FIRST-TIME MOTHERS' EXPERIENCES OF CHILDBIRTH IN WESTERN CANADA: APPROPRIATING MEDICAL EVENTS AS SOCIAL EVENTS

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Abstract

This thesis examines women's experiences of childbirth, specifically their interactions with healthcare practitioners and technology use during labour and delivery. I refer to the evolving history of childbirth in order to understand the historical context of birth and how contemporary women respond to the current normative practices involved with childbirth. In the analysis of interviews with nine first-time mothers, who had vaginal births, within eight months of the interview in Southern Alberta, I draw attention to the actualities of the women's experiences and perceptions of childbirth and technology use. There are three primary findings presented in this research. They include how women construct their authentic and original self through their own unique experiences; women's medical appropriations; and lastly, how women create a social space within the hospital through their interactions with their labour support members. Women's perspectives show various moments of negotiating their power and agency when resisting certain medical standards.

want to thank my mom and dad for their unconditional love and support, especially when I had my moments of doubt. Thank you mom for your help and encouragement throughout my thesis—you made me feel confident with my work.

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Chapter One: Introduction

My research contextualizes childbirth practices in order to understand contemporary birth experiences of the women who participated. I interviewed nine women in a small city in Southern Alberta who had recently given birth in the local hospital. By referring to the historical context of childbirth in Canada, women's individual experiences are seen in relation to the dynamic changing social and cultural structures. Women's insights reflect both their interactions with authoritative healthcare practitioners and their roles as active agents during labour and birth. Thus, the research considers the social and cultural structures that shape the interactions between individuals (Scheper-Hughes & Lock, 1987; Lynam, Browne, Reimer Kirkham & Anderson, 2006).

The research therefore invokes the voices of nine first-time mothers in order to better understand the complexities of women's experiences of childbirth and technology use during birth. The qualitative interviews allowed me to highlight the value of women's experiences and contextualize their experiences of childbirth in the local area. The women's narratives therefore reflect their involvement with and their experiences of cultural structures.

The history of the medicalization of childbirth, which will be further discussed in Chapter Two, informed my understanding of childbirth and technology for the research project. My research question is threefold. With the increased use of technology during labour and childbirth: (1) what are women's "lived" perceptions of technological childbirth; (2) what are their understandings of the necessity of technology; and (3) how does technology use affect the care they seek or receive? The question is examined through qualitative interviews with nine first-time mothers who gave birth in Lethbridge, Alberta.

My research is based on qualitative interviewing, which allowed me to highlight women's experiences from their points of view. Women's experiences have typically been undermined by dominant groups and therefore by documenting women's narratives, women are recognized as "knowers" (Anderson, Armitage, Jack & Wittner, 1990; Smith, 1987). I refer to women's agency in what Kleinman (1980) describes as the "local health care system," which includes the popular, professional, and folk sectors. The local health care system is socially and culturally constructed and therefore, the interactional processes between the different sectors reveals how people understand health. I read and interpreted the data with an inquiring mind and identified three findings: (1) how women navigate their childbirth experiences and form the authentic self; (2) how women appropriate medicine; and (3) how the research participants described their social setting during childbirth.

The organization of the thesis

The increasing reliance on medicalization and technology to assist or mediate childbirth has undermined a woman's experience with childbirth (Davis-Floyd, 1987; Duden, 1993; Martin, 1987; Mitchinson, 2002). As a medical event, childbirth can be an isolating experience, where medical professionals acquire authority over women, particularly through the use of technologies (Martin; Mitchinson; Davis-Floyd). Medical professionals rely on technology and medical expertise, instead of referring to women, in order to diagnose and treat women's bodies (Martin; Mitchinson, 2002; Rothman, 1982). As a result, women themselves have become insecure with their capabilities to birth without interventions provided by medical professionals and therefore rely on the medical expertise of professionals (Moore, 2011; Society of Obstetricians and Gynaecologists, 2008). The impact of hospital care and the creation of formal medical care led to

women's reliance on both medical expertise and technology in order to feel confident with childbirth, which is further detailed in Chapter Two.

In Canada, the majority of women experience childbirth mediated through medical professionals using a combination of medical terminology, techniques, practices, and training referred to as "authoritative knowledge" (Davis-Floyd 1987; Jordan 1993; Kline, 2010; Mitchinson 2002). Under the gaze of authoritative knowledge and in the context of childbirth, the mother and fetus are transformed into "patients" (Guillemin & Holmstrom 1986; Jordan, 1993; Parry, 2008). Consequently, women are expected to be compliant and to submit their bodies to technological procedures to ensure the health of the fetus (Mitchinson, 2002; Oakley, 1984). In the process, as Chapter Two presents, women's experiences of giving birth are often made secondary to the interpretation of the technological output (Moore, 2011; Romano & Lothian, 2008; Rothman, 1982).

During the women's health movement, women challenged medical authority and asserted the value of their embodied experiential knowledge (Kline, 2010; Morgen, 2002; Warsh, 2010). Chapter Two explains the impact of the women's health movement and its potential influence on institutional organizations, such as the Society of Obstetricians and Gynaecologists (SOGC), which recommends less interventionist birth approaches and better labour support from healthcare practitioners (SOGC, 2008). Thus, as Chapter Six details, healthcare practitioners are encouraged to provide medical assistance and mental and emotional support to women (SOGC, 2008). Furthermore, women gain a greater sense of control by having positive labour support from their family members and healthcare practitioners (Campero, Garcia, Diaz, Ortiz, Reynoso, & Langer; Leap, 2009; Meyer, 2013; Moore, 2011; Namey & Lyerly, 2010).

Medical interventions are increasingly standardized and hence women expect the use of technology (Brubaker, 2007; Hall, Tomkinson & Klein, 2012; Miller, 2007) during labour and childbirth. Chapter Five outlines women's experiences with technology and how women find comfort with the use of medical assistance and technology in order to ensure their safety and ease labour pains (Miller; Hall, Tomkinson, & Klein). However, in Chapter Five I argue that women challenge medical authority by appropriating biomedical technologies used during labour to create unique meanings for their childbirth experiences (Hasson, 2012; Hadolt, Hörbst & Muller-RockStroth, 2012). Thus, women demonstrate the blended use of biomedical knowledge and experiential knowledge (Abel & Browner, 1998).

Chapter Two details the history of the medicalization of childbirth to substantiate the dominance of childbirth as a "medical event" in contemporary Canadian society. Smith (1987) noted that in the context of Canadian historiography, in general, women have been excluded from positions of authority and knowledge making, which consequently silenced women's perspectives in historical narratives. Histories of childbirth practices in industrialized countries like Canada generally identify a shift from childbirth as a social event, which was characterized as a communal experience that included family and friends, to childbirth as a medical event. Thus, exploring the history of the medicalization of childbirth shows a gradual shift to normalizing and standardizing childbirth in standardized and regulated spaces, such as the hospital (Warsh, 2010). Chapter Two therefore provides background information for women's acceptance of hospital births and their reliance on medical professionals as normal.

In Chapter Three I refer to the works of Dorothy Smith (1987; 2007), Scheper-Hughes and Lock (1987) and Lynam, Browne, Reimer Kirkham, and Anderson (2006) to

outline the theoretical underpinnings for the research. The theoretical framework explores the value of conducting an analysis of both social structures and individuals within society. By doing so, the researcher considers cultural influences on health management and how these influences affect an individual's social and cultural participation in certain events. Thus, as I explain in Chapter Three, women's subjective experiences are seen in relation to the social and cultural structures in the local area.

I explain my use of qualitative interviewing in Chapter Three to clarify the value of recognizing women as "knowers" (Olesen, 1994) and to explore my interviewees' perspectives and experiences to reveal the social and cultural structures that women interacted with (Brinkmann & Kvale, 2015). The chapter highlights and explains features of qualitative interviewing, such as feminist ethical practices, the power dynamics between the interviewer and interviewee, reciprocity within the interview interaction, and with data analysis and interpretation from which I established three findings. Each of these features influenced the research process and ethical considerations.

Chapter Four describes women's initial expectations of childbirth and describes the resources that women sought in order to gain insight of and prepare for childbirth. I refer to Kleinman's (1980) "local health care system," which he argues organizes health care in a locale, in order to provide insight on the "popular sector." The "popular sector" involves informal knowledge groups, such as women, their family members, and friends, all of whom share information, which ultimately impacts women's understanding of childbirth. Despite receiving a range of advice and information about childbirth, Chapter Four details how women navigate their first-time experience with childbirth and create a sense of the authentic self. I will develop my argument of the authentic self and women as

dialogical characters (Taylor, 1990) in Chapter Four. Thus, Chapter Four reveals how women establish their experiences as socially situated, yet individually unique.

Chapter Five explores women's experiences with technology during childbirth and how women appropriate medical practices. I describe a range of technologies that women referred to such as electronic fetal monitors and pharmacologic pain relief. Women are involved in the process of appropriation, which alters the meaning or purpose of a tool or an act (Hasson, 2012). In Chapter Five I argue that medical appropriation allows women to regain a sense of power and control, which, as noted in Chapter Two, was typically reserved for medical professionals (Davis-Floyd, 1987; Duden, 1993; Martin, 1987; Mitchinson, 2002). However, the chapter shows that despite the appropriation of tools and acts, which may allow women to feel more empowered, women continue to experience and validate the authoritative power of their healthcare practitioners. I will develop the argument that women experience moments of resistance, compliance, and agency in the hospital.

In Chapter Six, I discuss how women reclaim aspects of medicalized birth as a social event. In Chapter Two, I describe the historical shift from birth as a "social event" to a "medical event." However, in Chapter Six I argue that the women who were interviewed transform the medical space of the hospital into a social space. The chapter includes an analysis of the relationship between women and their family members who were present during labour and birth and their healthcare practitioners. Women describe the relationships and interactions between themselves, family members, and their healthcare practitioners as crucial to establishing birth as a social and inclusive event. In Chapter Six, I discuss the importance of shared decision making and sharing knowledge between women and their health care practitioners. I will develop my argument later that

by including healthcare practitioners in their social experience of childbirth, women identify their healthcare practitioners as fictive kin. The complexities of women's experiences of childbirth in the hospital are explored in the research findings.

The final chapter provides a conclusion of the research project, which highlights the perspectives of a small sample of women from Lethbridge, Alberta. The nine interviews provide unique insights on women's experiences of childbirth within a particular social context. Furthermore, as shown in Chapter Four, Chapter Five, and Chapter Six, women highlight various moments of negotiating their power and agency when resisting certain medical standards. Chapter Seven also describes the limitations of the research study. Furthermore, the chapter includes potential areas for research that have been inspired by the interview data.

Chapter Two: The Shifting Locations of Childbirth: From Home to Hospital

Introduction

Scholars, Judith Young (2010) and Lesley Biggs (2004) note that in the nineteenth century, professionally trained midwives, who were typically British, practiced in Canada. Biggs illustrates that during this time midwifery services provided opportunities for both women as midwives and pregnant women to experience childbirth as a social process rather than as a state of illness. Childbirth therefore brought women together to learn about their bodies and childbearing. For instance, Biggs states, "[k]nowledge about maternity care was acquired informally, based on women sharing information with one another; often one or two women in a community would be seen as having special skills" (pp. 20-21).

According to Mitchinson (1991), the decline of midwifery as an occupation, particularly in urban communities,[1] occurred in nineteenth century Canada and was influenced by the formation of medical organizations that excluded midwives. She lists a series of organizations that were formalized in Canada to promote science and medicine: in 1833 the Medio-Chirurigical Society of Upper Canada; in 1854 the Halifax Medical Society; in 1863 the Canadian Institute organized and included a medical section to promote medical prestige; and in 1867 the Canadian Medical Association was created and symbolized occupational and professional unity among medical professionals (Mitchinson, 1991). The creation of the College of Physicians and Surgeons of Lower Canada in the mid nineteenth century promoted notions of exclusivity for who could, or

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[1] Midwifery remained in use where there was limited access to medical professionals particularly in twentieth century rural Canada. Most medical professionals worked in hospitals, which were typically located in urban areas (Young, 2010).

could not, be considered a medical "professional" and privileged certain trainees to provide medical care and assistance. Furthermore, regulations and standards for education and training were authorized by these medical organizations. These organizations primarily comprised men, excluding women from influencing and creating authoritative and medical discourses that would impact the care that women might be able to receive during childbirth (Cahill, 2001). Contrastingly, no similar or parallel occupational unity was created or formalized among midwives. Moreover, the introduction of legislation in 1865 that required midwives to be licensed, despite the fact that there were no midwifery training programs to provide such licenses in Upper Canada, led to the decline of midwifery at that time. By mid twentieth century, medical professionals viewed midwifery as outdated and dangerous, which strategically reinforced their own authority and medical services (Biggs, 2004; Mitchinson, 2002). Medical professionals used the typical image of the "neighbour midwife" to represent midwifery as folklore and delegitimize the range of practices and expertise held by midwives, which further framed midwifery as outdated and inferior (Biggs; Mitchinson). For instance, Baltimore physician, D.W. Cathell, advised physicians to help midwives in order to affirm "the 'practical superiority of qualified physicians over the unskilled midwife'" (Mitchinson p. 93); another physician, J.R. Goodall, expressed his support for physician care by suggesting that "midwives were fine for other countries but not for Canada" (Mitchinson, p. 95). Such comments reinforced the binary between midwifery care and medical care, promoting notions of midwifery as primitive and therefore suitable only for patients or areas that were seen as "less civilized" or less progressive. Medical care was, by extension, the modern alternative to midwifery. The comparison between medical

professionals and midwives shows the developing hierarchy between the two professions, which eventually led to midwifery being displaced by the male medical professional.

Childbirth as a social event

Unlike medical professionals, midwives tried to accommodate a labouring woman's needs and welcomed friends and family and thus encouraged childbirth as a social and communal event.[2] Leavitt (1999b) argues that when childbirth occurred in the home women received support from friends and relatives, which was essential for a communal experience. Moreover, women had support networks to provide emotional support and help with decision-making during childbirth; with this support women could better contest medical advice (p. 636).

Medical professionals found fault with the social setting as it required them to report to and receive permission for medical procedures from support members and women during childbirth. Dr. Edward Henry Dixon's 1857 advice book for physicians expressed physicians' "annoyance" with the presence of family and friends who would advocate and sometimes reject medical treatments for the labouring woman (Leavitt, 1986, pp. 102-103**).** Thus, as suggested by Mitchinson (1991), medical professionals preferred less social and communal environments with birth, particularly because "in a home birth the physician is an interloper and must fit his needs with those of the household. He is visibly and directly accountable to the patient's family" (Mitchinson, p. 182), which restricted his power. Physician William Buchan, complained about "…that ridiculous custom…of collecting a number of women together on such occasions. These,

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[2] Childbirth was primarily an event embraced by women which was often exclusionary to men (Leavitt, 1999; Mitchinson, 1991)

instead of being useful, serve only to crowd the house, and obstruct the necessary attendants" (Mitchinson, p. 190). Therefore, medical professionals argued for birth as a privatized event because it allowed them to be the primary decision makers without interference from a woman's friends or relatives (Mitchinson). These narratives show the increasing focus on having childbirth centred on convenience for the medical professional and less on women's experiences.

Medical professionals sought to affirm and claim authority over medical knowledge of the body as the medical literature in the nineteenth century promoted modern medical practices. Mitchinson (1991) identifies three primary modes that were increasingly used to distribute gynaecological knowledge: journal literature, school program requirements, and gynaecological practice. She refers to Canadian physician, William Tyler Smith's 1858 textbook, *The Modern Practice of Midwifery,* which criticized physicians for being 'timid' if they did not interfere with a 'natural' childbirth. Similarly, an article in the *Canada Medical Record* criticized physicians who allowed women to endure long labours instead of intervening. By 1874, an editorial in the Canadian *Lancet* asserted that obstetrics had become a specialized area in Canada, thereby, as argued by Mitchinson, demonstrating the belief that obstetrics was superior to midwifery care. The literature of the era exemplifies that obstetricians were recognized as specialists; even women and their relatives expected obstetricians to actively intervene with labour and childbirth (Mitchinson).

In the twentieth century some medical professionals warned against the use of technology and interventions with childbirth, while others were able to successfully promote their ability to intervene as beneficial and safe for women. Dr. D. Mackintosh from Nova Scotia believed that promoting the benefits of objectivity and science led

people to expect too much from medical professionals (Mitchinson, 2002). Similarly in his 1951 text, *The Nature of Medical Practice*, F. B. Exner cautioned readers to consider how science was viewed as superior and asserted the belief science and medicine were social constructions (p. 22). Conversely, referring to *The Physician Himself and Things that Concern His Reputation and Success* (1898), D.W. Cathell argued for the superiority of science because of its objectivity; he asserted ignoring emotions strengthened science. Medical professionals such as Cathell argued that it was safer and more hygienic for women to give birth in the presence of a highly trained medical professional and eventually within hospitals (Leavitt, 1999a; Mitchinson). There, women were under the supervision of professional care and expertise and were thus urged to believe that they were making the responsible decision for their child by giving birth in the attendance of medical professionals.

Cahill (2001), Mitchinson (1991; 2002), and Davis-Floyd (1987) document that childbirth was further medicalized as medical professionals looked at "clinical details rather than the patient for information on how the birth was progressing" (p. 204). By referring to clinical details, interventions were justified by medical professionals, on the basis that a woman differed from the norm or what medical professionals constituted as a 'typical birth' (Mitchinson, p. 204). Furthermore, Barbara Katz Rothman (1982) asserts the procedures of controlling women's labour and childbirth were not representations of normality or health, and consequently, women were "worked on" and controlled by the medical professional (p. 174). Thus, medical professionals became increasingly active, rather than passive, actors with childbirth, and women were correspondingly silenced (Cahill; Davis-Floyd; Martin, 1987; Mitchinson; Rothman).

The spatial shift: Childbirth moves to the hospital

By the twentieth century, Canadian hospitals increased in numbers from 481 in 1929 to 924 hospitals by 1952 (Mitchinson, 2002). Birth rates within hospitals also accelerated during this time period: in 1926, 17.8 percent of births took place in hospitals; in 1935, 32.2 percent of births were in hospitals; and by 1960, 94.6 percent of births took place in hospitals (Arnup as cited by Warsh, 2010, p. 119). As noted by Warsh, Canadian women were not only directed to use hospital services by medical professionals, Canadian women also began to actively seek the help of medical professionals in hospitals.

The spatial shift from the home birth to the hospital birth enforced notions circulating broadly at the time that safety was insured by a revisioning of childbirth as a "medical event" (Cahill, 2001; Davis-Floyd, 1987) The familiar space of the home for childbirth was being increasingly displaced by the location of childbirth in the actual spaces, expectations, regulations, and practices within hospitals. From this perspective, as a medical event, a safe birth required medical assistance from medical professionals. Hospitals were equipped with drugs, medical machines and technology all potentially used to monitor and to intervene during a woman's labour and childbirth; hospitals were understood as working spaces for medical professionals to provide medical care at a more efficient rate (Davis-Floyd; Jordan, 1993; Mitchinson, 2002). Thus, with the medicalization[3] of childbirth, medical professionals claimed they were indeed removing any unpredictability and potential complications with childbirth.

