important" (n=30), or "Important" (n=12). Among home birth women, 60 percent responded either "Very Important" (n=8) or "Important" (n=13).

For hospital birth women, the possibility that something might go wrong repeatedly comes up as their reason for going to the hospital. Having experts and medical technology close at hand are the main reasons they feel the hospital is the safest place for delivery.

Home birth women agree there is a chance something could go wrong and give this serious consideration. They feel that through careful

prenatal screening, their chances for complications are minimal, and that if something comes up, they can receive medical help given their close geographical proximity to the hospital. One home birth woman told me that she believed complications causing instantaneous death to the child were so rare that even preparations for a Cesarean section could not be made in time to save the child.

Home birth comments:

"I had done a lot of previous reading on both sides of the question. The more I read the more I became convinced that home birth was appropriate for me at this time. I was satisfied that if any emergency came up, there would be time to handle it (to the hospital if need be).

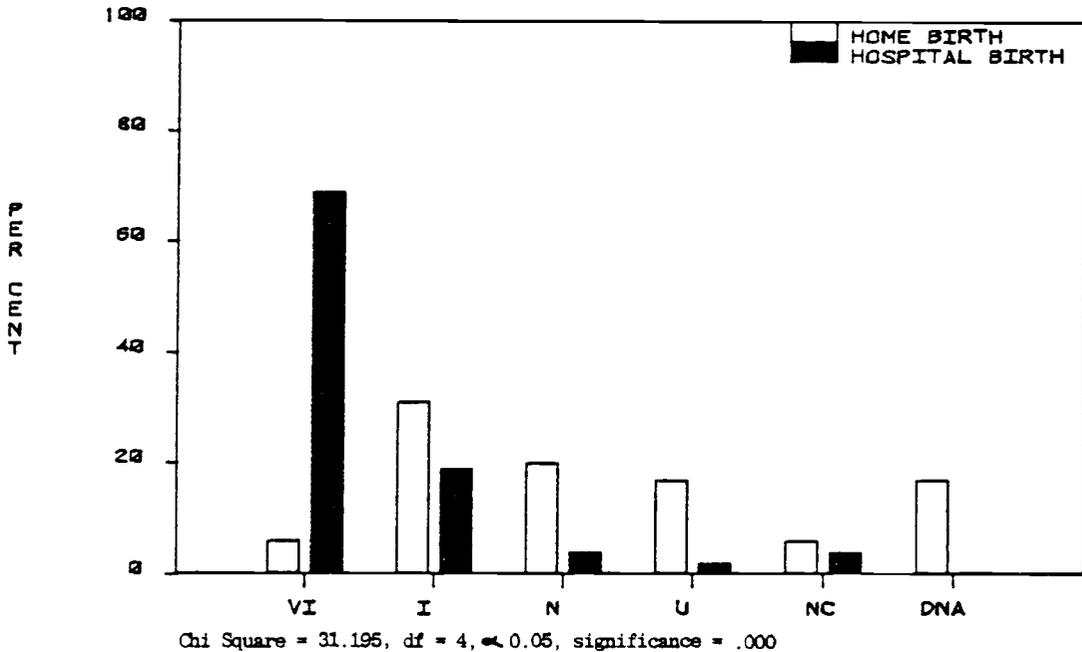
"The most common reaction was that I was putting my child in danger. That, I believe, is the result of the AMA's propoganda."

Hospital birth comment:

"I feel that hospitals and doctors have come so far in the past few years in letting the parents be in control that I wouldn't consider having a child at home where there's even an unlikely chance of complications."

Availability of sophisticated medical technology.

Figure 19.



The availability of sophisticated medical technology was rated even higher than "possibility of unforeseen complications" by hospital birth women; 88 percent responded either "Very Important" (n=33) or "Important" (n=9). Even women with strong opinions on the type of birth they wanted (for example, labor room delivery, no medication) felt safer knowing that medical technology was available.

Home birth women had a different perspective; 37 percent responded either "Very Important" (n=2) or "Important" (n=11). Subjective definitions of "risk", "safety", and "available" are all intimately tied up in this factor which is an area of major difference between the two groups.

Home birth comment:

"...it [childbirth] took on drastic changes...suddenly in the hands of hospitals which mechanized and manipulated the birth of every child. Birth became frightening and complex...I am amazed at the misconceptions people have and their overall dependence on the medical profession."

Hospital birth comments:

"Our main concern was to have every possible help in having a safe delivery. The child's well-being was of the utmost importance to us."

"This 11 lb. 5½ oz. baby ended up being Cesarean. As much as I favor home deliveries and LaMaze preparation, I'm very thankful for medical technology. If we'd gone through this 50 years ago, quite likely none of the three of us would be here."

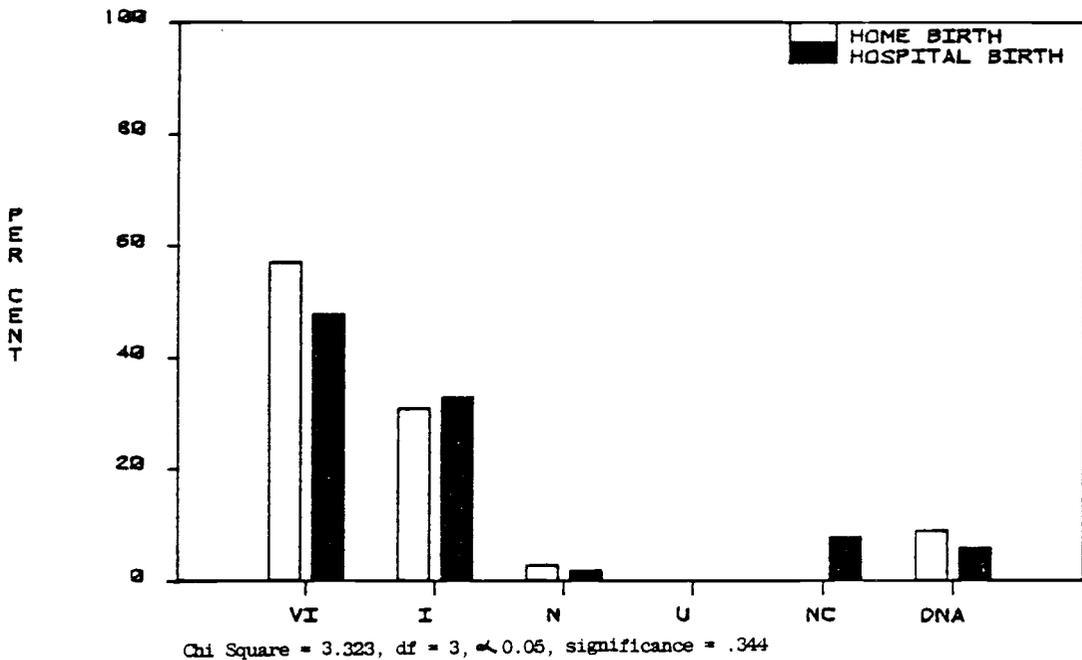
"The Fetal Monitor was very important to both the father and me."

Secondary Factors

Two secondary factors received high ratings from both groups; "approval of decision by husband" and "relaxed prenatal visits." Chi-Square values for these factors revealed no significant difference in their ratings by home and hospital birth women.

Approval of decision by husband.

Figure 20.

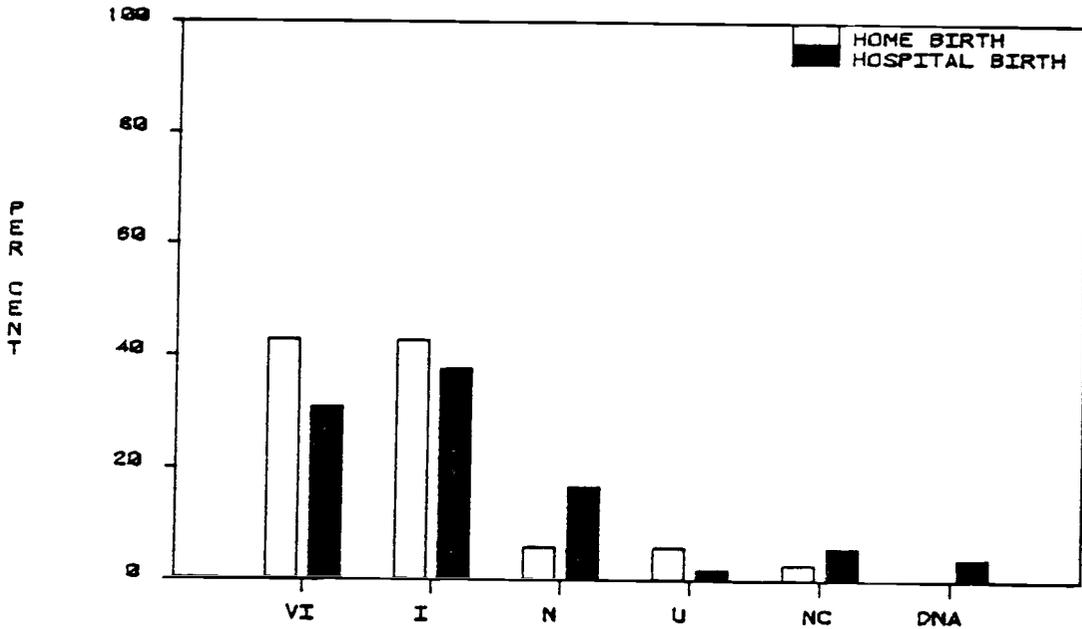


Home birth women ranked "approval of decision by husband" slightly higher; 86 percent responded either "Very Important" (n=20) or "Important" (n=11), than hospital birth women; 81 percent responded "Very Important" (n=23) or "Important" (n=16). Related to the high

importance attached to husband's participation in labor and delivery, apparently women also want to give birth in an environment where their husbands feel comfortable and can give their support freely.

Relaxed prenatal visits.

Figure 21.

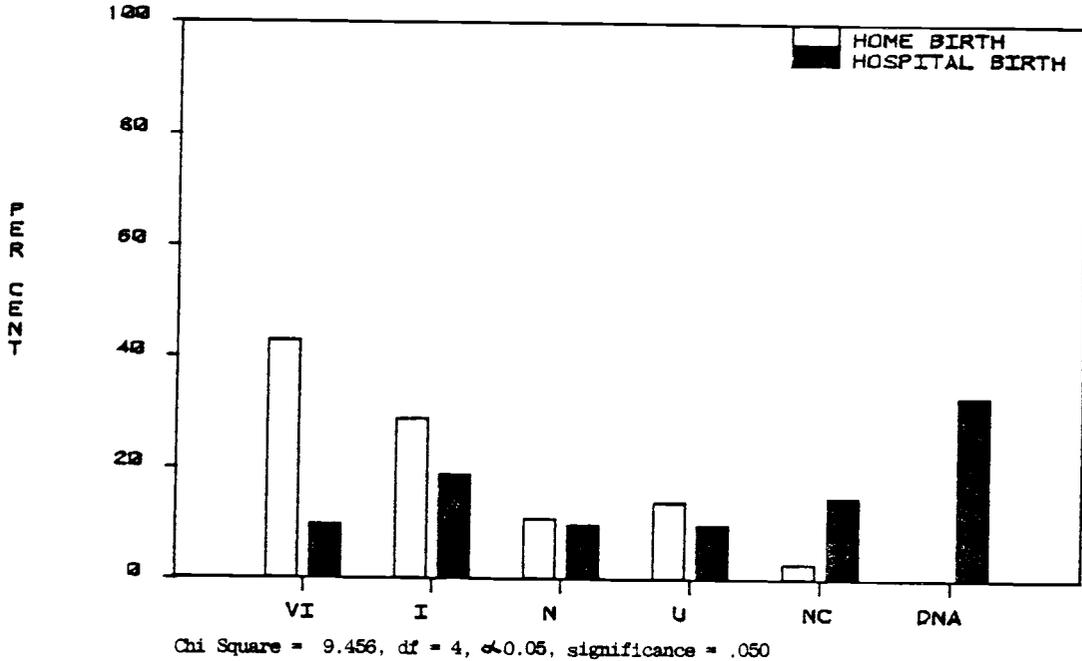


Chi Square = 4.018, df = 4, α 0.05, significance = .403

While important to both groups, home birth women attached higher priority to relaxed prenatal visits; 86 percent responded "Very Important" (n=15) or "Important" (n=15). Among hospital birth women, 69 percent responded "Very Important" (n=15) or "Important" (n=18). As we shall see, the amount of personal care given during prenatal visits can be a major source of satisfaction or dissatisfaction.

If your birth attendant was a woman, how important was that?

Figure 22.



Among home birth women, having a female attendant was an important consideration; 72 percent responded either "Very Important" (n=15) or "Important" (n=10). But, given the number of home births with male attendants statewide, there appears to be variable significance attached to this factor. Undoubtedly, the majority of home birth women would not shun a competent, caring male attendant simply on the basis of sex. He would certainly be preferred over going to a hospital to obtain a female attendant. Generally, women attendants are appreciated because they are viewed as compassionate and understanding. If they have borne children themselves, a particular bond exists. For women who stress the importance of relaxed prenatal visits, a woman attendant

is desirable because intimate subjects (e.g., changes of the breasts, preparation of the perineum, concerns about sexual intercourse during and after pregnancy) are more freely discussed with a woman.

For hospital birth women, having a woman attendant was either "Very Important" (n=5) or "Important" (n=9) to 29 percent of the group. It was ranked higher by those who considered a Certified Nurse Midwife or Registered Nurse their main attendant.

The importance of having a female attendant is particularly hard to evaluate given the wide variety of responses. All home birth women were attended by a female midwife, although nearly 30 percent responded this was not an important factor. One hospital birth woman, attended by a male R.N. while in labor, felt he offered more compassionate care than women. So, it appears that quality of care and the place of birth take precedent over the sex of the attendant.

Home birth comment:

"When we can view and experience pregnancy and birth as healthy and uncomplicated the results will be more home births, less male doctors, more women involved and generally contented, peaceful babies and parents."

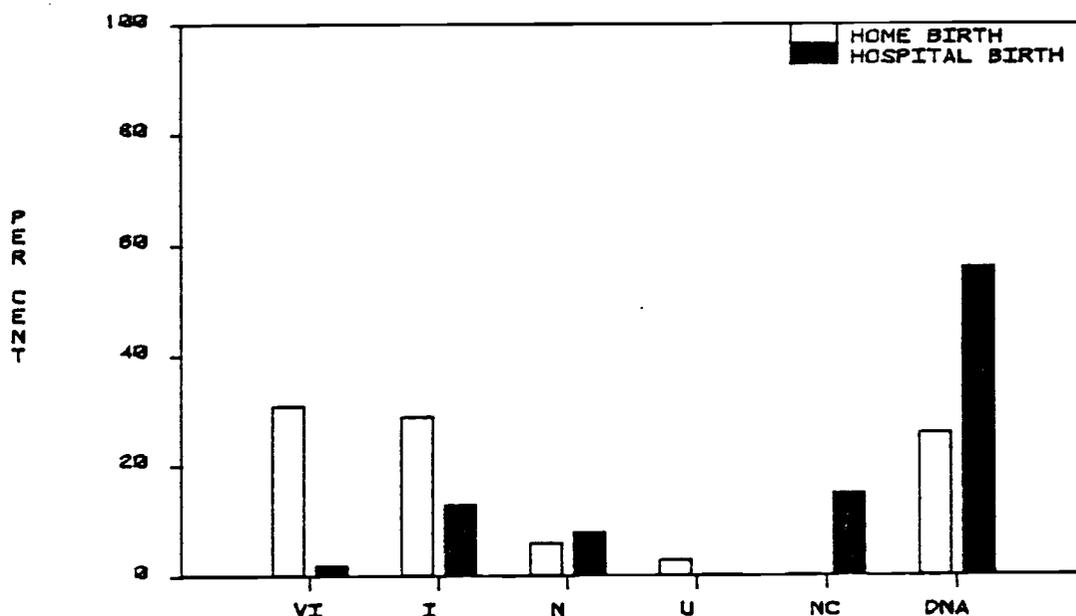
Hospital birth comments:

"I think nurse midwives are a wonderful thing. Doctors are always in too much of a hurry. My nurse midwife made my childbirth experience very satisfying."

"The male nurse [is] much better than all the women--more compassionate."

Recommendation of birth attendant by a friend.

Figure 23.



