Choice and Women's Autonomy in Birth

Rhetoric in the United States and its effect on Public Policy

By

Schuyler Beckwith

Submitted to
Central European University
Department of Public Policy

In partial fulfillment of the requirements for the degree of
Masters of the Arts in Public Policy

Supervisor: ViolettaZentai

Author's Declaration

I, the undersigned ……Schuyler Beckwith……. hereby declare that I am the sole author of this thesis. To the best of my knowledge this thesis contains no material previously published by any other person except where due acknowledgement has been made. This thesis contains no material which has been accepted as part of the requirements of any other academic degree or non-degree program, in English or in any other language.

This is a true copy of the thesis, including final revisions.

Date: ……June 10, 2014……

Name (printed letters): …Schuyler Beckwith……

Signature: ……SCHUYLER BECKWITH……

Abstract

The maternal health care system in the United States is broken. A significant majority of birthing women turn to doctors who employ the technocratic model of birth, which relies on a number of sometimes unnecessary obstetrical interventions before and during labor. The holistic model of birth, used primarily by midwives, focuses on the natural ability of women in birth and serves to empower a woman to make her own choices in her birthing path. This thesis explores rhetoric in the birth and abortion movements since the Roe v. Wade decision in 1973 and gives the reader a unique perspective of how public opinion and public policy surrounding women's choice and autonomy has evolved. An extensive literature review provides the reader with necessary background on each movement while the author connects shifts in rhetoric to public opinion and public policy changes.It also provides recommendations on changes policy makers and educators can make moving forward including obstetrical regulatory reform, consistent midwifery regulation, providing more prenatal education opportunities, instating a nationwide educational campaign about choices in birth, and encouraging lawmakers to consider science above all else when making policy.

Acknowledgements

Firstly I would like to thank my supervisor, ViolettaZentai, for her guidance and support through this process. I would also like to thank Agnes Toth from the Academic Writing Center; who has been an immense help by providing her critical eye and good advice, and Dr. Austin Choi-Fitzpatrick from CEU's School of Public Policy who provided critical feedback for research leading up to this thesis.

I wish to thank my classmates from the Department of Public Policy and throughout CEU; thank you for helping make this one of the most exciting years and I look forward to long lasting friendships.

Lastly, and above all else, I want to thank my parents and brother. I would not be here without their constant strength and love.

Table of Contents

Introduction[1]:

Maternal health care in the United States is broken. Many women are unsatisfied with their birth experiences as the process has become more mechanical and less focused on the needs of birthing women. Since birth moved into the hospital setting and out of the home, pregnant women are viewed as having an illness. Historically medicine has been dominated by male doctors while birth was traditionally taken care of by female midwives and family members. Technological innovations in medicine shifted childbirth from a natural, maternally focused event in a woman's life to something that must be suffered through. As this shift to technocratic childbirth took place in the early 20th century, use of a midwife and doulas declined while women began to turn to male doctors in hospitals and birth became "a completely mechanistic procedure" with doctors recognizing the fetus as a second patient (Mathews 1991 42-43). Expecting mothers and laboring women were considered to be suffering from an illness rather than viewed as women going through a natural and empowering biologically normal process. Women's control and decision-making over their own reproductive bodies shifted into the hands of a heavily patriarchic medical system. Midwifery declined exponentially as women were socially and literally pressured into giving birth in hospitals attended by male obstetricians.

Negative birth outcomes are on the rise in the United States, and it is the opinion of this author that if women are provided with accurate and unbiased information during pregnancy about all of their options, birth could potentially shift back out of the hospital which I believe would provide more positive outcomes. Home birth is a completely safe and viable option for women facing low risk pregnancies. Interventions in birth are crucial and can be lifesaving in rare cases where complications arise, but erroneous use of interventions

[1] Parts of this thesis were adopted from previous work by the author titled "Choice: Women's Rights in birth and Abortion."

in birth is a dangerous path to go down, and there is a widespread use of unnecessary technical and surgical interventions. For example, the use of Pitocin to increase the speed at which labor takes place typically leads to more painful contractions. This leads to use of pain medication, often through a procedure known as an epidural, where a shot is administered to the spine in order to block the nerves in the lower body from feeling pain produced from contractions. Because all of this ends up causing distress to the baby, still inside the mother's womb, these situations often end in birth by Cesarean section, an invasive and serious surgery. Another disturbing and dangerous intervention widely used in technological birth is the use of an episiotomy, the surgical cutting of the vaginal wall to speed up deliver, which is proven to cause a number of potentially serious long term health effects (Declercqet al. 2006 10). Many of these often unnecessary interventions have not been truly tested as to their long term effects.

One of the reasons use of these technological and surgical interventions has increased can be attributed to the fact that birth is now attended to by obstetricians, trained surgeons, in 99% of the cases in the United States. Hospitals are profit-driven, though, which has an adverse effect on maternal health care. Maternal death rates continue to increase and neonatal death rates have been stagnant for quite some time, putting the United States behind all other industrialized countries (Wagner 2006). This thesis will show connections in rhetoric between the birth and abortion movements since the 1970s in the United States, focusing on choice and women's autonomy, in order to provide a unique understanding of how this has shaped public opinion and ultimately public policy. It is important to understand the evolution of maternal health care as it has been shaped by this rhetoric because as birth has moved in to the hospital, consequently becoming more technologically focused, choice has been co-opted by doctors away from birthing women.By examining how the evolution of

technology in medicine has affected "choice" in birth, the comparison with rhetoric in abortion provides unique insight into public perception of what "choice" really means.

The word "choice" has historically and culturally been associated with abortion and the right of a woman to terminate her pregnancy. This literature presented in this thesis supports the argument that the same word can be used in the context of women receiving enough accurate and unbiased information so she can freely choose her birthing path. Previous literature has focused on these two issues, birth and abortion, and rhetoric within each movement independently, but a comparison between the two is missing. It is important to provide such a contrast because both issues have been very important in shaping where reproductive rights are today. Throughout the history of the abortion and birth movements, discourse surrounding a demand for autonomy over one's own body has evolved into two different arguments: one involving fetal personhood and one focused on choice, and both arguments will be discussed here. Throughout literature described in this thesis, different models of birth are referred to in different terms, from the medical, biomedical, or technocratic model to the social, holistic, or midwifery model. These two different approaches to care in birth will be referred to as the technocratic model and the holistic model in this thesis unless quoted otherwise.

This thesis will proceed as a literature review and policy paper. The history and background of each movement will be discussed in the introduction, which helps the reader gain an understanding of how these issues have been discussed in the past. Chapter one begins by discussing framing in birth and distinguishes between the technocratic model of birth, predominantly used by doctors in the hospital, and the holistic model used by midwives. The second subsection of chapter one provides a discussion about how birth has come to be feared by women and how opponents of home birth and the media have adopted this risk rhetoric when it comes to birth. Chapter two focuses on how rhetoric in the abortion

movement has evolved since the Roe v. Wade decision in 1973 and highlights a study of the rhetoric used in the newsletters of two organizations from Minnesota. Chapter two also contains a section looking at the parallels in the rhetoric of the birth and abortion movements, which provides the reader a unique perspective in which to consider how public opinion has evolved around choice and women's autonomy. Chapter four goes on to discuss some of the dangers of different interventions used in birth and more specifically highlights several policies in the United States surrounding birth and midwifery. Policy recommendations for legislators and educators are presented in the fifth chapter.

