5-2024

# Comparing Preparedness by Midwives and OBGYNs: Should the United States Implement a Midwifery Model of Care?

Abigail Matthews
*Washington University in St. Louis*, a.l.matthews@wustl.edu

# Comparing Preparedness by Midwives and OBGYNs:

# Should the United States Implement a Midwifery Model of Care?

Abigail Matthews

Washington University in St. Louis

Women, Gender, and Sexuality Studies

## Abstract

In the wake of high maternal and infant mortality rates in the United States, there is a need for childbirth care reform, and investigating the methods with which individuals prepare for this life event grants us insight into the strengths and weaknesses of the current system. The purpose of this study is to evaluate the impact on preparedness between individuals that used OB/GYNs and those that used midwives to determine how different practitioner types were perceived by their patients. I conduct a qualitative and quantitative survey of people that have given birth in the United States and analyze the results for statistical and thematic trends. My major finding is that individuals did not perceive childbirth as a static event but a process that encapsulated pregnancy, childbirth, and postpartum experiences. I also identify that midwives have a more positive impact on the birth experience; they recommended more resources, were reported as superior in preparing their patients for postpartum, and provided a continuity of care that was desired by most participants. To answer the question of whether a midwifery model of care should be implemented in the United States, I compare these results with those I had found in a previous study conducted in the Netherlands and conclude that nationwide implementation would be culturally and systemically disruptive. I suggest that it is best to prioritize the birthing person's experience and opinions within the context of the systems already in place within each nation.

## Acknowledgements

The completion of this project would not have been possible without the efforts and encouragement of my thesis advisor, René Esparza. You did me a great kindness by attaching yourself to this project before you'd even met me, and you stayed the course with all the understanding and support that I could have asked for.

I would also like to thank Barbara Baumgartner for whom this project never would have left my notebook. It was your courses that guided my interest into this topic and your belief in me that gave me that final push to commit to the project. I am also appreciative for the comments you gave me along the way and for connecting me with Carolyn Sargent. I am grateful to the both of you for your willingness to impart your knowledge and wisdom to help me shape the beginning stages of my thesis.

Additionally, to my readers Amy Cislo and Cynthia Barounis, thank you for not only reading this entire project, but for showing genuine enthusiasm about my progress on it.

Finally, to everyone in my life that I called in the past year to ask your advice about this project, thank you for not hanging up on me. You were all right; the reward of completing this thesis was worth the time and energy put in.

# Table of Contents

Introduction....5

Methods....8

Literature Review....13
*Historical Background*....13
*Childbirth Paradigms*....16
*Medical v. Midwifery Model of Care*....18
*Method of Birth*....23
*Location of Birth*....25
*Childbirth Education*....27
*Changing Cultural Trends*....28
*Racial Discrimination in Childbirth*....30

Findings....31
*Resources*....32
*Preparedness*....33
*Experience*....35

Discussion....40
*Preparedness*....40
*Resources*....43
*Comparing Practitioner Types*....46
*Cross-Cultural Analysis*....51

Conclusion....53

Appendix A....58

Appendix B....61

Appendix C....61

Appendix D....62

References....63

## Introduction

"Get the epidural," one *New York Times* op-ed declares (Klein, 2017). The *LA Times* asks, "is the natural-birth movement more *feminist*?" (Mettler, 2017). These articles are just two examples amongst many describing the ongoing and tumultuous debate between "morally superior" natural childbirth and "morally inferior" medicalized childbirth. In favor of medicalized childbirth are articles such as one published in *SheKnows* claiming that the rise of OBGYN Instagram influencers is "restoring the personal, physician-patient relationship that was cherished by our grandparents" (Harding, 2020). Those advocating for the alternative declare that their midwife helped them in "dealing with the doctors" and describes birth as "a beautiful process which can be missed if you are intoxicated"[1] (Wezowski, 2016). With these ever-increasing mountains of opinions about the "right" way to give birth occurring in the online space, the actual experiences of childbirth have become buried and ignored.

Childbirth is by no means a new topic of discord in the United States. This discourse has most recently been incited by the COVID-19 pandemic, an ongoing public health crisis that has unabashedly exposed cracks in our current healthcare system (D'Ambrosio, 2022). Even before the pandemic, however, researchers have sought to understand how childbirth has functioned within broader American society. This investigation has led the most critical of these researchers to compare the United States with other nations' healthcare systems that they deem to be superior.

In 2023, the Commonwealth Fund released a report comparing the United States' health outcomes with those of similar countries. The most notable finding from their report is that "despite high U.S. spending, Americans experience worse health outcomes than their peers

[1] The term intoxicated is used here to mean "under the influence of drugs" such as Pitocin or an epidural.

around [the] world" (Gunja et al., 2023). One graph in particular highlights one area in which the differences between the United States and its peers are quite stark: maternal mortality rate. With a bar reaching far above the others, the US rate is 23.8 maternal deaths for every 100,000 live births. On the opposite end of the graph sits a drastically smaller bar line touting a rate of 1.2; this is the Netherlands' rate (Gunja et al., 2023). It is this dramatic contrast that has led many to put both nations' systems under a microscope for comparison. Comparison between the two nations is not new, but recent reports from a global organization such as the Commonwealth Fund have caused an increased urgency amongst researchers in their search for ways to reduce these rates in the United States.

Many researchers have acknowledged the benefit of this comparison and have done their part in suggesting solutions to the current state of childbirth care in the United States, several of which collaborated to create a book on the topic entitled *Birth in Eight Cultures.* It was after I read the chapter "Giving Birth in the United States and the Netherlands: Midwifery Care as Integrated Option or Contested Privilege?" from that very book that this project was born. This chapter was my first exposure to the midwifery model of care, and my main takeaway was that the Netherlands seemed to have a healthcare system that *worked*. The midwifery model of care became a particular passion of mine, especially considering my goal to become a labor and delivery nurse, and I became determined to investigate if it were possible to incorporate certain Dutch practices into our current American system in an attempt to improve childbirth outcomes.

It was this passion and curiosity that spawned this paper which ultimately represents the culmination of a year's worth of research. Half of this project was completed as an independent research project conducted during a semester studying abroad in the Netherlands. The Dutch component of this larger project was used as the foundation for the research conducted in the

United States. Within the period of four weeks, I created, distributed, and analyzed a survey of a population of twenty-one white, college-educated women, the majority of which were originally from countries outside of the Netherlands. The key findings from that research project were that non-native Dutch women from countries under the medical model had difficulties adapting to the midwifery model of care; midwives were the primary source of antenatal education; and continuity of care was the most important factor in producing a positive childbirth experience.

My ultimate goal in conducting the research detailed in this paper is to evaluate how one's childbirth provider affects an individual's perceived preparedness for pregnancy and childbirth, with a particular emphasis on comparing midwives and obstetricians. While the creation and conclusions of this paper are inevitably influenced by the study conducted in the Netherlands, the focus will remain on the data collected in the United States. However, both the Dutch and American cohorts will be used to further the secondary aim of this paper: to investigate the similarities and differences of experiences of those giving birth within these oppositional systems.

This broader research project offers a valuable insight into the discussion regarding which childbirth care reforms are not only most needed, but also which could be plausibly implemented given the current state of the United States. Continuing to compare the United States and the Netherlands remains a valuable way to identify universal desires regarding childbirth experiences and how different cultures require different reforms to improve their childbirth systems. By evaluating a highly privileged population of people that have given birth in the United States, my research allows us to more closely determine areas of the system that seem to be functioning effectively as well as aspects of the system that need reform across the board. Targeting the issues experienced by those that are likely to receive what is considered the

"best" the current system has to offer would undoubtedly improve outcomes for those with less privilege, even if it would not fix all the issues faced by those most marginalized.

There are, however, also limitations to this study. While most of those limitations are the result of time and sample size and are therefore possible to overcome in future research, it is important to acknowledge how my positionality affects this project. My identity as a middle-class white woman does not make me the ideal spokesperson for the populations most impacted by the negative childbirth outcomes I discuss, notably poor people and people of color. Additionally, I hold an implicit bias that the midwifery model of care is fundamentally superior to the medical model which has certainly informed my whole research process. However, I do believe that my desire to become a career as a labor and delivery nurse lends me the ability to equally critique both differing models of care.

I would also like to note that, despite the growing push for inclusive language in healthcare, most literature regarding childbirth uses highly gendered terms to describe pregnant and birthing people. While nearly all my surveyed participants selected "mother" as their preferred identifier, this paper will be making a concerted effort to use the gender neutral terms suggested by MacKinnon et al. (2021) to refer to participants and populations at large. However, due to the nature of the topic and literature cited, there will be instances where entire populations will be referred to as "women" and the term "mother" will be used when discussing participants that identify that way.

## Methods

The data for this research was collected from responses to surveys that were composed of a mix of qualitative and quantitative questions. I chose to use a survey as my method because it allowed me to collect foundational data about my population's perceived preparedness while also

giving them the opportunity to broach topics in their qualitative responses that I had not otherwise included in the questions. This approach proved useful because it yielded results that addressed the broader topics explored within the literature and offered a more specific look into individual experiences.

I created the survey using Qualtrics Survey Maker because it provided an accessible interface, advanced analytical tools, and desired security standards. I included a broad informed consent agreement as my first question followed by a series of demographic questions. This demographics section was sourced from Qualtrics's sample deck of common American demographic questions such as race, marital status, age, and education level. The question regarding gender was framed using parental identifiers instead of gender identity. This section was concluded with a qualifying question that ended the survey for any participant that reported to never having given birth in the United States.

I also collected data on the recency, state, setting, and method of the participants' birthing experience. The former two categories were used to provide context for specific participants' later answers because childbirth practices vary regionally and statewide in the United States and the landscape of childbirth has seen shifts even within the ten-year period of this particular population. The latter two categories were considered important on their own as the literature is invested in conversations comparing home and hospital births as well as vaginal and cesarean births. The setting and method of birth were also regularly paired with a participant's answers to the rest of this section's questions that established the three subgroups of my population: those that gave birth using a midwife, those that gave birth using an OB/GYN, and those that had done both.

The remaining questions of this survey were revised from those used in the accompanying research project from the Netherlands. In the creation of that original survey, I referred to the Childbirth Education Questionnaire (CEQ) developed by Dencker et al. (2010) to determine the types of emotion-based statements that the literature had already been using to study childbirth experiences. I also referred to Vogels-Broeke et al. (2020) in highlighting the resources that were most likely to be used by participants and which might need further investigation into. Because I have never given birth, these sources were invaluable in providing appropriate insight into preparation resources and childbirth perceptions that I could measure.

Most of the survey questions were five-point Likert scale questions that gaged usefulness of resources or agreement with general statements. This made up the quantitative portion of the survey. The qualitative portion included both open-ended and optional questions, one of which asked participants to provide three descriptor words they felt described their experience(s). This particular question was used to determine general associations regarding childbirth experiences individually and more broadly, but, given the fact that I provided example adjectives, it is possible that the answers to these questions were skewed based upon my own implicit biases. To combat this, however, each participant was given the opportunity to write a final open-ended response addressing anything they wanted to share. This offered participants the opportunity to provide nuance to previous answers or share entirely unrelated anecdotes they deemed important to the topics at hand.

All participants were asked the qualifying, demographics, and preparedness questions and, depending upon the subgroup they fell into, would be directed to an additional section specific to their experience with their type(s) of childbirth practitioner. Within these sections, I was interested in further investigating the aforementioned list of resources from Vogels-Broeke

et al. (2022), specifically looking at their usage and perceived usefulness. This offered a closer look at general and individual preparation processes and comparing the subgroups of my population revealed the impact childbirth practitioners had on these processes. I was also investigating general attitudes towards the different types of practitioners and how individuals perceived their preparation by these practitioners.

Overall, I hoped to provide questions that were formulated, formatted, and presented in a way that would be accessible to both the participants and the researcher. The brevity, clarity, and design of the survey was focused on simultaneously procuring the most accurate of data and full completion of individual surveys, and the result was a survey that did not exceed a duration of ten minutes and had a completion rate of approximately 90 percent.

It should be noted that the original intent of this research project was to conduct focus groups after the completion of the survey, sourced from survey respondents. This would have provided additional qualitative data that would have enriched the overall survey data. The proposed research project, both with and without focus groups, was reviewed and approved by Washington University in St. Louis's Institutional Review Board. Due to obstacles in recruitment and the narrow time frame, the focus group portion of this project was dropped, and the survey became the sole source of data for this cohort. However, this did allow for a more lateral comparison between the project conducted in the Netherlands that was solely conducted via survey.

