

Mother Beware: Perilous Scholarly and News Media Discourse around Homebirth

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Abstract

Scholarly and news media discourses have been sounding the alarm about the dangers of homebirth. This has had the effect of strengthening the popular belief that women's reproductive processes are inherently prone to malfunction and, thus, require technological intervention in order to ensure "safe" births. Yet the foundation, upon which such claims rest, specifically, a widely touted 2010 study indicating the risk homebirth poses to infant mortality, is marred by fallacies that seem due to negative gendered presumptions about female biology. Such errors are perilous and disempowering. In the first place they are perpetuating unwarranted alarm around the supposed dangers of planned homebirth, and invite further restrictions of women's already limited birthing rights in the U.S. Secondly, the study and attending news media discourses are having the effect of obscuring full consideration of maternal wellbeing, particularly as it relates to maternal mortality and maternal morbidity. As such these discourses are contributing to an androcentric vision of childbirth wherein women are viewed as birth-objects or resources rather than creative-agent, and are furthermore normalizing "compulsory maternal sacrifice."

Key Words: Birth; Homebirth; Reproductive Rights; Motherhood; Compulsory Maternal Sacrifice; Maternal Morbidity

Introduction

Mainstream medical professionals and medical scholars have turned their attention to what they see as the dangers of planned homebirth. In 2010, a highly-touted study, "Maternal and newborn outcomes in planned home birth vs. planned hospital births: a meta-analysis," was published in the American Journal of Obstetrics and Gynecology (AJOG, 2010). The study, comparing hospital birth with homebirth, ignited headlines in popular news media publications. Emphasizing the incidence of infant mortality, the study concluded that infants fare much better when birthed in the hospital. Respected journals such as the Lancet were promoted to decry as irresponsible many women's decision to give birth at home. In January 2011, popular media outlets such as the Hollywood Tabloid website, HollyBaby.com, followed suit, claiming that planned homebirth is dangerous and irresponsible. Similar opinions were expressed by both readers and medical professionals in response to headlines that the rate of homebirths is increasing.

Together, the study in question and the accompanying media discourse around the dangers of homebirth perpetuate gender and nature/culture dualisms. Yet this popular condemnation of homebirth is based on incomplete medical research that, while highlighting (perceived) higher risk of infant mortality in homebirths, fails to take into account research offering contradictory conclusions about such risks—

namely, research concluding that planned homebirth is generally safe for both mother and child. In addition to the problematic character of the key study in question this work examines the normalized dismissal of birthing women's wellbeing in the discourse around the study. Such dismissal is a consequence of an overlooked ideological orientation informing dominant scholarly and popular discourse: patriarchal androcentrism.

Androcentrism and Reproduction

According to Antonio Gramsci, ruling elites assert significant control over society through command and control of the ideas flowing from and through cultural institutions. He termed this social hegemony, ideological leadership in civil society. Social hegemony produces a power and control that is different from pure political domination's exertion of physical force. Rather it involves the exertion of an *ideological* influence/guidance wherein empowered groups shape the thinking of the people, often at their expense and for the betterment of the empowered group. When successful, social hegemony evokes the "spontaneous" consent of the masses (Gramsci 2005: 12). Social hegemony usually involves a kind of group or individual egocentrism which the ecofeminist philosopher, Val Plumwood, terms "hegemonic centrism.

...a primary-secondary pattern of attribution that sets up one term (the One) as primary or as centre and defines marginal Others as secondary or derivative in relation to it, for example, as deficient in

relation to the centre (Plumwood 2002: 101)

These centrismisms amount to a “master” perspective which in turn fosters blind-spots that prevent the master subject from seeing the world and those in it outside of “the dominant framework” (Plumwood 2002: 99). Moreover centric thinking fosters misperceptions of those marked out as “other.” Others are spoken *to* or *for* rather than listened to. Centric thinking has the effect of “backgrounding” the other: pushing others to the *background*—marginalizing their interests and perspective. “When the other’s agency is treated as background or denied, we give the other less credit than is due to them. We easily come to take for granted what they provide for us, and to starve them of the resources they need to survive....” (Plumwood 2002: 30). Feminist philosopher Iris Marion Young describes the implementation of such centrismisms as “cultural imperialism,” one of the five forms of oppression she identifies (Young 2006). Cultural imperialism involves the cultural transmission of dominant groups’ systems of thought (values, attitudes, beliefs) represented as the norm for all.

Since only the dominant group’s cultural expressions receive wide dissemination, their cultural expressions become the normal, or the universal, and thereby the unremarkable. Given the normality of its own cultural expressions and identity, the dominant group constructs the differences which some groups exhibit as lack and negation. These groups become marked as Other (Young 2006: 12).

The present work seeks to address the role of androcentrism in shaping discourse around women’s decisions to choose homebirth. Androcentrism is a form of centrism that normalizes the patriarchal viewpoint where elite male identity, interests, experiences, and beliefs are normalized and portrayed as the “mythical norm” against which all others are to be judged. From civilization’s earliest legal codes in Ancient Mesopotamia to Ancient Greek philosophy to Christian theology and Enlightenment rationalists, history is flooded with proof of the ubiquity of patriarchal beliefs and practices (Nall 2010; Nall 2007). Perhaps the most influential of all Western philosophers, Aristotle articulated the reality of patriarchy and the predominance of androcentrism when he defined family in “Politics” (350 BCE). He wrote:

“The family is the association established by nature for the supply of men’s everyday wants.....”

The androcentric conceptualization of women and reproduction is of particular importance. Val Plumwood writes that Aristotle conceptualized women’s reproductive agency as

...an adjunct to or mere condition for real agency, which was claimed for the male reproductive role, the woman being substitutable, merely ‘the nurse’ for the male seed. Aristotle’s age erased women as social and political agents, enabling Aristotle to disappear women’s reproductive agency in his award of the reproductive ownership of the child to the father. Aristotle saw the father as contributing the rational element of form as compared to the mother’s contribution of mere matter (Plumwood 2002: 30)

The cooptation of reproductive agency has long been central to patriarchal androcentrism. In the Bible not only was childbirth conceptualized as a form of punishment for the sin of Eve (Genesis 3:16), the basis for male supremacy over females was based upon the contention that “man is not of the woman but the woman of the man. Neither was man created for the woman but the woman for the man” (1 Cor. 11:3, 7, 9). Such diminishment of maternal agency continues in everyday language. Contemplate, for example, which of the following sentences one is more likely to hear in the context of a woman’s decision to carry out a pregnancy.