History/Background

At the beginning of the 20th century nearly all women gave birth at home, by 1940 total hospital births were up to 56% and by 1969 more than 99% of women (Taffel 1984). This drastic change in birth settings signified the acceptance by the medical community of "a model that perceives women as essentially abnormal, as victims of their reproductive systems and hormones, [and] one that defines pregnancy as inherently pathological [and] a clinical crisis worthy of active intervention" (Cahill 2001 334). Although home birth has increased recently, reaching .89% in 2012 (NCHS 2014), the successful reframing of the issue of birth by the obstetric community in the United States and across the world as something to be feared. Hospitals have influenced the process of being born as it has become a profit-driven industry. Referring to obstetrics as an "industry" depersonalizes it (Kennedy 2000) while diminishing the significance of the laboring woman and her natural, engrained abilities to give birth.

In 1973 the Supreme Court's decision in Roe v. Wade became a mobilizing force for the pro-choice movement and especially for the pro-life movement. Activists used the legalization of abortion and emotionally powerful imagery and language to frame arguments and recruit others. By reframing the issue as urgent and life threatening – threatening to the

life of the fetus – organizers successfully motivated people who normally would not take action into getting involved in the pro-life movement. By changing the "perceived seriousness of the condition as such that what was previously seen as an unfortunate but tolerable situation [some women got illegal abortion] is now defined as inexcusable, unjust, or immoral [any women can access abortion legally]" (Gamson et al 1982 in Snow et al 1986 474). This kind of rhetoric mirrors that found in birth debates as the use of language about potential dangers of pregnancy is being perpetuated and plays a part in convincing women that hospital birth is their safest option. Roe v. Wade ignited action in the case of abortion issues while continued use of language about risk has instilled fear in pregnant women and society as a whole.

After the Roe v. Wade decision an alliance formed between feminist health advocates and pro-choice physicians. The American Medical Association (AMA) was in support of criminalizing abortion but hesitantly shifted their position a few years before the court's decision was made public. Because they feared losing control of the diagnosis process, the AMA passed a resolution in 1970 in support of legalized abortion only to say that physicians should not merely provide them on request (Joffe et al. 2004), which ensured continued control over these decision making processes. Pro-choice feminists of the day believed women should not be limited in any way, and should have full control of their own body, especially when it came to reproductive rights, but agreed with the AMA on legalizing abortion. Risk assessment by the medical community has motivated women around the world to move their choice of birth from home into the hospital whereas something different happened after this risk assessment was made on the issue of limited access to abortion. Abortion becomes more dangerous as access is limited, with women turning to unregulated and potentially dangerous options to terminate unwanted pregnancies. It is interesting to point

out that these similar risk frames have not had the same impact on abortion regulation as it has had about opinions and ultimately laws on birth.

The pro-life movement consisted of a small group of physicians, lawyers and politicians before the 1973 Supreme Court Decision, with the only coordinated activity coming from the Catholic Church (Munson 2002 78). Within a short time of the court's decision the National Right to Life Committee (NRLC) formed and distinguished itself from the Catholic Church in order to general more financial and public support (Munson 2002 85). Affiliates were formed all over the United States and gained membership quickly around the same time as pro-choice advocates began referring to pro-life activists as "anti-choice" (Vanderford 1989 171), an important and useful tactic in their efforts to reclaim the word "life." These trends represent important shifts in rhetoric in an attempt to frame the message on each side of the abortion movement. According to Munson, pro-life advocates did not see themselves as being involved in a movement immediately after the Roe v. Wade decision was made. Advocates believed people would react with disgust once they realized the real implications of the Supreme Court's decision and would force it to be overturned (Munson 2002 86). Once it became clear that this was not the case, advocates recruited family and friends to become more involved in the pro-life movement. Participation in a social movement is seen as less costly and more beneficial to individuals when loved ones or friends are also involved (Goodwin et al 2004, Munson 2002). Pro-life activists eventually realized the need for drastic action in recruitment and tactics and their rhetoric shifted to a consistent conversation focused on the fetus's right to life rather than on rights of women over their own reproductive choices (Munson 2002 134). It can be said, in fact, that pro-life rhetoric about fetal personhood has been the driving force in the development of an adversarial approach in law to the relationship between the fetus and mother-to-be

(Johnsen1987 36). This issue is addressed in detail later in the thesis but helps the reader gain an understanding of how rhetoric in abortion has impacted perceptions in birth.

In the 1960s and 70s the feminist and consumer movements converged with the natural childbirth movement as all three were concerned with control and decision making (Mathews 1991 43). Language about baby and mother's safety was used by the medical community to exert control over the birthing process. After realizing birthing women wanted a more comfortable and friendly alternative to the conventional and impersonal design of obstetrical units, hospitals and physicians began introducing free standing birth centers (FSBCs) as well as rooms within the hospital where labor, delivery and recovery all took place, which previously had happened in three separate spaces (Mathews 1991 46). These efforts are described as futile by the authors because even as the medical community acknowledged a need for women-centered maternal care, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics put out a joint statement opposing alternative methods and endorsing only in hospital experiences as safe (Mathews 1991 49). Because obstetricians are trained surgeons they naturally look at any problem from that point of view; as a problem to be solved through surgical interventions. The shift in perspective of natural birth as dangerous and pregnant women as diseased have been promoted by obstetricians and the medical community.

The technocratic model of birth has become the common choice for expectant mothers as technology in medicine has evolved over the last century and home births have accounted for less than one percent of births in the United States since the late 1960s. This can be explained by the promotion of pain relief in labor and the expansion of interventions used and "although the biomedical approach may be faster or easier, it does not appear to be more effective at assuring health" (Worman-Ross 2013 462). When pregnancy is defined as an illness, women are instilled with a sense of fear when thinking about birth and experiences

with physicians' reactions to pregnancy in many cases support this. There are many examples of lived experiences in the hospital where women are made to feel uncomfortable throughout the birth process.

> *"In my first birth experience, I felt bullied, robbed, cheated, and fearful in the hospital environment…I could not use my voice in the hospital and my doctor did not listen anyways. I was a passive patient instead of being an active participant."*
> Boucher et al. 2009 122

These feelings of passivity and forced or manipulated submission to a cascade of interventions can partly be attributed to the asymmetry of information between doctors and birthing mothers. "A lack of critical education and informed consent in medical care" is missing when it comes to hospital birth settings, and these are "essential tools for a woman to understand what is happening to and make decisions about her body and baby" (Worman-Ross 2013 467). When women are given a chance to understand the process the body goes through during pregnancy and birth, they are given an opportunity to make informed decisions about their birth plan. Although research shows that home birth is a safe and viable option for women facing low-risk pregnancies, politicians, insurance plans, much of the medical community, and most of society in the United States does not support this option (Boucher et al. 2009 119). A description of the differences between the technocratic model of birth followed by obstetricians and the holistic model utilized by midwives is discussed in Chapter One, along with a discussion of the evolution of a risk framework in birth.

Chapter 1: Discussion of framing in birth

This chapter will discuss framing in birth and how those frames have affected public opinion and policy. It will begin with a brief explanation of two framing tactics, collective action frames and the use of reflex emotions and how both have been utilized in rhetoric surrounding birth. The technocratic and holistic models of birth will then be explained and discussed. This will lead into a discussion about how birth has successfully been framed as risky business by the medical community, opponents of home birth and the media.

Benford and Snow (2000) describe collective action frames as "action oriented sets of beliefs and meanings that inspire and legitimate the activities and campaigns of a social movement organization" (page 614) and are "constructed in part as movement adherents negotiate a shared understanding of some problematic condition or situation they define as in need of change, make attributions regarding who or what is to blame, articulate an alternative set of arrangements, and urge others to act in concert to affect change" (page 615). How social movements frame their issue plays an important role in how the movement progresses and how it is perceived by its opponents and the public.