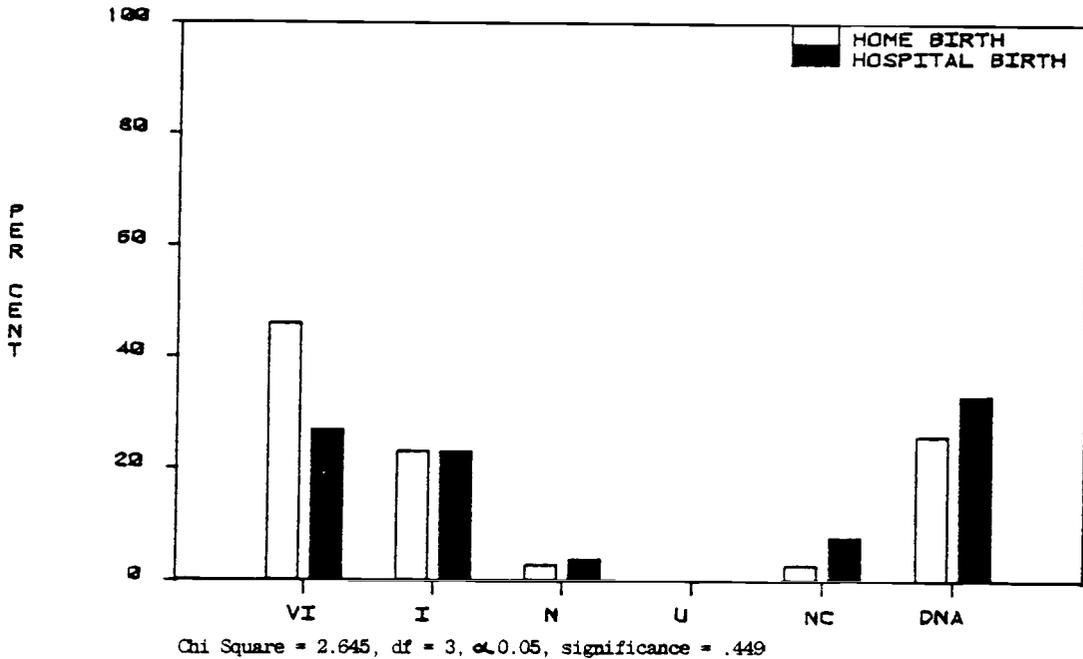
Home birth women rely more on the recommendations of their friends than hospital birth women; 60 percent responded either "Very Important" (n=11) or "Important" (n=10). Because there is no certification for lay midwives in Oregon, the evaluation of a friend who knew the midwife's capabilities would obviously be valuable. Also, recommendations are particularly crucial when a one-on-one, intimate relationship with a midwife is desired.

Only 15 percent of the hospital birth women responded either "Very Important" (n=1) or "Important" (n=6). The hospital has a good reputation as evidenced by those who come from the coast and adjacent counties to give birth there. However, a woman may see several

doctors and nurses at her prenatal visits and usually does not know who will deliver her child until she goes into labor (unless she has a private practice physician). An intimate relationship similar to the home birth arrangement does not exist for the majority of hospital birth women. Rather, the reputation of the facility is stressed. Of the seven hospital birth women who considered this an important factor, five had attendants who were not OB/GYNs.

Prior good relationship with birth attendant.

Figure 24.



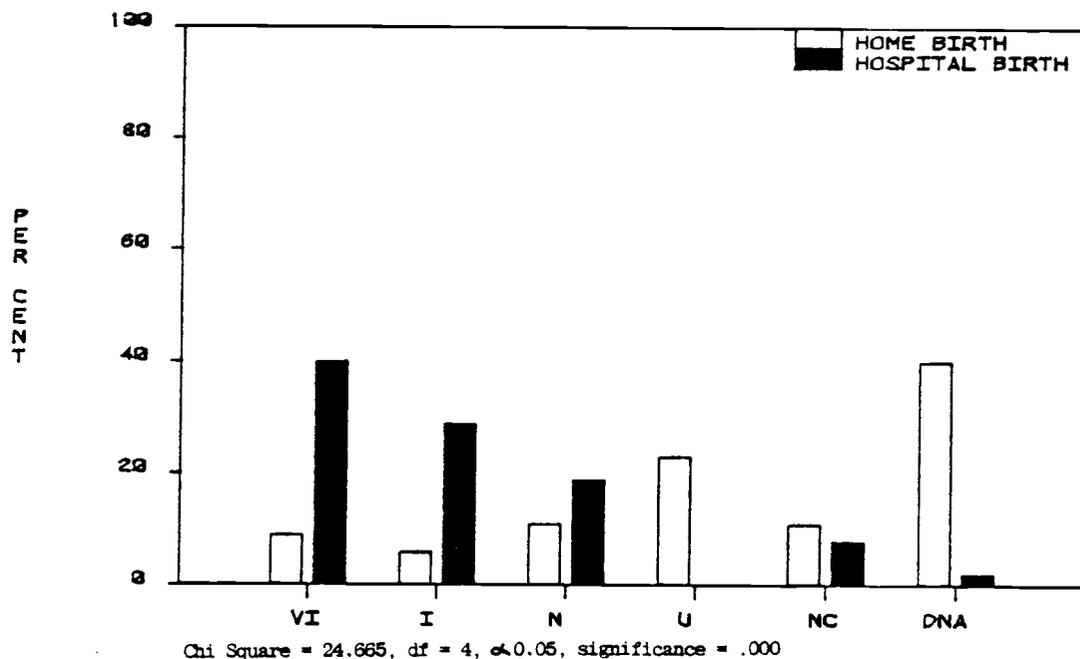
Home birth women ranked prior good relationship with the birth attendant higher; 69 percent responded "Very Important" (n=16) or "Important" (n=8) than hospital birth women; 50 percent "Very Important" (n=13) or "Important" (n=11).

Home birth women may have known the midwife through childbirth classes, lay midwife meetings, or attending a friend's home birth. For a few, this was the second child delivered by the midwife.

Hospital birth women might develop rapport with their attendants through routine gynecological care. A lay midwife, however, cannot by law prescribe medical contraceptives nor prescribe medications for infections or other problems.

Help of hospital nurses and staff.

Figure 25.



For 69 percent of the hospital birth women, the help of the hospital nurses and staff was either "Very Important" (n=19) or "Important" (n=14). This importance was expected, to a certain extent, because the hospital receives women with complications requiring intervention and even surgery. These women would, of course, need more help after delivery. If the 20 percent who had high risk pregnancies are taken into account, that still leaves nearly 50 percent who felt staff help was important. Although no hospital birth women responded "Unimportant", reaction was quite varied. Some felt nurses treated them in a patronizing manner, while others relied on nurses for the emotional support not forthcoming from their doctors.

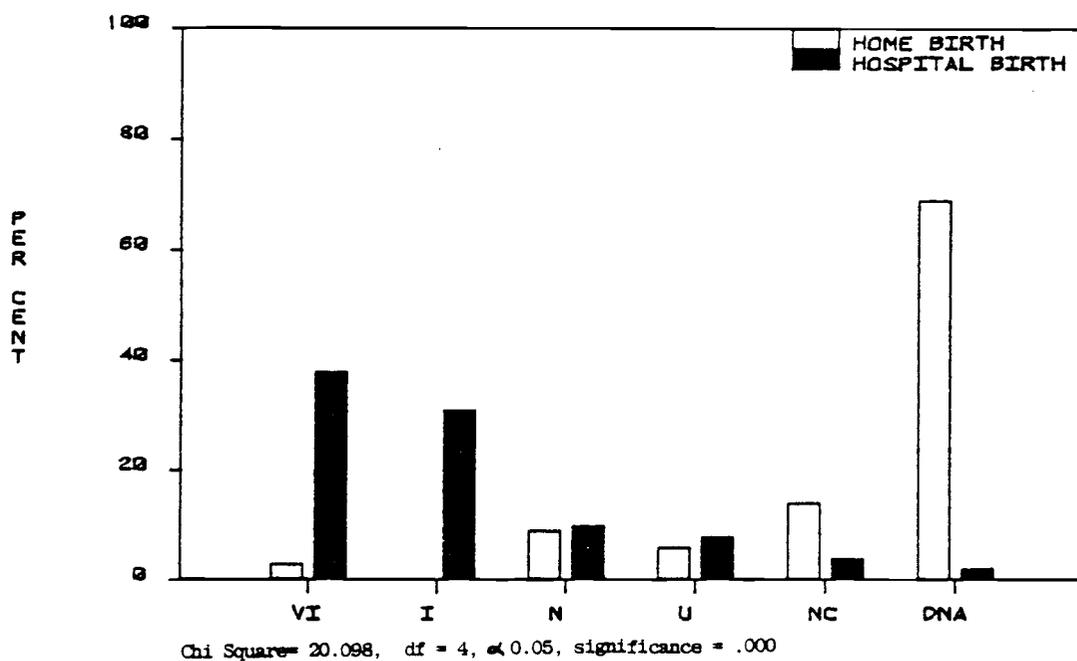
The majority of home birth women responded "Does Not Apply" (n=14), although "Unimportant" received eight responses. It is hard to interpret the meaning of the 14 percent who responded either "Very Important" (n=3) or "Important" (n=2) to this factor. Perhaps they misread the question, considered their midwife a nurse, or genuinely felt this was an important factor but one that did not override other positive aspects of home birth.

Hospital birth comment:

"I felt dealing with the nurses in the hospital nursery was very difficult. They treated me as if I knew nothing about infants. Yet the hospital rest was beneficial."

Time to rest before returning home.

Figure 26.



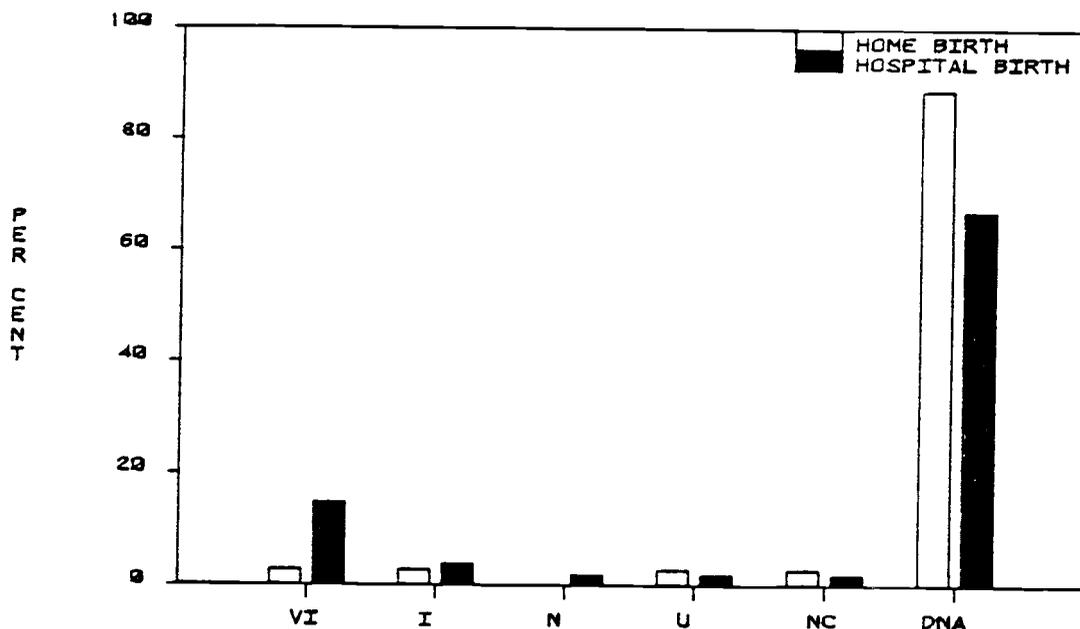
Hospital birth women felt that a period of rest in the hospital was desirable; 69 percent responded either "Very Important" (n=18) or "Important" (n=15). However, 15 percent responded either "Unimportant" (n=4), "Not Considered" (n=2) or "Does Not Apply" (n=1). These responses may be representative of the attitudes behind changes in hospital postpartum practices. In the 1940's, a "lying-in" period of seven to ten days was common. Currently, hospital stays are getting shorter. A woman can go home as soon as her attendant feels she is able. Most doctors prefer to watch the neonate and mother for at least 6 hours following delivery in case a problem arises, but

theoretically he/she could discharge them in less time. A more common hospital stay is 48 hours after a normal delivery.

The majority of home birth women responded "Does Not Apply" (n=24) although one responded "Very Important."

Previous difficult delivery.

Figure 27.



Only 19 percent of the hospital birth women (n=9) and 6 percent of the home birth women (n=2) stated that a previous difficult delivery was an important factor in their decision. Previous Cesarean sections, history of miscarriages, or prolonged labor were problems listed by hospital birth women.

One home birth woman specifically attributed her previous difficult delivery to physician intervention. She put four x's on "Very Important" for "fear of interference with birth process." Since her hospital delivery, she has experienced two home births and said she would "very likely" plan the same type of delivery if she were to have another child.

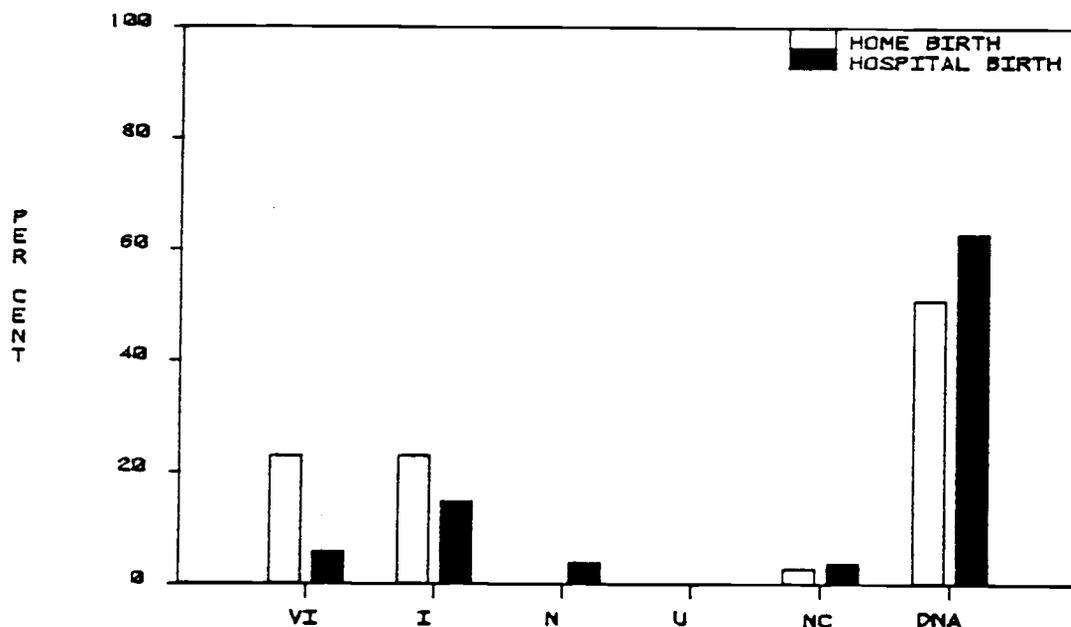
Another home birth woman, who planned a previous home delivery but transferred to give birth at the hospital, ranked previous difficult delivery as "Important". Assuming some complication arose, it is interesting that this woman opted for home delivery a second time. She did check "availability of sophisticated medical technology" as "Very Important" and lived less than nine minutes from the hospital. Apparently satisfied from her previous experience that an emergency could be handled, she commented, "It was important for us to make the decisions on how, why, and where the birth was to take place."

Hospital birth comment:

"After four miscarriages, two live births--of which on one living child who had to be delivered by c-section, and the hoped for delivery of twins--no other delivery than hospital was considered possible by my husband and myself."

Previous uncomplicated delivery.

Figure 28.