“I’ve decided to have the baby.”

“I’ve decided to have my baby.”

“I’ve decided to birth my baby.”

“I’ve decided to make my baby.”

Typically, we use the word “have” to indicate passivity: “Tomorrow I am going to have surgery, another test, etc.” We are resigned to these things; they are beyond our control/agency. Conversely, words like “get,” “win,” “finish” connote agency, willed action on our part. As passivity is generally associated with objects or those presently lacking agency, speaking of mothers’ birth projects in this way suggests dominant culture continues to conceptualize the maternal role in childbirth as inactive and acted upon. Her perceived role as “resource” is further indicated in the general dismissal of mothers’ assertions of agency over birth conditions despite significant rates of maternal morbidity.

Background: The Assault on Birth Rights

Discussions about the assault on women’s reproductive rights tend to concentrate almost exclusively on questions of when or if women have a right to terminate a pregnancy. What is much less understood or discussed is that women’s reproductive rights have also been significantly infringed upon in terms of the right to decide when, where, and how to birth. In addition to facing increasingly limited access to safe, affordable abortions, today women in 23 U.S. states are effectively *forced* to choose hospital birth. In these states midwife-attended homebirths are effectively illegal:

Today, just 27 states license or regulate so-called direct-entry midwives - or certified professional midwives (CPMs) - whose level of training has met national standards for attending planned home

births. In the 23 states that lack licensing laws, midwife-attended births are illegal, and midwives may be arrested and prosecuted on charges of practicing medicine or nursing without a license. (Unlike CPMs, certified nurse midwives, or CNMs, who are trained nurses, may legally assist home births in any state. But in practice, they rarely do, since most of them work in hospitals.) (Elton 2010).

Meanwhile, major medical institutions decry homebirth and its purported risks to women's newborn infants. Both the American Medical Association and the American College of Obstetricians and Gynecologists (ACOG) adamantly oppose homebirth (MSNBC 2009; Elton 2010) on grounds that it puts infants at unnecessary risks, and that hospitals and medical professionals are most qualified to ensure safe delivery.

Critics of medicalized childbirth, including midwives (Ina May Gaskin), homebirth activists (Ricki Lake), medical anthropologists (Robbie Davis-Floyd), doctors (Michel Odent), and maternity health organizations (Childbirth Connection) argue that medicalized birth is subjecting women to increased rates of maternal morbidity, which refers to "serious disease, disability or physical damage" resulting from birth complications (United Nations Population Fund 2013) and a 31.8 percent chance, nationally, of undergoing the major abdominal surgery of cesarean-section. Moreover, in nearly 50-percent of hospitals (Public Citizen 2010), women are denied the choice of having a vaginal birth after cesarean-section (VBAC). This effectively forces them to not only give birth in a hospital setting but also plan to undergo a cesarean-section.

Denunciations of homebirth entail implied but unarticulated statements of value, namely the elevation of concern for the birthing woman's fetus and the comparatively minute (perceived) risks posed by homebirth over the frequent harm befalling mothers under the medical model. A statement by the American College of Obstetricians and Gynecologists reads:

Childbirth decisions should not be dictated or influenced by what's fashionable, trendy, or the latest cause célèbre. Despite the rosy picture painted by home birth advocates, a seemingly normal labor and delivery can quickly become life-threatening for both the mother and baby (MSNBC 2009).

Such assertions trivialize the legitimate concerns and interests that propel many mothers to choose midwife-facilitated homebirth. This outcry is perhaps related to growing awareness that women are increasingly turning to alternative birth practices. A 2011 study found that while the number of American homebirths had persistently declined from 0.69 percent in 1989 to 0.56 in 2004, it increased by 20

percent between 2004 and 2008 (MacDorman et. al. 2011: 1). The study authors examined the birth certificates of some 4.2 million births and found that, in 2008, 28,357 births took place at home in the U.S. This number accounts for 0.67-percent of all births (MacDorman et. al. 2011: 1). Yet it must be noted that birth certificates are not always precise in terms of distinguishing between planned and unplanned homebirths.

Homebirth: A Reckless, Dangerous, and Immoral Choice?

A prominent thread of popular and scholarly discourse has coincided to assert that birth outside of medical control is irresponsible and immoral. In July 2010, the *Lancet* published an editorial titled, "Home birth - proceed with caution." The piece begins by pitting the benefits of homebirth for the mother against those of her infant: "Although home birth seems to be safe for low-risk mothers and, when compared with hospital delivery, is associated with a shorter recovery time and fewer lacerations, post-partum hemorrhages, retained placenta and infections, the evidence is contradictory for outcomes of newborn babies delivered at home" (*Lancet* 2010). The editorial goes on to state: "A recent meta-analysis published in the *American Journal of Obstetrics & Gynecology* provides the strongest evidence so far that home birth can, after all, be harmful to newborn babies" (Wax, Lucas, Lamont, Pinette, Cartin, Blackstone 2010). The editorial summarizes the study's finding that the increase in neonatal death among homebirths was mainly attributable to "breathing difficulties and failed attempts at resuscitation - two factors associated with poor midwife training and a lack of access to hospital equipment" (Wax, Lucas, Lamont, Pinette, Cartin, Blackstone 2010). It then makes the following assertion:

Women have the right to choose how and where to give birth, but they do not have the right to put their baby at risk (Wax, Lucas, Lamont, Pinette, Cartin, Blackstone 2010).

A number of news outlets including the *LA Times* picked up on the editorial, further conveying its warning: "Mothers shouldn't put babies at risk with home birth, editorial says" (2010).