Throughout history, emotional tactics have been used to instill fear in mothers. The media continuously depicts birth in a way that makes it looks rife with life-threatening complications and extremely painful. Because figures of authority in the media and throughout the obstetric community use language that normalizes patriarchal power relations within birth, birthing mothers are stripped of agency in decision making throughout their pregnancy and especially in the birth process. Goodwin and his co-authors describe reflex emotions and how they're used as framing tactics in their article "Emotional Dimensions of Social Movements." Fear is considered a reflex emotion, and "involve[s] the processing of information through mechanisms different than our normal cognition: quicker, more primitive neurological routes that allow us to respond immediately" (Goodwin et al. 2004

416). Obstetricians use fear to bully women into unnecessary interventions during the birth process and opponents of homebirth use fear to convince women to give birth in to a hospital. In an eye-opening article by Kathryn Worman-Ross and Tamara L. Mix, cited throughout this thesis, it is argued that this decline is a result of efforts by the medical community to control the power and knowledge relationship between doctors and birthing mothers. The authors interviewed thirty homebirth mothers and eleven homebirth midwives in Oklahoma and focused on the effects of these women's birth experiences. Some of the women interviewed talked about their doctor's use of "the dead baby card" as it was used to coerce birthing mothers into interventions. One birthing mother describes her experience in the hospital:

> *"When we came to the point where we were pushing with [my first son], his heart rate dropped…and the doctor just says to me – it's probably the first time he's spoken to me the whole time – and he says [in deep, arrogant voice], 'I need to cut an episiotomy or your baby's gonna die!'"* Worman-Ross 2013 p 464

Many of the women who talked about this issue felt they were bullied in to unnecessary procedures after their doctor told them it was for the safety of their baby(Worman-Ross 2013), this use of the reflexive emotion, fear, becomes a coercive tool used by obstetricians. In most cases doctors hold all the knowledge about childbirth and use that power to co-opt choice from birthing women. Opponents of homebirth have used existing rhetoric to convince mothers that use of interventions are safe and necessary in order to ensure the birth of a healthy baby.

Technocratic versus Holistic models of birth

The holistic model of birth is one that is focused on the woman and her natural abilities and provides a supportive environment for mothers-to-be and their families. In the technocratic model of birth "the professional maintains a pivotal and controlling role" (Walsh 2002 478) while birthing mothers and their mental and physical health often come second to that of the fetus. The illness mentality of hospitals is often what motivates women to choose an alternative setting for their birth.

In Table 1, the technocratic and holistic models of birth are contrasted. This table is adopted from an article by Robbie Davis-Floyd, who compiled this information according to words and behavior of two groups of women she interviewed, one group of professional women who chose hospital birth and another that chose homebirth. The author is a birth expert and has written many scholarly articles and appeared in documentaries on the subject. She writes that "the technocratic model functions as a powerful agent of social control, shaping and channeling individual values, beliefs and behaviors" (Davis-Floyd 1994 1125). As the reader can glean from the rhetoric described in the table below, the holistic model of health encompasses a more empowering and less controlling approach to birth.

Table 1: Technocratic versus Holistic Models of Birth

Technocratic	**Holistic**
The body is imperfect and separate from the self.	Self and body are one.
The body is mechanical - a vehicle, a tool for the self.	The body is an organism, intimately interconnected with the mind and the environment.
Life is controllable.	Life is not controllable.
The self should control the body.	The body cannot be controlled.
Pregnancy is out-of-control, and therefore unpleasant.	Pregnancy is uncontrollable and pleasurable.
The pregnant body is a vessel for the fetus, who is a separate being.	Mother and baby are essentially one – that is, they form part of an integrated system that can only be harmed by dissection into individual parts.
Fetal growth is a mechanical process in which the mother is not actively involved.	The mother actively grows the baby.
The desires of the mother and the needs of the baby can and often do conflict during labor and birth.	The safety of the baby and the emotional needs of the mother are the same. The safest birth for the baby will be the one that provides the most nurturing environment for the mother.
Birth is a mechanical process.	Birth is hard work a woman does.
Technology is better than untrustworthy nature.	Nature is best, and can be trusted. Technology should support but not interfere.
The mind is more important than the body.	Mind and body are one – organically interconnected.
As long as a woman's mind is aware, she in an active participant in birth.	A woman gives birth with her whole being.
Pain is bad. Not to have to feel pain in labor is a modern woman's intrinsic right.	Pain in an integral part of the labor process. To eliminate that part interferes with the systematic whole.

Medical knowledge is authoritative.	Intuition and inner knowing are authoritative.
To be strong and powerful, one must be in control.	Strength and power come from letting go of control.
Active participation and control in life are good.	The most active participation can involve giving up control.

Source: Davis-Floyd 1994

Those promoting the technocratic model of birth use emotional manipulation in order to co-opt power over birthing women. Women are taught to fear their own body and succumb to the authority of doctors (Worman-Ross 2013 459), as is the case in the technocratic model, but women who experience natural childbirth often step away with a great sense of empowerment. This sense of empowerment is expressed quite vividly by one home birth mother:

> *"I remember feeling after my first home birth, that I was pretty damn close to superwoman…the effect afterward was that I thought 'Wow! I can do anything! I did that, and I can do anything.' It was just a tremendously empowering experience and the polar opposite of what hospital birth, especially my first one, had been like for me"* Worman-Ross 2013 p 471

Through the holistic model of birth a woman is permitted control over her body and her choices in the birth process, and in the presence of a skilled midwife, more women are likely to share these empowering experiences rather than in the hospital setting. This model is rarely utilized by birthing women in the United States anymore because of the medical community's successful efforts to frame birth as risky business.

The holistic model of birth is based on reliance and trust in the woman and the cues her body gives on how to proceed is facilitated as the attending midwife stands back and lets the woman be in control of the process. The technocratic model of birth often limits or completely cuts off women's choices by co-opting knowledge and using this power to create docile bodies (Foucault 1977 as cited in Worman-Ross 2013 457), whereas the holistic model practiced by midwives places a woman's autonomy over her body back in her own hands. In this day and age many confuse the most technologically advanced options as providing the highest standard of care (Christlaw 2006 265) and many women are convinced that

interventions during birth are safe and the best option. Women have been culturally conditioned to fear birth and the medical community and society as a whole perpetuates these fears by neglecting to inform women about lived experiences of women who have had positive births. If women are told that in more cases than not those who have low-risk pregnancies are able to have empowering natural birth experiences would likely re-think choosing to give birth in a hospital.

Framing of birth as risky business

As discussed in the introduction, birth shifted from being primarily attended to by midwives and doulas into the hospital where predominantly male doctors birthed babies and consequently the cultural and social norms surrounding birth shifted as well. The obstetric community successfully transformed the minds of women in the United States and across the world to think about birth in a completely new way. No longer was birth looked at as a natural process a woman's body goes through, it was looked at an event to be feared and endured and if pain and hardship could be avoided, many women wanted that. Increased use of medical intervention in birth became the norm as medical technology has continued to evolve. Many women consider use of an epidural to control pain the norm and rates of Cesarean section births continues to rise, from 22.8 percent in 1989 reaching 32.8 percent in 2012 (Martin et al. 2013). The medical community framed this change as if they were doing what was best for the baby and the mother, but it can be argued that these changes only served to line the pockets of hospitals and doctors because many of these interventions come with a hefty price tag.