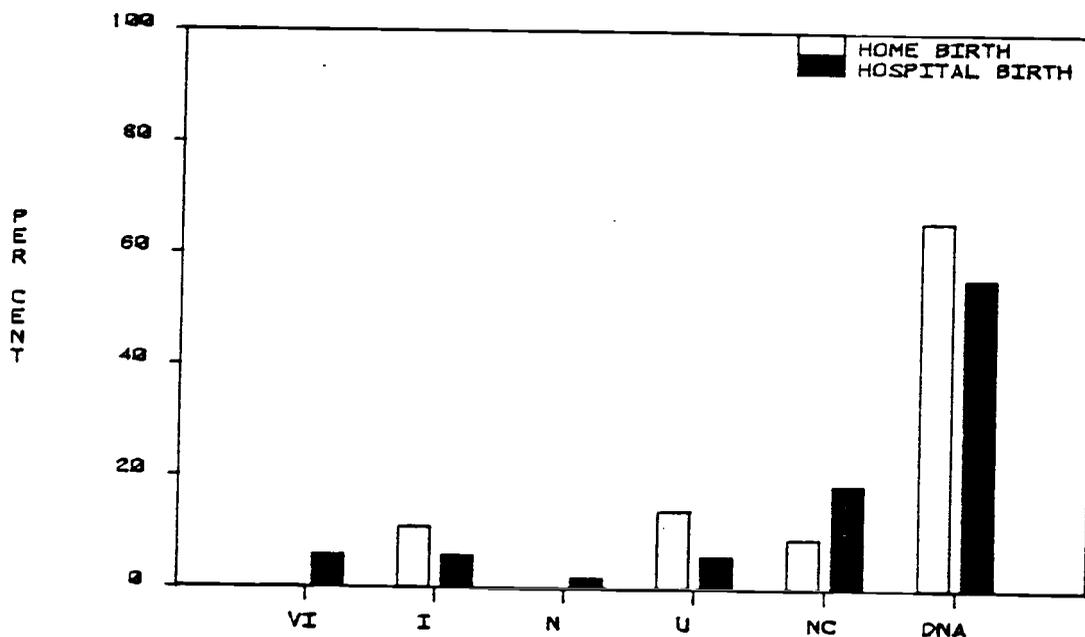


As noted, all home birth women can not be characterized as having a history of fast, easy deliveries--a commonly held stereotype. However, the majority of home birth women who had previous births (whether at home or in a hospital) considered them uncomplicated. Of the three who responded "Does Not Apply", two considered their complications iatrogenic and one relied on medical care when it became necessary. Among home birth women, 46 percent rated previous uncomplicated delivery as either "Very Important" (n=8) or "Important" (n=8)1

Among hospital birth women, 21 percent responded either "Very Important" (n=3) or "Important" (n=7). None of the hospital birth women who experienced previous uncomplicated births viewed this as a stimulus for remaining at home for the next delivery.

Previous non-pregnancy related illness.

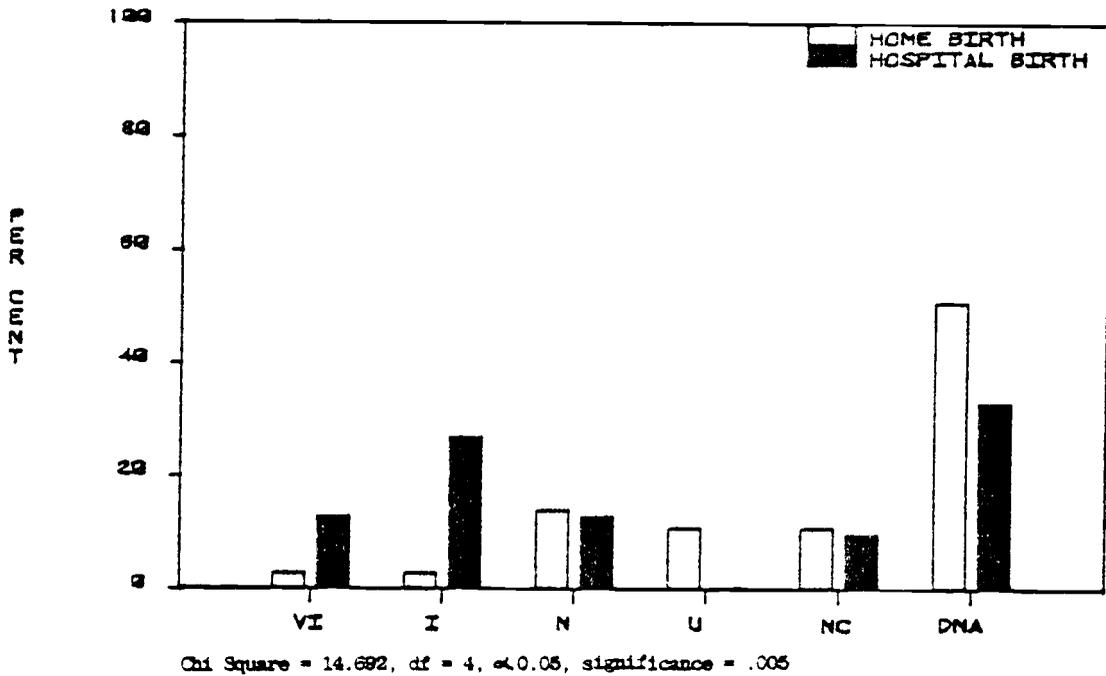
Figure 29.



"Previous non-pregnancy related illness" was included to test for non-pregnancy, medical factors which may have predisposed the woman towards a hospital orientation. High blood pressure, diabetes, and herpes complex are examples of pre-existing conditions which would affect the "normality" of a pregnancy and/or the woman's health. For 85 percent of the total sample, this was not a factor of much importance. For some of those, it was important that they did not have an illness considering only five women responded "Does Not Apply" to "prior overall good health." Among hospital birth women, 13 percent responded either "Very Important" (n=3) or "Important" (n=3). No home birth women responded "Very Important", but 11 percent (n=4) responded "Important". No comments were volunteered to explain the circumstances of home birth women marking this "Important."

Previous satisfactory hospital experience
(maternity or otherwise).

Figure 30.



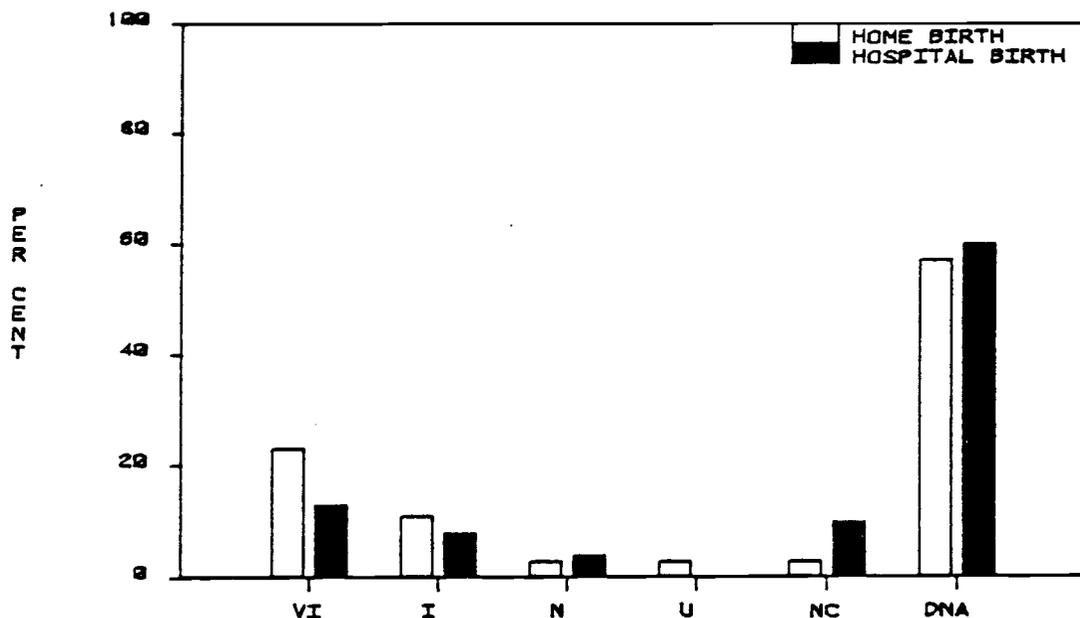
A much higher proportion of hospital birth women indicated that a previous satisfactory hospital experience was important; 40 percent responded either "Very Important" (n=6) or "Important" (n=13). Among home birth women, only 6 percent responded either "Very Important" (n=1) or "Important" (n=1). This does not mean, however, that home birth women have only had negative hospital experiences as 37 percent responded that a previous satisfactory hospital experience was "Neither Important or Unimportant" (n=5), "Unimportant" (n=4), or "Not Considered" (n=4).

Hospital birth comment:

"Have always had good medical care and positive experience in the hospital. Excellent physician [Family Practice M.D.] whom I trust."

Previous unsatisfactory hospital
experience (maternity or otherwise).

Figure 31.



As demonstrated in their comments, a negative encounter with the medical profession is a very strong incentive for some women to change hospitals, change doctors, or go to a C.N.M. For a small proportion, this, when combined with other factors, may be the impetus to change the place of delivery to the home. Among hospital birth women, 21 percent responded either "Very Important" (n=6) or "Important" n=4). Of the home birth women, 36 percent responded either "Very Important" (n=8) of "Important" (n=4). For the ten home birth women who had also experienced hospital deliveries, this factor carried notable importance. Six responded, "Very Important", two responded "Important", one "Not Considered," and one "Does Not Apply".

Home birth comments:

"The final straw for us was our hospital tour of Good Samaritan Hospital, watching the treatment which a 20 minute old baby girl was receiving in the weighing/measuring process."

"Out of natural curiosity, an interest in alternatives, and a bad experience with a hospital for a miscarriage I had a few years prior to my first full-term pregnancy, I came to several conclusions and still hold to these..."

"Having had both hospital and home deliveries I say emphatically that the home experience was better in every way and I recommend it for all normal births."

Hospital birth comment:

"When I found out I was pregnant with my second child I decided to have a G.P. deliver my baby. With our first child I had an OB/GYN and was very dissatisfied in his service. It was a clinic and I didn't know the man and it seemed that he could care less about me. His attitude was just unbelievable.

My decision to have a G.P. was the greatest thing I could have done. He was just great! He was very supportive and talked to us about things that were going on with the baby. And the after or postnatal visits were excellent too. He seemed like he really cared!"

Relatively high financial cost of hospital delivery and Relatively low cost of home delivery.

The idea that women choose home delivery merely because it is less expensive appears to be an unwarranted assumption. Interpretation of financial factor ratings is done in conjunction with insurance coverage and household income information. Figure 33 summarizes this data.

Generally, home birth women ranked both the high cost of hospital delivery (see Figure 32) and the low cost of home delivery (see Figure 34) with greater importance than did the hospital birth women, perhaps because all the home birth women knew ahead of time they would be

Figure 32. Relatively high financial cost of hospital delivery.

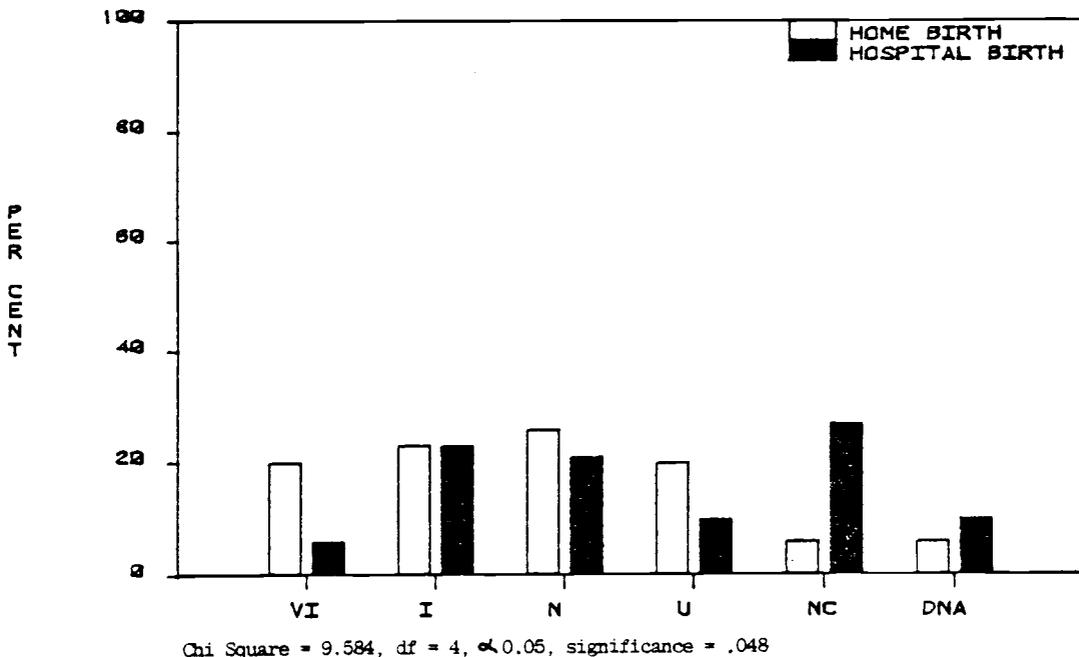


Figure 33. Summary of Financial Factors.

Relatively high financial cost of hospital delivery.

	<u>Home Birth</u>		<u>Hospital Birth</u>	
	<u>n</u>	<u>Percent</u>	<u>n</u>	<u>Percent</u>
VI	7	20	3	6.3
I	8	22.8	11	22.9
N	9	25.7	10	20.8
U	7	20	5	10.4
NC	2	5.7	13	27.1
DNA	2	5.7	5	10.4

Relatively low cost of home delivery

	<u>Home Birth</u>		<u>Hospital Birth</u>	
	<u>n</u>	<u>Percent</u>	<u>n</u>	<u>Percent</u>
VI	4	11.4	-	--
I	13	37.1	2	4.2
N	9	25.7	6	12.5
U	3	8.6	1	2.1
NC	4	11.4	15	31.3
DNA	2	5.7	23	47.9

Medical insurance coverage at the time of birth.

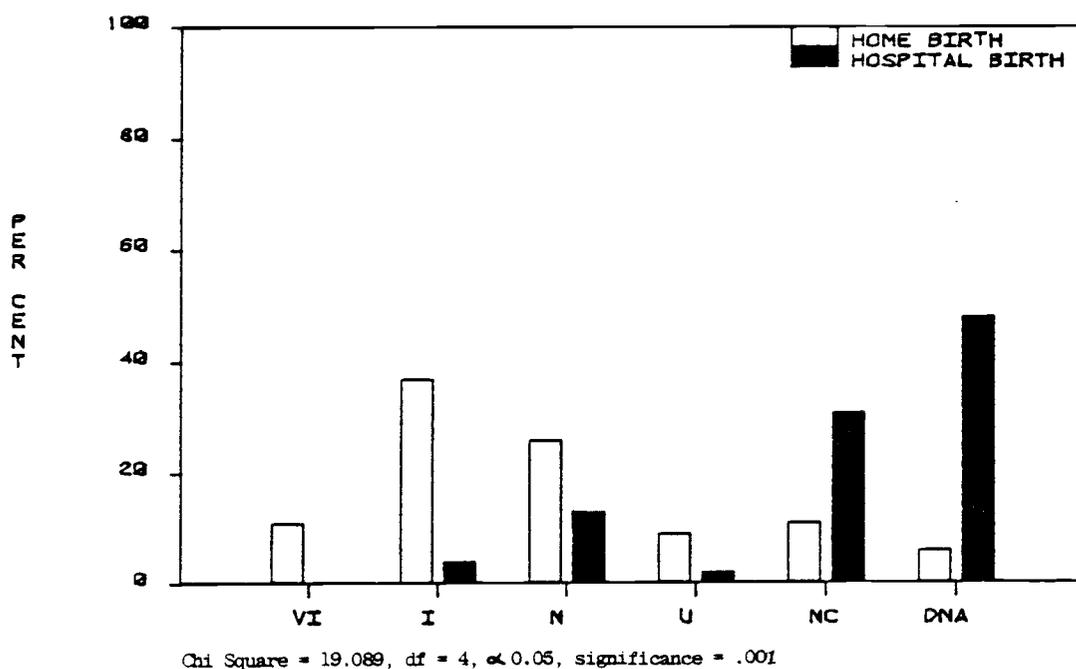
	<u>Home Birth</u>		<u>Hospital Birth</u>	
	<u>n</u>	<u>Percent</u>	<u>n</u>	<u>Percent</u>
Fully covered	0	--	15	31
Partially covered	0	--	21	44
Insurance, not covered	15	43	2	4
No insurance	20	57	7	15
No Answer	<u>0</u>	--	<u>3</u>	6
	35		48	

Total annual household income indicated for the past year.

	<u>Home Birth</u>		<u>Hospital Birth</u>	
	<u>n</u>	<u>Percent</u>	<u>n</u>	<u>Percent</u>
\$10,999 or less	15	42.9	12	25
11,000 to 15,999	6	17.1	7	14.6
16,000 to 21,999	4	11.4	17	35.4
22,000 to 26,999	6	17.1	6	12.5
27,000 or more	3	8.6	4	8.4
no answer	1	2.9	2	4.2

paying out of pocket for the services of their attendant, childbirth education classes, and birthing supplies. A woman without medical insurance would find home birth cheaper; however, a woman with insurance coverage would find home birth the more expensive alternative, even if she had to pay a deductible.

Figure 34. Relatively low financial cost of home delivery.



The majority (75 percent) of hospital birth women were either fully or partially covered by medical insurance at the time of the birth. In contrast, 43 percent of the home birth women had insurance coverage. While some insurance companies will pay for the services of a licensed home birth attendant, none will cover the cost of a lay midwife, a policy one home birth woman labeled "a real crock!"

