

**Expert on her own Body:
Contested Framings of Risk and Expertise in Discourses on Unassisted
Childbirth**

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A thesis submitted to the Faculty of Graduate Studies and
Research in partial fulfillment of the requirements for the
Degree of Master of Arts in Sociology with Specialization
in Women's Studies

December 2012

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Abstract

In spite of transitions to the culture of childbirth in late 20th century developed nations, the past decade has seen a rise of a new movement advocating for unassisted childbirth – that is, childbirth managed entirely by the labouring woman and in the absence of medical doctors, midwives or other professionally-trained caregivers. Unassisted childbirth advocates have generated an intense debate regarding who should define and control the childbirth experience, presenting a profound critique of the medical management of childbirth. This thesis examines risk discourses on unassisted childbirth as articulated by three key stakeholder groups: physician organizations, the midwifery community and unassisted childbirth advocates. Through a discursive analysis of public and professional written media on unassisted childbirth published between 1994 and 2012, I argue that for all three of the stakeholders, childbirth is typically framed in terms of a language of risk and safety; however, the conceptualizations of what constitutes risk and safety varies considerably among the three groups. Physicians argue that childbirth itself is an inherently risky process in need of medical supervision and management, while unassisted childbirth advocates argue that the real risks arise from the devalorization of birthing women’s knowledge of their bodies and in relying on medical experts to manage birth. Midwives appear to have a more complex framing of risk in childbirth, often mediating between dominant biomedical notions of risk and their own focus on birth as healthy and normal. This thesis adds to the literatures on the sociology of risk and childbirth by highlighting risk as an area of contestation, as experts and lay people interpret and make judgements about expertise, health, safety, autonomy and medical control in relation to childbirth. In addition, the findings demonstrate the continuing tensions and debates in the early 21st century around the quality of the birth experience, the medical management of childbirth and women’s decision-making in regards to reproduction.

Acknowledgements

First, I would like to offer many thanks to Dr. Pamela Wakewich for her ongoing support, encouragement and feedback throughout the researching, writing and editing of this work. Her many ideas regarding the subject matter often helped me to clarify my thoughts and her comments surely strengthened the final work. I would also like to thank Dr. Kristin Burnett for her insightful comments and detailed editing of the project, and finally Dr. Ivy Lynn Bourgeault for her comments and suggestions on the final draft of the thesis.

I would also like to acknowledge the financial support I have received for this project. I would like to thank the Social Sciences and Humanities Research Council (SSHRC) for the Joseph-Armand Bombardier Scholarship for 2010-2011; the Ontario Graduate Scholarship Program for the OGS Scholarship for 2011-2012; the Department of Sociology at Lakehead University for the Graduate Funding Package and the Dr. Gerd Schroeter Memorial Bursary; and finally the Women's Studies Department for Graduate Funding.

I would like to thank the many friends and fellow graduate students I have who have provided support, encouragement, conversation and much laughter throughout the writing process. I would also like to thank my parents and my mother-in-law for the love and support as well as many hours of childcare they have provided so that I may complete my studies. I need to thank my partner Tyler for his love, his ongoing encouragement and support, his endless patience and understanding. Finally, I would like to thank my children, Jacob and Daniel, whose entrances into the world helped to inspire my future research endeavors, although I did not know it at the time. They have continued to provide me with great happiness, awe and much comic relief at the end of a day's work.

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Chapter One – Introduction

*In an unassisted childbirth no one acts as a midwife. Instead, the birthing woman herself determines the course of her labour. Partners or friends may participate to varying degrees, but no one instructs the woman as to how to give birth, when to push, what position to be in, etc. Occasionally suggestions may be offered but it is assumed that **the woman giving birth is the true expert on her own body.** [original emphasis] (Shanley, 2011: “What is Unassisted Childbirth?)*

The legalization and subsequent availability of midwifery care in much of Canada has led to a shift in Canadian women’s choices about maternity care and an increase in some women’s agency regarding the childbirth experience. Ariss and Burton note that the midwifery or the “alternative birth movement” had a “desire to bring about significant social change regarding the medical and social contexts of birth” (2009: 8). As a result, an increasing number of women are now opting for the midwifery model of care, which offers a choice between delivering in the hospital, in a birthing centre, or at home, all under the supervision of a trained and professionally accredited midwife. While the “medical model of care”, an approach to the body thought to be part of a technologically-oriented modern, industrial culture (Rothman 1982: 24), has been critiqued for treating pregnancy and childbirth as illnesses that require medical treatment; midwifery models of care tend to view pregnancy and childbirth as normal and “natural” events in need of few interventions. Midwives tend to allow more flexibility and choice in where and how a woman chooses to give birth as compared with what has come to be seen as the highly technologized and less client-friendly biomedical birthing model. However, some women feel as though any professional care during the deeply personal time of childbirth is unnecessary and opt instead for a model of unassisted childbirth. As recent media coverage of the new unassisted childbirth movement suggests, the practice of giving birth unassisted has received increasing attention from both the general public as well as professionals commenting on the safety and desirability of choosing to give birth in such a way.

Unassisted childbirth, also referred to as freebirth, unhindered birth or do-it-yourself (DIY) birth, occurs when a woman gives birth, usually in her home, without the presence of a medical doctor or midwife. Unattended or unassisted deliveries have occasionally taken place due to precipitous labours where, although the mother plans to have medical or midwifery supervision for birth, she is unable to make it to hospital or call for help before the birth occurs. In this instance, however, the use of the term unassisted childbirth refers to an expectant woman's deliberate choice to forgo medical and midwifery care in favour of giving birth without any professional assistance. Sometimes women who have chosen unassisted childbirth have families and friends to witness and assist with the birth, other times only a partner is present and in some instances the birthing woman opts to be completely alone. Use of the terms unassisted childbirth, freebirth or birthing alone refers to all of these scenarios, the commonality being that there is no trained or professional attendant guiding or assisting with the birth process and that this lack of birth attendant is a conscious choice made by the expectant mother.

Unassisted childbirth is quasi-legal in Canada as there are no formal laws prohibiting the practice, yet fears of possible legal or social repercussions as well as the desire for privacy result in women often remaining quiet about their choice to birth unassisted. Nevertheless, the role of technological spaces such as the internet has created places where women can discuss their choice to birth unassisted. The internet has also permitted the sharing of information about unassisted childbirth and the development of an online community or movement interested in sharing and promoting the practice. In addition to this, the practice of choosing unassisted childbirth has recently garnered mainstream media attention from across Canada as the movement appears to have gained increased momentum. Barton writes "choosing to deliver

without skilled help remains a controversial and uncommon choice. But now, spurred by the internet, unassisted childbirth is reaching a broader range of women than ever before” (2009: 1).

It is impossible to know at this point precisely how many women in Canada are choosing unassisted childbirth. There are no statistics currently available about the practice and the likelihood of a large study is small based on difficulties in tracking individuals who, for the most part, desire to stay out of ‘the system’. It is apparent, however, that the issue of unassisted childbirth is gaining increasing public attention, as evidenced by recent medical association responses and media reports. The *Canadian Medical Association Journal* reported in 2011 that the practice is prompting alarm amongst the medical community (Vogel 2011: 648). Similarly, in 2009, the Society of Obstetricians and Gynaecologists of Canada released a public statement (“The Dangers of Unassisted Childbirth” SOGC: 2009) in response to media coverage of the issue. The Canadian mainstream media has covered unassisted childbirth in different times and places, typically creating exposés on the topic by showcasing women who have given birth unassisted and presenting comments from physicians and midwives on the subject. Canadian media coverage of unassisted childbirth includes but is not limited to: CBC news (Seright 2011), the Globe and Mail (Barton 2007) and Global Toronto May 9, 2011. It remains unclear if the proportion of women choosing unassisted childbirth is actually increasing. The dialogue around unassisted childbirth, however, indicates that women’s choices of where and with whom they give birth are contributing to a growing public dialogue about medicalization, autonomy, safety and risk in childbirth.

There is a vibrant and active online community surrounding unassisted childbirth. Websites such as Laura Shanley’s Bornfree page (www.unassistedchildbirth.com) and Mothering.com host discussion boards which offer support and assistance to women planning to

give birth unassisted. These websites also provide space for women to share their success stories with other like-minded individuals. An abundance of unassisted birth resources, videos, blogs and discussion groups can be found online as well. While some of the more popular websites such as the ones mentioned above are based in the United States, it is apparent on some forums that participants come from many places. For example, the Mothering.com forum “Find your Tribe” has women connecting from Australia, the UK, the Middle East, Canada, Africa, and so on. While the dialogue around choosing unassisted childbirth may appear as though it is an international discourse, it is important to note that the desire to give birth outside of the medical model is located primarily in countries where there are well-established, Western-based health care systems and where most residents have choices in access to care. In places where prenatal care and access to primary health care are still largely inaccessible to the majority of the population, there has been no evident call for unassisted childbirth.

While most of the discussion boards and blogs appear to be American-centred, there are some websites and discussion boards that are specifically for Canadian women, pointing to the fact that despite national health insurance and the availability of professionally accredited and publicly-funded midwifery care in most provinces, there remains a desire among some Canadian women to reject professional assistance and give birth without trained birth attendants. There is even a Yahoo mailing list called “CanadianUC” (UC is a relatively common abbreviation of unassisted childbirth) and there are Canadian-identified members of the mothering and bornfree forums, as well as numerous blogs discussing unassisted childbirth in Canada. The presence of online communities and discussions, as well as the Canadian media coverage of unassisted childbirth certainly points to the fact that at least some Canadian women are choosing to birth

unassisted, even in provinces where professional midwifery care is well established and funded by public health benefits.

In addition to the availability of unassisted childbirth material online, a few women have published books on unassisted childbirth, sharing their own and others' experiences with freebirthing as well as outlining the benefits and advantages of giving birth this way (see, for example: Shanley 1994; Griesemer 1998; Halfmoon 1998; Morgan 2003). The presence of such resources suggests that, in resource and health-care rich places, there is an international community of women interested in and pursuing unassisted childbirth as well as supports available for them to do so.

Despite the wide availability of material supporting and even promoting unassisted childbirth, not surprisingly there are also professional and lay people who disagree that unassisted childbirth is a reasonable choice and are concerned with addressing the health risks they see it entailing. For example, the Associate Executive Vice President of The Society of Obstetricians and Gynaecologists of Canada has responded to reports of unassisted childbirth with this dire warning: "Unassisted childbirth is unsafe – period. The people advocating this as a mainstream option for women are tragically uninformed and are promoting high-risk dangerous behaviour disguised as sound medical advice" (Senikas as cited in SOGC 2007: 1). Warning calls about the risks of unassisted childbirth have appeared in the media from medical professionals and, to a lesser extent, midwives, leading to a public debate about unassisted birth. Unassisted childbirth advocates have responded to these warning calls, via blog postings and internet discussions, and fostering a lively online discussion about the safety and risks associated with giving birth without assistance.

AIM OF THE THESIS: FRAMING THE RISKS OF UNASSISTED CHILDBIRTH

Using sociological and feminist theories about the social framing of risk, this thesis explores how socially constructed notions of risk and the pregnant/birthing body are framed and contested in public discussions about women's choices in childbirth, especially when the choice entails a complete rejection of the hegemonic medical model of pregnancy and birth. The medical model of pregnancy typically understands childbirth as a process that is laden with risks or possible complications that have the potential to lead to the injury or death of the mother and/or foetus. Thus, pregnant women cared for in the medical model are encouraged to avoid taking risks known to harm the growth and development of the foetus and are generally offered a series of blood tests and other antenatal checks to closely monitor the health and development of the foetus (Lupton 1999a: 89). The labour and birth process is typically monitored thoroughly in a hospital setting where complications or risks can be identified and dealt with by currently accepted means necessary in order to protect the life and outcome of the foetus.

Conversely, advocates of unassisted childbirth argue that childbirth is a natural and normal life event and prefer to understand complications as "variations of normal" (Vogel 2011: 649). Women advocating for unassisted childbirth often position risk as occurring not in the process of childbirth itself but rather in the reliance on the medical management of birth, which some argue often leads to interventions and various iatrogenic complications (Shanley 1994: 11). Therefore, notions of risk are conceptualized in highly different ways amongst the two groups based on their competing interests. What comes to be seen as 'safe' in terms of how, where and with whom to give birth also diverge among the two groups, based on their different constructions of 'risk' in childbirth.

The deep dissatisfaction with the medical model of care is one of the central tenets of the unassisted childbirth movement and, although midwifery care offers an available counter-model, research has shown that women choosing unassisted childbirth typically come to see midwifery care as unnecessary because they see birth as a ‘natural’ process not requiring intervention (Miller 2009: 62) or they see midwifery care as too similar to the medical model of care (64). The role of midwifery in the unassisted childbirth movement thus remains in an uncomfortable position. Like unassisted childbirth advocates, midwifery models tend to view pregnancy and childbirth as normal life-course events and midwives often encourage autonomy and informed decision-making around childbirth. However, public support for unassisted birth by midwives has the potential for negative repercussions from the medical community, as well as regulated midwifery as a profession itself, thereby potentially reducing the public credibility of midwifery. On the other hand, a uniform public statement opposing unassisted childbirth could possibly alienate members of the natural birth community¹, something which midwifery groups would likely not wish to do. Therefore, for the most part, Canadian midwives have remained relatively quiet on the issue of unassisted childbirth. Conversely, midwives in other jurisdictions have spoken up about freebirthing, occasionally framing their arguments in terms of risk. The variety of responses by midwives demonstrates the complexity with which midwives contend with issues to do with ‘risk’. This research therefore includes the position or stance of midwives in regards to the unassisted childbirth movement, particularly attending to the ways in which discourses of risk are both invoked and resisted by midwives.

I have chosen to study this topic because I am interested not only in how women make decisions about how and with whom to give birth but I am also interested in how individuals

¹ I use the term “natural birth community” loosely, to describe a large and diverse grouping of individuals interested in supporting and promoting an approach to childbirth that does not use medical intervention. For more analysis of the use of the word “natural” to describe non-medicalized birth see: Mansfield 2008.

conceptualize, evaluate and understand risk and health. I also want to look at how people accept or reject dominant discourses in our society about risk and the body. I “discovered” the practice of unassisted childbirth online while researching and planning for my own midwife-attended homebirth. When I came across the unassisted childbirth websites I was rather shocked because the thought of giving birth without some level of professional supervision had never even occurred to me. My anecdotal sense is that most people believe that the medical management of birth is necessary in order to minimize the risks of childbirth, therefore giving birth unassisted is not typically considered to be a mainstream birthing option. Medical care and assistance during labour and birth is so normalized in contemporary Western culture that the practice of unassisted birth is not surprisingly met with strong emotional reactions.

It was the online discussion forums, sharing of birth stories and media attention to unassisted childbirth that attracted me to study this from a sociological and feminist perspective. I wanted to understand how women came to the decision to birth unassisted, how they evaluated risk in childbirth and came to understand the risks they were or were not willing to take. I also wanted to understand if the choice of and debates around unassisted childbirth reflected any broader public debates about women’s bodies, reproductive choices, control and autonomy of the process of birth.

I have identified what I have come to see as three key players in the discussions around risk and unassisted childbirth: professional medical organizations, midwives and unassisted birth advocates. By conducting a discursive analysis of these groups writings about risk in childbirth, I will examine some of the factors shaping the current practice of and debates around unassisted childbirth from both sociological and feminist perspectives. Through an analysis of some of the dialogue around unassisted childbirth, I hope to show how larger issues of women’s control of

the body, reproductive rights and the medicalization of childbirth are being challenged and debated in the public “controversy” surrounding unassisted childbirth. In addition, this thesis aims to show how conceptualizations of risk are not universal; they diverge and overlap, often in complex ways. This work also considers whether there are larger questions about power that are being discussed and contested in the public debates over the choice to give birth unassisted. These include: what types of knowledge are considered legitimate and authoritative? Who has the power to define what constitutes risk? Why is women’s autonomy at the time of birth a contested and debated subject?

I argue that unassisted childbirth can be seen largely as an extension of the cultural shift in attitudes surrounding childbirth and the politics and control of women’s bodies. This research is particularly relevant at this time because there continues to be public dialogue about maternity care and choices around childbirth. In Canada, the re-emergence of midwifery as an alternative to the medical model of care has broadened many women’s options about maternity care and the management of childbirth. Recently, the province of Ontario announced funding for the opening of two birthing centres in the province (Ontario Midwives 2012: “Midwives welcome opportunity to lead new birth centres in Ontario”). Like most birthing centres around the world, these would be run by midwives and provide a place for women to give birth outside of hospitals. Research into the safety and outcomes of midwife-attended birth versus physician-attended birth; and home birth versus hospital birth continues to be conducted and publicized (see, for example, Janssen et al. 2009).

There has also been an increasing dialogue about unassisted childbirth in the media in the United States, Canada, the United Kingdom and Australia. Furthermore, the fact that Canadian medical organizations such as the CMA and SOGC have recently spoken out about the practice

of unassisted childbirth shows that the issue has garnered attention and concern from both medical professionals and lay people. Examining how unassisted childbirth is discursively framed by its supporters and those who oppose unassisted childbirth has the potential to add to the literature on the social construction of risk particularly by shedding light on the social context in which women's bodies and the risks of childbirth continue to be socially understood and contested.

PLAN OF THE THESIS

In order to develop my analysis of the social constructions of risk within the medical, midwifery and unassisted birth communities, I begin Chapter Two by reviewing the literature on the sociology of risk and the theories about risk as a socially-constructed phenomenon now dominant in Western contemporary social life. This section also reviews the literature on risk and the medical management of childbirth, focusing on some of the feminist critiques of the medicalization of childbirth. I then review some of the literature on the models of midwifery care, midwifery training and education, and philosophy of midwifery models. This section looks at midwifery regulation, the professionalization of midwifery project and the possible medicalization of midwifery. Following this is a look at some of the other research published on unassisted childbirth and the qualitative literature on the choices women make in childbirth.

Chapter Three outlines the qualitative methodology used for this research and will ground the thesis in a feminist-reflexive approach. Outlining the principles of critical discourse analysis and narrative analysis, I demonstrate how these approaches were useful in analysis of the data surrounding unassisted childbirth. This section shows how the information and data was approached in order to conduct a discursive analysis into the study of risk, choices in childbirth and the decision to give birth unassisted.

Chapter Four presents the data analysis, attending to the ways in which unassisted childbirth is discursively framed amongst the medical organizations who have weighed in on the topic; midwives who have publicly spoken or reflected upon the practice and unassisted childbirth advocates. This section shows how conceptualizations of risk diverge among the three groups and how the language used to describe “risk” in childbirth invokes different understandings of women’s bodies and the safety of childbirth. The analysis shows that in the context of discussions around childbirth, arguments are often framed in terms of risk, even when the choice is to birth outside of medical understandings of the body. It shows that while midwives often desire to practice maternity care outside of risk-based approaches, the dominance of discourses of risk often lead midwives to practice in the context of an “ever closing window of normality” (Scamell and Alaszewski 2012: 219). While women who choose to birth unassisted are opting not to have attendants at their births, the issue of risk is not ignored in this community. Rather, the physical risk in childbirth is both downplayed and accepted as part of life. At the same time, within much unassisted birth discourse, medical interventions into childbirth are framed as posing more of a risk to health and safety of mothers and their infants than is the birth process itself.

Chapter Five contains the final discussion and analysis of the research. Here, the project’s findings are linked with the theoretical questions about risk as a social construction. The section looks to the issues of who has the knowledge and power to define risk. It also examines how each group mediates the risks involved with childbirth. The conclusion of this chapter looks to areas for further research, in terms of unassisted childbirth specifically and also the broader areas of childbirth and the notion of risk. Finally, this thesis asks whether the apparent increase in popularity of unassisted childbirth indicates some potential failings of contemporary maternity

care, both from the medical model and the midwifery model. Certainly there are competing conceptualizations of what constitutes acceptable risk in childbirth and perhaps this indicates the need for an improved dialogue on 'risk' in relation to childbirth between women and their maternity care providers.

Chapter Two – Conceptualizing Risk

The notion of “risk” has become a concept so widely used today that it pervades many aspects of everyday life. Understood as a possible danger, threat or hazard, sociologists have suggested that “risk” has become a prevalent organizing principle in modern Western societies because of the increasing frequency with which discourses of risk are employed and the many areas in which it is invoked (Beck 1992, Lupton, 1999a). Beck emphasizes that risks are perceived as things that may cause harm and are located in the future; therefore emphasis is placed upon avoiding, minimizing or preventing the damaging effects of various risks (1992: 33). Ideas around risk are typically related to perceptions of probability and uncertainty. This is because the notion of risk occurs when there is some level of uncertainty (Mythen 2004: 14). As Adam and Van Loon (2000) point out: “the essence of risk is not that it *is* happening, but that it *might* be happening” (2) [original emphasis, also cited in Mythen 2004: 14].

Sociologists are interested in the concept of risk as a social phenomenon. Arnoldi (2009) discusses three reasons for understanding risks as social problems:

risks are social and political *problems* – for example, the problem of creating an ecologically sustainable society; risks are understood against a *social and political background*, that is, people worry about different risks due to different social and cultural backgrounds; and risk is a key concept in various *practices* and *knowledges* for which people are governed and society is structured. [original emphasis] (1-2)

Contrary to the technico-scientific approaches to risk, which are typically concerned with calculating the probability of dangers or hazards (Lupton 1999a: 17); the socio-cultural approaches to risk focus on understanding how risks become understood socially and culturally. The technico-scientific approaches to risk typically see risks as real entities which can be calculated or studied and the debates about risk in these fields are primarily around the seriousness of the risks’ effects, the effectiveness of the science used to calculate the risks and how individuals respond or react to risks in a variety of ways (Lupton 1999a: 18). Conversely,

socio-cultural theories approach risk in a multitude of ways, ranging from a “realist” perspective similar to the scientific approach to a strong social constructionist perspective which examines how certain events, activities or behaviours are constructed as risks through discourse (Ewald 1991: 199; Lupton 2006: 13).

THEORETICAL APPROACHES TO RISK

There are typically understood to be three major approaches to the sociology of risk: the “risk society” approach associated with Beck (1992, 2008) and Giddens (see, for example, Giddens: 1990); the cultural / symbolic approach of anthropologist Douglas (1985, 1992); and finally the “governmentality” approach to risk which takes from and expands upon some of the work of Foucault (Lupton 1999a: 24). Although there are important differences between these three main approaches, they all share the understanding that “risk” has become a dominant concept in modern Western societies and that, because of this; individuals, groups and institutions are increasingly being monitored and regulated (Lupton 1999a: 25). Additionally, Lupton (1999a) notes that all three socio-cultural perspectives on risk generally share the view that risk has: “become an increasingly pervasive concept of human existence in western societies; risk is a central aspect of human subjectivity; risk is seen as something that can be managed through human intervention; and risk is associated with notions of choice, responsibility and blame” (25). The following section will review the three broad theoretical approaches to risk, noting the similarities and differences in how risk is conceptualized among them.

The Risk Society

In the “risk society” thesis, the central principle is that notions of risk have changed, and become more pronounced, over time. While in the past there was a general human understanding that there are certain unavoidable hazards such as natural disasters, late modern societies have moved

towards an understanding that there are increasing levels of risks in late modern society, and that these risks are directly associated with modernity (Lupton 1999a: 5). The key difference is that the responsibility for the late modern risks lies with people (Lupton 2006: 12). Beck (1992) posits that: “Risk may be defined as a *systematic way of dealing with hazards and insecurities induced and introduced by modernization itself*. Risks, as opposed to older dangers, are consequences which relate to the threatening force of modernization and to its globalization of doubt” [original emphasis] (21). The new risks are global and their effects reach far and wide, from food contamination to radiation to worldwide pollution (Lupton 2006: 12). These risks of modernization begin to challenge modernist notions of progress because ‘modernization risks’ threaten human life itself (Hannah-Moffat and O’Malley 2007: 9).

Beck (1992) differentiates between what he refers to as the pre-modern class society and the late modern risk society:

Class societies remain related to the ideal of *equality* in their developmental dynamics.... Not so the risk society. Its normative counter-project, which is its basis and motive force, is *safety*.... Whereas the utopia of equality contains a wealth of substantial and *positive* goals of social change, the utopia of the risk society remains peculiarly *negative* and *defensive*. Basically, one is no longer concerned with attaining something ‘good’, but rather with *preventing* the worst; *self-limitation* is the goal which emerges. The dream of class society is that everyone wants and ought to have a *share* of the pie. The utopia of the risk society is that everyone should be *spared* from poisoning.... The driving force in the class society can be summarized in the phrase: *I am hungry!* The movement set in motion by the risk society, on the other hand, is expressed in the statement: *I am afraid!* [original emphasis] (49)

In the “risk society” theory, the late modern period has resulted in a proliferation of risks and various hazards that have arisen because of industrialization, urbanization and increasing globalization (Lupton 2006: 12). The problem for most contemporary societies is thus, “the prevention and minimization of ‘bads’... Both individual personal lives and the political arena are dominated by concerns and debates about risk” (Ibid).

In the “risk society”, individuals have increasingly become responsible for informing themselves about the plethora of “risks” to which they are exposed and then taking action to avoid or manage these various risks. Lay people therefore have to rely on experts in order to gather accurate information about risks. Compounding this, argues Beck, is that modernization risks need to be managed through techniques of ‘uncertainty’ because statistical calculations cannot be relied upon for events that have never occurred in the past. Predictions can thus be false and “expertise itself is opened up to challenge” (Hannah-Moffat and O’Malley 2007: 10). Furthermore, because it is becoming more widely known that experts disagree with one another, governments sometimes fail to act, and there is an awareness of how it is often science and modernity that are generating the risks, lay people continue to have many uncertainties about risks and often a certain level of distrust of expert systems (Lupton 2006: 12).

In sum, the risk society approach takes a realist approach to risk, arguing that there are in fact vastly more risks in the modern world because of modernization itself. Risks such as environmental destruction, global warming, nuclear threats and pollution have become part of modern life. Mythen points out that, “the tentacles of manufactured risk protrude into countless cultural spheres, such as food consumption, leisure, sexuality and employment. As western cultures enter into the risk society, the institutional mechanisms for handling risk falter, producing systemic crisis” (2004: 23). Because risks and knowledge about risks have become such a dominant concept, avoiding and managing risks becomes a commonplace part of everyday life (Mythen 2004: 96). For Beck and other proponents of the “risk society”, pathological insecurity is a feature of contemporary society. Thus, “the discovery of, and intervention against, risks leads to the search for more risks, but each new discovery only makes clearer that our security was illusory: life is endless risk” (Hannah-Moffat and O’Malley 2007:

10). The widespread awareness of global risks produces social and psychological effects and thus: “anxiety and insecurity become an integral part of the modern condition” (Wilkinson 2001:4 as cited in Mythen 2004: 96).

Cultural/Symbolic Approach

The cultural/symbolic approach to the study of risk largely stems from the work of cultural anthropologist Mary Douglas. Lupton notes that for Douglas ideas around, “risks are part of shared cultural understandings and practices that are founded on social expectations and responsibilities. Pre-established cultural beliefs help people to make sense of risk, and notions of risk are therefore not individualistic but shared within a community” (2006: 13). According to this approach, risk and danger are used to allocate blame for bad events (Douglas 1992: 5).

Douglas argues that for both communities and for human bodies, risk is used to police the social order. “What is selected in a community to be labelled as ‘risks’ are phenomena that in some way threaten moral principles. Those individuals or social groups who are identified as posing this threat are deemed to be responsible and therefore subject to opprobrium and demands for restitution” (Ibid).

Douglas argues that risk perceptions are cultural. Contrary to technico-scientific approaches to the study of risk, which view risk perceptions in a very individualistic manner and typically focus on individual cognition and choice (Lupton 1999a: 37), Douglas argues that individuals “come already primed with culturally learned assumptions and weighings” (1992: 58 – also quoted in Lupton) in making risk assessments. Thus, a critique is lodged that lay perceptions of risk should actually not be viewed as inferior to expert judgements because these views have particular value within certain cultural contexts (Lupton 1999a: 37).

This approach to the study of risk has been labelled functional structuralist because of its attention to how perceptions around risk function to maintain the existing social order (Lupton 1999a: 26). Although Douglas also takes a realist approach to the actual dangers, believing that there are in fact great hazards facing people, she analyzes how these become politicized within a particular cultural context:

Certain dangers are selected out from others for attention by a society and entitled ‘risks’ for certain reasons that make sense to a particular culture, based on its shared values and concerns. In other words, Douglas sees risk as a socially constructed interpretation and response to a real danger that objectively exists, even if knowledge about it can only ever be mediated through sociocultural processes. (Lupton 1999a: 39)

This type of theorizing on risk brings our attention to how risks are understood socially and culturally, thus enabling a more social constructionist view on risk as there is greater attention paid to social processes in identifying what is a risk. This kind of conceptualization of risk also encourages a questioning of the notion that lay perceptions of risk are flawed or regularly misinterpreted. Clearly interpretations of what constitutes a “risk” are not homogenous and individuals do not always make risk assessments based solely on expert advice. What constitutes a risk continues to be contested both among experts as well as among lay people.