Literature on framing processes in social movements help gain insight into the success of these changes in collective community views on what normal birth is. Frame amplification has been used by those opposed to out of hospital birth. "Frame amplification involves the idealization, embellishment, clarification, or invigoration of existing values or beliefs"

(Benford 2000 624). This has been an important tactic for those who oppose out of hospital birth. Homebirth in the United States has declined dramatically in the last century and women no longer consider birth a natural and empowering process. In the research by Worman-Ross and Mix, it was discovered that the women's doctors used their authority and medical expertise to convince many of the mothers interviewed of the need for unnecessary and potentially dangerous interventions during birth. Eventually, after having unpleasant experiences with obstetricians in hospital settings, all of the women interviewed sought out alternative birthing methods, through the use of a midwife and many gave birth at home, but their experience in the hospital provides useful insight into the rhetoric used by the medical community to encourage birthing mothers of the need of medical intervention. The widespread presumption by society that birth takes place in a hospital is a result of the successful framing of birth as risky business. Leaders in the medical field have successfully framed it this way because they are seen to "embody a higher wisdom," because of their knowledge of medicine, and "a more profound sense of justice," because they frame interventions as doing what is best for the baby (Simons 1970 42). In the midst of labor, vulnerable birthing mothers are often told, not asked, how doctors want to proceed. Doctors often use frame amplification in order to convince these birthing mothers to submit to interventions, framing the intervention as a life saving measure for the baby. One potential draw-back to the study done in Oklahoma is that the authors only interviewed women who had negative hospital or obstetrical experiences. The authors could have provided more valuable insight if they had highlighted some families with contrasting perceptions of in-hospital birth.

As argued earlier, many interventions are widely used even though there is no medical necessity for them. Interventions like fetal heart monitoring have been widely used in order to help shield doctors in cases of litigation. This level of constant monitoring is looked down

upon by many reputable institutions, though, because the long term effects of it have not been studied. The American College of Obstetricians and Gynecologists updated their policy against use of electronic monitoring on women in labor in 2009 in order to help streamline variability in interpreting its guidelines, but still promote as minimal use as possible (ACOG 2009) Despite lack of institutional support, this technique is still widely used by obstetricians in the hopes of minimizing what can be used in court against them in a potential lawsuit; if a doctor can prove he or she had been keeping track of the baby's heart rate, the doctor will be less vulnerable in court (Wagner 1998 28). Other studies have shown that even though an epidural is likely to decrease a birthing woman's pain, it typically leads to a cascade of other interventions and could potentially lead to use of forceps, longer labor, and cesarean section because of fetal distress (Anim-Somuah 2011). Many of these problems are much less likely to occur if a woman experiences natural childbirth. Use of less technical answers to problems would be employed by midwives attending a birth outside of the hospital. If women were given more information about the potential health and psychological consequences of some of the interventions used, they may feel empowered to challenge their obstetrician during hospital birth. These health and psychological consequences will be discussed further later in this thesis.

Opponents of Home Birth

One outspoken opponent of home birth, Dr. Frank Chervenak, has published many articles supporting his position claiming that hospital birth is the safest option and any doctor who supports anything different is falling short in their professional responsibility. Dr. Chervenak feeds into the rhetoric that birth is risky business with supported research but fails to consider how his skewed data affects the results in some cases and ignores cold hard facts about the success of out of hospital births. The Midwives Alliance of North America (MANA) provided a reaction after Dr. Chervenak's study was released, vehemently condemning his findings and strategically dismantling his methodology and discrediting his research (Gordon

2013). This is an example of what looks like professionally conducted research providing the public and other professionals with skewed and inaccurate information. When things like this happen it is imperative for other professionals to provide and outside perspective like MANA did.

In a study conducted by the American Association of Birth Centers, more than 15,500 women were interviewed who received care in 79 centers led by midwives in 33 different US states between 2007 and 2010 (Stapleton et al. 2013) The study found that compared to the national rate of one in four, the cesarean birth rate in the birth centers was about one in sixteen (Stapleton et al. 2013), a dramatically lower rate that can be attributed to the fact that medical interventions to induce labor were used far less often in the birth centers. Dr. Chervenak and his colleagues completely ignore this kind of information in many of their articles, and failing to mention information that goes against your own research is a crucial misstep when presenting academic research. In one published article Dr. Chervenak and his co-authors even goes as far as to say that "planned home birth does not meet current standards for patient safety in obstetrics" (Chervenak et al. 2013 33) and goes on in his fear mongering about unpredictable complications. Dr. Chervenak and his co-authors clearly believe that the "safety" of the fetus supersedes that of the birthing mother and her right to choose where she is most comfortable giving birth, furthering with their rhetoric co-optation of information by physicians who control the choices women make. The authors say that patients have a right to choose from an array of medically reasonable alternatives, but disagree that anything other than hospital birth is a reasonable alternative, and promote the over-riding of women's own instinctive decisions saying obstetricians are ethically justified in doing so (Chervenak 1991). Contributing to the wide-spread belief that home birth is absolutely unsafe for any woman facing a complicated or completely normal, healthy pregnancy is irresponsible.

The Media and Birth

Media representation in the United States has helped instill a medicalized process of birth in women across the country. Reality television shows featuring birth experiences were analyzed by researchers Theresa Morris and Katherine McInerney (2010) who found that birth was always portrayed as perilous and dramatic. The episodes examined almost always featured complications in birth and "depict[ed] women as powerless, physicians in control, and technology as the saving grace for women's imperfect bodies" (Morris 2010 140). These findings clearly show that the medicalized birth process is glorified by the media and often sensationalize women's experiences in order to create provoking television. This only serves in skewing public opinion into thinking that birth is something to be feared. If positive birth experiences were shown more often, or at all, women could potentially feel more empowered to make their voices heard in their own birthing process.

The movie "Laboring Under and Illusion" illustrates very clearly the dramatic depiction of birth in popular media and contrasts those images with footage from calm home births. Director and producer of the movie, Vicki Elson, a social anthropologist who has been studying birth in the media for decades, provides commentary as she highlights scenes from popular television shows that nearly always show the mother in distress, being rushed to the hospital or frantically attended to in the midst of labor, screaming for drugs to dull the pain, and screaming at the husband or others in the room (Elson 2009). She contrasts these jarring depictions of birth with footage from real life home births, that show families calmly waiting and birthing women struggling but not in an overly dramatic way (Elson 2009). The media depicts birth this way not only because it provides for tantalizing television, but because it is the way society as a whole has been manipulated to think.

Chapter 2: Discussion of framing in abortion

Calls to action, as described briefly in the discussion of collective action frames, have been used by many social movement organizations, especially in the abortion movement, and the case of two organizations in Minnesota will be highlighted later in this chapter. This chapter also serves to highlight some important rhetoric shifts after the Roe v. Wade decision in 1973, which helps the reader understand the history of rhetoric in the abortion movement.

Use of emotional manipulation is used throughout any social movement but is especially poignant when it comes to abortion rhetoric. Pro-life advocates have used pointed and emotionally disturbing images and words to garner support for themselves and avid opposition to abortion. Use of the word "partial-birth abortion" to describe the procedure of extracting an intact fetus evokes certain reflex emotions. Opponents to abortion are attempting to scare pro-choice supporters and in some cases are trying to goad supporters into reacting aggressively in anger (Goodwin et al. 2004 417). Protesters against abortion often carry large pictures depicting magnified bloody pictures of aborted fetuses. Abortion clinics across the United States regularly ask volunteers to escort patients from their car into the clinics because aggressive protesters stand outside harassing people.