The study in question, "Maternal and newborn outcomes..." concluded that the risk of newborn neonatal death (i.e., within the first 28 days of life) is between two and three times higher among women who give birth at home rather than in the hospital (Wax JR, Lucas FL, Lamont M, et al. 2010: 243.e3). Based on 12 studies and 500,000 births from nations including the U.S., Canada, Australia, Sweden, the Netherlands, and Switzerland, the study also concluded that women having hospital births, compared to homebirths, were twice as likely to experience third-degree lacerations, and three times as likely to encounter infection or vaginal lacerations (Wax JR et al. 2010: 243.e5- 243.e6, see table 2).

The study generated significant discussion within popular media. Several articles informed the public of the purported dangers of birth beyond the bounds of medical control. One article ran the ubiquitous headline: "Home

Births Linked to Higher Newborn Death Rate,” and proceeded to discuss the study’s conclusion that non-medicalized birth increases risks for newborn infants (WebMD Health News 2010). Other headlines included “Home Births linked to higher infant death rates” (WhattoExpect.com 2011), “Home Births New Born Death Rate ‘Higher’ Says Study” (PostChronicle.com 2010), and “Risks of Planned Home Births Greatly Outweigh the Benefits” (Reynolds 2010). The last of these joins in the obscuration of maternal wellbeing by emphasizing almost exclusively the risks posed to the infant.

While most articles at least briefly mentioned the study’s findings concerning increased interventions in the hospital, almost all centred their focus on the neonatal death rate as indicated in the previous headlines. Based on the study, the American Congress of Obstetricians and Gynecologists, comprised of 52,000 members, declared that babies birthed at home were two to three times more likely to die within their first month (Scientific American, 2011). Such findings bolster the ACOG’s stated and official opposition to homebirth due to “safety concerns and lack of rigorous scientific study” (Wax, Lucas, Lamont, 2010: 243.e1). The blogger known as “Dr. Isis the Scientist,” an avowed critic of homebirth, joined others in using the Wax study as ammunition against homebirth. In an August 23, 2011 blog titled, “Your Home Birth is Not a Feminist Statement,” Isis took aim at the woman behind a popular twitter feed, Feminist Hulk, who told *Ms. Magazine* she “chose home birth” and was “so lucky to have labored in an environment that made me feel relaxed and safe, with a birth team that gave me tons of love and support.” Isis contends that such women “place health and welfare in jeopardy in order to feel ‘in control’ and avoid intervention,” citing the Wax study as proof: “infants born at home, with a midwife in attendance, are 2 times more likely to die than infants born in hospital with an MD or midwife in attendance.”

Despite its objective, scholarly tone, the previously discussed study, “Maternal and newborn outcomes” is flawed. Consequently, the various proclamations concerning the neonatal death rate made on its basis are, too. In an October 2011 letter to the *Lancet*’s editor, birth researchers and scholars, Gill Gyte, Miranda Dodwell, and Alison MacFarlane addressed problems with both the study in question and the *Lancet*’s previously mentioned editorial. The authors argued that the editorial was mired with half-truths. While highlighting the fact that the meta-analysis included 12 studies and 500,000 births, and concluding that homebirth can be “harmful to newborn babies,” the editorial omitted three crucial facts about the study: 1) the widely touted conclusions regarding neonatal mortality rates were based on “only six studies and fewer than 50,000 women”; 2) study authors found no significant difference between homebirth and hospital birth in their comparative analysis of perinatal mortality rates (death of the baby up to a week after birth), a comparison based on 500,000 women; and finally, 3) the *single* study

responsible for providing the majority of data for the neonatal mortality comparison “was of poor methodological quality.” Specifically, it “used birth-register data that did not record planned place of birth, so is likely to have misclassified as planned home births some unplanned home births, which are known to have a greater chance of poor outcomes” (Gyte, Dodwell, Masfarlane 2010). In sum, the most widely touted finding of “Maternal and newborn outcomes” study, that medically managed births are two to three times safer for newborns than homebirth, is based on imprecise data and 90-percent fewer birth outcomes than is implied in both the study and popular discussion of the work.

Even if it were the case that the study in question provided reliable conclusions, it is not self-evident that the most reasonable remedy for the purported cause of such outcomes, “poor midwife training and lack of access to hospital equipment,” is to abandon homebirth. Location, home or hospital, does not seem to be the principle problem. Improved midwifery training and portable equipment seem to be the simplest remedies. Instead dominant discourse, informed by an androcentric medical lens, presents readers with a fallacious false choice: either ill-equipped homebirths, or medically controlled hospital births. Earlier campaigns waged by professional obstetricians, against midwives, utilized similar tactics.

Another problem with the “Maternal and newborn outcomes” study is that it significantly drew upon a study surveying homebirths that was conducted from 1976 to 1982. Thus American homebirth, largely attended by traditional midwives, is being judged on arguably outdated data compiled right before and shortly after the publication of American midwife pioneer, Ina May Gaskin’s landmark work, *Spiritual Midwifery* (1977). As a result of a variety of factors including increased medical management of birth (Dye 1980: 98) and efforts to criminalize non-medically managed birth (Dye 1980: 104), traditional midwifery was nearly eliminated (Holly Powell Kennedy 2009: 417) during the 20th century. The resurgence of “traditional” direct-entry midwifery is a product of grassroots efforts during the 1960s and 1970s (Rooks 2007: 4). Gaskin’s work throughout the 1970s is widely recognized as significantly contributing to the foundation for the education and training of contemporary direct-entry (non-nurse) midwives (Block 2007: 218; Nelson 2010; Granju 1999). Specifically, Gaskin’s book, *Spiritual Midwifery*, was met with international acclaim; she founded one of the first out-of-hospital birth centers, “The Farm,” in Summertown, Tennessee. In 1982, Gaskin participated in the creation of the Midwives Alliance of North America (MANA), an organization responsible for supporting, educating, and credentialing midwives. In sum, the midwives attending planned homebirth today are arguably in a better position to ensure better birth outcomes than they were before the rise of such supportive and educational structures. Acknowledgement of this significant context was notably absent from the study in question. The use of such a study to confront birthing women over their agentic decision-making over birth location and environment indicates is more indicative of androcentric bias than it is of homebirth danger. It further exposes the way in which scientific research and/or commentary is often presented as “value-

free” but actually masks, perhaps unintentionally, a variety of presuppositions and values.