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[3] Childbirth was increasingly treated in the medical realm and therefore medicalization is described by Inhorn (2007) as "the biomedical tendency to pathologize otherwise normal

Hospital births were distinguished from home births by the presence of standard medical practices and institutional regulations insuring that standards were met and kept. Such regulations included at the time, and in many cases continue to include: limits on number of non-medical people present at times before, during, and after the birth of the child; devoted attention to cleanliness both in terms of conditions outside and inside the women's body; control of bodily functions. These, formalized, routine prescriptions communicated and demonstrated external control over the female body as medical professionals tamed the perceived "unnatural" and unhygienic aspects of labour and birth (Davis-Floyd, 1987; Mitchinson 2002). As childbirth as a medical event quickly became the majority child-birthing experience for Canadian women, hospital procedures became understood by women themselves and practiced as the norm. Thus, enemas or shaving of women's genitals became standardized practices that were expected and unquestioned. As Mitchinson implies, hospitals were characterized by rules and regulations out of women's control; hence their experience of childbirth became largely dependent on decisions made by medical professionals.

As an established, exclusive profession, medical professionals increasingly excluded women from any decision-making processes during childbirth (Cahill, 2001; Davis-Floyd 1987; Jordan 1993; Mitchinson 2002). Medical terminology re-enforced the power relation between women and medical professionals (Jordan; Mitchinson). As a male-dominated occupation, the medical profession gained the authoritative medical voice, thereby leading to the objectification of women and increasing women's passivity.

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bodily processes and states" (p. 13), which inevitably leads to medical control and management.

Medical terms were inaccessible to lay people, which enabled the medical vocabulary to thrive in the hospital setting. As a result of being excluded from the "medical world," women's knowledge was further undermined and largely oblivious to medical professionals; thus, women's self-knowledge was devalued. Therefore, the power imbalance became increasingly prevalent between medical professionals and women (Davis-Floyd; Jordan; Mitchinson).

Medical professionals advertised and promoted medicinal interventions and technological interventions. For example, in 1914 "Dr J.H. Dye advertised in the Weekly Manitoba Liberal: 'TO WOMEN WHO DREAD MOTHERHOOD Information How They May Give Birth to Happy, Healthy Children Absolutely Without Fear of Pain— SENT FREE'" (Mitchinson, 2002, p. 207). Similarly, as noted by Mitchinson, in 1908 Frederick Fenton from the University of Toronto and in 1913 Joseph B. DeLee expressed their support over the use of pain relief and anaesthesia for childbirth. By the second decade of the twentieth century, as argued by Mitchinson, medical literature conventionally assumed that some form of pain relief would be used during childbirth, which showed that pain relief had become a normalized addition to childbirth.

Mitchinson (2002) notes that while there were problems and complications with the administration of drugs during childbirth, medical professionals such as obstetricians and gynaecologists advertised the use of pain management as a medical advancement, which ultimately framed the medical professional as a hero (p. 212). By using drugs, such as ether, chloroform, nitris oxide, and morphine, women had the opportunity to engage with prescribed medical pain management techniques. Cheryl Warsh (2010) refers to Carl Gauss and Bernhardt Kronin's introduction of "Twilight sleep" in 1908, "a combination of morphine and scopolamine. […] [which] did not eliminate labour pains but obliterated

the memory of it after the birth" (Warsh, p. 121). Some women's groups, such as the National Twilight Sleep Association (NTSA), established in 1914, lobbied for the use of Twilight sleep as a way to escape the "torture" of childbirth. However, Warsh argues, with the dangers and complications with the procedure, including possible death, the demand for the service declined. Warsh also refers to Canadian obstetricians who highlighted the difficulties with administering and monitoring Twilight Sleep in a 1915 series of articles published in the Canadian Practitioner and Review. Nonetheless, as noted by Warsh, Nickle Pavilion Kingston General Hospital records showed that anaesthesia was used in more than 90 percent of childbirths by 1940 and by 1977, drugs were continuously administered to minimize the pain during labour and childbirth; epidurals by 1977 were used in 29 per cent of births in the United States (Warsh, p. 122). Thus, despite the dangers with using drugs during labour and childbirth, the use of drugs for pain management has been increasingly employed.

Technological intervention was employed as a means to offset the "pathologies" associated with childbirth, thereby supposedly making childbirth safer for women (Cahill, 2001; Inhorn, 2007; Warsh, 2010). Technological interventions include: forceps, episiotomies, vacuums, electronic fetal monitoring, and caesarean sections. While each of these interventions were created to counteract the dangers that women faced during childbirth, Warsh notes that many interventionist practices were unnecessary and thus, the improper application of such tools led to further dangers, problems, and interventions. As an example, Warsh refers to Joseph B. DeLee's recommendation in 1920 that forceps and episiotomies should be used routinely in order save mothers and babies. However, as stated by Warsh, forceps also "could lead to head injuries and perineal lacerations in women" (pp. 123-124). Despite the dangers associated with such devices, "American

obstetricians began advocating for routine episiotomies, […] [primarily to shorten] the labour process in hospitals" (Warsh p.124). By 1950, episiotomies were accepted as one of the standard procedures in hospitals. Furthermore, Warsh refers to the popularity of electronic fetal monitoring, which was also used routinely to provide a fetal heart rate and alert medical professionals to changes with the heart rate and fetal distress. However, "[c]ontroversy arose over whether the monitors were too indiscriminately used and whether the staff was too quick to intervene in natural labour. Furthermore, the monitor's readings were imprecise and not always interpreted correctly by staff" (Warsh, pp. 125-126) and correlations between monitor use and caesarean sections were apparent. Despite its original use for high-risk pregnancies, by the 1970s and 1980s the monitors were routinely employed.

With the evolving reliance on the "authorized" knowledge and advice of medical professionals, women's experiences of childbirth changed from social and embodied experiences in familiar spaces to what in the early history of the medicalization of childbirth must have seemed as foreign, unfamiliar experiences isolated within controlled sterile spaces (Cahill 2001; Duden, 1993; Leavitt 1999a; Mitchinson 2002). Exemplifying the authoritative power held by medical professionals, Mitchinson refers to Jennie Graham's experience. When Graham told a nurse that something was wrong and the nurse replied, "'What do you know?' Graham had the wit to come back with 'But it's happening inside me. I do know'" (Mitchinson, p. 179). Mitchinson's use of Graham's vocal defiance shows that a woman's bodily self-awareness was ignored by medical professionals and a woman's knowledge was not recognized as a legitimate resource. By underestimating women's knowledge of their bodies, medical professionals in the twentieth century relied heavily on their own educated observations and documentations

to develop the standards for how a "normal" birth was successfully achieved. As noted by Mitchinson, systematic observing and documenting childbirth allowed medical professionals to establish regulated standards for childbirth, which they believed would reduce the "guesswork" and "uncertainty" of childbirth.

Emily Martin (1987) notes that women's care was divided into stages and labour as such became more incrementally managed by doctors. Through the use of technology, childbirth management extracted the baby from the woman. For example, if labour took too long, doctors might deem the lack of progress as "abnormal" and choose to intervene. Robbie Davis-Floyd (1987) describes these invasive medical approaches and practices as part of a paradigm of "the technological model of birth" (p. 1); in this model, the body is mechanistic, isolated, and subject to invasive operation. In this paradigm, women were further displaced from being active participants in childbirth as doctors no longer needed to wait for their bodies to birth a child; instead technology was used to induce birth or remove the child through mechanical means, such as caesarean-sections. Thus, technology was an added mechanism that allowed doctors to increase authority and control over women's natural capacities.

The medicalization of childbirth: Contemporary research

Framing childbirth as a "medical event" with inherent problems and risks provided health practitioners the "right" to intervene. Childbirth, as medical event, was met with both accommodation and resistance among factions of health care providers and among Canadian women themselves. However, Canadian women consistently rely on medical assistance when their children are in the process of *"being delivered"* (Rothman, 1982, p. 174). Women's reliance on medical professionals was and continues to be affirmed by women's increased requests for drugs and other medical assistance or

intervention to erase or ease any pain experienced during childbirth (Martin, 1987; Mitchinson, 2002).

Scholars Barbara Duden (1993) and Janelle Taylor (2004) argue through the use of technological aids, such as ultrasounds, the fetus became a 'visual product'; visualization is used as a technology to document women's and fetal progress during pregnancy. Ultrasounds allowed medical professionals to turn the body "inside-out" and judge how women's bodies were progressing to properly nurture and accommodate the ideal fetus. Referring to the ultrasound fetus image as a "fetish," Taylor states "[f]etishism of the fetus consists in attributing to its value as "life," as if this were a property magically inhering in the fetus alone, in a manner that obscures the fact that the continued vitality of any actual fetus depends utterly and completely upon its continued sustenance by the woman who carries it" (p. 189). Taylor, following Petchesky, agrees that the effects of the use of ultrasounds led to increased external control over women's bodies, however, at the same time ultrasounds revealed the extent of fetal development. As Taylor points out, ultrasounds reveal "the fetus—to the medical gaze on the one hand and to the gaze of the mass-mediated public on the other" (p. 189); a mass-mediated public that includes child-birthing women. In this way the use of technology can simultaneously disempower women while at the same time strengthen women's attachments to technological interventions monitored and managed, by medical professionals, both medically and socially to ensure the safety of the fetus.

The context for an increasing demand for medical intervention from Canadian women in the late twentieth century, and at the time of this research (2013-14) includes the shift from the home to the hospital that was fostered by the professionalization of medical practice. Hospital birth, as a part of a broader social movement towards the

establishment of biomedicine as state medicine, affected a shift in the social relations of childbirth. Coincidentally, at the same time that hospital births became the North American norm, Warsh (2010) notes that by the late twentieth century women delayed childbirth and had fewer children. While technology and obstetric care improved maternal mortality rates, "[o]ne consequence of a lowering birth rate, better survival prospects for mothers and infants, and a more educated and prosperous female population was that mothers-to-be demanded a better childbirth experience" (Warsh, p. 118). Questioning the "standard" childbirth, that increased the likelihood for intervention with childbirth, women in a consumer movement began to advocate for their desires and expectations of childbirth. Thus, women became more concerned with their treatments and the overall experiences.

Women's health movement, 1970s-1980s in North America

Much of the questioning by women was fuelled by the women's rights movements in North America during the 1960s (Warsh, 2010). The movement supported and encouraged women to take control of their own bodies and contest medical control, hospitalization, medicalization, and technological interventions, with special attention to those involved with labour and childbirth (Morgan, 2002; Ruzek, 2012; Kline, 2010). Activists created counter-narratives and medical alternatives through publishing literature, opening affordable health clinics, and asserting women's experiences as valid sources for information and knowledge (Morgan, Ruzek, Kline). Sociologist Sheryl Burt Ruzek asserts that in the twentieth century women experienced and critiqued "medical sexism" through medicalization of and external control over women's bodies. Specifically with regards to the medicalization of childbirth, women objected to dehumanizing medical practices, such as "holding women's legs to delay birth, pulling

babies out with forceps, unnecessary strapping and drugging, and unwarranted withholding of drugs" (Ruzek, 49). Activists rejected the perceived dehumanizing care and therefore challenged medical authorities; the "idea of women creating "observational" data out of their own health and body experiences was truly "revolutionary" (Ruzek, pp. 308-309) in the late twentieth century in Canada and the United States. Thus, health movement feminist activists contested the control held by physicians and argued for women's right to control their health. The developments in this era shaped contemporary women's agency with their health and impacted the services provided by their healthcare practitioners.

Literature published by activists during the women's health movement provided women with accessible information about their bodies, asserting that knowledge was power (Kline, 2010, Morgan, 2002). Medical information about women's bodies, they argued, had formerly been limited to medical professionals, making it difficult for women to make assessments and decisions about their health and bodies. The text, *Our Bodies, Ourselves*, written for women by The Boston Women's Health Collective,[4] was first published in 1971 in the United States. In the text, women authors collectively expressed feelings of discontent and "abuse" by medical professionals. The women of the Boston Women's Health Collective saw medical professionals as authoritative and patriarchal, arguing that "[n]ot only should women have access to information about their bodies […]

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[4] As noted by Warsh (2010), The Boston Women's Health Collective was formed after the 1969 women's conference in Boston. The group of women, who met at the conference, continued their discussions about women's health, forming The Boston Women's Health Collective.

they should also help to *create* this knowledge" (Kline, p. 3). Kline notes that during a time when there were numerous movements, *Our Bodies, Ourselves* was revolutionary because the text focused on embodiment and declared the personal experience as political. *Our Bodies, Ourselves* was an accessible resource for women; it informed women about control over their bodies, which was important as they claimed withholding information hindered women's abilities to gain knowledge and therefore limited their autonomy over their bodies and choices.

As noted by Marina Morrow (2008), activists in the women's health movement critiqued the health services and argued for the inclusion of "women-centred" care. "Woman-centred" care emerged from the belief that there needed to be a focus on women, "encouraging the involvement and participation of women in their care, and operating from the principles of empowerment, respect, and safety" (Barnett, White, & Horne as cited by Morrow, p. 53). Thus, Morrow argues this model asserts that gender differences needed to be recognized within health care, along with the social, political, and economic factors that impacted women's health. As an example of creating alternatives to the medical model of care, by 1975, American activists, such as Seaman and Wolfson, founded the National Woman's Health Network. This network influenced nearly 2,000 women's self-help and medical projects in the United States. Feminist health clinics formed by feminist activists and groups aimed to provide humanistic and affordable care to women (Morgen, 2002; Ruzek 1978). By addressing concerns with women's health, alternative models of care were created.

Activists of the women's health movement aimed to disrupt the silence and exclusion of embodiment from the medical system; women, as patients, were not expected to claim knowledge over their bodies or question physician care or the medical

treatment they received. Individual initiatives, such as those by Carol Downer, demonstrated women's efforts to learn about their bodies. Junod (2012) uses the example of Carol Downer who demonstrated her first cervical self-examination at the Everywoman's Bookstore in Los Angeles in 1971. Referring to Downer, Sandra Morgen (2002) writes, "she had never seen a cervix before. That privilege had been reserved for the doctor, who wielded his speculum beneath a sheet that shielded women from the sight of their own bodies" (p. 7). After experiencing the empowerment of viewing her own body, Downer and Lorraine Rothman toured 23 cities in the United States in 1971 to show women how to perform self-examinations. However, Downer's efforts were not met without challenge, and in 1972 she was arrested for practicing medicine without a license and was then acquitted after a two-day trial (Junod, pp. 61-62). Despite the challenges posed by Downer, Morgan shows Downer's narrative exposed the power dynamics of medical care and knowledge operating in the United States during the late twentieth century.

Historians, Wendy Kline (2010) and Cheryl Warsh (2010), discuss the impact of the women's health movement on advocates for alternative maternity care. Following the publication of *Our Bodies, Ourselves,* discussions of women's childbirth experiences revealed most women were discontent with medical and obstetrical care that they received (Kline). Activists sought alternatives to the medical model of care (Kline, Warsh). Women advocated for alternative ways to prepare for childbirth that would not rely on the medical assistance of medical professionals. As Warsh notes, practices such as self-hypnosis and the Lamaze method and prenatal classes were popularized and employed to reduce pain during labour and childbirth.

By the 1980s, it became routine for women to attend prenatal education classes, which allowed women to communicate with each other in a social environment. However, citing sociologist Elizabeth Armstrong, Warsh (2010) explains that prenatal education was still used to benefit hospital staff because women were taught what to expect and how to "behave" in hospitals. There was little discussion about the emotions and pain of childbirth and a focus on the tools and procedures "emphasized a mechanistic rather than natural or emotional view of childbirth and led to many women's further alienation" (Warsh, pp. 148-149). Nonetheless, Warsh emphasizes that prenatal classes provided information for pregnant women in order to better prepare them for pregnancy, labour, and childbirth without invasive technologies. By the 1970s and '80s, in the United States, "[n]urses deserted delivery tables to "catch" babies in bathtubs" (p.130) and more women sought the services of birth centres. In Canada, there were efforts to provide options for alternative maternity care. For instance, in 1979 there was a petition for a birth centre in Ontario; in 1994, Ontario and Quebec allowed licensed midwives to attend home births; and in 1998 British Columbia followed suit. Nonetheless, medical societies resisted the presence of midwives, specifically through legal action. For instance, in 1990 Albertan midwife, Noreen Walker, who successfully helped deliver a baby, was charged for practicing medicine without a license (Warsh, p. 146). By advocating for alternative care, women showed resistance to medicalization.

With the increased awareness of the importance of the personal experience, environmental settings in hospitals also changed and were shaped to better accommodate patients. By 1995, there was popular demand for hospitals to simulate aspects of home births with the delivery rooms. Altering hospital rooms to resemble home-spaces showed both the possibility for hospital care and practices to change and that women wanted to be

comfortable with their spaces during their childbirth. With the advocacy of the "woman-centred" (Morrow, 2008) care approach in the women's health movement, hospital practices and settings changed and by 2002, women reported better birthing experiences in the birthing rooms, using fewer medications and having more mobility (Warsh, 2010, p. 150). Changing the space and care in hospitals was an example of how women were able to achieve better experiences during childbirth, which affected the emotional and psychological well-being of women.

Alternative views were accepted within the medical sphere, as shown in textbooks and hospital practices, and women were able to gain more freedom and agency with their labour and childbirth. Despite points of disjuncture between medical care and alternative care, some medical professionals advocated for alternatives in childbirth, which impacted hospital spaces and medical practices. Gynaecologists and obstetricians, such as Dr. Robert Caldeyro-Barcia and Dr. Michel Odent argued against the lithotomy position of delivery, where women were required to lie on their backs for delivery (Warsh, 2010). Medical literature in 1960s began "to note what Native and other cultures had known for centuries: that the "lateral" rather than "supine" positions of delivery facilitated contractions, were more relaxing to women, and were even better for their blood pressure" (Warsh, p. 149). However, there was no indication that hospitals accommodated women who did not want to birth in the "supine" position. Generally, women were still instructed to accommodate medical professionals. Thus, Warsh questions the extent that women's needs were being accommodated during labour and childbirth.

National concern over the involvement of technology with reproduction was evident during the 1993 Canada's Royal Commission on New Reproductive

Technologies. The Royal Commission highlighted intersecting aspects of technology, human rights and bodily autonomy. While the document addressed issues with reproductive technologies, there was a curious absence of commentary on the effects of new technologies on labour and childbirth. Nonetheless, the Commission was significant in showing growing public concern over technological applications with reproduction and the human body. The Commission also addressed topics relevant to childbirth technologies, such as medicalization, which impacted women's experiences of autonomy and empowerment with medical care. While it addressed concerns technology use and health, scholars remain critical of the Commission. Subsequent surveys show that while Canadians were aware of the dangers and complexities of the medicalization of childbirth, the actual practices in hospitals did not reflect significant changes.

Concern with the medicalization of childbirth in Canadian hospitals sparked a 1998 survey of hospital practices that assessed the necessity of routine procedures such as enemas, perineal shaves, intravenous infusions, and electronic fetal monitoring (Warsh, 2010). The purpose of the survey was to evaluate hospital practices and to consider "whether maternity ward practices reflected the most recent evidence or customs that had been found to be unnecessary and/or potentially dangers. While the results showed that practices varied depending on the place and size of hospital,

> [p]rocedures [such as fetal heart monitoring, intravenous infusions, and performed episiotomies] continued to be routine in a large number of hospitals, despite the evidence that shaves and enemas were unnecessary and perceived as "degrading" by women in labour, that intravenous infusions of glucose and other fluids could be harmful to the baby and could be replaced by feeding the mother during labour, and that continuous electronic fetal monitoring resulted in higher rates of caesarean birth and use of forceps and vacuums (Kaczorowski *et al.* 1998, 11-12 as cited by Warsh, p. 133).