The proposed recruitment method submitted to the review board involved the researcher emailing local midwives, doulas, and mom collectives asking if they would share the survey link with individuals within their social circles. Later recruitment methods included word of mouth by colleagues in addition to flyers posted on the Danforth and Medical Campuses of Washington

University in St. Louis and surrounding coffee shops. The individuals that agreed to share the survey link consisted of two doulas based in the Midwest, and it is possible but unknown if other individuals I contacted also shared the link. As evidenced by the survey results, this led to a population largely localized to the Midwest, specifically Illinois and Missouri. These recruitment methods also centralized a college educated population and was accessible to people that were active in online spaces about childbirth. This also aligned well with the population studied in the Netherlands that were entirely college-educated and recruited from online childbirth education and support groups.

After collecting data for three months, twenty-nine responses were collected and, after filtering our pilot and wholly incomplete responses, the final number of participants was twenty-four. These twenty-four respondents were largely homogeneous. As predicted based upon the recruitment methods used, the majority were married, college-educated women that had given birth in Midwest states and selected “Caucasian” as their race identifier and “mother” as their parental identifier. Three-fourths reported that they had given birth at least once within the past three years which allows an applicable view of current childbirth experiences. Because of the small size of this sample population, it cannot give an accurate depiction of all childbirth experiences in the United States, but it does offer certain valuable insights into the state of childbirth today. These women hold significantly more privilege than their demographic counterparts, and their experiences give us a glimpse into the “best” of what the United States has to offer. This allows us to more closely critique aspects of the current system that even the most privileged cannot escape.

## Literature Review

As the COVID-19 pandemic began exposing the systemic cracks inherent to our American healthcare system, it also led to an increase in home births. The increased rates were originally a result of shutdowns and social distancing, but this trend has continued as we have transitioned into a world now-considered "post-COVID." Scientists and laypeople alike have weighed in on this phenomenon, fueling the debate about what is "best" for birthing people in the United States. Most current literature considers the United States to be a distinctive country to give birth in, citing the exorbitant amount it costs to give birth, the predominance of hospital births, and the overwhelming cultural preference for physician-assisted births.

Kennedy et al. (2020) restated the distressing fact that Americans not only spend more money on childbirth than their peers in the Netherlands, Canada, Australia, and the United Kingdom, but they also have higher rates of infant and maternal mortality. In their discussion of these two disparate facts, Kennedy et al. (2020) declared that failures in the systems and broader cultural beliefs within the United States that was causing this incongruity. These failures can only be fully understood within the broader historical context of how our current maternity care system came to be and the forces that compel it to continue functioning despite these numerous failures.

### *Historical Background*

As with every other culture in the world, the act of childbirth in the United States was initially relegated solely to the sphere of women and was overseen almost exclusively by midwives. Throughout the seventeenth and eighteenth centuries, the tradition was to give birth under the supervision of a midwife, and male physicians were summoned if the birth became

complicated or required surgical intervention (Roth, 2021). However, the landscape of birth experienced a dramatic shift from these traditions in the nineteenth century as male physicians began vying for absolute power over women's bodies and sought to remove midwives from their place in the birthing room (Davis-Floyd and Cheyney, 2019; Roth, 2021). During this century, new technologies and novel understandings of physiology led some physicians to promote medical intervention such as bleeding, purging, and strong medication (Bogdan, 1978). The increased use of forceps and anesthesia were both seen as controversial at first, but eventually became somewhat commonplace as medical interventions for births, complicated or not (Dye, 1980).

Over the course of the twentieth century, physicians gradually replaced midwives as the predominant childbirth practitioners. Male physicians acted as a united front in a concerted effort to valorize their medical expertise and demonize the work of midwives (Dye, 1980). One infamous example of these efforts can be found within J. Whitridge Williams' 1912 article "Medical Education and the Midwife Problem in the United States." Despite his acknowledgement that childbirth outcomes under the care of midwives was better than with physicians, he advocated for the standardization of medical school education and downplayed the expertise of midwives. Williams and his contemporaries were inevitably successful in marking their profession as not just prestigious, but necessary for a successful birth, effectively excluding anyone that was not an affluent white man from the realm of childbirth.

As it became more widespread to have a physician-assisted birth, the language surrounding childbirth was also reconceptualized. Birth became understood as a "medical event" and laboring women were dubbed "patients" (Roth, 2021). With both new definitions came the underlying implication that the act of giving birth necessitated active management by

paternalistic physicians. This interventionist attitude also led childbirth to be increasingly depicted as an inherently risky health condition. It was the combination of these new understandings of birth that ultimately led to the hospital becoming the default setting for birth by the 1930s (Thomasson and Treber, 2008). Hospital births shifted from occurring in less than 5 percent of births at the turn of the century to over half by the end of the 1930s (Thomasson and Treber, 2008). By that time, obstetrics had been firmly established as the authority over women's bodies and their medicalized rules began governing pregnancy and childbirth.

This medicalization has continued well into the twenty-first century and, in light of new technologies, has arguably grown more extreme. Louise Marie Roth, in her 2021 book *The Business of Birth*, spends a considerable amount of time discussing how modern laws and technologies interact to protect the wellbeing of physicians instead of, and often at the expense of, their patients. One such technology discussed is the Electronic Fetal Monitor, which, despite its common and continuous use by physicians, has been noted to add risks in situations that are otherwise low-risk (Spector-Bagdady et al., 2017). EFM is known to report false positives, greatly decreases freedom of movement for laboring people, and has no empirical evidence to prove it has a positive impact on childbirth outcomes (Spector-Bagdady et al., 2017; Roth, 2021). This is one of many technologies that have become commonplace in twenty-first century childbirth that are rooted in science fetishism and interventionist attitudes of physicians. It is only with this historical context that we can pinpoint where current failures within our system originate and how larger institutions such as capitalism and patriarchy influence the practices regarding childbirth.

*Childbirth Paradigms*

While the United States is seen as distinct amongst its peers when considering childbirth due to its inclination towards the extreme, its historical trajectory is reflected in other nations such as the United Kingdom and Australia. The history of childbirth in the Netherlands, however, proves a stark contrast amongst these nations because midwives have been and continue to be the primary childbirth practitioner for Dutch women. The variations in the histories of these countries result in drastic differences in current childbirth practices. In their chapter of *Birth in Eight Cultures*, Davis-Floyd and Cheyney (2019) contrast the historic and modern practices of the United States and the Netherlands to provide a greater understanding of the midwifery model of care. They use Davis-Floyd's three childbirth paradigms to analyze how each framework shapes decisions, perceptions, and outcomes of childbirth within each country.

Davis-Floyd and Cheyney (2019) describe a spectrum of childbirth paradigms with a range bookended by two extremes: technocratic and holistic. Under the technocratic paradigm, the patient is treated as an object and technology is used to manage the medical event that is childbirth. The United States' near-exclusive operation under this paradigm is what makes it stand out even amidst other systems with similar values. Standing in contrast to this high-technology, objectifying framework is the holistic paradigm which focuses on the mind-body-spirit of the patient. It is often characterized by an emphasis on healing, a belief that childbirth is natural, and a prioritization of the patient's experience. While not exclusively holistic, the Netherlands is often presented as the best example of this childbirth paradigm due to its childbirth system being fundamentally structured around midwives as the default care provider.

Davis-Floyd in her description of these two paradigms also defines a third that stands as a midway point between the other two: the humanistic paradigm. The characteristics of this

approach include a prioritization of partnership and compassion between provider and patient during childbirth. Davis-Floyd and Cheyney (2019) point out that the humanistic paradigm can be found in both nations, though rarer in the United States, and describe it as having "the most potential to open the technocratic system, from the inside, to the possibility of reform" (Davis-Floyd as qtd. by Cheyney et al., 2019, p. 195). Having an established set of definitions for these three childbirth paradigms grants us a greater understanding of why certain practices are conducted systemically and individually within each of the three.

The midwifery model of care in the Netherlands incorporates aspects from all three paradigms but relies most on the holistic. In the United States, giving birth under the care of a midwife is often the only escape from the prevailing technocratic system that has fully normalized hospital births under the supervision of OB/GYNs regardless of risk. These differing models of care lend themselves to variable rates of intervention, continuity of care, and infant and maternal outcomes. Davis-Floyd, rather than pronouncing one paradigm as definitively superior to another, suggests that it is a combination of these three paradigms that will provide the "most effective obstetrical system ever known" (Davis-Floyd, 2001, p. S5).

These frameworks are useful for putting the historical events of childbirth of a particular country into the context of current obstetrical practices. They describe the values that are foundational to the broader system and are often not expressly stated in day-to-day conversations of childbirth. The United States operates under a technocratic paradigm, whether it describes itself in such language or not, and this allows us to take a closer look at how these unstated values shape the type of conversations and decisions made within the realm of childbirth. Reliance on technology, objectification of the laboring patient, and the mind-body separation manifest in the dominance of obstetricians, high rates of medical interventions, and a

pathologization of childbirth. These are the basic tenets of the medical model, of which the United States is the premier example of.

### *Medical v. Midwifery Model of Care*

In 1979, Barbara Katz Rothman defined the medical and midwifery models of care and how they differed. The difference between these two manifests both within individual experiences and in broader society as a whole. The midwifery model is characterized by its holistic approach while the medical model, as evident in its name, prioritizes medical authority and operates under the technocratic paradigm (Roth, 2021). Within the realm of childbirth, the medical model manifests through active management, objectification of women, prioritization of technology, and reliance on medical interventions. These factors culminate to create an environment in which "doctors 'deliver' babies rather than women giving birth" (Roth, 2021, p. 17), a stark contrast to the patient-led, low-intervention, collaborative midwifery model of care.

These models become institutionalized when the broader culture agrees on which actors of an event are granted authoritative knowledge[2]. Sargent and Bascope (1996) conducted an analysis of three different birthing systems to analyze how the medical and midwifery models determined the agreed-upon authorities of childbirth. They looked at three separate communities from Mexico, Texas, and Jamaica to determine the role that technology played in the establishing of authoritative knowledge. Their analysis allows us a closer look at the how the medical and midwifery models of care present themselves in living, breathing systems and the ways in which they impact the individuals that must navigate these systems.

[2] Browner and Press (1996) discuss this within the context of biomedical hegemony in the United States. Their results are important within this research because it suggests that patients are inclined to trust biomedical authority, but also must compare this advice with their own embodied experience.

Their investigation into a holistic birth system led them to a village in Mexico that was too small to have a clinic, resulting in all childbirth being supervised by women in the community, some of which were described as midwives. In their description of a low-technology birthing system, it is the midwifery model of care that predominates; as a result of birth being placed back into the sphere of women, it becomes a deeply collaborative system (Sargent and Barscope, 1996). Authoritative knowledge within this community in Mexico is placed within the hands of the community members participating, from the midwife to the laboring women. This allows for embodied experience to dominate over technological reliance, and it is this community-based collection of experiences that dictate the procedures of birth, not a physician. It is not the fact that there is a lack of technology that bridges the gap between the laboring person and the birth attendant, but a rejection of the medical model that prioritizes technology over embodiment.

Sargent and Barscope then turn their attention to hospital births occurring in Texas, with specific attention to the experience of Spanish-speaking women within this system. They analyze how these women navigate the high-technology environment of the medical model. Within the United States's healthcare system, the women are expected to defer to the "superior" knowledge of the physicians and hospital staff. Their embodied experience is devalued so that the knowledge of the obstetricians can be perceived as sacrosanct (Sargent and Barscope, 1996). Within this system, there is no collaboration, and the access to technical knowledge such as how to perform a cesarean Section determines the hierarchies inherent to this medical model of care. Importantly, Sargent and Barscope (1996) point out that the women they interviewed acknowledged the importance of their physicians' technical expertise but felt completely excluded from the decision-making of childbirth (Sargent and Barscope, 1996).

The medical model's establishment of biomedical knowledge as superior has led to a general loss of collective knowledge of childbirth amongst communities where midwives once thrived. Sargent and Barscope (1996) analyze Jamaica as their third birthing system because of the nation's successful attempts to eliminate midwife-attended births in favor of hospital births without firmly establishing technologies often associated with the medical model of care they're attempting to implement. The result of this is that many births go unattended, despite the fact that they take place in a hospital. The researchers highlight that, despite the poor experiences the women had while in the hospital under the care of nurse-midwives, they also expressed fear and anxiety about the idea of giving birth at home (Sargent and Barscope, 1996). The medical model has been become institutionalized within this community and, as a result, it is the broader cultural assumption that a birth is not safe if it does not take place in a hospital, under the management of a medical professional, and with the technologies deemed "necessary" for childbirth.