Governmentality Approach

The third approach to risk, and one that is used by Foucauldian analysts, expands on Foucauldian notions of control of the body and the power of discourse in constructing what is thought to be a “risk”. Similar to the risk society perspective, this framework also sees the concept of risk as emerging out of modernization and thus locates the increasing frequency of risk discourses in a post-modern world-view. Those operating from a governmentality perspective focus on discourse as a key mode of shaping what is socially understood to be risky (Lupton 2006: 13). Lupton describes the importance of discourse analysis when discussing risk:

A discourse may be understood as a bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words and imagery. Through discourses we perceive and understand the social, cultural and material worlds in which we move. Discourses both delimit and make possible what can be said and done about phenomena such as risk. (1999a: 15)

Discourses shape what comes to be known and understood about risk; therefore, the focus becomes analyses of how the choices that individuals are faced with are shaped by discourses of risk. A strong social constructionist perspective is found here, in that “risks” are not viewed in an objective sense, but are seen as being shaped out of social processes: “Nothing is a risk in itself; there is no risk in reality. But on the other hand, anything can be a risk; it all depends on how one analyzes the danger, considers the event” (Ewald 1991: 199). It is argued that risk discourses, understood as being socially constructed, serve to regulate and govern both individuals and populations in a profound way.

The notion of “governmentality”, which Turner (1997) defines as “a mechanism for regulating and controlling populations through an apparatus of security” (xiii), is primarily concerned with analyzing the “ways that ‘government’ (i.e. not just state programmes but any systemic practice attempting to direct the conduct of others) envisions the world. Risk, in this approach, appears as a particular way of envisioning problems and forming the techniques of governance to deal with them” (Hannah-Moffat and O’Malley 2007: 14). Governmentality is also understood to arise from a society wherein expert knowledge(s) proliferate and power circulates in a variety of ways, controlling populations via non-coercive means:

Since the sixteenth century, as Foucault and exponents of the ‘governmentality’ perspective have described, a huge network of expert knowledges has developed, accompanied by apparatuses and institutions built around the construction, reproduction, dissemination and practice of these knowledges. This is an outcome of the emergence of the modern system of liberal government, with its emphasis on rule and the maintenance of order through voluntary self-discipline rather than via coercive or violent means. Risk is understood as one of the heterogeneous governmental strategies of disciplinary power

by which populations and individuals are monitored and managed so as to best meet the goals of democratic humanism. (Lupton 1999b: 4)

These theorists note that risk becomes, “a major apparatus through which individuals in a society are encouraged to engage in self-regulation” (Lupton 2006: 14). Foucault asserts that citizens internalize proper behaviour and thus self-govern - this self-governing is also tied in with morality and notions of the ‘common good’ (Foucault 1991 [1978]: 91). For theorists expanding these ideas in terms of risk, the focus becomes self-regulation in terms of safety and the avoidance of risks. Risk here becomes increasingly privatized and individuals, conceptualized as autonomous and expected to self-regulate, are bombarded with proliferating risk discourses and they are charged with protecting themselves from harm. The governmentality perspective does not assume that the world is becoming proliferated with risks (as does Beck), but is concerned with analyzing how certain things become conceptualized as “risks” and what the consequences of this re-conceptualization may be. While ‘governmentality’ theorists do not deny that risk may be experienced, the focus is not around the experience of risk or even the reality of risks, but rather the ways in which certain events, bodily states, or experiences are understood to be risks rather than another kind of phenomenon (Hannah-Moffat and O’Malley 2007: 9).

Drawing on Foucault’s concept of “bio-power”, wherein the development of disciplines and emergence of ‘problems’ such as birth rates, public health and longevity led to “an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (Foucault 1991 [1978]: 140), risk theorists attend to the ways in which populations are controlled through this bio-power and the proliferation of discourses on risk. The emergence of population studies and “normalization” defined as: “the method by which norms of behaviour or health status are identified in populations and by which individuals are then compared to determine how best they fit the norm” (Lupton 1999b: 4) also altered the way that ‘risk’ was

conceptualized. A phenomenon emerged wherein individuals who were thought to deviate from identified norms at a population level were placed in the category of ‘at risk’ (Lupton 1999b: 4-5). Lupton points out that to be designated ‘at risk’ is: “to be positioned within a network of factors drawn from the observation of others. The implication of this rationalized discourse is that risk is ultimately controllable, as long as expert knowledge can be properly brought to bear upon it” (1999b: 5).

In discourses of risk, we see not only the process of comparison necessary to conceptualize an individual as “at risk” but also the notion of control that appears. The future becomes something to be predicted, managed and controlled as “risks” proliferate. The reliance on statistical calculations is increasingly part of a neoliberal governance (Hannah-Moffat and O’Malley 2007: 17). These calculations allow prediction to become an ‘objective’ fact with important ideological consequences because statistical pronouncements which appear objective and precise: “operate as a form of ideological impression management giving authority to the assertions of scientists and states. In turn, this elevates the role and importance of certain types of ‘expertise’ while discrediting other forms of knowledge” (Ibid). Therefore, we can argue, what comes to be framed as ‘risk’ is primarily defined by ‘expert knowledge’ and thus who is categorized as ‘risky’ or ‘at-risk’ follows, whether or not individuals conceptualize themselves in such a way.

Foucauldian risk theorists are not so much interested in varying degrees of risk or responses to risk but rather, “the forms of knowledge, the dominant discourses and expert techniques and institutions that serve to render risk calculable and knowable, bringing it into being” (Lupton 1999b: 6). Fox points out that, what he terms the ‘postmodern’ approach to risk, actually:

moves beyond the culturalist or constructionist model, to argue radically that hazards are themselves socially constructed: created from the contingent judgements about the adverse or undesirable outcomes of choices made by human beings. These 'hazards' are then invoked discursively to support estimations of risk, risky behaviour and of the people who take risks. (1999: 19)

Recognizing the socially constructed nature of discourses of risk allows us view critically what becomes constituted as risk, how expert discourses on risk are employed, embraced and contested by both experts and lay people. It also allows us to see how those who refuse to be disciplined by the dominant discourses on risk may be punished, whether literally or discursively.

Moving away from the realist view of risk that primarily focuses on risk as an objective reality to be measured, the socio-cultural perspectives on risk focus on culture and social context in understanding the "risk society". As Lupton writes, "Unlike in the hard sciences, where risk is separated from its socio-cultural context and treated as an autonomous phenomenon, sociologists argue that risk can never be separated from the social and cultural lens through which we view it and understand it" (Lupton 2006: 15). It is not only lay perceptions of risk that are conceptualized in terms of the social and cultural worlds in which they lie but also that "expert" knowledges are understood as stemming from the social world because even expert views cannot be isolated "from the wider social and cultural milieu in which such people construct their own judgements about risk. Both lay and expert knowledges are the products of the pre-established beliefs and assumptions that individuals bring with them in making their judgements about risk" (Ibid).

GENDER AND RISK

While the increased knowledge about risk has arguably produced lives that are both safer and more secure, the proliferation of awareness on risks also comes at a cost, in that average

individuals are expected to be acutely aware of and make decisions based on risk calculations, even if they may be highly unlikely (Hannah-Moffat and O'Malley 2007: 1). Individuals are expected to take responsibility for their own risk management in a variety of facets of life, from health care to work safety to leisure time to parenting and family life.

More recently, some scholars have pointed out that theorizing on risk tends to present “universal and gender-neutral” subjects in analyses on risk and they have taken care to point out that risk practices are gendered (Hannah-Moffat and O'Malley 2007: 1.) What constitutes risk as well as who is responsible for the avoidance or management of risk is often divided along gendered lines. Taking this further, these theorists argue that risk and gender are mutually constitutive:

Gendered knowledges, norms and hierarchies are linked with understandings of what constitutes a risk; the tolerance level of risk; the extent to which risk consciousness will be accepted or denied in public discourse or self-image; and whether risks are to be avoided and feared, regarded as one of the costs of a certain lifestyle, or even valued as an experience and valorized as an opportunity for displays of courage and strength. (Hannah-Moffat and O'Malley 2007: 5)

Thus, it is important to attend to the ways in which experiences and interpretations of risk are gendered. Hannah-Moffat and O'Malley also argue that scholars should be:

attentive to the processes through which risk discourses fracture and create gendered subjectivities and to how risk regimes produce inequalities, undermine gains and reconfigure social and individual problems. Risk, for example, can be conceived of as a mechanism that produces structural gender inequality and/or forms of gender discrimination. (25)

Gender-based analyses of risk discourses can also allow us to see how dominant discourses on risk are often positioned along gendered lines and also how they may be perceived among both men and women. Attending to both risk and gender may also allow us to see how, “gendered knowledges inform risk practices and thus the (re)organization of social, economic and political regimes” (Ibid). By focusing on gender and risk, scholars can therefore attend to the ways in

which discourses on risk can shape gendered subjectivities. It also allows us to see how popular discourses on risk management may in fact be resisted along gendered lines.

CONCEPTUALIZING RISK AND THE PREGNANT / BIRTHING BODY

The development of biomedical knowledge and power in the mid twentieth century has meant that in countries with well-established Western-biomedical systems, pregnancy has become predominantly conceptualized as a medical condition to be cared for and managed by a physician. In these systems, childbirth typically occurs in a hospital setting with many technologies and interventions promoted and readily available to increase the safety of the birth process for women and their infants. As Leavitt points out, during the eighteenth and nineteenth centuries: “an important part of women’s experience of childbirth was their anticipation of dying or of being permanently injured during the event” (1986: 14). Thus, childbirth and the associated dangers have been a common part of women’s conceptualizations of the birth experience. In the nineteenth century, however, as childbirth began to be managed by physicians and increasingly intervened upon, “Both physicians and women developed the perceptions that birth events were not fated but could be shaped in large part by planning and making use of medical advances” (Leavitt 1986: 199).

While historically childbirth was associated with danger or hazards to the health of both mothers and infants, conceptualizing childbirth as a time of “risk” specifically coincided with some developments that began in the late nineteenth century. As childbirth gradually moved from home to hospital towards the mid-twentieth century; and primary birth attendants shifted from midwives to doctors, “obstetrical dangers became institutionalized within a growing body of medical knowledge” (Cartwright and Thomas 2001: 218). Despite decreases to maternal and infant mortality rates in the mid-twentieth century, obstetrical research and technological

developments continued throughout the twentieth century, thus: “Danger was transformed into biomedically constructed and sanctioned notions of *risk*. This was more than a mere semantic shift: ‘Danger’ implies a fatalistic outlook on birth, ‘risk’ implies an activist stance.” (Ibid). Regardless of the dramatic improvements to maternal mortality rates in the twentieth century, childbirth continued to be constructed as a time of risk by the medical profession, despite evidence to the contrary. As the conceptualization of childbirth shifted from a time of largely uncontrollable danger to one of manageable risk, the use of technologies and interventions into the management of childbirth thus increased.

A pregnant or birthing body has thus become, over time, a state that is largely defined and understood in terms of “risk”. Discourses of risk surround pregnancy in a number of ways as others appraise a pregnant woman’s body as the vessel for another potential human life. Within medicine, there is increasing attention paid to the risks to fetal health in the period before conception occurs. Known today as ‘preconception health’, this arena of medicine focuses on the health of the female body prior to conception, aiming to improve the woman’s body in preparation for pregnancy in order to decrease potential risks to the proper development of a foetus. A 2006 article in the *Maternal Child Health Journal* states that, “The goal of the preconception visit is to identify medical and social conditions that may put the mother or fetus at risk” (Frey and Files 2006: S73) and goes on to argue that “Preconception care is the primary prevention of maternal and perinatal morbidity and mortality” (S75). According to this study, women are generally aware of certain risks such as alcohol and drug use as well as the importance of folic acid supplementation; however, most women are not sufficiently aware of the risks associated with fish consumption and exposure to cat litter in the period before conception has occurred.

Additionally, the 2011 report “Clinical Preventive Services for Women: Closing the Gaps” released by the Institute of Medicine recommends that preconception care should become part of standard health care for women, recommending at minimum one visit in order to establish all the necessary preventative care and risk factors for each woman (Institute of Medicine 2011: 167). While certainly attending to women’s health needs is important, conceptualizing the pre-pregnant body as risky to a potential foetus further entrenches the idea that women’s bodies are vessels for another potential human life and also contributes to the widespread medicalization of women’s bodies.

During pregnancy, the woman’s body continues to be framed in terms of discourses of risk. The risks to be contained or managed involve risks to the mother’s own health but also emphasize assessing and managing the risks to the foetus that she carries. From a governmentality perspective, writes Lupton: “the centrality of risk discourse in relation to pregnancy can be linked to apparatuses of ‘biopolitics’ in neo-liberal societies, efforts on the part of the state and other agencies to discipline and normalize citizens, to render them docile and productive bodies” (1999c: 61). Individual bodies are compared to others through the process of normalization and failure to fall within the prescribed norm will designate an individual as “at risk” or “high risk”. To have this designation is “to be singled out as requiring expert advice, surveillance and self-regulation” (Ibid). Although discourses on risk come from both experts and lay people, it is the experts’ concept of risk that holds the most power over the pregnant woman’s body because of the authority given to ‘scientific’ and ‘neutral’ forms of knowledge (Lupton 1999c: 63) over lay or corporeal knowledges.

The pregnant body is often conceptualized as an objective state that is determined not by the woman herself but by experts trained in medicine: “Today, a woman is mostly declared

‘pregnant’ by a test-strip or a gynaecologist on the grounds of hormone level and ultrasound scan. She then becomes the uterine environment of a developmental process which has to be professionally managed” (Samerski 2007: 60). Once pregnant, a woman is then expected to manage a plethora of risks to the foetus that she carries, such as avoiding tobacco, alcohol, stress, engaging in proper eating and light exercise (Lupton 1999c; Samerski 2007; Possamai-Inesedy 2006). Simultaneously, however, pregnant women are also expected to submit to medical care to manage the well-being of both her body and the foetal development (conceptualized as separate). Medical care typically takes the form of pre-natal check-ups, ultrasounds, diagnostic tests and usually culminates in a medically-managed birth. Samerski posits that “A modern woman diagnosed pregnant cannot be in ‘good hope’ anymore, but is instead talked into a state of ‘bad expectation’. Everything that could possibly happen is ascribed to her as a frightening risk which she can either accept or guard against” (2007: 60). Even when there appears to be no problems with the pregnancy or foetal development, women are still expected to engage in the medical surveillance of their pregnancies which consists of intermittent but continuous and routine risk-based screening. Lupton notes that, “In reality, therefore, there is no such thing as ‘no risk’ in pregnancy, for the potential is ever present for danger to threaten foetal wellbeing, particularly if a woman should let her guard down” (1999c: 66). This has the effect of “rendering pregnancy a perilous journey” (Ibid) that the pregnant woman must overcome.

In her study on genetic counselling during pregnancy, Samerski argues that in the “logic of risk, everything is possible as long as it has not been ruled out. Therefore, pregnant women must be informed about all the birth defects ever registered and are to consider them as ‘risks’ to their own children” (2007: 64). Samerski argues that presenting genetic testing to women during pregnancy places them in a “decision trap” and that risk-based discourses around pregnancy and

genetic testing: “fosters the myth that the outcome of a pregnancy depends on the pregnant woman’s responsible decision making” (71). The language of “risk” that surrounds pregnancy thus serves to trap women in a position wherein they are expected to mitigate risks to their bodies and their foetus individually and autonomously, yet they are also expected to submit to medical screening and look to medical and scientific knowledge in decision-making, ignoring corporeal knowledge. As Hannah-Moffatt and O’Malley point out, from a governmentality perspective, “the re-imagining of pregnancy in terms of risks subjects women to new regimes that interrogate their bodies and their backgrounds in new ways” (2007: 14). The interplay of discourses around risk coupled with gendered expectations about mitigating risk for selfless purposes create a unique subjectivity for the pregnant woman: “Governed by risk, the pregnant woman re-emerges as a revised subject of gender: a ‘risky subjectivity’” (Hannah-Moffatt and O’Malley 2007: 3).

There has been a substantial body of feminist work that has taken issue with the ways in which childbirth has been framed in the medical model. While ‘medical model’ will be discussed further in the following section, it is important to note here that within the medical model of care, there is an assumption that “the body is always ready to fail, even in ostensibly low risk cases” (Lane 2008: 158). This logic becomes intensified during childbirth when it is managed in a medical setting. The routine use of interventions in the birth process is legitimated because “risk” is conceptualized in the medical model at an individual not a structural level (Ibid). The social conditions surrounding birth were usually given little attention until the more recent consumer demands regarding maternal satisfaction in a hospital birth experience. Lane goes onto argue that:

In the medical model, birthing is conceptualized as a set of discrete internal, muscular, and chemical reactions unrelated to external (social, historical, and personal) factors.

When the body fails, it is logical under this philosophy for an external agent to correct the internal malfunction. Immediate contextual factors, including positive and negative social exchanges and emotional responses to physical surroundings, are rarely examined or considered in the causal framework of the medical model. However, these contextual factors are the primary social determinants of risk precipitating medical intervention. (159)

In the medical model of care, childbirth is seen as an individual bodily process that is laden with risks for both the mother and the foetus. Thus, the use of various obstetrical interventions becomes routine in many hospital settings. While interventions into birth will be discussed further later, the point here is to demonstrate out how discourses of “risk” so often frame how we think about, discuss and, for many women, experience childbirth.

Viisainen points out that in relation to place of childbirth, there are, generally speaking, two approaches to the notion of “risk”. One is associated with the medical model and medical discourse and here: “the pregnant body is the locus of risk” (2000a: 51, 2000b: 793). The other approach, which will be elaborated upon later in this work, views risk as occurring in the medical interventions to childbirth which are so common in the medical model of care. In the medical model approach to risk: “the physicians seek to control the inherently risky pregnant body” (2000a: 51) and often times actively manipulate the body in order to guard against the possibility of risk.

Wagner (1994) points out that the classification of risk groups forms the basis of Western contemporary obstetrical care. The premise is relatively simple:

Through screening procedures, and the use of a risk scoring system that gives points for each risk factor present, pregnant women are divided into two groups: those with low risk for trouble and those with high risk. Women in the low-risk group receive routine prenatal care, with the possibility that screening at subsequent visits may shift them to the high risk-group. Women in the high-risk group receive special attention and further tests and are often referred to large central hospitals for further care. (97)

The goal of this kind of care is to identify potential problems before they occur and also to allocate resources appropriately (Ibid). However, a number of concerns with the risk-based model of obstetric care have been voiced. The risk scoring system divides women into risk groups regardless of the level of risk present and thus there is never a condition of *no* risk. “Low risk” is the lowest level of risk possible in this framework and the possibility of moving to higher risk levels is always present because screening for risk continues throughout pregnancy and birth. Lane (2008) argues that: “the imposition of a risk category on all women acts as a form of micro-social regulation bringing about acquiescence to medical intervention. It is true that the majority of women are deemed medical low-risk cases, but the very term “risk” implies the probability of mischance” (158-159). The use of risk language thus brings attention to the possibility of complications, whether or not the likelihood of complications is present.

Davis-Floyd argues that the philosophical foundation of the field of obstetrics was the view that the female body is inherently defective (1992: 51). Wagner also asserts that the risk model of obstetric care: “is based on the medical model notion that pregnancy and birth are inherently risky and dangerous. Seeing birth as life threatening leads to surveillance and quick interference at the first sign of deviation from normal” (Wagner 1994: 97). Framing the female body during the time of pregnancy as dangerous, risky and anomalous is common in medical discourse; therefore, it is also argued that the continuous screening for risk factors affects the way in which a woman views her own pregnancy even if she is deemed low-risk (Ibid). Lane argues that within maternity discourse, the rhetoric of risk goes so far as to mark all pregnant or birthing bodies as a site of risk: “Adverse events are not only regarded as inevitable, but their timing is seen to be capricious and unpredictable. By deduction, therefore, all women are subject to obstetrical control and surveillance because all women are regarded as “at risk” (2008: 159).

The intensity with which women are expected to engage in self-sacrifice on their journey to motherhood has arguably increased with the advancement of risk-based medicine. While women are expected to heed expert advice during pregnancy, they are also expected to avoid risk independently throughout their pregnancies. At the time of birth, however, protection from ‘risk’ is typically placed squarely in the hands of medically trained birth attendants who are responsible for managing childbirth. Tsing’s (1990) research on ‘monster mothers’, women who have been convicted of criminal activity for having unassisted births, shows how extreme the consequences can be for women who disrupt the cultural norms regarding both responsibility as well as dependency on medical care at the time of childbirth:

Discourses on fetal and child protection overlap with medical preferences for a supervised birth process; together these build the assumption that healthy babies can be delivered only under a doctor’s supervision. The criminalization of unassisted birth draws from each of these semi-autonomous sources. (283)

Lupton argues that while avoiding medical care may be viewed as lazy or irresponsible for most adults, when pregnant women do this it can be considered criminal because they are seen as placing the health and wellbeing of their foetus at risk (1999c: 66). She argues that “the implications of risk discourse in relation to pregnancy is that the woman who fails to heed expert advice is portrayed as posing a risk to her foetus” (Ibid). So strong are the discourses on risk that surround pregnancy and childbirth that failure to seek medical assistance in managing risks can indeed characterize a woman as not only irresponsible but can go so far as to render her a calculating criminal (Tsing 1990: 283).

Theories on risk provide a useful conceptual frame for my research on unassisted childbirth because they provide the analytic lens through which I am able to analyze the discursive construction of ‘risk’ in childbirth. Through this theoretical lens I can analyze how socially constructed notions of the pregnant/birthing body are put forth and contested in public

discussions about women's choices in childbirth, especially when the choice entails a complete rejection of the hegemonic medical model of care. The following section will review some of the maternity care options available to women during childbearing, including the literature on the decision to birth unassisted. Social science and feminist research on women's decisions in maternity care and birth is also reviewed, which often draws attention to the complexity with which constructions of risk surround decision-making in childbirth.

REVIEWING THE LANDSCAPE OF MATERNITY CARE

The Medical Model of Care

In Canada, most pregnant women have prenatal care and give birth in what is referred to as the 'medical model of care'. 'Medical model' is a broad term that encompasses a number of options for women receiving prenatal care in Canada. Depending on type of training and practice of the physician, some women will have all prenatal care and give birth attended by her family physician, while others will be transferred to an obstetrician in the final trimester of pregnancy and still others will be cared for by an obstetrician for the duration of the pregnancy.

Additionally, in some regions of the country, prenatal care is offered by nurse-practitioners. Generally speaking however, 'medical model of care' refers to a type of pregnancy management where the pregnancy is confirmed by a physician and the pregnant woman is typically monitored by a series of antenatal medical appointments, prenatal screening/testing and will give birth in the hospital under the careful monitoring of both nurses and physicians or a nurse-practitioner.

Within this medical model, pregnancy and childbirth are understood primarily in medical terms and the moment of birth usually becomes a highly medically managed encounter. Thus, it has been argued by many scholars and feminists that childbirth has been medicalized:

By medicalization of childbirth and midwifery is meant the increasing tendency for women to prefer a hospital delivery to a home delivery, the increasing trend toward the use of technology and clinical intervention in childbirth, and the determination of medical practitioners to confine the role played by midwives in pregnancy and childbirth, if any, to a purely subordinate one. (Van Teijlingen et al 2000: 1)

While midwives are highly trained professionals and certainly their training is, in a sense, “medical”, for conceptual purposes I am defining midwifery as separate from the medical model of care. This is because there are certain philosophical differences in many midwifery models of care as opposed to the medical model and also because, at least in Ontario, midwifery re-emerged in response to women’s social activism in regards to changing the social context of childbirth (Ariss and Burton 2009: 8).

The medical model of pregnancy typically understands childbirth as a process that is laden with risks or possible complications that have the potential to lead to the injury or death to the mother and/or foetus. Thus, pregnant women cared for in the medical model are encouraged to avoid taking risks known to harm the growth and development of the foetus and are generally offered a series of tests and antenatal checks in order to closely monitor the health and developmental of the foetus (Lupton 1999: 88). Within the medical model, the body is conceptualized as potentially failing in all circumstances, whether or not there is “high risk” present (Lane 2008: 158). While there is little attention paid to the iatrogenic risks of medical assistance/intervention into pregnancy and childbirth, any risk within the mother’s body itself is considered too much risk.

The moment of birth, in a medical model of care, also becomes a space of risk-management on the part of physicians. Rothman argues that in medicalized childbirth, the woman is not conceptualized as actively giving birth, but rather: “Childbirth, in the medical model, is a surgical procedure performed by an obstetrician on the pelvic regions of women,

involving removal of a fetus and a placenta” (1982: 181). Parry argues that in a medicalized and fetocentric context, pregnancy and childbirth are seen as a highly dangerous time when the health of mothers and babies are at risk (2006: 459). In the conceptualization of risk in medicine, there is much emphasis on risk in terms of the body itself, and little to no emphasis on the risks of medical interventions into birth and the iatrogenic complications that may result. Because risk is conceptualized as something which can be controlled by human intervention, in a risk-adverse medical culture, any risk at all, no matter how remote, is often acted upon defensively.

Generally speaking, the term “medicalization” refers to a way of thinking which treats social issues as medical problems. Many feminist scholars have examined the medicalization of women’s bodies (Martin 1987) and provided critiques of the medicalization of childbirth and the frequency with which medical interventions are employed in the birth process (see for example, Davis-Floyd 1992, 2001; Rothman 1982; Martin 1997, 1990; Rich 1976). Martin argues that bodies, and particularly women’s bodies, are conceptualized as machines and doctors as the technicians charged with “fixing” the machines (1987: 4). Through examining medical textbooks, Martin argues that childbirth is viewed as labour for both the mother and the physician, with the resulting infant being the product of this labour. Physicians thus viewed caesarean-sections as producing the best possible product and “saving” the baby from the perilous experience of vaginal birth (64). She argued that only focusing on the avoidance of “poor outcomes”, and concentrating on the product (baby): “ignored what the woman may have been equally concerned about: the nature of her own experience of the birth” (64-65).

Critiques of medicalized childbirth from feminist scholars have spanned decades and typically make the point that a hospital setting with many interventions into birth stems from patriarchal beliefs about women’s bodies and render women largely powerless in the birth-

process. Rich (1976), in her feminist critique of the institution of motherhood, also linked medically-managed childbirth with hierarchical and patriarchal institutions and the control of the women's bodies. She writes that during medically-managed or "alienated" childbirth, women are: "above all, in the hands of the male medical technology. The hierarchal atmosphere of the hospital, the definition of childbirth as a medical emergency, the fragmentation of body from mind, were the environment in which we gave birth, with or without analgesia." (176). She also argues that:

No more devastating image could be invented for the bondage of women: sheeted, supine, drugged, her wrists strapped down and her legs in stirrups, at the very moment when she is bringing new life into the world. This 'freedom from pain', like 'sexual liberation', places woman physically at men's disposal, though still estranged from the potentialities of her own body. (170-171)

The feminist arguments and critiques against the medical management of childbirth have not centred around the introduction of technologies to improve health outcomes for both mothers and infants during birth as it is certainly recognized that, when needed, medicine can and does save lives. Rather, these analyses of medicalization have focused instead on the issue of women's loss of control over childbirth practices, especially in light of the male-dominated arena of obstetrics/gynaecology.

Another central tenet of the feminist critique of the medicalization of women's bodies is that, in the medical model, the male body exists as the norm (Rothman 1982: 24) and the female body is viewed as abnormal. Thus, childbirth becomes not something healthy and normal but rather complications or "stresses on the system" (Ibid). Davis-Floyd (1992), in a similar vein to Martin, also writes about the body-as-machine metaphor, but argues that the female body, in medicine as well as science in general, is conceptualized as an "abnormal, unpredictable and inherently defective machine" (53) and she argues that this very metaphor has formed the foundation for the field of modern obstetrics (51). She goes onto to write that: "Obstetrics was

thereby enjoined from its beginning to develop tools and technologies for the manipulation and improvement of the inherently defective and therefore anomalous and dangerous process of birth” (Ibid).