The results of the survey showed that women faced unnecessary and degrading procedures. Furthermore, by 2002 the Canadian government provided $1.5 billion for medical technologies in hospitals, showing governmental commitment to increasing, rather than decreasing, technology intervention (Warsh). In discussions about how the funds would be distributed, David Banta, an American assessor of medical products, questioned the necessity of electronic fetal monitors, insisting that simple and less invasive tools, such as the fetoscope, could be used. Similarly, Jill Sanders, president of the Canadian Coordinating Office for Health Technology Assessment, stated, "inevitably some technologies are creeping into usage that won't be effective" (as cited by Warsh, p. 126). However, as noted by Sanders, the mandate of the Canadian Coordinating Office for Health Technology Department was to determine whether a product was harmful. According to Warsh, fetal monitoring exemplifies technology that is not explicitly harmful for the fetus or mother, however, it is more expensive, and is generally accompanied by other interventions. Warsh ultimately questions the effectiveness and necessity of the application of all technologies.

Contemporary research on technology use during labour and birth

In twenty-first century Canada, medical interventions, in particular fetal monitoring and interventions used for pain management, are increasingly standardized during labour and childbirth. The current guidelines, provided by the Society of Obstetricians and Gynaecologists of Canada (SOGC, 2008), explain fetal health surveillance during labour, address one-to-one nursing care, survey protocols with

intermittent auscultation[5] and electronic fetal monitoring, and make recommendations for the use of continuous intrapartum[6] electronic fetal monitoring. The SOGC identifies intermittent auscultation and electronic fetal monitoring as the two primary methods to monitor fetal health in labour. However, the SOGC acknowledges that the standard use of electronic fetal monitoring responds to the recorded increase in interventions. In a comparison between intermittent auscultation and electronic fetal monitoring, the SOGC concluded that there are no significant benefits of using electronic fetal monitoring for low-risk pregnancies. Despite the increased risk of multiple interventions, the use of technology, such as electronic fetal monitoring, has increased and is routinely used in hospitals for both high-risk and low-risk pregnancies (Altaf, Oppenheimer, Shaw, Waugh, & Dixon-Woods, 2006; Fleming, Smart, & Eide, 2011). In the 2009 Maternal Experiences Survey of mothers, conducted by the Public Health Agency of Canada, nearly all births took place in hospitals or clinics. Almost all women who participated in the survey reported the use of technologies, such as electronic fetal monitors; 85% of hospitals reported that most women submitted to electronic fetal monitors and 90.8% of women surveyed revealed that their healthcare practitioner employed the use of electronic fetal monitoring during labour (Public Health Agency of Canada, p. 131). The Maternal Experiences Survey also highlighted women's experience of pain management during labour and childbirth, identifying both "medication-based" and "medication-free" methods to cope with pain. In particular, 57.3 % of women in the survey reported having

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[5] Tools such as a stethoscope or Doppler are used to monitor fetal health (Maternal Experiences Survey, 2009, p. 131).

[6] "Occurring during labour and delivery" (Intrapartum, n.d)

an epidural or spinal anesthesia during labour and 81.1% found the epidural helpful in easing pain.

When health care practitioners rely too heavily on technology, women's roles during labour and childbirth are undermined and women express dissatisfaction (Hall, Tomkinson, & Klein, 2012). During labour and childbirth, women's feelings of objectification stem from their health care providers relying too heavily on technology (Fleming, Smart, & Eide, 2011). Hall, Tomkinson, and Klein note women who sought minimal technological assistance described feeling degraded because the technology minimized their role with labour and birth. Brubaker (2007) notes that women are resistant to medicalization of birth; the women in Brubaker's research resisted the use of some technological procedures even when they felt that it was harmful or risky to do so. As discussed by Brubaker, women do not understand their resistance as retaliation against the control exerted by health care practitioners, but rather as an assertion of their own bodily autonomy and agency. Romano and Lothian (2008) note using technologies during labour can limit women's mobility and overall comfort during labour and childbirth. For instance, electronic fetal monitors and epidurals limit women's mobility during labour and therefore potentially hinders women's access to "comfort measures like a shower, bath or use of a birth ball" (Romano & Lothian, p. 99). Romano and Lothian argue in order to limit their use of technological interventions, women should ideally expect access "to a wide variety of comfort measures and [be able] to work actively with the increasingly painful contractions […] [and] have continuous emotional and physical support" (p. 100). Similarly, Simkin (2002) writes ideally, "[s]upportive care may be defined as nonmedical care that is intended to ease a woman's anxiety, discomfort,

loneliness, or exhaustion, to help her draw on her own strengths, and to ensure that her needs and wishes are known and respected" (p. 721).

The Society of Obstetricians and Gynaecologists identifies technological births as problematic and suggest less interventionist ways to help women during birth. In 2008 the SOGC released a statement on "normal childbirth," stressing that in Canada, childbirth has become increasingly medicalized to the point where "social and cultural changes have fostered an insecurity in women regarding their ability to give birth without technological intervention" (p. 1163). In the statement, "normal childbirth" refers to the "type of delivery of the infant" (p. 1163) and is identified as a vaginal delivery without the use of forceps, vacuums, or caesarean section. The statement asserts that health care professionals should facilitate births that are less technological and less medicalized; the SOGC addresses the role of health care professionals, stating: "[h]ealth care professionals should be committed to protecting, promoting, and supporting normal childbirth (p. 1164). Furthermore, the SOGC provides a list of recommendations for maternity health care professionals, including:

- Spontaneous onset of labour
- Freedom of movement throughout labour
- Continuous labour support
- No routine interventions
- Spontaneous pushing in the woman's preferred position
- Use of fetal surveillance by intermittent auscultation
- Institutions offering options for pharmacologic [7] and non-pharmacologic [8] approaches to pain relief (SOGC, p. 1164)

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[7] Examples of pharmacologic pain relief from the SOGC (2008) include nitris oxide, opioids, and epidurals (p. 1163).

[8] Examples of non-pharmacologic pain relief from the SOGC (2008) include showers, massage, and the environmental design of birthing architecture and furniture (p. 1164).

The list of recommendations supports the intention for a less interventionist and medical approach to childbirth. Thus, the ideal role of health care practitioners is to offer support to labouring women, expanding health care practitioners' roles from solely providing medical advice and assistance to providing emotional and mental support to help women achieve their desired childbirth experience.

Nonetheless, women seek the use of medical technology in order to ease the course of labour and birth. Miller (2007) notes in her research on women's transition to first-time motherhood, that her research participants discuss childbirth as a "natural event" alongside their consent for the use of medical expertise and interventions, particularly for pain management. Therefore, women themselves describe childbirth as a combination of "natural" and technological. Hall, Tomkinson, and Klein (2012) argue that women referred to technology as a way to reassure them of the well-being of their baby. Similarly, Brubaker (2007) discovered that women referred to technology as a way to show that they were doing a good job; women were comforted when they could see the heart rate and when health care practitioners showed their approval of the women. Similarly, Lyerly (2006) argues that technology can in fact have the effect of improving women's birth experiences. Lyerly suggests that women are not required to experience overwhelming physical pain during labour and birth, thus drugs offer options for a less painful labour. Therefore, she proposes technologies, such as epidurals can enhance women's birth experiences. In particular, epidurals are helpful for women who experience "exhaustion […] particularly during a difficult or lengthy [labour] […] [because] it may give her the chance to rest, even sleep, as her [labour] progresses and replenish her energy for the physical demands that delivery entails" (Lyerly, p. 108). Lyerly argues for the

value of technology with helping rather than hindering women's experiences of labour and childbirth.

Using technology in conjunction with the care provided by healthcare practitioners during labour and childbirth can facilitate women's empowerment during birth (de Jong, Hill & Summerfeldt, 2014; Lyerly, 2006; SOGC, 2007). Women's experiences are affected by their interactions with health care practitioners, therefore asserting the integral role that health care practitioners play for women during labour and childbirth (de Jong, Hill & Summerfeldt; Schneider, 2002). For example, one-to-one support during labour and birth has the effect of providing women with additional information and emotional support (Brubaker, 2007; Maternal Experiences Survey, 2008). The SOGC "Fetal health surveillance: Antepartum and intrapartum consensus guidelines" claim that increased communication,[9] care and labour support for women during labour and childbirth can impact women's experiences and well-being. As noted by the SOGC, women's birth experiences can have long-term effects on women's psychological well-being. Therefore, it is recommended by the SOGC that health care practitioners should include women in the planning and decision-making processes of their labour and childbirth. Furthermore, labour support is identified as an integral impacting factor for the outcome of women's experiences. Labour support[10] consists of:

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[9] The SOGC (2007) notes, "[d]uring pregnancy, women should be offered information on the benefits, limitations, indications, and risks of IA [intermittent auscultation] and EFM [electronic fetal monitoring] use during labour" (p. S27). Health care professionals should communicate the risks and benefits of the various technological practices in order to provide women with information on the technologies used. However, EFM is adopted as a hospital standard and therefore, women's choices are limited and the current practices do not reflect the recommendation.

[10] The SOGC highlights that women receive labour support from a range of people and therefore, "It is unclear, however, who should provide the labour support [nonetheless]

Emotion support (continuous presence, reassurance, and praise), comfort measures (touch, massage, warm baths/shower, encouraging fluid intake and output), advocacy (communicating the woman's wishes), and provision of information (coping methods, update on progress of labour) (p. S28)

Therefore, social support is essential with labour and childbirth for a positive experience (de Jong, Hill & Summerfeldt; SOGC). Furthermore, by explaining the purpose of the technologies used, health care practitioners signify shared authority with women during labour and birth (Hall, Tomkinson, & Klein 2012). By doing so, health care practitioners are able to ensure maximizing women's feelings of integrity during labour (Hall, Tomkinson, & Klein). Thus, as implied by Lyerly (2006), rather than viewing the technology itself as a negative aspect, the application of technologies and the care provided by health care practitioners impact women's experiences as positive or negative.

Conclusion

The literature illustrates how childbirth from the nineteenth century to the twentieth century became increasingly medicalized and less social. Feminist efforts founded the women's health movement of the 1960s through to the 1980s and changed the treatment of women's reproductive health as activists during that era contested medicalization that disregarded women's subjective knowledge and experiences of their bodies. A historical review of the secondary literature is relevant in order to frame a discussion of contemporary women's experiences of birth and to further explore how contemporary practices of care with labour and delivery have evolved from the past. Thus, my research uses the historical review in order to understand how present childbirth practices have come to be. In doing so, my research aims to collectively explore

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[…] every effort should be made to provide women in labour with continuous support." (p. S28)

contemporary women's experiences of childbirth. Two chapters which follow explore the extent by which a modest sample of contemporary women living in Southern Alberta assert or affirm their bodily knowledge and autonomy with hospital births and reveal the interactions between themselves and the health care practitioners who serve them. The purpose of this research project is to provide a glimpse into the contemporary experience of childbirth in Lethbridge, Alberta.

Chapter Three: Methodology

Introduction

In this chapter, I outline the theoretical perspectives and methodology used for this qualitative research study. First, I explain my theoretical underpinnings for the research study referring to the works of Dorothy Smith (1987, 2007), Scheper-Hughes and Lock (1987) and Lynam, Browne, Reimer Kirkham, and Anderson (2006). The theoretical framework highlights the value of women's standpoints and subjective experiences, while considering these experiences in relation to the social and cultural structures. Following my discussion of the theoretical framework, I review features of qualitative interviewing, feminist ethical practices, data-analysis and interpretation. These theoretical, methodological, and ethical considerations influenced the course of my research. I conclude with my description of the interview research process and data management, which includes concrete practicalities of the research project. Thus, this chapter will outline the research process and scholars who have influenced my interpretive approach to the research data.

Theoretical underpinnings

Standpoint theory is a theoretical framework used to highlight the experiences of marginalized groups, including women. Smith (1987) argues that as a result of men holding positions of power and authority, masculine dominated perspectives have been seen as normative. Women's perspectives correspondingly have been ignored and excluded "from the making of cultural and intellectual discourse" (p. 107). Since women have been excluded from positions of authority and knowledge making, "women have been deprived of the means to participate in creating forms of thought relevant or

adequate to express their own experience or to define and raise social consciousness about their situation and concerns" (Smith, 1987, p. 18). Furthermore, in writing about the historical silencing of women, Smith states "excluding women also excludes their knowledge, experience, interests, and perspectives and prevents their becoming part of the systemic knowledge and techniques of a profession" (p. 25). Hartsock "uses women's experiences to critique the epistemological and ontological basis of traditional theories of power and economic organization" (p. 10). Hartsock implies "feminist standpoint" can be used to understand an alternative view. Hartsock argues "it is not a single privileged perspective, but the interplay between different perspectives, that gives us the best kind of knowledge" (p. 8). Rather than conceiving of a shared standpoint[11] common to all women, Hartsock uses the term "concrete multiplicity" to recognize a multiplicity of perspectives. Welton further notes, the "new focus on multiplicity is grounded in the idea that diverse perspectives, feminist and otherwise, are the only way to get a better account of the world" (p. 18). These multiple perspectives are beneficial because they can be seen in conversation with each other in order to create better understandings of the experiences of marginalized groups.

I use the works of Dorothy Smith (1987), Katherine Welton and Nancy Hartsock (1997) to examine first-time women's experiences of birth from their perspectives. Inquiry should start "from the actualities of people's everyday lives and experience to discover the social as it extends beyond experience" (Smith, 2007, p. 328). By starting

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[11] In response to critics, who argue that standpoint theory essentializes women's experiences, Welton writes, "Hartsock's standpoint theory was not grounded in an essentialized conception of womankind, but rather in the epistemological significance of shared life experiences, common to women on materialist grounds, but not innately essential to them" (p. 17).

from the standpoint of the women involved in a study, Smith argues that standpoint theory "preserves the presence of subjects as knowers and as actors" (1987, p. 105); therefore the first-time mothers are identified in this thesis as active subjects rather than as objects of study. In her description of the observer and observed, Smith suggests that the researcher as the observer gets a partial view of the observed object based on the "underlying historically determined structure of relations" (p. 115). Instead, the "standpoint of women directs us [researchers] to an "embodied" subject located in a particular actual local historical setting" (Smith, 1987 p. 108). Smith argues that all experiences, such as birth for the first-time mothers in my research project, are socially situated and therefore express the current social and cultural conditions. Additionally, the complexities of experiences reveal the power struggles faced by women as first-time mothers in the hospital, and draw attention to moments of both compliance and resistance with the childbirth experience.

Using standpoint theory as an entry point to explore the personal experiences of women, which have typically been excluded (Smith, 1987), I refer to Scheper-Hughes and Lock (1987) to further consider the relationships between three theoretical approaches: the individual body, the social body, and the body politic. As previously highlighted, using standpoint theory, referring to the personal experiences reveals the complexities of the everyday lived experience. These lived experiences are influenced by social and cultural norms and can therefore not be theorized as separate. By viewing the three bodies in relation to each other, a better understanding of the individual's situated experience within society can be established by considering the individual's lived experience, and the individual's struggle with power, control, and agency.

To begin with, I offer a short description of the three bodies, which play an integral role in describing the "mindful body," which I refer to in my analysis of the first-time mother's experience of childbirth and perception of technology use. Describing a long list of cultural differences and influences with the production of the "self" and "individual" to describe illness, Scheper-Hughes and Lock argue that medicalization "entails a missed identification between the individual and the social bodies, and a tendency to transform the social into the biological" (p. 10). In the West, the body is understood biomedically, and scientists judge objective information in order to provide a "*real* biomedical diagnosis" (p. 8); the body is seen objectively, singularly, and mechanically pulled apart to be seen in pieces. The Western conception of the individual body thus relies on one "self," separate from the body, and independent from other individuals.

A structuralist approach is used to understand the social body as a physical and cultural artifact (Scheper-Hughes & Lock, 1987). Through this approach, bodily characteristics are seen as "natural" and the body is used to justify "particular social values and social arrangements" (Scheper-Hughes and Lock, p. 19). Thus, within a society, people are able to "misrepresent to themselves their social world as the only possible way to think and to behave and perceive as "natural" what are, in fact, self-imposed cultural rules (Scheper-Hughes & Lock, p. 22). As a result, the individual and their understanding of their body is socially constructed and understood as "natural."

Scheper-Hughes and Lock (1987) term the third body as the body politic, which not only considers "nature" and "culture" when addressing the individual within society, but also analyzes the individual in relation to power and control. As noted by Scheper-Hughes and Lock, regulation extends not just to individuals, but populations "and

therefore of sexuality, gender, and reproduction" (p. 27). Social regulation influences the actions and behaviours of people within society, so heavily that people themselves begin to self-regulate their actions in order to uphold social order. In order to assert power and control, "new forms of power/knowledge over bodies" (Scheper-Hughes & Lock, p. 26) are created. For example, medical terminology contributes to the divided categories of the authoritative medical professional and the passive patient. Through power and control, the authoritative medical professional has the power to both diagnose and remove illness from the patient. People adapt in order to meet the expectations of those in power who have established rules and regulations that are supposed to better society.

The three theoretical approaches to the body within a society are explained in relation to each other using emotion and forming the fourth theoretical approach termed the "mindful body" (Scheper-Hughes & Lock, 1987). Each of the described bodies differs with respect to how individuals are understood and operate socially and culturally, yet Scheper-Hughes and Lock assert emotions "affect the way in which the body, illness, and pain are experienced and are projected in images of the well or poorly functioning social body and body politic" (p. 28). Referring to the "mindful body," theoretically, the individual is able to challenge social or cultural norms through moments of individual struggle, resistance, and agency. The boundaries between mind and body or nature and culture are hence disrupted and the individual, social, and political bodies are seen in relation to each other. Not only does the research project look at the individual experience within the social and cultural settings, but the research study questions the social and cultural structures that influence the power struggles faced by the first-time mother. Thus, as described by Scheper-Hughes and Lock, the individual, social, and body politic interact in "production and expression of health and illness" (p. 31).

The "mindful body" considers the relationship between the individual, social, and body politic in order to analyze social and cultural structures. Social and cultural structures are dynamic, ever-changing, and dependent on the particular setting and context. For example, referring to the "mindful body" can reveal how culture shapes conceptions of health and illness. Similar to Scheper-Hughes and Lock (1987), Lynam, Browne, Reimer Kirkham, and Anderson (2006) discuss the opposing views of culture as embodied and culture as constructed (p. 28). Instead of minimizing an analysis by only evaluating descriptions of an experience, or by only analyzing the social structures, Lynam et al. argue the benefit of looking at how structures "shape/influence" experience (p. 28). Lynam et al. refer to the works of Bourdieu as a way to link the individual experience to social practices and institutions, noting that "the physical and social structures of society both reflect and sustain, or conserve, social conventions and traditions, allowing them to be viewed (uncritically) as 'normal'" (p. 29). Thus, an individual's decision making is influenced by the social practices of the particular organization.

Lynam, Browne, Reimer Kirkham, and Anderson (2006) argue the value of conducting an analysis of both society and individuals within society in order to consider the ways that individuals assert themselves as active or passive agents within society. In doing so, the researcher considers cultural influences on health management and the influences on an individual's social and cultural participation in certain events. In other words, the researcher evaluates how cultural practices are legitimized or challenged. Using standpoint theory, the researcher endeavours to explore the embodied experience of the subject, such as the first-time mother. However, scholars, such as Scheper-Hughes and Lock (1987) and Lynam et al., argue that the individual experience is influenced by

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social and cultural structures. Therefore, the individual experience should be considered in relation to the social and cultural influences. Thus, the individual as an agent has moments of resistance, struggle, and compliance within the social and cultural structures.

Interviewing as methodology

Qualitative interviewing allows for the exploration of an individual's perspective of their experience and can be used to reveal social and cultural structures that the individual engages with. Interviewing involves a conversation with a participant in order to gain insight on an aspect of an individual's experience of social and cultural structures through the individual's narrative (Hesse-Biber & Leavy, 2011). Interviewing is particularly useful because "people are subject to discourse, power relations, and ideologies that are not of their own making but that nonetheless affect and perhaps even constitute what they talk about and how" (Brinkmann & Kvale, 2015, p. 3). Interviewing can therefore be used to learn about the social world and hence make sense of the individual's experience within a social and cultural context.