Rhetoric within the abortion debate can provide useful insight on how the conversation about choice has evolved since the 1973 Roe v. Wade decision. Involvement in both the pro-life and pro-choice movements increased exponentially after the Supreme Court's decision and defamation of each side by the other was used as a strategy to delegitimize opponents (Vanderford 1989). While the study by Vanderford focuses on the newsletters from two specific organizations, the Minnesota Citizens Concerned for Life (MCCL) and the Abortion Rights Council of Minnesota (ARC), general implications on how this rhetoric shaped public perceptions of each side of the movement can be gleaned. Similar strategies are used by both Minnesota organizations in vilifying their opponents, and the

author attributes these tactics to rhetorical roles of discourse rather than basing it off the ideals of each side (Vanderford 1989 167). Both organizations linked the others core leaders to high powered, wealthy people of influence, specifically linking pro-choice advocates with members of Minnesota's state legislature and pro-lifers with leaders in the Catholic Church (Vanderford 1989). These rhetorical tactics helped shape perceptions of each organization and magnify certain value systems in hopes of mobilizing supporters into action in each movement. This is referred to as value amplification which is "the identification, idealization, and elevation of one or more values presumed basic to prospective constituents but which have no inspired collective action for any number of reasons" (Snow et al. 1986 469). This tactic was used by each side in hopes of mobilizing their base into action and both sides mainly used discourse in their newsletters that was attacking their opponents, rather than discussing their core stance on the issue of abortion. Successful framing requires perceived credibility of the framers (Benford and Snow 2000) and these activists attempted to discredit their opponents through dramatic rhetoric, which may have had an adverse effect on each side. The author of the Minnesota study analyzed newsletters sent by each organization between 1973 and 1980 and found that both sides accused the other of using emotions to manipulate their supporters (Vanderford 1986). Pro-choice publications examined often accused the pro-life supporters of using fear based language to invoke emotional responses from their supporters (Vanderford 1986 170), a tactic often used by those opposed to home birth as well. The pro-life newsletters aligned the pro-choice movement with the Communist Chinese government saying that abortion was closely related to the policies restricting numbers of children per family implemented in China to control the population (Vanderford 1986 172). Fear of communism during that time, the height of the Cold War, and these Red Scare tactics were used to spread panic when it came to abortion, potentially mobilizing supporters in the process.

There is enough evidence presented here to show that public opinion of birth and abortion has been shaped by the technocratic approach that separates a woman from her fetus. In both cases, the concept of fetal personhood has come to trump a woman's right to choose, either to terminate her pregnancy or where to give birth. A woman's right to choose has become, in some people's minds, second to the rights of the fetus. Most pro-life advocates believe that "abortion is an assault on human life" and most pro-choice advocates believe that "attempting to restrict abortion in an assault on human autonomy" (Acton 2013). It has been claimed that pro-choice advocates disregard pro-life activists' well-intentioned belief that a fetus should be considered a human life, a parallel argument used by some scholars and activists who oppose home birth. These rhetorical tactics are used by opponents to abortion and home birth to inspire emotions in people and garner support. In birth the term 'fetal rights' has come to replace the phrase 'doctor knows best' in terms of how to frame control and submission to authority (Johnsen 1987 37). The next section will show how rhetoric in the birth and abortion movements has similarly evolved and what affect that has had on public opinion.

Parallel rhetoric in birth and abortion

As previously discussed, both the birth and abortion movements have come to be based on a framework of women's choice in some way or another. This section will discuss some similarities between the birth and abortion movements to help the reader understand how rhetoric about choice and reproductive rights has evolved. In birth, advocates for birth outside of a hospital say that "a woman must have the freedom to control her own body and her own reproductive system. She must have access to accurate, complete information about her choices for pregnancy and birth. To limit the information she receives or prevent her in any way from freely choosing the kind of childbirth she wants is to go down the road toward totalitarian control of women's reproductive lives by doctors" (Wagner 2006 158). Almost

these same exact words have been said in regard to women and their right to choose to terminate a pregnancy. The parallel is almost literal.

As the women's rights movement progressed, women who typically had accepted their role of submission felt support and began to speak out. Consciousness-raising sessions became a popular took to create space where women could share their feelings about "attempting to fulfill society's expectations of 'wives' and mothers'" without being judged (Rosenwasser 1972 46). During this time when the Roe v. Wade case was being heard in front of the Supreme Court and women began demanding a more family friendly birth experience, many people were becoming more aware of the many issues faced by women. In the early 1960s the Equal Pay Act was passed, congressional hearings were held to discuss passing an equal rights amendment for women and events at the national level were happening in order to motivate career women (Rosenwasser 1972 47). As society was being exposed to this rhetoric, women in general were becoming eager to regain control over their own reproductive choices. Both the alternative birth and feminist movements used words like "choice" and phrases like "resist loss of control" (Mathews 1991, Rosenwasser 1972). These parallels have been shown through each movement's rhetoric surrounding fetal personhood and its rights to life over the right of a mother to make choices for her reproductive and mental health.

Similar to the harassment tactics used by opponents of abortion, a more subtle tactic is used to shame families who choose home birth. There are countless stories of women and families who have chosen out of hospital birth being harassed by hospital staff and doctors. This example highlighted in Marsden Wagner's book, Born in the USA: How a Broken Maternity System Must be Fixed to put Women and Children First, helps show the dramatic and irresponsible reactions some hospital staff have when dealing with home birth mothers.

> *"In 2002, a woman in California having her fourth baby in a planned home birth developed a possible minor problem during labor, and her midwife transferred her to*

> *a large HMO hospital. The hospital staff attempted to scare the woman by telling her that she had put the life of her baby in serious jeopardy by attempting a home birth….The birth proceeded normally, and after both mother and newborn had been checked by a doctor and found to be fine, the woman asked to be discharged. The pediatrician said no, terrified that a baby born after the mother had labored at home might develop serious medical problems. When the mother insisted, the pediatrician called the police to file a complaint to force her and her baby to stay in the hospital until he said that it was okay to go home."*
>
> Wagner 2006 138-139

If a mother-to-be chooses to have a home birth, this means a loss of business for doctors, and hospitals and their staff argue against home birth vehemently. This is an extreme example of steps taken to instill fear in women of out of hospital births but it is indicative of a larger cultural issue. It also mirrors aggressive tactics taken against women to make sure they do not make choices for their bodies that are deemed medically unsafe. These examples of parallel rhetoric in the birth and abortion movements help give the reader a deeper understanding of how public opinion has been shaped. Chapter four will discuss where we are in the United States in terms of home birth. The previous sections help the readers understand how rhetoric has shaped public opinion and the following chapter will give insight into the lived experiences of home birth mothers and midwives.