In describing medicalized childbirth, Davis-Floyd uses the term “technocratic birth” (1992), indicating a model of pregnancy and childbirth that typically makes use of a series of medical rituals in childbirth which, she argues, serve as initiation for both mother and child into an American way of life that privileges “the superiority of technology over nature” (2). The key assumptions in the technocratic model of pregnancy and birth are that the foetus develops within its mother’s body in a mechanical and involuntary manner, that the physician is responsible to ensure it develops and grows properly and that the doctor will deliver the child at the end of the pregnancy (1992: 28). Davis-Floyd argues that this medical paradigm provides most women with: “the overarching conceptual and structural framework for their experience of pregnancy, whether or not they espouse its basic tenets” (Ibid). The goal of this model of birth is always to produce a perfect baby (58) and it is believed that some level of medical intervention is necessary in all births (57).

It has also been argued that the technological and risk-based management of pregnancy and childbirth, while seeming to view the female body as inherently defective and as site of profound risk, also places a higher value upon the life and wellness of the foetus than upon the mother. Davis-Floyd argues that the goal of technocratic childbirth is to produce a perfect baby, the mother becoming a “by-product” of this process (1992: 58). Wagner argues that in the medical model, the risk approach has the effect of making a pregnant woman into not only a patient, but also a passive object in which a series of tests are performed upon (1994: 98). Furthermore, she argues that the risk approach: “focuses more on the risk to the fetus than the

risk to the woman, and this intense focus carries the danger that the pregnant woman may come to be seen simply as a container for the baby. Thus, obstetricians have gradually come to consider themselves advocates for the unborn baby” (Ibid).

Weir argues that the gradual turn in medicine from *prenatal* care towards *perinatal* care shifted attention from the care of the mother towards the care for and reduction of mortality for the foetus (2006: 69). She argues that technological developments such as ultrasound imaging and extensive medical research into pregnancy significantly changed the time when a foetus was thought to be a real person or subject. Weir calls this the “threshold of the living subject” and she argues that this has resulted in a profound change regarding how a foetus is to be protected, considered to be a citizen and thus governed. She argues that:

The perinatal threshold folded a new division of time and bodily substance into the maternal body during pregnancy and birth...In so doing, it consolidated the existence of the living subject prior to and during birth, providing a rationale for its care: the conservation of fetal life so as to optimize infant health. Where previously the birth threshold only definitively concluded at the end of the birth process with a separation of mother and child, the perinatal threshold distinguished mother from the unborn *during* pregnancy and birth. [original emphasis] (3)

She argues that risk techniques were connected to pregnancy and birth during the time that the focus shifted from maternal care towards the reduction of perinatal (fetal) mortality and morbidity. Beginning in the 1950s, Weir argues that: “Standardized, population-based, routine risk assessment in clinical practice came to saturate in succeeding decades, promising an ever receding utopia of health” (3-4). Like other critics of risk-based medical care, Weir also points out that the increasing attention towards risk has done little to increase outcomes, while drastically increasing rates of medical interventions (4).

The public criticisms about the nature of medically-managed births for many women lead to some changes regarding the ways in which childbirth is typically managed during a hospital birth. It was recognized that rendering women unconsciousness during birth resulted in poor

outcomes for both mothers and infants, and this fell out of fashion in the 1950s to be replaced with pain relieving techniques that allowed mothers to stay conscious during birth (Sullivan and Weitz 1988: 27). The use of enemas and pubic shaving were widely criticized for being uncomfortable, humiliating and providing no benefit to birth outcomes and there are currently strong recommendations against the routine use of shaving and enemas (Chalmers et al 2009: 23); however it has been shown that these practices are still in use infrequently in some Canadian hospitals (Ibid.). Additionally, the rates of episiotomy have dropped dramatically, as it has been recognized that there is potential for harm from the use of routine episiotomy and that it should only be used on an as-needed basis (Ibid.). Generally speaking, the women's health movement and push towards more humane hospital birthing practices successfully decreased some of the hospital birthing practices that were most widely criticized for being futile or even harmful for women; however there still remain concerns about the ways in which biomedicine typically approaches and manages childbirth.

A more recent concern about the medicalization of childbirth has been the increasing frequency with which caesarean-sections are performed. The proportion of caesarean-sections in Canada increased from approximately five percent of births in the 1960s to over twenty-five percent in 2004-2005 (Public Health Agency of Canada – Canadian Perinatal Health Report 2008: 97). Because caesarean sections are major surgery and are associated with higher rates of hemorrhage, complications, fever, infection and mortality (Meisnik and Reale 2007: 606); this increase has been of concern for many health care providers, childbearing women and the general public. Also of concern regarding the medicalization of birth is a phenomenon referred to as the “cascade of interventions” wherein one intervention in childbirth, such as induction of labour can have the effect of beginning a cascade of interventions which ultimately lead to more

instrumental vaginal deliveries or delivery by caesarean section (Tracy and Tracy 2003: 717).

The “cascade of interventions” has become a widely used term which describes how medicalized childbirths often play out, particularly in the hospital setting. Lane (2008) writes:

It is not claimed here that there is a direct, causal effect between entering hospital and intervention. What follows is a ‘cascade of intervention’-a situation where a minor, initial intervention is followed by a further intervention and where the cumulative effect is a catalogue of treatments that deny autonomy, choice and satisfaction for most women. (160)

An example of the cascade of interventions is the use of continuous electronic fetal monitoring (EFM) in otherwise uncomplicated (low-risk) labours. The use of EFM has been linked with an increased incidence of the use of caesarean section and operative vaginal deliveries (Thacker, Stroup and Peterson 1995: 613) yet has also been shown to have little value in decreasing rates of fetal death and cerebral palsy (Grimes and Peipert 2010: 1397). In fact, it has been shown that the test can produce false results (Ibid), which inevitably will lead to further intervention. The heavy reliance on technologies to assess risk, some argue, results in an ever increasing use of technology. Davis Floyd argues that the technocratic model: “holds that whatever predicaments our technocratic ideology gets us into, our technological skills will get us out of” (1992: 284). Although in the majority of cases, risks arising from interventions can be effectively treated with further interventions, thereby preserving the safety of the birthing mother and infant, it is the growing use of interventions into normal labour/delivery that is of concern for many.

Examining the increasing caesarean rates has become a priority for many health researchers and has also sparked the development of some consumer advocacy groups, such as the International Cesarean Awareness Network (ICAN) aimed at: “lowering the caesarean rate through education, providing support for caesarean recovery, and promoting VBAC (vaginal

birth after caesarean)²” (International Cesarean Awareness Network Canada- About). Websites such as “The Unnecesarean” draw attention to what some feel is an “unnecessary cesarean epidemic”, occurring predominately in the United States (Arnold 2012). Consumer groups such as these argue that issues regarding the cascade of interventions and unnecessary caesareans need to be adequately understood and addressed within the medical community.

The critiques of medicalization or “technocratic childbirth” (Davis-Floyd 1992) can be seen as part of a larger feminist critique of the medicalization of women’s bodies which argues that medicalization stems from patriarchal beliefs that have long sought to control the female body:

Feminist critics have viewed the medical profession as a largely patriarchal institution that used definitions of illness and disease to maintain the relative inequality of women by drawing attention to their weakness and susceptibility to illness and by taking control over areas of women’s lives such as pregnancy and childbirth that were previously the domain of female lay practitioners and midwives. (Lupton 1997: 97)

The medicalization critique has been widely used in the sociology of medicine and feminist research on medicine, the body and health as it allows us to address the changing social constructions of ideas about health, body and medical care.

There have been some critiques that have arisen regarding some of the assumptions contained within theories on medicalization, namely that it is presented as too dichotomous, with doctors presented as overly hungry for power and patients as powerless and victimized by the medical encounter (Lupton 1997: 97). Lupton (1997) writes:

Supporters of the medicalisation critique have generally identified a central paradox: medicine, as it is practised in Western societies, despite its alleged lack of effectiveness in treating a wide range of conditions and its iatrogenic side-effects, has increasingly amassed power and influence. (95)

² The spelling of caesarean on the ICAN website appears differently in the title than in the description. The spelling here reflects the spelling as it appears on the ICAN website.

The criticism of medicalization often fails to take into account that many people seek to be medicalized (Ibid), by turning to physicians for a wide range of issues or wanting extensive medical treatments in hopes of better health. Indeed, Davis-Floyd (1992) reported that one of the most surprising results of her research was the extent to which the childbearing women she interviewed espoused the medical or “technocratic” model of childbirth (282).

Clearly, the medical model of care is the dominant way of conceptualizing and treating pregnancy and childbirth. Despite many sociological and feminist critiques of medicalization, most women in Canada continue to receive prenatal care and give birth under this model of care. Viisainen (2000a) notes that research into women’s choices in terms of birth place shows that women who view pregnancy and childbirth as a site of risk are more likely to choose obstetrical care and hospital birth, while those who view the interventions as risky are more likely to select midwifery care and/or home birth (2000a: 51). A study on Canadian women’s experiences with maternity care showed that the majority of women (58.1 percent) received care from an obstetrician/gynaecologist, another 34.2 percent from a family physician and 0.6 percent from a nurse-practitioner (Heaman and O’Brien 2009: 38). The remaining 6.1 percent of women received care from a midwife (Ibid). Despite decades of research and social activism pointing out the faults of medically over-managed pregnancy and childbirth, most Canadian women continue to choose the medical model of care. Furthermore, most women report satisfaction with the type of prenatal care received, 52.3 percent of women receiving care from Obstetricians reported that their birth experience was “very positive”, as well as 58.3 percent cared for by a family physician and 53.6 percent cared for by a nurse-practitioner (Chalmers and Royle 2009: 163). Additionally, most women reported being “very satisfied” with the information they received from health care providers, the compassion and understanding they received as well as respect, dignity and

decision-making they were awarded with during their pregnancy and birth (Ibid). Thus, it appears as though the concerns about medicalized childbirth stripping dignity and respect from women during childbirth does not necessarily ring true for all Canadian women. Despite the changes that medicine has made into the management of birth, there continues to be a minority of women who are deeply dissatisfied with the nature of medically-managed birth.

The theoretical framework of “governmentality” does not explicitly use the language of “medicalization”; however, Lupton notes that they do contend that: “society is medicalised in a profound way, serving to monitor and administer the bodies of citizens in an effort to regulate and maintain social order as well as promoting good health and productivity.” (1997: 100). Contrary to the medicalization critique, which tends to see doctors as powerful and patients as powerless, the issue of power in Foucauldian work becomes more complicated:

From the Foucauldian perspective, power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate, and experience their bodies. The central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm, bringing them into a field of visibility. It is exercised not primarily through direct coercion or violence...but rather through persuading its subjects that certain ways of behaving and thinking are appropriate for them. (99)

We can see here that from a governmentality perspective, the issue is not about doctors as powerful and patients as powerless, but rather that the medical model largely shapes how most people think about and make decisions regarding pregnancy and childbirth.

The medical model of care remains the most common way of conceptualizing, treating and managing pregnancy and childbirth. Although there have been changes made to the ways that childbirth is managed in hospitals and many women continue to choose physician attended hospital birth and report satisfaction, there are still some women who vocalize great dissatisfaction with the biomedical approach to childbirth and have sought other options for a

more holistic and woman-centred model of prenatal care and support during pregnancy and childbirth.

The Midwifery Models of Care

The midwifery models of care approach pregnancy and childbirth somewhat differently than the medical model of care. Internationally, a midwife is defined as a licensed professional who has completed the required courses and certifications for their country of practice and who:

is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. (International Confederation of Midwives, 2005)

Midwifery care is common worldwide and, prior to the advent of obstetrical care, midwives or female birth attendants were the main helpers during childbirth across many cultures. Midwifery care made a sharp decline in Western countries with the advent of obstetrical practice and the medical management of birth. The typical place of birth in most industrialized countries moved from home to hospital throughout the twentieth century. Western medical practices began to dominate and control of childbirth was relegated from midwives to doctors (Shroff 1997: 17).

In 1997, Shroff argued that midwifery care remained largely unknown or misunderstood in Canada because of numerous factors including: “the medical take-over of reproductive health-care, growing social and economic support for technological medicine, patriarchal domination of health care, colonial oppression which propped up Western medical practices, among many other factors” (16). Following a period of decline of midwifery practice in Canada coupled with the dominance of medicalized childbirth; in the 1960s and 1970s, the Alternative Birth Movement came forward, linking medicalized birth with the oppression of women and advocating for

women's control over their own birth experiences (Paterson 2010: 128). Following this, midwifery began making a "rebirth" in the early 1990s (Shroff 1997: 17), as an alternative to the medicalized maternity care offered by physicians in the medical model. In Canada today, the newly available, publicly funded and regulated midwifery care is becoming the choice for a small but growing number of families (Malott, et al. 2009: 979).

Until the 1990s, Canada was the only industrialized nation that did not have formally recognized provisions for midwifery care. Although there is certainly a rich history of midwifery in Canada, stemming from a variety of places including traditional Aboriginal midwives, European-trained nurse-midwives, and "lay" or neighbour midwives (see Biggs 2004; Burnett 2010), the use of midwives as primary attendants at births gradually declined throughout the twentieth-century for a variety of political, social and economic reasons (Mitchinson 2002). Beginning in the 1970s and 1980s, and culminating in the 1990s, a new push towards the acceptance of midwives as legitimate medical professionals began to take place in Canada. The push for revived midwifery stemmed from numerous forces including trained nurse-midwives, the re-emergence of lay midwifery as an alternative to medicalized childbirth as well as the broader women's health movement which argued that women needed increased control of their health and reproduction (Bourgeault, Benoit and Davis-Floyd 2004: 4-8). In the 1990s, Canadian provinces began to legalize and formally regulate midwifery practices into provincial health care systems, beginning in Ontario and following by Quebec, British Columbia, Alberta, Manitoba, Saskatchewan, Nova Scotia and the Northwest Territories (Canadian Midwifery Regulators Consortium 2012: "Legal Status of Midwifery in Canada"). The provincial midwifery styles and models of practice have drawn upon both international and local models to create unique Canadian models of midwifery care (Bourgeault, Benoit and Davis-Floyd 2004: 3). With the

development of new models of midwifery care came the emergence of a new type of Canadian midwife – a certified midwife (Benoit et al 2010: 477). The certified midwife that emerged from the professionalization of midwifery project was a highly trained health professional, regulated and accountable to the midwifery regulatory body of her province (Canadian Midwifery Regulators Consortium 2012: “What is a Canadian Registered Midwife?”).

Most midwifery models, including those in Canada, emphasize holistic and woman-centred care, and view pregnancy and childbirth as normal, life-course events. The midwifery models of care have thus provided alternatives to the medical model for many pregnant women. It has been found that many Canadian women who choose midwifery care as opposed to the medical model are often resisting the medicalization of pregnancy and childbirth in myriad ways (Parry 2008: 802). Furthermore, because of midwifery’s focus on birth as normal, the choice of midwifery care often helps many women avoid unnecessary medical interventions involved with pregnancy and childbirth (Parry 2006: 463).

Midwifery training and models of care also vary significantly internationally, making it difficult to generalize a great deal about midwifery as a whole. For example, nurse-midwives receive training as nurses first and then go on to obtain specialization in midwifery in a formal institution (Bourgeault 2006: 31). In the United States for example, the midwifery education level obtained for Certified Nurse Midwives (CNM) and Certified Midwives (CM) is a master’s or doctoral degree (American College of Nurse-Midwives 2011: “Comparison of Certified Nurse Midwives, Certified Midwives and Certified Professional Midwives”). These midwives typically practice in hospital settings which have a more medical approach to pregnancy and birth than would be found in homebirth or birth centre settings. In regions where nurse-midwives are common, such as the United States, nurse-midwives typically work closely with and hold a high

degree of legitimacy and support with the medical profession (Bourgeault 2006: 31) than do other types of midwives.

Unlike CNMs and CMs, Certified Professional Midwives (CPM) in the U.S. are not trained as nurses first, instead they are registered with the North American Registry of Midwives (NARM) and practice as midwives independently. CPM's are not legally recognized in all U.S. states and registration with NARM does not necessarily equal legal recognition in each state (National Association for Certified Professional Midwives 2012: "What *is* a Certified Professional Midwife?"). Most CPM's work in birth centre or homebirth settings and carry smaller caseloads (Ibid.). They are primarily trained by apprenticeship and certification as opposed to universities or colleges (American College of Nurse-Midwives 2011: "Comparison of Certified Nurse Midwives, Certified Midwives and Certified Professional Midwives"). Because CPM's do not require a diploma or a degree, practice primarily in homebirth contexts, and are not regulated in all U.S. states, it is possible that they are not as highly esteemed by medical professionals as are nurse-midwives or the regulated midwives such as those found in Canada.

In other regions of the world, midwives are educated via direct-entry university programs, therefore are not required to have a background in nursing. Midwives in the U.K. may be educated via direct-entry university midwifery training programs or, if they have a background in nursing, complete a shorter midwifery program in order to achieve licensing (National Health Service 2012: "Training to be a Midwife"). For many decades, the UK emphasized nurse-midwifery but more recently have begun offering direct-entry programs due to increased interest in the benefits to such an approach (Benoit et al 2001: 155). In the UK and American nurse-midwifery contexts, midwives are well integrated into the existing health care systems. It has been argued that direct-entry midwives, however, have more autonomy and face

less subordination than do midwives in a nurse-midwifery model of care (Benoit et al 2001: 155).

Traditional, lay or unregistered midwives are difficult to define in light of the fact that the nature of lay midwifery is that there is no formal training and regulation. Nevertheless, lay midwives differ from CNMs, CPMs and the licensed and regulated midwives found in most countries. Lay midwives train by apprenticeship with experienced midwives and typically remain outside of mainstream medical systems. They offer care independently and primarily in home birth settings. Lay midwives, because of their status as independent midwives, typically receive little support from mainstream medical models and will often not have legal recognition or public funding.

In Canada, each province has its own model of midwifery care that is funded and regulated via provincial guidelines. This means that although the option of choosing midwifery care is available for many Canadian women, the accessibility of midwives is scattered across the country because of provincial funding restraints, shortages of midwives and regional inequalities. However, the national midwifery organization, the Canadian Association of Midwives (CAM) continuously lobbies for equal access to midwifery care across the country (Canadian Association of Midwives 2012: “Mission Statement”). Despite the regional differences, generally speaking, Canadian midwives view continuity of care and the development of a relationship between the midwife and the family as a high priority (Canadian Midwifery Regulators Consortium 2012: “Canadian Model of Midwifery Practice”).

Due to the fact that health care in Canada is provincially regulated, each province is able to decide if and when midwifery should be legalized and incorporated into existing health care systems. This means that each province has a unique midwifery model that varies in terms of

funding and access and also in terms of how midwives receive their training and set up their practices. For example, Ontario was the first Canadian province to license and regulate midwifery as a profession of independent health practitioners (Bourgeault 2006). Thus, Ontario now has a well-established midwifery presence that is integrated into already existing health care. The College of Midwives of Ontario serves as the formal registration and licensing body for midwives throughout the province. All practicing midwives must register with the College in order to legally practice. Unlike in the U.S. where ‘lay midwives’ or unregulated, apprenticeship-trained midwives are still relatively common, Canadian provinces have laws regarding who can legally offer midwifery services, based on stricter regulations regarding education, training and licensing. Although Ontario was the first Canadian province to recognize midwifery as a regulated health care profession, the Ontario midwifery model was a latecomer internationally in terms of legalization and regulation and has thus been able to build a unique model of midwifery that draws upon the successes of midwifery programs internationally (Bourgeault, Benoit and Davis-Floyd 2004: 4). Direct-entry university midwifery programs are offered at three Ontario universities and midwives practice as publicly funded health professionals through the Ontario Ministry of Health and Long Term Care.

Ontario midwives can achieve licensing by graduating from the Ontario Midwifery Education program, which is a four-year, direct-entry Bachelor of Health Sciences in Midwifery Degree. Once successful completion of this program has occurred, the individual must register with the College of Midwives of Ontario. If an individual receives training outside of the province, they may be considered for licensing by the College or they may have to attend a bridging program in order to achieve licensing (College of Midwives of Ontario 1994: “Philosophy of Midwifery Care in Ontario”). The Midwifery Education Program (MEP) in

Ontario is a unique program which offers students a combination of university classroom education and hands-on apprenticeship style placements with practising midwives (Kaufman and Soderstrom 2004: 191-197). There is no requirement for a background in nursing, separating the Ontario Midwifery Education Program from other models of training which place value on prior nursing education. The decision to have direct-entry midwifery as opposed to nurse-midwifery was made in light of concerns regarding the medicalization of midwifery (Van Wager 2004: 83); fears that nurse training socializes nurses to be subordinate to doctors as well as evidence from other countries that there has been an increased desire for midwives to separate themselves from nursing (Benoit and Davis-Floyd 2004: 170). The Ontario Midwifery Education Program launched in 1993, incorporating elements of other midwifery training programs and valuing the importance of hands-on midwifery training in both hospitals and at homebirths. In an attempt to achieve the best of both worlds of midwifery training, the Midwifery Education Program incorporated both classroom learning and clinical placements with preceptors or experienced midwives (Kaufman and Soderstrom 2004: 197). Incorporating some apprenticeship training into the Ontario model of midwifery education helped to quell the fears regarding formal education being too medicalized and separate from women's needs, as the apprenticeship affords the opportunity to train midwives within the context of woman-centred and continuous care (Van Wagner 2004: 83).

The Ontario model of midwifery education has been successful since its establishment in 1993 and has served as a pioneer model of midwifery education which subsequent midwifery education programs, like those developed in British Columbia and Quebec, have been able to draw upon (Kaufman and Soderstrom 2004: 202). Currently in Canada there are midwifery education programs in Ontario, British Columbia, Alberta, Quebec and Manitoba (Canadian

Association of Midwives 2012: “Midwifery Education in Canada”). Each of these programs are direct-entry, degree-based programs designed to train midwives to be primary care providers for pregnant women throughout the pregnancy, birth and postpartum period. While there are similarities between the midwifery education programs, each province has also been able to mould its own program, in some instances enabling the development of unique models to address the needs of the communities in which they serve. For example, the Manitoba program, offered by the University College of the North (UCN), was spearheaded by the desire for Aboriginal midwives in the North. The UCN midwifery program thus blends traditional Aboriginal teachings with Western midwifery knowledge in its curriculum delivery (University College of the North 2012: “About UCN Midwifery.”).

Some features of midwifery models of care clearly differ from the typical medical management of pregnancy and birth. For example, the philosophy of midwifery care in Ontario, as put out by the College of Midwives of Ontario (College of Midwives of Ontario 2012: “Philosophy of Midwifery Care in Ontario.”) states a number of philosophies that guide midwifery care in Ontario. One of these, which explicitly differentiates from the medical model is the statement that: “Midwives regard the interests of the woman and the fetus as compatible. They focus their care on the mother to obtain the best outcomes for the woman and her newborn” (1). This is clearly an approach distinct from the risk-based medical model which has been accused by many as conceptualizing mother and foetus as separate (Wagner 1994: 98) and placing the interests of the foetus ahead of the mother (Weir 2006: 69). Viewing mother and infant as having compatible interests allows this midwifery model of care to practice in a way that values the health and wellbeing of the mother, recognizing that this in turn will allow for the wellbeing of the foetus/infant.

There are three principles of which the Ontario Model of Midwifery is based and these are: continuity of care, informed choice and choice of birth place (Association of Ontario Midwives 2012: “Model and Philosophy”). These three principles of midwifery, which were developed in response to women’s demands, were highly important to midwives in the period when regulation was taking place and midwives only wanted regulation if these principles could be incorporated into the model of midwifery proposed (Van Wagner 2004: 76). Van Wagner (2004) notes that this model of midwifery care is designed to protect certain elements of traditional, unregulated midwifery: “such as the midwifery philosophy of birth as a normal, healthy process, and to safeguard against the dangers seen in regulation and integration into the system – medicalization, fragmentation of the client-caregiver relationships, and restricted client choices” (86). In the period when regulation was being negotiated, midwives successfully argued that offering continuity of care meant that not only did midwives have to build strong midwife-client relationships, but they needed the ability to prescribe medications without having to transfer care (Bourgeault 2006: 158). Informed choice and choice of birthplace also meant that midwives required the ability to offer their care at the time of birth both at home and in hospital, because it was recognized that most women will birth in hospitals but some will always choose homebirth (Bourgeault 2006: 162).

Thus, the three principles of midwifery care in Ontario: continuity of care, informed choice, and choice of birth place are part of the unique model of midwifery created during the 1990s. Through legalization and regulation, Ontario midwives were able to achieve recognition as an autonomous health care profession that works within a philosophy of woman-centred care (Bourgeault 2006: 262). The midwifery model of care in Ontario: “is built on the philosophical basis that considers birth a profound event in a woman’s life, not just a physiological process.”

(Macdonald 2006: 238). Although midwifery care has been professionalized and regulated in Ontario since 1993, it remains counter-hegemonic to the medical model (Ariss and Burton 2009: 12), in that it continues to advocate for childbirth as a normal part of the life-course.

In contrast to the medical model, which has been criticized for focusing on childbirth as a dangerous event in need of careful medical assistance, most models of midwifery are careful to highlight their conceptualization of pregnancy and birth as “normal”. In a recent position statement by the Canadian Association of Midwives (2010), they emphasize the important role midwives are playing in the recommendations and promotion of normal birth, writing that:

Trust in the normal childbirth process is fundamental to the philosophy and practice of midwifery, the language midwives speak and the care they provide to women. Midwifery education includes the development of specific skills and clinical practices that facilitate normal, undisturbed labour progress and spontaneous delivery through the efforts of the mother, without routine use of drugs and interventions. For midwives, the concept of normality rests on the physiology of labour and the capacity of women to give birth with their own power. (Canadian Association of Midwives 2010: “Position Statement on Normal Birth.”)

Midwifery care, with its emphasis on informed choice, respecting women’s desires to give birth safely with power and dignity, is often a sought after choice for women who wish to give birth outside of the medical model.

Although midwifery care is covered under many provincial health plans, it remained the choice/option for only 6.1 percent of pregnant women throughout all of Canada as of 2008 (Heaman and O’Brien 2009: 38). Nevertheless, there are quite large regional variations across the provinces and in some regions midwives account for a substantially larger proportion of maternity care. This likely reflects the availability of midwifery services, whether or not and for how long midwifery has been publicly funded and the availability of physicians to provide pre and post natal care. For example, in Ontario the percentage of pregnant women utilizing

midwifery care was still under ten percent as of 2009 (Heaman and O'Brien 2009:38) and at ten percent in 2010 (Tollinsky 2010: 5).

While these numbers appear to be relatively low, it is important to note that the limited availability of midwives in some regions of the province means that a large number of women who would like to have midwifery care are turned away. There are currently about 500 midwives practicing in Ontario and province-wide, four out of ten women cannot obtain midwifery care because of the high-demand and limited midwives (Tollinsky 2010: 5). In Toronto, some midwives have to turn away three times as many women as they can accommodate (Ibid). Furthermore, there are some areas of Ontario where there are more midwives practicing and thus midwifery care accounts for a significantly higher proportion of the total care. In some cities in Northern Ontario, such as Thunder Bay and Sudbury, approximately 25 percent of births are attended by midwives (Larmour 2009: 6). It is therefore somewhat difficult to generalize a great deal about the overall utilization of midwifery care across Canada, as there are substantial variations nationally, provincially and regionally; however, it is safe to say that the profession of midwifery and demand for midwives has grown substantially since the early 1990s and continues to expand today.

The issue of choice of birthplace has been particularly salient for most Canadian midwives and in provinces with regulated midwifery practices, women can choose to give birth in a hospital attended by a midwife, in a birth centre where these are available, or at home, provided there are no risk-factors inhibiting home-birth. An Ontario study on planned home births showed that approximately 25 percent of midwifery clients had homebirths (Hutton, Reitsman and Kauffman 2009: 181), accounting for 1.6 percent of the total births in the province. It has been shown that care in the midwifery model of care results in lower intervention rates

(Johnson and Daviss 2005: 1416) and similar neonatal and maternal mortality rates (Ibid).

Utilizing midwifery care offers Canadian women the opportunity to have maternity care in a model that is woman and family focussed, offers a choice between birthing in a hospital, birthing centre or at home and has proven to be equally as safe as birthing in a hospital under the care of a physician. Most women who utilize midwifery care report satisfaction with their care, and as the Canadian Maternity Experiences Survey found, “Women whose birth was attended primarily by a midwife were more likely to rate their experience of labour and birth as ‘very positive’”, 71.1 percent compared with 58.3 percent for clients of obstetricians (Chalmers and Royle 2009: 163).