Interviewing women allows the opportunity to better understand women's experiences from their point of view. As noted by DeVault (1990), not only does interviewing women reveal the challenges that women face with expressing their experiences within a male oriented language framework, but by documenting women's narratives, they themselves are recognized as "knowers." The narratives of women are valuable because women's experiences, such as with childbirth, are systematically different from men's, yet have been absent due to the suppression by dominant traditions, groups and organizations (Anderson, Armitage, Jack & Wittner, 1990; Smith, 1987). Dorothy Smith (1987) argues the value of returning to actual experiences in order to grasp

a better understanding of women's experiences, within a particular social and historical context, which have been historically undermined or ignored.

Feminist approaches to interviewing encourage respectful and considerate research practices; the researcher is accountable for recognizing the different power dynamics before, during, and after the interview (Hesse-Biber & Leavy, 2011). Feminist methodologies focus on the ethics of care, respect and collaboration (Campbell & Wasco, 2000) in order to reduce the power dynamic between the interviewer and interviewee. When describing different approaches to interviewing, Oakley (1981) argues that traditional ways of interviewing[12] are based on a masculinist paradigm that encourages the researcher to assume that a value-free approach can exist. Such assumptions are adopted in order to provide the allusion of unbiased and objective research, which would presumably make the research more valid and more scientific (Oakley). Oakley is critical of the traditional interviewing approach as the interviewer's role within the research is unacknowledged and she therefore avoids using traditional methods of interviewing "as an essential way of giving the subjective situation of women greater visibility" (p. 48). In order to provide a contextualized interview, she recommends avoiding close-ended questions and prefers open-ended questions to "probe" and explore women's narratives from their perspective. Thus, with semi-structured interviewing, the interviewee has an active role in guiding the conversation and providing answers that reflect their lived experiences and therefore acknowledges women's experiences as legitimate.

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[12] Oakley (1981) argues three criteria for traditional interviewing, which include: (1) the interviewer treats the interview as a "one-way process" (p. 30); (2) the interviewer treats the interviewee as an "objectified function as data" (p. 30); and (3) the interviewer does not consider "personal meaning in terms of social interactions" (p.30) and is therefore detached from the interview.

As the researcher, I realized the need to allow space for women to express how they "felt" about the experience of birth. Instead of following a straightforward purely descriptive question-answer format, I posed open-ended questions, which provided the opportunity for the women to share their experiences of birth in-depth. My adoption of this qualitative research approach "offer[s] a more human, less mechanical relationship between the researcher and 'the researched'" (Jayaratne & Stewart, 1991, p. 90). By listening carefully to and documenting the subjective perspectives of women who recently gave birth, I acknowledge women's experiences as valid and women themselves as "knowers" (Olesen, 1994). My research suggests that interviews about birth can provide insight into women's experiences by encouraging women to express themselves in their own terms. Anderson, Armitage, Jack and Wittner (1990) write that during an interview, if "we [researchers] want to know how women feel about their lives, then we have to allow them to talk about their feelings as well as their activities" (p. 100). To conduct research about birth, I started to listen to the women's experiences in stereo—that is "to listen with restraint to the meanings of the experience of the respondents" (Levesque-Lopman, 2000, p. 103). Thus, it is important to listen to the verbal and non-verbal expressions as this reveals clues to the social organization of their experiences. Listening to the interviewees' narratives and meaning-making processes demonstrates ethical respect (Anderson & Jack, 1991).

By using semi-structured interviewing, the interview is a product of both the interviewer's knowledge and the interviewees' knowledge and experiences. The interview questions were developed keeping in mind that the interview is socially situated and the participant's responses are shaped by the interview questions (Brinkmann & Kvale, 2015). Thus, the interview takes place within an interpersonal context and the "meaning

of interview statements relate to their context" (Brinkmann & Kvale); the interview is a co-construction between the interviewer and interviewee. The narrator or first-time mother revealed aspects of herself—a culmination of her subjective experiences and interpretations about birth and technology. The first-time mother uses her narrative to make "sense of [the] social reality in our own lives" (Brinkmann & Kvlae). The first-time mother therefore expresses herself in a way that she knows will make sense in that particular context. For instance, research participants may have felt the need to give me what they thought I needed or wanted for the research project and therefore their answers might be tailored to fit my research mandate about birth experiences. Thus, Abrams (2010) urges the researcher to consider the impact of the interview context with shaping the research participant's narrative.

Reciprocity within the interview exchange.

Alan Wong (2009) reports, as the interviewee, his emotions and mental stress surrounding the interview process to gain insight about what interview participants might experience before, during, and after an interview. Despite my efforts, I recognize that ultimately I guided the interview process and the interpretive production of the research. As the interviewee, Wong writes, "[in] addition to some minor angst over how interesting my stories would be, I was unsure how much information I wanted to divulge" (p. 248) and he describes "feelings of discomfort" (p. 249) after disclosure of personal information. Furthermore, Wong questions during the interview "What was the truth? What was I getting right? (p. 250). His questions raise awareness of the pressure that the interviewee may feel in providing the 'right' information. Correspondingly, during the research interviews, I responded to any question about the quality of the participant's response by stating that the responses were "good." In order to offer assurance to my

research participants, I employed social cues of encouragement and engagement to facilitate the interview process.

Qualitative researchers must be aware that they enter the lives of research participants, and thus interviewing, requires the researcher to engage with research participants in a humanistic way (Dickson-Swift, Jeames, Kippen, & Liamputtong, 2007). When the researcher gathers information, Dickson-Swift et al. assert that some "researchers [feel] like they were 'using' their participants as a means to an end" (p. 343). Self-disclosure can help equalize the power dynamic between the researcher and the participant (Dickson-Swift et al.). Furthermore, DeVault (1990) writes, that even though each person has a designated role with an interview "changes in the role of researcher, based on incorporating rather than denying personal involvements" (p. 101) have been discussed and applied with feminist methodology. Before beginning the audio-recorded interviews, I engaged in informal conversations, to establish rapport between myself, and the women. During my interviews, I recognized that the women were sharing personal aspects of their life. Thus, if women asked me personal questions, I provided a response. For instance, several of my participants asked whether or not I had experienced birth. I explained that even though I have not experienced, several friends and family members included me in their experience. However, I limited self-disclosure recognizing that the purpose of the interview was to listen to the participant's story (Dickson-Swift et al). Thus, while self-disclosure helps minimize the power imbalance during an interview, the interviewer must maintain the flow of an interview.

Data analysis

Transcription as empowering the researcher.

Transcription is an interpretive act performed by the researcher, whereby the researcher is active while transcribing and present in the transcriptions themselves (Bird, 2005). As noted by DeVault (1990), listening occurs both during and after the interview, with transcription and analysis. The researcher must actively listen to the way the interviewee speaks, to the silences, to the tone, etc. Each of these aspects affect the structure and hence the interpretation of the interview itself. Despite the desire to include each detail of the interview, no "transcription technique preserves all the details of respondents' speech" (DeVault, p. 108). Talk is therefore acknowledged as "messy" and despite the researcher's intention, some emotion and context will be lost with transcription.

During transcription, the researcher maintains an active and subjective role with interpreting the content; the transcription is a shared story between the participant and the researcher. Since the interpretations of my participants' interviews about birth are influenced by my transcribing the interviews verbatim, transcribing is one component of the interpretive act. Bird (2005) asserts that, as an interpretive act, the transcriber has an active role with the construction of the narrative. The researcher has the power to edit the interview in particular ways to include or exclude aspects, such as tone, accent, and repetition (DeVault, 1990). Due to this power, each decision made by the researcher in the construction of the transcript distances the narrative from the participant and represents an "interpretive act" by the researcher (Bird). In order to recognize myself in the role of researcher and transcriber, I made notes after the interviews and during my transcription of the interview; thus, showing that I, as the researcher, am situated in the

research processes, and am in control of decision-making while transcribing. In wielding this power, I must remain conscious of the perspectives of the narrator.

Data analysis and interpretation.

As previously noted, DeVault (1990) describes the challenges of women's talk because women are speaking within a masculine discourse. Thus, DeVault cautions the researcher to be aware of the political task with "labeling" women's experiences, particularly because of the "dangers of mis-labeling that can result from the use of language that does not fit" (p. 110). In order to prevent "mis-labeling," DeVault suggests that feminist researchers carefully describe women's experiences, and remain conscious of the consequences of approaching such a task without care. Through coding and the information collected from the literature review, I identified three findings, which are: (1) how women navigate their childbirth experiences and form the authentic self; (2) how women appropriate medicine; and (3) how the research participants described their social setting during childbirth. During the data analysis, I was influenced by the data from the literature review and considered how the women's experiences were similar to or differed from assertions or claims in the previous literature. Referring to the actual lives of the women reveals the complexities of the experience (Smith, 1987). Therefore, in my analysis of the data, I also focused on how the women described their experiences and refer to their descriptions of labour and birth.

I read the interview transcripts with an inquiring mind and analyzed them to find relevant themes. The features of talk revealed the social and cultural structures that women operate within to show the "orderliness of social life" (DeVault, 1990, p. 107). Data analysis "is the process of making sense of the data and discovering what it has to say" (Holliday, 2007, p. 89). During this process, the interviewees' narratives are used for

evidence to develop themes (Holliday). While creating relevant themes, Holliday urges

the researcher to be conscious of the ways in which the themes emerge and how these

"are also influenced by questions or issues that the researcher brought to the research" (p.

97). Thus, by applying Holliday's suggestions, I subjectively interpreted my research

participants' narratives to create relevant themes in order to address my primary research

question; I therefore, enter the research with a particular agenda.

The interpretation of the interview transcripts places the researcher in a powerful

position with the interpretation and representation of an interview. Borland (2004)

explains the dynamics of interpretive authority and how interpretations by the researcher

can be problematic for feminists, where on

> the one hand, we [researchers] seek to empower the women we work with by
> revaluing their perspectives, their lives, and their art in a world that has
> systematically ignored or trivialized women's culture. On the other, we hold an
> explicitly political vision of the structural conditions that lead to particular social
> behaviours, a vision that our field collaborators, many of whom do not consider
> themselves feminists, may not recognize as valid (Borland, p. 523).

Thus, while I hold the utmost intention of respecting the unique perspectives of my

research participants, I am aware of the dangers of unintentionally misrepresenting the

experiences of my research participants. Interpretation becomes problematic when

different social and cultural perspectives about experiences, such as childbirth, shape the

researcher's analysis and conflict with that of the narrator. As an example, when Borland

reflects on her research with her grandmother, she includes a response from her

grandmother's review of the research, writing, "[the] interpretation of the story as a

female struggle for autonomy within a hostile male environment is entirely YOUR

interpretation. You've read into the story what you wished to…The story is no longer MY

story at all" (Borland, p. 529). Borland's grandmother's response begs the question of

who owns the narrator's story versus the interpretation of the narrative. Borland addresses this question by noting that "the story does not really become a story until it is actualized in the mind of a receptive listener/ reader" (p. 529), and what Borland as the researcher provides is her understanding of the story. Thus, as an interpretation, the interview text evolves into a co-construction between the interviewee and interviewer. Ownership of the text is therefore shared.

Feminist ethical practices

Ethical feminist research holds the researcher accountable for interactions with participants, the production of the research, and the dissemination of the research. Guillemin & Gillam (2004) describe ethics in practice as "the ethical obligations a researcher has toward a research participant in terms of interacting with him or her in a humane, nonexploitative way while at the same time being mindful of one's role as a researcher" (p. 264). As an ethical feminist researcher, I sought to be respectful and professional in encounters with my research participants. For example, I ensured that research participants chose the location and time for their interviews, anticipating that they would choose a location where they felt comfortable and safe. In most cases, I traveled to research participants' homes, since all of the research participants had newborn children. Traveling to research participants' homes in order to conduct an interview was important because most of the women preferred to stay at home, particularly because they did not want to take their child to a public space. Before the interview I stated that the interviewee was not obligated to answer any questions that made her uncomfortable and the interview could end at any point.

During the analysis phase, I engaged with the data in a respectful way by recognizing my own power over interpretation within the research, and therefore I

acknowledged that a value-free approach to my research was impossible. I endeavored to avoid becoming the "ventriloquist" to remain visible in the research product and therefore recognized my own presence as an active agent in the construction of the research (Fine, 1992). Activist feminist research has the capacity to be "committed to positioning researchers as self-conscious, critical, and participatory analysts, engaged with but still distinct from our informants" (Fine, p. 220). An activist approach was endeavored by asking the women to explain their experiences in great detail in order to better understand the meaning of their narratives

Pillow (2003) explains the use of the "confessional tale" in research where the researcher reflects on her/his own experiences and their linkages to the research (Ellingson, as cited by Pillow). The "confessional tale" is not a tool to validate research, but "to assure the reader that [the] findings are *thoroughly* contaminated. This contamination with [the] lived experiences results in a rich, complex understanding' (Ellingson, as cited by Pillow, p. 183). This approach necessitates the disclosure of my own position with the research. My interest with the research topic, and how my experiences shaped my understanding about childbirth and the importance of care from healthcare practitioners are critical parts of the thesis. Thus, the researcher is implicated in the entire research process—the creation of the interview questions, the interview and where the interviewer "probes," and the interpretation of the data (Finlay, 2003).

My interest in the research topic is twofold: first, several friends and family members have shared their birth experiences with me, which inspired critical thought regarding how these women perceive their experience. Secondly, my mother, as a healthcare practitioner and midwife, has shared her intriguing perspectives on technology use during childbirth. In particular, my standpoint of understanding childbirth from

listening to both women's experiences and a healthcare practitioner's perspective has created my unique understanding of childbirth and maternity care. Thus, varying viewpoints led me to question not only how women experience technology use, but also how women perceive the effects of technology use on the care provided by their healthcare practitioners.

My initial research into experiences of childbirth revealed my limited perception about technology; I defined technology as anything that was machine-like. However, once I began to interview women who shared stories of their experience of vaginal childbirth and their thoughts on the use of technology, I realized that women identified technology more broadly as a much wider range of procedures, such as episiotomies, morphine, epidurals, etc. I too began to wonder, what is considered technological? What makes technologies beneficial or detrimental? Whose choice is it to utilize technologies during childbirth?

In addition, after reading literature by Anne Drapkin Lyerly[13] (2006), I began to question not only technologies, but how women's experiences were shaped by the ethics of and environment of *care* from health care workers. Conversations with my mother and pertinent contemporary and historical literature on birth and technology ultimately shaped my interview guide, particularly the informing questions about how technology may have shaped the care women received from healthcare practitioners.

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[13] In the article *Shame, Gender, Birth*, Lyerly (2006) discussed varying dynamics that shape women's birth experiences. In particular, Lyerly highlights the relationship between the care from health care practitioners and the ways technologies are used during birth.

As I have noted above, personal experiences and influences from friends and family have shaped the evolution of my understanding on this research. Thus, it is essential to note that this research is not value-free; therefore reflexivity is a basic tool to help me reflect on how my own personal biases influence the research.

Practical management and design of the research project

I submitted my application for Ethical Review of Human Subject Research and received approval from the University of Lethbridge Human Research Subject Research Committee (HSRC) on June 24, 2013. The consent forms, recruitment posters, and notices for staff were reviewed and approved by the University's ethics board. Recruitment posters and snowball recruitment were used to invite women to participate in the research study. The posters were posted in public places, such as the YWCA, prenatal classes, prenatal online groups, and gyms. In order to reach a broader audience, I hoped posting through social media groups and other online advertisement sites would attract a range of participants. The recruitment posters described the research project, and requirements for participation, and contained my contact information. The participation criteria for this research were: first-time mothers who were English speaking, over eighteen years old, and who had a vaginal birth within 8 months of the interview. The criteria for this research were chosen in order to create a coherent sample group that could reflect the current medical childbirth practices in Lethbridge, Alberta. The participants determined the meeting place and time for each interview in order to ensure that they would be in a space that was comfortable.

Twelve women were approached and nine women who met the research criteria agreed to participate in the study. Table 1.0 provides the details for each participant. To provide anonymity, all research participants were assigned pseudonyms. The ages for the

interview participants ranged from twenty-two to thirty-eight. Six of the interview participants identified themselves as Caucasian, one identified herself as Latina, and one identified herself as African. The education for the women ranged from high-school education through trade certification to post-secondary degree.

Table 1.0

Participant profile

Name	Age	Nationality	Ethnicity	Education	Employment
Chelsea	27	Canadian	Caucasian	Bachelor of Arts	Student/Mother
Taylor	35	Canadian	Caucasian	Diploma	Licensing officer (Government of Alberta)
Alexandra	38	Swiss/Canadian	Caucasian	Trades	Heavy equipment technician/ stay at home parent
Samantha	26	Canadian	Caucasian	High school/Some college	Stay at home parent
Megan	22	Canadian	Caucasian	High school	Stay at home parent
Diana	29	Canadian	Caucasian	Post-secondary	Social work (Child Services)
Jessica	38	Canadian	Caucasian	Bachelor of Management	Project manager
Betty	27	Nigerian	African	Bachelor of Nursing, Registered nurse	Nurse
Jennifer	27	Canadian	Latina	Bachelor of Arts	Membership coordinator at Telus Spark

Participants were informed that they could withdraw from the study at any point in time. Interviews ranged from twenty-minutes to an hour and a half. In accordance with scholars such as Oakley (1981), I did not propose a standard interview time, which helped women to speak at their own pace. I encouraged participants to understand that there was no "right" answer by responding to their narratives with appropriate social cues, such as nodding and saying "mhmm" or "yes" when appropriate. Nonetheless, several participants stated they were afraid of being too graphic or detailed with their responses because they did not want to intimidate me. With these moments, a disconnect potentially might have occurred between my research participants and myself because the narrator might assume I was unable to identify with their childbirth experiences. This disconnect relates to Reinharz and Chase's (2007) critique of the "sisterly bond" and the assumption that "women who interview women automatically like their interviewees and will easily form bonds of mutual understanding with them" (p. 81). Therefore, as suggested by Reinharz and Chase, the "sisterly bond" is a constructed relationship and rather than attempting to forge a "sisterly bond" during the interview, I focused on establishing rapport with the participants. One of the ways to establish rapport and make participants more comfortable, as discussed by Reinharz and Chase, is through interviewer self-disclosure. Thus, in order to build rapport I disclosed the various reasons I was researching childbirth, such as the influences of my family and friends' childbirth experiences. However, as recommended by Reinharz and Chase, I, as the interviewer, was mindful of how much disclosure was necessary.

I digitally-recorded all interviews, took field notes, and transcribed all interviews. Digitally-recording the interviews allowed me to focus on the participants' narrative.

However, the digital-recorder did inhibit the interaction with participants as several participants' demeanors changed when the digital-recorder was "on" versus "off." Furthermore the presence of a digital-recorder "gives a decontextualized version of the interview, however: it does not include visual aspects of the situation, neither the setting nor the facial and bodily expressions of the participants" (Kvale, 1996, pp. 160-161). Therefore, taking field notes allows the researcher to reflect on the one-to-one interaction during the interview, recording non-verbal cues, including body language (Bird, 2005). During the transcriptions, I recorded these observations to aid with the data-analysis and to record my own interpretations throughout the research process. I thereby included myself as an active actor throughout the research. Recording my observations on the one-to-one interaction was particularly useful as I was able to perceive how women were responding to me throughout the interview. For example, several women were hesitant to go into detail because they thought their stories would frighten me because I have never experienced birth, thus leading to my understanding of how women may internalize or remain silent about childbirth. Each interview contained rich data, with multiple layers to be explored and better understood to reveal the complexities and the actualities of the life world (Smith, 1987).