Sargent and Bascope's study is not recent, but it is increasingly relevant. It offers context for how aspects of the midwifery model of care might be implemented, but also highlights why recurrent trends pushing for "natural" births fall flat in the face of cultural assumptions. The United States conceptualizes childbirth within the technocratic paradigm and operates under the medical model. These frameworks offer us a better understanding to why the dominating opinion of physicians and laypeople alike is that the "right" way to give birth is in the hospital and attended by a doctor. The medical model is inherent to the American healthcare system and allows little room for people to conceptualize childbirth outside of the parameters inherent to this system. Authoritative knowledge is granted exclusively to those that have medical expertise, and

this devaluing of one's embodied experience highlights why women are not pushing for alternative birth methods.

Physicians have a vested interest in maintaining this authoritative knowledge. While there are a few obstetricians that have spoken out against the negative aspects of our current culture surrounding maternity care (Berry, 2007), the majority continue to advocate for in-hospital and obstetrician-led births. One of the reasons for this dominating opinion is that these births are the most expensive birthing option and therefore preferable in America's current for-profit healthcare system. Calculating the average cost of childbirth in the United States is difficult because healthcare is intrinsically tied to employment and varies between states, and, as a result, women of lower socioeconomic status are more likely to have higher than average costs. Despite these variabilities, a 2020 report estimated the national average cost as $13,811 for individuals under employer-provided insurance with cesarean sections costing, on average, slightly more (Melillo, 2020). The average cost for homebirths is more difficult to determine due to a lack of standardization, but researchers have found that this cost is likely significantly lower than the typical hospital birth (Anderson and Gilkison, 2021). Notably, Anderson and Gilkison (2021) also point out that an increase in homebirths could save the country over $300 million in healthcare costs. The midwifery model of care runs directly counter to the profit-driven healthcare system in the United States because it deemphasizes the interventions and technologies that keep the cost of healthcare high.

The midwifery model of care cannot be assumed to be the framework used by all midwives, especially in the United States. American midwives are not the default birth attendants and can broadly be thought of as a specialized healthcare provider focusing on childbirth. They operate within the medicalized American healthcare system and the laws

surrounding midwives vary broadly from state to state. While there is a correlation between midwives and holistic birthing practices, using a midwife alone cannot prevent someone from experiencing a medicalized childbirth experience.

I would also like to take the time to define doulas. While the exact parameters of this role differ between the Netherlands and the United States, it is broadly understood to be an individual that "provides emotional, physical, and educational support to a mother who is expecting, is experiencing labor, or has recently given birth" (*Having a Doula | What Is a Doula & What Are the Benefits?*, 2024). Doulas serve as healthcare advocates for people giving birth and, especially in the United States, offer the emotional support that patients often do not receive from their physician. Importantly, midwives and doulas do not serve the same function as birth attendants. For the purpose of this paper, midwives are individuals that are providing healthcare directly while doulas are providing peripheral support to the person giving birth.

In light of the increasing awareness of the high maternal and infant mortality rates, the medical model has come under considerable scrutiny. The most recent threat to this model's supposed superiority has come in the form of debates about method of birth. As the broader public has begun questioning the effectiveness of the high-interventionist methods of birth, such as the increasingly prevalent cesarean section, those holding the authoritative knowledge within this system have attempted to uphold the superiority of this model and double down on the need for a medicalized method of birth.

*Method of Birth*

A debate about method of birth has come about amidst the discussion of the medicalization[3] of birth. While this phenomenon has recently sparked questions of its reversibility in nations not currently under the medical model, the medicalization of birth in the United States is largely considered complete. The most obvious example of this complete medicalization of birth is the current rate of cesarean sections. While some argue bigger babies and smaller hips are to blame for the high rate of cesarean sections (Liston, 2003; Mitteroecker et al., 2016), others believe that it is the reimbursements from health insurance companies and/or the convenience they grant to physicians (Roth, 2021).

The World Health Organization recommends a cesarean section rate of 10-15 percent, yet approximately one third of all births in the United States, low-risk or not, occur via cesarean section (Roth, 2021). These high rates have not resulted in people having safer deliveries, as many cultural narratives perpetuate, but have put individuals at greater risk for a variety of issues. Maternal and infant outcomes are adversely affected by cesarean sections for low-risk births; maternal death is three times more likely after a cesarean than a vaginal and infants are more likely to experience injury during delivery (Roth, 2021). These adverse outcomes can be explained by the fact that a cesarean section is not a "convenient" method of giving birth but is rather an invasive abdominal surgery that should be reserved for the specific scenarios that necessitate it. Additionally, having one cesarean section makes it both more difficult to give birth vaginally and increases the risk of complications in any successive (Roth, 2021).

[3] Medicalization, as coined by Irving Zola in 1973, is characterized by "an increasing range of social phenomena [being] linked to the institution of medicine" and "the extension of the range of social phenomena mediated by the concepts of 'health' and 'illness'" (Have, 2003, pp. 153-154).

Medicalization of birth has slowly eroded a person's ability to choose their desired method of birth. Physicians have a vested interest in promoting cesarean sections because they are predictable in ways natural birth is not, and hospitals prefer cesareans because they minimize the risk of medical malpractice suits (Roth 2021). Obstetricians are often quick to surgically intervene in births because cesarean sections allow them to schedule births at their own convenience and offer a legal failsafe in malpractice cases. Despite this, many obstetricians ignore the factors that lead to their overreliance on cesarean sections in favor of perpetuating the narrative that it is "picky" mothers that are choosing cesareans over natural births. These physicians hold full authoritative knowledge over childbirth and, as a result, the method of birth is no longer guided by the embodied experience of the mother and has instead become a convenient decision made to maximize profits and efficiency.

Cesarean sections are not the only means by which medicalization shows itself in the birthing room. Interventions during birth are also on the rise. Cheyney and Davis-Floyd describe an "obstetric paradox" wherein "clinicians intervene in birth, see outcomes worse than expected, and in response, intervene *more* in birth in an attempt to improve safety, thus escalating medicalization" (Cheyney et al., 2019, p. 170). This escalation highlights how technology is prioritized as the guiding authority over the lived experience of the birthing person.

Examples of these interventions include continuous electronic fetal monitoring, episiotomies, artificial induction, breaking a woman's water, and vaginal deliveries with forceps and/or vacuum. As with the cesarean sections that offer convenient scheduling, these interventions are often conducted in an attempt to manage the unpredictable nature of childbirth. An example of the escalation of interventions would unfold in the following order: a patient is hooked up to an Electronic Fetal Monitor (EFM), Pitocin is administered after several hours of

slow or no dilation, the EFM detects signs of fetal distress, and an emergency cesarean section is then performed (Roth, 2021). At each step of this process, the birth is actively managed, and it is technology, not the patient, that is used to determine the progression of the labor. These interventions also serve to uphold a strict timetable that rejects the natural progression of labor in favor of hitting arbitrary time markers the hospital or physician deems appropriate for labor.

The widespread normalization and standardization of these practices showcases how ingrained the medicalization of birth is in the United States. In their comparison of birth outcomes between medical and midwifery models, Souter et al. (2019) found that, in low-risk pregnancies, midwifery care in labor was associated with decreased interventions and lower cesarean and operative[4] vaginal births. Their conclusion for this disparity between obstetrician- and midwife-attended births was the different approaches to care as well as the patient's commitment to a vaginal birth (Souter et al., 2019). Methods of birth have direct consequences on childbirth outcomes, and widespread overreliance on medicalized births has led to cultural narratives supporting the perceived necessity for interventionist birthing methods.

### *Location of Birth*

The methods of birth described above occur exclusively within the hospital setting because that is where most births in the United States occur. However, location of birth has been shown to have a considerable effect on outcomes and experiences of birth and is often used as the primary means of comparison between the medical and midwifery models of care. While the former forces birth into the hospital, the latter, given that it is functionally more patient-centered, allows for more flexibility of location.

[4] Operative vaginal births are births conducted vaginally with the aid of an instrument such as forceps or a vacuum.

Home births are closely associated with the midwifery model of care because nations operating under that model also have high rates of home births. In the 1970s, 99 percent of births in the United States were occurring in the hospital while comparatively, the Netherlands touted a 70 percent home birth rate during that same period (Cheyney et al., 2019). In the wake of the global rise in cesarean sections and a dramatic increase in the number of freestanding midwifery practices, the Netherlands still maintains a roughly 20 percent home birth rate, one of the highest amongst other developed nations (Davis-Floyd et al., 2013; Galková et al., 2022).

Women who have prepared for home births have been more satisfied overall with their births (Christiaens and Bracke, 2009), and those who prefer home births have lower fears of childbirth both before and after birth than those who prefer hospital births (Sluijs et al., 2020). While not typically as accessible in the United States as in other countries, birthing centers offer an alternative for those seeking a non-hospital birth that doesn't occur in their own home. In a comparison of obstetric units and midwifery units in Denmark, Overgaard et al. (2012) found that individuals that gave birth in the midwifery units reported a significantly better birth experience and overall care satisfaction than those reported by those who gave birth in the obstetric units.

Because location of birth is contingent upon both models of care and the broader childbirth paradigms, an individual's decision regarding it will be affected by the cultural narratives surrounding it. Informing women about the outcomes of different methods and locations of birth vary based upon these cultural narratives and lead to differences in education and preparedness between models of care.

### *Childbirth Education*

Amidst the accessibility of social media and the now-commonplace prevalence of online resources, current literature has been working to determine the relationship between preparedness and childbirth outcomes, often specifically evaluating childbirth education. Yohai et al. (2018) found that Israeli women that attend a prenatal childbirth preparation course report shorter labor, higher satisfaction with labor overall, and have higher rates of breastfeeding. Additionally, attending prenatal childbirth classes is associated with more positive birth outcomes and lower rates of postpartum depression for women in Iran (Hassanzadeh et al., 2022). Further, attending one of these antenatal education classes and/or having a birth plan increased the likelihood of giving birth vaginally for American women (Afshar et al., 2017). Overall, no matter the region of the world, preparing for pregnancy and childbirth had an effect on birth outcomes and childbirth classes are the premier example of this.

In their study, Morton and Hsu (2007) evaluated some of the issues faced by antenatal educators, citing struggles with misinformation online, a decrease in childbirth class attendance, and an increase in surgical births. They highlighted the framework within these classes operated: the patient is a consumer of a for-profit healthcare system that provides maternity care. Childbirth classes are highly dependent upon cultural beliefs and, as a result, the medical model has infiltrated and influenced their overall effect. While the research shows that education and preparedness for birth is beneficial to both mother and infant, the medical model again manifests as a roadblock for these benefits by prioritizing medicalized, technological births instead of physiological, natural births.

In comparison, Lothian (2010) examined the preparation process for women planning to give birth at home. These preparatory practices included reading and research, prenatal care

visits, childbirth classes, and the creation of a birth plan. She writes “the women were confident in their ability to give birth, confident in the process of labor and birth, and confident in their midwife’s ability to support them in labor” (Lothian, 2010, p. 66). This description serves as a sharp contrast to Roth’s portrayal of the pregnant woman as immobilized and hooked up to “machines that go ‘ping!’” (Roth, 2021, p. 114), bullied into unnecessary interventions she is not properly informed about, and meeting her care provider at the time of delivery.

Prenatal education gives women the knowledge required to have autonomy over their own bodies in delivery, a value that is only prioritized in the midwifery model of care. The complete medicalization of childbirth in the United States has made this education increasingly difficult to access (Lothian, 2010) but, in the growing age of technology and accessibility of knowledge, this education may be a viable means to reverse some of the effects of this medicalization.

### *Changing Cultural Trends*

As mentioned, the United States has seen an increase in home births over the past few years, a trend that predates but was accelerated by COVID-19. Despite this trend and the growing push for “natural” childbirth, the government has taken measures to make these options inaccessible for most people. One of many examples is the direct obfuscation of the roles of midwives at large and highly variable regulations for midwives from state to state. While some states allow for independent practice and grant prescriptive authority (Jefferson et al., 2021), others like Oklahoma provide very limited licensure for midwives which can lead to inaccessibility. This lack of standardization nationally combined with the fact that certified

midwives are regulated by a board of nursing further establishes the medical model as the superior and often the only model women have access to.

The medical model in the United States has dominated cultural understandings to the point that midwives are depicted as the fringe maternity care providers. This degree of saturation has led many to wonder if the medicalization of childbirth is even reversible or not.