Although one hospital birth woman remarked that medical insurance was the most important factor in her decision, the survey results show that financial considerations are not paramount for either group. The fact that the 25 percent of hospital birth women without insurance, and the 43 percent of home birth women with insurance, paid the relatively higher delivery cost demonstrates this.

Home birth comment:

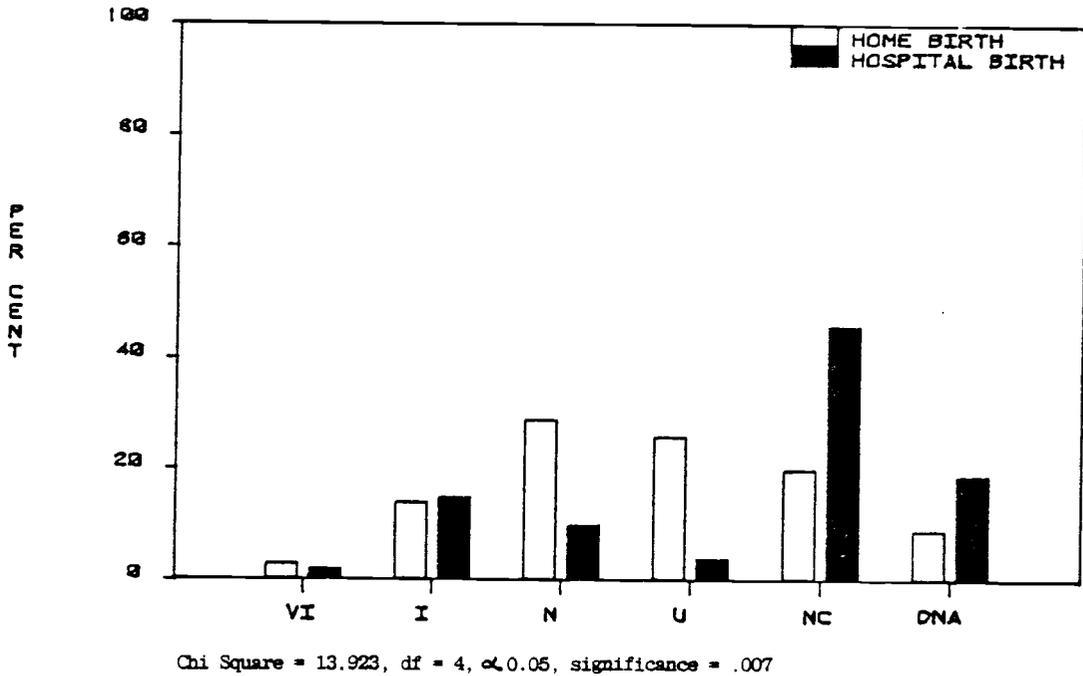
"Many people think we probably chose home birth to save money--not so. Our insurance would have covered all doctor and hospital costs. Using a lay midwife we payed ourselves. Well worth the money!"

Hospital birth comment:

"The fact that I had medical insurance was the deciding factor in my hospital birth."

Approval of decision by parents.

Figure 35.



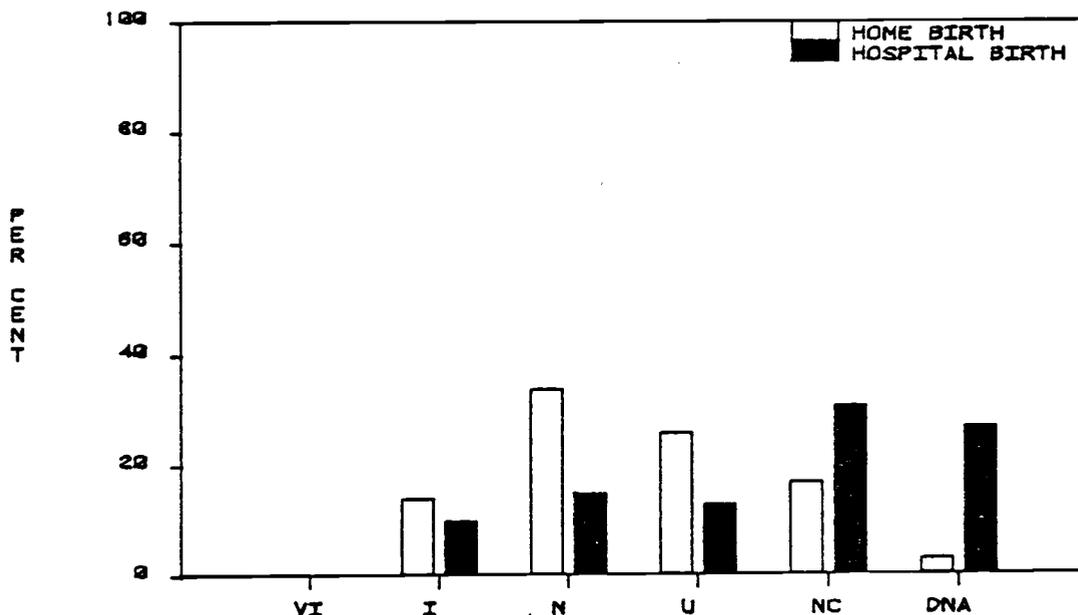
There was mutual agreement by the two groups that parental approval of their preferred type of delivery was not a significant consideration. Of the hospital birth women, 17 percent responded either "Very Important" (n=1) or "Important" (n=7), and 17 percent of the home birth women also responded either "Very Important" (n=1) or "Important" (n=5). Given these similarities, the researcher was surprised to find a significant difference between the answers as indicated by their Chi-Square value.

The difference appears in the lower ratings of the factor. A larger proportion of home birth women (26 percent) stated that their parents approval was "Unimportant", indicating perhaps, that there had

been some discussion on the matter. Only four percent of the hospital birth women responded "Unimportant"; rather, 46 percent responded "Not Considered". Parental approval for hospital birth women would be somewhat of a moot question since the majority of parents assume their daughters will give birth in a hospital.

Approval of decision by friends.

Figure 36.



Chi Square = 5.758, df = 3, α 0.05, significance = .123

"Approval of decision by friends" was not marked "Very Important" by anyone. Home birth women ranked it slightly higher; 14 percent "Important" (n=5) than did hospital birth women; 10 percent "Important" (n=5). For home birth women, the largest percentage of answers occurred in the "Neither Important or Unimportant" category (34 percent, n=12) while for hospital birth women, the largest percentage occurred in the "Not Considered" (31 percent, n=15) category. This does not parallel the importance attached to friend's participation which was much more disparate between the two groups.

Responses to Open-Ended Questions

Two open-ended questions were included on the survey which allowed women to mention unique circumstances and elaborate on themes or important items which may have been omitted from the questionnaire. Many of these comments have been included, in part, throughout the foregoing discussion of the survey results. Among hospital birth women, the majority of comments reiterated the belief that the hospital was the safest or best place for birth. Seven women commented they were pleased because the hospital had individualized their birth experience. Another major area of comment was either satisfaction or dissatisfaction with the hospital and staff. This will be addressed in the following section.

Many home birth women wrote long explanations concerning their decision to have a midwife attended home birth. The comments show a desire to control the birth process and stress the importance of being educated about childbirth. Many women listed the reasons they believe the home is the safest or best place for delivery.

Following are comments which demonstrate major themes of the open-ended responses and the number of responses recorded. All comments are included in their entirety in Appendix C.

Comments indicating the hospital is the safest or best place for birth (or with mention of desire to have medical technology).

11 comments by hospital birth women

I also feel that the hospital is the best place for birth and efforts should be made to make it a relaxed, friendly, personal

atmosphere. Pregnancy and childbirth are medical phenomena but they are not a malady nor a disease.

Good care of newborn and attention to interaction of mother and child, specifics in care [was very important]. Confidence in experienced staff.

Availability of emergency equipment for mother and/or baby should something go wrong.

Comments indicating a desire for an individualize, intimate hospital birth experience.

7 comments by hospital birth women

My childbirth experience was very positive. We used a labor room delivery, which to my husband and myself was much more intimate than the delivery room but we still had the availability of the hospital and staff in case of an emergency.

We had important roles in the birth decision making process. We wanted our opinions and desires listened to and heeded, if possible. This was very important to us. We knew what we wanted in our first birth experience.

Comments indicating previous knowledge (or influence) for hospital delivery or against home delivery.

2 comments by hospital birth women

I know of three women of my acquaintance who opted for home birth, one successfully. The other two had moderate to severe difficulty with their labors. One labored 38 hours at home before getting help and eventual hospitalization.

Comments indicating previous knowledge (or influence) for home birth or against hospital birth.

9 comments by home birth women

Having lived in a self-sufficiency community of 1100 people where only home births are practiced [was a very important factor].

I was born at home with only my father and mother present so I felt confident that home is the place to be. My mother has taught classes so I had cultural support from my family and never considered the hospital unless there was a real problem.

Comments indicating a desire to control or be responsible for the birth process.

11 comments by home birth women

It was important to us to be the primary decision makers. If a child is damaged due to birthing mistakes, the parents are faced with this tragedy daily, after delivery all of the hospital staff are no longer involved nor responsible. Parents need to feel they are sufficiently educated to be involved in all decisions.

It's important to me that my birth be controlled by myself. We (my husband and self) made well informed decisions and relied on our attendant for help and support.

Being able to do whatever I wanted, whenever I wanted. Making our own rules and regulations about how we wanted our birthing experience to be. Not having the hospital staff telling us what to do and when to do it.

Taking responsibility for labor, delivery and the child rather than abdicating this responsibility to the hospital medical attendants.

The exact opposite point of view concerning who is responsible for the birth was given by the woman who had an unplanned home birth. She felt the responsible place to be was the hospital.

Complications do arise and I'd like the comfort of modern technology and doctor's expertise in the event that a complication would arrive. If the child died because I had him at home, I'd never forgive myself.

Comments indicating the home is the safest or best place for birth and/or mention of birth definition.

12 comments by home birth women

I am concerned with giving the baby the best start, and am convinced that natural home birth has all the best advantages for the child. (You need good help for several weeks.)

To be able to be in the comfort of our home without anyone else there but us and ----, [was very important]. That to us was the only natural way (without medical people and sick people in the same building). It was important that our baby not catch anything from the hospital.

Birth is a family process and should be individualized for every family. I would never consider a hospital delivery for a normal pregnancy. Having my girls see and experience their sisters being born was very special to me. I know they'll have a healthy attitude about their own child bearing.

It all happened quickly and just right for a sunny afternoon--so normal and everydayish. We all took it in stride and accepted it as a normal aspect of our lives. I can think of no better way to start a baby's life than in the homes of those who love and plan to care for her.

Childbirth in this society is a sad situation and has been for over 40 or 50 years now. From a normal, family, home event, it took on drastic changes. An event so natural and uncomplicated (roughly 95 percent of the time) suddenly in the hands of hospitals which mechanized and manipulated the birth of every child. Birth became frightening and complex. Unfortunately this is the accepted norm or society today.

It surprised me how ignorant people are when it comes to giving birth. One man thought it was illegal to give birth at home. A good friend of mine was totally shocked when I told her...The most common reaction was that I was putting my child in danger. That, I believe, is the result of AMA propaganda. One girl (who was pregnant) said she had gone to the Corvallis Clinic because it was "the thing to do". She did not know how she was going to deliver, who her doctor would be, what drugs would be used--anything. She was leaving it up to the doctors to do it for her. People don't realize they have a choice!

Comments pertaining to the advantages of home birth.

More enjoyment or relaxation at home, 7 comments
 Bonding and newborn care very important, 6 comments
 Mention of family or sibling participation, 3 comments
 Psychological/emotional state needs of the woman important,
 2 comments

Very glad to be in my own home where relaxation and security,
 for me, was really possible.

Didn't want to be in a hospital. Wanted a quiet birth with
 low lights for both myself and baby.

Calm emotional state, cleanliness at home. Speeding recovery
 and help from neighbors with cleaning, meals and other children
 for days after birth [were important].

The birth experience was beautiful. I could not have had such
 an experience in the hospital.

Able to be outside in labor, not have to go anywhere birth.
 All women in attendance. Sibling at birth was very impor-
 tant.

Comments indicating the importance of being educated aboutchildbirth.

2 comments by hospital birth women
 8 comments by home birth women

The LaMaze class was very important in informing me and
 making me feel comfortable. It was sort of like a trial
 run. The class was recommended by the OB.

I had done a lot of previous reading on both sides of the
 question. The more I read the more I became convinced
 that home birth was appropriate for me at this time.

I believe in both parents being totally prepared and
 knowledgeable as much as possible. Being prepared for
 emergencies is a necessity also.

Nearly all the women (and their husband's) were educated not only about the process of birth but how to participate as well. In varying degrees, this bestows more responsibility on the couple. That 42 percent of the hospital birth women rated "fear of interference with the birth process" as important implies not only that the hospital staff is being watched with a critical eye, but that women have definite expectations for their birth experience.

Degree of Satisfaction

The level of satisfaction, or how well the woman's birth experience met her expectations, may be a key factor in determining what type of delivery she will plan if she becomes pregnant again. Three questions were asked to discern the level of satisfaction: 1) Overall, how satisfied or dissatisfied were you with the performance of your main birth attendant?; 2) Overall, how satisfied or dissatisfied were you with the entire birth experience?; and 3) If you were to have another child, how likely is it that you would plan the same type of delivery as this last child? (for example; hospital birth, home birth).

Perhaps it should be reiterated that although stillbirths were known to have occurred in the area during the study period (both at home and hospital births), they were not included in the sample. Thus, every woman surveyed had fulfilled society's major criteria concerning childbirth: both mother and child were healthy. The overwhelming majority of both groups were satisfied with their decision about what

type of delivery to have. Those who were dissatisfied with their birth attendant, no matter how minimally, listed similar reasons regardless of the place of delivery. The major sources of dissatisfaction were either disregard for the individual's wishes (lack of control) or lack of personal care (intimacy). Among home birth women, all except one, (97 percent) responded that they were "very satisfied" with their main birth attendant. In the exception's case, the baby arrived 10 minutes before the midwife. The woman responded "somewhat satisfied".

Two home birth women who checked "very satisfied" nonetheless noted potential areas for improvement. One stated that the midwife "could have been more gentle" and the other, referring to the midwife's assistant who lived a good distance away and was anxious to return home, commented, "We felt her impatience during the cutting of the umbilical cord before leaving."

Among hospital birth women, 92 percent were "very satisfied" with their main birth attendant. The four hospital birth women who were less satisfied with their attendants all had OB/GYNs deliver their child. One woman who responded "very dissatisfied" remarked:

I felt safer in a hospital with medical care available, although the detachment of the staff and OB was very disappointing. I surely did not go to the hospital because of the warm, welcome feeling they offer!

This woman stated she had "not considered" what type of delivery she would plan if she were to have another child.

Figure 37. Degree of Satisfaction.

Satisfaction with the main birth attendant

	<u>Home Birth</u>	<u>Hospital Birth</u>
Very satisfied	97%	92%
Somewhat satisfied	3%	2%
Neither satisfied or dissatisfied	--	2%
Somewhat dissatisfied	--	2%
Very dissatisfied	--	2%

Satisfaction with the entire birth experience

Very satisfied	91%	69%
Somewhat satisfied	6%	23%
Neither satisfied or dissatisfied	3%	2%
Somewhat dissatisfied	--	4%
Very dissatisfied	--	--

If you were to have another child, how likely is it that you would plan the same type of delivery as this last child? (for example; hospital birth, home birth)

Very likely	97%	85%
Somewhat likely	--	8%
Neither likely or unlikely	--	--
Somewhat unlikely	--	--
Very unlikely	--	--
Haven't considered it	--	6%

Another woman, who said she was "very satisfied" with her doctor [Family Practice M.D.] but only "somewhat satisfied" with her birth experience, stated:

The doctor got very cocky all of a sudden at the birth. He also made a very large episiotomy after telling me he would wait until necessary. [He] did it routinely.

This woman stated it was "somewhat likely" that she would plan the same type of delivery again.

Among home birth women, 91 percent (all except three women) responded they were "very satisfied" when evaluating their overall birth experience. Of the two responding "somewhat satisfied", one had a long labor (44 hours), and the other, who previously mentioned the assistant midwife's impatience, was also disappointed that her baby was immediately put to her breast to nurse. She stated,

I am disappointed (only slightly) that I did not hold and caress and examine the little miracle before plugging him in so soon after arriving.

The third home birth woman responded "neither satisfied or dissatisfied". She appeared rather ambivalent about the birth process and commented,

Great to get over being pregnant. Kids are more important than the childbirth experience.