One indication that the study is informed by the conceptual narrowness of a patriarchal lens that views pregnancy as inherently pathological is its omission of two significant studies that contradict its conclusion. One study of planned home births in the U.S. and Canada, published in June 2005 in *BMJ* (formerly the *British Medical Journal*), concluded:

Planned home birth for low risk women in North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital births in the United States (Johnson, Daviss 2005: 1).

In a March 2011 story discussing an investigation of the “Maternal and newborn outcomes” study (Wax et al., 2010), *Scientific American* reported that independent epidemiologists questioned the study’s selective data choices. The article cites Diana Petitti, an epidemiologist at the Arizona State University Center for Health Information and Research in Phoenix, as saying that the study:

...should not have excluded data from a major Dutch study, published in 2009, that examined more than 300,000 home births for many outcomes, including the risk of newborn deaths. That study found no increased risk of death after home birth in the first week of life (*Scientific American* 2011).

Of course, as mentioned before, the Wax study also found no difference in death in the first week of life; but this conclusion was not emphasized by researchers nor was it amplified in the subsequent media discourse. Overlook such facts indicates the blindspots afforded by hegemonic centrism.

In short, there are reasons to doubt the accuracy of the “Maternal and newborn outcomes” study, a work which has been trumpeted by the *Lancet* and American Congress of Obstetricians and Gynecologists as proof of the danger homebirth poses to infants. Moreover, there is ample evidence that currently there can be no authoritative or definitive claim that medicalized birth is safer for newborns than planned homebirth. Indeed, there appears to be a growing body of knowledge indicating that planned homebirth is more likely to reduce medical interventions and maternal morbidity, increasing neither the rate of maternal mortality nor the rate of infant mortality.

Following the path of the 2010 Wax study, in 2013 researchers at New York-Presbyterian/Weill Cornell Medical Center concluded that home-birther babies are “roughly 10 times as likely to be stillborn and almost four times as likely to have neonatal seizures or serious neurologic dysfunction when compared to babies born in hospitals” (“Birth Setting

Study Signals Significant Risks in Planned Home Birth”). The conclusion is based on birth certificate data from nearly 14 million births between 2007 and 2010. In particular researchers examined the frequency of 5-minute Apgar scores of zero among infants birthed by women at home and in hospital. The Apgar score is a test used to determine infants’ health one and five minutes after their mothers birthed them. “A 5-minute Apgar score of zero is considered stillborn, although about 10 percent of these babies survive, usually with major health problems” (“Birth Setting Study...”). Following its publication, lead study author, Dr. Amos Grunebaum, chief of labor and delivery at New York-Presbyterian/Weill Cornell Medical Center, told *ABC News* that while “Childbirth is one of the most wonderful moments in humanity,” that “it’s not only about experience. It’s also about making sure the baby is born safely.” Critic Wendy Gordon, Assistant Professor of Midwifery at Bastyr University, contends that 5-minute Apgar tests include “babies who had lethal congenital anomalies, who would not have survived no matter where they were born or who attended the birth,” and that a study interested in examining the relationship between birth deaths and birth location ought to have excluded those birth deaths that “had nothing to do with place of birth or attendant.”

Gordon also points out that even if the study were accurate that the “ten times higher” language used in the study’s press release, language repeated throughout mass media coverage of the study, is misleading. The absolute risk of zero Apgars among homebirthed infants, according to the study, is 1.6 out of every 1,000. A final criticism of the study is that birth certificate is unreliable because many states’ birth certificates do not differentiate between planned and unplanned homebirths (Gordon 2013).

The phrase “the baby is born,” as spoken by Dr. Grunebaum, however common, is indicative of the linguistic denial of maternal agency discussed at the start of this work. This manner of speaking, which clearly extends far beyond the medical establishment, bolsters the broader practices and thinking that envision birthing women as birth objects. Babies are not simply “born.” Women birth babies. Failing to acknowledge this creative authorship of new life in our everyday personal and public exchanges may well contribute to normalizing patriarchal, paternalistic medical and legal debate about how best women ought to be “delivered of their birth.”

Homebirth Endangers Mothers?

At the start of 2011, Hollywood gossip website, *HollyBaby.com*, further contributed to the increasingly (flawed) “commonsense” claim of the dangers of homebirth. The website offered an intense, opinionated reaction to the birth plans of Hollywood couple, Owen Wilson, a popular Hollywood actor, and Jade Duell. At the start of 2011, it was publicized that Duell decided to have a homebirth in the couple’s Maui, Hawaii mansion, a choice supported by Wilson. Duell’s birth became the center of attention among those fearing the dangers of non-medicalized birth and those advocating homebirth. In its January 13, 2011 posting, *HollyBaby.com* urged Wilson to pressure his girlfriend to reconsider her decision to birth at home and to have her baby in a hospital. The article warned that “giving

birth at home is very risky business,” and it attempted to support such a claim by quoting Maui-based psychologist Heather Wittenberg: “The fact is that childbirth has killed more women in history than anything else.” Then the piece explains that those at HollyBaby.com “were shocked to find out that the risk of dying in childbirth in the US is worse than in 40 other countries, according to Amnesty International.” It also adds Wittenberg’s rhetorical question: “I understand that parents today want less medical intervention. But at what cost?” Implicitly, the posting suggested that there is a correlation between maternal mortality and homebirth. The clear “commonsense” message of the posting insists: choosing to give birth at home is irrational and dangerous.

While the article in question mentions maternal mortality it does not give specific numbers. Today, out of approximately 4 million annual U.S. births, approximately 500 women die “during childbirth or from pregnancy-related complications” (BBC 2009). Organizations such as Amnesty International argue that given our nation’s resources, the 2006 rate of 13.3 deaths per 100,000 live births is, when compared to other nations, unnecessarily high (AI 2010: 7). What is lacking from Hollybaby.com’s discussion is any mention of the factors that contribute to maternal mortality. This lack of detail allows readers to embrace the implied assertion that non-medicalized birth is the culprit for maternal mortality, and that it is irresponsible to give birth without the assistance of medical professionals.