The Netherlands, a nation often touted as the premier example of holistic home birth (Cheyney et al., 2019), is struggling in the face of rising medicalization of childbirth. Their home birth rate has been declining over the past few decades (Davis-Floyd et al., 2013) and even the independently practicing midwives have succumbed to the medicalization of childbirth (Have, 2003). The fact that the Netherlands, with its long history of respecting and encouraging the occupation of the midwife, has fallen prey to medicalization has led to uncertainty about how exactly this process can be halted or slowed. More research needs to be done on counter-movements working to sway public opinion and create policy to resist medicalization (Christiaens, et al., 2013) so that this phenomenon can be better understood and hopefully halted.

Most of the authors that turn to the Netherlands as a resource for how to prevent further medicalization usually suggest a division between high and low risk births, seeking to reestablish the physiological, normal birth as the default (De Vries and Barroso, 2007). They also suggest a continued application of woman-centered continuity of care (Johanson et al., 2002) and a renewed passion for and accessibility of home births (Christiaens et al., 2013). If the United States wants to lower their infant and maternal mortality rates and increase overall satisfaction with childbirth, these considerations will need to be made and, likely adapting a humanistic paradigm, adopted in ways which the current system might allow.

*Racial Discrimination in Childbirth*

The conversation about childbirth in the United States is not complete without an acknowledgement of the ways in which race is an active factor in poor outcomes and experiences. A disproportionate number of those dying or almost dying from pregnancy-related causes are black women and this is a significant factor in the United States' exceptionally high maternal mortality rates (Villarosa, 2022; (*Working Together to Reduce Black Maternal Mortality | Health Equity Features | CDC*, 2023). Black women have higher rates of cesarean rates, their infants are often born early and underweight, and they experience racism directed towards them by medical personnel (Huesch and Doctor, 2015; Villarosa, 2023). This discrimination is also not escaped by upper-class Black women, as evidenced by Serena Williams's traumatic birth story, amongst other similar stories that have made the news over the past few years. Villarosa, the leading investigative journalist on this topic, highlights the fact that "a Black woman with a master's, PhD, JD or MD is more likely to die in pregnancy or during childbirth…than a white woman with an eighth-grade" education (Villarosa, 2022, p. 45).

This medical racism is baked into the very fabric of the American healthcare system. Because black women are the most affected by the flaws in our current system, they also stand to benefit the most from improvements made to it. The population of this study is almost exclusively white women, and they hold a considerable amount of privilege when it comes to childbirth when compared to their black counterparts. The experiences explored in this paper will therefore not be universal but will illuminate the ways in which not even privilege can grant someone a positive childbirth and highlight the systemic issues that are likely amplified for those without the same privilege.

## Findings

Of the twenty-nine total responses collected, twenty-four completed at least 50 percent of the survey and were used in analysis. Regarding overall demographics, the identifiers selected by participants allowed me to characterize most of them as married Caucasian women between the ages of twenty-four and forty-four. Two-thirds of respondents had a Bachelor's degree or higher and all reported having at least a high school education. All but two had given birth in the Midwest or Southern regions of the United States, with the majority selecting Missouri and/or Illinois. Of the twenty-four total participants, eleven used an OB/GYN only, six used a midwife only, and seven used both.

Household income was not a question I asked participants, but I believe that general education level and context given in qualitative responses points towards most, if not all, participants being middle class or higher. While class almost certainly informed my respondents' experience and represents a more general barrier of care, the data I collected did not allow for a comprehensive class analysis. Such an analysis would be a valuable lens for future research, especially if it compared how race and class impacted childbirth experience both separately and in tandem.

The results of this study offered insight into preparedness, resources used, and overall experiences as well as which of these differed between types of practitioners. I was able to identify three major findings within these three topics. Of these major findings, the one I find the most striking in response to my proposed hypothesis was that all participants reported feeling more prepared for pregnancy and childbirth than for postpartum and emergency, but those that used midwives felt that their practitioner better equipped them for all scenarios than those that used OB/GYNs. Additional findings that answered tangential research questions I had were that

childbirth classes were the most recommended, utilized, and useful resource reported, midwives recommended twice as many resources to their patients as OB/GYNs did, and that midwives were reported as having a more positive impact on individuals' experiences, with respondents specifically emphasizing support and compassion.

### *Resources*

Participants gave responses about which resources they used, how useful they found them to be, and whether their specific childbirth practitioner recommended them. Every participant reported having used friends and family as resources and all but one used other pregnant people.[5] Following those two in popularity were medical websites, books and journals, and childbirth classes, each of which were used by 88 percent of respondents. In contrast, doulas were used the least often, utilized by 54 percent of participants.

It became clear early on in reviewing the data that the resources that were used the most often were not necessarily considered the most useful by participants. This is evidenced most clearly by the perceived usefulness of doulas. While used by only half of the participants, 85 percent of those considered doulas moderately or very useful, a usefulness percentage eclipsed only by childbirth classes which 90 percent found useful. Following behind those two were podcasts and medical websites, both of which were listed as useful by 76 percent of participants that used them. The resource that was considered least useful by participants was TV and film which was reported by "not useful at all" by 42 percent of the nineteen participants that used

[5] See Appendix A for the full list of resources provided within the survey. While participants were given the option to write in resources not included within the question, they were bound to the description given for the others. Terms such as "other pregnant people" and "TV and Film" were referred to in the manner of Vogels-Broeke (2020).

them. This finding highlights that we cannot assume that a widely used resource is automatically an effective one.

Participants were also asked to identify which resources their practitioner recommended, and it is here that differences between midwives and OB/GYNs emerged. Childbirth classes were most recommended by all practitioners, recommended by 82 percent of respondents' midwives and 60 percent of their OB/GYNs. In contrast to these oft-recommended childbirth classes that are typically institutional, media-based resources such as apps, podcasts, TV and film, and social media were rarely recommended by either practitioner type. The implication of this is that practitioners, regardless of type, are less likely to recommend resources that, while more accessible, might lack a desired level of authority or oversight.

Within the group that used midwives, doulas were the second-most popular, but they were only recommended by 55 percent of this group's midwives. Comparing these two percentages is striking and implies that childbirth classes are the primary resource recommended by midwives and it is slightly less common to offer additional resources beyond that. In contrast, the second-most popular recommendation made by respondents' OB/GYNs was not an option listed on the survey but instead written in; 33 percent of those that used OB/GYNs wrote that their practitioner recommended no resources at all. This finding seems to further the implication that additional resources are less likely to be recommended to patients, but the fact that so many participants reported having received no recommendations is a startling glimpse into the role of an OB/GYN in the preparation process.

### *Preparedness*

To discover a broader look at preparedness, I asked my participants to report their overall preparedness and preparedness-by-practitioner for four different scenarios: pregnancy, childbirth,

postpartum, and emergency situations. Based upon the responses from my Dutch cohort[6], I was unsurprised to find a considerable gap in perceived preparedness, both overall and by practitioner, between the former two scenarios and the latter two. Overall, participants reported feeling most prepared for childbirth, with 71 percent agreeing with the statement that they felt adequately prepared for it, and this was followed by pregnancy with 67 percent agreement. In contrast, 46 percent of participants felt prepared for emergency situations and only 33 percent felt the same about postpartum (see Figure 1). The disparity seen between these scenarios implies a gap in the information provided by resources given to people undergoing the process that is childbirth, from pregnancy to postpartum. The quantitative data that points to a lack of postpartum and emergency preparedness is also reiterated in the anecdotes shared by participants and will be discussed amongst the other qualitative findings.

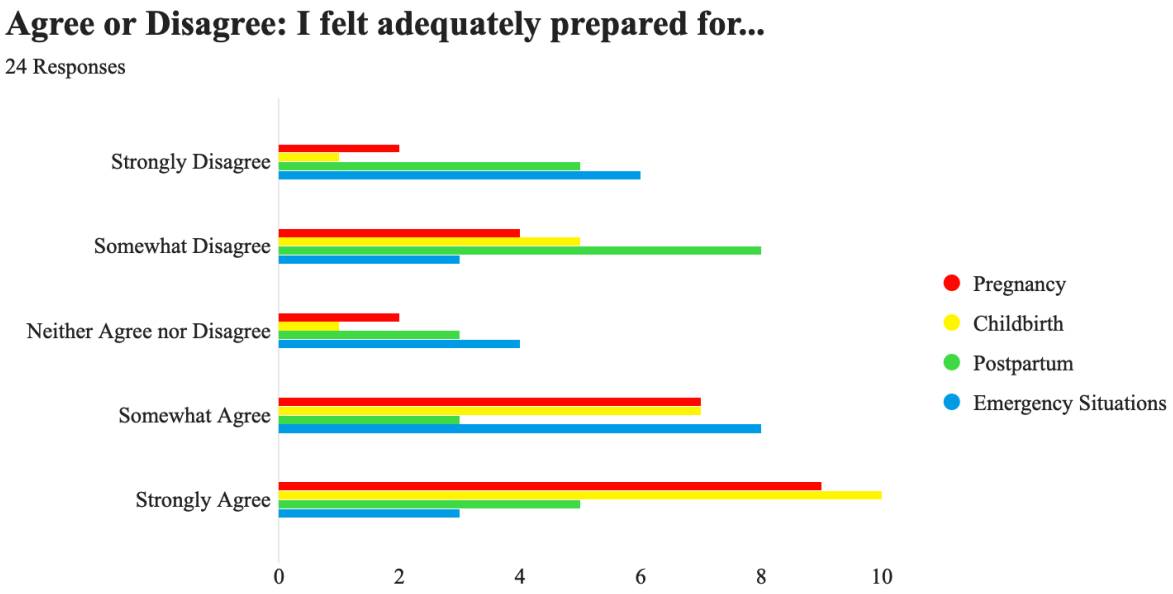



*Figure 1: Preparedness*

[6] While not a key takeaway from the Netherlands project, I did find that less than half of this cohort felt their midwife adequately prepared them for emergencies and only a quarter felt the same for postpartum. It is because of this that I believed that there would be a similar trend for my American cohort.

I also asked participants how well their specific practitioner prepared them for each of the four scenarios. The trend of feeling less prepared for emergencies and postpartum continues throughout their responses. A higher percentage of those that used midwives reported feeling prepared by their practitioner than those that used OB/GYNs (see Figures 2 and 3). None of those that used a midwife disagreed with the statement that their practitioner adequately prepared them for postpartum. This is significant not only because overall preparedness for postpartum was low, but also because 53 percent of those that used OB/GYNs disagreed that they felt prepared for postpartum. It should also be noted that a considerable proportion of those that used OB/GYNs gave neutral reports across all scenarios, a trend that is also seen within the midwife group regarding postpartum and emergencies only. This might be due to recency of childbirth experience affecting memory of provider-patient interactions, but it might also indicate a general lack of reliance on the provider as a preparation method.

When comparing overall preparedness between the subgroups of my population, I found that there was no significant difference in overall preparedness between those that used midwives and those that used OB/GYNs despite seeing significant disparities between preparedness-by-practitioner. I believe this indicates that the preparation done by one's practitioner, while it could be advantageous, is not the sole factor in making an individual feel properly prepared for the childbirth process.

*Experience*

The qualitative portion of my results provided me with the opinions and emotions of each participant regarding their personal childbirth journey and I was able to decipher themes that seemed to permeate throughout these anecdotes. Overall, the vast majority agreed with the statement that they spent a considerable amount of time and effort preparing for their childbirth

experience, and a similar majority disagreed with the statement that preparing was more stressful than beneficial. These findings showcased that all participants not only considered their pregnancy and childbirth as a process that necessitated preparations, but that they also deemed this preparation process to be valuable.