Among hospital birth women, 69 percent were "very satisfied" with their overall birth experience. For approximately half of the remaining 31 percent, medical complications were the main reason given for a less satisfying experience. Cesarean section, toxemia, fetal distress, and difficult labors or deliveries were among complications

listed by women who responded "somewhat satisfied". Alternatively, the desire for intimacy and control were again offered as explanations by the other women who commented on their dissatisfactions. One woman who planned a Certified Nurse Midwife attended birth, eventually had an OB/GYN deliver her child due to fetal distress. She was "somewhat dissatisfied" with the overall birth experience and commented:

I was very dissatisfied with the kind of prenatal care I received from the male doctors in the Corvallis Clinic. They did not seem able to read my chart but always required me to repeat my history or current condition verbally; they over scheduled so that I was repeatedly turned away or seen by a nurse assistant for my prenatal visits. I never felt free to discuss any problem with them. My "main" doctor saw me a small percentage of my visits and was not present for the birth. He also had a revolting approach to weight gain (probably a prejudice toward big women). Another doctor, who I had seen once (from the clinic) delivered my child (while chewing gum) because I needed help getting the child out. My main birth attendant was -----, a nurse practitioner midwife. I was very satisfied with my prenatal visits with her and the help she gave me up to delivery.

This woman had seriously considered a birthing home delivery but was "talked out of it by nurses in a health department". In spite of her dissatisfaction, she responded it was "very likely" she would plan the same type of delivery (hospital birth) if she were to have another child. Her need for assistance in delivering the child and meconium staining complication may have affected her feelings on the merits of hospitalization.

In essence, all home birth women responded they would "very likely" plan the same type of delivery if they were to have another child. The woman whose home birth was accidental said she would still

try to go to the hospital even though she successfully gave birth unprepared in less than an hour. Her comments (see page 147) concisely summarize two major hospital birth values: that modern medical technology provides a comforting insurance policy against complications, and that even uncomplicated births are legitimately the domain of physicians. She rated many factors similar to other hospital birth women. For example, among the factors she rated "Very Important" were "possibility of unforeseen complications," "contact and closeness allowed with newborn," and "previous satisfactory hospital experience."

The converse is true of the hospital birth women who stated it was only "somewhat likely" they would plan the same type of delivery. All exhibited many characteristics similar to home birth women. Of the four who responded "somewhat likely", two had gone to a C.N.M. and felt having a woman attendant was important. They attached less importance than the hospital norm to "availability of pain controlling medication" and more importance to "fear of interference with the birth process". Interestingly, both women rated "availability of sophisticated medical technology" as "Very Important," and they both listed fetal distress as a complication. Had their deliveries been uncomplicated, they may have re-evaluated their ratings, but both had experiences which reinforced the hospital as the appropriate place for delivery. They would probably not be likely candidates for home birth next time.

The other two women who responded "somewhat likely" went to Family Practice M.D.s and also exhibited several home birth values. One, already mentioned, was dissatisfied with her doctor's attitude and routine episiotomy. She felt the male labor and delivery nurse was very compassionate. Among the factors she rated "Very Important" were "relaxed prenatal visits," "previous unsatisfactory hospital experience," and "sibling's and/or other family member's participation in labor and delivery." She rated "availability of sophisticated medical technology" as "Important" rather than "Very Important" and "having a licensed attendant" as "Unimportant." She also rated "fear of interference with the birth process" as "Important" and noting that she had "extremely severe back pain for 8 hours," rated "availability of pain controlling medication" as "Important."

The other woman who went to a Family Practice M.D. considered the labor and delivery R.N. her main attendant and felt a woman attendant was important. She gave birth after five hours of labor with no major complications and noted that "dealing with the hospital nursery was very 'difficult.'" She took Bradley rather than LaMaze childbirth classes and rated "fear of interference with the birth process" and "closeness and contact allowed with newborn" as "Very Important". She rated "help of hospital nurses and staff," "time to rest before returning home" and "having a licensed attendant" as "Neither Important or Unimportant." "Availability of pain controlling medication" and, perhaps most significantly, "availability of sophisticated medical

technology" were rated "Unimportant". This woman stated that medical insurance coverage was the deciding factor in her decision, which is uncharacteristic of both groups.

Statistically, one would expect a minute number of hospital birth women to change their preferred place of delivery because only four percent of all births are home births and only one-third of home birth women in this sample had previous hospital births. While the above woman may be the best candidate for elective home birth at a future date, she still responded it was "somewhat likely" she would choose the same type of delivery. None of the women in the hospital birth sample said it was "very unlikely" that they would plan the same type of delivery, although some "hadn't considered it." Rather, the majority of dissatisfied hospital birth women can be expected to exert more control by increasing demands to deinstitutionalize obstetrical services. The following comment by a hospital birth woman indicates the desire for control and intimacy within the hospital.

We very strongly believe in unmedicated births. Also, I think this is one of the greatest efforts a woman must ever undertake and [she] should be given a great deal of support and encouragement by any and all in attendance...

We feel that immediate and prolonged contact between the parents and child is of paramount importance.

I have been to both OB/GYN groups in Corvallis (too impersonal) and a Family Practitioner (too set in his ideas and methods) and have not been really satisfied with any of them. But, I also feel that the hospital is the best place for birth and efforts should be made to make it a relaxed, friendly, personal atmosphere. Pregnancy and childbirth are medical phenomena but they are not a malady nor a disease.

This comment also illustrates a fair amount of "consumerism" exhibited by many women.

Increased popularity of Certified Nurse Midwives, labor room deliveries, unmedicated births, rooming-in, and shorter hospital stays are all the result of consumer pressure rather than hospital initiated policy changes.

In this sense, the women who shared both home and hospital birth values are those most successful at implementing structural changes within the medical profession. Most of these women maintained considerable bargaining power with respect to their client status. They were members of the dominant racial class, they had attended college, and they were knowledgeable about childbirth. It is not surprising then, that the hospital in the study area is viewed as progressive by many. A teaching hospital serving low income women in a large and urban area would not be expected to manifest such changes so quickly.

The experiences of those who were dissatisfied with some aspect of their birth experience contradicted those who felt the hospital individualized their care and believed that their attendants were caring and concerned. While the amount of intimacy and control they expected cannot be assessed, the important fact is that their expectations were met.

Some of the comments of those who were satisfied with their birth experience follow:

Hospital birth comments:

I would like to say that no matter what the trouble I had, childbirth is the most wonderful and exciting thing that a woman can do. It is made so much more comfortable and

wonderful with the help of good doctors and nurses, [the kind] that make Good Samaritan Hospital the best around. They are great people. Caring and dedicated.

The OB/GYN doctors here in Corvallis are so personal, such excellent doctors. We really appreciate each of them and feel it a real privilege to live here and have their availability.

My decision to have a G.P. was the greatest thing I could have done. He was just great! He was very supportive and talked to us about things that were going on with the baby. And the after postnatal visits were excellent too. He seemed like he really cared!

Home birth comments:

The birth experience was beautiful. I could not have had such an experience in the hospital.

We are very thankful to God to live in a place where we still have the right to give birth at home with a midwife. It was one of the neatest blessings.

Having had both hospital and at-home deliveries I say emphatically that the home experience was better in every way and I recommend it for all normal births.

Biographical Data

The majority (90 percent) of the women in the sample were married, and marital status was not significantly different between the two subgroups.

Differences in the ages of the women, however, were apparent. Among home birth women, 74 percent were between 25 and 35 years of age whereas 79 percent of the hospital birth women were between 19 and 30 years. Home birth women were, on the average, three years older than their hospital counterparts.

Overall, 77 percent of the sample had graduated from high school and attended some college. While a slightly lower percentage of home birth women had attended college (74 percent compared to 80 percent for hospital birth women), a slightly higher level of college achievement is represented as the four Master's degrees were all attributed to home birth women.

Home birth women can generally be characterized as having more liberal political views. Twenty-six percent of the home birth women (compared to 40 percent of the hospital women) subjectively described their views as either "very conservative" or "conservative". Conversely, 54 percent of the home birth women described their political views as either "liberal" (31 percent) or "very liberal" (23 percent). Among hospital birth women, 40 percent described their views as "liberal" and only six percent as "very liberal". The majority of both groups (home: 71 percent, and hospital: 67 percent) stated that they had voted in the last election.

Perhaps the most dramatic biographical difference between home and hospital birth women appears in the area of religious preference. All hospital birth women were affiliated with Christian religions, the largest percentage (31 percent) responding "nondenominational Christian". Home birth women, on the other hand, were only half as likely to be affiliated with an organized Christian religion. Rather, 47 percent responded they had either non-Christian (nine percent) or personal (17 percent) religious beliefs, and 11 percent considered themselves atheists.

Sixty percent of both groups stated their occupation at the time of the survey was "homemaker" and, similarly, 40 percent of each group intended it to stay that way. Although there is approximately the same percentage of those working or planning to work outside the home, the area of professions differs. Among home birth women there was a high percentage of professionals (including 2 R.N.s) and self-employed women; no one responded she was involved in clerical or sales work. Hospital birth women were equally represented in professional and technical fields, and while no one responded that she was self-employed, nearly 36 percent of those working were in clerical and sales positions.

Home birth women were most likely to work in Health or Child Care (29 percent) or to own a Retail or Wholesale commercial enterprise (29 percent). Hospital birth women were more equally distributed among Health and Child Care (13 percent), Education (13 percent), Retail/Wholesale commercial enterprise (19 percent), and Government (16 percent).

In terms of total annual household income, home birth women averaged \$18,000 or \$3,000 less than the hospital birth women's average of \$21,000.

A question on residency in Oregon was included to discover any distinct correlation which might exist between length of residency in at state where lay midwifery had a positive legal status and choosing this option. The results were inconclusive. For home birth women, the average length of residency in Oregon was ten years and the mode was five years.

For hospital birth women, the average was 16 years but the mode was one year or less. Due to the wide array of answers, it is impossible to know what percentage, if any, of the hospital birth women might have investigated and become interested in home birth had they lived longer in an area where it is openly practiced and discussed. One woman commented on the convenience of using the hospital: "I was new in town...so hospital delivery was the easiest method to count on."

In summary, the biographical data of the home birth women suggests a cultural background which values and promotes independent behavior. The element of control and personal responsibility so important to them during childbirth is also evident in other areas of their lives. Undoubtedly, high level of education, liberal political views, and unorthodox religious beliefs indicate a tendency for critical thought. Thus, when childbearing becomes a relevant issue in their lives, home birth women similarly subject the medical profession to strict scrutiny.

While some women obviously considered themselves members of distinct subcultures by way of their religious, occupational, or sexual orientation, all of the women exhibited certain traits which contributed to and supported their decision to opt for home birth. Legal acceptance was never mentioned as a conditional factor.

For many, experiential as well as intellectual reasons were mentioned as justification for viewing the medical profession critically. Some worked in hospitals, one had been born at home herself and had her mother's encouragement, one had lived in a "self-sufficient" community

where only home births were practiced, and one attended home births as a lay midwife's assistant. One third responded they had experienced an unsatisfactory hospital stay which may have acted as a stimulus to seek alternatives and contributed to their high rating of "fear of interference with the birth process."

That one third of those working were self-employed, and none in clerical or sales positions, may be another indication of autonomy.

Home birth values then, should not be seen as isolates. Rather, home birth is the behavioral expression of the woman's self concept (including her appropriate role during birth) consistent with her subcultural values. Among those who practice home birth based on religious conviction, the values are easily recognized and defined. But for the majority of home birth women, the distinction is not so easily discerned. A wide variety of experiences and values may all culminate in or be the result of a socialization process which, somewhere along the line, diverges from the larger culture substantially enough for this small percentage of women to literally take their child's life in their own hands.

CHAPTER V
CONCLUSIONS AND IMPLICATIONS

The survey results reveal several factors which exhibit bimodal distribution based on the woman's preferred place of delivery. Both home and hospital birth women rated social/psychological factors the highest relative to medical, financial, and experiential factors. Specifically, the two factors rated as most important by both groups were "contact and closeness allowed with newborn" and "husband's participation in labor and delivery". Even women with high risk pregnancies rated these factors highly. The desire for intimacy was further substantiated by the relatively high rating of "relaxed prenatal visits" and "approval of decision by husband". Of these four factors, only "contact and closeness with newborn" revealed a significant ($\alpha .05$) difference of rating: all home birth women rated it "Very Important," whereas hospital birth responses were mostly divided between "Very Important" and "Important".

Home and hospital birth women who did not experience complicated deliveries, but were dissatisfied with their attendant and/or birth experience, based their dissatisfaction on lack of intimacy and control. Many of those satisfied with their experience stated that intimacy and control were the basis of their satisfaction. The survey findings indicate that the personal nature of childbirth (intimacy) overrides both spatial (where it takes place) and medical (complications)

considerations. This supports Hypothesis 1: social and psychological factors are most important to enjoyment and satisfaction during normal, uncomplicated deliveries.

For home birth women (who all expected normal, spontaneous births) additional social/psychological factors were rated highly. Being at home, having a female attendant, family participation, and control of the birth process were all rated significantly higher by home birth women. Hospital birth women rated all medical factors higher than home birth women. For all medical factors, except pregnancy specific condition, this significance is manifest in the "Very Important" and "Important" ratings.

The overwhelming importance attached to social/psychological factors supports Hypothesis 3: Women who choose home birth are more likely to rate social and psychological factors as important than are women who choose hospital birth. However, for many hospital birth women, the "availability of sophisticated medical technology" is viewed as such a comfort that it might be more accurately defined as a social/psychological factor.

Some hospital birth women exhibiting home birth values are exerting considerable pressure to deinstitutionalize obstetrical care. Thus, those who desired intimacy or a family-centered birth had labor room deliveries, made arrangements to have other family members present and, perhaps, had a less authoritative attendant.

The resistance to this consumerism (and home birth) by the medical profession can be viewed as an effort toward retaining professional autonomy and limiting structural change. The validity of consumerism, however, appears to be indicative of substantial cultural change.

Attitudes toward the medical model of childbirth

All of the women in this study were willing to become dependant on physicians and technology when labor became complicated or in the event of a life threatening emergency. Home birth women believe the possibility of this happening is minute but make provision should it become necessary. Thus, home birth is not a rejection of medical technology, per se. Rather, it is selective and manipulative use based on differing perceptions of when the medical profession is necessary.

Hospital birth women accept society's definition that labor and delivery are medical phenomenon from their onset. They believe that since life threatening complications could develop at any time, the hospital is the appropriate and safe place for delivery. Thus defined in pathological terms (albeit potential ones), they feel the responsibility for managing the course of events and the outcome lies with the licensed professionals whose judgement and training they trust and are dependant on.

Home birth women do not accept society's definition that child-birth is a medical event at its onset. Rather, they make a distinction between a normal and a complicated delivery that the larger population

does not. They define labor and delivery as a normal, intimate or family-centered process which should take place at home unless or until a complication occurs which requires hospitalization to insure a safe outcome. This supports Jordan's (1980) contention that all alternative birthing models must use medical criterion of safety as justification and, thus, the current home birth trend does not constitute a total redefinition of the birth event. It represents a change in degree rather than kind.

Unless hospitalization is required, home birth women feel the responsibility for managing the course of events and the outcome lies with themselves, aided by their chosen attendant. One third commented outright that control and personal responsibility were key factors in their decision. Given the high premium placed on these elements, it becomes apparent that these women could not have achieved their desired childbirth experience in a hospital. Twaddle and Hessler (1977: 225) have stated, "the power of the patient is almost completely eroded in the hospital...Even such elementary decisions as going to the bathroom are [made] by the hospital staff." Barring any serious medical complications then, hypothesis 2: women choose home birth to control the social and psychological setting of labor and delivery, is substantiated.

Biographical data of the home birth women reveals that their childbirth values are derived from a cultural background which promotes independent behavior, critical thought, and personal control.

Lester Hazell, who studied 300 home birth couples in the San Francisco Bay Area, found that the couples exhibited a consistent pattern of attitudes related to childbirth and other selected topics. Hazell's study, though descriptive rather than comparative, supports themes similarly espoused by the home birth women in this study. When asked to comment on why they favored home birth, all of the people interviewed by Hazell felt that the parents were responsible for creating a family-oriented situation for childbirth, and nearly all believed that there was reason to distrust the medical profession, many having had negative experiences themselves.

All felt they generally assumed a high level of responsibility in their lives, were more self-assertive, less bound up by status symbols, and very concerned about external control on their lives (Hazell 1976: 31-34). Similarly, Hazell found that members of the home birth set were willing to seek professional help when they perceived the presence of an illness or abnormality in their pregnancy.

Home birth women necessarily are more responsible for their birth considering that they must buy certain supplies, make decisions throughout labor, clean up and dispose of the afterbirth, and accommodate the newly arrived infant immediately. The amount of responsibility (control) and intimacy varies according to the individual and the degree of reliance on medical expertise. The range of possibilities may be placed on a hypothetical continuum demonstrating various alternative arrangements within and outside the hospital (see Figure 37).