Historically, the factors involved in the death of birthing women have been diverse. These included poor nutrition, women’s work-load in a patriarchal society, access to the means of preventing or terminating pregnancy when necessary, as well as access to life-saving technology in the minority of cases where birth becomes complicated. The article’s unsupported claim that childbirth has killed more women in history than anything else, if true, is nevertheless an example of the fallacy of oversimplification. The mortality rate of birthing women exploded when women began giving birth in hospitals in mass. The cause of death was not birth-itself, but rather important factors such as exposure to bacteria in the hospital (Wertz 1989: 138).

The implication of *HollyBaby’s* warning against childbirth at home, given its mention of maternal mortality, is that such birth practices may endanger women’s lives. Such assertions are not unique to the tabloid, but frequent the comment sections of birth related articles featured on mainstream news media websites. Consider the responses to a May 2011 article on CNN’s website discussing the growing rate of homebirths in the U.S. One user, “jim,” wrote: “the ‘natural’ state of affairs is that either the mother or baby will die in about 10-20% of childbirths.” User, “Gabor47,” who purports to be a retired obstetrician who practiced for “four decades,” wrote: “having a baby at home is significantly more dangerous than having it in a hospital.” Another

named “shady” wrote: “the reason you should [give birth] in a hospital and not in a barn with a midwife are the 5% of cases where things go wrong.” Such assertions amount to unsupported claims that are unfounded, upon examination of known facts. When the user, “shady,” equates midwifery and homebirth with giving birth in the barnyard he/she is implementing the long-standing dualistic concept, culture/nature. Here we see the way in which dualisms are implemented, as ecofeminists such as Plumwood (2002) argue, to facilitate unsubstantiated discourses of dominance. To be identified with the uncultivated animal realm is to be dirty, ignorant-inferior. This stereotyping of natural birth processes has the effect of not only diminishing female reproductive agency but also reinforcing negative presumptions about the human relationship with nature. In short the culture/nature dualism, arguably responsible for the present ecological crisis faced by humanity, is strengthened as homebirth is linked to the perilous realm of “nature” and hospital birth, positively stereotyped, is linked to the radical interventionist realm of “culture.”

Despite these alarmist assertions, a good deal of evidence contradicts such claims. In a study of more than 5,000 homebirths in the U.S. and Canada, no maternal deaths were recorded (Kenneth C Johnson et. al. 2005). The “Maternal and newborn outcomes in planned home birth vs planned hospital” study found no statistical differences between hospital birth and homebirth in relation to maternal mortality (Joseph R. Wax et. al. 2010: 243.e6). As stated above, even the Lancet’s editorial critical of homebirth acknowledged that “home birth seems to be safe for low-risk mothers and, when compared with hospital delivery, is associated with a shorter recovery time and fewer lacerations, post-partum hemorrhages, retained placenta and infections...” (Lancet 2010). Interestingly, in 2008 Vermont had the second highest percentage of homebirths in the U.S. (1.96-percent) (MacDorman et. al. 2011: 3), yet, as of 2006, the state was one of only five states to have achieved the U.S. government “Healthy People 2010” goal of reducing the maternal death rate to 4.3 per 100,000 (Amnesty International 2010: 7). On the most conservative assessment, we might conclude that given the lack of a comprehensive and sizeable study of birth location and maternal mortality, there is simply no evidence to suggest that homebirth poses greater risk to birthing mothers than hospital birth. Conversely, one could argue that, as far as we currently know, homebirth is at least as safe as hospital birth given the results of known studies.

Substantial evidence indicates that race and economic standing is a significant determiner of poor birth outcomes. The dominant discourse’s implicit suggestion that women’s organic reproductive processes are the central cause of maternal mortality masks well-established facts. Principle factors associated with maternal mortality include obesity, lack of healthcare coverage, and impoverishment (BBC 2009). Since a disproportionate number of African Americans are impoverished and uninsured it is perhaps unsurprising to learn that, according to a 2010 Amnesty International report, race is a particularly crucial determiner of maternal mortality: “African-American women are nearly four times more likely

to die of pregnancy-related complications than white women” (Amnesty International 2010: 3). Indeed the report explains that a disproportionate number of women of color lack health insurance, and are “less likely to have access to adequate maternal health care services” (AI 2010: 4). Thus a sensible discourse around maternal wellbeing would concentrate more specifically on issues of the intersecting oppressions of racial prejudice, economic marginalization, and the accompanying lack of access to quality healthcare providers, be they obstetricians, birth center care providers, or traditional midwives. The concentration, instead, on informed mothers’ choice of birth location is a distraction from verifiable factors that contribute to maternal death. Arguably, the discourse in question is framed by a lens that justifies control of women’s reproductive processes on grounds of providing mother and/or child security from the dangers or unreliability of the body and its reproductive processes. Moreover it appears that the androcentric perception of childbirth functions to uphold ethnocentric and class-centered biases that obscure the role inequality plays in influencing negative maternal outcomes. Here once more female biology and the realm of nature, which she has been historically associated with, are used as the sacrificial decoys.

Ignoring Maternal Wellbeing

The discourse decrying the dangers homebirth poses to women’s children indicates a problematic disregard for the frequent violence birthing women experience during medicalized childbirth. Indeed, the emphasis on the wellbeing of the emerging new life at the expense of serious consideration of the mother’s wellbeing exemplified by the *Lancet’s* editorial and the study in question, is informed by and perpetuates patriarchal gender, wherein women’s bodies are objectified as mere means to an end and women are expected to engage in what the author calls “compulsory maternal sacrifice.” A common consequence of the diminishment of female agency has been an increase in her objectification: “Where she is conceived as lacking any independent value or agency, she does not present any limit to intrusion (unless this limit originates in her relationship to another male) – thus her boundaries permit or invite invasion” (Plumwood 2002: 105). The present work indicates that dominant discourse around homebirth bolsters a denial or backgrounding of maternal agency and intrusion upon the boundaries of female agency.