While midwifery is often aligned with the movement away from medical birth towards “natural” birth and this has been an effective strategy to promote the new models of midwifery, some midwives and scholars have pointed out that focusing too heavily on natural birth can essentialize the female body (Macdonald 2006: 236) and lead to a romantic image of non-Western birth systems (239). Additionally, because technologies and interventions are now available and are sometimes needed, the idea of “natural” birth tends to become understood somewhat differently in the present climate. Scholars have found that women’s conceptualizations of “natural” varied greatly, some even viewing interventions as natural, provided that they were decided upon by the mother (Macdonald 2006: 250, Viisainen 2001: 1118). Viisainen argues that: “The two contemporary Western cultural models of childbirth are generally presented as binary opposing models, forming a black and white world. When it comes to practical choices, the world exists much more in shades of grey” (2001: 1119). While the midwifery model of care still remains an alternative to the medical model of childbirth, it is important to note that midwifery does not exist wholly outside of medicine. The Ontario philosophy of care even highlights that while midwives promote health throughout pregnancy,

they also emphasize the appropriate use of technology (College of Midwives of Ontario 1994: “Philosophy of Midwifery Care in Ontario.”). It is sometimes assumed that by choosing midwifery care, a woman is completely rejecting the technologies and interventions available for childbirth; however, in models of midwifery care such as the regulated one in Ontario, midwives are not against technologies, rather they highlight the importance of only using them as appropriate and in consultation with the mother, who is viewed as the primary decision-maker.

The new midwifery models of care, despite their successes, have not been without criticism. Since the emergence of midwifery as a legal profession, especially in Ontario where professionalization and integration into public health care happened relatively early, there have been concerns about how professionalization has limited the extent to which midwives could offer ‘woman centred care’ (Bourgeault 2006: 260). Because the re-emergence of midwifery arose, at least partially in response to the medicalization of childbirth and was based on women’s demands for more agency and autonomy in childbirth (Ariss and Burton 2009, Bourgeault 2000: 176), there have been concerns about midwifery itself becoming increasingly medicalized (Van Teinlingen, et al. 2000). Bourgeault (2000) shows how state regulation of midwifery meant that certain aspects of the early vision of midwifery have shifted as a result of regulation and professionalization, namely, the relationship between midwives and clients from one of egalitarianism towards hierarchical midwife-client relationships (180). Bourgeault also argues that midwives, having secured self-regulation as well legal protection, inadvertently shifted accountability from the women they served towards a regulatory body, effectively changing the relationship between midwives and their clients (182). There has also been research looking at how midwives, with their focus on birth as normal and natural, operate within a cultural climate where discourses of risk are increasingly used to understand pregnancy and childbirth (Weir

2006, Scamell and Alazsewski 2012). While this will be discussed further in the analysis section, it is important to note that tensions may exist in regards to midwifery and notions of risk in pregnancy and childbirth.

The position of midwifery thus remains within a cultural climate of normalized medical childbirth and midwives are often balancing the profession's philosophy of woman-centred care, choice and autonomy for birthing women, and limiting intervention in the birth process within the hegemonic understanding of childbirth as dangerous, full of risk and always requiring medical attention and intervention. The requirement for formal training and licensing for Canadian midwives and the bureaucratic regulations that come with licensing may mean that new midwives are now required to follow regulations set forth by the province in a way that was not required for lay or unregulated midwives.

Although the use of midwifery care remains a small proportion of the total maternity care choice in Canada, research points to the fact that the interest in and use of midwifery care is growing in almost every province. Canadian university training programs have expanded and grown in number since the first opened in 1994, allowing for more trained midwives to enter the workforce every year. The national maternity experiences survey showed high levels of satisfaction among women who give birth with a midwife and much research into midwifery backs this up. However, since midwifery has become a legal profession in Canada with various legal and professional regulations, there have been concerns about midwifery losing its egalitarian roots, and, certainly within the unassisted childbirth community, some concerns that midwifery may be veering too closely to the medical model of care.

Unassisted Childbirth

In an unassisted childbirth, an expectant woman makes a deliberate decision to give birth, usually at home, without the presence or assistance of a medical doctor or midwife. The birthing mother may accept assistance from friends, family members or partners but one of the central principles of unassisted childbirth is that the birthing mother does not require instruction on how to give birth (Shanley, 2011: “What is Unassisted Childbirth?”). While typically the birthing woman is accompanied by someone, be it a partner, family member or friend, occasionally unassisted births occur literally alone (See, for example, Shanley 1994: 131-137).

While there has not been a great deal of research on unassisted childbirth, the issue has not been ignored by social scientists. Miller (2009) has studied the practice of unassisted childbirth in the southern United States and written about how freebirthing women rely on both the medical model and the midwifery model to shape their experiences of childbirth. She finds that women choosing unassisted childbirth go through a complex decision-making process and construct agency in a unique manner that relies on both medical and midwifery discourses. She also finds that while women are resisting the norm of medicalized birth by choosing unassisted birth, they still largely understand childbirth in a medical way, as evidenced that the scientific or clinical language with which they describe birth (Miller 2009 :71). Miller’s research presents an important contribution to a sociological understanding of unassisted childbirth and her interviews with American women choosing unassisted birth shed light on the social context within which the decision to birth unassisted occurs.

Freeze (2008) has also written about unassisted childbirth, focusing on the history and development of the practice as a “movement”, predominantly in the United States, and posits that unassisted childbirth challenges some of the core tenets of childbirth paradigms. Freeze conducts

interviews, surveys and significant internet-based research in order to present a thorough account of the development and dialogue within and around the unassisted childbirth movement. Freeze is a quite vocal supporter of unassisted childbirth, having written about her own unassisted birth experiences on her blog “Stand and Deliver” (Freeze 2012: “Stand and Deliver.”). Freeze’s in-depth research into unassisted birth thus provides a thorough account of the social context of childbirth in the United States as well as much insight into how unassisted childbirth is framed by the women who choose it.

Research based out of Australia argues that the incidence of both high-risk homebirth and unassisted childbirth is growing because of problems with contemporary maternity care. Dahlen, Jackson and Stevens (2010) argue that unassisted childbirth may be on the rise because of high rates of intervention in physician-managed birth leading women to flee ‘the system’ in favour of seeking more fulfilling birth experiences (48). Inadequate access to midwifery care in Australia (49), they argue is compounding this phenomenon as more women are having to choose between physician-attended hospital births or unassisted childbirth.

This research differs from the above in a number of ways, primarily in that my focus is on how the notion of “risk” in childbirth is used by both supporters and those against unassisted birth. Instead of interviewing women who have had unassisted births, I am looking at some of the discursive constructions that surround the practice of unassisted birth paying particular attention to the language of risk. Instead of looking at why and how women choose to give birth alone, my research explores both the discourses within the unassisted childbirth community that promote the practice as a legitimate choice and the reactions to the unassisted childbirth movement coming from professionals such as doctors and midwives.

WOMEN'S CHOICES IN CHILDBIRTH

The Women's Health Movement certainly played a role in raising awareness of the medical management of birth and in increasing awareness of how medical practices may have subordinated women (Rothman 1982). In advocating for better maternity care practices, the Women's Health Movement helped to advocate for alternative models of care, such as midwifery, in offering women a model of maternity care which was based on egalitarian relationships between clients and their caregivers (Bourgeault 2000: 174).

There is a body of feminist and social scientific research that examines women's individual choices and experiences with childbirth, medical care and the role of midwives, all of which are useful in looking at the constructions of risk around unassisted childbirth. For example, Viiasainen (2000b) examines how parents in Finland evaluate certain risks in order to come to a decision to have a homebirth and finds that parents assess not only the medical risk that complications could arise during childbirth, but they also take into account the iatrogenic risks of hospital birth and the social risks of going against the dominant expectation that birth should occur in a hospital. She finds that the hegemonic definition of childbirth as medically risky results in homebirth being framed as high risk and that parents end up having to negotiate, in often complicated ways, their perceptions of the risks in childbirth. Viiasainen's assertion that risks in homebirth are not only about biomedical risks but also social risks is useful in allowing us to see how the language of "risk" is not only applied in terms of medical risk. Unassisted birth can be seen as an even more extreme form of risk than midwife-attended homebirth and thus, women choosing it will also evaluate multiple forms of risk in making their childbirth decisions. Conceptualizations of safety and risk clearly vary, as Viiasainen's (2000) work shows, and can be understood in other ways than biomedical risks.

Lungren's (2010) work also looks at the decision-making practices amongst women choosing homebirth but focuses on when professional care is unavailable. Through interviews with seven women in Sweden who had homebirths, four of whom birthed unassisted, Lungren finds that women choosing home birth live with "*huge contrasts* between an inner and an outer image of birth' (61). The inner image consists of a trust in themselves as capable of birthing unattended and being competent enough to decide if a hospital transfer is needed. The external image of birth entails the idea that childbirth is a dangerous process requiring skilled medical intervention. The women Lungren interviewed had a profound mistrust of the system of obstetrics and experienced their homebirth as a profoundly empowering experience.

Other qualitative research into homebirth includes Cheyney's (2008) work which looks at women's understandings of homebirth. Through interviews with thirteen women who have had midwife-attended homebirths, she finds that in dealing with the hegemonic understanding that birth should occur in a hospital "just in case", the women come to a different understanding of birth, which Cheyney terms "systems challenging praxis". The women come to their decision to homebirth through "processes of challenging established forms of authoritative knowledge and valuing alternative ways of knowing, combined with embodied experiences of personal power and a deep desire for intimacy in the birthplace" (254-255). Although Cheyney does not include women who have had unassisted births in her study, it could be argued that women who choose unassisted childbirth are also engaging in systems challenging praxis in a more extreme form. This research is useful towards obtaining an understanding of the resistance to medical hegemony that often takes place in choosing unassisted birth. Cheyney's findings about valuing alternative ways of knowing is helpful in terms of looking at how often trust and intuition are valued more so than biomedical knowledge within the unassisted childbirth communities.

There is also a body of research on the evolving nature of midwifery. It has been shown that the relationship between midwives and supporters of unassisted birth is often complicated (Freeze 2008: 261) thus some of this work around the reconceptualization of midwifery with professionalization is useful in looking at unassisted childbirth. For example, MacDonald (2006) reviews the history of midwifery in Canada and, through interviews with midwives and midwifery clients during the 1990s, shows how the conceptualization of “natural” birth is being redefined in light of the availability of medical technologies to midwives. She argues that contemporary understandings of “natural” birth among midwives and their clients have shifted from more essentialized conceptions of natural birth and thus natural “is being redefined by the personal, political, and pragmatic choices of midwives and their clients” (236). In this understanding, certain medical interventions can still be understood to be part of a natural birth process if they are made in a caring and compassionate way, with the mother feeling as though she made the decision. The new midwifery’s engagement with certain medical technologies is one of the many reasons that some women choose unassisted birth over midwife-attended homebirth.

Certainly women’s choices into how to give birth are complex. Some social science and feminist research points out how women evaluate “risk” in choosing where and with whom to experience birth. While biomedical notions of risk and biomedical knowledge in general are certainly highly valued, some research points to alternative sources of knowledge and conceptualizations of risk. This research builds upon these ideas, using risk discourses as a framework for analysis of the language which often surrounds the practice of unassisted childbirth.

CONCLUSION

The literature on risk contends that Western societies are increasingly dominated by concerns about and the prevention of risk. Contrary to the objectivist approaches to risk, social theorists show how determinations of risk are not universal, they vary in terms of debates by various and sometimes competing expert knowledges as well as cultural and social differences. The Foucauldian theorists show us how the notion of risk itself is socially constructed, in that anything can be thought of and made into a risk through language.

In recent decades, pregnancy and childbirth have increasingly been framed in the language of risk and this is at least partially to do with the conceptualization of pregnancy and birth as a medical condition rather than a normal life-course event. Historically childbirth has been conceptualized as a time of intense danger in a woman's life, and even though mortality rates have improved, biomedicine continues to conceptualize the birthing body as a risk which can be acted upon. In the language of risk, pregnancy and birth become a frightening journey where risks to fetal development and, to a lesser degree, mother's health have to be mitigated at every turn. Mother's become responsible for this risk-management in that they have to be independently responsible to avoid certain risks known to be harmful, yet at the same time they are expected to place responsibility for their pregnancy in the hands of a physician, in some ways relinquishing their power and autonomy during the birth process.

The Women's Health Movement, coupled with the strong critique regarding the overuse of medicine and interventions during childbirth has led to some shifts in how childbirth is managed in hospital, and more Canadian women are again having their births attended by midwives. While the medical model of care remains hegemonic, the Canadian midwifery models represent important counter-models for women choosing to give birth in a different way. Despite

widespread neoliberal rhetoric about Canadian women's choices and options terms of maternity care, the idea that every Canadian woman has a choice of care providers remains problematic because there continues to be wide variations in terms of access to midwifery care throughout the country (Benoit, et al. 2010: 480). The medical model of care remains dominant and the medicalization of childbirth continues to be a pressing issue for many interested in women's health. While midwifery care does open up some possibilities for handling childbirth in an alternative way, midwifery remains inaccessible to many Canadian women. For some women, midwifery care does not offer sufficient choice and autonomy in the childbirth process and they choose to give birth alone.

The language of risk surrounds many debates about the safety or dangerousness of childbirth and it is from here that my analysis begins. Is childbirth inherently risky? Or are hospitals risky in light of high rates of interventions? Who is ultimately responsible for safe birth outcomes; the mother, the care provider, or both? Looking at how the language of risk frames the debates around the legitimacy of choosing unassisted childbirth stands to shed light on the socially constructed nature of conceptualizations of risk as well as the cultural climate in which women's reproductive choices continue to be made.

Chapter Three – Methods and Methodology

As discussed in the previous chapter, risk has become a governing principle in contemporary Western societies. As medicine has become increasingly risk-averse, the time of pregnancy and childbirth is often framed in terms of risks which must be strictly guarded against by mothers and intervened upon by physicians. Sociologists influenced by Foucauldian notions of knowledge and power have asserted that what is constructed as “risk” is largely shaped through the ways in which certain phenomena are framed discursively. It is from this premise that my analysis of the construction of risk around the practice of choosing unassisted childbirth begins.

I am concerned here with three key stakeholders involved in this discussion: Canadian medical associations, particularly the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Canada Medical Association (CMA); midwifery groups and individual midwives who have responded to the issue of unassisted birth; and the writings of individuals who self-identify as choosing to have unassisted childbirths. These three groups approach childbirth in differing ways, both in terms of how birth is conceptualized and managed as well how risk and childbirth is discursively framed and understood.

This study uses a combination of primary and secondary source material that addresses risk, childbirth and the choice to birth unassisted. Primary source material includes the statements on unassisted childbirth by professional physician organizations, midwives and the women who advocate for unassisted childbirth. A total of 25 primary source materials were selected based on their relevance to the discussion of the construction of risk within discourses and responses to the practice of unassisted childbirth. Secondary source material pertinent to the analysis includes social science literature on risk as a dominant concept in contemporary Western societies, literature on the body and health, feminist work on the medicalization of women’s bodies and childbirth and research pertaining to maternity care and women’s choices.

The data indicates that medical professionals and physician organizations typically underscore the risks of childbirth which arise from within the body itself, and thus argue that unassisted childbirth poses too many risks to be a responsible choice. The women who advocate for unassisted birth also utilize the language of risk in framing their discussion of childbirth; however, they position risk as occurring in the medical management of and medical interventions into the process of childbirth. These women argue that safety and the avoidance of risk can be preserved if one takes responsibility for their own birth experience and thus contend that birthing unassisted is a responsible and legitimate choice for childbearing women. The position of midwives is not quite as clear, and, as will be shown in the analysis, midwives from diverse models of care react in a multitude of ways – some of which use the biomedical discourses of risk and others which are more sympathetic to the desire for intervention-free and autonomous birthing experiences.

This chapter will outline the methodology and methods used for this research, grounding the study in a qualitative and feminist approach. I will show what kinds of data were gathered and analyzed and, by outlining the methods of critical discourses analysis and narrative analysis, I explain how the data was analyzed. Following the tradition of feminist and reflexive approaches to research, this chapter has also allowed me to ‘locate myself’ within the research, by acknowledging my approach to the data and any limitations that may come from my social location and experiences. This is done in order to avoid what feminists have pointed out is overly detached approaches to social research. This chapter also lays out the strengths and limitations of my approach to the data and outlines the overall purpose of this research project as well as the contribution this research makes to broader fields of social inquiry.

METHODOLOGY

Using the methods of critical discourse analysis and narrative analysis, which focus on textual data and ask questions about the issues within the context in which they occur rather than presupposing a set hypothesis (Carter and Little 2007: 1316), this research uses a qualitative methodological approach to examine the public and professional discourses in Canada that surround unassisted childbirth. Critical Discourse Analysis (CDA) is defined as:

fundamentally concerned with analyzing opaque as well as transparent structural relationships of dominance, discrimination, power and control as manifested in language. In other words, CDA aims to investigate critically social inequality as is expressed, signalled, constituted, legitimized and so on by language use (or in discourse). (Wodak 2002: 2)

Examining the written texts about, and in reaction to, unassisted childbirth, allows for an analysis of how the issue of rejecting medical and midwifery care has been framed in the general public. It also allows for analyses of how the various groups involved in the debate may have competing interests as well as understandings of women's bodies and health risks during the time of childbirth.

Qualitative research moves beyond description and adds interpretation and understanding to the issue being studied (Lichtman 2010: 12). Qualitative researchers are interested in asking "why" questions (Ibid) and often look for new questions with different ways of answering them. In order to describe and interpret the public discourses around unassisted childbirth, I have thus conducted an in-depth qualitative analysis of the written and published materials that I have collected which deal with unassisted childbirth. Primary data sources include published statements by members of the three key groups identified: physician organizations, including the SOGC and CMA; midwives, including statements about unassisted childbirth by midwives operating within various models of midwifery care; and unassisted childbirth advocates, as their

words appear in published books and online forums on the topic. Secondary source material includes published research on the social construction of risk in childbirth, as it relates to the medical and midwifery models and the choice to give birth unassisted.

While there may have been a variety of ways to approach the topic of unassisted childbirth, I have chosen to conduct a discursive analysis of the dialogue surrounding unassisted childbirth for particular reasons. I opted not to interview women who have birthed unassisted partially because this research is being conducted in a relatively small Canadian city, and based on issues around anonymity, I anticipated that it would be difficult to find a large enough sample of participants willing to be interviewed about having unassisted births. I chose to look instead to the competing discourses about risk and autonomy in childbirth that have been constructing the debate around the choice to give birth without medical assistance. My intention in this project was to look specifically at how risk was contested in the discourses around the practice of unassisted childbirth as this textual analysis allows for the revealing of some key underlying assumptions regarding childbirth. In a similar vein to Tsing's (1990) research on "monster mothers", women who have been criminally convicted for having unassisted births, my aim was to look at the discourses that surround the practice of unassisted childbirth and the ways in which women's decisions around birth are discussed publicly. Tsing writes:

My study offers an alternative focus: on the overlapping, competing discourses that construct the publicly available story, rather than on the woman's subjective experience. This alternative alerts us to the ways that our demands for the "truth" of experience involve naturalizing conventions that can obstruct our appreciation of the cultural construction of the crime" (284)

Similarly then, my research draws our attention to how childbirth and women's choices continue to be socially framed, understood and debated in Canada as well as other Western nations. It also

brings our attention to the multiple ways in which notions of safety, control and risk are framed in terms of the experience of childbirth.

Feminist Qualitative Methodology

As a feminist researcher, I am also interested in how issues such as women's power, choice and autonomy in relation to reproduction have been debated in these discussions around unassisted childbirth. Bringing a feminist lens to research means recognition that my interpretation is acknowledged as my own and that my interpretation is never neutral, it aims to look critically at the dominant perspective. Maynard argues that:

all feminist work is theoretically grounded; whatever perspective is adopted, feminism provides a theoretical framework concerned with gender divisions, women's oppression or patriarchal control which informs our understanding of the social world...No feminist study can be politically neutral, completely inductive or solely based in grounded theory. (Maynard 1994: 23)

By utilizing a feminist lens for this research, I acknowledge that women's decisions around choices in childbirth are made within a context of gendered inequality, the dominance of the medical model of care and gendered expectations around good motherhood. I also acknowledge that there is not a universal "women's experience" from which we can generalize, as speaking universally about women falsely constructs 'woman' as a single category across ethnic, class, sexual identity and other differences (Kitzinger and Wilkinson 1997: 566).

One of the central tenets of feminist research, as articulated by Sandra Harding (1987), is that:

the inquirer her/himself be placed in the same critical plane as the overt subject matter, thereby recovering the entire research process for scrutiny in the results of research. That is, the class, race, culture, and gender assumptions, beliefs, and behaviours of the researcher her/himself must be placed within the frame of the picture that she/he attempts to paint. (9)

Acknowledging positionality within the research itself allows for the researcher to appear: “to us not as an invisible, anonymous voice of authority, but as a real, historical individual with concrete, specific desires and interests” (Ibid). This helps researcher’s to avoid what Haraway terms the “god trick”, or research which claims to see everything from a position of nowhere in particular (1988: 134). It is also recognized in feminist research methodologies that the interpretations that researchers reach are social in themselves. It is therefore argued that: “Feminist researchers can only try to explain the grounds on which selective interpretations have been made by making explicit the process of decision-making which produces the interpretation and the logic of method on which these decisions are based” (Holland and Ramazanoglu 1994: 133). It is for these reasons that I have chosen to articulate not only the methods of data analysis used for this research, but I have also chosen to articulate my particular social location and my own relationship to the subject matter. This will be elaborated upon further in the strengths and limitations section of this chapter.

METHODS

The data for this study was purposefully selected in order to conduct the analysis. No random sampling techniques were used as I wished to look at specific documents published or appearing between January 1994 and November 2012 relating to unassisted childbirth, of which there are a limited number. This period of time was chosen partially based on the availability of data relating to unassisted childbirth and risk. Shanley’s book on unassisted childbirth was originally published in 1994 and as I wished to include this because of its importance and recognition within the unassisted childbirth community, I opted to begin the time period shortly before this publication. The end of the time period for inclusion in the sample reflected the timing of this research and the continuing commentary on unassisted childbirth which was published in 2012.

All materials identified and collected between August 2011 and November 2012 were included in the sample. The data used includes primary sources such as published statements by medical doctors and physician groups reporting on or warning against the practice of unassisted birth, such as the Canadian Medical Association (CMA) and the Society of Obstetricians and Gynaecologists of Canada (SOGC).

Second, any statements or publications by midwives or midwife groups in regards to unassisted birth specifically that I was able to find were included. Also included were published statements on unassisted childbirth by midwives outside of Canada, such as the dialogue among American midwives that appeared in the journal *Midwifery Today* and discussions by UK midwives in *The Practising Midwife*. I also chose to include statements by the Royal College of Midwives in the UK speaking out against unassisted childbirth as well as the comments on unassisted birth put out by the American College of Nurse-Midwives. Although these data sources come from outside of Canada, they were included in order to bring attention to the various models of midwifery care around the world and attend to the ways that risk and childbirth may be discursively framed within different models of midwifery care.

Third, the voices of women advocating for unassisted childbirth were included. I opted to look closely at the few published books on the topic of unassisted childbirth as these provide insight into the arguments made by those who advocate for unassisted childbirth as an option for birthing women. Also included were the arguments for unassisted childbirth that appeared in the midwifery journals mentioned above as well as the voices of women explaining and advocating for unassisted childbirth that appear on online blogs and discussion boards. Research into unassisted childbirth by scholars interested in the subject matter were included as well, as this research provides valuable information about how women who choose freebirthing formulate

their decisions and arguments in favour of autonomous childbirth. All of these sources were able to show how differing conceptualizations of privacy, safety and risk were employed by women choosing and advocating for unassisted childbirth.

Secondary source material for this project included research and theories on the socially constructed nature of risk, paying particular attention to how risk is conceptualized as a social phenomenon in Foucauldian theories on governmentality. I have drawn upon these theories in approaching the literature from the theoretical framework of risk and governmentality and this has largely shaped what I looked for in terms of the discursive construction of risk and how power and autonomy in terms of women's bodies was typically framed. While drawing on the theoretical framework of governmentality, I have also looked to the broad areas of feminist and sociological research into women's health, the body and childbirth. Research into the medical management of childbirth was also incorporated, paying particular attention to feminist critiques of the medicalization of women's bodies and bodily processes, as well as research on women's experiences with childbirth in the medical model of care.

In terms of midwifery, secondary source material included research into the professionalization and regulation of Canadian midwifery models of care and how this has impacted the ability of midwives to offer woman centred care within the broader climate of health care in Canada. Research into how midwives contend with risk-based medicine in their approach to low-risk pregnancies has also been included in order to assess how various midwives may have to navigate between their philosophy of care and the dominant medical system which is increasingly focused on risk-assessment and management. Research into Canadian women's experiences with childbirth in the midwifery model of care was also featured for comparative purposes with care received in the mainstream medical model. Because I included the voices of

midwives practicing in models of care outside of Canada, I also drew on research regarding the complexity and heterogeneity of midwifery training and midwifery models of care.

Secondary source material on unassisted childbirth included research published on the unassisted childbirth movement in the United States and research on women's experiences choosing and having unassisted childbirths. Theories on risk as a socially constructed phenomenon were also drawn upon here, in order to show how risk is not conceptualized in the same way among all individuals living in the so-called "risk society". The section also looks to critiques of the medicalization of women's bodies and the medicalization of midwifery with professionalization in order to situate where such resistance to the medical or midwifery management of childbirth may come from.

Data Analysis

Bringing a feminist and critical lens to the analysis means that my research is closely tied with the method of critical discourse analysis, which focuses on critically examining how language may reproduce various forms of social inequality. The issue of gender was thus a central focus of my analysis, not only because of the obvious fact it is women who bear children but more so because of the gendered expectations that are placed on childbearing women to manage and mitigate risk, in often selfless ways. Attending to the ways in which women's bodies were framed in the competing discourses around unassisted childbirth allowed for some insight into how the female body is or is not conceptualized as a site of risk.

Conducting the analysis of the discourses around unassisted childbirth also used some techniques from the qualitative method of narrative analysis. Esterburg (2002) describes narrative analysis as a technique which attends to the ways that language is used to describe stories and experiences and draws on methods from literary scholars. She notes that: "Rather

than viewing the language that people use as unimportant, narrative analysis assumes that language conveys meaning and that how a story is told is as important as what is said.” (181-182). In a similar vein, my data analysis also paid particular attention to how particular discourses, particularly around risk, were invoked and by whom in order to construct arguments about unassisted childbirth.

Conducting a qualitative analysis of the data through the lens of narrative inquiry allows us to see beyond what the document explicitly states and draws attention to: “how the narratives were composed, to whom, and with what effect” (Riessman 2011: 323). Riessman argues that narrative inquiry allows for qualitative research in which:

we can analyze the scenes, the positioning of characters, self and audience, and we can “unpack” the grammatical resources narrators select to make their points. We can analyze how narrators position their audiences (and, reciprocally, how the audience positions the narrator). Preferred identities are constituted through such performative actions. (Ibid)

Thus, narrative inquiry into the public discourses surrounding unassisted childbirth can allow for a thorough examination of how the arguments for and against unassisted childbirth are constructed by the various groups involved.

In order to conduct a discursive or narrative analysis of the collected material, I began by reviewing the written work and identifying emerging themes. I grouped the documents into sections, paying particular attention to who wrote the specific document and who the audience was intended to be. A central theme identified *a priori* was the use of the language of “risk” in describing pregnancy and childbirth, particularly in terms of choosing to give birth without medical assistance. Because this was a qualitative in-depth analysis of the discourses and narratives surrounding unassisted childbirth, I explored a number of sub-themes in the selected material which emerged from the data analysis, such as:

1. How do the various groups (medical model, midwifery and unassisted childbirth advocates) construct the notion of risk in childbirth?
2. Does each group have a vested interest in constructing risk in childbirth in a particular way? If so, how is this done through the language used?
3. What knowledge sources do the various groups rely on in order to understand risk in the ways that they do?
4. How are women's bodies discursively framed in the discourses around risk and unassisted childbirth? Are women's bodies constructed as being a site of risk in each group?
5. What risks are highlighted by each groups' arguments about risk in childbirth? What risks are minimized or ignored?

STRENGTHS AND LIMITATIONS

While this research is timely - in light of the increasing public dialogue about unassisted childbirth and the controversy that it has spurred in the media, there are certain limitations to the approach that I have used for this study. Because this is a discursive analysis of written and published materials relating to unassisted childbirth, there is no way of truly knowing how each group, or individuals within each group, actually conceptualizes risk. I could rely solely on the written documentation that I have gathered and then analyze and draw conclusions from the language used. Thus, the lack of perspectives from individual professionals working in the fields of obstetrics and midwifery may be a limitation of this research. However, looking at how discourses around risk surround the dialogue about unassisted childbirth certainly adds an important piece to the literature on the social construction of risk in childbirth by highlighting risk as an area of contestation. My findings demonstrate the continuing tensions and debates in

the early 21st century around the medical control of childbirth and women's decision making in regards to reproduction. This also may open up ideas for further research into how health professionals and pregnant women navigate the risk-based climate of prenatal and maternity care and how this may continue to impact contemporary maternity care.