Bauwens and Anderson (1978) in a study of home births in a metropolitan county of Arizona have suggested that women consciously choose home birth to reduce cognitive dissonance which occurs at the time of labor and delivery when the pregnant woman must adopt a low-status subordinate position in the hospital hierarchy. The Oregon women who chose home birth, like the Arizona women, were not willing to make the necessary adjustment in their life style or self-perception to adopt this subordinate position.

Figure 38. Possible maternity arrangements within and outside the hospital.

PLACE OF BIRTH:	HOME			BIRTH CENTER	Labor Room	HOSPITAL Delivery Room	
	Father, friend, relative	lay midwife	licensed attendant, including: N.D., D.C.	OB/GYN FP, M.D. D.O. C.N.M.	OB/GYN FP, M.D. D.O. C.N.M.	OB/GYN FP, M.D. D.O. C.N.M.	Surgical
TYPE OF ATTENDANT:							
SELECTED CHARACTERISTICS:	<p>←———— control increases —————→</p> <p>←———— intimacy increases —————→</p> <p>←———— amount of active participation increases —————→</p> <p>←———— availability of sophisticated medical technology decreases —————→</p> <p>←———— scientific orientation (medical model of childbirth) decreases —————→</p>						

The Functions of Home Birth

In utilizing Merton's (1968) "Paradigm for Functional Analysis" as an organizational tool, several aspects of the home birth controversy can be critically defined.

Social equilibrium, according to Merton (1968: 188), is maintained when individuals derive satisfaction from achievement of cultural goals and from striving to obtain them. Some cultures lead individuals to center their emotional convictions upon culturally acclaimed ends with far less emotional support for the methods of reaching these ends. With a deep conviction to the goal, behavior becomes limited by considerations of technical expediency, or which of the available procedures is most efficient in netting the value or goal.

The overwhelming premium American culture places on a safe delivery, coupled with medical-historical developments, has resulted in the highly technological in-hospital births characteristic in the United States today. Cultural emphasis placed on goals varies independently of the degree of emphasis placed on the means. Either may come under attack or assessment at different times (Merton 1968: 187).

This research has shown that some women accept the goal of a safe delivery but reject the means. For these women, the amount of personal stress associated with hospital delivery renders hospitalization dysfunctional, and home birth emerges as a viable functional alternative.

In addressing the safety justification for home birth, Jordan (1980: 88-89) has commented:

We have the curious situation in the United States today that demands for change in the medical system are based on this very systems' chief criterion for adequate performance, so that the medical way of doing birth in the U.S. is under attack precisely because it has been shown too inferior to other systems by its own standards.

Two factors will have an important effect on the future of home birth. First, the American medical profession, the structural constraint within which home birth must operate, is powerful, organized, and has proven itself a force with which to be reckoned. According to Merton (1968: 415-416), nonconformist behavior (as in elected home birth) may be labeled "criminal" as a last resort of social control, a strategy being implemented now in many states.

Second, the nonconformist as described by Merton (1968: 414-415) is considered to depart from the norm for largely disinterested purposes (e.g., "higher morality"). This is usually not the case with home birth. The act of home delivery is a very personal, individualistic act which affects a woman only a few times in her life. Few people make home birth advocacy their career and home birth women are not an organized public body. For home birth to become an effective, legitimate, functional alternative, the values behind the act must become politicized--not merely the act.

Implications

Currently the medical profession finds itself under attack from many segments of society. Escalating medical costs, rising numbers of malpractive suits, and information on disparities of income among hospital personnel have eroded much of the "alturistic" image formerly associated with physicians. Concern over the health of the elderly and poor has focused attention on the merits of Health Maintenance Organizations, National Health Insurance, and expanding role of midlevel practitioners. Certainly the quest for "alternatives" to nearly every facet of American culture, skepticism toward unlimited technological development, and the women's movement have all exerted pressure on several societal institutions, the medical profession included. Leo Reeder (1978) has addressed the effect of this pressure in an article which outlines the changing nature of professional-client relationships. This change, namely the emergence of consumerism, has resulted in a less passive role for the patient with an emphasis on knowledge and participation. This is particularly true where long term care is involved, for example, in psychoanalytical programs or management of chronic illness.

The amount of active participation in maternity care necessarily varies. Some women passively accept home or hospital birth according to their role expectations and cultural beliefs. Other women, in a position to evaluate their needs, make active choices. Some choose

to give birth in the hospital, exerting pressure to have their expectations met. Some choose to give birth at home, thus removing their birth from the medical arena entirely. While home birth women may not effect changes in hospital policy, their immense satisfaction at having recovered the joy and intimacy of birth will continue to serve as a radical check for hospital standards.

How and where then, does the home birth trend fit into American culture on the whole? Jeremy Rivkin in his book Entropy--A New World View (1980) argues that the increasing industrialization and specialization characteristic of modern American society creates disorder and alienation in the lives of individuals. Several authors (Rivkin: 1980, Illich: 1976) have similarly assessed the affects of specialization within the medical profession. Ivan Illich (1976) argues that the medical profession has become largely ineffective and, in many cases, harmful to individual's health. Illich calls for a limitation on medical technology and the systematic legal and political deprofessionalization of health care institutions.

Referring to the medicalization of society, Illich points out that Americans have become compulsively dependent on medicine. He uses the term "cultural iatrogenesis" to describe this subtle and deep reliance on the medical profession. This, he says, destroys the potential for people to deal with their health needs in a personal, comprehensive, and autonomous way. Thus, Americans can no longer accept pain nor see birth and death as natural processes of life.

Home birth, when seen in this light, may be viewed as the ultimate self-help movement. Just as Illich acknowledges the need for various surgical procedures, so home birth women acknowledge the need for medical intervention in certain instances. However, given the underlying natural forces which operate during childbirth, they view this as the expectation rather than the norm. By choosing to deliver their children at home, these women consciously produce a birth experience satisfying and meaningful to themselves and their family. In addition, it appears that regardless of the place of delivery, a personally meaningful, intimate birth experience is becoming a value held by the larger culture as well.

Applications of the Survey Results

The survey results reported in this study should be of interest to a number of professionals. Anyone who attends births may benefit by becoming more aware of what is important to the pregnant woman. These considerations, while often uncommunicated, may have a large bearing on the woman's satisfaction with her birth attendant.

People involved with legislating home birth may benefit by realizing that home birth women are generally making an educated and informed choice. They accept the responsibility for any unforeseen complications which may arise and, having considered them seriously, make provisions in the event they do. Women choosing home birth do

not reject the validity of medical technology in dealing with complicated deliveries. Based on the information available, the assumption that home birth necessarily imposes a greater risk for mother and child is a false one.

Perhaps the most practical contributions this study may offer are to hospitals and clinics currently incorporating family-oriented programs into their maternity care. Several specific suggestions can be made:

- 1) If physicians do not have the time, C.N.M.s and R.N.s should fill the gap and offer personalized care, particularly prenatal care, and they should be recognized as filling a vital function in offering continuous emotional support throughout labor and delivery.

- 2) Pain relieving medication should not be offered until it is specifically requested. Psychoprophalaxis and active participation of the husband should be encouraged instead.

- 3) An anticipated increase in the demand for participation by family members should be accommodated without reservation. Sacred Heart General Hospital of Eugene has initiated a policy of allowing siblings to be present throughout the birth process, with successful results. At the home births represented in this study, there were no restrictions on the number of people who could be present and the average was only 3.3, including the father.

- 4) Neonatal nurseries should be reserved for infants who need special care. Provisions for rooming-in should become established.

Jordan (1980: 52) has pointed out that in Europe, maternal/infant separation has never been practiced routinely and rooming-in is standard.

5) By encouraging a personal approach to maternity care and less reliance on medication and technological equipment, it may be possible to reduce the dissonance associated with hospitalization which was registered by the fairly high rating of "fear of interference with the birth process" by all women.

Endnotes

1. Wertz and Wertz(1981: 179-180) have attributed this popular misconception to 19th century perceptions of upper-class women who were believed to suffer difficult labors because they were fragile, susceptible to nervous strain, and lacked proper nutrition and exercise. Furthermore, some doctors believed that the evolutionary result of education was to produce smaller pelves in women and larger heads in infants, leading to more difficult births among "civilized" women.
2. For an ethnography of a contemporary American home birth, see Birth Goes Home(1978) by Lester Hazell. Mabel, The Story of One Midwife(1982) by Elizabeth Redditt-Lyon, contains 30 home birth stories many of which occurred in the study area. In Birth In Four Cultures(1980), Brigitte Jordan describes typical hospital deliveries in Sweden, Holland, and the United States.
3. In 1953, the majority of the Manus were not living in the traditional houses over lagoons. However, these stilt houses where mainly elders resided, were the preferred place to give birth despite their general level of disrepair(Mead: 1956).
4. Vomiting increases uterine contractions in two ways: 1) the act exerts intra-abdominal pressure which is transmitted to the uterus; 2) uterine pressure causes distention of the cervix which in turn stimulates the release of oxytocin from the pituitary which in turn stimulates contractions(Jordan 1980: 54).
5. Despite the fact that the study was reported in the December 19, 1980 issue of the Journal of the American Medical Association, and had been conducted in their state, several North Carolina physicians presented a bill entitled "An Act to Abolish the Practice of Lay Midwifery" to the early 1981 North Carolina State General Assembly. The bill did not pass in its original form but did pass as HB 695 entitled "An Act to Study and Regulate the Practice of Lay Midwifery in North Carolina"(NAPSAC Fall 1981: 10).
6. Stillbirths are recorded in the death records and were not considered a desirable part of the sample population.
7. The adjusted base is calculated as the sample minus the undeliverable surveys. The adjusted response rate is then calculated as:

$$\text{Response Rate} = \frac{\text{Number completed}}{\text{Adjusted base}} \times 100$$

Endnotes(continued)

8. The 1981 Vital Statistics for Oregon indicate an increase in both the number and proportion of out-of-hospital births statewide. In the study area, however, the number and proportion of out-of-hospital births declined slightly.

	1980		1981	
	State	Study Area	State	Study Area
Total	44,223	2,920	44,150	2,819
out-of-hospital	1,679	142	1,961	133
Percent out-of-hospital	3.8%	4.8%	4.4%	4.7%

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APPENDICES

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APPENDIX A

OREGON LEGISLATIVE ASSEMBLY—1981 Regular Session

Senate Bill 410

Sponsored by Senator KITZHABER (at the request of Oregon Medical Association)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Revises procedure required for nurse practitioners to gain prescription writing privileges.
Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to nurse practitioners; creating new provisions; amending ORS 678.375; repealing ORS 678.385 and
3 678.390; appropriating money; and declaring an emergency.

4 **Be It Enacted by the People of the State of Oregon:**

5 Section 1. ORS 678.375 is amended to read:

6 678.375. (1) The board is authorized to issue certificates of special competency to licensed registered
7 nurses to practice as nurse practitioners if they meet the requirements of the board pursuant to ORS 678.380.

8 (2) No person shall practice as a nurse practitioner or hold oneself out to the public or to an employer, or
9 use the initials, name, title, designation or abbreviation as a nurse practitioner until and unless such person is
10 certified by the board.

11 (3) A registered nurse, certified as a nurse practitioner, *[is] may be authorized to prescribe drugs for the use*
12 *of and administration to other persons if approval has been [given under ORS 678.390.] granted by the Board of*
13 *Medical Examiners for the State of Oregon as recommended by the advisory council pursuant to sections 4 to 8 of*
14 *this 1981 Act. [The drugs which the nurse practitioner is authorized to prescribe shall be included within the*
15 *certified nurse practitioner's scope of practice as defined by rules of the board subject to ORS 678.385.]*

16 *[(4) The dispensing of certain limited medications prescribed by a nurse practitioner in accordance with the*
17 *formulary established under ORS 678.385 and dispensed by a registered pharmacist or an employer thereof may*
18 *be filled by a pharmacist according to the terms of the prescription. The filling of such a prescription shall not*
19 *constitute evidence of negligence on the part of the pharmacist if the prescription was dispensed within the*
20 *reasonable and prudent practice of pharmacy.]*

21 *[(5) As used in this section:]*

22 *[(a) "Drug" means medicines and preparations for internal or external use of human beings which are*
23 *recognized in the formulary adopted pursuant to ORS 678.385.]*

24 *[(b) "Prescribe" means to direct, order or designate the preparation, use of or manner of using by spoken or*
25 *written words.]*

26 SECTION 2. ORS 678.385 and 678.390 are repealed.

27 SECTION 3. Sections 4 to 8 of this Act are added to and made a part of ORS chapter 677.

28 SECTION 4. (1) Recognizing that the scope of practice of the nurse practitioner is a collaboration of the

NOTE: Matter in bold face in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted; complete new sections begin with SECTION.

SB 410

(2)

1 professions of nursing and medicine, the Advisory Council on Nurse Practitioners' Prescribing Privileges is
2 created. It shall consist of nine members as follows:

3 (a) One physician member of the board as designated by the board;

4 (b) Two physicians licensed by the board designated by the Oregon Medical Association, one of whom
5 shall be engaged in medical practice in a rural area;

6 (c) One nurse member of the Oregon State Board of Nursing who is licensed to engage in the practice of
7 registered nursing designated by the board of nursing;

8 (d) Two certified nurse practitioners designated by the Oregon Nursing Association, one of whom shall be
9 from a rural area; and

10 (e) Three pharmacists designated by the State Board of Pharmacy, one of whom shall be a member of the
11 board of pharmacy. One pharmacist shall be engaged in hospital practice; one shall be engaged in community
12 practice; and one shall be from a rural area.

13 (2) The advisory council shall elect its own chairperson with such powers and duties as the advisory
14 council shall fix.

15 (3) A quorum of the advisory council shall be five members.

16 (4) The term of each member of the advisory council shall be for two years. A member shall serve until a
17 successor is appointed. If a vacancy occurs, it shall be filled by the appointing authority for the unexpired term
18 by a person with the same qualifications as the retiring member.

19 **SECTION 5.** (1) The advisory council created under section 4 of this 1981 Act shall advise and recommend
20 to the board on all matters relating to nurse practitioners' prescription writing privileges which include:

21 (a) The development of scope of practice for nurse practitioners who may be granted prescription writing
22 privileges by the board under this 1981 Act.

23 (b) Recommendations for appropriate educational requirements a nurse practitioner must demonstrate to
24 be considered for prescription writing privileges by scope of practice.

25 (c) Recommendations for appropriate guidelines for the collaborative relationships between nurse
26 practitioners who may be authorized to prescribe under this 1981 Act and physicians licensed to practice
27 medicine by the board.

28 (d) Development of an appropriate formulary by scope of practice. Controlled substances listed in
29 schedules III, IIIN, IV and V for controlled substances may be considered for inclusion in any formulary that
30 may be prescribed by a nurse practitioner if recommended by the advisory council and approved by the board.

31 (e) Recommendations of certified nurse practitioner applicants who seek prescription writing privileges
32 based on a documented relationship with a physician and specific acceptable practice protocol within a specific
33 scope of practice.

34 **SECTION 6.** (1) The board shall consider all recommendations of the advisory council as required under
35 this 1981 Act.

36 (2) The board may approve, modify or deny recommendations of the advisory council as provided under
37 this 1981 Act.

38 (3) Upon recommendation of the advisory council, the board may grant the privilege of writing
39 prescriptions described in the formulary by scope of practice.

40 (4) A certified nurse practitioner may make application to the board in a manner prescribed by the board
41 for special drug dispensing authority if the certified nurse practitioner's practice is located in an area of the

[3]

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1 state where geographic conditions severely limit the ability of the certified nurse practitioner to meet
2 emergency patient needs. The advisory council shall recommend to the board criteria to be used by the
3 advisory council in reviewing the application, to include but not be limited to the proximity in road miles of the
4 nearest pharmacy, general road conditions and weather conditions. Such special dispensing shall be from
5 prepackaged drugs authorized by the board, prepared by a licensed pharmacist.

6 (5) The board may renew the privilege of writing and dispensing drugs for a nurse practitioner who applies
7 for the privilege and satisfies the requirements of this 1981 Act at the request of the advisory council. The
8 biennial renewal fee is \$30.

9 (6) The privileges of writing prescriptions or dispensing drugs, or both may be suspended or revoked by the
10 board if the board has reason to believe any condition or limitation of the privilege has been abused or misused.
11 The procedure shall be a contested case under ORS 183.310 to 183.500.

12 (7) Nothing in this section requires a hospital, as defined in ORS 442.015 (11)(a), to allow a nurse
13 practitioner to write prescriptions for the hospital pharmacy.

14 (8) The board shall collect a fee of \$30 from the nurse practitioner at the time approval is granted.