All written notes, recordings and transcripts were kept in a locked office at the University of Lethbridge until they were transferred to digital files. Typed notes and transcripts were kept in password-protected files on my personal laptop. Paper copies of the transcripts were kept in a locked office. The retention period for the information collected is finite: it will be kept for 5 years on a digital file on a password protected personal laptop, after which all data will be destroyed.

Conclusion

To conclude, the purpose of my research is to explore contemporary women's first-time birth experiences and perceptions of technology. These experiences are used to consider the social and cultural structures that inform an individual's actions (Scheper-Hughes and Lock, 1987; Lynam, Browne, Reimer Kirkham, & Anderson, 2006). By referring to the historical context, my understanding of the interviewees' narratives are contextualized and reflect the dynamic and ever-changing nature of cultural and social structures. Furthermore, as alternative views to dominant masculine narratives, women's perspectives shed light on the actualities of the complexities of their experiences, thus producing narratives involving moments of compliance, struggle, or resistance to dominant social structures. Using interviewing as a methodology enabled me to explore women's lived perceptions and therefore, this research is not generalizable, but does provide useful insights on contemporary women's experiences. The features of interviewing that I have described in this chapter influenced my research process and ethical considerations throughout my interactions with my research participants and their narratives.

Chapter Four: Navigating the Authentic Self

Introduction

I interviewed nine women about their experiences of childbirth and their perceptions about technology. Chapter Four provides data on women's perceptions of their initial expectations of childbirth upon learning about their pregnancy and details the resources that women sought in order to gain further information about childbirth. Referring to Kleinman's (1980) "local health care system," which he argues organizes health care in a locale, the chapter focuses primarily on the "popular sector," or the lay, non-professional context of everyday life. The popular sector comprises women who consult with their family members, friends, and prenatal class cohorts to gain information about healthcare. The information gained from the popular sector influenced women's understandings and perceptions of "normal" birth. These early initiatives with learning about birth are significant because the people with whom and the classes in which they engaged shaped my research participants' perceptions about birth and technology.

The chapter analyzes the data on women's childbirth experiences as deeply charged cultural and social realities in which women construct the individual within society. The concept of the individual and self are localized and differ culturally. In particular, Clifford Geertz (1983) describes

> [t]he Western conception of the person as a bounded, unique more or less integrated motivational and cognitive universe, a dynamic [centre] of awareness, emotion, judgment, and action…is however incorrigible it may seem to us, a rather peculiar idea within the context of the world's creatures (p. 59)

The social construction of self in the Western context, and so the western Canadian context as well, is described as unique and individualistic (Geertz; Taylor, 1991). While individualism allows a person to establish a sense of a moral self, "the dark side of

individualism is a [centring] on the self…and less concerned with others in society"
(Taylor, p. 4). In other words, individualism may lead to narcissism and hence enforce the
opposition between the individual and society (Scheper-Hughes & Lock, 1987). The
focus for the individual is therefore creating a sense of uniqueness and originality
(Geertz; Scheper-Hughes & Lock; Taylor). The narratives of childbirth experiences
generate this sense of self, shaping women's medical practices and perceptions in
dynamic ways as their experiences unfold.

My research participants' narratives reveal the "reflexive "I"" (Scheper-Hughes &
Lock, 1987), which refers to the unique, individualized self within society. While
navigating the unknown experience of labour and childbirth, the women whom I
interviewed interpret their experiences as unique in relation to other women's experiences
in the local context. In doing so, women draw awareness to their individual, first-time
experiences of pregnancy and childbirth in order to avoid universalizing women's birth
experiences (Feldberg, 2011; Leap, 2009). Women describe pregnancy, labour, and
childbirth as an intimate process that can only be experienced. In order to create their
authentic experiences, women reflect on and establish their personal sense of fear, pain,
and happiness faced with pregnancy, labour, and childbirth. Consequently, women's
descriptions of birth included moments of satisfaction, discomfort, and confusion.

Seeking insider reports: Speaking with other women and attending prenatal classes

The popular sector described by Kleinman (1980) refers to lay and non-
professional individuals in society. Within the popular sector, the interactions between
individuals are important because these interactions shape an individual's decisions
regarding how health will be approached and which health services will be sought
(Kleinman). I began my interviews by asking each research participant how she imagined

her process of childbirth. Several of my research participants expressed feelings of unease and nervousness when preparing for the unknown experience of childbirth. Most women reflected that because they were first-time mothers, they faced the "unknown." For instance, Taylor stated, "it was kind of just unknown. I didn't know what to expect." The first-time mother's feelings of "unknowing" were consistent throughout a woman's pregnancy and birth, particularly for the first-time mother (Miller, 2007) who used technology and medical information in order to prepare to cope with pregnancy and childbirth. In order to cope with fear, all of my participants sought a range of informal information from friends and family, and formal information from healthcare practitioners.

All of the women whom I interviewed discussed their expectations of childbirth emphasizing their fear of pain, and how they actively sought "insider information" about childbirth and pain. Alexandra "just thought it was going to be really painful," and similarly Megan imagined it would be "scary and painful." Creating expectations for birth helps women "prepare mentally and physically for the experience" (Martin, Bulmer, & Pettker 2013, p. 103). Samantha and Jennifer, who spoke with other women in preparation for labour, explained that they wanted to deliver vaginally; and in order to prepare for the experience they, along with others, sought the wisdom of other women, illustrating that women seek a non-medicalized social support system. To address the fear of childbirth, Samantha explained that she spoke with her mother and sister in particular, noting that it was helpful because it helped her prepare for "what kind of ways labour could come on. Whether it's back labour or abdominal labour, because I guess it's totally different pains." Seeking the advice of other women symbolized resistance to the medical voice and asserted the importance of women's embodied knowledge. Scholars

(Mitchinson, 2002; Martin, 1987; Warsh, 2010) cited in Chapter Two, state that even though twentieth century healthcare professionals were often framed by medical discourse as the experts on childbirth, contemporary women sought the "insider knowledge" from women who had already experienced childbirth. This illustrates how contemporary women have reclaimed ownership over their bodies and health.

Speaking with family and friends in the preparatory stage about labour and childbirth influenced participants' expectations of the services they would receive from their healthcare workers. In particular, by speaking with women who had previously experienced childbirth, participants felt reassured that they were capable of delivering vaginally with minimal technological intervention. For instance, Diana rationalized her decision to seek a less interventionist birth by referring to her mother's experience of birth in which she stated, "back in her day, you just had a kid right?" Diana assumes that her mother's birth was intervention free, which resulted in her belief that "you just had a kid." Thus, women were encouraged to reject the hyper-medicalization of birth where birth is "conceptualized as a time of risk and danger" (Parry, 2008, p. 786). Even though all of the women I interviewed selected hospital delivery and followed medical advice, all of the women whom I interviewed viewed birth as a "normal" event that women were capable of handling and, unless absolutely necessary, did not require the use of invasive technological practices.

Women sought additional insights in advance of labour and birth by attending prenatal classes, showing the overlap between the popular sector and folk sector (Kleinman, 1980). As noted in Chapter Two, Kline (2010) and Warsh (2010) confirm prenatal classes were created as a way for women to receive information about birth so that women would not have to rely solely on the advice of medical professionals.

Furthermore, as noted by Stoll and Hall (2012), the purpose of prenatal classes "was to teach [women] pain management techniques during labour" (p. 229), which would therefore help women cope with labour pains and limit women's dependence on medical interventions during childbirth. Thus, as noted in Chapter Two, prenatal classes were an initiative arising from the women's health movement in order to encourage women's self-awareness of their bodies (Warsh, 2010). Eight of the nine research participants whom I interviewed attended prenatal classes. My research participants shared similar insights on the usefulness of the classes—they could access more information about medical services, pain management, and technologies that were available during labour and birth. Chelsea described the information provided in prenatal classes as "very helpful" because it was "just reassuring to know [she was] not going to die […] And they also talked about all the options for like pain management and stuff at the labour classes and things that your partner can do to help you." Chelsea described having an increased feeling of reassurance about her body after attending prenatal classes, which aligns with Stoll and Hall's argument of prenatal classes increasing women's confidence with their bodies and ability to survive childbirth.

Significantly, prenatal classes provided a space for women to create a social cohort. Social scientists, historians, and especially feminist scholars have documented the effect of the increasing medicalization of childbirth procedures and how consequently childbirth became a less social experience for women (Cahill 2001; Davis-Floyd, 1987; Duden, 1993; Leavitt 1999a; Mitchinson 2002). Following activist efforts from the women's health movement, women sought to reclaim childbirth as an embodied experience where women create and share knowledge (Kline, 2010; Morgen, 2002). Forming friendships with other childbearing women assists women with their experiences

of pregnancy and the transition into motherhood (Nolan et al., 2012). Samantha asserted that her prenatal classes not only provided information for birth expectations about pain, but also provided a space for women to create a social cohort. Samantha stated, "honestly I think the best thing that came out of prenatal was making new friends and meeting new ladies that are going through kind of the same thing or go through different experiences with their childbirth." Samantha also noted that her relationships with the other women whom she met while she attended prenatal classes carried on after she gave birth, and as a cohort the women engaged in conversations where they, as explained by Samantha, "kind of [compared] what happened with this person or what happened with that one." Thus, women shared their respective knowledge arising from their birth experience, showing the range of birth experiences. Nolan et al. argue it was important for women to share their different experiences because women "needed opportunities to reassure themselves that their mothering was on a par with that of other women" (p. 181). Furthermore, Nolan, et al. argue that women's self-efficacy increased with their informative interactions with other women, rather than depending on medical professionals. The prenatal classes represented a space where women could access information and interact with other women, thereby enforcing social practices with birth. Hence women gained further insights on how to prepare for birth by seeking information from each other, rather than relying solely on the advice of medical professionals. As a result of these interactions among women, despite my argument in Chapter Two that childbirth shifted from the social to the medical (Cahill; Davis-Floyd; Duden; Leavitt; Mitchinson), women in this study invented social environments during pregnancy and childbirth.

My research participants' experiences differed from their expectations, yet they accepted the differences as a learning process, and prepared for labour and birth in

various ways. Nonetheless, as similarly found by Miller (2007), women were unable to predict the realities of the childbirth experience. However, Schneider (2002) states women accepted the disparities between their expectations and the actualities of their experiences because they validate their experiences as unique. Samantha summarized what many women expressed; despite her previous comments on the value of speaking with other women, "it also wasn't helpful because what I felt, what I felt, it was in an area that I just did not expect and it wasn't at all what I expected. Because nobody can really describe exactly what it is." Thus, regardless of her efforts to prepare for birth, Samantha emphasized the lack of control over her bodily actions and reactions to labour; however, because of the lack of control, Samantha did not validate the experiences of other women, but created new knowledge for herself. Similarly, Megan and Diana both explained having epidurals that had no effect with relieving the pain of labour, yet asserted that despite using pharmacologic pain relief, they had a "natural" birth. The women's narratives show how women distinguish their experiences as and individually situated. My research participants' experiences related to the findings of both Miller and Schneider in that women prepared for birth by speaking with women and therefore formed expectations, however their own experiences differed significantly from their expectations. Samantha, Jennifer, and Alexandra explained that it was helpful to learn about labour by speaking with other women, however, because it was their first time experiencing childbirth, women still felt unprepared or surprised by their actual experiences. Nonetheless, women necessarily had to accept the process as not fully controllable, despite preparations, and instead embraced the uniqueness of their experiences.

My interviewees' narratives showed the range of experiences with labour and childbirth. All of the women expressed a level of "unknowing" with childbirth because they were first-time mothers and would have to establish their own experiential knowledge throughout the process of labour and childbirth (Abel & Browner, 1998). Several of my participants shared similar insights as Alexandra who noted that with childbirth, "you cannot control your circumstances," therefore implying the uniqueness of each woman's birth experience. Yet, my participants also acknowledged the value of the multitude of knowledge from their friends, family, prenatal classes and in particular, while experiencing labour their healthcare practitioners. For instance, Taylor who earlier stated that she did not want to enter the hospital with any expectations because of the fear of losing control, stated "it was nice to have my somebody guiding me, but giving me the ownership that empowered me to make those decisions." All of the women that I interviewed asserted the value of sharing experiences with other women in order to help them prepare and feel more capable with childbirth.

Conclusion

The interviewed women prepared for labour and birth in various ways in anticipation of childbirth. The women did so by speaking with friends, family, attending prenatal classes, and attending regular physician visits. Speaking with a range of people from the local community showed the first-time mother's initiative to identify herself in the local health community. By interacting with other people, the first-time mother is engaged as a dialogical character shaped by the information exchanged between herself and others (Taylor, 1991). As a dialogical character, the personal interactions the first-time mother experiences are crucial in shaping how she identifies her authentic self because she uses the information from other women in order to compare and contrast her

experience. Thus, women themselves do not anticipate a universal childbirth experience and acknowledge that childbirth is "individual and social, natural and cultural, [and] physical and psychological" (Leap, 2009; Sbisa, 1996). The data show that women initially identify themselves in relation to other women, yet emphasize their own childbirth experiences as unique and separate from other women's experiences.

The data reveal how first-time mothers construct the individualized self through their reflections of their birth experiences. There are contested interpretations of the self/individual that shaped how my research data was interpreted. On the one hand, individualization is criticized as narcissistic and self-centred; conversely, individualization can be understood as the desire to shape a unique, original self through self-discovery and self-fulfillment through the social interactions between people (Geertz, 1983; Taylor, 1991). Taylor attributes the unique self to modern freedom and autonomy centred on people, and the "ideal of authenticity requires that we discover and articulate [people's] own identity" (p. 81). The interviewed women used the "reflexive I" (Scheper-Hughes & Lock, 1987) to emphasize their experiences as unique and authentically theirs. My research participants' experiences align with the literature from both Miller and Schneider in that women's realities of their births differed from their expectations, yet they saw these differences as a way to mark individual uniqueness.

Individual experiences reveal historical, social, and cultural influences and illuminate the significance of them (Taylor, 1991). Taylor urges the individual to consider the significance of the differences between the individual and others, which distinguishes and shapes the authentic self. The women that I interviewed were critical about the information shared by other women; my research participants established perspectives about judging birth as medical or non-medical. For example, Diana noted that in the past

"you just had a kid" without intervention and therefore she would be capable to do the same. Nonetheless, her conception of birth in the past is simplified as she assumes that there were no interventions. By understanding their experiences as individualized, unique and separate, the women do not see their childbirth experiences as culturally influenced and produced. The women that I interviewed revealed the individualistic perception of their birth when they spoke about other women's experiences and how the information that they learned was helpful, but referred to their experience as separate and unrelated from those experiences, and entirely unique. By having an individualized approach to their experience, the women that I interviewed do not see their experiences of medicalized childbirth in relation to the local social or cultural constructions to approaching health care and childbirth practices.

Although women locate themselves within the local context and understand birth experiences at a broad level, they understand their own experiences of navigating pregnancy and motherhood as separate and unique. Women listened to the narratives of other women's birth accounts in order to familiarize themselves with the range of possibilities with birth experiences. Along with gathering information from the popular sector, women sought the services of prenatal classes, showing the overlap between the popular, folk, and professional sectors. Prenatal classes provided women with additional information about relaxing techniques for labour and birth, formal medical information in order to prepare them for the hospital standards, and provided them with a space to establish a cohort with whom to share information. Most of the women that I interviewed explained that it was helpful to learn about labour by speaking with other women. Nonetheless, because it was their first time experiencing childbirth, they still felt unprepared or surprised by their actual experiences. In consequence, women necessarily

had to accept the process as not fully controllable, despite preparations, and instead embrace the uniqueness of their individual experience (Leap, 2009). Even though the women that I interviewed did not view their own birth experiences as historically and culturally influenced, they were engaged in political actions, such as self-care. As a political act, self-care, as Chapter Two shows, allowed women to contest medical authority. Thus, the women that I interviewed reveal the importance with shaping the authentic self, the value of distinguishing individual experiences, and the need to relate the individual to the local social and cultural understandings of health.

Chapter Five: Medical Appropriations

Introduction

Chapter Five describes my research participants' perceptions of technology use during childbirth. These descriptions reveal a range of technologies used during childbirth. In particular, when women go to the hospital for medical care, they enter the "professional sector" (Kleinman, 1980) and they are expected to follow the advice of the healthcare practitioners. The professional sector is comprised of "professional" medical personnel trained and certified by a central authority, in this case the state. The social science of medicine generally refers to the professional sector of state medicine as *biomedicine*. Biomedical practices, what I refer to here as the biomedical framework, sanctioned by the hegemony of the state, are presented through public health and health care providers in general as often "best practices" that as such are acceptable, and in some instances unquestionable. However, in Chapter Four I note that the three sectors of popular, folk, and professional, discussed by Kleinman overlap and therefore show women's initiatives to combine different types of knowledge in order to address pregnancy and childbirth.

Historically, women's experiences and self-assessments of their bodies have been undermined and ignored. However, by seeking information and asserting the value of their knowledge and inclusion in their health care, particularly during the women's health movement, women have attempted to reclaim their embodied knowledge and experiences (Junod, 2012; Kline, 2010; Morgan, 2002; Warsh, 2010). Women are involved in the process of appropriation in various ways such as with the use of electronic fetal monitors and the use of pharmacologic pain relief. Appropriations are achieved by altering the intended meaning or purpose of a tool or an act (Hasson, 2012) and appropriations

consider "the users creativity and agency in adapting technical artifacts to their needs" (Hadolt, Hörbst, & Muller-RockStroth, p. 187). Despite these appropriations, women still encounter medical authority, which undermines women's bodily knowledge. The chapter explores the interview data on women's experiences and perceptions with various technologies and examines women's appropriation of biomedicine, technology use during childbirth, and women's negotiations with hospital policies and expectations.

Appropriation has been used to highlight the power dynamics between dominant and subordinate groups (Eglash, 2004; Rogers, 2006). Rogers highlights how appropriation is used as a mode of dominance or exploitation,"[T]echnically, rhetorical appropriation refers to any instance in which means commonly associated with and/or perceived as belonging to another are used to further one's own ends. Any instance in which a group borrows or imitates the strategies of another […] thus would constitute appropriation" (Helene Shugart, 1997, as cited by Rogers, p. 476). Appropriation in this sense refers to the "unauthorized taking" typically done by the dominant or ruling group (Rogers), which leads to the exploitation of subordinated groups. However, in the chapter, I adapt appropriation to discuss resistance and to consider how the women I interviewed interpret the use of biomedicine "to create oppositional or alternative meanings, identities, and pleasures" (Rogers, p. 484). The chapter therefore highlights women's appropriation at a local level. The presence of the popular sector, the domain of everyday experience provides women with comparative resources in their appropriations of the medical practices and perceptions encountered in childbirth. The selective localization of medical events as social events reflects the sense of the authentic self discussed in the previous chapter. Lived experience in this local health care system relevant to childbirth located in

this western Canadian town is a crucial presence in the medical appropriations of the women participating in this study.

Using a biomedical framework to understand childbirth

In Chapter Two, I discussed the shift from social birth to medicalized birth characterized by the reliance on the advice of medical professionals, thereby allotting the medical professional the authoritative voice (Cahill 2001; Mitchinson, 2002). Despite literature that argues that medicalization is a form of social control (Brubaker & Dillaway, 2009; Conrad, 1992; Halfmann, 2011) and that women accept authoritative knowledge, "many women who welcomed the new advice produced by medicalization viewed it as a resource to be used selectively" (Abel & Browner, 1998, p. 36). Several of my research participants echoed similar conceptions in referring to both formal biomedical knowledge and informal experiential knowledge. Part of the use of medical knowledge is attributed to the sense of "unknowing" and the fear of losing control with the birth experience.