Recall that the “Maternal and newborn outcomes” study not only claimed medicalized birth produced a lower neonatal death rate, but also admitted that women giving birth in a hospital rather than at home were, as stated above, twice as likely to experience third-degree lacerations, and three times as likely to encounter infection or vaginal lacerations (Wax, Lucas, Lamont 2010: 243.e5- 243.e6, see table 2). Even if we were to suspend, momentarily, concerns about the quality of the study’s findings on

neonatal death, it is nevertheless worth noting that according to the authors’ findings the “absolute risk” of neonatal death is relatively low. The study’s data indicates that out of 16,500 homebirths, 32 infants died, a neonatal death rate of about 2 per 1,000. Comparatively, the absolute likelihood that a woman experiences “vaginal laceration” in a hospital birth was reported to be 22.4-percent or about 224 women per 1,000 compared to 7.9-percent in homebirth or 79 per 1,000. Thus, in addition to scrutinizing the quality of the study itself, it is also worth asking the question: given the significant absolute risk to women’s bodies, why hasn’t the increasingly violent character of medicalized hospital birth garnered more attention? Shouldn’t the significantly greater absolute risk of suffering during the birth process be given greater weight in determining where and how one should give birth? The diminishment of the significance of these questions indicates the hidden patriarchal androcentric bias in the dominant discourse around childbirth. As is further explained, compelling evidence suggests that the violence of medicalized birth is increasing. Consequently, it is having profound effects on women’s lives, including their sense of self and relationship with their loved ones. Yet a conceptual framework that presumes the inherent worth of the mother would not so freely dismiss or marginalize her birth experience in determining what birth-related reproductive choices women are morally or legally obligated to make.

Authors of the “Maternal and newborn outcomes” study acknowledged that American women are turning to homebirth in order to escape pharmacological interventions (drugs) and “medical technology” (Wax, Lucas, Lamont 2010: 243.e7). Despite such a statement, full acknowledgement of birthing women’s interests is not significantly indicated in the study. Indeed, the general outcry against homebirth appears to be a negative reaction to women’s attempts to rectify the rapidly growing rate of medical intervention. Consider that the U.S. study that provided a significant amount of their data looked at about 11,000 Washington State hospital births, all of which took place between 1989 and 1996 (Wax, Lucas, Lamont 2010: 243.e4- 243.e5, see table 1). The study provided nearly 40-percent of the data for the conclusion concerning neonatal death rate (Elton 2010). Consequently, this study, the paternalistic *Lancet* editorial, and ACOG have made authoritative and influential recommendations about where women ought to give birth largely on the basis of statistics that are 15-years old. Such data provides a skewed depiction of women’s hospital birth experiences. The cesarean-section delivery rate in hospital birth rose from 20.7-percent in 1996 to 31.8-percent in 2007 (Menacker and Hamilton 2010:5). This is a profound increase of more than 50-percent. Whereas just 5.5-percent of U.S. births were cesarean sections in 1970 (Epstein 2007: 10), today the cesarean section is now the most common surgery performed in the United States. The latest figures indicate that, as of 2009, the cesarean-section has risen to 32.9-percent (Hamilton, Martin and Ventura 2010:4) with rates topping 40-percent, in 2008, in areas such as Palm Beach County (Palm Beach Post 2008).

According to the director of Public Citizen’s Health Research Group, Dr. Sidney Wolfe, about 1/3 of these are unnecessary (Public Citizen 2010). This means that of the

1.3 million cesarean-sections conducted on women annually, at least 400,000 are unnecessary. Wolfe's conclusion is based on his study of the 2007 cesarean-section rates at New York hospital practices (Public Citizen 2010). Thus, by heavily relying upon outdated statistics that very likely under represents the rate of medicalization in hospital birth, study authors fail to fully acknowledge or address women's concerns.

Of course talk of having a cesarean-section has been so normalized that many may not be understood why such statistics are alarming. First, consider precisely what a cesarean-section entails:

Seven layers of tissue and muscle are severed. There is also significant blood loss. In a vaginal birth, 300 to 500 milliliters - fittingly about eight or nine menstrual periods' worth - is normal; anything over 500 is considered a hemorrhage. The average blood loss during a cesarean is 1000 milliliters (Block 2007: 115).

Jennifer Block, former editor at *Ms. Magazine* and an editor of the revised *Our Bodies, Ourselves*, explains that fears about the consequences of increased cesarean sections began during the late 70s and early 1980s.

In 1979, the National Institutes of Health, the research arm of the Department of Health and Human Services, appointed a 19-member task force on 'Cesarean Childbirth' and in 1980 held the first U.S. conference on the issue. 'The rising cesarean birth rate is a matter of concern,' read the final consensus statement, part of a 537-page report. The trend 'may be stopped and perhaps reversed, while continuing to make improvements in maternal and fetal outcomes, the goal of clinical obstetrics today.' The data available at that time showed the cesarean rate just clearing 15% (Block 2007: 109).

Subsequent studies have reinforced the target of reducing cesarean sections to 15 percent. Medical doctor Jose Villar conducted a 2005 World Health Organization (WHO) study examining the relationship between adverse health outcomes and cesarean section in 100,000 births. The work, published in the *Lancet* in June 2006, "found that after controlling for risk factors so that poor outcomes could be attributed to the delivery method alone, the rate of 'severe maternal morbidity and mortality - infection requiring re-hospitalization, hemorrhage, blood transfusion, hysterectomy, admission to intensive care, and death-rose in proportion to the rate of cesarean section'" (Block 2007: 114). A study conducted in 2006 by CDC statistician Marrian MacDorman "found that low-risk babies born by cesarean were nearly three times more likely to die within the first month of life than those born vaginally" (Block 2007: 114).