Chapter 3: Where we are now

This chapter begins with a brief discussion of the potential dangers of widespread use of obstetric interventions in birth and proceeds to highlight examples of positive home birth experiences. The next section discusses several policies in birth. Many scholars have stated that there is a wide gap between what interventions are used and what practices have been scientifically proven as best for the mother and child (Wagner 2006, Boucher et al. 2009, Cahill 2001, Johnson 2005). Very little research has been done on the long term effects of almost all interventions used today. Even though this is the case obstetricians promote and widely use these untested approaches. There has been one study conducted in the United States that links use of pain medication in labor to drug addiction later in life of the baby (Nyberg 2000) but long term effects of drugs like Pitocin for labor induction and the pain medication used during labor has not been studied. Ricki Lake, an actress and birth activist in the United States was involved in the making of a documentary called "The Business of Being Born" where she interviews scholars, midwives, and home birth mothers all over the country. Lake interviews Marsden Wagner, an author cited several times in this thesis, was a doctor and activist focused on issues surrounding birth and was Director of Maternal and Child Health for the California State Health Department before serving as the Director of Women and Children's Health for the World Health Organization. The passion displayed by all of those interviewed in this documentary helps one understand the gravity of the issue of birth but Dr. Wagner's words are especially jarring. He discusses the track record held through history of effects of different interventions in birth. When x-ray technology advanced, it was used on pregnant women in an attempt to study the fetus, and it was eventually realized that this caused cancer (Lake 2008). The drug Thalidomide was used to alleviate morning sickness but was linked to children being born with limb malformations (Lake 2008). Wagner also writes quite a bit about the drug Cytotec, used by some doctors to

induce labor, of which it is not approved for by the Food and Drug Administration (FDA), and has been proven to cause uterine rupture during birth (Wagner 2006 7). The obstetric community does not have a promising track record in testing drugs before using them on pregnant women. If hospital and obstetric regulations in the United States were reformed to help hold doctors and hospitals more accountable, mothers and children may face a better chance at a healthy life.

Lived experiences have been documented over the years by Childbirth Connection, an organization focused on improving maternity care in the United States, through their Listening to Mothers initiative. For their second survey, conducted in 2005, 1,573 women who gave birth to a single baby in a hospital were interviewed; 1,373 through an online survey and 200 were interviewed by telephone (Declercq et al. 2006 9). Many of the women were only exposed to childbirth through watching television rather than attending classes and the survey found that as their pregnancy's neared the end, most of them felt confident but a majority was fearful of the birth (Declercq et al. 2006 10). This risk perception is perpetuated through rhetoric in the media and through scholarly article released by opponents of birth outside the hospital who make inflammatory statements. In reference to what should be included in a comprehensive cost-effectiveness analysis, Dr. Frank Chervenak and his co-authors said it would need to take into account, among other things, "the lifetime costs of supporting the neurologically disabled children who will result from planned home birth" (Chervenak et al. 2013 34). This dramatically misleading comment involves the kind of rhetoric that scares women away from giving birth outside of a highly medicalized environment.

Research and real life experience shows that birth outside of a hospital can be entirely safe and even empowering. Ina May Gaskin, a world renowned midwife who started a midwifery center in 1971 on an old commune in rural Tennessee, has attended over 3,000

home births with zero maternal deaths (Shapiro 2012). Gaskin has helped thousands of women give birth in a comfortable environment with a focus on the woman and her natural abilities. Complete disregard of the lived experiences of birthing women and the importance of empowerment through birth fails to show the whole picture of the reality of home versus hospital birth. Home birth is a safe and viable option for women facing low risk pregnancies. When women are not given all of the information about their options for giving birth they could be robbed of a life changing and empowering experience. Much of this rhetoric can be said to be profit driven; if obstetricians perform multiple interventions on birthing women hospitals make more money; but some of it can also be related to a deeply rooted and desperate attempt at co-opting power from women, a parallel theme of the abortion and alternative birth movements. When choice and agency is disregarded, women are viewed as merely reproductive vessels in both cases.

Rates of Cesarean section births have been consistently on the rise since the evolution of technology in medicine. Childbirth Connection lists many potential reasons for this increase, including lack of trust in a woman's own abilities in giving birth, side effects of commonly used labor induction interventions, casual attitudes towards the surgery, lack of knowledge that vaginal birth is even an option (especially in cases of multiple or breech births and many doctors refuse to even consider performing a vaginal birth after cesarean, or VBAC), lack of knowledge of potential risks of c-section, and, most disturbingly, incentives to doctors to have the birth proceed quickly (Childbirth Connection 2013). There is a culture around medicine that has evolved into an industry where doctors are often sued by patients if they feel their care was not adequate or their doctor did something wrong. This has affected the approach many obstetricians take when it comes to birth. A number of studies have shown that a significant reason doctors perform Cesarean sections is because of a fear of litigation (Rhoden 1986 2021). The use of this aggressive approach, performing an invasive

surgery, is viewed as the best defense by many doctors who fear being sued for lack of intervention if something ends up being wrong with the infant. But studies show that when Cesarean section rates rise above 15 percent,maternal mortality increases as well (Bertran et al. 2007), and this has become a crucial issue that needs to be addressed in the United States.

Because doctors have laid out a recipe for what a normal birth "should" look like, panic ensues if the woman's birthing process veers slightly off that path. These prescribed norms ignore the fact that every single woman's body is different and diminishes the autonomy women have when it comes to making choices in birth. The creation of the field of obstetrics in birth objectifies the fetus while integration between the mother and fetus is suspended and fetal rights are valued over maternal rights and instincts (Walsh 2002 479). The concept of fetal personhood and how it effects public perception and policy surrounding birth has been discussed previously in this thesis. This chapter proceeds to talk about policies on birth and midwifery and contrasts the different models of health in birth.

Policies on birth

Regulations surrounding birth are typically made at the state level. If a woman is provided options in family planning, when it comes to the birth process, she is likely to find more knowledge about health and safety issues for each potential path. If women arm themselves with accurate and unbiased information, they are more likely to fight against unnecessary obstetrical interventions in birth. This ability to choose has been co-opted from women by the technocratic model of birth and a patriarchal, archaic system of laws governing access to abortion. Policies on birth and midwifery are presented and give the reader a deeper understanding of how rhetoric discussed throughout this thesis has helped shape the maternal health care system today.

Only 28 states legally allow Certified Professional Midwives (CPM) to practice outside a hospital even though they meet the standards of certification set by the North

American Registry of Midwives (NARM) and regulations are pending in 14 other states (Push for Midwives 2014). Certified Nurse Midwives (CNMs) have advanced training in nursing and midwifery and are permitted to practice outside of the hospital in all 50 states (MANA 2014). Because CNMs have medical training, it is the most widely accepted certification for practicing outside of the hospital. Direct-entry midwives and CPMs are also trained to provide full-scope out of hospital maternity care but because of their lack of medical training are not legally allowed to practice in some states. These issues are regulated on a state by state basis and although the North American Registry of Midwives (NARM) provides standards of certification, women are provided different options in different states. Streamlining midwifery laws across the country would help level the playing field when it comes to women's choices in birth. If there are consistent regulations in each state, nationwide education efforts can be undertaken in order to help spread accurate and unbiased information about women's options outside of a hospital setting.

Ethics surrounding childbirth has been a hotly debated topic for decades. With the evolution of technology, pregnant women are able to test their fetus for hundreds of different conditions and there are many options available to birthing women when they are faced with potential pain in labor. Informed consent is not always provided to families, though, and research shows that many families make uninformed decisions about prenatal testing (Green 1994, Rosenthal 2006) and even surgical interventions in birth (Rosenthal 2006). One important issue here is the influence caregivers have over birthing mothers, especially while they are in an extremely vulnerable state. Many women consent to advice from doctors on an assumption that a medical professional is always right, but a number of different factors come in to play in situations before and during birth. Nurses play an important and often underappreciated role for women giving birth in a hospital and can help support women during labor in ways doctors are not able to (Torres 2009 20). Another ethical issue doctors

are faced with is whether or not to perform unnecessary interventions. As has been shown throughout this thesis, many obstetricians perform these interventions because of convenience and it could be believed that some even do it for profit.