15 (9) If the application of a certified nurse practitioner who seeks the privilege of writing prescriptions for
16 drugs is denied, the nurse practitioner may appeal the denial as from the final order in a contested case to the
17 board under ORS 183.480 to 183.500.

18 SECTION 7. The application of the nurse practitioner shall be on a form prescribed by the board and shall
19 be accompanied by a nonrefundable application fee of \$60, payable to the Health Division Account. The
20 amount of the fees is continuously appropriated to the board and shall be used only for the administration and
21 enforcement of ORS 414.325, 453.025, 475.005, 616.855, 678.385, 678.390, 743.128 and 750.055.

22 SECTION 8. The dispensing of certain limited medications prescribed by a nurse practitioner in
23 accordance with any formulary established pursuant to sections 5 and 6 of this 1981 Act and dispensed by a
24 registered pharmacist or an employer thereof may be filled by a pharmacist according to the terms of the
25 prescription. The filling of such a prescription shall not constitute evidence of negligence on the part of the
26 pharmacist.

27 SECTION 9. This Act amends statute sections repealed by chapter 842, Oregon Laws 1977. Any statute section
28 amended by this Act that is repealed by chapter 842, Oregon Laws 1977, remains subject to the operative date
29 of the repeal in chapter 842, Oregon Laws 1977, if the repeal becomes operative, and to applicable provisions of
30 sections 50 and 51, chapter 842, Oregon Laws 1977, and ORS 182.605 to 182.635.

31 SECTION 10. This Act being necessary for the immediate preservation of the public peace, health and
32 safety, an emergency is declared to exist, and this Act takes effect on its passage.

APPENDIX B

Childbirth Survey

1. How many children do you have?(if one, skip to question 2)
 _____ number of children
- 1a. Please list the number of children delivered at each of the following locations.
 _____ at home
 _____ home planned, transferred to hospital
 _____ hospital planned, hospital
 _____ at a clinic
 _____ other (please describe) _____
2. Was your last child born: (check one)
 _____ at home
 _____ home planned, transferred to hospital
 _____ hospital planned, hospital
 _____ at a clinic
 _____ other (please describe) _____
3. Thinking now only of this last birth, how many of each of the following professional people, if any, were attendants at the birth? And, please circle the type of professional you considered the main attendant.
 no. of each
- _____ O.B./G.Y.N. (Doctor of Obstetrics and Gynecology)
 _____ M.D. (Family Practice)
 _____ N.D. (Naturopathic Doctor)
 _____ D.O. (Doctor of Osteopathy)
 _____ C.N.M. (Certified Nurse Midwife)
 _____ R.N. (Registered Nurse)
 _____ Lay Midwife
 _____ no professional attendants
 _____ other (please describe) _____
4. And, how many of each of the following, if any, were also present at this birth?
 no. of each
- _____ father of the child
 _____ sibling/s of the child
 _____ grandparents of the child
 _____ male friends
 _____ female friends
 _____ other (please describe) _____
 _____ no one else present
5. From the time of your first definite indications (for example; contractions, broken water) approximately how many hours was your labor?
 _____ hours
6. Some people experience various kinds of problems during labor and delivery, while others do not. What minor or major complications, if any, did you experience during your labor and delivery?
 Minor:
- Major:

(Please turn page)

7. Thinking back on your decision about what kind of delivery to have, how important was each of the following in influencing your decision? (Check one for each factor) Ratings: Very Important(VI), Important(I), Neither Important or Unimportant(N), Unimportant(U), Not Considered(NC), Does Not Apply(DNA).

	VI	I	N	U	NC	DNA
a. previous non-pregnancy related illness.....	—	—	—	—	—	—
b. help of hospital nurses and staff.....	—	—	—	—	—	—
c. relaxed prenatal visits.....	—	—	—	—	—	—
d. approval of decision by husband.....	—	—	—	—	—	—
e. having the birth at your home.....	—	—	—	—	—	—
f. if your birth attendant was a woman, how important was that?.....	—	—	—	—	—	—
g. approval of decision by parents.....	—	—	—	—	—	—
h. possibility of unforeseen complications.....	—	—	—	—	—	—
i. contact and closeness allowed with newborn.....	—	—	—	—	—	—
j. previous unsatisfactory hospital experience, (maternity or otherwise).....	—	—	—	—	—	—
k. relatively high financial cost of hospital delivery.....	—	—	—	—	—	—
l. having a licensed attendant.....	—	—	—	—	—	—
m. availability of pain controlling medication.....	—	—	—	—	—	—
n. siblings and/or other family members' participation in labor and delivery.....	—	—	—	—	—	—
o. husband's or partner's participation in labor and delivery.....	—	—	—	—	—	—
p. fear of interference with birth process.....	—	—	—	—	—	—
q. previous uncomplicated delivery.....	—	—	—	—	—	—
r. friend's participation in labor and delivery.....	—	—	—	—	—	—
s. time to rest before returning home.....	—	—	—	—	—	—
t. previous difficult delivery.....	—	—	—	—	—	—
u. pregnancy specific condition (ie. toxemia, multiple birth).....	—	—	—	—	—	—
v. relatively low cost of home delivery.....	—	—	—	—	—	—
w. approval of decision by friends.....	—	—	—	—	—	—
x. previous satisfactory hospital experience, (maternity or otherwise).....	—	—	—	—	—	—
y. recommendation of birth attendant by a friend....	—	—	—	—	—	—
z. prior overall good health.....	—	—	—	—	—	—
aa. prior good relationship with birth attendant....	—	—	—	—	—	—
bb. availability of sophisticated medical technology.	—	—	—	—	—	—

8. What other factors, if any, were very important to you which were not included above? (please describe)

9. Overall, how satisfied or dissatisfied were you with the performance of your main birth attendant?(check one)
- very satisfied
 somewhat satisfied
 neither satisfied or dissatisfied
 somewhat dissatisfied
 very dissatisfied
10. Overall, how satisfied or dissatisfied were you with the entire birth experience?
- very satisfied
 somewhat satisfied
 neither satisfied or dissatisfied
 somewhat dissatisfied
 very dissatisfied
11. If you were to have another child, how likely is it that you would plan the same type of delivery as this last child?(for example;hospital birth, home birth)
- very likely(skip to question 12)
 somewhat likely(skip to question 12)
 neither likely or unlikely(skip to question 12)
 somewhat unlikely(go on to question 11a.)
 very unlikely(go on to question 11a.)
 haven't considered it(skip to question 12)
- 11a. Briefly explain why it is unlikely that you would plan the same type of delivery.

12. How many minutes was the nearest hospital from your residence at the time of the birth?(check one)
- less than 9 minutes
 10-20 minutes
 21 minutes and over
13. Did you take childbirth education classes, or not?
- yes, which method? _____ (go on to question 13a.)
 no(skip to question 14)
- 13a. Did your husband or a male partner take classes with you?
- yes
 no
14. Did you happen to have medical insurance at the time of the birth?
- yes(go on to question 14a.)
 no(skip to question 15)
- 14a. Did that medical insurance cover the services of your birth attendant?
- yes, fully
 yes, partially
 no

The last few questions are about you, yourself.

15. How long have you lived in Oregon?(please circle whether years or months)
- (years) (months)
16. Please indicate your total annual household income for the past year to the nearest \$1,000.00. (please turn page)
- _____ dollars

17. Are you presently: (check one)
- married
 living together
 separated
 single
 divorced
 widowed
18. Are you currently: (check one)
- employed full or part-time for pay (skip to question 19)
 on leave (skip to question 19)
 unemployed, looking for work (skip to question 19)
 homemaker (go on to question 18a.)
 student (go on to question 18a.)
 other (please describe) _____
- 18a. Do you plan to seek employment within the next year or two?
- yes (go on to question 19)
 no (skip to question 20)
19. Please describe your specific type of work and indicate in what industry.
- _____ specific job
 _____ industry
20. What is your religious preference, if any? (check one)
- Conservative Protestant
 Liberal Protestant
 Nondenominational Christian
 Catholic
 Jewish
 other (please describe) _____
21. Did you vote in the last election, or not?
- yes
 no
22. Generally, would you say your political views are: (check one)
- very conservative
 conservative
 liberal
 very liberal
 other (please describe) _____
23. What is your highest level of education? (check one)
- | | |
|--|--|
| <input type="checkbox"/> 8th grade or less | <input type="checkbox"/> college graduate |
| <input type="checkbox"/> some high school | <input type="checkbox"/> some post-baccalaureate classes |
| <input type="checkbox"/> high school graduate | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> technical school beyond high school | <input type="checkbox"/> Ph.D. |
| <input type="checkbox"/> some college | <input type="checkbox"/> other (please describe) _____ |
24. What was your age on your last birthday?
- | | |
|--|--------------------------------------|
| <input type="checkbox"/> 18 or younger | <input type="checkbox"/> 31-35 |
| <input type="checkbox"/> 19-24 | <input type="checkbox"/> 36-40 |
| <input type="checkbox"/> 25-30 | <input type="checkbox"/> 41 and over |
25. Is there anything you would like to say about your childbirth experience or about this survey? (Please use additional paper if necessary)

APPENDIX C

Enclosed are the results of the childbirth survey distributed by Susan D. Fuhr-Dunn. They are simply the tabulated answers and do not distinguish between hospital or home delivery.

A total of 83 surveys were returned. Thirty-three women had home deliveries attended by a lay midwife, two had home deliveries with the father attending. Forty-five women had hospital deliveries attended by various professionals including OB/GYN's, CNM's, GP's and one D.O.

The surveys were sent to women of Benton, Linn and Lincoln Counties who gave birth between the period of Nov.1980-Nov.1981. Oregon Vital Statistics for 1980(p.44-45) show the following figures for those three counties:

<u>COUNTY</u>	<u>HOSPITAL BIRTHS</u>	<u>OUT-OF-HOSPITAL BIRTHS</u>	<u>TOTAL</u>
Benton	1,361	52	1,413
Lincoln	237	34	271
Linn	1,180	56	1,236

Thank-you for your interest and for participating in the research.

7. Thinking back on your decision about what kind of delivery to have, how important was each of the following in influencing your decision? (Check one for each factor) Ratings: Very Important(VI), Important(I), Neither Important or Unimportant(N), Unimportant(U), Not Considered(NC), Does Not Apply(DNA).

	VI	I	N	U	NC	DNA
a. previous non-pregnancy related illness.....	<u>3</u>	<u>7</u>	<u>1</u>	<u>8</u>	<u>12</u>	<u>50</u>
b. help of hospital nurses and staff.....	<u>22</u>	<u>16</u>	<u>13</u>	<u>8</u>	<u>8</u>	<u>15</u>
c. relaxed prenatal visits.....	<u>30</u>	<u>33</u>	<u>10</u>	<u>3</u>	<u>4</u>	<u>2</u>
d. approval of decision by husband.....	<u>43</u>	<u>27</u>	<u>2</u>	<u>—</u>	<u>4</u>	<u>6</u>
e. having the birth at your home.....	<u>29</u>	<u>6</u>	<u>11</u>	<u>—</u>	<u>24</u>	<u>12</u>
f. if your birth attendant was a woman, how important was that?.....	<u>20</u>	<u>19</u>	<u>9</u>	<u>10</u>	<u>8</u>	<u>16</u>
g. approval of decision by parents.....	<u>2</u>	<u>12</u>	<u>13</u>	<u>11</u>	<u>29</u>	<u>12</u>
h. possibility of unforeseen complications.....	<u>38</u>	<u>25</u>	<u>9</u>	<u>2</u>	<u>5</u>	<u>2</u>
i. contact and closeness allowed with newborn.....	<u>66</u>	<u>14</u>	<u>—</u>	<u>—</u>	<u>2</u>	<u>—</u>
j. previous unsatisfactory hospital experience, (maternity or otherwise).....	<u>14</u>	<u>8</u>	<u>3</u>	<u>1</u>	<u>6</u>	<u>49</u>
k. relatively high financial cost of hospital delivery.....	<u>10</u>	<u>19</u>	<u>19</u>	<u>12</u>	<u>15</u>	<u>7</u>
l. having a licensed attendant.....	<u>18</u>	<u>22</u>	<u>18</u>	<u>12</u>	<u>10</u>	<u>2</u>
m. availability of pain controlling medication.....	<u>6</u>	<u>16</u>	<u>19</u>	<u>23</u>	<u>13</u>	<u>4</u>
n. siblings and/or other family members' participation in labor and delivery.....	<u>31</u>	<u>16</u>	<u>6</u>	<u>2</u>	<u>15</u>	<u>10</u>
o. husband's or partner's participation in labor and delivery.....	<u>68</u>	<u>10</u>	<u>1</u>	<u>—</u>	<u>2</u>	<u>1</u>
p. fear of interference with birth process.....	<u>29</u>	<u>22</u>	<u>9</u>	<u>—</u>	<u>15</u>	<u>2</u>
q. previous uncomplicated delivery.....	<u>11</u>	<u>15</u>	<u>2</u>	<u>—</u>	<u>3</u>	<u>48</u>
r. friend's participation in labor and delivery.....	<u>7</u>	<u>14</u>	<u>7</u>	<u>4</u>	<u>25</u>	<u>24</u>
s. time to rest before returning home.....	<u>19</u>	<u>15</u>	<u>8</u>	<u>6</u>	<u>7</u>	<u>25</u>
t. previous difficult delivery.....	<u>8</u>	<u>3</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>63</u>
u. pregnancy specific condition(ie. toxemia,multiple birth).....	<u>10</u>	<u>7</u>	<u>3</u>	<u>2</u>	<u>2</u>	<u>58</u>
v. relatively low cost of home delivery.....	<u>4</u>	<u>15</u>	<u>15</u>	<u>4</u>	<u>19</u>	<u>25</u>
w. approval of decision by friends.....	<u>—</u>	<u>10</u>	<u>19</u>	<u>15</u>	<u>21</u>	<u>14</u>
x. previous satisfactory hospital experience, (maternity or otherwise).....	<u>7</u>	<u>14</u>	<u>11</u>	<u>4</u>	<u>9</u>	<u>34</u>
y. recommendation of birth attendant by a friend....	<u>12</u>	<u>16</u>	<u>6</u>	<u>1</u>	<u>7</u>	<u>36</u>
z. prior overall good health.....	<u>32</u>	<u>36</u>	<u>6</u>	<u>—</u>	<u>3</u>	<u>5</u>
aa. prior good relationship with birth attendant.....	<u>29</u>	<u>19</u>	<u>3</u>	<u>—</u>	<u>5</u>	<u>25</u>
bb. availability of sophisticated medical technology.	<u>35</u>	<u>20</u>	<u>9</u>	<u>7</u>	<u>4</u>	<u>6</u>
8. What other factors, if any, were very important to you which were not included above? (please describe) (see continuation sheet)						

The responses to questions #8 and #25 were all read, combined and categorized according to recurrent themes. Comments in question #25 are included in full in addition to their categorization.

9. Overall, how satisfied or dissatisfied were you with the performance of your main birth attendant?(check one)
- 77 very satisfied
2 somewhat satisfied
1 neither satisfied or dissatisfied
1 somewhat dissatisfied
1 very dissatisfied
10. Overall, how satisfied or dissatisfied were you with the entire birth experience?
- 65 very satisfied
13 somewhat satisfied
2 neither satisfied or dissatisfied
2 somewhat dissatisfied
 very dissatisfied
11. If you were to have another child, how likely is it that you would plan the same type of delivery as this last child?(for example;hospital birth, home birth)
- 75 very likely(skip to question 12)
4 somewhat likely(skip to question 12)
 neither likely or unlikely(skip to question 12)
1 somewhat unlikely(go on to question 11a.)
 very unlikely(go on to question 11a.)
3 haven't considered it(skip to question 12)
- 11a. Briefly explain why it is unlikely that you would plan the same type of delivery.
12. How many minutes was the nearest hospital from your residence at the time of the birth?(check one)
- 33 less than 9 minutes
32 10-20 minutes
18 21 minutes and over
13. Did you take childbirth education classes, or not?
- 70 yes, which method? 38-Lamaze, 17-Bradley (go on to question 13a.)
13 no(skip to question 14) 4-ACHI, 7-other
- 13a. Did your husband or a male partner take classes with you?
- 64 yes
4 no 15-blank
14. Did you happen to have medical insurance at the time of the birth?
- 56 yes(go on to question 14a.)
27 no(skip to question 15)
- 14a. Did that medical insurance cover the services of your birth attendant?
- 15 yes, fully
21 yes, partially
17 no

The last few questions are about you, yourself.