I also came at this research from a feminist perspective, meaning that I approached the research materials from a certain critical lens. I thus brought to this research an awareness of gendered inequality and an awareness of how traditionally biomedicine has been a male-dominated profession with a history of medicalizing women's bodies. Like other feminist researchers, I believe that social research should work towards improving the conditions of women's lives by pointing out where assumptions, beliefs and other aspects of gender inequality lie. Brooks and Hesse-Biber (2007) write that:

By documenting women's lives, experiences, and concerns, illuminating gender-based stereotypes and biases, and unearthing women's subjugated knowledges, feminist research challenges the basic structures and ideologies that oppress women. Feminist research goals foster empowerment and emancipation...in the service of promoting social change and justice for women. (4)

One crucial aspect of feminist research is that it challenges traditional social research methods by pointing out that "objectivist" research only tries to make invisible the beliefs of the social researcher (Harding 1987: 9). It is for this reason Harding posits that:

the beliefs and behaviours of the researcher are part of the empirical evidence for (or against) the claims advanced in the results of the research. This evidence too must be open to critical scrutiny no less than what is traditionally defined as relevant evidence. Introducing this "subjective" element into the analysis in fact increases the objectivity of the research and decreases the "objectivism" which hides this kind of evidence from the public. (9)

It is for these reasons that I have chosen to be open about my own background and interest in this subject matter.

My interest in unassisted childbirth is informed not only by my own experiences as a feminist but also as a mother of two young children. Having given birth twice, once in a hospital and once at home, but both with the care of midwives has given me certain knowledge about childbirth and the choices that women make in choosing how/where/with whom to give birth. It was through research and planning for my homebirth that I came across the unassisted childbirth online community. I was immediately intrigued because the women discussing unassisted birth were engaging in such a thorough rejection of the medical model of care for pregnancy and childbirth. Also, the descriptions they provided of their children's births almost always described the experience in immensely positive terms such as empowering, liberating, exhilarating and so on. I was also interested in understanding how women come to making the decision to birth alone because it so directly contradicts the dominant discourse of childbirth as something painful, frightening and fraught with danger. Additionally, I was fascinated with the ways that women connect and shared information over the internet; providing support, encouragement and advocacy to one another in order to resist mainstream models of care and beliefs surrounding childbirth. This often occurs whether the women are giving birth alone or with professional help but still aiming for a 'natural' childbirth experience. Finally, my own experiences as well as my values and feminist commitment to support reproductive rights, has led to my desire to understand how women make choices around childbearing, especially when these choices fall outside of the norms or dominant cultural beliefs. It was later, upon seeing the media coverage of unassisted birth and the public statements by medical groups warning against the practice, often using the language of risk, that I decided to look at socially constructed notions of risk around the unassisted childbirth debates from an academic approach.

In terms of conducting research about unassisted childbirth, I am aware of how my own social location positions me as both an “insider” and an “outsider” in terms of the research subject matter. This is because I have had children, one of them born at home, and have thus grappled with making decisions about where and with whom to give birth. On the other hand, I did not choose unassisted childbirth and instead went with the more common choice of midwife-assisted homebirth. Whether or not I avoided unassisted childbirth because of an internalization of the belief that childbirth is inherently filled with risk remains an unanswered question, but it is something that I have tried to keep in mind while conducting this research. While I do not feel that social research should be entirely objective and value-free, I nevertheless have attempted to think through the ways in which my own experiences may have shaped the research questions that I asked and thus the findings that I came to.

There were points during the research process when I was reminded of my own assumptions and potential biases. When I first began looking into unassisted childbirth in a more in-depth fashion, I assumed that the reasons women were making this choice were based on certain principles that could be thought of as feminist, such as women’s bodily autonomy, resistance to the medical model of care, taking back power from medical professionals and so on. I was somewhat surprised to find that some of the discussions on online forums and unassisted childbirth books indicated reasons very different than those I had assumed were guiding their decisions. Some women state that their decisions were based on advice from and faith in God, or a trust in their husband to ensure that the birth would go smoothly. Miller finds that some women rely heavily on their husbands as decision makers and “head of the family” (2009: 67). In one interview, a woman stated that she “submissively” took her cohosh³ when her husband declared she should have the baby that night (68). I also came across beliefs in women’s “primal” ability

³ Black cohosh and blue cohosh are plants that are sometimes used by midwives and naturopaths to induce labour.

to birth in a safe manner and much gender essentialism regarding the knowledge and feelings of women. Perhaps most troubling were the racist and ‘othering’ generalizations about non-Western women’s abilities to give birth instinctually as opposed to “developed” Western women’s trouble with childbirth (see Shanley 1994: 9).

My surprise at these findings was an interesting reminder of how our own social locations and experience can and do shape what we look for in conducting social research. As a non-religious person and feminist researcher, my own experiences, beliefs and values shaped the assumptions I made and questions that I asked in the research process. These aspects of my own social location may have constrained what I was able to learn during the course of conducting my research because inevitably my research findings were filtered through my own perceptions and worldview.

For many qualitative, feminist researchers interested in narrative inquiry, attention is paid not only to how the researcher’s location and interpretations may affect the research itself, but also how the researcher’s own voice constitutes the writing up of the research. Chase writes that narrative researchers: “view *themselves* as narrators as they develop interpretations and find ways in which to present or make public their ideas about the narratives they studied” [original emphasis] (Denzin and Lincoln, 2000 referenced in Chase 2005: 657). Thus, the findings of this research are not intended to present any absolute truths about how the various interest groups studied here conceptualize risk, but rather are one feminist interpretation of the discourses around birth that were invoked in conversations about unassisted childbirth.

PURPOSE OF THE RESEARCH

The purpose of this study is to highlight the social constructions of risk as they appear in public discourses around unassisted childbirth. This study contributes to the broader fields of research

that look at the debates and discussions around women's bodily autonomy and decision-making relating to reproduction in general and childbirth more specifically. It also adds to the research on the social construction of risk and governmentality by showing how the language of risk is utilized to govern citizens and how resistance to dominant conceptualizations of risk occurs among certain social groups.

The following chapter will begin by looking at the constructions of risk among those in the medical community, paying particular attention to reports by professional organizations based out of Canada. Following this will be an analysis of the position of midwifery within the dialogue about unassisted childbirth. Attention will be paid to how diverse groups of midwives conceptualize risk in childbirth, how they may both resist and employ biomedical language and discourses of risk in their work and how diverse midwifery groups and individual midwives respond to the practice of intentionally birthing without professional assistance. Finally, an analysis of writings in the unassisted childbirth community will be conducted, paying particular attention to if and how they may also deploy the language of risk in their discussions about choice, privacy and autonomy in childbirth.

Chapter Four

Framing of Risks in Unassisted Childbirth: A Comparative Analysis

Drawing on public written documents appearing from the mid-1990s to 2012, in this chapter I summarize the framing of risk in each of the three key stakeholders' discourses (the physician organizations, midwifery community and unassisted childbirth advocates) about unassisted childbirth. As noted in Chapter Three, using the techniques of critical discourse analysis and narrative analysis, I discuss both the risks that are named, and those which are not addressed in each of the stakeholders' narratives as well as the similarities and differences in their approaches to framing risk. I argue that both the physician groups and unassisted childbirth advocates often frame their arguments about the management of childbirth within the language of risk and safety. However, the conceptualizations of what constitutes risk diverge, with physicians typically arguing that childbirth itself is inherently risky, and unassisted childbirth advocates arguing that risks arise from relying on medical experts to manage birth. The position of midwifery is not quite as clear, as midwives appear to have a more complex relationship to notions of risk in childbirth as they often mediate between dominant biomedical notions of risk and the midwifery model's focus on birth as healthy and normal. There are also key differences in how midwives are trained and practice in different jurisdictions, thus their diverse reactions to unassisted childbirth may reflect their training orientation and the nature of their practice. Analyzing the various groups' conceptualizations of risk shows how risk is not a static concept but rather can be conceptualized quite differently depending upon the arguments being constructed. What constitutes "risk" is an area of contestation, as both experts and lay people interpret as well as make judgements about health, safety and autonomy in relation childbirth choices.

RISK IN BIOMEDICINE

As was demonstrated in Chapter Two, the biomedical model has increasingly used the language of risk in discussions of health, pregnancy and childbirth. Dangers, adverse outcomes and accidents, such as illness, injury or even death have become subsumed under the language of “risk”; the key difference being that while dangers and accidents are not seen as preventable, “risks” are thought to be something which can be managed, prevented or mitigated by human action (Ewald 1991: 201-202). This process has thus helped to normalize the medical management of and technological intervention into pregnancy and childbirth. In the biomedical approach to risk, even a remote possibility of a poor outcome is considered to be too much and is strictly guarded against, both by mothers’ charged with the responsibility for protecting their foetuses from risk and by medical professionals trained to calculate risks and intervene when medically indicated.

In light of the increasing public dialogue regarding the choice to forgo medical care and opt instead to give birth alone, this section will review how women’s bodies and the notion of risk are discursively framed in the reactions to unassisted childbirth that have been recently published in Canadian medical journals and press releases. Key themes to be explored are: how, through the language used, does the biomedical model construct risk in relation to the female body and childbirth? How is the choice to have an unassisted birth presented by those associated with the biomedical model? What kinds of risks are highlighted by professional medical organizations and which risks are ignored?

Discussions of Unassisted Childbirth in Medical Journals

The unassisted childbirth movement⁴ has recently made a number of appearances in media stories and medical journals. Although there are not any Canadian statistics collected about this method of birth, and presumably it makes up a very small proportion of the total births in Canada, the issue appears to have sparked some interest and concern among Canadian medical organizations. Unassisted childbirth advocates are putting forth an intense critique of the medicalization and medical management of childbirth, arguing that safety in birth can be preserved by avoiding medical professionals and relying on oneself to guide the birth process (Shanley 1994: 10). Medical professionals, however, see the issue quite differently and are concerned with what they see as the significant risks of unattended childbirth.

In 2007, the Society of Obstetricians and Gynaecologists of Canada (SOGC) put out a news release titled “The Dangers of Unassisted Childbirth”. This statement followed a period of increased public dialogue regarding unassisted childbirth: “This practice known as unassisted childbirth or ‘freebirth’, has garnered recent media attention in Canada, where some have touted the practice as a mainstream option for pregnant women seeking a ‘natural’ experience” (2007: 1). This news release occurred around the same time that the Royal College of Obstetricians and Gynaecologists (RCOG) issued a statement (RCOG 2007: “RGOC statement on unassisted childbirth or ‘freebirth’.”). In 2007, The American College of Obstetricians and Gynecologists (ACOG) also put forth a one-word statement on unassisted childbirth: “dangerous” (ACOG cited in Maher 2007). The RCOG states that they are aware of the practice and note that little research is available. They state: “Before choosing a place of birth all women should be fully informed of the potential risks, which may include the need for intervention, transfer to hospital and/or pain

⁴ It is unclear whether the online presence of unassisted childbirth discussion constitutes a “movement” as the internet can make even very fringe activities appear more common than they may be. See Freeze (2008) for further discussion about unassisted childbirth as a contemporary movement.

relief. Obstetricians and midwives are concerned with the safety of both patients, mother and child” (2007: 1). While the ACOG and RCOG’s statements are clearly concerned about the safety, or lack thereof, of unassisted birth, the statements are brief. It is the tone of the SOGC’s news release and the intensity of its reaction that is of particular interest here.

The SOGC is clear on its position that choosing unassisted childbirth is dangerous. The news release’s subtitle reads that “a small but troubling” group of childbirth advocates are promoting unattended childbirth as a mainstream option for women seeking natural birth. The SOGC warns, however, that the decision is “fraught with danger and controversy” (2007: 1). The release opens with the grim statistic that over 500,000 women die each year from childbirth, predominantly in under-developed countries but that “medical professionals fear that this number may be on the rise in developed countries like Canada due to a rise in unassisted birth” (Ibid). The SOGC takes a strong stance on unassisted birth, arguing that while they do support “natural childbirth”, which they leave undefined, having a skilled attendant (including homebirths with midwives) can mean “the difference between life and death” (Ibid).

The associate executive vice-president of the SOGC is quoted as saying “Unassisted childbirth is unsafe –period. The people advocating this as a mainstream option for women are tragically uninformed and are promoting high-risk, dangerous behaviour disguised as sound medical advice” (SOGC 2007: 1). Wording his position firmly in the language of risk, Senikas’ argument leaves little room for discussion or understanding of alternative conceptualizations of safety; the point is clear - unassisted childbirth is risky. The piece goes on to argue that:

With up to 15 percent of all births involving potentially fatal complications, the risks of an unattended childbirth outweigh any possible benefits. Skilled attendants have the training required to identify and react to potential problems for the mother and baby as early as possible – both during childbirth and in the critical period that follows. Choosing to give birth without this type of assistance poses a danger to the mother and child and can lead to tragic consequences. (SOGC 2007: 1).

It is very clear that for the SOGC, the risks associated with unassisted childbirth arise from and are located within the birthing body. The biomedical framing of risk in childbirth has been critiqued by scholars such as Lane, who argues that risks in the medical model are thought to be “capricious and unpredictable” (2008: 157) and thus every birthing woman is thought to require surveillance. It is clear from this public statement by the SOGC that the risks in childbirth are conceptualized and framed as occurring within the body in an unpredictable fashion. It is only the skilled and biomedically trained attendants who are able to manage the risks with their surveillance of and actions upon the birthing body. Without this, the dangers and risks of birth appear to be unmanageable.

The SOGC news release, overall, posits that unassisted childbirth is a risky behaviour with dangerous consequences. While this is certainly not surprising, given that obstetricians are highly specialized physicians with expertise in childbirth and training to deal with the complications that may arise during pregnancy and birth; it is not necessarily the overall message of this public statement that is under scrutiny, but rather the motivations and the intensity with which they chose to address this topic, how they frame the risks associated with unassisted childbirth and what pieces are missing from their understanding of the choice to birth alone.

The SOGC makes it very clear that for them, unassisted childbirth presents a risk to the safety of women and infants during the time of birth. Using language such a “high-risk” (2007: 1), “unsafe” (Ibid), “dangerous” (Ibid), and posing “tragic consequences” (Ibid) to describe the decision to birth unassisted and “tragically uninformed” (Ibid) to describe the women choosing this, the SOGC is straightforward in their assertion that unassisted childbirth is unequivocally and universally risky regardless of the health status of the woman and the context in which she is giving birth. It is apparent in this document that risk, like in other medical discourses regarding

childbirth, is framed as being located in the process of childbirth itself as choosing to have no medical attendant can mean: “the difference between life and death” (Ibid).

The SOGC highlights the small percentage of cases where something may possibly go wrong: “with up to 15 percent of all births involving potentially fatal complications...” (2007: 1) While the SOGC highlights the inherent dangers of childbirth, it is possible to look at this statistic and read that in more than 85 percent of births, there are likely to be no fatal complications. Indeed, unassisted childbirth advocates as well as midwives, to a certain extent, typically underscore the fact that upwards of 80 percent of births will go smoothly with no birth attendants or interventions. Clearly, the SOGC is not interested in highlighting the relative safety of birth, nor do they discuss the risks of interventions into childbirth, including a national caesarean section rate of 25 percent many of which lead to additional complications for birthing mothers. As is so common in much medical discourse, for the SOGC, the risks of childbirth are located within the body itself and, although the risks are small, they see the risks as being actively mitigated by the medical management of birth. For the SOGC, a woman either gives birth safely with minimal risks by having birth attendants monitor risks or, she gives birth dangerously alone putting herself and her infant under undue risk. There is no room in such a statement for recognition of the intricacies of decision-making processes, the importance of autonomy for some childbearing women or the fact that many women continue to give birth without assistance based on inequities in access to health care. The SOGC’s argument is thus unidirectional in that its only focus is upon the bodily risks of childbirth and the importance of outside management of these (largely unpredictable) risks.

The SOGC’s statement that up to 15 percent of births involve “potentially fatal complications” (1) is also not backed up by any concrete evidence about where this statistic

comes from. Instead the statement is generalized in their assertion that: “most of these deaths occur in least-developed countries where women have limited or no access to healthcare facilities and resources, medical professionals fear that this number may be on the rise due to a growing interest in unassisted births” (Ibid). Nothing is provided in the SOGC statement about what types of complications may arise; whether the deaths are maternal deaths, infant deaths or both; and how often each fatal complication occurs and how they would be treated or managed by a midwife or physician. Instead of providing evidence of the possible complications of an unassisted birth, only blanket statements about the risks are made, making the argument appear more fear-mongering than legitimate medical advice. Highlighting the risks of complications in births allows the SOGC to exaggerate the dangers associated with unattended births without providing concrete evidence to back this up. As there are no statistics available about the safety or dangers of birthing alone, there is not a lot of data to back up the SOGC’s stance that choosing unassisted birth necessarily means choosing danger.

By failing to cite any of the substantive research or evidence about the complications of medically-supervised childbirth, (see Leveno et al: 2007; Wen et al: 2005; Corroli, Cuesta and Abalos 2008; Minkauskienė et al: 2004 for example), as decades of research has gone into research regarding childbearing, the SOGC instead offers quite vague statements about risks and complications. The assumption here is that the dangers associated with childbearing are part of common knowledge and do not need to be explicitly stated to the reader. Despite quite low infant and maternal mortality rates in Western nations, the idea of childbirth is often associated with high levels of fear, pain, danger and, of course, risk (Rust Smith 2004: 1). It is the cultural entrenchment of the notion of birth as dangerous and risky that the SOGC is relying upon in their argument about the inherent risks of unattended birth.

In addition to the lack of concrete evidence provided by the SOGC, the argument that death in childbirth occurs in least-developed countries and that the risk to increasing mortality rates in Canada is the rise in unassisted childbirth is problematic in itself. The statement that mortality rates are higher in under developed countries may indeed be true but it fails to account for the variations in infant mortality rates (IMR) within Canada by region; as well as the disparities in mortality rates between Aboriginal and non-Aboriginal people in Canada. Discrepancies in health and birth outcomes between Aboriginal and non-Aboriginal people are well documented: “First Nations (Status Indians on-reserve, Status Indians living off-reserve and Inuit IMRs ranged from 1.4 to over 4 times the overall Canadian and/or non-Aboriginal rates” (Smylie et al. 2010: 147). In light of the fact that Canada has rather large variations in mortality rates mostly related to differences in social determinants of health, and that much work needs to be done to improve Aboriginal health and infant mortality rates, the SOGC statement that unassisted childbirth may increase mortality rates seems particularly out of touch. If reducing infant mortality rates in childbirth was the SOGC’s priority, it seems that less attention might be paid to the small section of women who may choose to birth alone and focus more on the social inequalities within the population that have been proven to result in increased risks to health and survival of infants. Presenting unassisted childbirth in the Canadian context as always a choice also masks the inequalities in access to health care that continue to exist within Canada itself and ignores the examples of rural and northern women in Canada who give birth unattended due to geographic distance from health services, limited access to healthcare practitioners and the unpredictability of birth timing (Kornelson and Grzybowski 2006: 263).

The SOGC also does little to address or attempt to understand why anyone would choose unassisted childbirth, aside from stating that it is a “natural birthing alternative” (1) and that the

women choosing it are “tragically uninformed” (Ibid). There is no one reason for choosing unassisted childbirth and there may be multiple, complex and even perfectly valid reasons for making this choice. The assumption of the SOGC is that the women choosing this are uneducated and failing to comprehend how risky childbirth truly is. Unassisted childbirth, however, is not illegal and while the SOGC may argue that it is full of risks, many unassisted birth advocates argue that obstetrician-attended births carry their own set of iatrogenic risks and that birthing alone preserves the safety of both themselves and their babies. The SOGC does not cite specific data about poor outcomes associated with unassisted childbirth, yet proceeds by making sweeping statements and generalizations about unassisted childbirth advocates as misinformed women. Without evidence as to what the dangers of unassisted birth are and data proving that outcomes are worse, the warning call coming from the SOGC appears to be more about panic regarding a handful of unruly childbearing women than about legitimate concern about maternity care in Canada.

What fails to be recognized in the SOGC’s warning call is that unassisted childbirth advocates are not necessarily a handful of rogue ‘uninformed’ women making this choice for no particular reason. Rather, the points that unassisted birth advocates generally make exist within a context of much debate and research into the risks associated with interfering in the birth process along with decades of academic and lay critiques of the interventive nature of medicalized or technocratic birth (Davis Floyd 1992). The unassisted birth point of view that safety in birth may be preserved by avoiding medical intervention exists along a continuum of debates regarding the best and most appropriate way to manage birth. The SOGC’s endorsement of midwife-attended homebirth, while presumably appreciated by Canada’s practising midwives, does not acknowledge that in the not-too-distant past, Canadian physician groups also framed homebirth

with midwives as unequivocally too unsafe (see Bourgeault 2006: 73). Midwifery's emphasis on "natural" birth has had a long history of being discredited by obstetricians, at least until mounting research demonstrated the safety of midwife-attended births, both in hospitals and at home.

The importance of the experience of childbirth is also not acknowledged or recognized in this statement by the SOGC. While the preference for natural birth is named as a desire for women choosing unassisted birth, for the SOGC, the focus is only on the inherent risks of childbirth. The SOGC states that they support "natural birth", however they leave this undefined and do not acknowledge that giving birth without medical intervention can be very difficult under the care of physicians who, many argue, tend to intervene precipitously in order to avoid risks. By focusing only the risks of childbirth complications, they fail to acknowledge the quality of the experience of giving birth, which many unassisted childbirth advocates argue is vastly improved by birthing autonomously and without medical monitoring or interference. However, the SOGC takes for granted that the risks of childbirth complications outweigh the risks of medical intervention and the possibility of a disempowering birth experience. The SOGC also assumes that anyone who conceptualizes risks and the childbirth experience any differently is woefully and perhaps dangerously uninformed.

The SOGC, as the national professional body of obstetrics and gynaecology in Canada, is a powerful organization of professionals in the field of reproductive health. Thus, a statement such as "The Dangers of Unassisted Childbirth" comes from a position of authority, potentially silencing the voices of those with different conceptualizations of risk. The assumption in this article is that only doctors can truly understand and manage the (inherent) risks of childbirth; although they concede that midwives can also play a similar role, as the article even endorses

homebirth with a registered midwife, so long as the birth is attended by some sort of trained professional experienced and knowledgeable about birth. The assumption here is that in order to preserve safety and limit risks, one must look to and rely upon experts as this type of knowledge is superior. The lack of evidence provided by the SOGC as to what the risks of childbirth are and outcomes of attended versus unattended births may also indicate an assumption by the SOGC that the dangers of childbirth are part of taken-for-granted public knowledge and not something that needs to be spelled out for the general public. This, however, fails to account for the ways in which risk may be conceptualized in different ways at an individual level.

Weir argues that discourses of risk act as a form of discipline and governance upon the pregnant body, as the woman is expected to submit to authority (2006: 13). Risk, however, is not an objective reality (Weir 2006: 13). Risks are created by particular ways of understanding a phenomenon. While childbirth may have always been associated with some level of danger, the notion of childbirth as “risky” has not existed across time and space; it is a particular way of understanding a biological function that is unique to a Western biomedical system existing in the late twentieth and early twenty-first century. Cartwright and Thomas argue that it was medicalization that shifted the understanding of childbirth from “dangerous” to “risk” (2001: 218) as risk is thought to be something which can be managed and controlled. Conceptualizing childbirth as risky makes the medical management of birth appear natural, at the same time, the medical management of birth creates more and more risks as scientific knowledge and research continue to develop screening tools and interventions. The SOGC’s argument makes it seem as though the risks of childbirth are biological facts. While childbirth itself may be a biological fact, the risks surrounding it are socially created and contested. Blanket statements about the risks of childbirth serve to limit women’s choices about where and how to give birth.

Research has shown that moving childbirth to medicalized hospital settings did not itself decrease mortality rates (Leavitt 1986: 174). In the 1920s and 1930s, many middle-class American women began to choose hospital births over homebirths, despite the fact that there was no evidence that this improved safety of the birth process (Ibid.) Maternal mortality remained high in the 1930s (Leavitt 1986: 182) even though hospital birth was framed as the safer option. It was the mid-twentieth century when maternal mortality rates finally declined and this coincided not necessarily with the move from home to hospital, but rather with: “increasing hospital regulation of obstetric practices, antibiotics to treat infection, transfusions to replace blood lost by massive hemorrhaging, and prenatal care to identify many potential high-risk cases” (Leavitt 1986:194).

Even with the decline in mortality rates, the process of childbirth continues to be conceptualized as a time of risk despite evidence to the contrary. The medicalization of childbirth has become normalized so much so that childbirth as risky has become the primary way that medicine and childbearing women continue to conceptualize birth (Hausman 2005: 25). This becomes problematic for multiple reasons:

The represented risks of fetal injury or harm...continue to drive the medical management of pregnancy and childbirth as well as to insure women’s complicity with its norms; the risk of doing damage to their babies (as well as fears of giving birth to babies already ‘damaged’) propels many women to demand highly technological and interventionist management of pregnancy and childbirth. Thus, the notion that childbirth is risky overrides the commonsense idea that it is nevertheless normal and thus not, in most circumstances, deserving of intense medical scrutiny. (Hausman 2005: 34)

The SOGC’s warning against unassisted childbirth highlights the risks of birth and effectively warns women that not following the prescribed medical norms can have tragic consequences.

The relatively strong reaction to unassisted childbirth put forth by the SOGC and to a lesser extent, the RCOG and ACOG is particularly surprising in light of the fact that very few women

are likely to choose unassisted birth. The vast majority of Canadian women still choose to give birth in hospitals attended by doctors. A smaller proportion of women choose hospital births with midwives and only a quarter of Canadian midwifery clients choose midwife attended homebirth, despite research pointing to its safety, high consumer satisfaction, as well as endorsement from the SOGC. The percentage of homebirths throughout Canada for 2006-2007 was 1.2 percent of the total births (O'Brien and Young 2009: 107), of which the vast majority are midwife attended. While there are certainly regions of Canada where homebirth rates would be higher and increasing availability of midwives is likely to make this proportion grow, it is nevertheless unlikely that a large proportion of Canadian women are going to choose unassisted birth.

The strong reaction to unassisted childbirth put forth by the SOGC is thus, I argue, less about fears regarding unassisted childbirth increasing Canadian mortality rates and more about ensuring that women follow the prescribed social norms regarding birth: that birth is risky and requires medical management. The lack of evidence provided by the SOGC about the specific risks of unassisted childbirth demonstrates that the idea of birth as a risky process requiring medical intervention is assumed to be, for the most part, common knowledge so does not need to be explicitly stated to the reader. While certainly there are known complications in birth, the issue is that the SOGC is focusing only on these risks and refusing to acknowledge any alternative conceptualizations of risks; namely, that medical interventions may bring about their own sets of risks and that some women will accept small health risks in favour of emotional well-being and the potential for a satisfying and empowering childbirth experience. The argument by the SOGC that “unassisted childbirth is unsafe – period” (1) is uni-dimensional and serves to silence the voices of those who may view childbirth in a different manner. With little discussion about what precisely is unsafe about birthing alone, the SOGC’s argument is firmly

entrenched in the language of risk so common in contemporary discourses around health and risk: any risk at all, no matter how remote, is too much and one must do everything in their power to reduce and manage these risks.

Another article appeared in the Canadian Medical Association Journal (CMAJ) in April 2011 addressing the concerns about unassisted birth becoming a choice for an increasing number of women. The article titled “‘Do it yourself’ births prompt alarm” (Vogel 2011) differs from the SOGC news release in that it appears to be a discussion about unassisted birth, rather than an explicit warning call that the practice is much too risky. Vogel writes that “A growing number of women are choosing to give birth without the assistance of doctors or midwives, provoked by dissatisfaction with modern obstetric care, fear of unnecessary medical intervention and a desire to reclaim birth as a natural, private act” (648). It goes on to say that this practice is a choice that “professionals say is fraught with peril. The fear the fledgling ‘freebirth’ movement may undo the gains in mother-infant mortality” (Ibid).

Unlike the SOGC piece, the CMAJ article explores the reasons why some women may choose unassisted childbirth, including the risk of intervention with attended births and unhappiness with the medical model of care, thereby contextualizing the choice to birth without assistance within the larger debates about autonomy and decision making in regards to childbirth. Vogel highlights that: “The women, however, believe unassisted childbirth is emotionally and physically the *safest* option for themselves and their babies” [emphasis mine] (Vogel 2011: 648). Vogel also points out that many of the women choosing this already have children and may have had a bad experience with physicians or midwives. The article also offers quotes from Laura Shanley who argues that birth is “not an inherently dangerous medical event” and that “(p)eople counting, measuring and managing birth” (quoted in Vogel 2011: 649) results in women’s bodies

shutting down because, similar to sex and other bodily functions, childbirth is meant to happen privately (Ibid). Shanley argues that while there may be some deaths due to unassisted birth, there will also be deaths due to medical interventions into childbirth, thereby framing another competing conceptualization of risk not commonly found among physician organizations. The article also features other women who have chosen unassisted birth, one of who stated that she had to assess what her “personal risks were” (Rundle quoted in Vogel 2011: 649) in making her decision.