Women use medical knowledge and experiential knowledge to prepare for and to understand their childbirth experience. The women that I interviewed were first-time mothers and expressed nervousness about childbirth. In order to compensate for feelings of uncertainty, women granted more control to doctors and health care workers who could provide surveillance to ensure their well-being. For example, Jessica stated in her interview that she did not "go in with any expectations of how [childbirth] would go, which [she] thought was better than going in with all these expectations of how things should go and when things should happen and then being disappointed when they don't." Thus, as implied by Jessica, she was afraid of being disappointed with her birth experience but chose to accept anything that would happen during labour and childbirth.

Therefore she relinquished an active role in the process. Jessica further assumed a passive role by stating, "I expected the nurses to tell me what to do." Jessica refers to medical advice as a framework by which she can understand her birth. She thereby downplayed her role and efforts during labour and childbirth and implied a complicit relationship with her healthcare practitioners. Her expectation for a woman to be told "what to do" refers back to insights I share with Parry (2008) about the pervasiveness of medicalization in childbirth.

Healthcare practitioners refer to science and the medical institution to promote the value and necessity of medical practices and to enforce the medical model of birth as the normative for first-time mothers (Moore, 2011). As a result, women accept the professional advice and knowledge of the healthcare practitioner as scientific and therefore legitimate and unquestioned (Kleinman, 1980). Alexandra asserted her opinion that women should not have expectations when going into labour because realistically, you cannot "control your circumstances" and therefore, for her, it was essential "not to control it and not to have romanticized expectations of what's going to happen." Alexandra further explained that her birth expectations were restrained and she expressed dependency on the healthcare practitioner, "because no matter what, at the end of the day, your doctor is going to make sure that you have a baby—and a healthy, alive baby." By relying on the healthcare practitioners to make things "right," women acknowledged their lack of control with birth while accepting the control wielded by their healthcare practitioner.

Using technology as tools for reassurance

My historical overview in Chapter Two showed that in framing childbirth as problematic, healthcare practitioners reserved the "right" to intervene with birth

(Rothman, 1982). Healthcare practitioners used technology as surveillance to offset potential complications with the baby, demonstrating the notion of childbirth as pathological and unsafe. As noted by Lothian (2009), contemporary maternity care "expects trouble" (p.49) and therefore less invasive interventions are standardized within hospitals. These standards reflect the local understanding of health and illness with pregnancy and childbirth. For example, all of the women whom I interviewed expected to use technology. Betty illuminated a common concern amongst the women whom I interviewed when she further explained, "It's for your baby's sake, you understand? If they don't get, like if you refuse it and they don't get the baby's heart rate, what if something happens to the baby?" Healthcare practitioners use the standardized policies to monitor the fetus to detect abnormalities. The practice is understood by women as a precautionary device in order to ensure the safety of the baby. In particular, the notion of risk and the fear of risk impacted Betty's decision as she noted, "What if something happens to the baby?" Women implied that technology was a tool to ensure the safety and well-being of the baby, therefore they felt inclined to accept its use during labour and childbirth. With birth framed as pathological, women's experiences aligned with the SOGC's (2007) statement that women have become "insecure" with their capacities to birth without technological intervention.

The SOGC (2008) recommends that healthcare practitioners communicate the risks and benefits of the various technological practices in order to prepare women with information on the different methods[14] available to monitor the baby; thus, women's

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[14] The SOGC (2008) notes, "[d]uring pregnancy, women should be offered information on the benefits, limitations, indications, and risks of IA [intermittent auscultation] and EFM [electronic fetal monitoring] use during labour" (p. S27).

choices are proposed as an ideal scenario. There are no long-term differences between the electronic fetal monitoring and intermittent auscultation (SOGC, 2007). Nonetheless, as noted by Warsh (2010), electronic fetal monitoring in Canada is routine rather than chosen by women. Betty offered insights on the use of the fetal monitors by stating, "I just knew that it's something that has to be done […] regardless if it's comfortable or not," thereby implying two things: (1) women perceive that the application of technologies, such as electronic fetal monitors are essential rather than optional, standard practices; and (2) that women do not have a "choice" but to comply to the use of technologies within hospitals. Ideally, the SOGC suggests practices for healthcare practitioners, which aim to promote choices for women. However, women adopt the medical approach to birth because medical techniques and technologies are embedded in the cultural approach to childbirth in Canada and are therefore unquestioned (Moore, 2011; Müller-Rockstroh, 2012).

Several of my research participants appropriated the use of the technology as a tool to assure them that their bodies were capable of childbirth. In Chapter Two I noted that the increasing use of technology with childbirth was meant to accommodate the healthcare practitioner and consequently excluded women from the decision-making process with labour and birth. However, contrary to negative conceptions of technology, Brubaker (2007) discussed that some women appreciated the use of technology because it ensured that their baby was healthy and withstanding labour. For most women, reassurance with the well-being of their baby is essential. Chelsea and Megan discussed similar insights with technology as "helpful" to report the health of the baby and to show that their bodies were "working" properly. Megan stated, "[the fetal monitor] was relaxing to just lay in the bed and know that you're in the hospital—just in case anything

happens." Thus, Megan viewed the fetal monitor as a tool that was used by the healthcare practitioner on her body in order to engender trust with her baby's health. Chelsea similarly explained that the use of technology was "reassuring" for her because it showed that her baby was "alright." Furthermore, Chelsea implied that she, too, used the technology to externally view her body in order to monitor her progress and ensure that she was doing a "good" job and her body was functioning properly to ensure the safety of her baby. When the purpose of technology use is explained to women and women themselves can utilize the technologies as tools, it helps "demystify" knowledge and the childbirth experience (Hasson, 2012). Women appropriate the use of technologies, such as the fetal monitors, to reduce their fears of complications, to show that their bodies were functioning properly, and to ensure the well-being of their baby. Thus, certain technologies have the capacity to enhance women's experience and in fact have a role with helping women achieve an empowering experience (Hall, Tomkinson, & Klein, 2012). Referral to the use of technology as helpful exemplifies the appropriation of the fetal monitor as beneficial to the first-time mother.

Feeling constrained by technology

On the other hand, even though technology had the ability to provide assurance, technology also constrained women and had the effect of distancing the mother from having an active role with labour and birth. In contrast to Brubaker's (2007) findings, several of the women whom I interviewed illuminated that when they felt uncomfortable with the medical care they received, they did not reject the use of technology or other interventions. When healthcare practitioners and women refer to the institutional knowledge of science, medicalization is normalized and difficult for women to challenge (Moore, 2011). Samantha and Alexandra both explained their discomfort with the

electronic fetal monitor. When Samantha was asked how the fetal heart monitor made her feel, she replied "I didn't like it [the fetal heart monitor] so much 'cause those…I was laying down for part of it and when you're laying down on your back and you're pregnant, it's not very comfortable." Similarly, Alexandra revealed her experience with the fetal monitor as frustrating stating, "it bugged me to be hooked up [to the monitor]. […] Like it limits your movements, it limits like you, like you can't get comfortable. Not even because of labour, but because, you can't bend—like your arm has to stay a certain way because of the needles and stuff." Based on both Samantha and Alexandra's experiences, technology has the effect of immobilizing women and increasing dependency on the healthcare practitioner. Physical mobility throughout the stages of labour "helps women cope with strong and painful contractions" (Lothian, 2009, p. 50). When women are able to move on their own accord, they can properly respond to their contractions and find comfort through movement (Lothian). Despite the documented evidence of the benefits of physical mobility throughout labour, women I interviewed were typically unaware of an alternative approach to cope with labour, which exemplifies some of the ways that women uncritically "accept medical birth knowledge" (Moore, 2011, p. 380) that relies on monitoring and constraining women.

Women unconsciously challenge biomedical technologies by asserting their agency and embodied knowledge. When I asked whether or not the healthcare workers ever took the monitors off so that she could move around, Alexandra responded, "I had to ask to get that taken off so I could go to the bathroom. They really wanted to keep the monitor on the whole time." The reluctance of Alexandra's healthcare practitioners to remove the monitor or propose she had a choice shows the preference for healthcare practitioners to insist on the use of the technology and for women to comply to the point

where, as Alexandra explained, "I just felt, well I just felt tied down like I didn't feel like there was the freedom to, to move or do whatever." Based on these descriptions of physical limitations and dependency on the healthcare practitioner, Samantha and Alexandra illuminate experiences of the struggle between the agency and intentions between women and their healthcare practitioners.

When healthcare practitioners did not query the women to gain the women's perspectives about their labour progression, technology had the effect of objectifying women. As discussed in Chapter Two, the medicalization of childbirth resulted in childbirth becoming an objectifying and managed event that was time-efficient for the healthcare practitioner (Cahill, 2001; Davis-Floyd 1987; Martin, 1987; Mitchinson, 1991). Consequently, healthcare practitioners refer to technologies, such as the fetal monitor to bypass the first-time mother's self-assessment. In particular, Chelsea explained her frustrations with how the fetal monitor affected the care from the nurses, stating, "sometimes I felt like they just came in, looked at the graph thing and then left. And I was like 'hello'?" Chelsea provided insight to some of the frustrations related to the use of technology, which led her to feel objectified by the healthcare practitioner, who referred to the monitor's digital graph instead of acknowledging her. Scholars Duden (1993) and Taylor (2004) note the use of technological aids has the effect of turning the body "inside-out" and therefore healthcare practitioners rely nearly entirely on the technology rather than the women themselves. Furthermore, as noted by Fleming, Smart, and Eide (2011), when healthcare practitioners rely too heavily on technology, women tend to have negative birth experiences because they feel ignored. Collectively, Samantha, Alexandra, and Chelsea expressed discontent with the fetal heart monitors, however none of the women felt sufficiently confident to convey displeasure with the clinical practice of the

healthcare practitioners; thus women complied with hospital routine procedures and legitimized the healthcare practitioners' objectifying actions.

Seeking technology to ease labour pains

A number of the women whom I interviewed described childbirth as a "natural event," however they also approved of seeking medical interventions, particularly with the use of medically assisted pain management. Thus, women contest traditional binaries between "natural" and "medicalized" births in order to establish their subjective understandings of the range of medicalization with childbirth (Brubaker & Dillaway, 2009; Miller, 2007; Moore, 2011). Historically, during the women's health movement, activists challenged medical authority by employing self-assessment of their bodies (Kline, 2010; Morgan, 2002; Ruzek, 2012), which impacted contemporary women's approaches to birth. Along with encouraging the value of embodied knowledge, activists of the women's health movement argued that women should be able to make choices about pregnancy without judgment (Brubaker & Dillaway).

For most of the women whom I interviewed, the decision to seek pharmacologic pain relief was based on self-assessments of their bodies during labour. Thus, instead of the use of pharmacologic pain relief for the physician's convenience, women have appropriated the use of pharmacologic pain relief to satisfy their own preferences, leading to an empowering experience. My interviewees' decisions to seek pain management were spontaneous; as a first time experience, they wanted to self-assess the degree of pain during labour before committing to the use of pharmacologic pain relief. For instance, Diana explained "I went about half way and then I was like, screw this [laughs]. Like I didn't know it was going to be that bad, right. Ugh, like you couldn't even explain it." Thus, amidst the labour process Diana relied on the medical resources in order to better

cope with her pains. All of the women whom I interviewed initially strove for a less interventionist birth, viewing birth as a "natural" occurrence. Similar to the women interviewed by Brubaker (2007), most interviewees did not dismiss the possibility of seeking medical assistance for pain relief and instead found comfort with the availability of pharmacologic pain relief because they were unsure how painful childbirth would be. Women's decisions were impacted by their embodied knowledge and their knowledge of biomedicine.

Pharmacologic pain relief was used by six of the women whom I interviewed in order to ease their labour pains, according to their own assessment of their pain levels. Women appropriate the use of pharmacologic pain relief by firstly choosing to use the drugs and secondly by using the drugs to ease labour pains. Kline (2010) noted that during the women's health movement, activists argued the importance of self-assessment of health and self-care rather than depending solely on the knowledge of healthcare practitioners, particularly for women during labour and birth. As noted by Lothian (2009), there are several different hormones at play during women's labour that enhance contractions and labour pains. When a women becomes stressed, her body's natural process of releasing hormones during labour is hindered and in particular, "stress can slow progress" (Lothian, p. 49) of active labour. Lyerly (2012) notes the importance of feeling relaxed during labour; however, because of the range and severity of pain they experience, some women seek the use of pharmacologic pain management in order to facilitate a vaginal delivery. Betty and Alexandra used pharmacologic pain relief in order to help them "relax" and successfully deliver vaginally. Betty explained that, as a healthcare practitioner herself, she was aware of the effects of morphine and therefore, she made the decision to use morphine prior to going into labour, noting that the

morphine "was ok. It wasn't like fantastic relieving the pain. It just edged it off a little bit and makes you relax." Betty emphasized the importance with relaxing during labour in order to reduce the amount of stress and facilitate childbirth.

The use of pharmacologic pain relief helped assisted several of my interviewees' to rest during labour and to regain their strength and deliver vaginally with minimal interventions. Reflecting on her experience and the information that her healthcare practitioner told her, Alexandra noted, "if your body's not relaxing and you're only at 3 centimeters and you're having to like push. I don't know there's just too much stress." Jennifer described technology as a tool that helped her achieve the best birth experience possible for herself. Jennifer noted that while she was aware of the pharmacologic pain relief available, she initially wanted to work towards "natural" childbirth if possible. After an unexpected lengthy four day labour, Jennifer noted that in her state of exhaustion, she began to consider a caesarean section. Instead, Jennifer opted for an epidural, which helped her rest and to restore her energy in order to deliver vaginally.

The medical management of birth in the early twentieth century, described in Chapter Two, showed healthcare practitioners were praised for their efforts to actively deliver, and women's efforts were unheard (Cahill, 2001; Mitchinson, 2002). By the late twentieth century, as explained by Morrow (2008), activists in the health movement argued against the medical model of care and proposed the inclusion of "women-centred care," which was modeled for healthcare practitioners to focus on women and women's role with their care. As a result of considering women's preferences with their care, Lyerly (2012) suggested in the twenty-first century the use of pharmacologic pain relief can be utilized to help women while still facilitating a less technologically interventionist birth. In this rein, the women I interviewed appropriated technology to help relax, which

they perceived helped them successfully deliver vaginally. Ultimately, all the interviewees suggested the appropriate use of technologies helped them avoid more technological and invasive procedures, such as a caesarean delivery (Goldberg and Shorten, 2014; Lyerly).

On a whole, women perceived technology as helpful when healthcare practitioners inquired and considered women's personal preferences, and used technology in conjunction with, rather than on, their bodies. Whereas in Chapter Two I discussed the detriments of using technologies with childbirth, my interview participants' experiences reveal that women appropriate medical practices, such as monitors and pharmacologic pain relief, which in turn reveals their agency and choice. Jennifer's experience of requesting pharmacologic pain relief related to several of my other participants' experiences. Jennifer explained that she was initially hesitant to seek the use of an epidural, however she was met with surprise when "it didn't feel like another procedure" because the healthcare practitioners explained everything and thereby validated her experience. When healthcare practitioners communicate with women during labour, they provide women with accessible information to enable women to make informed decisions (Goldberg & Shorten, 2014). In addition to making Jennifer feel comfortable, her healthcare practitioners facilitated her desire to deliver vaginally by waiting for the drugs to wear off so that she could feel the urge to "push." Thus, Jennifer expressed possessing agency with her birth. Therefore, contrary to previous notions of pharmacologic pain relief being used to convenience healthcare practitioners (Mitchinson, 2002), Jennifer's experience aligns with Lyerly's (2006; 2012) argument that women use technology in conjunction with their bodies in order to make childbirth more manageable. Furthermore, several of my interviewees' experiences support Lyerly's suggestion that improved

communicative care by healthcare practitioners impacts how women perceive their experience with technology and childbirth more generally.

Technology was proposed as a "promise" for women and when the actuality of the experience differed from the expectation, it became an "expectancy violation" (Soliday, Sayyam & Tremblay, 2013, p. 415). Mitchinson (2002) argues that in the increasing medicalization of birth, technologies, such as the epidural, are used by healthcare practitioners to control birth, which serve to remove the unpredictability[15] of women's bodies. Soliday, Sayyam, and Tremblay explain the primary reason women seek the use of epidurals during labour as advised by healthcare practitioners is for effective pain relief. Diana and Megan illustrated the experience of having "deviant" bodies when the epidurals failed to provide any pain relief. Soliday, Sayyam, and Tremblay note that ineffective epidurals can "cause some women distress, including a sense of personal failure or desperation" (p. 414), thereby affecting women's overall satisfaction with their birth experiences and the way they felt agency with their choices to seek assistance. Diana and Megan explained that they attempted to labour without the assistance of pharmacologic pain management, however they did not anticipate the extreme pain and therefore they chose to have an epidural in order to relieve the discomfort. Diana explained that she decided to ask for an epidural, however, the epidural

> didn't work. So she [the healthcare practitioner] shoved that thing in my back like 3 different times and that was horrible. […] Anyways, it didn't even work. It froze my lower back, like right here. Like nowhere else. Like it was ridiculous, but so then I got morphine. That didn't really do anything—it took the edge off, but I still felt like *everything*.

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[15] Mitchinson (1992; 2002) notes the ways in which technology has been perceived, by health professionals to control women's deviant bodies.

Diana expressed her disapproval of the recommended technology because she did not anticipate that the epidural would fail to relieve her pains. Similarly, Megan explained, "I tried [the epidural]…[i]t took 2 hours, 2 different people, 8 different pokes and 2 back ultrasounds and it *didn't* work. And a shot of morphine. And it didn't work. It was *horrible*." In her description, Megan asserted the traumatizing effects of her unanticipated use of technology. Women felt betrayal from technology since the pain relief measure did not work the way it was supposed to. For Diana and Megan, technology was interpreted as a promise to relieve the pain, however, both women experienced recommended technology as a failure to deliver the promised pain relief. Thus, similar to the findings of Abel and Browner (1998), embodied knowledge was "the basis on which some [women] rejected biomedical advice that proved not to bring about promised changes" (p. 319).

Despite having epidurals, Diana and Megan perceived that they did not use any drugs during childbirth and praised their success in having no medical pain relief measures during labour and delivery. Lyerly (2012) would attribute Diana and Megan's meaning making process of birth to the notion of considering "normal" birth as birth with a range of assistance (some women require more or less assistance than others, and therefore "normal" birth exists on a spectrum of intervention). Rather than enforcing the binary between "natural" and "medical" births, women assert the range of experiences with technology (Lyerly; Moore, 2011). Whereas Diana's and Megan's encounter with medical technology brought unexpected results, they appropriated their experience of childbirth as "natural." For instance, Diana stated "I pretty much had a natural labour, except for the morphine because nothing else worked" and Megan stated, "[the doctor] made me push out the last 2 centimeters and that was it—I had no drugs [laughs] cause they didn't work." Diana further commented on how she felt about the drugs not working

by stating, "I'm kind of proud to say that I've kind of done it without. I mean, I had morphine. But, I don't know, it's kind of almost liberating." Diana therefore felt liberated because she perceived she did not have to rely on the help of the pharmacologic pain relief administered by the healthcare practitioner in order to deliver her child. Megan commented on the use of epidurals noting "I just wanted to feel everything and know that I didn't have to rely on drugs and like everybody kept telling me: "you *have* to get drugs, you *have* to do it," thus implying that women are incapable of giving birth without pharmacologic pain relief and should therefore submit themselves to the technologies wielded by healthcare practitioners. Megan then stated "I wanted to prove to everybody that I didn't need drugs, like I could do it for him [the baby]," showing the desire to portray the selfless mother, which relates to previously discussed conceptions of fear of the potentially complications with childbirth (Lothian, 2009). Thus, Megan and Diana learn about their own strength, agency, and ability to birth by relying less on technological interventions.