Agree or disagree: My OB/GYN adequately prepared me for...

| Field | Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree |
|---|---|---|---|---|---|
| Pregnancy | 6.7% | 13.3% | 26.7% | 26.7% | 26.7% |
| Childbirth | 13.3% | 26.7% | 20.0% | 20.0% | 20.0% |
| Postpartum | 33.3% | 20.0% | 26.7% | 20.0% | 0.0% |
| Emergency Situations | 13.3% | 33.3% | 26.7% | 13.3% | 13.3% |

*Figure 2: Preparedness by Practitioner: OB/GYN*

Agree or disagree: My midwife adequately prepared me for...

| Field | Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree |
|---|---|---|---|---|---|
| Pregnancy | 9.1% | 9.1% | 9.1% | 18.2% | 54.5% |
| Childbirth | 0.0% | 9.1% | 9.1% | 36.4% | 45.5% |
| Postpartum | 0.0% | 0.0% | 27.3% | 45.5% | 27.3% |
| Emergency Situations | 9.1% | 18.2% | 27.3% | 27.3% | 18.2% |

*Figure 3: Preparedness by Practitioner: Midwife*

When asked to provide three words they felt best described their experience preparing for pregnancy and childbirth, the most common words given were “positive” and “empowering” (see Appendix B for a visualization). Nearly all the words carried a strong emotional

connotation, both positive and negative, e.g. “exciting” and “scary.” Of the sixty-nine total words provided, only fourteen had negative connotations, with the remaining being neutral or positive. In addition to describing their overall experiences, participants were asked to complete the same question but this time to describe how their practitioner prepared them. For those that used OB/GYNs, the words with the most repetitions were “professional” and “basic” (see Appendix C) while those that used midwives commonly listed “supportive” and “compassionate” (see Appendix D). These findings indicate that most participants had strong emotional associations with the childbirth process, but that there were differences in the perceived role and relationship of their specific practitioner.

To evaluate their rationales for choosing their practitioner type, I asked participants to provide a short, written response detailing why they chose one over the other. For the group that used OB/GYNs, the answers could be grouped under four broader categories with some overlap: familiarity with their provider, belief that there was “no other option,” trust in the medical institution, and desired birth location. The reasons for choosing a midwife were less variable than the previous group, and the majority cited a desire for a holistic birth as their reasoning, expressed using the terms holistic, natural, home and/or unmedicated to describe their desired birth. With both of these groups, there were a few participants that did not choose or did not have a decision, citing emergencies as well as a convenience for why they gave birth with their specific practitioner type.

As I sifted through the qualitative data about participants’ reasoning for choosing their specific practitioner type, I also referred to the demographics results I had collected. While I cannot confirm how class specifically played a role in choosing a provider, it should be noted that only one response mentioned the cost of childbirth at all, referring to insurance coverage as

their sole reason for using an OB/GYN. Without the added complexities that come with being a person of color or low income trying to navigate the American healthcare system, these participants' responses highlight which factors dictate the provider choices of the most privileged population. It should also be noted that I did not find any correlations between level of education and provider choice. This leads me to believe that it is not necessarily education or accessibility guiding this population's decision-making, but rather what type of knowledge they are exposed to and where they receive this knowledge.

These two groups were also asked about the overall positive impact they felt their provider had on how prepared their felt for pregnancy and childbirth (see Figure 4). While there were mixed opinions amongst those that used OB/GYNs, 82 percent of those that used midwives agreed that their provider had a positive impact. Conversely, within the group that used OB/GYNs, 40 agreed, 33 percent were neutral, and 27 disagreed. This finding further points to a general indifference or uncertainty respondents felt towards their OB/GYN's role in their childbirth process. I also isolated these subgroups further, looking at those that exclusively used a particular provider type. Of those that only used midwives, 100 percent of them strongly agreed that their provider had a positive impact. In the other group, 45 percent agreed (somewhat and strongly) and 18 percent disagreed that their providers had a positive impact. These responses are likely attributed to the fact that excluding participants that have experienced care under both practitioner types is likely to illuminate more convicted opinions. Those that have only used one provider type not only lack the experience of the other group but are also more likely to have a strong opinion that led them to avoid the other practitioner type.

I also granted participants the optional opportunity to provide additional information they felt would be worthwhile to my understanding of their answers. Half of the respondents included

a few short sentences commenting on one or more topics, and several themes emerged that aligned with previous answers. Several of them sung the praises of childbirth classes, both online and in-person, with one participant noting that "encouraging a pregnant woman to interact with other women going [through] the same thing in a group environment [is] so positive and helpful." Several pointed out frustrations they had with the medical institution and specific OB/GYNs, the lack of information about or support provided for postpartum, and the importance of trusting one's provider and oneself. I was struck most by one participant's reasoning for choosing a midwife, describing her desire for a "homebirth midwife with hospital privileges." This statement, along with similar impressions from other participants, pointed to a general respect of medical authority, but a preference for a mode of birth that would prioritize more patient-centered care.

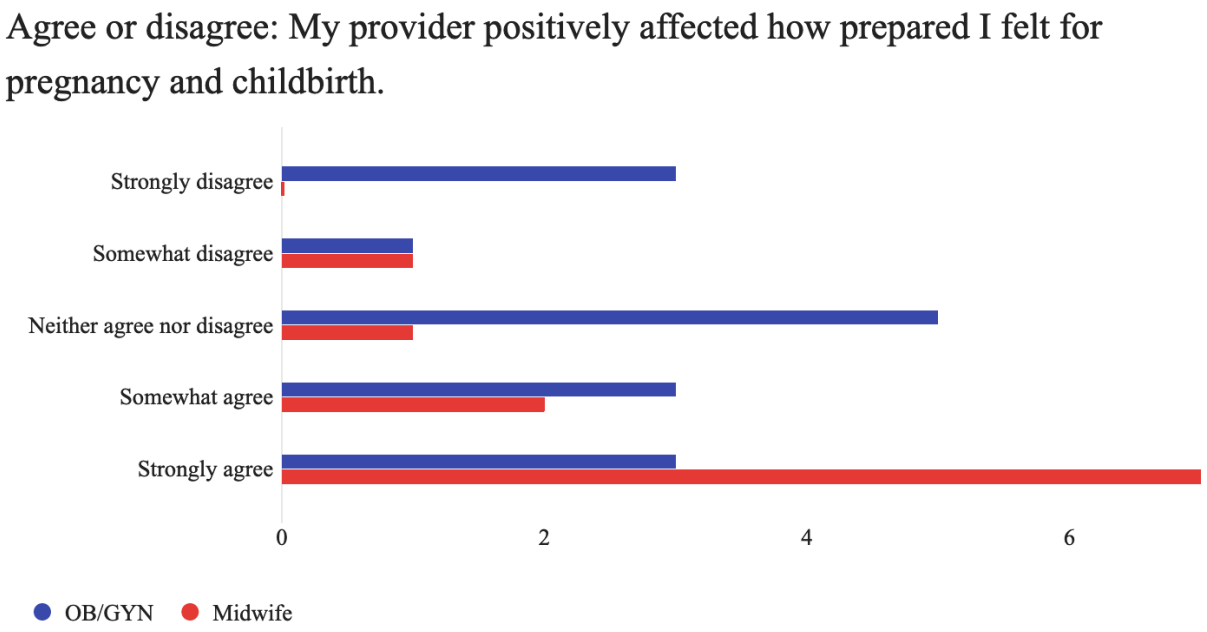



*Figure 4: Practitioner Impact*

## Discussion

The predominant hypothesis going into this study was that individuals under the care of a midwife would feel more prepared for pregnancy and childbirth than those that used an OB/GYN because they were more likely to utilize a holistic approach to birth. My findings suggest that midwives did not affect how prepared participants felt for pregnancy and childbirth overall, but that participants that used midwives were more likely to consider their practitioner effective at preparing them than those that used OB/GYNs. This study also highlighted that being adequately prepared means proper preparation for postpartum and emergency situations, not just pregnancy and childbirth. The process of giving birth is often reduced to the nine-month period from conception to delivery, with little consideration for the physiological, emotional, and logistical changes that occur after the singular event of childbirth.

### *Preparedness*

The most obvious takeaway regarding preparedness is that there is a dire lack of information and support provided for postpartum and emergency situations. Some of the short responses given included stories about emergencies which were not only traumatic on their face, but also led to the respondent being stripped of their autonomy and decision-making capabilities. One participant remarked that after the doctors had discovered she had a prolapsed cord, she "was so drugged up that [she] wasn't mentally present." Another described her diagnosis of gestational diabetes and how her doctor suddenly became "more focused on [her] disease" instead of treating her holistically. These are just a few examples of the ways in which unpredictable situations can lead to the desires of the laboring person to be ignored in favor of what a practitioner deems best.

I theorize that, culturally, there is a limited awareness that someone *should* be preparing for postpartum and emergencies. As pointed out in the findings, most participants had watched TV and film during their preparation process and this likely contributes to their lack of adequate preparation for postpartum in particular. While there is no shortage of overdramatized and emergency situations depicted on screen (Berry, 2007; Bessett & Murawsky, 2018), the postpartum period is almost never seen. Childbirth seems ubiquitous in media (especially in TV), but recovery, breastfeeding, and adapting to life with a newborn is much less common. Postpartum depression also carries its own unique stigma and lack of awareness, as does having an infant in the NICU or losing your child. This lack of representation in media leads many aspects of childbirth to remain absent from the cultural perception of this period in a person's life and further research should be done to analyze how postpartum is depicted with TV and film.

Another proposed reason for feeling unprepared for postpartum is the capitalist policies that dictate the modern-day work culture. The United States's maternity leave policies[7] do not grant pregnant workers adequate opportunity to recover and this cuts the postpartum healing period drastically short. Within these shortened periods of leave, postpartum transforms into a "return to normal" from the disruption that is pregnancy and childbirth, causing many not to see a reason to prepare for issues that might arise during this period. These time constraints also make people ration out their time off from work, forcing them to decide which aspect of pregnancy, childbirth, and postpartum necessitates the most amount of the limited time available. Because capitalism is built upon classism and racism, this is doubly true for low income and

[7] The Family and Medical Leave Act provides 12 weeks of unpaid leave for parents, under certain circumstances. Parental leave is not guaranteed for all job types and low income and people of color (groups that are more likely to work in less-protected environments) have significantly less ability to take. As a result, the average amount of leave taken in the United States is 10 weeks, which is only slightly more than the 6-8 weeks post-delivery that cover the medically-defined postpartum period (Shepherd-Banigan & Bell, 2014).

people of color, with their leave periods even shorter or nonexistent. Additionally, the lumping of parental leave under the Family and Medical Leave Act ignores the physiological fact that pregnancy, childbirth, and postpartum are clearly defined health events that have variable effects from each other.

While also theorizing how capitalism plays into this lack of awareness, temporality of these processes should also be considered. Pregnancy and childbirth are temporal events that are tied to a timeline that, in most cases, deviates very little and offers a clear start and end date. In contrast, postpartum lacks this temporal foundation and does not have a clear date that is generally accepted by the public demarcating its end. This makes it an easily-forgotten factor when considering returning back to work in addition to the other preparations one must make leading up to the birth of their child. Ignoring postpartum as a valuable healing period also allows society at large to focus their attention on the child that's born instead of its parent. The postpartum period is often associated with the centering of the child and the mother (formerly the patient) acting as its caretaker.

It is crucial to address the systemic issues that lead to the paternalistic treatment of people giving birth, but I suggest that a more short-term solution is to increase the knowledge of what to expect and how to better manage these emergency situations. A simple area to begin is to increase awareness for doulas whose job it is to act as healthcare advocates. They are particularly useful in emergency situations or when the patient is compromised during the throes of labor. Another useful implementation would be to prioritize the inclusion of information about postpartum and emergency situations within the resources catered to people that are pregnant or planning to become pregnant. Any resource that claims to outline "what to expect when you're expecting" should include expectations beyond the normative birth and give advice for what to

do *after* delivery. Information about negative aspects of childbirth, such as postpartum depression or the likelihood of emergencies, can often incite fear in people, but emphasizing the importance of being informed and the ability to recruit healthcare advocates such as doulas would help reduce how unprepared people feel for these situations.

### *Resources*

The resource list presented in this survey can be split into three approximate categories: mass media, community-driven, and institutional. The media-based resources (apps, TV and film, podcasts, or social media) were reported by many to be the least useful and none of them were recommended by any OB/GYNs. A notable exception to this occasionally used, rarely recommended, and somewhat useful trend amongst the media-based resources are podcasts. Podcasts were added to the resource list after analyzing the data collected from the survey completed in the Netherlands; several participants had named podcasts as a valuable asset in their individual preparations for pregnancy and childbirth. This begs the question about what differentiates podcasts from its fellow media-based resources. A thorough investigation of the content and realism depicted in podcasts should be conducted to evaluate the factors leading to its widespread use and overall success. I theorize that it is the accessibility and variety of podcasts that lead to their success. There are thousands of podcasts about pregnancy and childbirth which allows for someone to personalize the type of content they engage with. It is also likely that these podcasts are being treated similarly or as an alternative to books and journals. I believe many people might be using podcasts because they find them as engaging as social media and as informative as books and journals.