The Vogel article also explores the positioning of midwifery, which will be discussed further in the following section, between the rather explicit warnings against unassisted birth from obstetricians and the arguments that advocates of freebirth put forth for birthing alone; namely privacy, safety from medical interventions and reproductive rights in general (649-650). Overall, the Vogel article, unlike the SOGC piece, does make clear that there is more than one way to conceptualize risk and safety in childbirth. Perhaps because this is an article written by a health journalist and not an explicit statement by a professional medical organization, or perhaps because the article appears in a journal read by a more diverse medical audience who may have different ideas on the relative risks related to childbirth, the tone of the piece is quite different from the SOGC’s public statement. While this article does feature the warning issued by the SOGC, generally speaking the article presents the issue of unassisted childbirth in a more balanced manner, showing that while unassisted childbirth may present some risks like those noted by the SOGC, the choice to birth alone is often guided by alternative conceptions of safety and risk.

In the mainstream medical model of care, so dominated now by discourses of risk, the conceptualization of risk is located squarely within the pregnant and birthing body, as there is

little discussion about the iatrogenic risks associated with risk-screening and routine medical interventions during pregnancy and childbirth. It has also been noted that risk in this framework exists predominantly as some possible future harm that can never be truly located. It has been argued that the medical model with its emphasis on risk has medicalized the life processes of pregnancy and childbirth so much so that screening and interventions have become the norm rather than the exception, and some argue that this incites: “varying degrees of anxiety, irritation, humiliation, pain and fear, rather than comfort, confidence and security” (Lane 2008: 160) in the process of childbirth. Lane (2008) points out that: “In many cases, intervention occurs precipitously and defensively ‘just in case something goes wrong’. It is now conventional for medical staff to state that a safe birth can only be judged in retrospect.” (160). The location of risks in the future and judgements of safety only being able to be identified in retrospect is a particularly interesting facet of risk discourse and something that has also been found among contemporary midwives practicing in the present climate of risk. In a risk-based approach to medical care, risk is always present regardless of how healthy or well a labour is progressing. It seems quite possible that unassisted advocates are keenly aware of this and choose to birth without the incessant worrying offered by physicians and midwives.

Discourses of risk serve to discipline and govern bodies in ways not possible prior to extensive medical research into pregnancy and fetal development. The conceptualization of childbirth as a process that is laden with risks makes the medical management of, and routine intervention into, childbirth both normalized and accepted by most childbearing women. For a small proportion of women, however, childbirth is not conceptualized as risky; it is seen as normal, natural and private. For these women, birthing at home without birth attendants is the preferred and acceptable choice. Although it is presumably a very small segment of childbearing

women making this choice, the practice of unassisted childbirth has drawn a significant reaction from Canadian obstetrician and physician organizations as well as physician groups internationally. Framing their arguments in terms of risk, medical professionals such as the SOGC warning against unassisted births are putting forth a particular argument about what they see as the biological risks of birth. However, what is not recognized in these commentaries is that risk as a concept itself is historically and socially shaped. Prior to the development of scientific and biomedical research into reproduction, childbirth was not conceptualized as risky in a way that can be managed, it was thought to be something largely uncontrollable.

The kind of risk discourse which appears in the SOGC piece appears to be less about presenting facts and evidence about specific risks in childbearing and more about worrying about the possibility of risk. The argument put forth is that the myriad risks of childbirth can only be managed by a physician or other accredited health professional. The SOGC's warning about unassisted childbirth also does not take into consideration that there are different ways to conceptualize risk, namely that risks can also arise due to medicalization and intervention in childbirth. Because unassisted childbirth constitutes a very small proportion of the total births in Canada, the vast amount of attention it has received seems disproportionate to the issue. Although the SOGC frames its arguments about unassisted birth in terms of biological risks such as concerns about increasing mortality rates, I argue that these warnings are more about the social norms regarding birth. In places such as Canada, with well-developed biomedical systems, the social expectation regarding childbirth is that it takes place in the hospital under the careful supervision of doctors. When women choose to ignore this social convention and give birth autonomously, it incites public reaction in the form of media reports and dire warnings from doctors.

AN ALTERNATIVE TO RISK? THE MIDWIFERY MODELS OF CARE

The availability of midwifery care in nations with highly developed medical systems has, in some instances, offered an available counter-model to the biomedical and risk-based approach to maternity care. As was demonstrated in Chapter Two, midwifery models of care vary a great deal in a variety of respects; including midwifery training and education, incorporation within existing medical systems, funding and regulation, and philosophical approach to pregnancy and childbirth. In many models of midwifery care, however, midwives will highlight the processes of pregnancy and childbirth as “normal” and a healthy part of women’s overall reproductive health. Thus, for many women the option of midwifery care provides a woman-centred model of care which offers maternity care and birth assistance in a model outside of the medicalized approach to reproduction often offered by physicians.

This section will review the position of midwifery within a context of mainstream maternity care increasingly viewing pregnancy and childbirth as a time of risk. When an individual chooses unassisted childbirth, not only are they rejecting medical doctors’ assistance during birth, but where midwives are available, they may also be rejecting the care of midwives during a homebirth. For this reason, I have chosen to include the position of midwives in the discussion about risk in childbirth and the choice to birth unassisted. I will look at some of the perspectives by midwives on the topic of unassisted childbirth and analyze how the choice to forgo medical and midwifery care is framed by midwives practicing in different regions and models of midwifery care. Responses by midwives by outside of Canada were included to show the diversity of midwives’ responses in various health care systems and are not intended to be generalized to the Canadian context. Key themes to be explored in this section are: How do

midwives construct discourses of risk in childbirth in their responses to unassisted birth? How do midwives resist risk discourses in thinking through unassisted childbirth?

Based on the differences in training and methods of practice by midwives throughout the world, the intention here is not to make generalizations about what the profession of midwifery thinks of unassisted childbirth, but rather to examine how risk and the choice to birth unassisted is framed by those midwives who have chosen to put out public statements about unassisted birth. Recent research into midwifery and the notion of risk has pointed out that in the context of regulated midwifery, midwives have to contend with risk discourses in multiple and sometimes contradictory ways, and for this reason I have also chosen to include research documenting midwives' engagement with discourses of risk.

Discussions of Unassisted Childbirth among Midwives

Given the diversity of midwifery models, it is unlikely that there will be a uniform statement from midwives about the practice of unassisted childbirth. What is available instead reflects diverse responses, some of which argue that unassisted childbirth is a risky choice and others which are more sympathetic to the desire for unassisted birth. On the one hand, most midwifery models of care clearly espouse autonomy and decision-making, choice of birth place, and value women's bodies as capable of giving birth without complications, all of which are also highly esteemed by women choosing unassisted childbirth. On the other hand, for many midwives, their training involves "doing birth according to medical standards" (midwife quoted in Davis and Davis-Floyd 1996: 239) and developing familiarity with biomedical technologies (248), especially when training occurs in a formal setting. Even though the likelihood of severe complications during childbirth is small, based on the number of births a midwife attends during her career, it is likely that midwives will have seen some complications during birth. Midwives

are also trained to notice complications so although they may support natural birth, part of their skill set is to assess and intervene when necessary in order to protect the health of the mother and her foetus. The differing responses to unassisted birth is thus not surprising, based not only on individual midwives' personal beliefs but on the many types of midwifery training, regulations and modes of practising.

It is not feasible to generalize about how all midwives view the topic of unassisted childbirth, largely because midwives have been fairly quiet on the issue – generally not releasing uniform statements in the same manner as the SOGC. It is possible that midwives may be waiting out the debates with some degree of angst, as the push towards rejecting any medical care during childbirth could certainly affect midwives clientele. With this being said, not all midwives have ignored the discussions around unassisted birth. A series of articles in midwifery journals appeared throughout the 1990s and 2000s. These articles and editorials discuss the issue of unassisted childbirth quite thoughtfully and offer a variety of reflections and points of view of individual midwives. Some midwife groups have also spoken more publicly about unassisted birth and have been featured in media coverage of the issues.

As Sara Wickham points out, there appear to be two main perspectives by midwives on the subject of unassisted childbirth (2008: 4). The first standpoint by midwives argues that “women have always sought out midwives, and that midwives play an important part in keeping birth safe” (Ibid). These midwives tend to caution women about the dangers associated with unassisted childbirth and often utilize the language of risk in a similar manner to that found in physician groups' discourses around unassisted birth. The second midwifery perspective tends to look critically at midwives' engagement with the medicalization of childbirth and these midwives tend to argue that, by taking on certain elements of medicalized birth, midwives may

be playing as much of a role as doctors in pushing women towards choosing unassisted childbirth.

Ina May Gaskin, an American midwife who has been widely celebrated for her promotion of natural birth and midwifery weighed in on the subject of unassisted childbirth in an article in *Midwifery Today*. Clearly concerned with the safety of unassisted childbirth, Gaskin tells a story of a woman who planned to birth alone, yet had complications and delivered a dangerously ill baby whose life had been saved by the grandmother's insistence on seeking out midwives' and then doctors' help (2003a: 39). Although the article does begin with this rather chilling story about the potential dangers of unassisted childbirth, Gaskin does continue on with a more thoughtful analysis of the issue.

Gaskin writes that knowing about a planned unassisted birth may put a midwife in an awkward position, especially if she is called upon if something goes wrong. Gaskin also challenges unassisted childbirth advocate Laura Shanley's assertions that women are in touch with their bodies enough to give birth without any outside instruction or help, arguing that sometimes women are not experienced enough to distinguish "true intuition from wishful thinking or outright delusion" (2003a: 40). It is interesting that Gaskin questions the validity of women's own intuition about birth, as valuing intuition as a form of authoritative knowledge has been found among homebirth midwives in the U.S. (Davis and Davis-Floyd 1996: 260). However, Gaskin is not necessarily arguing that intuition should not be trusted, but rather that midwives may be able to provide a certain objectivity about the birth that the birthing woman herself may not possess (39, 40). Gaskin clearly recognizes the importance of birth options outside of medical management (38) but, unlike some unassisted childbirth advocates, she does not agree that medical management and midwife attendance offer similar types of care; instead

she highlights that midwives offer women the opportunity to give birth outside of the medical model of care (39-40).

Gaskin's primary concern with unassisted childbirth is that advocates of the practice are not telling women the truth about the complications that may possibly arise from birthing alone.

She writes:

It is a fact that approximately 10-15 percent of all births will require skilled assistance to reach a healthy outcome for mother and baby...unexpected situations may arise during labor or birth. Women need to be aware that these are real complications with real causes for concern...A woman who has never given birth before, or who has had only one or two births, is unlikely to have developed the required level of risk assessment skills. (2003a: 40)

For Gaskin, complications in childbirth are just part of birth itself (Ibid) although they by no means occur during every birth. Gaskin warns women to think critically about the kind of advice unassisted childbirth advocates are giving, and argues that framing unassisted childbirth as positive and empowering fails to give women the full truth about the issue.

Although Gaskin was initially a self-trained "lay" midwife, she is registered as a CPM and her success and recognition at the Farm midwifery service has earned her an honorary degree and much public recognition (InaMay.com 2012: "Biography."). The Farm, a midwifery service in Tennessee that offers homebirth on site, has been recognized as having comparable outcomes as hospital births, with significantly fewer interventions (Durand 1992: 451). It is clear that Gaskin's approach to childbirth values women's abilities and prefers low-intervention births. However, it is apparent from this article on unassisted childbirth that Gaskin feels midwife attendance at a birth may be the key to safe outcomes, not necessarily a belief that the birth process itself is inherently safe. Invoking a clinical argument about a birth gone wrong, Gaskin effectively warns readers about the possibility of complications in birth which arise from within the body itself. Highlighting the importance of midwives' "risk assessment skills" suggests that

for Gaskin, risk is thought to be always present in birth and that midwives are going to have the appropriate skills to be able to react.

Unlike the reactions to unassisted birth that were found from physicians, Gaskin does not state that unassisted childbirth is unequivocally dangerous. Rather, in this article, Gaskin is cautioning against taking what unassisted advocates, such as Laura Shanley say without thinking critically: “What bothers me most about the avid promotion of unassisted childbirth is that these advocates generally neglect to concede that following their advice could possibly bring harm to anyone” (40). Gaskin wonders if Shanley’s website, which shares many birth stories of both planned and unplanned unassisted births would share an unassisted birth story that had gone wrong, or if this would be excluded in light of their advocacy about unassisted birth being safer than attended birth. Gaskin writes that she enjoys reading unassisted birth stories and that these stories may be helpful in providing insights for women planning for childbirth writing that: “It is important to believe in your body’s ability to give birth. I couldn’t agree more” [original emphasis] (40). Rather than condemning the women who choose unassisted childbirth as ill-informed or uneducated about birth, Gaskin argues that individuals need to think critically about the possibility that unassisted childbirth advocates, especially Shanley, may not be providing women with the entire truth about the decision to birth alone.

While Gaskin questions the legitimacy of the claims that unassisted childbirth advocates make, a more explicit warning call about unassisted birth was put out by the Royal College of Midwives (RCM). The RCM is explicit about their stance on unassisted childbirth, falling into the first category of midwives who are doubtful about the safety of unassisted birth. A 2007 news report makes the RCM’s opinion on unassisted childbirth well-known: “the Royal College of Midwives (RCM) cautions that women who choose freebirth may put their health and that of

their babies at risk should any problems occur during the pregnancy or birth” (Lynch 2007: 22). Invoking a similar language of risk to that used by the SOGC in their warning against unassisted birth, the RCM also positions risk as occurring within the pregnancy and birth.

An article appearing the following year titled “Home Alone – a concerning trend” also put out by the RCM takes a quite paternalistic and accusatory tone towards women choosing unassisted birth:

We wish to highlight freebirthing without a midwife in attendance as potentially dangerous for women and their babies. The overwhelming feeling some women have to experience physiological birth alone (regardless of their obstetric history) is likely to be driven by emotional needs. This conflicts with any concern for their physical wellbeing or those of their unborn baby. It is doubtful that the impact of a poor birth outcome on themselves or consequently their families is well thought-through. (Cooper and Clarke 2008: 34)

What appears here is a number of assumptions about the women who choose unassisted childbirth. The RCM takes for granted that women choose unassisted childbirth based primarily on emotional needs and that little attention is paid to physical safety and wellbeing. However, as will become apparent in the following section on unassisted childbirth, many advocates of freebirthing argue that birthing alone is in fact safer, not only emotionally, but also physically in light of there being absolutely no interventions or screening for risk in the birth process. The RCM also speculates that the possibility of poor birth outcomes is not “well thought-through” by women birthing alone, presuming that research into birth complications and the possibility of poor outcomes is not adequately considered by women choosing or advocating for unassisted birth.

The first perspective by midwives, articulated by Ina May Gaskin and the RCM cautions that unassisted childbirth is an unwise decision based on the possibility of dangerous complications. In a similar fashion to the medical approach to risk, these midwifery discourses point to an understanding of risk as located within the body at the time of birth. Although

discourses about the risks of medical interventions are common in midwifery models as a whole, in warning about the dangers of unassisted childbirth, these midwives are constructing risk as an inherent part of birth itself. Although both Gaskin and the RCM offer warnings about the potential risks of unassisted birth, their approach does differ in that Gaskin's article critiques the advocates of freebirthing more than the practice itself. She is careful to avoid assumptions about why women may choose it, instead she cautions readers to wonder if promoters of unassisted birth are providing the whole story, including the possibility of bad outcomes. Although these arguments do approach the topic similarly, the subtle differences may be explained by different approaches to childbirth that these midwives have. Unlike the RCM which operates within the context of a professionalized and regulated midwifery, Gaskin is originally a lay midwife and has become quite famous for advocacy around the de-medicalization of childbirth in the United States, increasing the accessibility of homebirth for American women and promoting the idea that women's bodies are capable of giving of birth (for example see Gaskin 2003b). It is possible that Gaskin's slightly more sympathetic stance comes from her strong commitment to increasing women's options and autonomy in maternity care and childbirth.

The second perspective that midwives have taken up in discussions about unassisted childbirth emerged in discussions and editorial pieces in the journal *Midwifery Today* occurring in the 1990s and early 2000s. These midwives appear to look critically at midwifery practice and argue that perhaps it is the way that midwives practice that is driving women towards choosing unassisted birth. Certified Professional Midwife Gail Hart wrote in a 2003 issue of *Midwifery Today*:

This whole movement toward unassisted birth should *shake us midwives up!* I hate to say this because I am a midwife, but we have done as much as docs and hospitals to scare women about birth and to frighten them out of trusting their bodies. We almost routinely intervene and interfere with pregnancy and birth. [Original emphasis] (Hart 2003: 4)

In these types of discussions, it is apparent that the midwives are questioning not the riskiness of birth itself, but rather the ways that both doctors and midwives intervene in the process of birth, which brings its own set of risks. These midwives tend to draw comparisons between midwifery care and the medical or obstetric model, pointing out that perhaps the similarities are what are driving some women away from having any birth attendants. Midwife and founder of *Midwifery Today* Jan Tritten asks: “Has our foundation in obstetrics led us away from our ability to see the bigger picture? Midwifery education-even direct entry-is founded on obstetrics. We need to change that foundation to change birth” (Tritten 2002: 2). Tritten wonders if perhaps midwives have let women down and this is why there is a movement away from midwifery care towards unassisted childbirth (Ibid). Tritten suggests that midwifery should work to develop its knowledge base separate from obstetrical knowledge and focus on working with women rather than managing birth (Ibid).

Although she is not speaking directly about unassisted childbirth, midwife Jilly Rossner, in an issue of the UK journal *The Practicing Midwife*, suggests that both midwives and obstetricians are too ready to believe that women’s bodies are flawed so much that interventions are needed in almost every birth. She argues that “We aim, as midwives, to be experts in normal birth. Currently much of what we do works against the natural physiology, and women have a normal birth despite, rather than because of, our care” (1998: 5). Hart also questions if midwives are really supporting normal birth and wonders if the way that birth is managed is pushing more women into having unassisted births:

I think we midwives have to examine our roles in this process. Are we so untrusting of birth that we must carry and recommend a bagful of herbs and medications, put our clients on special diets, dictate foods, herbs and supplements, tell them how and when they must labor, frighten them with a long list of rules, regulations and “protocols” and force them to fit our schedules? Do we horrify them with our talk of risks, consequences, worries and fears? Do we reassure them with our tests or do we frighten them? (1998: 4)

It is apparent that Hart is sympathetic to the choice to birth unassisted in light of the ways that midwives manage birth. She writes: “The unassisted birth movement is gaining ground. Women want something from birth that they are not often getting from ‘professional caretakers’. Let’s listen to them” (4). Hart argues that midwives may have something to learn from women choosing unassisted childbirth and that perhaps the movement away from midwives towards birthing alone indicates that midwives may have some changes to make in the way they practice attending births. She is clearly critical of the risk-based approach to childbirth, recognizing that speaking of risks can lend the way to a fear of childbirth.

Chair of the Association for the Improvements in the Maternity Services (AIMS), Beverly Lawrence Beech, also writing in *The Practising Midwife* suggests that perhaps if midwives were more willing to be hands-off during birth, more women would choose *unassisted* but not *unattended* birth (2008: 20). Although Beech is not a midwife, she is an advocate for improving midwifery and homebirth in the UK. The argument she presents speaks to the issue of control that is at the heart of the unassisted childbirth debate. It is clear that, at least for some women, the desire is for birth to occur autonomously and this is certainly possible even with an attending midwife.

These types of arguments, about the possibility of midwifery’s management of birth leading to more women choosing unassisted birth, appear in midwifery journals by individual midwives, not as public statements by certain midwifery groups. They are thus more likely to be put forward as discussion for midwives; as food for thought for professionals in the field, perhaps leading to more critical discussions about midwives’ role in supporting women through the process of childbirth. It would be unlikely that these types of arguments would appear as public stances by midwifery groups, as certainly this could affect the credibility of midwives’ in

the eyes of the medical profession. These midwives' points of view do not position childbirth as something which is inherently full of risk, but rather critically reflect upon the ways in which medicine and midwifery's focus on risk may lead to a rejection of any kind of assistance during childbirth.

Canadian midwifery groups have yet to take a firm stance on the issue of unassisted childbirth; although Anne Wilson, president of the Canadian Association of Midwives did make a statement in the CMA's journal article. Wilson does not say that the CAM is against unassisted birth, because they do not wish to alienate women who are cautious of intervention. She says: "If someone came to us who was considering an unassisted birth we would want to keep that person engaged, build a relationship of trust and if they ended up going ahead with it, at least you're someone they can call if they get half way through a delivery and change their mind" (quoted in Vogel 2011: 650). Wilson says that there is no way of offering statistics about the safety of unassisted birth because there are no such statistics available. For Wilson, the debate is about "autonomy versus beneficence" and because midwives provide care for women who do not wish to have interventions, they may wish to offer support for those choosing unassisted childbirth. This rather cautious approach taken by the CAM allows these midwives to neither alienate women choosing unassisted birth, nor take too radical a stance on birth so as to risk credibility with medical organizations such as the SOGC.

It is clear that there is no one midwifery view on the subject of unassisted childbirth. Instead, the published comments by midwives on the subject of unassisted childbirth exist along a continuum. On the one side is a cautioning against unassisted birth, and here, in a similar manner to the medical responses, midwives highlight the risks associated with childbirth, especially childbirth without a trained professional. Using language about safety, danger and

risk, these midwives argue that childbirth is best done with someone trained to recognize the many complications that can arise. In these kinds of statements, it is clear that many midwives have training in the biomedical approach to risk and recognize that part of the role of an attending midwife is to monitor risk and intervene upon the birth process in order to assure the safety of the mother and infant.

On the other end of the continuum is a different type of midwifery discourse; one that posits that perhaps the increasing trend towards unassisted childbirth is a sign that midwifery is not adequately meeting the needs of women who wish to give birth without any unnecessary screenings or interventions. This approach is more critical of the ways in which childbirth is framed in terms of risks, especially the biomedical approach to risk. These midwives recognize the desire that some women have to birth their children with someone who is truly “hands off” and wonder if midwives’ reluctance to support these wishes is in fact spurring a movement away from midwife-attended birth towards choosing unassisted birth. These midwives appear to want to engage women who choose unassisted birth, possibly to develop a relationship of trust and perhaps to help them understand what midwives are doing that may lead women away from choosing to have midwives attend their births to choosing to birth unassisted instead.

There are also midwives, such as the Canadian Association of Midwives and the American College of Nurse-Midwives, who neither associate themselves with the biomedical framing of risk, nor question midwifery’s ability to support women by being hands off. The Canadian Association of Midwives, presumably in the interests of offending no one involved and perhaps because they are sympathetic to the desire for autonomous birth, carefully state that there are no statistics about the practice of unassisted birth and thus do not present a strong opinion either way. Instead the CAM carefully states that they would want to engage with a

woman choosing unassisted birth. While this statement comes off as neutral, we can also read into this a quite different approach that that put forth in the biomedical framing of unassisted birth. In the medical framing of risk and unassisted birth, such as that put out by the SOGC, there is no acknowledgement of the fact that no research on the outcomes of unassisted birth exists. Instead it is assumed, and argued quite vehemently, that unassisted birth is inherently full of risk and that birth attendants are necessary to mitigate these risks. The CAM does not make this same assumption, instead highlighting the lack of evidence either way about the choice and saying nothing about the “risks” of choosing unassisted birth. By making a vague statement about the topic and taking no firm stance for or against unassisted birth, the CAM successfully avoids alienating everybody involved.

Rothman, a spokesperson for the American College of Nurse-Midwives commented on unassisted childbirth in a *Washington Post* article on the topic of “do-it-yourself” delivery. Rothman states that “expert guidance for women in labor is crucial -- and is best provided by a trained professional, not a self-educated layperson” (as quoted in Boodman 2007: 1). While Rothman acknowledges that the likelihood of an uncomplicated unassisted birth is high, nevertheless, she argues that “a woman having a baby is not in a position to be monitoring herself.” (2). While Rothman certainly cautions women about unassisted childbirth, she does not frame her stance in terms of severe risks but rather points out the benefits of midwife-attendance at a birth and how the monitoring midwives perform may improve outcomes for birthing women. Equally importantly, Rothman also acknowledges the possibility that arguments in support of unassisted birth represent some problems with the state of maternity care. She states: “To me the really interesting question is, Why would someone go outside the system?...What is so broken that they don't want to use it?” (3). Here, it is apparent that Rothman refrains from making

judgements about why unassisted childbirth advocates choose to birth this way and instead considers that it may be choice made within the context of a maternity care system that is not adequately meeting the needs of all childbearing women. While this midwife certainly encourages women to seek out midwives to attend their births, she also acknowledges the possibility that the choice to birth unassisted may be made for particular reasons, not necessarily from a place of ignorance.

Midwifery's Engagement with Risk

The hegemonic nature of contemporary discourses of risk and childbirth has meant that, although many midwifery models try to emphasize and preserve the normality of childbirth, the language of risk often infiltrates pregnancy and childbirth management so that it may become difficult for midwives to operate outside of the rhetoric of risk. Sometimes the language of risk set outs who can be eligible for midwifery care. For example, Ontario midwives define their role in the following way: “In Ontario, a midwife is a registered health care professional who provides primary care to *low-risk* women throughout pregnancy, labour and birth” [emphasis mine] (Ontario Midwives 2012: “Midwifery Q & A.”). As we see here, risk-assessment as a facet of contemporary maternity care routinely divides women into two groups, those who are “low-risk” and those who are “high-risk”. Ontario midwives, with their emphasis on normal birth are only permitted to manage the care of women deemed to be “low-risk”. High-risk women will be exempt from midwifery care, instead needing obstetrical care. Risk screening continues throughout pregnancy so that if a midwifery client initially deemed “low-risk” becomes “high-risk”, care will be transferred from the midwife to an obstetrician.

Some research has pointed to the complexity of how midwives navigate biomedical notions of pregnancy and childbirth as a time of “risk”. For example, in her research on risk and

pregnancy, Weir looks at how midwives in Ontario contend with risk-based perinatal care in the period following regulation and integration into the provincial health care system. Weir notes that:

In discussions and debates about risk-based prenatal care and childbirth, Ontario midwives have consistently allied with research-based guidelines and critiques, many associated with evidence-based medicine. Midwives have not been anti-medicine, but rather have selectively accepted research-based medical knowledge to limit risk-based care.” (Weir 2006: 81)

In Ontario, prior to midwifery’s re-emergence as an option for pregnant women, the province introduced the Ontario Antenatal Record – a “standardized prenatal risk assessment device” (Weir 2006: 76). Weir argues that this record, introduced in 1980 had the primary purpose of reducing fetal (not maternal) mortality at the population level (Ibid). In 1994, post-midwifery’s emergence as a health profession, it became policy for all midwives to fill out the Antenatal Record for each client having a planned hospital birth. Weir argues that as a result: “Hospital protocols ushered midwives into a pre-existing system of risk-based prenatal care standardization in part through the Antenatal Record.” (84). She argues that use of the Antenatal Record meant that a pre-existing governmental technique had to be taken up by midwives despite Ontario midwives’ desire to operate outside of risk based medicine. Thus:

The hospital requirement to submit a completed Antenatal Record for in-hospital births places midwives in the position of transmitting risk management into clinical practice. Although judgements of risk and judgements of the normal and pathological are...analytically distinct, in clinical practice both physicians and patients interpret risk as a sign of being between a state of health and illness, neither sick nor healthy. However, the ethos of midwifery takes a strong stand on pregnancy as a state of health. The stipulation to complete the Antenatal Record implicated midwives in risk-based prenatal care, a practice at variance with midwifery’s stated ethos.” (2006: 85)

Through interviews with Ontario midwives, Weir explores how midwives maintained their philosophy of care while also operating within the Ontario guidelines that typically

emphasize and categorize risk. The participants that Weir interviewed: “thought that risk-based prenatal care undermined the understanding of pregnancy as a state of health. For midwives, pregnancy care was governed by objectives broader than lowering the perinatal mortality and morbidity rate” (88). Many midwives thus resisted the risk-based tool of the Antenatal Record, by either ignoring the section on risk (89) or filling it out in ways that reflected what the midwives thought should appear on the record, rather than by its standards (Ibid). Many of the midwives objected to noting risk-factors on the record, preferring instead to note “indications” (105) or “stories” (91). Some midwives argued that the language of risk often oriented care to worst-case scenarios and interventions (92) and thus they made notes on the woman’s health in a broader manner, including physical and emotional health/wellbeing. The midwives’ reasons for objecting to clinical risk assessment were not because they thought that pregnancy never needs intervention, but rather they resisted the language of risk in order to emphasize the health and normality of pregnancy and birth while also avoiding the unnecessary interventions thought to be associated with risk screening (92).