The prevalent medical authority

The following analysis outlines three instances that exemplify the authority of the healthcare professionals over women. The first example refers to drugs that were used for medical purposes by healthcare practitioners. The analysis differs from the drugs used for pain management as the use of drugs for pain management is typically a choice made by women. In contrast, the medical recommendation of drugs is followed   to meet hospital procedures and standards; women have minimized roles in refusing the use of such drugs. In particular, this concerns the administration of oxytocin to deliver the placenta after the baby. The second example describes women being repositioned for birth. The third example highlights women's experiences with giving birth and the expectation for them

to ignore their bodies in order to meet the expectations and demands of their healthcare practitioners.

Following medical standards and procedures for drug use: Accommodating healthcare practitioners.

Healthcare practitioners have the power to impose authoritative knowledge to justify medical procedures and consequently women's preferences for "natural" birth were considered secondary to the directions of the healthcare practitioners. Taylor described her experience with the protocols used for active management of the third stage of labour. According to the SOGC (2009) protocol, the purpose of active management of labour and the administration of oxytocin is to prevent postpartum hemorrhaging.[16] The SOGC recommends that active management "should be offered and recommended to all women" (p. 980). Taylor noted that "she did not want the oxytocin" because she wanted to avoid putting anything "unnatural" in her body, thereby revealing her perception of the manmade drug as "unnatural." As an "unnatural" substance, Taylor perceived the technology as unsafe and unnecessary and therefore wanted to trust that her body would be able to function normally without the use of the drug. Interestingly, Taylor's opposing viewpoint showed the tension between two systems of knowledge: the healthcare practitioners on the one hand who view the administration of the oxytocin as beneficial, and women who were fearful of the drug on the other hand. When Taylor objected to the administration of oxytocin, the doctor asserted "it's just better [to use the oxytocin] because then it's [the delivery of the placenta] immediate." According to the SOGC,

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[16] Postpartum hemorrhage is defined "as excessive bleeding that occurs in the first 24 hours of delivery" (SOGC, 2009, p. 981).

"postpartum hemorrhage is the leading cause of maternal death worldwide […]. The majority of these deaths occur within 4 hours of delivery, which indicates that they are a consequence of third stage of labour" (p. 981). Nonetheless, while Taylor showed the initiative to challenge standard hospital procedure, she was denied a detailed explanation of why the healthcare practitioner understood it to be necessary. The failure to provide Taylor with a detailed answer revealed the hierarchy that affords the healthcare practitioner power to assert expertise and not to be accountable to Taylor as the "patient."

Medicalization of childbirth is critiqued for managing birth as an efficient and timely event (Cahill, 2001; Duden, 1993; Leavitt 1999a; Martin, 1987; Mitchinson, 2002). In her interview, Taylor reflected on her experience of birth as managed, controlled, and efficient. Upon reflection, Taylor further questioned the advice of the doctor when she noted that she's not sure if it was "convenience for them or not, so they didn't have to stick around," thus implying that that technology was used in order to make her birth process efficient for healthcare practitioners, who otherwise would have to wait for women to labour and deliver on their own time. Therefore, Taylor's experience aligns with Martin's analysis where women's needs were understood as secondary to those of the healthcare practitioner's, who used technology in order to extract the baby at an efficient rate. Taylor's narrative reveals a power struggle between women giving birth and healthcare practitioners. Ultimately Taylor complied with her physician's advice and attributed this compliance as "trust," showing the ways that healthcare practitioners might indirectly utilize this notion of safety (for the baby and mother) in order to convince women to accept the hospital standards. In this sense, Taylor uses "trust" to rationalize her compliance.

Ignoring their bodies: Corporeal neglect.

As historical literature shows, healthcare practitioners employed technology in order to make birth a more efficient event (Cahill 2001; Duden, 1993; Leavitt 1999a; Martin, 1987; Mitchinson 2002). In turn, women accepted the use of various technologies and methods of pain relief in order to aid their labour and successfully deliver their baby. Healthcare practitioners carefully monitored women's progression of labour, and in some cases women were induced in order to accelerate the labour progress. Research shows however that despite the continuous monitoring of women and administration of various drugs, when women were ready to deliver their baby, research participants described being positioned for the doctor and being told to "wait" for the doctor.

Women's choices for body positioning during birth were also contested. In the late twentieth century, obstetricians such as Dr. Michel Odent argued against the lithotomy position of birth (Warsh, 2010). Eventually medical literature in the 1960s suggested alternative positions for giving birth that would be more comfortable for women (Mitchinson, 2002). As per Lothian's (2009) advice, women should not give birth in the lithotomy position because "[u]pright positions—including squatting, sitting, or lying on the side—make it easier for the baby to descend and move through the birth canal" (p. 51). Similarly, Kopas (2014) found that there were fewer assisted births with women who did not use the lithotomy position, therefore Kopas recommended that women should avoid this position. One of my research participants, Samantha, stated "as soon as the doctor walked in and they got me onto my back, cause I was on my side, they got me all positioned." Samantha's experiences of being "positioned" to deliver was uniform among all of the interviewed women. All were placed in the lithotomy position when they needed to push. The lithotomy position accommodates the hospital

environment, where the beds are meant to "pull-apart"[17] so that the healthcare practitioner can deliver the baby. This local evidence shows that women are expected to accommodate the hospital and healthcare practitioners' preferences.

Several women I interviewed needed to ignore their discomfort when giving birth in order to abide by the preferences of the healthcare practitioner when describing the moments of pushing to deliver their baby. Healthcare practitioners often promoted directed pushing; Chalk (2004) notes, "[d]uring the second stage of labour, pushing can either follow the mother's spontaneous urge or be directed by the caregiver" (p. 626). Kopas (2014) argued that directed pushing is an intervention because women rely on the advice of the healthcare practitioner, rather than their bodies. Lothian (2009) argued spontaneous pushing allows women to respond intuitively to their bodies and is therefore safer for both the mother and the baby. However, when women engage with spontaneous labour, they are seen to deviate from the timelines of the healthcare practitioners.

As a result of the expectation of women to suppress their bodily urges to push, the women that I interviewed expressed their dissatisfaction with having to wait for their doctor to "catch" their baby. Jessica, Samantha, and Betty were told to "stop pushing" in order to wait for their doctor. Samantha stated "I tried not to [push] because they [healthcare practitioners] kept telling me don't do it, don't do it." Samantha attempted to comply with the nurse's orders and explained during that moment, "I'm like, I'm not! I can't help it!" Jessica affirmed, the nurses "wait until the baby's head is almost out before they call the doctor and they slowed me down because she was coming faster than the

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[17] Samantha explained that the maternity beds could be split in half so that she would not have to move when they needed to deliver their baby. Once the bottom half of the bed was split off, the doctor had better access to deliver the baby.

doctor could get there. So uh, I had to slow down and not push as hard until the doctor got there." Whereas technologies may assist women to reach the second stage of labour, there are no technologies to slow down labour, therefore women themselves are told to "stop pushing" in order to accommodate the timeline of the doctor. By ignoring women's embodied knowledge women are objectified and hence lose agency as active participants with their birth (Jordan, 1993). Women's role with their birth is minimized by the power of the medical authority and therefore women are delivered (Jordan, 1993; Rothman, 1982).

Participants were uncomfortable challenging the authoritative advice of the healthcare practitioner. Women, regardless if they feel uncomfortable with their recommended treatment, continue to obey the instructions that they are given. When I asked Samantha how she felt to be told not to push, she replied:

> I really wanted to, but I knew that if I did, maybe something bad would happen. Because you hear all these horror stories sometimes. And it's just like, oh I can't do that. Gotta just focus and try not to do this. And I just kept repeating to them: "I have to push! It feels like I have to push, I'm trying not to, but I have to!"

She explained that she really wanted to push, but at the same time she was afraid of potential consequences if she disobeyed her nurse's advice. Women's choices were further complicated during childbirth because they were also being held accountable for the well-being of the child (Holvey, 2014). For example, in this excerpt, Samantha talked about hearing horror stories, where something might happen to the baby. In order to avoid facing the potential conflict or "horror story," she found it necessary to obey the healthcare professionals. Thus, as similarly outlined by Hall, Tomkinson, and Klein (2012), women assume that their healthcare practitioners are attending to their fears and concerns, which, in this case, was related to the safety and well-being of the baby. Thus,

women's choices are limited if they try to conform to what the healthcare practitioner constitutes as a "normal" procedure. For example, Betty, who is also a nurse, stated, "well, I didn't have a choice because the nurse couldn't bring out the baby, it has to be the doctor that has to bring out the baby […]. And at the same time, I knew that it was because my labour was so fast. Because, being in the medical field, you know as a doctor what to expect." Even Betty, a nurse, also feels that she has no choice. Thus, participants tended to over rely on the advice of the healthcare practitioner who viewed birth as a being a staged and controlled process (Morrow, 2008; Mitchinson, 2002). Moore (2011) attributed women's tendency to comply with healthcare practitioners who have authoritative medical knowledge.

At other times, women asserted their agency and could resist the control imposed on them by healthcare practitioners (Moore, 2011). For example, whereas Samantha and Betty obeyed the healthcare practitioners and undermined their own bodily process during birth, Alexandra ignored her healthcare practitioners' advice to push. Alexandra contested the advice of the maternity care nurse when she was pushing, and stated, "she [the healthcare practitioner] was counting, she was like okay, I'm gonna count to 6 and you're gonna push for 6 seconds." Even though she was being told how and when to push, Alexandra stated, "I'd start pushing and she'd be like, 1 and I'd already be at like 5 or 6 in my head and I'm just like, stop counting! She was so annoying to me, like but she was really like a go-getter and okay lets get this baby out, let's do it!" Alexandra contested the advice of her healthcare practitioners by choosing to push at her own pace. When I asked Alexandra to expand on the notion of needing to push when she felt she needed to, she emphasized "just like I was pushing, when I felt like I could. You know and then they're like no you need to do more, longer. And I'm just like I'm done." Alexandra showed

resistance to the healthcare practitioners and their directions. Lothian (2009) discusses the detriments of "directed pushing," noting that it is more stressful for the baby and the mother. While Alexandra saw it as a "stupid reason" to get frustrated with the workers, she legitimized her own knowledge based on what she thought was best for herself at that moment—and asserted that she was pushing at her own rate.

Women establish multiple forms of authoritative knowledge during their experience of childbirth (Moore, 2011). Citing Cheyney, Moore discusses women's multiple forms of legitimate knowledge, in their "challenge [with] the (over)reliance on technology and hypervaluation of scientific ways of knowing that they believe characterize more medical approaches to childbirth" (Cheyney, 2008, as cited by Moore). As previously noted, when Alexandra "pushed" at her own rate, she made a definitive choice, however, she also held a positive opinion of her healthcare practitioners. For example, even though she was irritated with the nurse who was counting, Alexandra described her as a "go-getter" with the intention of "getting this baby out, let's do it!" Her narrative acknowledged that both the healthcare practitioners and mother have an active role with the delivery of the baby and while she may not like something, like the nurse's counting, she still respected the healthcare practitioner's efforts. Therefore, Alexandra established and legitimized two knowledge sets: her own embodied knowledge, and the medical knowledge of her healthcare practitioner.

Conclusion

In Chapter Two, I discussed the historical shift with childbirth as a social event to a medicalized event. Medicalization is often thought of as authoritative and undermining, particularly with regards to women's reproductive health (Kline, 2010; Morgan, 2002; Nichter, 1998; Ruzek, 2012). The dominant medical system enforces increased medical

surveillance and pathologization of women's bodies. Biomedical systems are therefore often framed as sites for feminists to resist. For instance, the ideal way to resist medical birth would be to birth at home. However, Kaufert (1998) notes that the "vision of health as the natural state of woman is both beautiful and powerful; unfortunately, it is as much imagery as actuality" (p. 287). Thus, women are engaged with the notion of pragmatism, with regards to their health, and therefore do not simply make decisions of compliance and resistance to medicalization (Abel & Browner, 1998; Kaufert; Lock). Women are therefore engaged with various moments of appropriation, resistance and compliance throughout their labour and childbirth.

The data show the tension between experiential knowledge and biomedical knowledge. Women seek the embodied knowledge of other women in order to gain insight on childbirth. Since all of the women whom I interviewed were first-time mothers, despite preparing for birth in various ways, they felt unprepared and unsure of what to expect with their own births. In order to prepare for birth, women spoke with other women to gain information, which shaped their understanding of childbirth. Along with personal information, women used biomedical information to provide an interpretive framework to understanding birth in contemporary Canada (Abel & Browner, 1998). Depending on the situation, women identified contradictions between the dominant medical view and practice with their lived experience and chose to follow or challenge biomedical knowledge (Rogers, 2006). For example, women lose their trust with biomedicine when the promised results are not delivered, which is evident with Diana and Megan's experiences with the epidural, which had no effect in relieving pain. In this case, Diana and Megan's embodied knowledge of having no relief from the drugs is the basis to reject medical authority.

Both healthcare practitioners and women are active players in the appropriation of biomedical knowledge and techniques. In the local health care system, biomedicine is the dominant mode of care. The women that I interviewed for this research gave birth within the local hospital and their experiences reflect the appropriation of biomedicine. Hadolt, Hörbst, and Müller-Rockstroh (2012) describe appropriations as "the ways in which biomedical techniques are (made) fit to specific local worlds, and consequently are changed and simultaneously bring about sociotechnical changes" (p. 186). The agency of both the healthcare provider and pregnant woman are recognized as impacting and shaping the cultural appropriation of healthcare techniques. For example, electronic fetal monitors are designed to provide the healthcare practitioner information on the baby, however if the screen is made visible to the labouring woman, she is able to gain insight on her body and the well-being of her baby. Conversely, when women's healthcare practitioners failed to acknowledge women as "knowers" and only referred to the technology, women expressed feeling objectified. Thus, the role of the user and recipient of the application of technology shape the purpose and appropriation of technology and biomedical techniques (Hadolt, Hörbst, & Müller-Rockstroh, 2015).

There are various instances when women appropriate biomedical technologies during labour. In particular, women appropriate technologies as tools for reassurance and to self-monitor their bodies. For example, women referred to the electronic fetal monitors to observe the well-being of their baby and to show that their bodies were indeed functioning properly with providing for their baby's needs. Referring to the monitor thus helped women cope with feelings of fear and uncertainty with their capabilities to deliver their baby. Women appropriated the use of pharmacologic pain relief in order to cope with the stress and pain faced during labour and childbirth. By self-assessing their pain

and having an active role with deciding to use pharmacologic pain relief, women assert authority over their bodies.

Despite women's appropriation of biomedicine for their own purposes, women rely on the authoritative healthcare practitioner in order to ensure a "safe" birth. All of my research participants expressed that their main priority was a safe delivery for themselves and their baby; women perceived a "safe" delivery as a "medical" delivery. Thus, women planned to deliver within a hospital because medically trained staff are available to provide the "best" biomedical care. The expansion of medical authority is evident when women are told to suppress their bodily urges to "push" in order to wait for the arrival of the doctor. Thus, while women do contest biomedical power and appropriate medical tools and practices, women are subject to medical authority.

Chapter Six: Transforming Birth from a Medical Event to a Social Event

Introduction

In Chapter Two, I argued that the historical shift from birth as a "social event" to a "medical event" occurred between the nineteenth and twenty-first century (Biggs, 2004; Cahill, 2001; Davis-Floyd, 1987; Leavitt 1999b; Martin, 1987; Mitchinson, 1991, 2002; Warsh, 2010; Young, 2010). By the twentieth century, Mitchinson highlights the ways in which through various influences, childbirth became increasingly medicalized and therefore understood as a medical rather than a social event. The shift from home birth to hospital birth was predominantly attributed to the increasing medicalization of childbirth, normalization of hospital care, and the authoritative medical professional. During the women's health movement, activists contested the authoritative medical professionals and asserted women's embodied knowledge as valuable and legitimate sources for information (Kline, 2010; Ruzek, 2012; Warsh, 2010).

In contemporary Canada, the majority of women give birth in a hospital setting with the assistance of healthcare practitioners (de Jong, Hill, & Sumemrfeldt, 2014; Moore, 2011). Despite the use of medical space for birth, healthcare practitioners are encouraged to limit their use of technologies and interventions (Romano & Lothian, 2008). In turn, healthcare practitioners are expected to provide medical and nonmedical care and support to help women achieve satisfactory and empowering experiences (Leap, 2009; Lothian & Romano; Simkin, 2002). As noted in Chapter Four, by creating and maintaining a social cohort throughout pregnancy and childbirth, women prepare mentally and emotionally for birth, which assists women's transition into motherhood (Martin, Bulmer, and Pettker, 2013; Nolan, Mason, Snow, Messenger, Catling, & Upton,

2012). My interviews reveal the relationships between women and their labour support members and the ways that they reinvented or maintained aspects of "social childbirth," which help women create satisfactory birthing experiences.

The chapter explores women's observation of the supportive care they received from family, friends, and healthcare practitioners during childbirth and further considers how women perceived the care from various people, combined with the use of technology, as valuable or detrimental. The role of family and friends continued throughout labour and birth, when most women had one to two companions. With the presence of this kind of social support, the research participants claimed that they were better able to endure the medicalized process and physical pain associated with labour and childbirth. Therefore, when addressing the uses of technology and its effects on women's childbirth experiences, the social environment is also discussed. These three themes are important because the responses of the women interviewed exemplify the ways in which women interacted with their healthcare practitioners in a southern Alberta hospital. Their responses also show how these interactions, along with the use of technology, mediate women's experiences of this life-changing event.

Support from family members and doulas

As Chapter Two showed, throughout the twentieth and twenty-first century, hospital regulations monitored the space that women occupied during labour and birth (Davis-Floyd, 1987; Moore, 2011; Morrow, 2008; Warsh, 2010). The women whom I interviewed describe the social environment they created and addressed the importance of the support that they received by their family, doula, and healthcare practitioners in the hospital. All of the women whom I interviewed stated that the hospital permitted two support members of their choice; all women were accompanied by at least one support

member (either a relative or close friend). Reflecting on this trend, of women's desire to invite family, my participants implied that because of the positive support that these women received, they perceived it as a key factor with minimizing the interventions that would be used during labour and childbirth.

The literature of childbirth shows, as a social event, women could collectively share experiences and provide emotional, physical and mental support during birth. Contemporary scholars, such as Price, Noseworthy, and Thornton (2007), affirm that the presence of supportive people, particularly a female relative, can improve women's birth experiences. Continuous labour support helped Diana, Alexandra, Jennifer, and Chelsea cope with labour and birth and to make decisions regarding the use of technology. Both Alexandra and Diana noted that having someone who had experienced childbirth present during their labour was valuable because they were able to provide relatable advice and encouragement. For example, Alexandra stated "it helped me to have someone know what to expect. Like [my sister in-law] just like, she knew what to do in the sense of like you're doing a great job." Similarly, Diana explained "I don't know if I could have done it without my mom. If I wasn't going to have her, I was going to have a doula. Just because [childbirth is] such a big experience right and I didn't know what I was going in to." Most of the women I interviewed expressed feeling "fearful" of childbirth. In order to combat the fear of a new experience within a foreign environment, having other women who experienced childbirth present was also a way for these women to ensure that they would be able to handle and survive childbirth.