Friends and family and other pregnant people, two community-driven resources, were the most commonly used, even if they were not the most useful. This is a direct inverse of doulas, a resource that is inherently community-driven that was depicted as highly useful yet rarely utilized. I believe this disparity is the result of a resource being sought after versus spontaneous. Receiving unsolicited advice can lead to frustration for the individual trying to prepare and people are unlikely to trust information that is not being given by professionals within the childbirth field. Comparatively, the information provided by doulas is inherently sought after because using a doula is an active choice on the behalf of the individual and they are seen as more knowledgeable about the topic at hand. I suggest further research should be conducted about the benefits and drawbacks to casual, interpersonal knowledge-sharing as well as the relative validity and perceived usefulness of community-based advice.

The disparity between how useful doulas were ranked and the number of individuals that used them highlights multiple glaring issues within the current American healthcare system. Not only do doulas provide support and a continuity of care that can be hard to access otherwise, but they often also function as healthcare advocates. It is unclear which of these roles the respondents relied on doulas the most for, but many written responses expressed an inability to properly advocate for oneself indicating a certain necessity for a doula. The fact that over half of the participants reported using a doula is an overall positive sign. Access to doulas is severely lacking and these individuals are grossly underpaid (Villarosa, 2022), but if there is an increase in their overall use, that will only improve childbirth outcomes. I believe that further research about the actual number of doulas being utilized and the reasons people cite for seeking a doula would give us a greater understanding of doulas as a resource.

Institutional resources (childbirth classes, medical websites, and books and journals) were among the most used, recommended, and useful. This showcases a general prioritization of resources based on science, backed by doctors, and reviewed by professionals. These resources are also likely to include anecdotal knowledge in addition to the scientific facts, a factor that was noted as important by respondents. It is also notable that these three resources served as the primary sources of preparatory information for all individuals; besides their practitioners and doulas, childbirth classes were the resource mentioned most often in the qualitative portion of the survey. I suggest that these institutional resources make more of a concerted effort to include content about postpartum and emergency situations. A mixture of scientific and anecdotal information about all aspects surrounding childbirth would lead to greater feelings of preparedness across the board.

I have considered childbirth classes institutional because they are often put on by a specific organization, whether that be a birthing center or a nonprofit organization. This classification highlights the fact that this resource can range from highly standardized to easily personalized, a trait that makes it capable of adapting to both the medical and midwifery model of care. Its malleability upholds it up as the one in which the most radical change can be made. These classes offer the greater capacity for increasing preparedness for postpartum and emergency situations and doing so would in turn grant individuals knowledge that would grant them greater agency over their pregnancy and childbirth experiences.

A childbirth class given by a hospital will likely be biased towards the medical model of care while one conducted by a more grassroots organization might veer towards the midwifery model, but our neoliberal healthcare system allows for individuals to “shop” for the one best catered to them. This consumer mindset regarding childbirth classes might act as a barrier for

some in receiving the information they desire and lead many to conform to normative rhetorics of birth. However, an important layer to this consumerist model of childbirth classes is that many of my participants reported that their childbirth classes were conducted online. Giving individuals the option to choose the childbirth class that suits them best, regardless of their location, will allow them a greater agency over their preparation for pregnancy and childbirth and might increase the awareness of nonnormative means of giving birth.

Overall, it is evident that accessible and valuable resources are an important element in preparing for pregnancy and childbirth. It is also clear that the recommendations made by providers might need an update for the digital age. There remains a contradiction between the high usage rate of resources found online and their overall usefulness. The fact that participants found TV and film less than useful might point to broader society at large realizing the inaccuracies of the depictions of pregnancy and childbirth shown on the silver screen, but it could also point towards the rising reliance on social media for news and information in TV's stead. There is also the concern that growing reliance on digital media will lead to unchecked misinformation about pregnancy and childbirth, but this concern should be held in balance against the fact that online resources increase overall accessibility for everyone. Childbirth practitioners remain the predominant source of information for individuals preparing to give birth, but widening our understanding of lesser-used resources can also allow us to make more radical interventions to improve preparedness and, as a result, overall birth outcomes.

### *Comparing Practitioner Types*

The participants' responses concerning their individual experiences revealed several significant patterns about how they perceived the role of their practitioner. While I'd originally

expected a sizable number of differences between the two practitioner types, it is important to note that the results also showed consistencies across all respondents' answers. I think it is particularly important highlight that (nearly) all the participants reported that they spent a considerable amount of time and effort in their preparations for pregnancy and childbirth and that they felt this time and effort was worthwhile. No matter the difference in their ideologies or the provider they choose, people are making the effort to become adequately prepared and interventions to improve resources and providers should treat their audience as active agents in their own pregnancy and childbirth experience.

Another consistency across all practitioner types and the two nations studied was the desire for a continuity of care. The absence, presence, and availability of one's provider was noted repeatedly as an important factor in shaping overall experience. Those that remarked that their provider was "absent" painted this unavailability as a negative aspect and lamented the inability to make an interpersonal connection with the person they were expected to trust during such an intimate experience. Conversely, there were two separate respondents that cited their frequent appointments with their practitioner as the primary contributing factor for their overall preparedness and informedness. Notably, one of these respondents used an OB/GYN and the other used a midwife which highlights that continuity of care is desired regardless of practitioner type.

Despite the consistencies I have pointed out above, there were drastic differences between the impressions of those that used OB/GYNs and those that used midwives. For example, the characteristic used most often by respondents to describe their OB/GYN was "professional" and the sum of them largely centered their provider's competency as a doctor. It is evident the methods employed by OB/GYNs are compared to the quintessential doctor figure

depicted by broader society. The term physician carries the association of a paternal figure whose job is to be an expert in their field, impart information they deem worthwhile, and provide comfort if necessary. Fulfilling the minimum requirement in each of these categories might lead a patient to consider their care as "basic"[8] but those that felt their doctor held up to these stereotypes might consider them a "friend."

In contrast to how physicians were perceived, midwives were described most often in terms of their availability, bedside manner, and knowledge base. The words associated with them were emotionally charged and emphasized personality, attitude, and/or approach. While the physician was painted as a paternalistic authority over the body, midwives were more likely to be associated with the archetype of the caregiver through words such as compassion and support which were cited by most participants. The ability to reassure and to provide help were seen as important aspects of the midwife approach, and the variability of the responses points towards experiences personalized for each respondent. Considering the overwhelming desire for continuity of care for all participants, it seems that the expectations and execution of a provider's approach are not properly aligned with the fundamental desires one seeks in their primary birth attendant. In this vein, I would like to see future research that offers further comparisons between the perceptions of and satisfaction with each provider type. Additionally, I think it would be useful to analyze the impact of a provider's gender might have on their patient especially considering how gendered the images of physicians and midwives continue to appear.

Location of birth was also an important factor when choosing a provider, particularly amongst those that used a midwife. Once again, we see evidence that a hospital birth is seen as the "default" setting in which to give birth and that a home birth represents an active choice that

[8] Nearly half of the participants that used OB/GYNs described their care as "basic." See Appendix C for the full list of words used.

took forethought and planning to execute. While many participants mentioned their desire for a home or hospital birth, I was surprised to find that the method of birth was rarely discussed. Beyond a few mentions of emergency cesarean sections, there was no indication that the desire to give birth vaginally or surgically played a factor in choices about location or provider type. This omission contrasts with the debates about natural versus medicalized birth ongoing in broader society but seems to indicate that this debate is not as widespread as presented by the media. I believe that method of birth becomes a secondary concern to location and practitioner. While method of birth was not mentioned with any frequency, a desire for an unmedicated birth was expressed by a few participants. This leads me to believe that method of birth is closely correlated with provider types; physicians are associated with medicated births and the possibility of a cesarean section and midwives are associated with unmedicated births with little risk of surgical intervention.

Comparing the experiences offered by OB/GYNs against midwives prompts a question of agency. Nearly all those that used midwives made an active decision to do so while a sizable proportion of those that used OB/GYNs did so under the assumption that there was "no other option." Would those that used OB/GYNs have had a more positive experience if they made an educated choice about their practitioner type? The answer to that question remains elusive, but the discrepancy in agency between my two populations highlights the negative effects of depicting the medical model of birth as the default. Midwives undeniably had a greater positive impact on their patients when compared to OB/GYNs, but the fact that so many respondents were unaware of any option beyond a hospital birth under the care of an OB/GYN points to a stripping of their agency. An individual's relative preference for a midwife or an OB/GYN is less important if that individual is also not granted the chance to make an informed choice about the

type of childbirth experience they desire and which practitioner is most likely to provide that experience.

Lastly, the reasons behind choosing one practitioner over another stresses the differences between the medical and midwifery models of care. The medical institution played an active role in nearly all participants' decision-making; some cited their trust in the system as their reasoning for choosing to use an OB/GYN while others felt judged by certain aspects of the medical institution and ultimately sought out a midwife as an alternative. The participants that were unaware of any other option beyond a medicalized birth were victims of the rhetoric perpetuated by the medical institution. Deconstructing this rhetoric should be a priority on a systemic level, but, in keeping with the previous interventions I have suggested, I believe increased awareness of birth methods outside of this default would offer people greater agency and autonomy over their pregnancy and childbirth experience.

The findings of this study also bring to surface a fundamental aspect of this rhetoric: the belief that childbirth is inherently risky. One respondent stated that they "wanted a doctor who could assist no matter what went wrong" when choosing to use an OB/GYN while another prioritized finding a midwife with "homebirth values with hospital privileges. These responses lead me to believe that midwives have the capacity for becoming more accepted overall than home births will in the United States. Currently, midwives operate almost exclusively within the structures created by the medical institutions, so midwife-attended births often still occur in the hospital and under the supervision of physicians that can intervene. Changing cultural beliefs about childbirth will take a considerable amount of time but making a concerted effort to increase the number of midwife-attended births, not necessarily home births, would help balance

the desire for safeguards for perceived risks and increasing agency in decision-making about location, method, and provider type.

### *Cross-Cultural Analysis*

An express goal of this study was to compare results from the United States with the data collected in the Netherlands and I was able to identity several issues posed by both cohorts. It has been established that the Dutch and American childbirth systems are diametrically opposed, but, despite these systemic differences, I was able to identity similarities within individual experiences. Overall, both cohorts reported utilizing childbirth classes as one of their primary resources in preparing for pregnancy and childbirth, desiring an attentive practitioner that provided a continuity of care, and valuing the general competency of their provider.

When comparing the two countries, it cannot be ignored that their systems are fundamentally different, and these systemic influences are evident within individual birth narratives. Because it is assumed that most babies born in the Netherlands will be delivered by a midwife, the largest variable left to consider is location: at a birthing center or at home. In contrast, there are considerably more variables at play in the United States. Regarding location, participants mentioned birthing centers, hospitals, their homes, and, in one case, a secondary location provided by a midwife. Regarding practitioner type, in the Netherlands, obstetricians are called in for high-risk cases and the remainder fall under the purview of midwives while participants in the American cohort referred to nurse practitioners, doulas, and nurses as birth attendants in addition to midwives and OB/GYNs. The added complexity in the United States results in additional decision-making in preparing for pregnancy and childbirth if an individual rejects the default birthing methods and represents a deterrent to rejecting the status quo of the

medical model. While an individual in the Netherlands that was unable to give birth with their preferred midwife in non-emergency situations could still expect that it would be a midwife by their side, their American peers had less security in the continuity of practitioner type.

The systemic differences between the Netherlands and the United States are obvious and important to consider, but cultural differences also played a significant role in shaping the results of their respective cohorts. One of my key findings from the Dutch cohort was the respondents' difficulty in adapting to the Netherland's widespread holistic model of care. These participants were almost entirely expats from medicalized countries, and this cultural background led to interpersonal and intrapersonal friction between participants and their midwives. They expressed a discomfort with the normalization of childbirth and how nonchalant their midwives were in the face of an event they subconsciously or outright believed was risky. These anxieties highlight the dissimilarity of the cultural narratives surrounding birth between the Netherlands and the United States. The rhetoric within a medicalized system such as the United States will lead individuals to desire safeguards to mitigate perceived risks while the midwifery model in the Netherlands perpetuates the cultural belief that childbirth is a natural and normal life event.

These cultural differences offer insight into the ongoing debate about whether the goal of healthcare reformists in the United States should be to fully adopt the current Dutch. The results of my study lead me to believe that this is impossible even with systemic changes due to prevailing cultural opinions. If the expats from medicalized countries had trouble adapting to the laissez-faire attitude Dutch midwives approached childbirth with, it is reasonable to expect that the American public would face similar troubles with a newly-implemented midwifery model of childbirth care. It is unreasonable to suggest the United States attempt to become more Dutch in

their approach to childbirth until it is normalized across all aspects of everyday life, from parental leave to media depictions.