15. How long have you lived in Oregon?(please circle whether years or months)
- 8- one year or less 28- 2-6 years 1- 12-16 years 26- 22 years or more
10- 7-11 years 10- 17-21 years
16. Please indicate your total annual household income for the past year to the nearest \$1,000.00.
- 27- \$10,999. or less 21- 16,-21,999. (please turn page)
13- 11,-15,999. 12- 22-26,999. 7- 27,000. or more

17. Are you presently: (check one)

- 75 married
5 living together
1 separated
3 single (one lesbian)
 _____ divorced
 _____ widowed

18. Are you currently: (check one)

- 20 employed full or part-time for pay (skip to question 19)
 _____ on leave (skip to question 19)
6 unemployed, looking for work (skip to question 19)
51 homemaker (go on to question 18a.)
4 student (go on to question 18a.)
2 other (please describe) _____

18a. Do you plan to seek employment within the next year or two?

- 22 yes (go on to question 19)
35 no (skip to question 20)

19. Please describe your specific type of work and indicate in what industry.

(See continuation sheet) specific job
 _____ industry

20. What is your religious preference, if any? (check one)

- 7 Conservative Protestant
8 Liberal Protestant
21 Nondenominational Christian
4 Catholic
 _____ Jewish
4 other (please describe) atheist
- 13 - other Christian religions
 6 - personal religious beliefs
 3 - nonChristian religions

21. Did you vote in the last election, or not?

- 57 yes
26 no

22. Generally, would you say your political views are: (check one)

- 8 very conservative
20 conservative
30 liberal
11 very liberal
3 other (please describe) _____
- 6 - moderate

23. What is your highest level of education? (check one)

- _____ 8th grade or less
3 some high school
18 high school graduate
3 technical school beyond high school
35 some college
- 14 college graduate
11 some post-baccalaureate classes
4 Master's degree
 _____ Ph.D.
 _____ other (please describe) _____

24. What was your age on your last birthday?

- 1 18 or younger
24 19-24
33 25-30
- 21 31-35
4 36-40
 _____ 41 and over

25. Is there anything you would like to say about your childbirth experience or about this survey? (Please use additional paper if necessary)

(See continuation sheet)

CONTINUATION SHEET

6. MINOR:

1. Back pain/pain-8
2. other labor discomforts
 muscle cramp -1
 hyperventilated -2
 nervousness -1
 temporary high blood pressure -1
 waters broke early, trickled -2
 waters broke late -1
 fainting -1
3. Fast, Precipitous Delivery -4
4. Long Labor, Long Pushing Stage-6
5. Meconium Staining-4
6. Fetal Distress
 fetal distress/monitored -2
 small birth size of twins -1
 position of baby (ie. breech, posterior)-4
 cord around neck had to be cut for delivery-2
7. Aid During Delivery
 inefficient uterus contractions-2
 pitosin/induced -2
 vacuum extractor/forceps used-2
8. Perineal Tear/Episiotomy-5
9. Retained/Delayed Placenta -4
 relatively high blood loss-2

MAJOR:

- | | |
|---|---------------------------------------|
| 1. <u>Fetal Distress</u>
fetal distress-3
baby needed oxygen-2
meconium staining-1
umbilical cord around neck-2 | 3. <u>Cesarean</u> -3 |
| 2. <u>Medical Condition</u>
IUD pregnancy-1
prematurity-1
toxemia-1
arrested labor-1
anesthesia to remove ingrown placenta-1 | 4. <u>Pain</u> -3 |
| | 5. <u>Position of baby</u> -1 |
| | 6. <u>Vacuum extractor/Forceps</u> -3 |

CONTINUATION SHEET

Combined responses of questions #8 and #25.

1. The hospital is the safest or best place for birth.(Or with mention of desire to have medical technology available.)
11-comments by women with hospital deliveries
2. The hospital was willing to accomodate my specific wishes,(for example, labor room delivery,or having family member besides just the father present).
7-comments by women with hospital deliveries
3. Wanted to control(or was responsible for) the birth process myself.
11-comments by women with home deliveries
4. I was well informed and educated about childbirth.
1-comment by a woman with hospital delivery
7-comments by women with home deliveries
5. The home is the safest or best place for birth.
11-comments by women with home deliveries
6. I had trust(or confidence) in my attendant.
2-comments by women with hospital deliveries
4-comments by women with home deliveries
7. Mention of unique medical or financial situations which were important factors(for example, history of stillbirths,Shirodkar Stitch, or medical coverage).
6-comments by women with hospital deliveries
2-comments by women with home deliveries
3. Previous knowledge(or influence) for hospital delivery or against home delivery.
2-comments by women with hospital deliveries
9. Previous knowledge(or influence) against hospital delivery or for home delivery.
8-comments by people with home deliveries
10. More enjoyment or relaxation at home.
7 -comments by women with home deliveries
11. Birth is a family event or mention of sibling participation as very important.
3-comments by women with home deliveries
12. Bonding and newborn care very important.
2-comments by women with hospital deliveries
6-comments by women with home deliveries
13. Birth is natural or not an illness.
4-comments by ~~women~~-with home deliveries

CONTINUATION SHEET

- 14. Psychological/emotional needs of the woman very important.
 1-comment by woman with hospital delivery
 2-comments by women with home deliveries
- 15. Satisfied with doctors and hospital staff.
 6-comments by women with hospital deliveries
 1-comment by woman with home delivery(unplanned)
- 16. Dissatisfied with doctors and hospital staff.
 5-comments by women with hospital deliveries
- 17. "It was great or best experience of my life".
 6-comments by women with hospital deliveries
 5-comments by women with home deliveries
- 18. Other various comments,for example:
 "Why didn't you ask us about our other deliveries?"
 "Good Luck!"
 "I was new in this town...so hospital delivery was the easiest method to count on."
 "Seems to be a great deal of assumption that everything is black or white and few shades of gray in life and decisions."
 10-comments by women with hospital deliveries
 9-comments by women with home deliveries

- 19. Please describe your specific type of work and indicate in what industry.

Professional	-11	
Technical	- 6	
Self-employed	- 7	
Clerical & Sales	-11	<u>TYPE OF WORK</u>
Skilled	- 5	
Semi-skilled	- 4	
Unskilled	- 3	
No answer	- 5	

Health and Childcare	-10	
Education	- 5	
Retail/Wholesale		<u>TYPE OF INDUSTRY</u>
commercial enterprise	-12	
Government	- 6	
Agriculture	- 1	
Writer/Artist	- 3	
Others	- 6	
No answer	- 9	

25. Is there anything you would like to say about your childbirth experience or about this survey?

Comments by people who had home births.

The birth experience was beautiful. I could not have had such an experience in the hospital. ***

We are very thankful to God to live in a place where we still have the right to give birth at home with a midwife. It was one of the neatest blessings. ***

The assistant of our midwife lived a good distance away and needed to go home. We felt her impatience during the cutting of umbilical cord before leaving. Also, our baby was put on my breast to begin nursing right away it seems. I am disappointed (only slightly) that I did not hold and caress and examine the little miracle before plugging him in so soon after arriving. ***

I wish everyone could have as wonderful a childbirth experience as we did! ***

My husband did a great job! The OB/GYN doctors here in Corvallis are so personal-we really appreciate each of them and feel it a real privilege to live here and have their availability. (unplanned home) ***

Having had both hospital and at-home deliveries I say emphatically that the home experience was better in every way and I recommend it for all normal births. ***

Kids are more important than the childbirth experience. ***

Home birth can be a very safe alternative. Too much medical interference from the doctors in Albany. ***

Very glad to see someone looking into this highly controversial, emotional subject. ***

When we can view and experience pregnancy and birth as healthy and uncomplicated the results will be more home births, less male doctors, more women involved and generally contented, peaceful babies and parents.

Daily exercise and excellent nutrition are very important.

My experience was: birth at 40, worked full time, swam 1 mile a day and ate well, etc. ****

Very glad to be in my own home where relaxation and security for me was really possible. ***

It was great. Anyone who does not have previous complications should have a home birth. ***

Childbirth is not an illness and needs not be treated as such. Healthy mothers and infants belong together in their homes. ***

I chose an un-certified midwife out of support of lay midwives, politically. Please don't assume all mothers are heterosexual. ***

As long as there are no prenatal complications that's the only way I'd deliver. It is great! ***

(25. continued)

We were very pleased with the birthing experience. I had top notch quality care of 2 very experienced women who knew their business. I had done alot of previous reading on both sides of the question. The more I read the more I became convinced that home birth was appropriate for me at this time. I was satisfied that for any emergency that came up, there would be time to handle it (to the hospital if need be).

I had no post-partum blues. I was surprised to find out that women who (in the hospital, 2 friends of mine) were given medication after transition. It seems that's the crux of pain there and during the pushing stage one would not want to be drugged up-it's not as painful.

I also knew I wouldn't get a routine episiotomy as it turns out- I didn't tear at all.

I did need to fully rest 2 weeks. I was a hard birth. At the end I was worn out and couldn't push (4 hours pushing) anymore. So I told the midwife to leave me alone for a few minutes. I took a nap! The baby turned around and came out normally. (posterior baby)

I'm very excited that a research survey on alternative childbirth is being done.

Might be interesting to see if people had medical insurance and if so would it cover any of the home birth expenses. Many people think we probably chose home birth to save money--not so. Our insurance would have covered all Dr.'s and hospital costs. Using a lay midwife we payed ourselves. Well worth the money!

My birth was a very rewarding experience. It was all I wanted. Each birth was easier and more wonderful. Having my girls see and experience their sisters being born was very special to me. I know they'll have a healthy attitude about child bearing.

It all happened quickly and just right for a sunny afternoon--so normal and every dayish. We all took it into stride and accepted it as a normal aspect of our lives. My toddler was never separated from us and she has suffered no ill affects of being shifted into the "older sister" role.

I never considered going somewhere to have my baby. We made her at home and we accepted her into our lives at home and we welcomed her birth at home. I can think of no better way to start a baby's life than in the home of those who love and plan to care for her.

It surprised me how ignorant people are when it comes to giving birth. One man thought it was illegal to give birth at home. A good friend of mine was totally shaken when I told her I planned to deliver at home; she didn't think it was wrong, the idea had never crossed her mind. (She got very interested in it and read a few books and later told me that it looked like I was doing the right thing.) The most common reaction was that I was putting my child in danger. That, I believe, is the result of AMA's propaganda. One girl (who was pregnant) said she had just gone to the Corvallis Clinic because it was "the thing to do". She did not know how she was going to deliver, who her doctor would be, what drugs would be used--anything. She was leaving it up to the doctors to do it for her. People don't realize they have a choice!

(cont.)

(25. continued)

About my delivery-

The pain was more than I could ever imagine. It was just unbearable. I can remember telling myself that I was ridiculous for putting myself through such agony. My back felt as if a knife had been plunged into it everytime a contraction started. And I was so tired! I had 3 hours sleep Fri. night, early labor all day Sat. and hard labor starting at 11:30 that night. My husband applied counter pressure on my back for hours until he finally exhausted himself and fell asleep. By that point my back was so sore he wasn't helping much anyway but transition had begun and the pain wasn't quite as sharp. There's no way I could have delivered on my back! I tried to rest between contractions propped up against the wall with pillows, but as soon as a contraction would start I had to sit up straight. Otherwise, I felt so helpless, out of control of the situation.

I did no breathing or anything to help alleviate the pain, just took in the full force of each contraction. I woke the midwife up about 40 minutes before the birth because I knew it was getting close. She said not to push, to breathe, so I tried and failed two or three times before she saw that the head was crowning and it was okay to push.

If she had had me breathe early in the labor, I would have been totally exhausted, both physically and mentally. I think that was the key to my birth tho. I was in an excellent frame of mind. I had all the confidence in the world in our midwife, knew I was in fairly good shape and decided to let my body just take over.

We were up and around in less than 48 hours taking my mother to the airport. Two days later, in a store, one girl was surprised we were out of the hospital already. When I told her we had the baby at home she said it was no wonder. We both looked too healthy for a hospital birth. ****

one home birth survey was recieved after this was sent out. Her comments are not included here.

Comments by people who had hospital births.

I feel that something should be done to make all medical expenses, not only maternity ones, affordable to the general public. ***

My experiences have all been very satisfactory. I've enjoyed being pregnant. The hospital and clinic I go to are very concerned about their patients and care. The doctors always keep up with medicine. ***

I was pleased with the hospital's plan to make childbirth individualized to my wishes and include my family. ***

The birth of my son was the most joyful experience of my life. ***

I think Nurse Midwives are a wonderful thing. Doctors are always in too much of a hurry. My Nurse Midwife made my childbirth experience very satisfying. ***

My childbirth experience was very positive. We used a labor room delivery, which to my husband and myself was much more intimate than the delivery room but we still had the availability of the hospital and staff incase of an emergency. ***

(25. continued)

We very strongly believe in un-medicated births.

Also, I think this is one of the greatest efforts a woman must ever undertake and should be given a great deal of support and encouragement by any and all in attendance. I had a student nurse who just kept saying, "You're doing great", or "Wow, you're so relaxed", and it really helped me know that I was doing a good job and doing it "right".

We have produced three healthy, vigorous 9½ pound babies in three very different experiences.

We feel that immediate and prolonged contact between the parents and child is of paramount importance.

I have been to both OB-GYN groups in Corvallis (to impersonal) and a Family Practitioner (to set in his ideas and methods) and have not been really satisfied with any of them. But I also feel that the hospital is the best place for birth and efforts should be made to make it relaxed, friendly, personal atmosphere. Pregnancy and childbirth are medical phenomena but they are not a malady nor a disease.

This 11 lb. 5½ oz. baby ended up being Cesarean. As much as I favor home deliveries and Lamaze preparation, I'm very thankful for medical technology. If we'd gone through this 50 years ago, quite likely none of the three of us would be here.

(25. continued)

I would like to say that no matter the trouble I had, childbirth is the most wonderful and exciting thing that a woman can do. It is made so much more enjoyable and comfortable with the help of good doctors and nurses that make Good Sam. Hospital the best around. They are great people. Caring and dedicated.

The entire birth process makes me ill. I hated the entire episode. I wish there was some other way to have a child.

Our child's birth was a wonderful, miraculous, sharing experience. Afterwards I felt so elated and relieved-I was intoxicated with joy!

We enjoyed our experience immensely.

When I found out I was pregnant with my second child I decided to have a G.P. deliver my baby. With our first child I had an OB/GYN and was very dissatisfied in his services. It was a clinic and I didn't know the man and it seemed that he could care less about me. His attitude was just unbelievable.

My decision to have a G.P. was the greatest thing I could have done. He was just great! He was very supportive and talked to us about things that were going on with the baby. And the after or postnatal visits were excellent too. He seemed like he really cared!

Childbirth was the most satisfying experience in my life. Having my husband present at the birth and seeing my daughter being born was the most beautiful thing that ever happened to me. I hope to do it again soon!

(Cesarean Section)

The second times easier.

I felt dealing with the nurses in the hospital nursery was very difficult. They treated me as if I knew nothing about infants. Yet the hospital rest was beneficial.

I was very dissatisfied with the kind of prenatal care I recieved from the male doctors in the Corvallis Clinic. They did not seem able to read my chart but always required me to repeat my history or current condition verbally. They over scheduled so that I was repeatedly turned away or seen by a nurse assistant for my prenatal visits. I never felt free to discuss any problem with them; my "main" doctor saw me a small percentage of my visits and was not present for the birth. He also had a revolting approach to weight gain(probably a prejudice toward big women). Another doctor who I had seen once(from the clinic)delivered my child(while chewing gum) because I needed help getting the child out. My main attendant was ..., a nurse practitioner midwife. I was very satisfied with my prenatal visits with her and the help she gave me up to delivery.

If there is anyway you can recommend more male nurses in labor rooms that would be great. It is the opinion of many of my friends that they are much more compassionate.

When toxemia became evident I felt satisfied with the care I was given. However, this condition made the birth experience less enjoyable.

APPENDIX D

Example of 2 x 2 contingency table construction used for obtaining all Chi-Square numbers.

Factor: Having a licensed attendant.

	VI	I	N	U	NC*	row total(n)
Home Birth	2 (6.1)	6 (18.2)	12 (36.4)	9 (27.3)	4 (12.1)	33
Hospital Birth	16 (34.0)	16 (34.0)	6 (12.8)	3 (6.4)	6 (12.8)	47
Column Number (percent)	18 (22.5)	22 (27.5)	18 (22.5)	12 (15.0)	10 (12.5)	80 (100)

Missing observations = 3

Raw Chi-Square = 18.9651 with 4 degrees of freedom.

Significance = .0008, confidence level (α) = .05

KEY

VI = Very Important

I = Important

N = Neither Important or Unimportant

U = Unimportant

NC = Not Considered

("Not Considered" was judged to be the opposite of "Very Important" for purposes of this analysis. "Does Not Apply" was deleted from all Chi-Square computations.)