In 1985, after extensive research involving participants from dozens of countries, the World Health Organization gave recommendations on the optimal rate of Cesarean sections, not higher than 10-15 percent (World Health Organization 1985). A rate higher than that is not proven to save lives or provide more positive outcomes in birth (Wagner 2006 59) yet, as mentioned previously, Cesarean section rates in the United States and all over the world continue to increase, reaching over 32 percent in 2012 (Martin 2013). Obstetricians and hospitals have ignored these well thought out recommendations because of many previously mentioned reasons, including fear of litigation, convenience, and profit (Cesarean section, an invasive abdominal surgery, costs at least five thousand more dollars than vaginal delivery (Wagner 2006 61)). Increased performance of Cesarean section birth is one of the many consequences of the shift to a technocratic model of birth, which will be discussed in the next section.

Prenatal education provided to expectant mothers is surprisingly under-utilized. The Listening to Mothers surveys have found that many more women are exposed to birth experiences through what they see on television rather than from attending birth education classes (Declercqet al. 2006 11). And even for women who do choose to attend birthing classes, unbiased information is not always provided. One study found that education classes offered by hospitals focused on socializing women to hospital routines (Carlton et al. 2005) instead of helping them understand all their options when it came time to give labor. If women were more educated about their options in birth, better health outcomes could potentially be experienced. Policy options are presented in the next section of this thesis that would help level the playing field between the medical system and women.

Chapter 4: Recommendations

Women and families planning to have children have a lot of information to digest when it comes to choices in childbirth. Many women rely on information they receive from their obstetrician, which can often be biased toward promotion of giving birth in a hospital. Research and stories highlighted throughout this thesis suggest that women often feel bullied or pressured into accepting sometimes unnecessary interventions. Introduction of technology into the birth process is believed to have a detrimental effect on crucial bonding that occurs between mother and child and father and child in the first precious moments of life. It can be shown that early physical contact is important for bonding and breastfeeding is very important but research discussed in this thesis shows that many women are separated from their baby immediately after birth. The Listening to Mothers surveys discussed earlier in this thesis have found that many women felt pressured or enthusiastically encouraged to accept interventions such as using Pitocin to induce labor, to resort to a Cesarean section, and a disturbing number of women experienced an episiotomy (Declercq et al. 2006 11), the dangers of which were discussed earlier in this thesis. These findings are troubling and provide little faith for the future of birth.

Many authors highlighted here argue for a more holistic model of birth moving forward in order to help improve maternal care in the United States. Midwives today show concern about how they are evaluated and regulated, especially because regulations for obstetricians are so lenient and inadequate (Wagner 2006 236). In a study about excellent midwifery practice, the author found that many of the midwives interviewed felt there is a need to redefine what success and productivity are for them, and it needs to be measured more appropriately (Kennedy 2000 14). If measurement of a successful birth experience shifts from purely health outcomes to a more holistic view of whether or not the woman felt empowered and the family respected in their experience (Kennedy 2000 13), perceptions of

what birth could and should be will likely shift as well. Inherently medicalized approaches to birth rob women with low-risk pregnancies of an opportunity to experience the empowerment of natural birth, and action needs to be taken to help spread accurate and unbiased information so women have an opportunity to make an informed choice in their birth path.

Recommendations:

Policy makers need to take action to help improve maternal health care in the United States. A number of recommendations are presented here. This list of recommendations was constructed by the author as a result of the research discovered and is based on the policies described in the previous section. The policies are aimed toward federal regulation for midwifery, obstetrics and birth educators.

Recommendation	Action
Regulate midwifery at the federal level	In order to promote a more holistic model of birth, including increasing access to midwifery services, midwifery must be regulated at the federal level rather than leaving it up to each state to do so. This would help give equal access to midwifery services to women around the country and send a positive message to the American people about the option of giving birth outside of a hospital setting.
Regulatory reform for obstetrics	The reality is, only two out of fifty states require hospitals to disclose information on maternity services (Wagner 2006 237). As described previously, rates of Cesarean section have reached dangerous levels in the United States and obstetricians often perform the procedure because of a fear of litigation. Because of lax monitoring and regulation of obstetrics, doctors rarely feel motivated to improve services for birthing women. Legislation at the federal level needs to be implemented in order to hold obstetricians accountable for their actions and obstetric measures of success need to be re-evaluated. If obstetricians were held to the same standards that practicing midwives are held to, the playing field would be more level and women may feel more comfortable choosing to give birth with a midwife in attendance.
Policy decisions need to be based on scientific evidence rather than assumed expertise of doctors	Lawmakers do a disservice to women when they make decisions based solely on input from the medical community. If decisions regulating health care services were made with a more holistic approach, greater numbers of women could potentially feel empowered to make their own choices.

A nationwide educational campaign to help women understand their options	Lawmakers can help influence public opinion about birth if money is allocated to unbiased health centers to implement a national campaign that spreads accurate and unbiased information about the realities of birth. This could happen with the creation of an online resource with accurate information on all options paired with a marketing plan to help raise public awareness about the online resource.
Prenatal education reform	If women were offered unbiased prenatal education that provided socially and culturally sensitive information about their options in birth, they may feel empowered to make different choices. Action should be taken at the federal level to provide funds for such education classes.

Conclusion

This thesis has highlighted parallels in rhetoric between the abortion and alternative birth movements. This provides an enlightening insight into how rhetoric can and has shaped public opinion and policy and helps give the reader a new perspective on how each movement has progressed through history. A discussion and comparison on how rhetoric has evolved through the birth and abortion movements has not been presented previously, and gives a unique lens through which to view the development of public opinion and public policy surrounding choice and women's autonomy especially in relation to reproductive rights.The word "choice" has typically been used in reference to a woman's right to choose to terminate her pregnancy but it is argued here that the same word can be used in describing a woman's right to choose her birth path. It is also argued that choice in birth is obstructed by the predominance of technology in birth and the medical communities desire to keep birth in a hospital setting.

Works Cited

American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin Number 106 (2009), "Intrapartum Fetal Heart Rate Monitoring: Nomenclature, Interpretation, and General Management Principles," *Obstetrics and Gynecology*, July 11, 2009. Accessed May 20, 2014. http://www.acog.org/About_ACOG/News_Room/News_Releases/2009/ACOG_Refines_Fetal_Heart_Rate_Monitoring_Guidelines

Acton, John (2013) "The Problem with Pro-Choice Rhetoric," The *Harvard Political Review*, Published online October 6, 2013. Accessed February 2, 2014. http://harvardpolitics.com/united-states/the-problem-with-pro-choice-rhetoric/

Anim-Somuah, Rebecca, Leanne Smyth (2011) "Epidural versus non-epidural or no analgesia in labour," *The Cochrane Database of systematic reviews*, December 2011. Accessed May 29, 2014.

Beckwith, Schuyler (2014) "Choice: Women's Rights in birth and Abortion," written for Social Change and Social Movements class, Spring 2014.

Benford, Robert D., David A. Snow (2000) "Framing Processes and Social Movements: An Overview and Assessment," *Annual Review of Sociology*, Volume 26, Pp 611-639.

Bertran, Ana P., Mario Merialdi, Jeremy A. Lauer, Wang Bing-Shun, Jane Thomas, Paul Van Look, and Marsden Wagner (2007) "Rates of cesarean section: analysis of global, regional and national estimates," *Paediatric and Perinatal Epidemiology*, Volume 21, Issue 2, Pp 98-113.