Other research on midwives’ engagement with biomedical notions of risk includes Scamell and Alaszewski’s (2012) research based out of the UK. These researchers argue that, although midwives focus on pregnancy and childbirth as normal, the monitoring that midwives conduct during pregnancy and childbirth result in an “ever closing window of normality” (219). The context in which this research took place was an English midwifery model wherein much emphasis was placed on the concept of “normal” in childbirth; and midwives attended both home and hospital births (209). Scamell and Alaszewski sought to explore why midwives: “who are committed in principle to normal childbirth are unable to articulate and define normality. Instead,

they often highlight the dangers of birth, creating the medicalisation of birth by categorizing an increasing proportion of births as high-risk” (210).

Through interviews with midwives, Scamell and Alaszewski find that the midwives often focus on the possibility of bad events during a birth, however remote the possibility. For these midwives, there is heightened awareness of the fact that blame is allocated to midwives if something goes wrong during a birth. Midwives are not celebrated if birth is normal and uneventful, but they will be blamed if complications arise that were not identified (2012: 211-212). For this reason, risk appeared to be at the forefront of the midwives’ minds during a client’s labour and birth. Scamell and Alaszewski write:

From this perspective, all births were potentially hazardous, and normality could only be recognized in hindsight, after a woman had given birth to her baby and was no longer in the crisis of labour. Interviews with midwives, including those who were senior and experienced, indicated that during childbirth imagined risk was ever-present in a future inhabited by potential adverse events...Midwifery practice coalesced around an apparently irresistible desire to anticipate and avoid even the smallest possibility of adverse outcomes, even when this might involve abandoning any commitment to the notion of normality. (213)

Thus, while the midwives resisted the medicalization of childbirth by emphasizing the normality of birth and trying to keep interventions to a minimum, the midwives in this study were also implicated in risk-based maternity care, in that the uncertainty of risk was an ever-present feature of the care of labouring women.

Scamell and Alaszewski posit that because the: “probability of actual harm to the mother or the baby (such as massive haemorrhage or significant birth asphyxia) during the process of spontaneous birth is small, midwives should be able to treat mothers as being capable of birthing their offspring without undue concern for risk” (2012: 209). However, typically a series of assessments are made upon the mother from the beginning of labour through to the completion of the birth; such as monitoring fetal heart tones, measuring the mother’s blood pressure, and

checking cervical dilation to in order to chart the progress of labour on to a prescribed curve. As these authors point out, these checks, intended to preserve the health and normality of a birth, actually introduce the possibility of abnormality or risk into the birth process itself (217). It was found that normality could not even be defined by midwives (215); normality could only be defined against the dominant discourse of risk (216) and thus became the absence of abnormality or risk. They argue that: “As normality lacks any language of its own through which midwives can defend its boundaries, it is easily subsumed by the linguistically and culturally more secure notion of risk” (219). For Scamell and Alaszewski, the midwives in this research contribute to the medicalization of childbirth through their engagement with the dominant biomedical discourse of risk.

Some midwives come forward with their engagement in risk discourse and critically assess the extent to which midwives should participate in the culture of risk surrounding childbirth. For example, Certified Nurse-Midwife Patricia Atkins Murphy asks: “What are the ethics of assessing all women to identify hypothetical risk factors (that may not predict disease with accuracy) in order to prescribe interventions (which may be of dubious value and possible harm) in the hopes of preventing an outcome (that will never happen to most of those subjected to this process?” (1994: 68). She cautions that the enthusiasm for preventing bad outcomes may inadvertently create blame and unnecessary interventions for mothers (69). Clearly, midwives are interested in preserving the health and wellbeing of mothers and babies; however, when it comes to preventative care, there appears to be some critical engagement regarding the effectiveness of a risk-based approach to medical care. The difficulties that arise for midwives may occur more for midwives working within the dominant medical approach to pregnancy and childbirth. Although midwives may be able to offer somewhat of an alternative to medically

managed birth, it is possible that midwives who work within a medical system are increasingly constrained by the norms around risk.

What becomes clear in examining how midwives interact with, espouse or resist risk discourses in relation to childbirth is that the engagement that midwives have with hegemonic risk discourses is complex. Neither fully able to reject risk-based medicine because of its dominance, nor wanting to fully espouse risk as a legitimate way to conduct maternity care because of its association with increased intervention rates and the negative connotations that come along with framing normal bodily processes in terms of multiple and frightening risks, it appears as though at least some midwives approach risk critically. Contrary to the medical model, the midwifery models of care often highlight pregnancy as a state of health and childbirth as a normal bodily process. Thus many midwives appear to try to operate outside of the rhetoric around risk. However, the dominance of the medical model with its increasing focus on risk may make it difficult for midwives to conduct their practice and speak with women entirely outside of the language of risk. It is thus not surprising that in commenting on the subject of unassisted birth, there are differing ways of framing the choice. While some midwives immediately utilize the terminology of “risk” in relation to the birth process and thus caution individuals not to give birth alone; other midwives critically reflect upon the medical and midwifery management of childbirth which may lead some women to choose to birth autonomously.

UNASSISTED CHILDBIRTH: A RISKY CHOICE?

There is certainly no one reason that a woman would choose unassisted childbirth, nor is there one type of individual who would choose it. Some have argued that the increasing amounts of women choosing unassisted childbirth is due to a profound dissatisfaction with available maternity care. Australian researchers Dahlen, Jackson and Stevens (2010) argue that:

As intervention rates rise in our country and more and more restrictions are placed around birth due to arguments about safety (often focused on medico legal concerns, rather than women's comprehensive health and safety) some women choose to flee the limited options of mainstream maternity care. (48)

They argue that freebirthing is more common in Australia and the United States, countries which have, "the highest intervention rates in birth and limited access to midwifery care" (49).

Certainly the medicalization of birth and the rampant use of interventions in labour and birth are a large part of the reason many women choose unassisted childbirth. While a lack of publicly funded and available midwifery care may certainly play a role in the supposed push towards choosing unassisted childbirth, lack of midwifery services fails to explain why some women in regions with access to publicly funded midwifery care still choose unassisted homebirth.

This section will explore some of the reasons women may choose unassisted birth, paying particular attention to the ways in which arguments are framed in terms of safety and risk. Research into the choice to birth unassisted finds that "for all women choosing UC, birthing without a midwife or a doctor is a choice they interpret to be the most natural, wisest, safest, and most empowering option they can envision" (Miller 2009: 63). Griesemer (1998) states that, "Birth is a simple process, but because of our fears, we do not accept the fact that birth is uncomplicated and safe" (87). Often, for women who choose unassisted childbirth, both medical management and midwifery attendance during birth constitute a level of intervention deemed to be either unnecessary or unsafe for themselves and their babies. For many proponents of unassisted childbirth, the issue of safety and risk is not something that is ignored or taken lightly; rather the conceptualizations of what constitutes risks in childbirth appear quite different than those found in the medical model. Key themes to be explored in this section are: How do unassisted birth proponents frame the issue of risk in their discussions of unassisted birth and

how is this different from the biomedical framing of risk? What kinds of risks are emphasized by the unassisted birth community and what kinds of risks are minimized?

Medicine as Risk

Like most mothers, for many women choosing unassisted childbirth, the health and safety of themselves and their babies are a high priority. However, as becomes apparent in much unassisted birth discourse, there is often a profoundly different conceptualization of what constitutes a risk to health and safety among those advocating for unassisted birth. Instead of highlighting the dangers and risks associated with childbirth itself, women who choose to birth unassisted highlight the risks of medical interventions into childbirth and thus conceptualize the avoidance of doctors as the safer option for themselves and their babies.

Laura Shanley, an American woman who is probably the most well-known advocate for unassisted childbirth, writes in her book: “Perhaps the greatest gift the modern-day physician can offer a woman is that of his absence at the time of birth” (1994:36). Shanley challenges the notion of childbirth as dangerous although she recognizes that fear of birth is a very real reason why women choose to give birth in hospitals. For Shanley, however, “women rarely bleed to death or come down with diseases until after they began submitting themselves to intervention” (11). For Shanley and many other women, unassisted childbirth is understood as a choice that entails fewer risks than hospital births attended by doctors and physicians.⁵

Lynn Griesemer, who has also written a book about unassisted homebirth and is based in the United States, argues that: “When birth is treated as a science and not an art or an act of love,

⁵ Shanley’s arguments about natural birth often utilize assumptions about Western vs. non-Western birthing practices. She writes; “The tribal woman, in a sense, has a consciousness that lies between that of the animal and that of the modern Western woman. Her births are successful for several reasons. She has not yet developed beliefs in fear, shame and guilt, and therefore is free from their devastating consequences” (9). This non-Western “other” is brought up repeatedly throughout the book and while I certainly recognize the problematic nature of her arguments, a thorough analysis of Shanley’s work is currently beyond the scope of this paper.

many deviations take place, most of them not in the patient's best interest, but to the benefit of those administering the science" (1998: 40). Invoking similar arguments as Shanley, Griesemer feels that safety in childbirth is preserved when the birth takes place in the home, unassisted by any professionals. She writes: "Going to the hospital ignorant is much more unsafe and irresponsible than being fully prepared for a birth at home" (91). She argues that women often choose to birth unassisted not in spite of, but *because* they are labeled "high risk" by medical professionals (61). Birthing unassisted at home in high-risk cases, such as twins or breech babies, allows a woman to give birth completely outside of any monitoring or interventions which are too common in typical hospital births, especially in cases labelled as "high-risk". For Griesemer, childbirth is inherently safe; it is the treatment of birth by medical professionals which poses the risks. She specifically argues that drugs used during birth are risky to the health of both the mother and the newborn. Women, she argues, are misinformed about the risks of drug use in labour so they put their own comfort above the safety of their babies (76).

Hygeia Halfmoon, author of *Primal Mothering in a Modern World*, writes of her own birth experiences which paved the way towards choosing unassisted birth. She writes that failing to follow her intuition about birth and instead going to a hospital resulted in an intervention-filled birth: "I did not heed my inner call and I have a C-section scar to prove it. I'm not the only one wearing this badge of discouragement, verification of a botched birth" (45). Halfmoon goes on to describe her first birth experience in an American hospital as being "medically raped" (50).⁶ Although this is not representative of all unassisted childbirth supporters, more extreme unassisted childbirth advocates do sometimes frame interventions as always unnecessary. For Halfmoon, all that is required for a safe birth is that, "[We] need to know ourselves well enough

⁶ For more discussion about the term "medical rape" or "birthrape" to describe medical interventions into birth, see Freeze 2008: 104-113.

to allow our instincts the opportunity to orchestrate birth as it was intended by Nature” (39-40). Halfmoon later went on to birth unassisted and found this to be a pleasurable and satisfying experience.⁷

An article from Europe that appeared in a nursing journal also highlights the distrust of the medical profession quite nicely: “Ms. Wilson says that, for her, having health professionals present is more of a *risk* than being left alone” [emphasis mine] (Lynch 2007: 22). It is apparent here that this woman choosing unassisted childbirth is also using the language of risk although locating the source of the risk in quite a different way. Rather than positing that the “risk” to the health/life of the mother or baby occurs from childbirth itself, she argues that for her, the risk is in the health professionals who attend births.

A series of articles published in *Midwifery Today* between the years 2000-2002, featured a dialogue between midwives and women who chose unassisted childbirth over midwifery care. In one of the articles, Leilah McCracken argues that:

Birth works. If left alone, women’s bodies push babies out just fine. Doctors dangerously extract babies all the time, and babies are injured in their births all the time. Birth itself is blamed for needless injuries; women’s bodies are blamed for “needing” such violent birth extractions in the first place.” (McCracken 2000: 34-35).

She goes on to say that: “when our babies are wounded, we are grateful to the doctors for saving them from the injuries that the doctors themselves inflict-through their own impatient, self-interested, poorly-researched birth attendance and perverse trust in technology over women’s bodies.” (McCracken 2000: 35). Although not directly using the language of “risk”, she does highlight what she considers to be the dangers that medical attendance at a birth can bring to

⁷ Halfmoon’s book is also laden with language that as a feminist researcher, I find problematic. She speaks of women’s innate, primal and instinctual abilities to mother and urges women to abandon mainstream parenting practices in order to mother the way that nature intended. This is not limited to unassisted birth, but includes extended breastfeeding, bedsharing, homeschooling, little separation of mother and child. She also recommends following a “fruititarian” diet. Again, a full analysis of Halfmoon’s arguments is beyond the scope of this paper.

mothers and babies. Medical doctor and natural childbirth advocate Sarah Buckley also argues that:

Undisturbed birth, then, represents the smoothest hormonal orchestration of the birth process and therefore the easiest transition possible – physiologically, hormonally, psychologically and emotionally from pregnancy and birth to new motherhood and lactation for each woman. When the mother’s hormonal process is undisturbed, her baby’s safety is also enhanced-not only during labour and birth, but also in the critical shift from intra- to extra-uterine life. (2002:19-20)

What is often highlighted in the discourses surrounding risk and unassisted childbirth is that when the mother’s safety is preserved, often through freedom from intervention and the maintenance of autonomy, this in turn will help to assure the safety of the infant, as the mother and infant are conceptualized as having the same interests.

Jackson, Dahlen and Schmied (2012), in their research on women who choose freebirth and high risk homebirth in Australia find that even though there is a common sense social and biomedical understanding that hospitals are safe places to give birth, their participants: “perceived that hospitals were less safe places to give birth in than home and perceived the hospital to present them with a unique set of physical and emotional risks they would otherwise not be exposed to at home” (564). Jackson, Dahlen and Schmied find that women choosing unassisted birth do not deny the inherent risks of birth itself but rather, “the women considered risk seriously but placed the iatrogenic risks of giving birth under intense scrutiny, challenging the implicitly agreed assumptions that hospital birth must be safer and exposing risks that are often simply accepted as part of birth” (2012: 565). While here the risks of birth from within the body are acknowledged, these women weigh these risks against the risks of hospital births and the perceived interventions that result, ultimately reaching the conclusion that unassisted home birth is safer (566).

As is apparent in much of the writings by unassisted birth supporters, the issues of safety and risk are not ignored. Rather, the dominant discourse about risk in childbirth is flipped on its head. Rather than framing childbirth as inherently full of risks which must be managed and mitigated by physicians, or midwives, those in support of unassisted birth argue that childbirth is almost always safe. The risks lie in the reliance on experts to manage the birth, as these experts are too often quick to interfere and utilize technological interventions. Freeze (2008) in her research on unassisted birth points out that in Western societies which are obsessed with risk, predominantly with the avoidance of risks, women who choose unassisted childbirth: “calculate acceptable boundaries of risk” (29). She argues that these women:

place birth risks in context of everyday activities, point out the risks of socially acceptable birth choices such as epidural anesthesia or elective caesarean section; emphasize that there is no avoiding risk in any location or type of birth; and view birth as trustworthy and safe, rather than as inherently risky or dangerous. (29)

Although extreme unassisted birth advocates position any medical intervention as unneeded, more frequently the argument is that birth is usually safe; only a small proportion of births require intervention. Most women conducting an unassisted birth will probably seek medical assistance if complications are apparent (see Freeze 2008: 227); however, the argument is that the majority of the time complications do not happen therefore assistance is not necessary at every birth.

“Medwives” and Midwives as Unnecessary

Although the belief system associated with unassisted childbirth is more closely tied with midwifery models of care, women who birth unassisted obviously opt to not have midwives attend their births. The term “medwife” has been used to denote a midwife with an overly medical approach to pregnancy and this term is certainly in use in the unassisted childbirth community. Unassisted homebirth advocate, Lynn Griesemer states on her website that one of

the reasons she would not want a midwife at her homebirth is that: “Some midwives act as “medwives”, bringing some of the medical procedures done in the hospital into the home. We need doctors and midwives in certain circumstances, but not for normal, routine births” (Griesemer 2012: “Reasons Why I Don’t Want a Midwife at my Birth.”). Although there is much discussion about midwives and “medwives”, within the unassisted childbirth online community, there is often little distinction about the types of midwives in different regions in the world. Discussions about unassisted childbirth in the United States may distinguish between CNMs and CPMs, but for the most part all midwives are generalized as professionals who attend births. In some discussions, there is little distinction made about how a nurse-midwife within a hospital would approach birth, as opposed to a publicly-funded, college-regulated, Ontario midwife who attends homebirths.

Although it would be easy to say that unassisted childbirth advocates reject midwifery care because of supposed “medwifery” leanings, the issue appears to be more complicated. Popular unassisted birth discussions often draw from arguments put forth by the natural birth movement and the ideas which guide much midwifery practice (Miller 2009: 54).

In essence, the philosophy of UC is that women should serve as their own midwives, utilizing the necessary knowledge gained from midwifery and adding that to what they see as women’s natural, intuitive birth knowledge. Despite this clear reliance on midwifery, use of a midwife is seen as inappropriate. From the UC perspective, midwives and doctors are “the same.” Although objectively quite different in their approach to birth, for advocates of UC these differences are irrelevant. Midwives and doctors are seen as two ends of the same spectrum-professionals who interfere with a woman’s natural ability to experience completely unhindered birth. (Ibid)

As Miller points out, the midwifery movement, in recent decades, has effectively made changes to mainstream childbirth practices and in some circumstances, midwives and doctors do work similarly and collaboratively (55). However, many women who choose unassisted childbirth,

while valuing the knowledge base of midwifery, come to see midwives as unnecessary at their own births.

Freeze (2008) points out that the unassisted birth community has created what she terms a “mythological history of midwifery” (263). Her argument is that midwives of the past are constructed as having had been part of the community and connected with childbearing women in a personal way. These mythological midwives did little to interfere in births, rather they only provided support; they were “untainted by the professionalization and specialization of knowledge” (264). The sense is that more contemporary midwives have changed from the idealized midwives of the non-specified past and that midwives now are too medical, professionalized, and authoritative (Ibid). Freeze finds a “pervasive distrust of the professionalization of midwifery” (268) among women in the unassisted birth community.

Miller (2009) also examined the relationship that women choosing unassisted birth have with midwives. Through interviews with freebirthing women as well as analysis of online birth stories, Miller finds that, “Although these women began pregnancy with the assumption that they would birth with a midwife, they developed a commitment to an unassisted birth, which they saw as more natural, more independent, and more personal than a homebirth with a midwife.” (62). Miller also finds that, “The assumption, whether accurate or not, is that when a midwife enters the home she becomes ‘in charge;’ unassisted homebirthers do not accept the fundamental midwifery tenet that women direct their own births when attended by a midwife.” (64). Self-sufficiency and autonomy during birth, for these women, is only attainable without the presence of any professional assistants. Freeze’s research finds that most of the women she interviewed supported midwives, especially direct-entry and homebirth midwives, and that some “view midwifery as a bridge to more empowered, confident and autonomous births” (269). However, a

small number of women equated midwifery with obstetrics, found midwives to be arrogant and overly medical, or thought that midwife-attended births were incompatible with believing in normal birth (271-272).

Other arguments for the choice to exclude midwives from homebirths are framed in terms of marital love and the profound need for privacy during the time of birth. Griesemer argues that birth is not only safe, but it is sensual and should be experienced intimately between (heterosexual) partners: “Childbirth is a love act involving the triangle of man, woman and child, but people are unaware that it is an intimate occurrence” (62). For Griesemer, midwifery fails when it makes birth into a woman’s issue and excludes husbands (252). Joy and intimacy in birth is achievable when birth is a sensual encounter between married couples.⁸ For Griesemer, midwives are not needed for fulfilling and safe homebirth experiences. She states that “Midwifery is a respectable profession, but it falls short when it cannot empower women to make birth choices that include unassisted homebirth” (Ibid).

Shanley also contributed to the dialogue about unassisted birth in *Midwifery Today*, and although she names a variety of reasons for choosing unassisted birth over midwife attended homebirth, the perceived meddling of midwives in otherwise normal births was one of the central concerns that Shanley discusses: “The fact is, too many midwives give lip service to the idea that ‘women know how to give birth!’ They tell women to trust their bodies and believe in their own abilities-but not to the point of giving birth without them” (Shanley 2002: 17). For Shanley, women are capable of giving birth without midwives and this choice should be respected as a legitimate option.

⁸ Despite paying lip-service to the idea that not all childbearing women are married, Griesemer’s assumptions regarding childbirth occurring in the context of heterosexual, married couples is apparent throughout her work.

Laurie Morgan, in her book *The Power of Pleasurable Childbirth* recounts her experience giving birth in a midwife-run birthing centre in the United States and notes her powerlessness and many abuses she suffered at the hands of the midwives. She writes that she was initially happy with the birth experience but later, upon more reflection about the birth, Morgan came to conclude that she had been “praising my rapist as a saviour” (14) because of the way that her midwives treated her during her labour and birth. Like other women writing about unassisted birth, Morgan later “discovered” unassisted birth and went on to have a pleasurable and satisfying birth experience without the assistance of midwives.

Concerns about the medicalization of midwifery, midwives’ use of interventions, even “natural” interventions, and increasing amounts of “medwives” in practice can certainly be found among freebirthing women. However, many of the explanations of why women choose not to have midwives has less to do with risks of medical interventions and more to do with the “naturalness” of childbirth. While avoiding medical care and hospitalization at the time of birth is often framed in terms of preserving their own and their babies’ safety and avoiding interventions, therefore decreasing risk; the rejection of midwives is typically (although not always) framed in less-harsh terms. Although certainly the monitoring that midwives may do during labour and birth can introduce an element of risk to an otherwise normal birth; it appears in a lot of unassisted discourse that midwives are framed less as a risk and more as just unnecessary. The argument seems to be that if birth is so normal and natural, which many midwives argue that it is, then professional attendance is not needed.

Taking Responsibility

One of the most striking differences between the philosophy of unassisted birth and that of mainstream birthing practices is the notion of taking responsibility. In choosing to give birth

unattended, a woman is unequivocally taking on the responsibility for her own birth and thus the outcomes of that birth:

Taking responsibility for our children begins at birth, if not beforehand. When I decided to have an unassisted birth, I waved the possibility of signing that responsibility over to a doctor or midwife, as well as the possibility of “blaming someone else”. I did not do it because I think complications cannot strike me or my children, because I am a hippie, or because I believe what someone happens to write on the web in their lunch hour. I did it because, after researching the options available to me, I made the conclusion that unassisted childbirth was the safest possibility. (Write About Birth: 2012⁹)

Contemporary Western culture has become fixated with the avoidance of risks, and individuals are increasingly expected to take responsibility for their own health and avoid known risks.

During the time of childbirth, however, the cultural norm is to place responsibility in the hands of trained professionals who, for the most part, do everything in their power to ensure a healthy outcome for both mother and baby. Medical professionals are thus hyper-vigilant in their management of risk, often employing interventions into birth regardless of whether risks or poor outcomes are likely. As unassisted childbirth advocates argue, little attention is typically given to the risks that stem from medical interventions. For women who believe that most people, themselves included, are capable of birthing without interference, unassisted childbirth is a legitimate choice.

Despite the fact that the likelihood of severe harm during an unassisted birth is relatively small, choosing unassisted childbirth means that if a poor outcome does come about as a result of birth (such as injury or death to the infant), the responsibility for that falls on the parent; there will be no doctor or midwife on whom to place blame. Scamell and Alaszewski (2012) note that in the context of midwife-attended birth (and I add physician-attended birth): “‘blame-free’ birth does not exist. All births are supervised by experts, and when something goes wrong, a search

⁹ This blog posting was accessed online during August of 2012 on the blog “Write About Birth”. As of November 2012, this blog no longer appears online. Citation reflects initial blog posting as read by this author.

and inquiry starts to identify who and what is to blame” (218). This forms the backdrop in which doctors and midwives practice maternity care; and some argue that this contributes to the medicalization of birth. Unassisted childbirthers, however, are willing to “risk” blaming only themselves if something goes wrong.

Freebirth is giving birth in the fullest freedom without paying anyone to be paranoid for you. There are no costs at any level as what is valued is core responsibility, rather than buying someone else to take on this primal opportunity to cultivate responsibility. No doctor or midwife fees, no hospital and equipment bills and no costs to the psyche in endless cycles of blame for birth disappointments.... Freebirth is the movement from a smaller space to a larger one – one in which trust, not fear, is affirmed by the presence of lovers, rather than doctors/fixers. (Parvati Baker 1995 – quoted in Griesemer 1998: 56)

Because there is virtually no evidence regarding the safety of unassisted birth, many women make their decision based on their personal desires regarding birth, placing great value upon the experience of childbirth as an important moment in a woman’s life and transition into parenthood.

There is something of a recognition in the unassisted birth community that, although chances are likely that birth will occur without major complications, occasionally difficulties do arise during childbirth. Many women who choose unassisted birth acknowledge the fact that they would transfer to a hospital for medical care if they thought the birth was not going to go as planned or if a major emergency came about during the birth (see for example:, Unassisted Childbirth forum, Mothering.com 2012: “What would make your transfer?”). Complications during birth are accepted as part of life and, although certainly unwanted, it appears as though individuals decide that they can live with the consequences of their decision to birth unassisted. These women may decide what medical conditions they would transfer for but ultimately they know and accept that if death or injury occurs as a result of their decision to birth unassisted, they will take on full responsibility for this.

Despite the recognition of complications in much writing coming from unassisted birth advocates, emphasis is placed on the “naturalness” of birth, the ability of the body to birth without assistance and on the risks of medical intervention into birth. While certainly much of this writing makes a strong critique of the medicalization of childbirth and shows how “risk” can be conceptualized in multiple ways, the risks that may arise from within the body are often quite minimized in the language used by unassisted birth advocates. It appears that faith in the process of childbirth can overshadow the possibility of risk to the physical health to both mother and child. Judie C. Snelson of the website *Unhindered Living* argues that: “Pregnancy is not an illness or a disease and therefore does not require the aid of medical personnel of any kind. Giving birth is a quick, simple, painless process. If you believe this in your mind, your body will make it so” (Snelson: 2006-2011 – Learn to Trust Your Body). Childbirth is clearly not experienced by all women as quick, simple and painless nor is it fair to state that in all cases it can or should be experienced this way. To follow this logic would be to say that complications arise in the body because the mind created them. Nevertheless, statements such as this one are not unusual in the writings by unassisted childbirth advocates. Although the possibility of severe obstetrical emergencies, including death, are small during childbirth; to argue that childbirth is always simple or safe minimizes the fact that sometimes dangerous complications do occur. Thus, while I have argued that the SOGC failed to acknowledge the risks of medical intervention into normal births, I argue that the unassisted birth advocates highlight these risks while greatly downplaying any dangers or risks from within the body, perhaps unfairly. For some advocates of unassisted childbirth, including Snelson and Shanley, childbirth appears as always safe, provided the birthing mother conceptualizes it as safe.

CONCLUSION

The biomedical approach to childbirth typically frames pregnancy and childbirth as bodily processes laden with risks. Because risk is seen as something that can be managed through human intervention (Lupton 1999a: 25), medical surveillance and intervention into pregnancy and childbirth are both normal and expected in this approach to childbirth. The hegemonic nature of the medical model means that the way that childbirth is conceptualized in this model: as painful, perilous, dangerous and risky, often becomes the dominant mode of conceptualizing birth among the general public. In speaking about unassisted childbirth, physician organizations typically frame the practice of unassisted birth as unequivocally too risky.

Unhappiness with the nature of medical management of birth led to the emergence of increased options for maternity care as more women demanded care outside of the mainstream medical approaches to birth. Midwifery re-emerged in some provinces in Canada in the 1990s, as an autonomous profession able to provide holistic maternity care for women seeking a woman-centred approach to pregnancy and birth. Many midwives have tried to operate their practices outside of the more risk-based approach to maternity care, but as Weir (2001) and Scamell and Alaszewski (2010) show, this has not always been easy, as the dominance of the concept of risk is sometimes difficult for midwives to resist. In reacting to unassisted childbirth, the tensions that midwives face - balancing a belief in the fundamental normality of birth versus the ubiquitous nature of discourses on risk – become apparent. While some midwives come forward in support of the choice to birth unassisted, recognizing some women's desire for autonomous and normal childbirth, other midwives invoke the language of risk, arguing that it is midwives who preserve the safety of birth, not birth itself which is inherently safe.