As I was comparing the data from the two cohorts, I also found a small yet interesting phenomenon consistent within both. When asked to provide descriptor words for their experiences, numerous participants used the words “informed” and “informative,” sometimes interchangeably and often in reference to oneself or the practitioner. It prompted me to consider the nuance between the perceived knowledge of the provider and the knowledge successfully imparted to the patient. As shown in my results from the Dutch cohort, there was a polarizing opinion on whether one’s birth experience should be self-led or provider-led, a preference that might provide insight into the nuance of this word choice. In the American cohort, there were a few comments by respondents that did not feel adequately informed, but there was no evidence that any of them found their practitioner misinformed. Overall, this overarching theme prompts larger questions regarding knowledge transfer and how this shapes practitioner-patient relationships.

## Conclusion

It is undeniable that people preparing for pregnancy and childbirth rely on their childbirth practitioner as a valuable resource during this process, and my research has shown that midwives are more successful in fulfilling this role than their OB/GYN counterparts. Midwives not only provided more resources on average than their OB/GYN counterparts, but also recommended resources that were deemed highly useful. There was also evidence that midwives were more likely to help their patients feel more prepared for postpartum, an aspect of pregnancy and childbirth that participants reported feeling overwhelmingly *under*prepared for. However, the

overall lack of preparedness participants felt regarding postpartum and emergency situations is a significant concern that should not be ignored.

An important insight into the disparity of preparedness by scenario is that individuals viewed childbirth not as a singular event but rather a process. This larger childbirth process is inherently shaped by an individual's preparation methods and is highly dependent on their choice of practitioner type. Because the medical model relies on the rhetoric that childbirth is a predictable, isolated medical event, it is crucial to reframe it as a process that is shaped in unequal parts by the individual and the system they operate under.

The additional resources that my participants employed varied in usage and usefulness, and, as expected from the results from my Dutch cohort, the most consistent and recommended was childbirth classes. Because of their widespread use and perceived value, childbirth classes are an apt first step to childbirth reforms in the United States. These resources are usually created by larger institutions such as hospitals or nonprofit organizations and, as a result, are often reflective of the model of care their institution stands for. This can contribute to the perpetuation of hospital births as the default, but, amidst the current rise of online classes, it can also provide more accessible information about alternative birthing options. Even amongst the participants of my Dutch cohort that gave birth under a midwifery model of care, they relied on childbirth classes from a variety of countries when preparing for pregnancy and childbirth. Amidst the growing awareness of the United States's poor maternal and infant outcomes, it would be prudent to prioritize childbirth classes as instrumental and make them accessible, accurate, and inclusive to avoid these poor outcomes.

The systems of the United States and the Netherlands might indeed be diametrically opposed, but the desires of the people within these systems are more similar than different. The

results from both studies highlight the fact that, regardless of whether a person prefers a holistic or medicalized birth, birthing people value a practitioner that is knowledgeable and invested. Continuity of care was a running theme throughout both research projects, and its importance was highlighted by mentions of both its absence and presence. This value is what breaks down the difference between the Dutch and American systems: continuity of care is embedded into the system of the former and ignored in favor of profit in the latter.

The majority of those in the Dutch cohort were prepared primarily by their midwives for birth and the rest of the resources they used were self-sought. This is a drastic difference when compared to the American cohort in which midwives recommended a variety of outside resources and all participants relied on at least two different resources in their preparations. The midwives used by my participants were reported as more present than their peers' OB/GYNs resulting in the former having more opportunities to ask for more resource recommendations and the latter having to rely on outside resources beyond the few given by their practitioner. The discrepancy here highlights the differences in continuity of care between the medical and midwifery models and how this has impacts on every aspect of the pregnancy and childbirth process. The increased reliance on resources in the United States in comparison to the Netherlands also illustrates the American cultural perception of childbirth as risky and the general necessity to overprepare through these resources.

It is also necessary to expand our definition of reproductive justice to include the postpartum period of birth. Beyond the fundamental physical and mental changes an individual should expect to undergo during pregnancy and childbirth, they should also be preparing for the new systems they must navigate after having a child. Parental leave, daycare, and insurance are important factors to consider in addition to the general caretaking duties that are required for a

newborn. Institutional resources that are deemed very useful (medical websites and books and journals in particular) should be held accountable to, at minimum, mention postpartum situations that an individual might want to prepare themselves for. It is crucial that these resources * emphasize the decision-making power of the individual. In keeping with the principles of reproductive justice, equality in reproduction cannot be achieved until the ability to have *and* raise children is available for all.

If our goal is to implement aspects of the midwifery model of care into our own (which I believe will ultimately make the childbirth experience more positive), future research must determine where these implementations would have the greatest effect. With the rise of digital media and the popularity of podcasts seen in this study, I urge future researchers to investigate these online resources in more depth. It will be useful to determine which are more prone to misinformation, how individuals are hearing about which resources, and the themes they contain.

I think that future research into the impact of childbirth practitioners should include an analysis of the practitioner's gender in relation to their patient. Because the United States's medical model has emphasized a paternalistic relationship between historically male physicians and their female patients, evaluating this in the context of modern-day perceptions of OB/GYNs would provide valuable insight into whether this relationship has changed as the field of obstetrics becomes increasingly female. It would also be valuable to consider how being LGBTQ+ might impact how an individual prepares for the highly gendered event that is childbirth.

I also hope that future investigations into these topics collect further qualitative data in addition to the largely quantitative study I conducted. Doing so would produce rich anecdotal data that could reveal cracks in the system that researchers might not have considered yet. This

could be achieved in studies that foster a personal relationship between the researcher(s) and participants and would also open the doors for discussions about the emotions and individuality that shape birth narratives. These conversations would provide valuable insight into how individuals define their birthing process and how this might differ amongst specific populations.

Lastly, I believe that future researchers should also reconsider how they frame the comparisons made between the United States and the Netherlands. While the instinct is to push the United States to be more like its Dutch counterpart, the growing medicalization currently ongoing in the Netherlands should not be ignored. It is more advantageous to center discussion about the methods that would best prioritize the birthing person's experience and opinions within the context of the systems already in place within each nation. The research I have conducted has offered a small glimpse into the practical reality that would result from abruptly shifting the United States to a midwifery model of care. The expats I studied expressed discomfort with the unfamiliar aspects of the Dutch models of care *because* they come from cultures that operated under functionally different models.

The solution to medicalization is not replacing it with the midwifery model. This is evidenced by the fact that countries that were built on the midwifery model are currently being medicalized. It is more realistic to ask the areas in which the midwifery model of care can be *integrated* into our current medicalized system to maximize the positive experience for individuals and birthing people as a whole.

# Appendix A

*Survey Questions*

- **Informed Consent**
  - My name is Abigail Matthews and I am an undergraduate researcher at Washington University in St. Louis. My research topic is childbirth in the United States.
    I would like to invite you to participate in a study I am conducting. This survey is **anonymous** and will take approximately **10 minutes** to complete. The purpose of this study is to determine how successful childbirth practitioners are in preparing their patients for pregnancy and childbirth. Your participation in this study is voluntary.
    There are no foreseeable risks or benefits to you participating in this study, but we hope that this research will help understand and establish successful preparation strategies midwives and OB/GYNs may be able to adopt for their future patients.
    If you choose to participate, you will be asked to select "I agree" as confirmation of your consent and a copy of this form will be made available to you for download at the end of the survey. You may email a.l.matthews@wustl.edu with any questions you may have before you participate.
    I have read the above and I understand its contents and I agree to participate in the study. I acknowledge that I am 18 years of age or older.
- **Demographics**
  - How would you describe yourself?
  - How old are you?
  - What is your current marital status?
  - Choose one or more races that you consider yourself to be.
  - What is the highest level of school you have completed or the highest degree you have received?
  - Have you given birth in the United States?
- **Birth Information**
  - When was your most recent birthing experience?
  - In which state(s) have you given birth?
  - Have you given birth using a midwife?
  - Have you given birth using an OB/GYN?
  - Which locations have you given birth in?
  - With which methods have you given birth?
- **Overall Preparedness**
  - How useful did you find the following resources in preparing for childbirth?

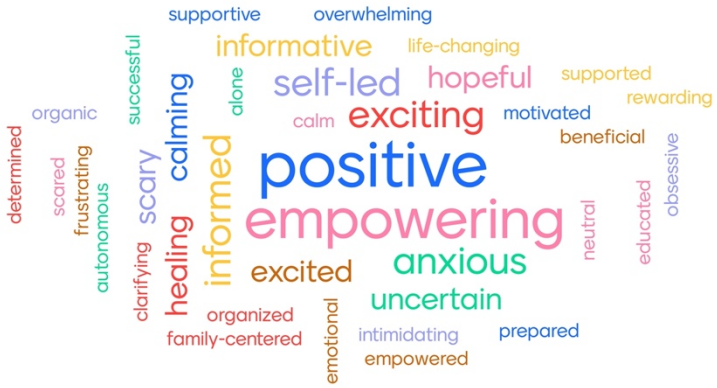
        - Childbirth Classes
        - Friends/Family
        - Doula
        - TV and Film
        - Podcasts
        - Other Pregnant People
        - Books and Journals
        - Apps
        - Medical Websites
        - Social Media
    - Agree or Disagree: I spent a considerable amount of time and effort making preparations for childbirth.
    - Agree or Disagree: Preparing for childbirth was more stressful than beneficial.
    - Agree or Disagree: I felt that I was alone in preparing for childbirth.
    - Please list three words that best describe your experience in preparing for your pregnancy and childbirth experience. *For example: positive, negative, self-led, calming, uncertain, etc.*
    - Agree or Disagree: I felt adequately prepared for…
        - Pregnancy
        - Childbirth
        - Postpartum
        - Emergency Situations
- **Questions for Those That Used Midwives**
    - Agree or disagree: I considered using an OB/GYN instead of a midwife.
    - What made you choose to use a midwife?
    - Agree or disagree: Having a midwife positively affected how prepared I felt for pregnancy and childbirth.
    - Please list three words that best describe the methods your midwife used to prepare you for your pregnancy and childbirth experience. *For example: positive, negative, self-led, calming, uncertain, etc.*
    - Agree or disagree: My midwife adequately prepared me for…
        - Pregnancy
        - Childbirth
        - Postpartum
        - Emergency Situations
    - Which resources did your midwife recommend to you to help in your preparations? Select all that apply.
        - Doula
        - Childbirth Classes
        - Friends/Family

        - Other Pregnant People
        - Books and Journals
        - Apps
        - Medical Websites
        - Social Media
        - TV and Films
        - Podcasts
        - Other (fill in)
- **Questions for Those That Used OB/GYNs**
    - Agree or disagree: I considered using a midwife instead of an OB/GYN.
    - What made you choose to use an OB/GYN?
    - Agree or disagree: Having an OB/GYN positively affected how prepared I felt for pregnancy and childbirth.
    - Please list three words that best describe the methods your OB/GYN used to prepare you for your pregnancy and childbirth experience. *For example: positive, negative, self-led, calming, uncertain, etc.*
    - Agree or disagree: My OB/GYN adequately prepared me for…
        - Pregnancy
        - Childbirth
        - Postpartum
        - Emergency Situations
    - Which resources did your OB/GYN recommend to you to help in your preparations? Select all that apply.
        - Doula
        - Childbirth Classes
        - Friends/Family
        - Other Pregnant People
        - Books and Journals
        - Apps
        - Medical Websites
        - Social Media
        - TV and Films
        - Podcasts
        - Other (fill in)
- **Final Question**
    - Is there anything you'd like to add about your experience in preparing for pregnancy and childbirth? Leave blank if not.