According to an Amnesty International (AI) report, the "risk of death following c-sections is more than three times higher than for vaginal births"

(Amnesty International 2010: 9). Indeed, WHO determined that women undergoing cesarean deliveries that are not medically necessary "are more likely to die or be admitted into intensive care units, require blood transfusions or encounter complications that lead to hysterectomies" (Associated Press 2010). Despite the U.S.'s spending more on health care than any other single country, "the likelihood of a woman dying in childbirth in the USA is five times greater than in Greece, four times greater than in Germany, and three times greater than in Spain" (Amnesty International 2010: 3). Unfortunately, mainstream discourse on the subject tends to identify the problem with homebirth or, more generally, female biology. Yet there is no solid link between planned homebirth and maternal mortality. Rather, evidence suggests that key factors contributing to increased risk of maternal mortality include cesarean section and race, along with its accompanying economic inequalities.

Beyond the question of maternal mortality, studies indicate that women who have surgical births are likely to be in much worse physical condition compared to women birthing vaginally. Cesarean sections often result in pain after the birth, bowel problems, and even incontinence issues. Moreover, the benignly named "bikini" scar produced by the cesarean actually produces "permanent disfigurement colloquially termed either the 'pooch,' 'apron,' or 'overhang'—a flap of skin or fat that bulges over the cesarean scar, which is sometimes so bothersome that it prompts later cosmetic surgery" (Block 2007: 115). Whereas about 1 to 2 percent of women who give birth vaginally experience infection, between 10 to 50-percent of women who have cesareans experience infection (Block 2007: 116). Thus the CDC reports that, as a "major abdominal surgery," cesarean delivery "is associated with higher rates of surgical complications and maternal rehospitalization" (Hamilton et al. 2010: 1). A crucial point here is that while maternal mortality and infant mortality are important matters deserving serious attention, the rapidly increasing rate of medical interventions, often negatively impacting women's lives, are deserving of at the very least an equal amount of attention. Yet this increasingly common violence is rendered normal or necessary by the dominant, androcentric conceptualization of childbirth, one which places fundamental value on the birthed life rather than the person birthing the new life.

The often unspoken complications resulting from "successful" cesarean sections are rather solemnly described by Jenny McCarthy in her otherwise comedic 2006 book, *Baby Laughs*. McCarthy describes the agony of being removed from her newborn for his first five hours of life (McCarthy 2006: 14). She discusses the incredible pain that follows cesarean section including a horrendous trip to the bathroom in which she "cried the whole way" (McCarthy 2006: 14-15). The following night she awoke at 3 AM, "shaking uncontrollably" until a nurse brought in heated blankets and informed her that the chill was a result of anesthesia. "I talked to other women who had C-sections, and we commiserated about how weird this part was. We all had the shakes BAD. Why didn't they warn us that was coming instead of letting us freak out, thinking we were having seizures?" (McCarthy 2006: 14-15).

The trauma of McCarthy's cesarean-experience is

shared by many other women. Block gives the following story one woman shared:

I felt raped. Lying naked on a cold table, strangers sticking tubes up my body, pulling my innermost organs out to fondle. I could not even pull myself out of bed for the first 3 weeks. My life was hell for months. I could not bond to my child. I had a feeling that they pulled her out from under the table. I now live with adhesion pain; numbness from hip to hip and up to my belly button; pain during intercourse. I am not healthy! This is not birth. I went in pregnant, and I came out a bleeding, empty woman (Block 2007: 146).

Birth is experienced in this manner by many other women.

A nursing scholar, Cheryl Beck's research concerning such experiences has led her to determine that a significant number of birthing women experience "birth trauma." Beck contends that "somewhere between 1.5% and 6% of mothers are suffering from post-traumatic stress disorder (PTSD) as a result of their birth experience—with all the flashbacks, avoidance, and paranoia that plague survivors of rape and war" (Block 2007: 145). According to Beck, the PTSD experienced by birthing women is associated with a "high level of obstetric intervention" at birth (Beck 2004: 223). In addition to being impacted by what is happening, women who experience birth trauma are significantly affected by the way they are treated during such processes: "They do not feel cared for, they're not communicated with, they're powerless. They talk about being stripped of their dignity" (Block 2007: 145). Beck's study indicates the way in which poor birth experiences can negatively impact women's lives in multiple ways. One common consequence of traumatic birth experiences detected by Beck was that women experienced a "numbing of self and actual dissociation" (Beck 2004: 220). Some women reported that the experience compromised their relationship with their infants. One mother who experienced "a fourth-degree tear" reported that she relived the terror she experienced during birth "constantly for 4 months," making it difficult to "enjoy the present with her infant" (Beck 2004: 219). Another mother reported an inability to engage in sex with her husband due to flashbacks of her birth experience, which was marked by "a high level of medical intervention during the delivery" (Beck 2004: 219). Similarly aware of the serious consequences such invasive procedures can have on some women, Dr. Sidney Wolfe describes the habitual implementation of unnecessary cesarean-sections as "unnecessary acts of violence against women" (Public Citizen 2010). While not all women experience cesarean-section this way, the fact that many do is cause for concern. Yet medical and popular discourse around childbirth emphasizes the "baby" while backgrounding the mother's experience.

"Patient choice" is one of the red-herrings cited to explain away medical interventions such as cesarean-sections. Evidence suggests that few women choose cesarean-sections without being given the impression such a procedure is medically necessary. The Listening to Mothers II survey of American birth experiences found that of the women who had planned first-time (primary) cesareans, 16-percent of all births, the vast majority were based on a medical rationale of some kind (Declercq, Sakala, Corry, Applebaum 2006: 36). Of those (16-percent) who had primary cesareans, just 2-percent did so for "no medical reason" (Declercq et al. 2006: 36). When considering all those who opted for the procedure independently, before labor began, the total is just 5-percent of primary cesarean-sections (Declercq et al. 2006: 37) or 0.8-percent of all birthing women. Moreover, 24-percent of women who had first-time cesarean-sections indicated that their maternity care provider recommended the procedure before labor began (Declercq et al. 2006: 37). Such statistics are significant in terms of birthing women's autonomy, and stand in stark contrast to the claim by hospital-based scholars such as Grunebaum who contends that parents are able to have satisfying birth experiences in "a hospital setting if you communicate your wishes to your doctor." In contrast Ina May Gaskin views homebirth as a fundamental reproductive right that prevents the commodification of women's bodies and labor: "If you don't have home birth as one of the choices women have then we can be exploited and birth can become a commodity the same way water is being grabbed and sold to people and the way food is being controlled by multination corporations" (qtd. in Anna 2011).