Women choosing to give birth unassisted have rejected both the medical and midwifery management of birth. Refusing to believe that childbirth is itself an inherently risky bodily process; these women flip the dominant discourses on risk around and argue that unassisted birth is safer than attended birth. Many writings on unassisted childbirth show that, for these women, risk is conceptualized as not being located within the woman's body at the time of birth, but rather outside of it, in the monitoring, distrust of the body and incessant searching for problems. Much unassisted birth writing highlights the risks associated with medical interventions, something which is discussed far less among medical professionals. For some women, birth is conceptualized as having risk regardless of where it takes place or who attends; however, the hospital is framed as carrying an additional set of risks to which these women chose not to be exposed (Jackson, Dahlen and Schmeid 2010: 564). In addition to this, for many women choosing unassisted birth, birth is recognized as a part of life and the fact that sometimes it result in injury or death is accepted as also part of life (Freeze 2008: 250). Unassisted birth advocates are willing to take responsibility for their own birth outcomes in exchange for the privacy, autonomy and empowerment offered by giving birth alone. Thus, not only are unassisted birth advocates rejecting the medical approach to risk, they are also rejecting the wider cultural imperative to avoid risk at any cost, instead valuing acceptance, responsibility, and autonomy.

As this analysis has shown, each group speaking about unassisted childbirth; the professional medical organizations, midwives and supporters and promoters of unassisted birth, invoke the language of risk in framing their argument for or against unassisted births. In a culture and time period where the language of risk envelops pregnancy and childbirth in myriad ways, this is unsurprising. However, what is demonstrated in this analysis is that interpretations of what constitute "risk" are contested, both among experts as demonstrated by the tensions around risk

faced by midwives, and between experts and lay people, as demonstrated by the different ways in which medicine and unassisted birth supporters frame risk in childbirth.

Chapter Five – Competing Constructions of Risk and Safety in Birth

The purpose of this study was to use sociological and feminist theories about the social construction of risk to demonstrate how notions of risk and childbirth were framed and contested in the competing discourses surrounding the practice of unassisted childbirth. Looking at the discourses on unassisted childbirth from three key stakeholder groups involved in the discussion: medical organizations, midwives and unassisted childbirth advocates revealed that the concept of risk in childbirth was invoked, through the language used, by each of the three groups in their comments on unassisted childbirth. However, the conceptualizations of risk and thus safety in childbirth varied, indicating multiple ways of framing the birthing body and the childbirth experience. I argue that framing childbirth as risk in different ways demonstrates the multiplicity and variability of risk conceptualizations and has implications for how different stakeholders argue their positions regarding expertise, health, safety, autonomy and the body in relation to childbirth choices and options.

This chapter reviews the key findings of this research project, provides a discussion of the potential implications of the findings and suggests areas for further research. I also provide a discussion on how differing constructions of risk in childbirth may affect decision-making around the acceptability of certain risks in the birth process. Rather than asking “Who is right?” in terms of the three groups included in the analysis, this section addresses the question of who has the power to define acceptable risks in childbirth, and what does this mean for childbearing women in terms of decision-making around birth. I argue that the findings of this study add to the literature on the social construction of risk, particularly in terms of the social context in which women’s bodies, the risks of birth and the medical control of childbirth continue to be framed and contested in public discussions around reproductive choices. This study may also point to the need for further research into women’s satisfaction and experiences with

contemporary maternity care. I suggest that there may be a need for an improved dialogue on risk between women and their maternity care providers as well as the need for biomedical framings of risk to take into account the importance of birth *experience* for some women.

RESEARCH FINDINGS: FRAMING OF RISK IN UNASSISTED BIRTH

As was discussed in Chapter Two, risk has become a widely used concept that pervades many aspects of today's everyday life. Some sociologists have argued that the notion of risk has become a prevalent organizing principle in modern Western social life because of the frequency with which risk discourses are used (Beck 1992; Lupton 1999a). Risks, as opposed to dangers, are conceptualized as being located in the future (Beck 1992) and involve a level of uncertainty, meaning that risks are something which *can* or *may* happen (Adam and Van Loon 2004). One of the central aspects of risk as a particular concept is that risks are conceptualized as things that can be managed by humans through various interventions (Lupton 1999a: 25). In the sociological work around risk that is influenced by Foucauldian analysts, it is argued that what becomes conceptualized as risk is shaped by social processes and the ways in which certain issues are discursively framed. Thus, it is argued, certain issues become framed as "risks" through the language used to describe or discuss the phenomenon (Hannah-Moffat and O'Malley 2007: 9).

In societies in which risk is a primary concern in many facets of life, pregnancy and childbirth have become bodily states increasingly understood in terms of risks. It has been argued that discourses of risk surround pregnancy and birth in many ways, so that mothers today are increasingly aware of the plethora of risks from which she must protect herself and her foetus (Lupton 1999c; Samerski 2007). The pregnant body is constructed as doubly at risk, as mothers are held responsible for warding off risks to both themselves and their foetus (Lupton 1999b: 63).

As Barbara Katz Rothman notes, it is “never a question of risk or no risk, but of which risks” (1982: 17). When mothers make choices about whether to have children, how to eat or manage health during pregnancy, whether or with whom to receive maternity care and how and where to give birth, these choices are often framed in terms of risk. There are risks to a mother’s health, risks to the baby, risks of medical intervention, risks of no medical intervention and so on. As with discussions around pregnancy and childbirth, the language that surrounds the practice of unassisted childbirth often invokes risk discourses, albeit in competing ways. Thus, both expert and lay interpretations of risks were opened for analysis in this study.

The biomedical conceptualization of risk, which is arguably the most influential construction of risk in shaping experiences of childbirth, typically emphasizes the risks of childbirth that arise from within the body. Feminist critiques of medical conceptualizations of the pregnant and birthing body have argued that too much emphasis is placed upon the potential failings of the female body in risk based medical discourses. In the medical conceptualization of risk, the body is discursively constructed as a space of ever-possible risk and thus the body is acted upon precipitously and defensively. The findings of this study showed that in discussing unassisted childbirth, obstetrician organizations framed the practice as full of risk. The risks of childbirth itself were emphasized and medical care and supervision were positioned as key to providing women with the assurance of safety during childbirth.

While great emphasis was put upon highlighting the risks of childbirth itself, there was no mention of the iatrogenic risks of intervention into the birth process by professional medical organizations commenting on unassisted childbirth. The SOGC framed women choosing unassisted birth as wanting a “natural birth experience” and claimed that they supported this, yet offered little in the way of showing how they may offer a model of maternity care which values

the desire of some women to give birth without unnecessary medical interventions. The SOGC's stance on unassisted birth failed to take into account the possibility of alternative conceptualizations of risk in childbirth as well as the importance of the birth experience for some women, instead describing the women who choose unassisted childbirth as "tragically uninformed" (SOGC 2007: 1). The focus by the SOGC was upon the body's potential to fail at the moment of birth and on the importance of relying upon experts to help mitigate these risks. The SOGC also did not provide any concrete evidence on the risks of childbirth, despite the wide availability such research. Instead of acknowledging that there is no research on the safety or risks of unassisted births in wealthy nations, the SOGC instead relied upon the culturally-accepted notion that childbirth is risky, not specifying what the particular risks were but instead assuming that childbirth as risk is part of taken-for-granted public knowledge which does not need to be spelled out. In their framing of risk and unassisted childbirth, the risk appears as unnamed, occurring from within the body and always needing medical or expert assistance.

The SOGC's argument, and the rather accusatory language with which it is constructed, thus comes across as threatening and full of fear. While a more sensitive approach to the topic is certainly possible, as evidenced by the Vogel article published in the CMAJ and the various responses to unassisted childbirth that midwives put forth, the SOGC's tone and language is threatening and paternalistic. The SOGC comes across as trying to force women to acquiesce to the social norms regarding childbirth – that it is not mothers' domain and is best left to experts – lest they face "dire consequences".

Midwifery discourses on risk and unassisted childbirth demonstrated that many midwives have a rather tense and ambivalent relationship with the dominant medical construction of risk. Research on midwives and risk showed that midwives may resist biomedical notions of risk in

some instances and take part in risk discourse in others (see Scamell and Alaszewski 2012; Weir 2006). In terms of midwives responses to unassisted childbirth, there appeared to be two types of reactions, one which highlighted the inherent risks of childbirth and cautioned women to choose birth attendants over unassisted birth and the other which questioned midwives' role in pushing women towards unassisted birth and appeared more sympathetic to the desire to give birth in a self-directed fashion. Some midwives appeared to understand why focusing on risks or the possibility of complications can be problematic for women during childbirth, especially in light of midwives focus on birth as normal and healthy and the perception that midwifery models represent an alternative to the medical-management of birth. These midwives pointed to potential problems with maternity care, including midwifery models of care, in perhaps pushing women into rejecting childbirth assistance, showing that some midwives appear to understand the context in which the choice to birth unassisted occurs. Other midwifery groups were careful to position themselves as neither in support of or against the practice of unassisted childbirth. These midwives tended to offer caution about birthing alone but also treaded lightly and withheld judgement, presumably for fear of alienating those considering unassisted birth.

The deliberate choice to give birth without a physician or a professional attendant, while certainly uncommon, nevertheless should be understood as occurring within the context of a debate about the management of childbirth. Critiques regarding the medicalization of women's bodies, the patriarchal history and practice of obstetrics, women's experiences giving birth in a medical model and the hard-won battle for midwives to be recognized as a legitimate profession in Canada, all exist as part of the history and context in which women are literally taking their birthing experiences into their own hands. However, the practice of unassisted childbirth is alarming for many individuals, not only medical professionals and maternity care providers, but

also members of the general public and this is primarily because there is a hegemonic societal conceptualization that childbirth is “risky”. Women who advocate for unassisted childbirth are not ignorant to the fact that childbirth is conceptualized as a time of risk. In fact, they also frame childbirth as risk, although emphasis is placed upon iatrogenic risks above the risks of the body. I argue that these women are not “tragically uninformed” but rather are resisting the medicalization of childbirth and the risk-based medical approach to childbirth in myriad ways.

The language and framing of risk from unassisted childbirth advocates, as well as the women who have been open about their choice to freebirth, showed that risks arising from within the body were very much minimized. The female body was framed as capable, reliable and able to give birth. The concept of risk, however, was not ignored in the discussions by unassisted childbirth advocates. Instead, risk was conceptualized as occurring outside of the birthing body, predominantly in the monitoring and interventions performed upon the body by professionals during labour and birth. While it was common for these women to highlight the risks and dangers of medical intervention and argue that birthing without professional assistance was the safer option, the focus on risk by doctors and midwives was also presented as a hindrance to normal and healthy childbirth. Women who advocate for unassisted childbirth typically frame childbirth as something that can usually occur autonomously and safely, without the need for an outsider to monitor and/or worry about possible risks. While the inherent risks of birth were minimized, they were not completely ignored in all of the discussions of risks in unassisted birth. Many women recognized that in the event of a complication in birth they would seek medical help. If, in the worst-case-scenario, medical assistance could not be obtained and the infant was injured or died, these women state that they are willing to take on full responsibility for this, as there would be no one else to blame. In the language of unassisted childbirth, it was preferable to

risk the remote possibility of a poor outcome by birthing alone than to risk the almost-certain possibility of a bad birth experience by choosing attendants.

While some may accuse the women who choose unassisted childbirth as ignoring the risks of childbirth, this project shows that many women who birth unassisted have given the notion of risk in childbirth some thought. While unassisted childbirth advocates often utilize the culturally-entrenched notion of risk in framing their decision to birth unassisted, they are also resisting the biomedical conceptualization of risk in multiple ways. These women emphasize that the risks of interventions can outweigh the risks of birth itself; and that sometimes individuals wish to exist outside of risk-based medicine, preferring to value experience and faith over intervention and control.

Not only is the conceptualization of what constitutes risk different among the three groups, but it also differs in terms of who can mediate risk and the ways in which this should be handled. For the medical organizations, risk in childbirth is mediated by physicians and hospitals and this is how safety is preserved. From this point of view, experts should be trusted to mediate the risks of childbirth. For unassisted childbirth advocates, risk is not mediated by experts as experts are conceptualized as posing another set of risks – that of medical intervention and the associated risks to the body and the birth experience. Instead, for women choosing unassisted childbirth, risks are mediated by themselves. From this point of view, it is the birthing mother who chooses how to give birth, how to maintain or preserve safety and whether medical assistance is needed. Because it is the birthing mother who ultimately has control, she is the sole one responsible for mediating risks.

For midwives, whose responses to unassisted childbirth range from disapproval to cautious support, risk is often conceptualized and mediated at multiple levels. On the one hand,

many regulated midwives are trained in biomedical notions of risk and thus see themselves as mediating risk in a similar fashion to doctors – by monitoring the body and relying on expert knowledge to guide decision-making around childbirth. On the other hand, midwives also attempt to normalize childbirth and make their model of care an alternative to medically-managed childbirth. In this way, the risks of birth are minimized in comparison to the medical model, so as to challenge the hegemonic perception that childbirth is an agonizing and perilous experience to which control should rest with doctors. Midwives thus occasionally challenge risk-based medical care from within the confines of their profession, by highlighting women’s ability to give birth and emphasizing pregnancy and childbirth as normal parts of the life-course. Using their knowledge about the physiology of childbirth coupled with midwifery’s usual emphasis on woman-centred and holistic care, midwives thus mediate risk at multiple levels.

POWER/KNOWLEDGE IN DEFINING RISK

Davis-Floyd, in her critique of the American “technocratic” approach to maternity care and childbirth argued that birth ends well most of the time, meaning that both mother and infant survive the process with healthy outcomes. The obstetrician who “managed” the birth thus experiences his use of technology as effective most of the time (1994: 267) so obstetricians see the health and survival of mothers and babies as “success” for their way of managing birth:

Birth is an amazingly resilient natural process. It can be technocratically de- and re-constructed in the hospital, or protected and nurtured at home, and it will still turn out well almost all of the time. ‘Safety’ is the disguise worn by technocratic ideology. The real issue in the home versus hospital debate is not safety but the conflict between radically opposed systems of value and belief. (Davis-Floyd 1994: 184)

I argue that the same logic contributes to the controversy surrounding unassisted childbirth. For healthy women who have had regular access to health care and a high quality of life in terms of social determinants of health such as income and education level for example; birth may very

well have good outcomes most of the time regardless of whether it takes place in the hospital, at home or in a car. Birth may also go well the majority of the time regardless of who attends it, whether it is a family doctor, an obstetrician, a direct-entry professional midwife, an apprenticeship-trained midwife, a nurse-midwife, a family member, friend or no one at all. The individuals arguing for the legitimacy of each way of giving birth interpret the success of their way of birthing as evidence that it is the best and safest way of giving birth.

It is therefore not uncommon for a woman who has given birth unassisted to walk away from the experience feeling as though the birth was not only successful in terms of survival, but also peaceful, joyful and empowering. Unassisted childbirth advocates experience their way of giving birth as successful because, most of the time, it probably is successful. In a similar fashion, midwives may also interpret their model of care as the best; especially if, like Gaskin, they see themselves as offering an alternative to intervention-laden medical birth, yet able to ward off risk with their training to assist with complications.

For unassisted childbirth advocates, the evidence of the risks in childbirth is greatly minimized in favour of highlighting the evidence on the risks of medical interventions into childbirth. The focus for unassisted childbirth advocates thus becomes how successful births are when they exist outside of medical intervention and how birth experiences may be vastly improved for the mother when they are achieved without medical assistance. When birth is achieved outside of medical or professional attendance, it is argued that power and dignity of the birthing mother are preserved in a way that, it is assumed, cannot be when an outsider guides the process. When an unassisted birth occurs without complication, this is used as evidence for the body's ability to birth and the non-necessity of professional attendance.

Biomedically-trained professionals would disagree that the risks of intervention outweigh the risks of not having professional assistance. Nevertheless, intervention is framed as more risky in the construction of arguments for the benefits of unassisted childbirth, and because there is virtually no research on birth outcomes among women having unassisted births in resource-rich places, it is difficult to draw conclusions with any certainty about the riskiness of the practice. The issue is more about how risk is constructed and understood in these competing models, what systems of belief are valued among the stakeholders and who is permitted to speak with authority about a given subject.

Kaufert and O'Neil, in their work on the constructions of risk around childbirth for the Inuit in Canada find two competing ways of constructing birth and mortality in childbirth, one used by the Inuit women arguing for keeping childbirth in the north and the other by the physicians advocating for all Inuit women to birth in southern hospitals:

The exchange between the physician and the woman deals partly with the difference between risk as a subjective experience and risk as a statistical artifact. The woman's definition of risk is community based and acquired through experience. She sees the rates quoted by the physician as theoretical constructs, lacking local validity. The physician dismisses her claims as irrelevant for a definition of risk which is objective, scientific, expressible in numbers...Ultimately, the conversation is about politics because it is about power. The question is who has the power to define risk and to insist that their view should prevail over those of others. (1993: 51)

In a similar manner to the disagreement between the Inuit community-based definitions of risk and the physicians' conceptualizations of risk, so too is the debate about unassisted childbirth about power. The physician's statements about unassisted birth, although not necessarily backed up by scientific evidence in this particular instance, are nevertheless more likely to be accepted as 'truth'. They come from a position of authority and expertise.

Freeze (2008) writes that: "Arguments over safety are just the surface layer of a fierce struggle over who has the right to define reality" (197). The view that childbirth is dangerous,

risky and needs medical attention is, for the most part, accepted. What the unassisted childbirth advocates bring forth, a view that the female body is quite capable of giving birth without assistance and that the experience of birth can be vastly improved if it is done autonomously, is very much counternormative. While science and medicine may have scientific evidence and statistics to back up their way of managing birth, unassisted childbirth advocates present their own (anecdotal) evidence about the joy and empowerment that comes from bringing their babies into the world on their own terms. Through the internet and social media, the women who are choosing to give birth in this way are able to gather information and share experiences, thereby building a community of women interested in and supporting unassisted childbirth.

The question here is not: who is right? All sides of the debate present a particular conception of risk that is valuable. Certainly, there are medical risks in childbirth; hemorrhages occur, occasionally mothers or infants die tragically in what most people assume will be a relatively smooth transition. The concerns presented by physician groups are thus not unreasonable. At the same time, birth attendants often do intervene and these interventions pose their own sets of risks. It is these risks which are not mentioned often in medical discourses but are a prime focus among women choosing unassisted birth. These women argue that, having done their own research about childbirth, they can birth safely with no interventions. Social media plays an important potential role here, as these women can access studies and information online about the risks and outcomes of not only childbirth itself, but the various interventions commonly offered in the management of childbirth. Not only are medical interventions framed as risk within the language of unassisted childbirth, but the possibility of intervention is framed as potentially ruining what could be a positive birth experience. Physicians', and to a lesser extent midwives', focus on the inherent risks of childbirth is framed as problematic because it

introduces the element of risk itself into what is thought of as a normal bodily process. This finding is important because it points to the complexity of how risk may be understood by different groups of people.

Although the biomedical conceptualization of risk in childbirth is certainly the dominant discourse in these discussions, as this research shows, it is not universal. Critiques of biomedicine's preoccupation with risks and the interventive nature of medicine because of fears around risk are being put forth by women arguing for essentially a different model of birth, one which respects the importance of the experience of childbirth. The women who support unassisted childbirth are also challenging the dominant discourse on risk by stating that they feel medical management of birth results in more risks to the health and safety of themselves and their infants, and it is these iatrogenic risks that they are not willing to take.

It is the recognition of the relative nature of conceptualizations of risk that was not adequately taken into account in the SOGC's warning call about unassisted childbirth. If physician organizations wish to address what appears to be a growing trend among childbearing women, they must acknowledge that there are multiple and complex ways to conceptualize risk in childbirth. If the decision is made to develop policy or guidelines around unassisted childbirth, instead of offering fear-mongering around the risks of birth or paternalistic assumptions about the ignorance involved in making the choice to birth unassisted, what is needed is recognition and sensitivity that decision-making around childbirth often involves complex risk-assessment strategies and different perceptions of what constitutes the most risk, or the most acceptable risk in childbirth. The choice to have an unassisted childbirth needs to be understood as occurring within the context of a biomedical maternity system that has historically been criticized for not respecting women's desires. It also needs to be understood as part of the contemporary cultural

context in which the management of childbirth continues to be researched and debated. The data on midwives' tense engagement with biomedical discourses of risk shows that risk in relation to women's bodies and childbirth continue to be areas of contestation and resistance. The women who choose unassisted childbirth seem to be, at least implicitly, aware of this. By arguing that midwifery care is perhaps veering too closely to obstetrics, as evidenced by use of the term "medwife" in the unassisted birth community, these women decide that they would be safer both physically and emotionally birthing without assistance.

AREAS FOR FURTHER RESEARCH

While this research certainly points to an interesting debate about the risks of childbirth, particularly with respect to a comprehensive analysis of the conceptualizations of risk and the birthing body by physician organizations, midwives and unassisted childbirth advocates, the findings here may lead to more questions and areas for additional research. Further research could ask physicians, midwives and women who have chosen unassisted childbirth directly how they conceptualize risk at the time of birth and in reflecting on childbirth afterwards. Additional research could interview childbearing women about what sources of information they use in making decisions about risk in pregnancy and childbirth. Potential further research could also address the complexity with which midwives deal with biomedical discourses of risk, especially by comparing different midwifery models of care.

Additional research could look into the possibility that the practice of unassisted birth is an indicator of the ways in which medicine and midwifery may not be adequately addressing the needs and desires of childbearing women. As discussed in Chapter Four, some women appear to be turning towards unassisted birth because of poor experiences with maternity care. Unassisted childbirth advocates often argue that physicians and midwives are too quick to intervene into the

birth process and that this affects a woman's experience of her body and her birth. If this is true and is a central reason for why some women choose unassisted childbirth, there may be particular lessons that physicians and midwives can take away from this. Perhaps as Beech (2008) suggests, if more care providers were willing to be hands-off during the birth process, more women would choose unassisted but not unattended birth (20). Of importance here is also variability of health care systems in different geographic locations, especially in terms of access to midwifery care. While I have attended to the ways that midwifery models of care vary by region, additional research could address how this plays out in terms of the call to unassisted birth. For example, more research could look into whether the drive to unassisted birth in Canada stems from the shortage of midwifery care or a true unhappiness with provincial midwifery. Additionally research could look to how the arguments may differ from the United States, where midwifery care is divided along nurse-midwifery and community midwifery lines. Further analysis of the difference between Canadian and American blogs and websites may reveal some nuances in the unassisted childbirth arguments that reflect the structure and differences between health care systems.

Another question left unanswered from this research is whether there is an increased pressure for women to have intervention-free births because of the valorization of "natural birth". Perhaps the discourses around "natural" birth as an ideal may be leading to expectations among birthing women that may not be fulfilled in medical or midwifery models of care. It seems possible that pressure for "natural" birth may be creating unrealistic expectations for childbirth experiences that are both safe and empowering. Unassisted childbirth may point to a need to address interventions into childbirth and how this may affect the experience of birth, especially when interventions are conceptualized by the birthing mother as unnecessary, not communicated

to the birthing women in an adequate manner, or not given with informed consent. Conversely, it is possible that unassisted childbirth may also indicate a need to re-conceptualize interventions. Clearly, interventions into birth are sometimes necessary and perhaps it is problematic that intervention-free birth, also known as “natural” birth, is such an ideal that individuals will do nearly anything to achieve this. It is possible that it is the very notion of “natural” birth that needs to be problematized. I am not suggesting that the increasing medicalization of women’s bodies and the medicalization of childbirth be ignored; rather, I am suggesting that additional research could look into the possibility that the ideal of “natural” birth, often left un-problematized in unassisted birth discourses, has created un-realistic pressures for women around childbirth to have a perfect birth experience which leads to a total rejection of any birth attendants.

Finally, while this research looked to the framing of risk in relation to unassisted childbirth, based on restrictions of the scope of this research, I was unable to critically assess some other aspects of the language and framing of the body that takes place in discourses of unassisted childbirth. As was referred to in Chapter Four, some of the writings by unassisted childbirth advocates deploy problematic assumptions about gender roles, “natural” female bodies and contain hetero-normative, racist and “othering” assumptions. Additional research which could be quite fascinating could look more in depth at some of the language around the body found in unassisted birth discourses; such as notions of “natural” birth, the essential female body, and assumptions around gender roles and birth across cultures. Further research may be able to explore in a more systematic fashion how gender and familial roles may impact the decision to birth unassisted. For example, as Miller’s research pointed out, for some women the decision to give birth unassisted is based on the desires of and direction from a male partner (2009: 67). It is

possible that additional research could explore gender roles and the potential contradictions of some of the unassisted childbirth discourses and decision-making.

SIGNIFICANCE OF THIS RESEARCH

This is the first study conducted to date on the framing of risk in public discourses surrounding the practice of unassisted childbirth. Based on the recent media coverage and public statements regarding unassisted childbirth, it is apparent that there is a dialogue occurring wherein women's choices in childbirth and the concept of 'risk' are debated. Critiques around medicalized childbirth and consumer demands for improved maternity care has led to a shift in many women's choices around childbirth. Despite improvements to the context of childbirth for many women; pervasive distrust in medical experts and the desire to have empowering birth experiences coupled with technological spaces such as the internet in permitting the widespread sharing of information, the practice of intentionally choosing to give birth without medical assistance appears to have increased, or at the very least, it appears to have gained more public attention. The practice has garnered commentary from both professionals and lay people interested in women's choices around birth as well as the safety and risks of childbirth itself. This research is thus timely, based on the dominance of the concept of "risk" in framing bodies and decisions in regards to health as well as the increasing attention paid to unassisted childbirth in the media and among professional medical organizations.

Looking at the competing discourses around birth by the three key groups identified: physician organizations, midwives and the women who have chosen unassisted childbirth certainly points to the fact that discourses of risk surround pregnancy and childbirth. This research also demonstrates the possibility that risk as a concept is understood in multiple ways beyond the dominant biomedical framing of risk. In looking at how risk and the birthing body

are discursively framed by both supporters and those against unassisted childbirth, it becomes apparent that women's bodies and decisions around birthing become sites of risk and of resistance to risk based medicine. What constitutes acceptable risk in making choices around childbirth is an area of contestation. I argue that professional medical organizations, such as the SOGC, should be respectful in shaping their responses to, and possible guidelines, regarding unassisted childbirth. Recognizing the complexity and multiplicity of conceptualizations of risk is key to bringing forth a dialogue on decision making in regards to childbirth that is productive and meaningful.

Unassisted childbirth advocates give numerous reasons for why they choose to forgo any professional attendance at the time of giving birth. Safety, privacy and autonomy are some of the reasons, but what remains unclear is whether the desire to birth outside of "the system" indicates certain gaps in maternity care services currently offered in places with highly developed maternity care. Perhaps what is needed is recognition by physicians and midwives that privacy and autonomy in childbirth is a strong desire for some women. Concern regarding the possibility that some interventions in the birth process may be unnecessary also needs to be addressed in all maternity care models, as women should be able to give birth with professional attendance without concern that unnecessary monitoring and interventions will occur. Perhaps the concept of risk itself should become part of the dialogue that occurs between a client and a caregiver so that safety in the birth process can be preserved while also maintaining the dignity and autonomy of the birthing woman herself.

Improved maternity care should provide increased communication between care providers and birthing women about risk. Improved dialogue on risk would obtain true informed consent, not only on the risks of childbirth itself, which are typically emphasized in the dominant

discourses around birth, but also around the risks of intervention. Women should be able to decide what risks they are willing are to take and/or avoid in order to preserve the health and safety of both herself and her baby. Improved maternity care could also mean that health care professionals, including physicians and midwives, acknowledge the importance of the birth experience. If women are walking away from obstetrician-attended or midwife-attended births feeling traumatized, disempowered or “birth-raped”, this indicates a failure to provide sensitive, caring, respectful maternity care. While this experience is not likely to be the norm, it nevertheless hints to some faults within maternity care that may lead some women towards unassisted childbirth. Research has shown that it is possible for women to accept interventions into their births in a way that still respects their autonomy and even their sense of “natural” (MacDonald 2006: 236). Thus, it is possible for births to be attended, and even intervened upon by professionals, in a way that leaves mothers feeling empowered provided that care providers are caring, sensitive, respectful and offer informed consent.

The presence of an unassisted childbirth ‘movement’, suggests that there may be some gaps in the maternity care offered in places with rich and developed health care systems. It appears as though, at least for a small number of women, any of the services offered, including homebirth with midwives, is not adequately meeting their desires for a positive birth experience where the mother is in charge of her own body. While perhaps changes to maternity care services would not bring women who are dedicated to unassisted birth back to accepting birth attendants, it is possible that what is needed is an improved dialogue on risk in relation to childbirth and an improved dialogue on the importance of birth experience. With this dialogue, perhaps women could become more trusting of their birth attendants and of their own birthing bodies.

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