# Appendix B

*Word Cloud: Overall Preparedness*

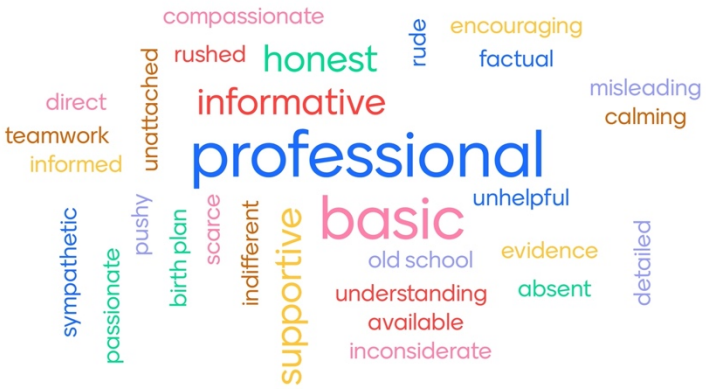
**Please list three words that best describe your experience in preparing for your pregnancy and childbirth experience.**
69 responses




# Appendix C

*Word Cloud: Preparedness by OB/GYN*

**Please list three words that best describe the methods your OB/GYN used to prepare you for your pregnancy and childbirth experience.**
42 responses



# Appendix D

*Word Cloud: Preparedness by Midwife*

**Please list three words that best describe the methods your midwife used to prepare you for your pregnancy and childbirth experience.**
33 responses

## References

Afshar, Y., Wang, E. T., Mei, J., Esakoff, T. F., Pisarska, M. D., & Gregory, K. D. (2017). Childbirth Education Class and Birth Plans Are Associated with a Vaginal Delivery. *Birth*, *44*(1), 29–34. https://doi.org/10.1111/birt.12263

Anderson, D. A., & Gilkison, G. M. (2021). The Cost of Home Birth in the United States. *International Journal of Environmental Research and Public Health*, *18*(19), 10361. https://doi.org/10.3390/ijerph181910361

Berry, S. C. (2007). *"Too posh to push" or too quick to cut? Deconstructing media representations of elective caesarean sections*. Simon Fraser University. https://summit.sfu.ca/item/8105

Bessett, D., & Murawsky, S. (2018). 'I guess I do have to take back what I said before, about television': Pregnant women's understandings and use of televisual representations of childbearing. *Sociology of Health & Illness*, *40*(3), 478–493. https://doi.org/10.1111/1467-9566.12658

Bogdan, J. (1978). Care or Cure? Childbirth Practices in Nineteenth Century America. *Feminist Studies*, *4*(2), 92–99. JSTOR. https://doi.org/10.2307/3177452

Browner, C. H., & Press, N. (1996). The Production of Authoritative Knowledge in American Prenatal Care. *Medical Anthropology Quarterly, New Series*, *10*(2,), 141–156.

Cheyney, M., Goozari, B., Wiegers, T., Davis-Floyd, R., & Vedam, S. (2019). Giving Birth in the United States and the Netherlands: Midwifery Care as Integrated Option or Contested Privilege? In M. Cheyney & R. Davis-Floyd (Eds.), *Birth in Eight Cultures* (pp. 165–202). Waveland Press.

Christiaens, W., & Bracke, P. (2009). Place of birth and satisfaction with childbirth in Belgium and the Netherlands. *Midwifery*, *25*(2), e11-19. https://doi.org/10.1016/j.midw.2007.02.001

Christiaens, W., Nieuwenhuijze, M. J., & de Vries, R. (2013). Trends in the medicalisation of childbirth in Flanders and the Netherlands. *Midwifery*, *29*(1), e1–e8. https://doi.org/10.1016/j.midw.2012.08.010

D'Ambrosio, A. (2022, November 17). *Home Births in the U.S. Increased Again, Maintaining Pandemic Trend*. https://www.medpagetoday.com/obgyn/pregnancy/101791

Davis-Floyd, R. (2001). The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics*, *75 Suppl 1*, S5–S23.

Davis-Floyd, R., Cheyney, M., Davis-Floyd, R., & Cheyney, M. (2019). Birth as Culturally Marked and Shaped. In *Birth in Eight Cultures* (pp. 1–16). Waveland Press.

Davis-Floyd, R., Faber, M., & DeVries, R. (2013, March 1). An Update on the Netherlands. *Midwifery Today*. https://www.midwiferytoday.com/mt-articles/an-update-on-the-netherlands/

De Vries, R., & Barroso, R. (2007). Midwives among the machines: Re-creating midwifery in the late twentieth century. *Neonatal Intensive Care*, *20*.

Dencker, A., Taft, C., Bergqvist, L., Lilja, H., & Berg, M. (2010). Childbirth experience questionnaire (CEQ): Development and evaluation of a multidimensional instrument. *BMC Pregnancy and Childbirth*, *10*(1), 81. https://doi.org/10.1186/1471-2393-10-81

Dye, N. S. (1980). History of Childbirth in America. *Signs*, *6*(1), 97–108. JSTOR.

Galková, G., Böhm, P., Hon, Z., Heřman, T., Doubrava, R., & Navrátil, L. (2022). Comparison of Frequency of Home Births in the Member States of the EU Between 2015 and 2019.

*Global Pediatric Health*, *9*, 2333794X211070916. https://doi.org/10.1177/2333794X211070916

Gunja, M. Z., Gumas, E. D., & Williams, R. D. (2023, January 31). *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*. https://doi.org/10.26099/8ejy-yc74

Harding, R. (2020, January 27). Gynecologists Are the New "It Girls" of Instagram. *SheKnows*. https://www.sheknows.com/health-and-wellness/articles/2156464/obgyn-health-influencers-instagram/

Hassanzadeh, R., Abbas-Alizadeh, F., Meedya, S., Mohammad-Alizadeh-Charandabi, S., & Mirghafourvand, M. (2022). Comparison of childbirth experiences and postpartum depression among primiparous women based on their attendance in childbirth preparation classes. *The Journal of Maternal-Fetal & Neonatal Medicine*, *35*(18), 3612–3619. https://doi.org/10.1080/14767058.2020.1834531

Have, H. ten. (2003). Medicalization and obstetric care: An analysis of developments in Dutch midwifery. *Medicine, Health Care and Philosophy*. https://www.academia.edu/845678/Medicalization_and_obstetric_care_An_analysis_of_developments_in_Dutch_midwifery

*Having a Doula | What is a Doula & What are the Benefits?* (n.d.). Retrieved March 1, 2024, from https://americanpregnancy.org/healthy-pregnancy/labor-and-birth/having-a-doula/

Huesch, M., & Doctor, J. N. (2015). Factors Associated With Increased cesarean Risk Among African American Women: Evidence From California, 2010. *American Journal of Public Health*, *105*(5), 956–962. https://doi.org/10.2105/AJPH.2014.302381

Jefferson, K., Bouchard, M. E., & Summers, L. (2021). The Regulation of Professional Midwifery in the United States. *Journal of Nursing Regulation*, *11*(4), 26–38. https://doi.org/10.1016/S2155-8256(20)30174-5

Johanson, R., Newburn, M., & Macfarlane, A. (2002). Has the medicalisation of childbirth gone too far? *BMJ : British Medical Journal*, *324*(7342), 892–895.

Kennedy, H. P., Balaam, M.-C., Dahlen, H., Declercq, E., de Jonge, A., Downe, S., Ellwood, D., Homer, C. S. E., Sandall, J., Vedam, S., & Wolfe, I. (2020). The role of midwifery and other international insights for maternity care in the United States: An analysis of four countries. *Birth*, *47*(4), 332–345. https://doi.org/10.1111/birt.12504

Klein, J. (2016, July 9). Opinion | Get the Epidural. *The New York Times*. https://www.nytimes.com/2016/07/10/opinion/sunday/get-the-epidural.html

Liston, W. A. (2003). Rising caesarean section rates: Can evolution and ecology explain some of the difficulties of modern childbirth? *Journal of the Royal Society of Medicine*, *96*(11), 559–561.

Lothian, J. A. (2010). How Do Women Who Plan Home Birth Prepare for Childbirth? *The Journal of Perinatal Education*, *19*(3), 62–67. https://doi.org/10.1624/105812410X514459

Luce, A., Cash, M., Hundley, V., Cheyne, H., van Teijlingen, E., & Angell, C. (2016). "Is it realistic?" the portrayal of pregnancy and childbirth in the media. *BMC Pregnancy and Childbirth*, *16*(1), 40. https://doi.org/10.1186/s12884-016-0827-x

MacKinnon, K. R., Lefkowitz, A., Lorello, G. R., Schrewe, B., Soklaridis, S., & Kuper, A. (2021). Recognizing and renaming in obstetrics: How do we take better care with language? *Obstetric Medicine*, *14*(4), 201–203. https://doi.org/10.1177/1753495X211060191

Melillo, G. (2020, May 15). *How Much Does It Cost to Give Birth in the United States? It Depends on the State*. AJMC. https://www.ajmc.com/view/how-much-does-it-cost-to-give-birth-in-the-united-states-it-depends-on-the-state

Mettler, L. G. (2017, November 17). *Op-Ed: Is "natural motherhood" more feminist?* Los Angeles Times. https://www.latimes.com/opinion/op-ed/la-oe-mettler-natural-motherhood-breastfeeding-attachment-parenting-20171117-story.html

Mitteroecker, P., Huttegger, S. M., Fischer, B., & Pavlicev, M. (2016). Cliff-edge model of obstetric selection in humans. *Proceedings of the National Academy of Sciences*, *113*(51), 14680–14685. https://doi.org/10.1073/pnas.1612410113

Morton, C. H., & Hsu, C. (2007). Contemporary dilemmas in american childbirth education: Findings from a comparative ethnographic study. *The Journal of Perinatal Education*, *16*(4), 25–37. https://doi.org/10.1624/105812407X245614

Overgaard, C., Fenger-Grøn, M., & Sandall, J. (2012). The impact of birthplace on women's birth experiences and perceptions of care. *Social Science & Medicine (1982)*, *74*(7), 973–981. https://doi.org/10.1016/j.socscimed.2011.12.023

Roth, L. M. (2021). *The Business of Birth: Malpractice and Maternity Care in the United States*. NYU Press.

Sargent, C., & Bascope, G. (1996). Ways of Knowing about Birth in Three Cultures. *Medical Anthropology Quarterly*, *10*(2), 213–236.

Shepherd-Banigan, M., & Bell, J. F. (2014). Paid Leave Benefits Among a National Sample of Working Mothers with Infants in the United States. *Maternal and Child Health Journal*, *18*(1), 286–295. https://doi.org/10.1007/s10995-013-1264-3

Sluijs, A., Cleiren, M. P. H. D., Lith, J. M. M., Wijma, B., & Wijma, K. (2020). Is fear of childbirth related to the woman's preferred location for giving birth? A Dutch low-risk cohort study. *Birth*, *47*(1), 144–152. https://doi.org/10.1111/birt.12456

Souter, V., Nethery, E., Kopas, M. L., Wurz, H., Sitcov, K., & Caughey, A. B. (2019). Comparison of Midwifery and Obstetric Care in Low-Risk Hospital Births. *Obstetrics and Gynecology*, *134*(5), 1056–1065. https://doi.org/10.1097/AOG.0000000000003521

Spector-Bagdady, K., De Vries, R., Harris, L. H., & Low, L. K. (2017). Stemming the Standard-of-Care SPRAWL: Clinician Self-Interest and the Case of Electronic Fetal Monitoring. *The Hastings Center Report*, *47*(6), 16–24.

Thomasson, M. A., & Treber, J. (2008). From home to hospital: The evolution of childbirth in the United States, 1928–1940. *Explorations in Economic History*, *45*(1), 76–99. https://doi.org/10.1016/j.eeh.2007.07.001

Villarosa, L. (2022). *Under the skin: Racism, inequality, and the health of a nation* (First edition). Doubleday.

Vitek, K., & Ward, L. M. (2019). Risky, Dramatic, and Unrealistic: Reality Television Portrayals of Pregnancy and Childbirth and their Effects on Women's Fear and Self-Efficacy. *Health Communication*, *34*(11), 1289–1295. https://doi.org/10.1080/10410236.2018.1481708

Vogels-Broeke, M., Daemers, D., Budé, L., de Vries, R., & Nieuwenhuijze, M. (2022). Sources of information used by women during pregnancy and the perceived quality. *BMC Pregnancy and Childbirth*, *22*(1), 109. https://doi.org/10.1186/s12884-022-04422-7

Wezowski, K. (2016, January 8). *Natural Birth: The Most Amazing Experience Ever | HuffPost Life*. HuffPost. https://www.huffpost.com/entry/natural-birth-the-most-am_b_8939664

Williams, J. W. (1912). Medical Education and the Midwife Problem in the United States. *Journal of the American Medical Association*, *LVIII*(1), 1–7. https://doi.org/10.1001/jama.1912.04260010003001

*Working Together to Reduce Black Maternal Mortality | Health Equity Features | CDC*. (2023, April 27). https://www.cdc.gov/healthequity/features/maternal-mortality/index.html

Yohai, D., Alharar, D., Cohen, R., Kaltian, Z., Aricha-Tamir, B., Aion, S. B., Yohai, Z., & Weintraub, A. Y. (2018). The effect of attending a prenatal childbirth preparedness course on labor duration and outcomes. *Journal of Perinatal Medicine*, *46*(1), 47–52. https://doi.org/10.1515/jpm-2016-0345