A final relevant fact is that as of 2009, 28-percent of hospitals disallow vaginal birth after cesarean-section (VBAC) and an additional 21-percent have de-facto bans on the procedure due to obstetricians' unwillingness to perform the procedure (Public Citizen 2010). This means that nearly 50-percent of hospitals deny women who have had a prior cesarean-section their right to determine whether or not to give birth vaginally. Similar conclusions were drawn in the Listening to Mothers II survey, which found that 57-percent of mothers who previously had a cesarean-section but expressed an interest in having a VBAC were denied this option for reasons ranging from refusal by their caregiver (45-percent) to hospital policies (23-percent) (Declercq et al. 2006: 36). While it must be recognized that such a trend is in part due to concerning cases in which women attempting VBAC ruptured their uterus (Public Citizen 2010), it is also the case that 75-percent of VBACs are successful while 5-percent experience a ruptured uterus (Block 2007: 90). In contrast, while repeat cesarean-sections reduce the likelihood of a ruptured uterus to 2-percent compared to the 5-percent who have a VBAC, they are nevertheless guaranteed "having another major surgery, with all the risks and drawbacks that entails" (Block 2007: 90). Consequently, some medical professionals argue that the VBAC rate should be increased. Howard Minkoff, chairman of the Obstetrics and gynecology department at Maimonides Medical Center in Brooklyn believes that the national VBAC rate, currently 9.6-percent, should be increased to 28.1-percent (Clark 2010).

Now consider that the overall rate of medical intervention for planned homebirths were, according to a 2005 study conducted by K C Johnson et al., “consistently less than half those in hospital, whether compared with a relatively low risk group...that will have a small percentage of higher risk births or the general population having hospital births” (Johnson 2005).

Compared with the relatively low risk hospital group, intended home births were associated with lower rates of electronic fetal monitoring (9.6% versus 84.3%), episiotomy (2.1% versus 33.0%), cesarean section (3.7% versus 19.0%), and vacuum extraction (0.6% versus 5.5%) (Johnson 2005: 2).

The Listening to Mothers II survey cites both the Johnson study and a 1989 study of outcomes in birth centers in noting the remarkable difference between the rates of such interventions in hospital birth

The experiences of women in these two large prospective studies were dramatically different from our national survey results. For example, whereas the Listening to Mothers II had an extraordinary 32% cesarean rate, both of these studies reported 4% cesarean rates (with no indication that the low rate of intervention or out-of-hospital settings involved excess risk when compared with low-risk women giving birth in hospitals (Declercq et al. 2006, fn 2: 75).

When factoring in the reduction of medical interventions including those that increase maternal morbidity and maternal mortality, homebirth appears to be an important, viable option for pregnant women.

Furthermore, it seems clear that the emphasis on infant wellbeing at the expense of a thorough consideration of the mother's wellbeing is informed by and perpetuates patriarchal gender norms and “compulsory maternal sacrifice.” Such a concept promotes the idea that, as mere means to the end of producing new life, women's wellbeing simply does not count as much as the life she has germinated in her womb. Moreover, it denies her maternal agency to determine the environment in and circumstances under which she will birth the life she is principally responsible for manifesting. At best, we might say that the definition of motherhood as entailing the essential ingredient of suffering (Rich 1976: 30) is so firmly lodged in the dominant American imagination that such professionals and assorted publications fail to realize that medicalized childbirth's routine implementation of invasive procedures on women merits serious consideration. Unsurprisingly, those viewing pregnant and birthing

women through a patriarchal lens, a framework in which women's personhood is always subordinated to potential or forthcoming persons, see and treat women as a mere means to an end. Rich theorizes that it is as if the suffering of women as mothers has become so “necessary to the emotional grounding of human society” that attempts to mitigate or remove such suffering are met with dedicated resistance (Rich 1976: 30). Moreover, adopting and maintaining such ways of thinking procure financial power, particularly those who have built an industry upon the tenet that women's birth process is fundamentally pathological and in need of professional remedy. For even when procedures such as cesarean-section are not implemented, an uncomplicated medicalized hospital birth in the U.S. costs on average “three times as much as a similar birth at home with a midwife” (Johnson 2005: 6).

Conclusion

Despite their fervent character, alarmist denunciations of planned homebirth seem to lack sufficient justification and dismissive of birthing mothers' concerns. An interesting byproduct of this examination is that, given the known facts, there seems to be reasonable grounds for supporting women who object to the increasingly violent and disempowering character of medicalized birth. There is evidence that planned homebirth may be better than hospital birth in terms of preventing maternal morbidity.

Above all else, it is now clear that mainstream media depictions of maternity are not alone in perpetuating unjustifiable gender and nature/culture dualisms. It is joined by mainstream scholarly discourse, along with accompanying news media, in contributing to such understandings of childbirth. Arguably, the discourse around the danger of homebirth reflects and perpetuates a deeply embedded gender bias in which women's bodies are viewed “as intrinsically flawed, and in need of control and intervention” (Maine 2000: 174). Medical discourse, and the news media echoing it, perpetuates a “reproductive double-bind,” whereby women are with encouraged to believe both that their inherent purpose in life is to bear children, but that their bodies are inadequate for such a task and, thus, require medical control. While women continue to be socialized early on to believe their bodies are made for procreation, they are conversely “deemed untrustworthy and dangerous to the potential life they carry” (Lorber 2011: 46). It seems increasingly clear that contemporary childbirth is a central site for the promulgation of the patriarchal definition of femininity and the distrustfulness of both the female body and the sphere of “nature.” Yet this interpretation of pregnancy and childbirth is ultimately sexist and dangerously mistaken; for it appears that inequality and a lack of full respect for women, their bodies, and their births is are the culprits of poor birth outcomes, not female biology. A healthy respect for female reproductive agency, however, may improve women's birth experiences and, at the same time, contribute to broader respect for women, and dislodge harmful culture/nature dualisms.

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