My research participants also emphasized that their male partners had an active role with supporting women during labour and birth. As Chapter Two discussed, until recently childbirth was primarily an event embraced by women, which often excluded

men (Mitchinson, 1991). Taylor, Chelsea, and Alexandra shared similar insights about the value of male support, confirming the research findings of Price, Noseworthy, and Thornton (2007), where women saw the involvement of their male partners with their birth experience as essential. Hence, contemporary women have a different experience of the "social" than women in the past. Chelsea's description of the support from her partner shows the social aspect of birth, which contrasts to the typical notion of childbirth as an exclusive event to women. For example, Chelsea explained, "I only had [my husband] and that was fine. Yeah, and he was super supportive. I don't know what I would do without him." Chelsea also explained the active role her husband had with helping her during her labour, "I'd forget what to do. [laughs] So it was so good to have him there and he'd be like okay, just breathe—follow me, breathe in breathe out. Oh, man, it was so good to have him there." Women whom I interviewed described the positive impact of their support members during birth. With the involvement of the others, the interviewed women implied that childbirth was a socially inclusive event, where they received advice and support from various people in their immediate or familial community.

Some women sought additional support, such as a doula, to provide more information during birth. As noted by Price, Noseworthy, and Thornton (2007), with the assistance of a doula, women may have a "greater sense of control, better self-perception, less analgesia and anesthesia use, less operative birth, shorter [labours], shorter birth times, higher Apgar scores, and a more satisfying birth experience" (p. 185). Jennifer sought the assistance from her mother and a doula. When I asked her about the social support that was given by these two women she stated, "[T]he doula was especially helpful because she was really knowledgeable and kind of knew how to you know, had some different strategies with how to cope with the contractions and stuff." Jennifer

explained the value of hiring a doula to provide insights on the medical procedures that she might encounter whereas, "emotionally, my mom was perfect. Especially in the labour room because she made me feel *safe*." Jennifer communicated a feeling that was common amongst the others I interviewed. In a foreign environment, the support members who helped her feel safe enabled her to create a comfortable social setting. With her support members, Jennifer was able to achieve a greater sense of control during childbirth, which affects women's roles with decision-making, attachment, and personal security (Namey & Lyerly, 2010). Thus, Jennifer stressed the importance of physical, emotional, and mental support along with gaining access[18] to medical knowledge in order to understand on the process of childbirth.

Support from healthcare practitioners

The role of the healthcare practitioner was multi-faceted; women expected healthcare practitioners to provide medical, physical and emotional care and support to them during labour. This expectation exemplified the roles of the healthcare practitioner as a medical expert and a support member for women. In contemporary Canada, as noted by Price, Noseworthy, and Thornton, (2007), women identify the role of their healthcare practitioner as integral to a positive birth experience. Women's long-term psychological well-being and attitudes towards parenting can be affected by their birth experience (Overgaard, Fenger-Gron, & Sandall, 2012) and therefore, the SOGC (2007) recommends continuous labour support. The SOGC also notes that having continuous labour support may lead to less interventionist approaches with childbirth. Overall, most of my research

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[18] While Jennifer's doula provided support during her labour and childbirth, she did not provide medical assistance.

participants expressed satisfaction with their healthcare practitioners. In her interview, Taylor stated, as a "mature" woman she did not "like to be vulnerable," but because of her perceived lack of knowledge, Taylor further explained that when people enter the hospital,

> you're relying on the doctors or the nurses, which is not something that appeals to me […] so it was very humbling because you're really just navigating yourself through the unknown. And they were very supportive. So it was very humbling.

Taylor's rich narrative showed the complexities of the power dynamics women encounter during labour and childbirth. Taylor acknowledged her discomfort with relying on her healthcare practitioners, but argued that through her healthcare practitioner's care and support, she obtained some degree of authority and power.

Healthcare practitioners on their part worked with women's other support members, demonstrating teamwork in order to meet the needs of women during labour and childbirth (Price, Noseworthy, and Thornton, 2007). Chelsea stated:

> the one nurse that was helping to coach me was wonderful. Just like um, she explained to me what was going on. So like, she'd check me and then explain where I was at and what I could do and she had suggestions—like you could try this or try that. Um, she reminded me how to breathe and she helped [my husband] as well.

In Chelsea's eyes, the healthcare practitioner formed a professional relationship and advised her partner in order to help her during labour. Chelsea noted that having her partner aid her during labour made her feel more comfortable. Thus, the support, knowledge and advice provided by her support member and her healthcare practitioner exemplify the ways that elements of "social childbirth" were reinvented and maintained within hospital spaces. Healthcare practitioners can thus facilitate women's empowering birth experiences by shifting the control towards women themselves (Leap, 2009). In particular, Chelsea emphasized their childbirth experience as an inclusive event with their

healthcare practitioners, where there was a dialogue between the two groups to facilitate the transitions throughout   labour and birth.

As the section reinforces, women created a space within the hospital where they upheld aspects of social childbirth. Most notably Taylor explained that she created a space where she felt comfortable and supported by the combination of family and healthcare practitioners. For instance, when I asked Taylor how she felt about relying on the doctors and nurses she explained, "it was fine. They were very nice at the end after I delivered, there was one nurse who stayed with us. She was fantastic, she wasn't—she just kind of shared her experiences and her advice." Taylor revealed the ways in which healthcare practitioners themselves upheld childbirth as a social event within the hospital space by sharing their knowledge and experiences. When the healthcare practitioners shared their knowledge, they signified birth as a social event, where knowledge was not exclusive to the healthcare practitioner. Therefore, healthcare practitioners created a bridge between scientific and experiential knowledge (Abel & Browner, 1998). Thus, birth brought women from the community together as a way to share information about the body and to learn from each other. Taylor also recognized the value of "owning" and creating her own unique experience, by stating, "it was nice to have my somebody guiding me, but giving me the ownership that empowered me to make those decisions." Thus, Taylor asserted that while her healthcare practitioners facilitated her birth, she maintained "ownership" of her experience.

In contrast, Chelsea experience illustrated how the actions of the healthcare practitioner can deviate from the SOGC (2008) recommendations for healthcare practitioners to provide continuous labour support, which in turn can facilitate an empowering birth experience (Leap, 2009). Chelsea outlined her frustrations when she

perceived she was being treated as "unequal" and therefore "undervalued." Reflecting on her experience with one of her healthcare practitioners, she stated "[t]he other nurse that was there—the one that was watching the monitors […] was really irritating." When I inquired why she perceived the healthcare practitioner as "irritating," she explained "[i]t was like she talked down to me like I was a little kid and she you know […] Like I had no intelligence, even though—like yes, I'm in a ton of pain, but I still have a brain. You know, like you can still use big-people words. And she was like baby-talking to me [irritated tone]." Not only did Chelsea feel talked down to, she also expressed that she "felt really undervalued I guess. I don't know, and disrespected." Therefore, Chelsea expected to be recognized as an active agent with her birth instead of being passive and ignored. When comparing her varying experience with two nurses, Chelsea explained that she appreciated that the other nurse "treated me like an adult and interacted with me. Like I was equal." The frustration of this power struggle with the healthcare practitioner was evident in Chelsea's narrative, where she stated a preference for the one nurse because she treated her "like [she] was equal." By comparing the two nurses, Chelsea affirms the notion that instead of the technology as an inherently negative feature of birth, the care that a woman receives from the healthcare practitioner can impact her feelings of integrity (Hall, Tomkinson, & Klein 2012; Lyerly, 2006). Interestingly, Chelsea's discussion of the role of her doctor was minimal. As described by Chelsea, the doctor's role was to help deliver the baby, whereas the nurses were present throughout labour and childbirth and were therefore significant in reinventing the hospital space as a social environment. Thus, Chelsea's explanation showed how she received a humane approach with the care that she received with the nurse who provided inclusive and communicative care.

Conclusion

Having adequate social support is beneficial for women to maintain control during their childbirth experiences (Campero et al., 1998) Maintaining some degree of control with labour support can help women achieve satisfactory childbirth experiences (Campero et al.; Meyer, 2013; Moore, 2011; Namey & Lyerly, 2010). When women's healthcare practitioners include women in the decision-making process and provide accessible access to information, women establish feelings of mutual respect, integrity, increased self-esteem and personal security (Campero et al.; Hall, Tomkinson, & Klein, 2012; Meyer; Namey & Lyerly). Each of these features underlies the social aspects of childbirth.

Women establish a cohort of social support members when they are pregnant to prepare for childbirth and transition into motherhood (Nolan, Mason, Snow, Messenger, Catling, & Upton, 2012; Price, Noseworthy, & Thornton, 2007). Connecting pregnancy, labour, and birth to women's families and communities facilitate women's feelings of empowerment and decreases feelings of alienation (Kaufert & O'Neil, 1993; Leap, 2009). Women create and maintain childbirth as a "social event" with support from family, friends, and healthcare practitioners. All of my research participants had support members to aid them throughout their labour and birth. Describing their family, friends, and healthcare practitioners as their support members counters Mitchinson (2002) who discussed birth in the twentieth century as an isolated event where women had little support. Contemporary participants in my study assert that not only do they have support, but also that these support members are integral in shaping their experience as ideal.

By attending to the individual needs of women, healthcare practitioners enforce childbirth as a personal and social event. The women that I interviewed described their

healthcare practitioners as providing professional and social guidance and support during labour and birth; women praised their healthcare practitioners for providing genuine concern and support over their well-being. By doing so, women expressed their satisfaction and gratitude with the care and advice they received and in this process establish a fictive kinship relationship. As noted by Karner (1998), "those who *provide care like family* and *do what family does* are given the label of kin with its attendant affection, rights, and obligations" (p.70). Not only did women note the value of the care that their healthcare practitioners provided, but women also highlighted the importance of sharing relatable information. For example, Taylor's nurse stayed with her and shared her own personal experiences. In the same way that women seek information about other women's birthing experiences to prepare for birth, women used the information from their healthcare practitioners to transition into motherhood (Nolan, Mason, Snow, Messenger, Catling, & Upton, 2012).

When women's healthcare practitioners failed to establish social relationships with the women that acknowledged their subjective knowledge and bodily experiences, women felt objectified. Chelsea described feeling "unequal" and "undervalued" because her healthcare practitioner repeatedly referred to the fetal monitor instead of speaking directly to Chelsea. The personal interactions between women and their healthcare practitioners are crucial with shaping a more equitable relationship that provides women with a greater sense of control (Campero, Garcia, Diaz, Ortiz, Reynoso, & Langer; Meyer, 2013; Moore, 2011; Namey & Lyerly, 2010).

To conclude, even though medical authority exists within hospitals, women expressed their efforts to establish the environment as a social space. By doing so, women achieved a greater sense of control and support with their labour and birth (Campero,

Garcia, Diaz, Ortiz, Reynoso, & Langer, 1998; Meyer, 2013; Moore, 2011; Namey & Lyerly, 2010). Many of the women that I interviewed implied that because of the support from their friends and family combined with that of the healthcare practitioner's, they felt more capable of successfully delivering vaginally. Thus, the women in this study uphold childbirth as a socially inclusive event by blending their interactions with familial support members and healthcare practitioners.

Chapter 7: Conclusion

The historical overview of childbirth practices from nineteenth century to twenty-first century shows a notable shift in childbirth from a social event, which included the mother's family, friends, and others from the community, to an increasingly medicalized event, where medical professionals dictated the care practices and the social environment (Biggs, 2004; Cahill, 2001; Davis-Floyd, 1987; Leavitt 1999b; Martin, 1987; Mitchinson, 1991, 2002; Warsh, 2010; Young, 2010). Following the women's health movement, childbirth practices shifted to focus on "women-centred" care, which accounted for the physical, mental, and emotional well-being of the mother (Morrow, 2008). As a result, the current guidelines for healthcare practitioners recommends continuous labour support and communication with the mother (SOGC, 2008). Exploring contemporary women's experiences within the historical context is relative to understanding the medical normatives in the current social and cultural conditions.

In summary, this research shows the perspectives of a small sample of women in Lethbridge, Alberta. The three findings established from the research data reveal the range of experiences and perspectives that women have regarding childbirth. Women create meanings from their experiences and establish authentic and original selves. In particular, the women whom I interviewed explained different moments of negotiating their power, agency, and resistance to certain medical standards and procedures. For example, women experienced and appropriated biomedicine at different points during hospitalization. In doing so, the women whom I interviewed utilized medical tools and knowledge for their own benefit. Thus, the three findings explore women's narratives reflective of their involvement with, and their experiences of, cultural structures.

In the research interviews, women provided insight on the complexity of the relationships between women and their healthcare practitioners, particularly when their healthcare practitioners adopted the role of fictive kin. Participants illuminated the ways in which they reinvented birth as a "social event" which included family, friends and healthcare practitioners. Women describe labour support as a crucial aspect in feeling confident and empowered during their birth experiences (Leap, 2009; Lothian & Romano; Simkin, 2002). Thus, participant narratives contested the previous conception of the healthcare practitioner as solely an authoritative presence. Women, therefore, regard birth as an empowering and social event. The three findings are important because the responses of the women interviewed exemplify the ways in which women interacted with their healthcare practitioners in a southern Alberta hospital. Their responses also show how these interactions, along with the use of technology, mediate women's experiences of this life-changing event.

Limitations of the study

By reflecting on my research process, I would like to acknowledge some key issues that arose. After speaking with my research participants and reviewing my own observations recorded throughout my research, I realized speaking with women about childbirth was more difficult because I had not experienced childbirth. This realization arose during my interviews when some of my research participants noted that they did not want to tell me the "gross" parts about birth because they feared doing so would scare me. Not only did these women express a reluctance to speak about birthing as a "messy" event, these moments revealed that I was not fully part of the "community" that women seemed to establish with each other after experiencing birth. In the "community," women could compare their birthing experiences with each other in order to learn more about the

different types of birth that women could experience. Thus, in each interview I explained my interest with my research topic and assured women that I did not consider the "messy" aspects of birth as "negative" descriptions.

Creating narrow criteria for recruiting research participants initially hindered my goal of a diverse sample. Nonetheless, my interviews provided rich data for analysis, as noted in Chapter Three, to gain insight on an individual's lived experience within a local context (Hesse-Biber & Leavy, 2011). The research criteria that I created for participation in my research included: first-time mothers, who experienced a vaginal birth without any major complications, and gave birth within eight months of the interview. I believed the research criteria would establish a uniform research sample of women who had experienced a recent birth. However, in retrospect, the narrow criteria hampered my abilities to recruit more women. Furthermore, fear that my research criteria were too narrow was reaffirmed when I spoke with my research participants and they commented that they knew several women who were interested in participating but did not meet the criteria, such as giving birth within the time period of eight months of the interview. Thus, my research in a homogenous city limited the diversity within my sample. Along with my narrow criteria, time constraints led to a smaller sample size. However, my research participants did provide rich information about their experiences in childbirth.

Concluding thoughts on my research and implications for future research

The research interviews inspired two areas that I would like to pursue: (1) how women experience their changing body image; (2) comparing women's birth experiences between larger and smaller cities. Women explained their struggles with physical changes of their bodies during pregnancy and feeling unequipped to handle the emotional and mental stress. Furthermore, women expressed anxiety with their bodies after pregnancy

and birth because of the physical changes incurred. Lastly, while researching and interviewing women for my research project, some of my family members were also pregnant. Upon hearing about my family members experiences, I realized a difference between their experiences in a larger city, such as Calgary, Alberta in comparison with the experiences of the women that I interviewed in Lethbridge, Alberta. Thus, in the future I would like to focus on comparing women's birth experiences between smaller cities and larger, more urban cities.

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Appendix A

Vaginal Birth Experiences: Contemporary First-Time Mothers' Perceptions of Technology During Childbirth

Interview Consent Form
Date

Dear Participant,

I invite you to take part in an interview for my master's thesis research project exploring first time mothers' experiences with technology during labour and childbirth.

This consent form, a copy of which I will leave for your records, describes the research objectives. If you have any questions about the research, I am happy to explain.

The purpose of this research is to hear from women on the topic of technology used during their personal experiences of labour and childbirth. Your insight will help service providers to improve future patient care.

If you agree to participate, with your permission, I will interview you and audio-record our interview. A mutual location for the interview will be determined by you to ensure that you will be comfortable. The interview will take one-hour and the process as a whole will not exceed two hours. A second one-hour interview may be needed. I will ask questions about your experience with labour and childbirth.

Please know that you are not required to answer any questions that make you feel uncomfortable and you may ask to end the interview at any time. You have the right to change your mind about participation at any time during any stages of the interview without consequence. If you do decide to end the interview, I will destroy any notes, recordings, and transcripts obtained during the interview. If you decide to complete the interview, after the thesis is completed I will provide participants with a copy of the interview transcripts after the thesis is published should you desire to have a copy.

I will assign a pseudonym to protect your privacy. Therefore, a pseudonym rather than your actual name will be used in the transcripts and any written aspect of the research that follows the interview. Thus, there are no specific risks with your participation in the research. If you feel uncomfortable about any aspect of this research project, please inform me to stop the interview and ask if you would like to continue at another time.

All materials from your interview, including this consent form, will be kept in a locked office at the University of Lethbridge, or in a password protected file on my personal laptop. The transcriptions will not contain your actual name or any other identifying information. During this process of the research the digitally recorded interviews, the transcripts and consent forms will be accessible only by myself and my supervisor. The

retention period for collected information will be 5 years, after which, the data will be destroyed.

If you have any questions about this research you may contact me, Arielle Perrotta, at any time via email (a.perrotta@uleth.ca) or phone (403-975-5769).

You can also contact my supervisor directly if you have any questions regarding my research or action by email or phone 403-380-1818. Questions regarding your rights as a participant in this research may also be addressed to the Office of Research Services, University of Lethbridge (Phone: 403-329-2747 or Email: research.services@uleth.ca).

You will receive a signed copy of this consent form for your own records

▪▪

I have read (or have been read) the above information regarding this research study on the experience of childbirth, and consent to participate in this study.

_____ (Printed Name)

_____ (Signature)

_____ (Signature of the researcher, Arielle Perrotta)

_____ (Date)

_____ (Place)

<div align="center">**Appendix B**</div>

Basic biography:

    1. Can you give me a short or basic biographical history of yourself referring to place of birth, in terms of citizenship, residence in Lethbridge, age, family, education, and work.

Anticipating labour or birth (prehistory):

    1. Can you describe your personal history of how you imagined the process of childbirth once you learned you were pregnant?
    2. How did you learn about the childbirth process?
    3. From whom did you learn about the childbirth process?
    4. Did you attend prenatal classes?
        a) If so, can you describe what you learned from prenatal?
        b) Did what you learned from the prenatal classes match the experience itself? How so? How not?

Social environment and relationship with health care provider

During both the labour or birth process separately:

    1. Who was with you at various times during labour and during the birthing process (medical practitioners, technicians, nurses, family, friends, other supporters?)

Actual experience of labour and childbirth:

    1. Can you describe in detail your experience of your labour including for instance, did things go the way you wanted to?
    2. Can you describe in detail your experience of childbirth?

Technology (i.e.: ultra sound & fetal monitoring, any other device that is wired and requires a technician):

    1. Was any form of technology (as suggested above) applied to you physically while you were in labour?
    2. Can you describe what kind of technology it was, how you felt, and if possible the experience from start to finish, including you own impression of how were treated?
    3. Was permission asked prior to the use of any technology?
          a) If so, who asked and how was this question framed?
    4. Were explanations or diagrams of the technology offered prior to application?
    5. Can you describe your experience of the care you received during labour and childbirth either from a nurse or doctor?
        a) Can you describe how the application technology made you feel?
        b) What were some of the positive experiences with the care when the technology was applied?
        c) Is there anything you would change, in regards to how you were cared for either in the labour of childbirth process? Please include your sense of how technology was used.

Is there anything you would like to add about you experience of prenatal classes; your experience of labour; about the birthing process and your relationship with medical providers and your stay in the hospital; or, about your postnatal care or experiences?