Boucher, Debora, Catherine Bennett, Barbara McFarlin, and Rixa Freeze (2009) "Staying Home to Give Birth: Why Women in the United States Choose Home Birth," *Journal of Midwifery and Women's Health,* Volume 54, No. 2, March/April 2009, Pp 119-126.

Cahill, Heather A. (2001) "Male appropriation and medicalization of childbirth: an historical analysis," *Journal of Advanced Nursing*, Volume 33 Issue 3, February 2001, Pp 334-342.

Carlton, Troy, Lynn Clark Callister, Eva Stoneman (2005) "Decision Making in Laboring Women: Ethical Issues for Perinatal Nurses," *Journal of Perinatal and Neonatal Nursing*, Volume 19, Issue 2, Pp 145-154.

Chervenak, Frank A., Lawrence B. McCullough (1991) "Justified limits on refusal of intervention," *Hastings Center Report*, Volume 21, Issue 2, Pp 12-18.

Chervenak, Frank A., Laurence B. McCullough, Robert L. Brent, Malcolm I. Levene, and Birgit Arabin(2013) "Planned home birth: the professional responsibility response," *American Journal of Obstetrics and Gynecology*, Volume 208 Issue 1, January 2013, Pp 31-38.

Childbirth Connection (2013) "Why Is the National U.S. Cesarean Section Rate So High?" Updated 6/24/13. Accessed February 10, 2014. https://www.childbirthconnection.org/article.asp?ck=10456

Christilaw, J.E. (2006) "Cesarean section by choice: Constructing a reproductive rights framework for the debate," *International Journal of Gynecology and Obstetrics*, Volume 94, Pp 262 — 268.

Declercq, Eugene R., Carol Sakala, Maureen Corry, and Sandra Applebaum (2006) "Executive Summary," Listening to Mothers II: Report of the Second National Survey of Women's Childbearing Experiences,*Journal of Perinatal Education*, Volume 16, Issue 4, Pp 9-14

Elson, Vicki (2009) "Laboring Under An Illusion: Mass Media Childbirth vs. The Real Thing," 50 minutes, Conway, Massachusetts.

Goodwin, Jeff, James Jasper, and Francesca Polletta(2004) "Emotional Dimensions of Social Movements." Pp 413-432 in Snow, David, Sarah Soule and HanspeterKriesi. Blackwell Companion to Social Movements. Blackwell.

Gordon, Wendy (2013) "Understanding Outliers in Home Birth Research," Midwives Alliance of North America blog, Posted September 17, 2013. Accessed February 2, 2014. http://www.mana.org/blog/0/understanding-outliers-in-home-birth-research

Green, J.M. (1994) "Serum screening for Down's syndrome: experiences of obstetricians in England and Wales," *British Medical Journal*, Volume 309, Pp 769-772.

Joffe, C.E., T.A. Weitz and C.L. Stacey (2004) "Uneasy allies: pro-choice physicians, feminist health activists and the struggle for abortion rights," *Sociology of Health & Illness*, Volume 26 Issue 6, Pp 775-796.

Johnsen, Dawn (1987) "A New Threat to Pregnant Women's Autonomy," *Hastings Center Report*, August 1987, Pp 33-40.

Johnson, Kenneth C and, Betty-Anne Daviss (2005) "Outcomes of planned home births with certified professional midwives: large prospective study in North America," *BMJ (British Medical Journal*), 330:1416, June 16, 2005.

Lake, Ricki (2008) The Business of Being Born. 87 min. Barranca Productions.

Martin, Joyce A., Brady E. Hamilton, Michelle J.K. Osterman, Sally C. Curtin, and T.J. Mathews (2013) "Birth: Final Data for 2012," *National Center for Health Statistics*, Center for Disease Control, Volume 62, Number 9, December 30, 2013.

Mathews, JJ and K Zadak (1991) "The Alternative Birth Movement in the United States – History andCurrent Status," *Women and Health*, 17:1, 39-56.

Morris, Theresa and Katherine McInerney (2010) "Media Representations of Pregnancy and Childbirth: An Analysis of Reality Television Programs in the United States," *Birth*, Volume 37, Issue 2, June 2010, Pp 134-140.

Munson, Ziad W. (2008) The Making of Pro-Life Activists: how social movement mobilization works. Chicago: The University of Chicago Press.

Midwives Alliance of North America (MANA) (2014) "Legal Status of U.S. Midwives," Accessed February 4, 2014, http://mana.org/about-midwives/legal-status-of-us-midwives.

Nyberg, Karin (2000) "Long Term Effects of Labor Analgesia," *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, Issue 29, Number 3, Pp 226.

Push for Midwives (2014) "Certified Professional Midwives, Legal Status by State," Accessed February 4, 2014. http://pushformidwives.org/cpms-by-state/.

Rosenthal, M. Sara (2006) "Socioethical issues in hospital birth: Troubling tales from a Canadian sample," *Sociological Perspectives*, Volume 49, Number 3, Pp 369-390.

Rosenwasser, Marie J (1972) "Rhetoric and the Progress of the Women's Liberation Movement," *Today's Speech*, Volume 20 Issue 3, Summer 1972, Pp 45-56.

Shapiro, Samantha (2012) "Mommy Wars: The Prequel, Ina May Gaskin and the battle for at home births," *The New York Times*, May 23, 2012. Accessed February 10, 2014. http://www.nytimes.com/2012/05/27/magazine/ina-may-gaskin-and-the-battle-for-at-home-births.html?_r=0

Simons, Herbert W. (1970) "Requirements, Problems, and Strategies: A Theory of Persuasion for Social Movements," *Quarterly Journal of Speech*, Volume 56, Issue 1, Pp 1-11.

Snow, David A., E. Burke Rochford, Jr., Steven K. Worden and Robert D. Benford (1986) "Frame Alignment Processes, Micromobilization, and Movement Participation," *American Sociological Review*, Volume 51 Issue 4, Pp 464-481.

Stapleton, Susan R., Cara Osborne, Jessica Illussi (2013) "Outcomes of Care in Birth Centers: Demonstration of a Durable Model," *Journal of Midwifery and Women's Health*, Volume 58, Number 1, January/February 2013, Pp 3-14.

Taffel, S (1984) "Midwife and out-of-hospital deliveries: United States," *Vital Health and Statistics*, Volume 21, Issue 40, Pp 1-43.

Torres, Jennifer M. and Raymond G. De Vries (2009) "Birthing Ethics: What Mothers, Families, Childbirth Educators, and Physicians Should Know About the Ethics of Childbirth," *The Journal of Perinatal Education*, Volume 18, Number 1, Pp 12-24.

Vanderford, Marsha L. (1989) "Vilification and social movements: A case study of pro-life and pro-choice rhetoric," *Quarterly Journal of Speech*, Volume 75 Issue 2, Pp 166-182. Accessed February 4, 2014.

Wagner, Marsden (1998) "The Public Health versus Clinical Approaches to Maternity Services: The Emperor Has No Clothes," *Journal of Public Health Policy*, Volume 19, Number 1, Pp 25-35.

Wagner, Marsden (2006) Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First, University of California Press, Los Angeles, California.

Walsh, Denis and Mary Newburn (2002) "Towards a social model of childbirth: part one," *British Journal of Midwifery*, Volume 10, Number 8, Pp 476-481.

World Health Organization (1985) "Appropriate Technology for Birth," *Lancet*, Volume 2, Pp 436-437.

Worman-Ross, Kathryn and Tamara Mix (2013) "'I Wanted Empowerment, Healing and Respect': Homebirth as Challenge to Medical Hegemony," *Sociological Spectrum*, Volume 22, Pp 453-481.